



Medicare Shared Savings Program

# SHARED SAVINGS AND LOSSES AND ASSIGNMENT METHODOLOGY

## Specifications

January 2022 Version #10  
Applicable to Performance Years Starting  
on January 1, 2022, and Subsequent Years

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## Revision History (from Version 9 to 10)

VERSION	DATE	REVISION/CHANGE DESCRIPTION	AFFECTED AREA
10	January 2022	Revised to add reference to rulemaking in 2021, and other descriptive information.	Section 1.1, Statutory and Regulatory Background
10	January 2022	Removed former Table 1 and renumbered remaining Tables.	Section 1.3, Agreement and Benchmark Periods
10	January 2022	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, 2022, and subsequent performance years, as established with the CY 2022 PFS Final Rule.	Appendix C, Table 8
10	January 2022	Revised to specify Assignment Window and Expenditure Period Dates for performance years within the agreement periods for July 1, 2019, January 1 2020, and January 1, 2022, ACOs.	Appendix B, Table 7

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# 1 INTRODUCTION

This document is not intended to supersede or replace regulatory requirements 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 & 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 each performance year of the agreement period, ACOs share in a percentage of the savings they generate if the expenditures of the ACO's assigned beneficiaries are below their benchmark (i.e., their unique targets) by an amount that meets or exceeds a minimum savings rate threshold, and if they meet the quality performance standard and otherwise maintain their eligibility to participate in the Shared Savings Program. 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 threshold.

This document is relevant to ACOs with agreement periods starting on or after July 1, 2019, except as noted otherwise. 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 provides additional tools and flexibility for ACOs that take on the highest level of risk and potential reward.

Previous versions of this document, relevant to ACOs with agreement periods beginning before July 1, 2019, are available at the [Program Statutes & Regulations webpage](#) of the Shared Savings Program website.

This document includes the assignment methodology applicable to all ACOs participating in the Shared Savings Program for the performance year starting on January 1, 2022, and in subsequent years.

## 1.1 STATUTORY AND REGULATORY BACKGROUND

Section 3022 of the Affordable Care Act<sup>1</sup> amended Title XVIII of the Social Security Act (the Act) (42 U.S.C. 1395 et seq.) by adding new section 1899 to the Act to establish the Shared Savings Program. The requirements for assignment under the program were amended by the 21<sup>st</sup>

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<sup>1</sup> 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.

Century Cures Act (December 2016, Pub. L. 114–255). The 21<sup>st</sup> 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 allowing ACOs in tracks under retrospective beneficiary assignment a choice of prospective assignment for the agreement period, permitting Medicare FFS beneficiaries to voluntarily identify an ACO professional as their primary care provider for purposes of assigning such beneficiaries to an ACO and requiring that such beneficiaries be notified of their ability to make and change such identification, and 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 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), 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:

- Calendar Year (CY) 2014 Physician Fee Schedule Final Rule, published December 10, 2013 (78 FR 74230).
- CY 2015 Physician Fee Schedule Final Rule, published November 13, 2014 (79 FR 67548).
- 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).
- Shared Savings Program Final Rule, published June 10, 2016 (81 FR 37950).
- CY 2017 Physician Fee Schedule Final Rule, published November 15, 2016 (81 FR 80170).
- CY 2018 Physician Fee Schedule Final Rule, published November 15, 2017 (82 FR 52976).
- Shared Savings Program, Interim Final Rule with comment period (IFC), published December 26, 2017 (82 FR 60912).
- CY 2019 Physician Fee Schedule Final Rule, published November 23, 2018 (83 FR 59452).
- Shared Savings Program Final Rule, published December 31, 2018 (83 FR 67816). The December 2018 Final Rule, referred to as “Pathways to Success,” redesigned the participation options available under the Shared Savings Program to encourage ACOs to transition to performance-based risk more quickly, and modified the program’s benchmarking methodology applicable to ACOs in agreement periods beginning on July 1, 2019, and in subsequent years, among other changes. The policies also included changes to address the additional tools and flexibilities for ACOs established by the Bipartisan

Budget Act of 2018, specifically in the areas of new beneficiary incentives, telehealth services, and choice of beneficiary assignment methodology, as well as refinements to the voluntary alignment process.

- CY 2020 Physician Fee Schedule Final Rule, published November 15, 2019 (84 FR 62568).
- The IFC that appeared in the April 6, 2020 Federal Register (85 FR 19230, 19267 and 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, 27573-27587) 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)<sup>2</sup> 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 PFS final rule, CMS finalized changes to Shared Savings Program policies which included, among others: (1) changes to the Shared Savings Program quality performance standard and quality reporting requirements for performance years beginning on January 1, 2021, to align with Meaningful Measures, reduce reporting burden and focus on patient outcomes; (2) revisions to the definition of primary care services, used in Shared Savings Program beneficiary assignment, applicable for the performance year starting on January 1, 2021,<sup>3</sup> and (3) codification of the Shared Savings Program's policy of adjusting an ACO's historical benchmark to reflect any regulatory changes to the beneficiary assignment methodology in the regulations governing the benchmarking methodology.<sup>4</sup> Further, in the CY 2021 PFS Final Rule, CMS 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 65524). Through the CY 2022 PFS final rule, CMS implemented revisions to the definition of primary care services, used in Shared Savings Program beneficiary assignment, applicable to the performance year starting on January 1, 2022, and subsequent performance years.<sup>5</sup>

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](#)" available at the [Program Guidance & Specifications webpage](#) of the Shared Savings Program website.

CMS developed the Track 1+ Model for testing by the Innovation Center under section 1115A of the Act. Information about the Track 1+ Model is available in the [New Accountable Care Organization Model Opportunity: Medicare ACO Track 1+ Model Fact Sheet](#) and the [Medicare ACO Track 1+ Model Participation Agreement](#). In certain proposed and final rules, CMS has explained the applicability of changes to Shared Savings Program policies to ACOs participating in the Track 1+ Model, either through revisions to existing Shared Savings Program regulations

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<sup>2</sup> Refer to 42 CFR § 400.200 for the definition of public health emergency (PHE).

<sup>3</sup> Refer to § 425.400(c)(1)(v).

<sup>4</sup> Refer to §§ 425.601(a)(9), 425.602(a)(8), and 425.603(c)(8).

<sup>5</sup> Refer to § 425.400(c)(1)(vi).



that apply to Track 1+ Model ACOs or through the addition of new provisions that would apply to Track 1+ ACOs in the same way that they apply to ACOs in Track 1. We also explained the circumstances under which certain changes in policies would become applicable through an amendment to the ACO's Track 1+ Model Participation Agreement.

## 1.2 OVERVIEW OF FINANCIAL TRACKS

For agreement periods beginning before July 1, 2019, eligible ACOs entered an agreement period for not less than 3 years<sup>6</sup> under one of three tracks: Track 1<sup>7</sup> (a one-sided shared savings only model), or Track 2<sup>8</sup> or Track 3<sup>9</sup> (two-sided shared savings and shared losses models). In 2018, eligible Track 1 ACOs could enter the Track 1+ Model. The Track 1+ Model is a time-limited Innovation Center model that is based on Track 1, but tests a payment design that incorporates more limited downside risk, as compared to Track 2 and Track 3.

As part of redesigning the program's participation options with the December 2018 Final Rule, CMS discontinued Track 1, Track 2, the deferred renewal option (under § 425.200(e)), and future application cycles for the Track 1+ Model for new agreement period start dates. CMS renamed Track 3 the "ENHANCED track".

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<sup>10</sup> under one of two tracks of the Shared Savings Program—the BASIC track<sup>11</sup> and the ENHANCED track.<sup>12</sup> For more information on the characteristics of these two tracks, refer to [Appendix A, Table 6](#).

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.<sup>13</sup> The glide path includes five levels (Levels A through E): Levels A and B are one-sided models (shared savings only);<sup>14</sup> and Levels C, D, and E are two-sided models (shared savings and shared losses) that provide for incrementally higher performance-based risk.<sup>15</sup> Eligible ACOs that are new to the program (identified as initial applicants rather than re-entering ACOs), determined to be inexperienced with performance-based risk Medicare ACO initiatives, may enter the BASIC track's glide path at any one of the five levels (Levels A through E). An ACO determined to be inexperienced with performance-based risk Medicare ACO initiatives that previously participated in Track 1, or a new ACO identified as a re-entering ACO because more than 50 percent of its

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<sup>6</sup> Refer to § 425.200.

<sup>7</sup> Refer to §§ 425.600(a)(1), 425.604.

<sup>8</sup> Refer to §§ 425.600(a)(2), 425.606.

<sup>9</sup> Refer to §§ 425.600(a)(3), 425.610.

<sup>10</sup> Refer to § 425.200(b)(4)(ii), (b)(5).

<sup>11</sup> Refer to §§ 425.600(a)(4), 425.605.

<sup>12</sup> Refer to §§ 425.600(a)(3), 425.610.

<sup>13</sup> Refer to § 425.600(a)(4)(i).

<sup>14</sup> Refer to §§ 425.600(a)(4)(i)(A)(1), 425.605(d)(1)(i) (Level A); §§ 425.600(a)(4)(i)(A)(2), 425.605(d)(1)(ii) (Level B).

<sup>15</sup> Refer to §§ 425.600(a)(4)(i)(A)(3), 425.605(d)(1)(iii) (Level C); §§ 425.600(a)(4)(i)(A)(4), 425.605(d)(1)(iv) (Level D); §§ 425.600(a)(4)(i)(A)(5), 425.605(d)(1)(v) (Level E).

ACO participants have recent prior experience in the same Track 1 ACO, may enter the BASIC track's glide path under Levels B, C, D, or E.<sup>16</sup>

ACOs in the BASIC track's glide path will be automatically advanced at the start of each performance year along the progression of risk/reward levels, or could elect to move more quickly to a higher level of risk/reward over the course of their agreement period.<sup>17</sup> There are limited exceptions to the automatic advancement policy.<sup>18</sup> Firstly, there is an exception for ACOs entering the BASIC track's glide path for an agreement period beginning on July 1, 2019, that participate in a first performance year of 6 months (July 1, 2019, through December 31, 2019), to address how we apply the automatic advancement policy for moving ACOs along the five levels of the glide path in an agreement period with a duration of more than 5 years. For Performance Year (PY) 2020, these ACOs may have remained in the same level of the BASIC track's glide path that they entered for the July 1, 2019, through December 31, 2019, performance year. Secondly, a low revenue ACO that is a new legal entity and is not identified as a re-entering ACO that enters the BASIC track's glide path at Level A, and is automatically advanced to Level B, may elect to remain in Level B for one additional performance year before being automatically advanced to Level E. This option provides eligible new, low revenue ACOs with three performance years under a one-sided model (4 performance years in the case of ACOs entering an agreement period beginning on July 1, 2019) of the BASIC track's glide path. To address the circumstances of the COVID-19 PHE, prior to the automatic advancement for PY 2021, any ACOs that participated in the BASIC track's glide path for PY 2020 may have elected to remain in the same level of the BASIC track's glide path that it entered for PY 2020, for PY 2021. Additionally, for PY 2022, eligible ACOs participating in the BASIC track's glide path could elect to forgo automatic advancement along the glide path's increasing levels of risk and potential reward.

ACOs eligible to enter the BASIC track but not the glide path participate in Level E for all performance years of the agreement period. This is a participation option available to ACOs that are identified as low revenue ACOs and experienced with performance-based risk Medicare ACO initiatives.<sup>19</sup>

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. All references to the ENHANCED track are deemed to include Track 3.<sup>20</sup> 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 for high revenue and low revenue ACOs based on applicant type and experience with risk, refer to [Table 7](#) and [Table 8](#) in the December 2018 Final Rule (83 FR 67911 through 67914).

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<sup>16</sup> Refer to § 425.600(d)(1)(i), (d)(2)(i); § 425.600(a)(4)(i)(B)(1).

<sup>17</sup> Refer to §§ 425.600(a)(4)(i)(B)(2), 425.226(a)(2)(i).

<sup>18</sup> Refer to § 425.600(a)(4)(i)(B)(2)(i) – (iii), 425.600(a)(4)(i)(B)(2)(v), 425.600(a)(4)(i)(B)(2)(vi).

<sup>19</sup> Refer to § 425.600(a)(4)(ii); § 425.600(d)(2)(ii), (d)(3).

<sup>20</sup> Refer to §§ 425.600(a)(3), 425.610.

### DEFINITIONS (refer to § 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 AND BENCHMARK PERIODS

Agreement periods beginning on July 1, 2019, will last for 5 years and 6 months, for a total of 6 performance years.<sup>21</sup> For an ACO that entered an agreement period with a start date of July 1, 2019, the ACO's first performance year of the agreement period is defined as the 6-month period between July 1, 2019, and December 31, 2019,<sup>22</sup> and the 5 remaining performance years of the agreement period each consist of a 12-month calendar year.<sup>23</sup>

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.<sup>24</sup>

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 (rebasin) 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 that would have been assigned to the ACO in any of the 3 most recent years prior to the start of the agreement period, using the ACO participant TINs identified before the start of the agreement period and the beneficiary assignment methodology selected by the ACO for the first performance year of the agreement period.<sup>25</sup> [Appendix B, Table 7](#) presents the

<sup>21</sup> Refer to § 425.200(b)(4)(ii).

<sup>22</sup> Refer to § 425.200(c)(3).

<sup>23</sup> Refer to § 425.200(c) introductory text.

<sup>24</sup> Refer to § 425.200(b)(5).

<sup>25</sup> Refer to §§ 425.601(a) introductory text, 425.601(e)(2).

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 on January 1, 2020. The benchmark years remain the same for all performance years of the agreement period.

## 2 ASSIGNMENT OF BENEFICIARIES

Before calculating an ACO's shared savings or losses, beneficiaries must be assigned to an ACO.<sup>26</sup> Beneficiary assignment is determined based on voluntary alignment (refer to [Section 2.2](#)) and claims-based assignment (refer to [Section 2.3](#)).<sup>27</sup> Voluntary alignment incorporates beneficiary preferences to supplement claims-based beneficiary assignment.

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

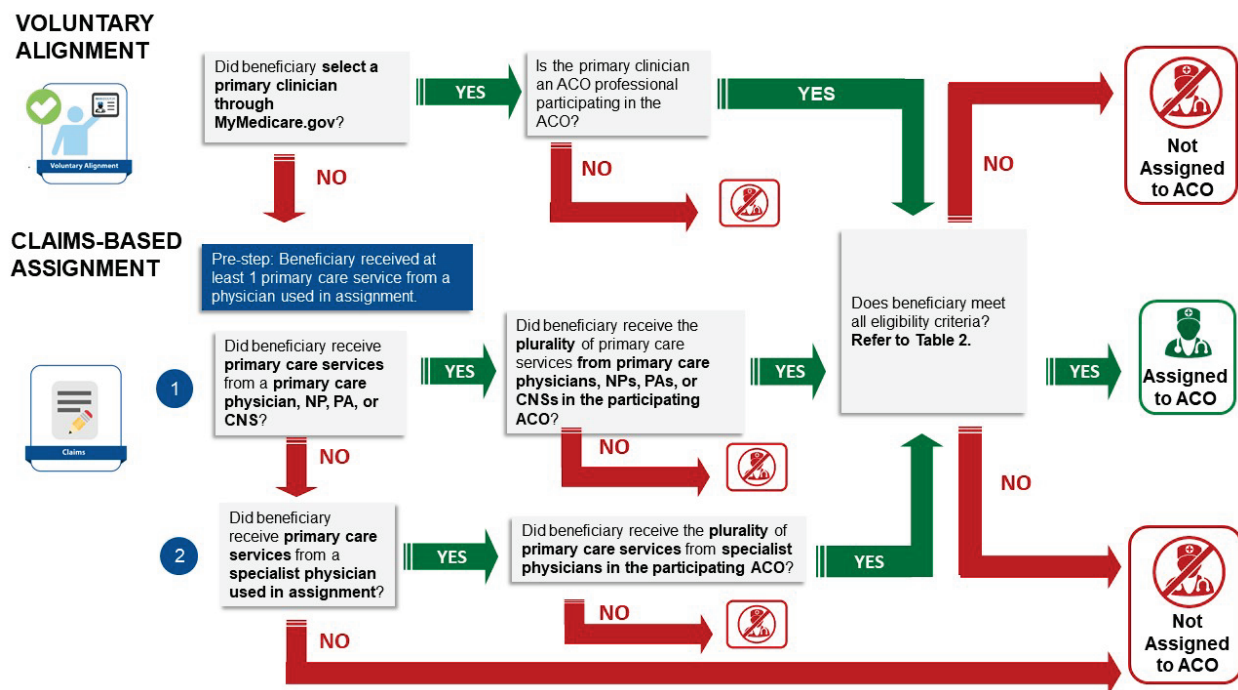


Figure 1. Voluntary alignment and claims-based assignment process flow [APPENDIX C: DATA](#)

### 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

<sup>26</sup> Refer to § 425.400(a)(1), (b).

<sup>27</sup> Refer to §§ 425.402, 425.404.

all of the criteria specified in § 425.401(a).<sup>28</sup> 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*

	<b>CRITERIA AND OTHER FACTORS USED TO DETERMINE ELIGIBILITY FOR ASSIGNMENT</b>	<b>MUST BE MET FOR CLAIMS-BASED ASSIGNMENT</b>	<b>MUST BE MET FOR VOLUNTARY ALIGNMENT</b>
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. <sup>29</sup>	Yes	Yes
B.	Beneficiary does not have any months of Medicare group (private) health plan enrollment. <sup>30</sup> 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. <sup>31</sup> Medicare Secondary Payer (MSP) 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. <sup>32</sup> 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 that 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 the Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model. <sup>33</sup>	Yes	Yes

<sup>28</sup> 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.

<sup>29</sup> Refer to § 425.401(a)(1).

<sup>30</sup> Refer to § 425.401(a)(2).

<sup>31</sup> Refer to the definition of “Medicare fee-for-service beneficiary” in § 425.20.

<sup>32</sup> Refer to § 425.401(a)(3).

<sup>33</sup> Refer to § 425.402(e)(2)(ii)(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 U.S. 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. <sup>34</sup> 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 <a href="#">Appendix B, Table 7</a> ), 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 that received care outside of the U.S., 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 <a href="#">Appendix C, Table 9</a> ). <sup>35</sup> Refer to <a href="#">Appendix D</a> for details on outpatient facility claims used in beneficiary assignment. In particular, CMS treats a service reported on an FQHC/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 his/her primary care services from the participating ACO. If a beneficiary meets the screening criteria A through E, he or she is eligible for assignment to an ACO according to the two-step assignment algorithm (refer to <a href="#">Section 2.3.3</a> ). <sup>36</sup>	Yes	No

<sup>34</sup> Refer to § 425.401(a)(4).

<sup>35</sup> Refer to § 425.402(b)(1).

<sup>36</sup> Refer to § 425.402(b)(3), (b)(4).

	CRITERIA AND OTHER FACTORS USED TO DETERMINE ELIGIBILITY FOR ASSIGNMENT	MUST BE MET FOR CLAIMS-BASED ASSIGNMENT	MUST BE MET FOR VOLUNTARY ALIGNMENT
G.	Beneficiary designated as a primary clinician through <a href="https://www.medicare.gov">MyMedicare.gov</a> an ACO professional participating in the ACO. <sup>37</sup> If a beneficiary meets the screening criteria A through D, and is not excluded according to the criteria at § 425.401(b) (refer to <a href="#">Section 2.3.2.2</a> ), he or she is prospectively assigned to an ACO. <sup>38</sup> 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
H.	If a beneficiary designated as a primary clinician through <a href="https://www.medicare.gov">MyMedicare.gov</a> a provider or supplier outside of the ACO, the beneficiary is not added to an ACO’s assignment list even if would otherwise have been assigned to that ACO through claims-based assignment. <sup>39</sup>	Basis for exclusion	N/A

## 2.2 VOLUNTARY ALIGNMENT

Beneficiaries may voluntarily align themselves to an ACO at any time during the year by logging into [MyMedicare.gov](https://www.medicare.gov) and designating a provider or supplier who they believe to be responsible for coordinating their overall care (referred to as a “primary clinician”).<sup>40</sup> 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 available data at the time assignment lists are determined for the benchmark and performance year.<sup>41</sup> Sections 425.402(e)(2)(ii)(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. 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.<sup>42</sup> Voluntarily aligned beneficiaries will remain voluntarily aligned in future performance years unless the beneficiary either changes their voluntary alignment

<sup>37</sup> Refer to § 425.402(e)(2)(ii)(B).

<sup>38</sup> Refer to § 425.402(e)(1), (e)(2)(ii).

<sup>39</sup> Refer to § 425.402(e)(2)(ii)(C).

<sup>40</sup> Refer to § 425.402(e).

<sup>41</sup> Refer to § 425.402(e)(1).

<sup>42</sup> Refer to § 425.402(e)(1), (e)(2)(ii).

designation through [MyMedicare.gov](https://www.medicare.gov) and/or no longer meets Shared Savings Program eligibility criteria. Voluntarily aligned beneficiaries with a date of death prior to the start of the benchmark or performance year are excluded.

For 12-month 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 2020, voluntary alignment for determining performance year assignment will be based on beneficiary designations through September 30, 2019. Beneficiaries assigned through voluntary alignment are accounted for in benchmark calculations in which 2018 or subsequent years are benchmark years, because voluntary alignment was used in determining assignment for the first time in PY 2018. Refer to [Appendix B, Table 7](#) 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 January 1, 2020.

## 2.3 CLAIMS-BASED ASSIGNMENT

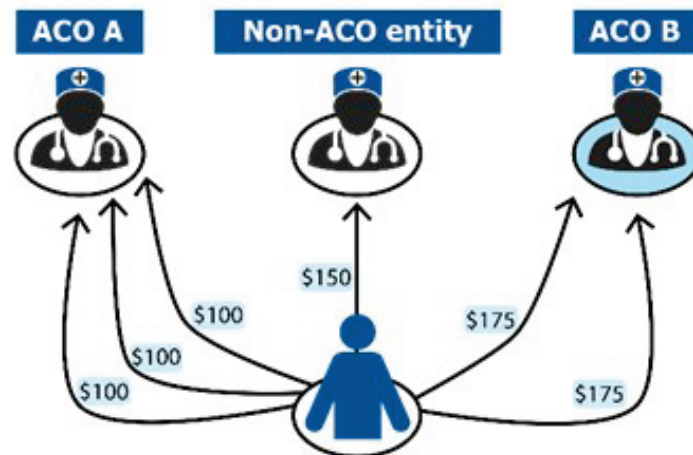
In performing claims-based assignment, CMS determines whether allowed charges for a beneficiary's primary care services (as identified for ACO professionals, including at ETA hospitals and Method II Critical Access Hospitals (CAHs), and services at an FQHC/RHC) in an ACO are greater than allowed charges 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 CMS Certification Numbers (CCNs)<sup>43</sup> that are not participating in the Shared Savings Program.<sup>44</sup> As illustrated in Figure 2, in making this determination, CMS determines where the beneficiary received the plurality of his or her primary care services.

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<sup>43</sup> FQHCs, RHCs, ETA hospitals, and Method II CAHs will be identified on claims by their CCNs.

<sup>44</sup> Refer to § 425.402(b)(3), (b)(4); § 425.404(b).





**Plurality of Primary Care Services**

Plurality of primary care services is based on allowed charges. *Plurality* refers to a greater proportion of **primary care services** as measured in allowed charges *within the ACO* compared to primary care services *outside the ACO*. The plurality is determined by the total allowed charges for primary care services and can be less than a majority of the total number of primary care services provided. In this example, the beneficiary is assigned to **ACO B**, because ACO B provided the greatest amount of allowed charges.

*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.<sup>45</sup> 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.<sup>46</sup>

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 in determining beneficiary assignment will vary. The run-out periods are summarized for ACOs under preliminary prospective assignment with retrospective reconciliation and for ACOs under prospective assignment in [Table 12](#) and [Table 13](#) of [Appendix F](#), respectively.

<sup>45</sup> Refer to § 425.400(a)(4)(ii).

<sup>46</sup> Refer to § 425.226(a)(1).

### 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.

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

- 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.

**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.

The ACO Provider/Supplier List includes the CCNs needed to identify claims for Method II CAHs, ETA hospitals, FQHCs, and RHCs used in assignment as described in Appendix D.

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 specified on the ACO Provider/Supplier List, as the basis for beneficiary assignment used in program operations, including the following:

- Determining beneficiaries’ eligibility for the SNF 3-day waiver according to §425.612;
- Calculating the ACO’s historical benchmark based on the 3 years prior to the start of its agreement period;
- Determining performance year expenditures used in financial reconciliation;
- Determining the ACO’s quality sample; 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.<sup>47</sup>

For more information on the ACO Participant List and ACO Provider/Supplier List, refer to the *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

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<sup>47</sup> Refer to § 425.118(b).

hospitals, 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.<sup>48</sup> Near the start of the performance year, ACOs under preliminary prospective assignment with retrospective reconciliation receive an assignment list that includes beneficiaries preliminarily prospectively assigned via claims-based assignment based on most recent data available and prospectively assigned beneficiaries as a result of voluntary alignment (refer to [Section 2.2](#)).

Assignment will be updated quarterly based on the most recent 12 months of data.<sup>49</sup> Each quarter, CMS runs claims-based assignment based on the most recent 12 months of data, 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 a rolling 12-month assignment window from that ACO, and who meet the assignment criteria identified in [Section 2.1, Table 1](#).

For final assignment for a 12-month benchmark year or performance year, the assignment window is the relevant 12-month calendar year. Refer to [Appendix B, Table 7](#).

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.<sup>50</sup>

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](#)).<sup>51</sup>

### 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 in the most recent 12 months for which data are available.<sup>52</sup> Near the start of the performance year, ACOs receive an assignment list that includes beneficiaries prospectively assigned via claims-based assignment and prospectively assigned beneficiaries as a result of voluntary alignment (refer to [Section 2.2](#)).

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<sup>48</sup> Refer to § 425.400(a)(2)(i).

<sup>49</sup> Refer to § 425.400(a)(2)(ii).

<sup>50</sup> Refer to § 425.400(a)(2)(iii).

<sup>51</sup> Refer to § 425.402(e)(2)(ii)(A).

<sup>52</sup> Refer to § 425.400(a)(3).

Prospective assignment uses an offset assignment window (refer to [Appendix B, Table 7](#)) 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), prospectively assigned beneficiaries who meet any of the following criteria are 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 7](#) for relevant assignment windows.

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 the— (A) beneficiary meets the eligibility criteria under § 425.401(a) (refer to [Section 2.1, Table 1](#)); and (B) 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 that 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 that had 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 designation specified in § 425.402(c) (listed in [Appendix C, Table 9](#)).<sup>53</sup> CMS treats a service reported on an FQHC/RHC claim as a primary care service performed by a primary care physician, according to § 425.404(b).

CMS identifies all primary care services furnished to beneficiaries identified in the pre-step.<sup>54</sup> 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., \$185 in 2019). 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.<sup>55</sup>

Under claims-based assignment, CMS assigns beneficiaries to ACOs through either one of two 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.<sup>56</sup> [Appendix C, Table 9](#) lists physician specialty codes for primary care physicians included in claims-based assignment Step 1, and [Table 10](#) 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 11](#), 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

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<sup>53</sup> Refer to § 425.402(b)(1).

<sup>54</sup> Refer to § 425.402(b)(2).

<sup>55</sup> All ACOs will have special identifiers (ACO IDs) in the form of Axxxx (with the x’s signifying a four-digit number).

<sup>56</sup> Refer to § 425.402(b)(3).



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 9](#)) 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.<sup>57</sup> [Appendix D, Table 11](#), specifies outpatient facility claims used in beneficiary assignment.

#### 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 or Step 2 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 9](#)) or a non-physician practitioner (refer to [Appendix C, Table 10](#)). 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 9](#)). 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 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-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 "Medicare Shared Savings Program, Shared Savings and Losses and Assignment Methodology, Specifications of Policies to Address the Public Health Emergency for COVID-19" available at the [Program Guidance & Specifications webpage](#) of the Shared Savings Program website.

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<sup>57</sup> Refer to § 425.402(b)(4).

## 3.1 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: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries.<sup>58</sup>

As described in further detail in this section, CMS uses the following steps to determine an assigned beneficiary's expenditures and Medicare enrollment type by 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, allowing for a 3-month claims run out,<sup>59</sup> from all of the following: claim payment amounts identified for inpatient, Skilled Nursing Facility (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 (DME) claims. For both Parts A and B claims, CMS excludes denied payments and denied line items from the calculation. [Table 2](#) below contains a list of the claim types 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, and uncompensated care payments, from inpatient claims.<sup>60</sup> Since Maryland hospitals receive payment outside the inpatient prospective payment system, these hospitals do not directly receive IME and DSH payments from Medicare. Therefore, the Shared Savings Program does not adjust for IME/DSH payments to Maryland hospitals.
- 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, specifically the Pioneer ACO Model, Next Generation ACO Model, Vermont All-Payer ACO Model, and the Direct Contracting Model. Population-based payments are a per-beneficiary

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<sup>58</sup> Refer to §§ 425.601(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).

<sup>59</sup> Refer to §§ 425.601(a)(1), 425.605(a)(4), 425.610(a)(5).

<sup>60</sup> Refer to §§ 425.601(a)(1)(i), 425.605(a)(5)(i), 425.610(a)(6)(i).

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.<sup>61</sup>
- Medicare payment adjustments resulting from incentive payment programs, including the Value-Based Payment Modifier, 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 Medicare-enrolled billing TIN associated with the Advanced APM Entity through which an eligible clinician becomes a Qualifying APM Participant (QP) and therefore are not included in ACO expenditures.

Expenditure amounts are calculated for each beneficiary each month as 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.

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<sup>61</sup> Refer to §§ 425.601(a)(1)(ii), 425.605(a)(5)(ii), 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, 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 and uncompensated care amounts)	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, 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, 5)	N/A	Claim through date
Carrier (including physician/supplier Part B <sup>62</sup> ) (Claim type = 71, 72)	Line NCH payment amount	'Carrier Claim Payment Denial Code' = '0' or 'D' through 'Y'	Line processing indicator code ≠ 'A,' 'R,' or 'S'	Line latest expense date
DME (Claim type = 81, 82)	Line NCH payment amount	'Carrier Claim Payment Denial Code' = '0' or 'D' through 'Y'	Line processing indicator code ≠ 'A,' 'R,' or 'S'	Line latest expense date
Hospice (Claim type = 50)	Claim payment amount	Any non-blank value for 'Claim Medicare Non-Payment reason code'	N/A	Claim through date

<sup>62</sup> 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 (e.g., <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 (ESRD);
2. Disabled: beneficiaries eligible for Medicare as a result of disability;
3. Aged/dual eligible: beneficiaries eligible for Medicare by age, and eligible for Medicaid; or
4. Aged/non-dual 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 1<sup>st</sup> of the month, enrolled in both Parts A and B, and not enrolled in a Medicare Group Health Plan for the month (herein 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, Step 1](#)) to the beneficiary's identified Medicare enrollment type for that month (determined as described in [Section 3.1, 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.

## 3.2 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](#)).

Annualization (as described in this section) and weighting of beneficiary expenditures (as described in [Section 3.5](#)) ensures that payments are adjusted for months of beneficiary eligibility, including new Medicare enrollees and beneficiaries who die during the year, and enables 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).**

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

**Calculate annualized expenditures.**

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

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

### 3.3 TRUNCATING ASSIGNED BENEFICIARY EXPENDITURES

After calculating annualized beneficiary expenditures for each Medicare enrollment type (refer to [Section 3.2](#)), CMS truncates annualized expenditures to an established threshold for those beneficiaries whose annualized expenditures are greater than the threshold.<sup>63</sup>

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

<sup>63</sup> Refer to §§ 425.601(a)(4), 425.605(a)(3), 425.610(a)(4)(ii).

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: 2020
- Medicare enrollment type: aged/dual eligible
- Truncation threshold for aged/dual eligible population (2020): \$208,129.72

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, \$208,129.72 is used.

### 3.4 APPLYING A COMPLETION FACTOR

Once expenditures are annualized and truncated, a completion factor is applied to expenditures. In calculating expenditures for annual reports, CMS allows up to 3 months after the end of the performance year for claims to run out.<sup>64</sup> As explained in the April 2011 proposed rule, the claims run-out period is the time between when a Medicare-covered service has been furnished to a beneficiary and when the final payment is actually issued for the respective service (76 FR 19554). For example, CMS determines expenditures for a calendar year by accounting for claims with dates of service during the 12-month period paid up to 3 months following the end of the year (e.g., paid no later than the end of March the following year).

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 up to a 7-day claims run-out period, depending on data availability, and applies a completion factor. Refer to [Appendix F, Table 12](#) and [Table 13](#) for additional information on claims run-out periods and completion factors.

<sup>64</sup> Refer to §§ 425.601(a)(1), 425.605(a)(4), 425.610(a)(5).

**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: 2020
- Medicare enrollment type: aged/dual eligible
- Truncation threshold (2020): \$208,129.72
- Completion factor with 3-month run-out: 1.013
- If annualized aged/dual eligible expenditures = \$20,000 (i.e., less than the truncation threshold)

$$\text{Annualized Expenditure} \times \text{Completion Factor}$$

$$\$20,000 \times 1.013 = \$20,260$$

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

$$\text{Aged/dual eligible Truncation Threshold} \times \text{Completion Factor}$$

$$\$208,129.72 \times 1.013 = \$210,835.40$$

### 3.5 WEIGHTING ASSIGNED BENEFICIARY EXPENDITURES BY MEDICARE ENROLLMENT TYPE

Once CMS has annualized expenditures ([Section 3.2](#)), truncated expenditures ([Section 3.3](#)), and applied a completion factor ([Section 3.4](#)) for each assigned beneficiary, CMS calculates aggregated per capita expenditures for each Medicare enrollment type.<sup>65</sup> 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, 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

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

<sup>65</sup> Refer to § 425.601(a) introductory text, (a)(1), (a)(2), (a)(4); § 425.605(a) introductory text, (a)(3), (a)(4), (a)(5); § 425.610(a) introductory text, (a)(4), (a)(5), (a)(6).

## 3.6 RISK ADJUSTMENT POLICIES

### 3.6.1 RISK ADJUSTMENT FOR ESTABLISHING THE HISTORICAL BENCHMARK

When establishing the historical benchmark, CMS uses the CMS Hierarchical Condition Category (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.<sup>66</sup> These adjustments account for changes in severity and case mix between the first and third benchmark years and between the second and third benchmark years.<sup>67</sup>

CMS risk-adjusts the county-level expenditures<sup>68</sup> used in calculating the regional component of the national-regional blend growth rate used to trend the first and second benchmark years to the third benchmark year (refer to [Section 4.1.2, Step 2](#) for additional discussion of the national-regional blend growth rates).<sup>69</sup>

CMS maintains the CMS-HCC prospective risk adjustment models for the Medicare Advantage (MA) program. CMS calculates CMS-HCC risk scores for all Medicare beneficiaries, including FFS beneficiaries. For each benchmark and performance year, CMS applies the MA risk adjustment model that was applicable for that benchmark or performance year. CMS removes the MA coding intensity adjustment in the applicable years and renormalizes the risk scores by enrollment type based on a national assignable FFS population.

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. Risk adjustment eligible diagnoses codes from final action FFS claims (inpatient, outpatient, and physician) are included in the CMS-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](https://www.cms.gov).

A beneficiary's final risk score for each month is the risk score determined for that beneficiary based on the beneficiary's risk adjustment model status for that month. There are risk adjustment models for MA subpopulations, which include community versus institutional residence, new versus continuing Medicare enrollee status, ESRD versus aged versus disabled entitlement status, ESRD dialysis versus transplant versus functioning graft status, and full benefit dual eligible versus partial benefit dual eligible versus non-dual eligible. Therefore, the risk scores used 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).

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<sup>66</sup> Refer to § 425.601(a)(3).

<sup>67</sup> Refer to § 425.601(a)(6).

<sup>68</sup> Refer to § 425.601(c)(4), (d)(4).

<sup>69</sup> Refer to § 425.601(a)(5).

A beneficiary's average risk score for a particular Medicare enrollment type for a given year will be renormalized to ensure that the mean national assignable FFS risk score for that enrollment type for that year equals 1.0. This adjustment ensures consistency in the FFS risk scores year to year since CMS refines and updates risk adjustment models over time.

To calculate the weighted average ACO-level risk score for each Medicare enrollment type, CMS multiplies 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.

### 3.6.2 ANNUAL ADJUSTMENT TO THE HISTORICAL BENCHMARK FOR CHANGES IN SEVERITY AND CASE MIX

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 for the ACO's assigned beneficiary population between BY3 and the performance year.<sup>70</sup> 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).<sup>71</sup> CMS uses CMS-HCC prospective risk scores to adjust the historical benchmark for changes in severity and case mix for all assigned beneficiaries, subject to a cap of positive 3 percent for the agreement period. This cap is the maximum increase in risk scores allowed for each agreement period, such that any positive adjustments between BY3 and any performance year in the agreement period cannot be larger than 3 percent.<sup>72</sup> That is, the risk ratios (ratio of performance year risk score to the BY3 risk score) applied to historical benchmark expenditures to capture changes in health status between BY3 and the performance year would never be higher than 1.030 for any performance year over the course of the agreement period. The cap is applied separately for populations of beneficiaries for each Medicare enrollment type.<sup>73</sup>

[Table 3](#) provides an illustrative example of how the positive 3 percent cap would be 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 increase in the aged/dual eligible risk score is subject to the positive 3 percent cap. In the example, 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.

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<sup>70</sup> Refer to § 425.601(a)(10); § 425.605(a)(1), (a)(2); § 425.610(a)(2), (a)(3).

<sup>71</sup> Refer to §§ 425.605(a)(2), 425.610(a)(3).

<sup>72</sup> Refer to §§ 425.605(a)(1), 425.610(a)(2).

<sup>73</sup> Refer to §§ 425.605(a)(2), 425.610(a)(3).



*Table 3. Hypothetical data on application of positive 3 percent cap on performance year to BY3 risk ratio*

MEDICARE ENROLLMENT TYPE	BY3 RENORMALIZED CMS-HCC RISK SCORE	PY RENORMALIZED CMS-HCC RISK SCORE	RISK RATIO BEFORE APPLYING CAP	FINAL RISK RATIO
ESRD	1.031	1.054	1.022	1.022
Disabled	1.123	1.074	0.956	0.956
Aged/dual eligible	0.987	1.046	1.060	1.030
Aged/non-dual eligible	1.025	1.001	0.977	0.977

### 3.7 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 identifiable final payments made under a demonstration, pilot, or time-limited program. We also apply the same completion factor that is used for annual expenditure calculations (refer to [Section 3.4](#) and [Appendix F, Table 12](#) and [Table 13](#)). 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, or uncompensated care payments 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 Hospital Value-Based Purchasing Program). Refer to 83 FR 67856.

## 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); 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 (detailed below); 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.

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 truncation thresholds and risk scores for this



benchmark year become available, CMS provides final historical benchmark reports to ACOs in the first performance year of an agreement period. This occurs approximately 6 months into the first performance year in order to allow time for claims run-out, availability of other inputs, and production.

For the second and each subsequent performance year, shortly after the beginning of the year, CMS adjusts the historical benchmark for the following, as applicable: for the addition and removal of ACO participants or ACO providers/suppliers in accordance with § 425.118(b) (see [Section 2.3.1](#)), for a change to the ACO's beneficiary assignment methodology selection under § 425.226(a)(1), and for a change to the beneficiary assignment methodology specified in 42 CFR part 425, subpart E.<sup>74</sup> CMS also adjusts the historical benchmark to account for regulatory changes affecting the Shared Savings Program's benchmarking methodologies.<sup>75</sup>

The 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 second or subsequent performance year, will be used to calculate the updated historical benchmark for determining shared savings/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 the annual update to the historical benchmark using a blend of national and regional growth rates according to § 425.601(b). 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 Benchmark:** An ACO's historical benchmark is established near the start of the ACO's first agreement period.
- **Updated Historical Benchmark:** At the time of financial reconciliation for each performance year, CMS: 1) 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, and 2) updates the historical benchmark using a blend of national and regional growth rates. The resulting benchmark is referred to as the updated historical benchmark.
- **Adjusted Historical Benchmark:** For the second and each subsequent performance year during the term of the agreement period, an ACO's historical benchmark is adjusted annually to account for the following, as applicable: for the addition and removal of ACO participants and ACO providers/suppliers in accordance with § 425.118(b) (see [Section 2.3.1](#)), for a change to the ACO's beneficiary assignment methodology selection under § 425.226(a)(1), and for a change to the beneficiary assignment methodology specified in 42 CFR part 425, subpart E. The ACO's historical benchmark will also be adjusted if there are regulatory changes to the Shared Savings Program's benchmarking methodologies. 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.

<sup>74</sup> Refer to § 425.601(a)(9). Refer to section 4.1.3.

<sup>75</sup> 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.

## 4.1 CALCULATING HISTORICAL BENCHMARKS

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 regional FFS expenditures used in benchmark calculations for all ACOs for agreement periods beginning on July 1, 2019, and in subsequent years, CMS does the following (refer to § 425.601(c) and (d)):

#### **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 assignment window from a Medicare-enrolled physician who is a primary care physician<sup>76</sup> or who has one of the specialty designations included in § 425.402(c).<sup>77</sup> 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/RHC claim as a primary care service performed by a primary care physician. The assignable beneficiary population will be identified consistently, across program tracks, and regardless of an ACO's choice of beneficiary assignment methodology (if applicable), using the assignment window for the 12-month calendar year corresponding to the relevant benchmark or performance year. Some beneficiaries who meet the definition of "assignable beneficiary" will ultimately be excluded from assignment to an ACO for purposes of determining the ACO's benchmark or performance year expenditures because they fail to meet the assignment criteria specified under § 425.401(a).<sup>78</sup>

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.<sup>79</sup> Refer to [Sections 3.1–3.5](#) 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.<sup>80</sup> CMS calculates assignable beneficiary expenditures using the same approach to calculating beneficiary expenditures as described in [Section 3.1, Step 1](#).<sup>81</sup>

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<sup>76</sup> As defined in § 425.20, for performance year 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.

<sup>77</sup> Refer to [Appendix C, Table 9](#) for a list of physician specialty codes used in assignment.

<sup>78</sup> Refer to 81 FR 37961.

<sup>79</sup> Refer to 81 FR 37985.

<sup>80</sup> Refer to § 425.601(c)(1)(ii).

<sup>81</sup> Refer to § 425.601(c)(2).

For each assignable beneficiary in a county, CMS computes annualized, truncated<sup>82</sup> 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, Step 2](#)), summing these weighted expenditures across all assignable beneficiaries in the county, and then dividing by total person years for that enrollment type among assignable beneficiaries in the county.<sup>83</sup>

CMS adjusts average per capita county-level FFS expenditures for severity and case mix of assignable beneficiaries in the county using CMS-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).<sup>84</sup> CMS determines the renormalized, CMS-HCC prospective risk score for each assignable beneficiary and computes weighted average CMS-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 among assignable beneficiaries in the county. Refer to [Section 3.6.1](#) for a description of the approach for determining beneficiary CMS-HCC prospective risk scores.

When calculating assignable beneficiary annualized, truncated expenditures, CMS-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.<sup>85</sup> 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 enrolled in a Medicare health plan for the second 6 months of the year, his/her disability eligibility fraction would be equal to 0.5 (6/12) and his/her annualized, truncated expenditures and CMS-HCC risk score would be computed based only on the first 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 CMS-HCC risk score to obtain risk-adjusted county expenditures.

Note that county-level expenditure and risk score data will be publicly released by CMS annually in the summer following the conclusion of the calendar year to which the data relates on the [Data.CMS.gov website](https://data.cms.gov).

## **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

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<sup>82</sup> Refer to § 425.601(c)(3).

<sup>83</sup> Refer to § 425.601(c)(1).

<sup>84</sup> Refer to § 425.601(c)(4).

<sup>85</sup> Refer to [Section 2.3](#) for descriptions of Medicare health plans.

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](https://www.cms.gov).

### **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.<sup>86</sup> 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.<sup>87</sup> This will result in a separate value for each of the four populations identified by Medicare enrollment type, representing county-weighted regional FFS expenditures for that Medicare enrollment type.

## **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 FFS adjustment. Refer to the Shared Savings Program's regulations at § 425.601 paragraphs (a) and (f).

### **Step 1: Calculate annualized, truncated per capita expenditures.**

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

### **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 herein as the national-regional blend).<sup>88</sup> To trend forward the benchmark, CMS makes separate calculations for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible).<sup>89</sup> The national-regional blend is a weighted average of national FFS and regional growth rates.<sup>90</sup>

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

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<sup>86</sup> Refer to § 425.601(d)(1).

<sup>87</sup> Refer to § 425.601(d)(2).

<sup>88</sup> Refer to § 425.601(a)(5).

<sup>89</sup> Refer to § 425.601(a)(5)(i).

<sup>90</sup> Refer to § 425.601(a)(5)(iv).

the 12-month calendar year corresponding to each benchmark year.<sup>91</sup> 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 benchmark year (BY1 and BY2). Expenditures for each year include a 3-month claims run out. 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 expenditures for each year (refer to [Section 4.1.1](#)) and then calculates the growth rates.<sup>92</sup> 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).<sup>93</sup> To calculate this share, CMS first calculates the county-level share of assignable beneficiaries that are assigned to the ACO for each county in the ACO's regional service area for that Medicare enrollment type. 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.<sup>94</sup> 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.<sup>95</sup> 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.

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<sup>91</sup> Refer to § 425.601(a)(5)(ii).

<sup>92</sup> Refer to § 425.601(a)(5)(iii).

<sup>93</sup> Refer to § 425.601(a)(5)(iv)(A).

<sup>94</sup> Refer to § 425.601(a)(5)(iv)(B).

<sup>95</sup> Refer to § 425.601(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 (2018): \$17,597; growth rate = 1.065  
 BY2 (2019): \$18,611; growth rate = 1.007  
 BY3 (2020): \$18,739; 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 (2018): \$14,000; growth rate = 1.071  
 BY2 (2019): \$14,500; growth rate = 1.034  
 BY3 (2020): \$15,000; 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:

$$\left[ \left( \frac{\text{Assigned Beneficiaries in County A}}{\text{Assignable Beneficiaries in County A}} \right) \times \left( \frac{\text{Assigned Beneficiaries in County A}}{\text{Total Assigned Beneficiaries}} \right) \right] + \left[ \left( \frac{\text{Assigned Beneficiaries in County B}}{\text{Assignable Beneficiaries in County B}} \right) \times \left( \frac{\text{Assigned Beneficiaries in County B}}{\text{Total Assigned Beneficiaries}} \right) \right]$$

$$\left[ \left( \frac{9,000}{10,000} \right) \times \left( \frac{9,000}{11,000} \right) \right] + \left[ \left( \frac{2,000}{12,000} \right) \times \left( \frac{2,000}{11,000} \right) \right] = 0.767, \text{ or } 76.7\%$$

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

$$1 - \text{weight of national component}$$

$$1 - 0.767 = 0.233, \text{ or } 23.3\%$$

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

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

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

$$[(1.065) \times (0.767)] + [(1.071) \times (0.233)] = 1.066$$

### Step 3: Risk adjust and trend benchmark year expenditures.

CMS risk adjusts the benchmark year expenditures using the renormalized CMS-HCC risk scores for the ESRD, disabled, aged/dual eligible, and aged/non-dual eligible assigned populations for each ACO (refer to [Section 3.6.1](#)). 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), risk ratio (Step 3 above), and blended national-regional trend factor (Step 2 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.<sup>96</sup> 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. These amounts are used in calculating the regional FFS adjustment as described in Step 5 below.

### Step 5: Calculate and apply regional FFS adjustment.

CMS adjusts historical benchmark expenditures by Medicare enrollment type by a percentage of the difference between the average per capita expenditure amount for the ACO's regional service area and the ACO's historical benchmark amount (referred to herein as the "regional FFS adjustment").<sup>97</sup> The percentage that is applied in calculating the regional FFS 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 FFS adjustment (refer to [Table 4](#) below).<sup>98</sup>

To calculate the regional FFS adjustment, CMS does the following for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible):<sup>99</sup>

- a. 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](#).
- b. 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 service area identified for the 12-month calendar year that corresponds to BY3. For each enrollment type, CMS multiplies the average per capita amount of expenditures for the

<sup>96</sup> Refer to § 425.601(a)(7).

<sup>97</sup> Refer to § 425.601(a)(8).

<sup>98</sup> Refer to § 425.601(f).

<sup>99</sup> Refer to § 425.601(a)(8).

ACO's regional service area for BY3 by the ACO's BY3 CMS-HCC risk score. Under this approach:

(1) For an ACO with a positive regional adjustment, if an ACO's population is healthier than the assignable beneficiaries in the ACO's regional service area, with lower average risk scores for the relevant period, the risk adjustment would reduce the amount of the regional FFS adjustment. If the ACO's assigned beneficiary population is comparably sicker than the assignable beneficiaries in the ACO's regional service area, with higher average risk scores for the relevant period, the risk adjustment would increase the amount of the positive regional FFS adjustment.

(2) For an ACO with a negative regional adjustment, if an ACO's population is healthier than the assignable beneficiaries in the ACO's regional service area, with lower average risk scores for the relevant period, the risk adjustment would increase the amount of the regional FFS adjustment. If the ACO's assigned beneficiary population is comparably sicker than the assignable beneficiaries in the ACO's regional service area, with higher average risk scores for the relevant period, the risk adjustment would reduce the amount of the negative regional FFS adjustment.

- c. 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).<sup>100</sup>
- d. CMS multiplies the difference for each Medicare enrollment type by the applicable regional FFS adjustment weight to obtain the regional FFS adjustment for each Medicare enrollment type.<sup>101</sup>
- e. 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 for assignable beneficiaries in that Medicare enrollment type identified for the 12-month calendar year corresponding to BY3 using data from the OACT.<sup>102</sup> 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.<sup>103</sup> 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.<sup>104</sup>
- f. CMS adds the capped regional FFS 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).

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<sup>100</sup> Refer to § 425.601(a)(8)(ii)(A).

<sup>101</sup> Refer to § 425.601(a)(8)(ii)(B).

<sup>102</sup> Refer to § 425.601(a)(8)(ii)(C).

<sup>103</sup> Refer to § 425.601(a)(8)(ii)(C)(1).

<sup>104</sup> Refer to § 425.601(a)(8)(ii)(C)(2).



To determine whether the ACO has lower or higher spending compared to the ACO's regional service area, CMS does the following:<sup>105</sup>

- 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 4](#) 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 FFS adjustment, CMS uses a weight of 35 percent when applying the regional FFS 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 FFS adjustment, CMS uses a weight of 15 percent when applying the regional FFS adjustment.

*Table 4. Percentage weight applied in calculating the regional FFS adjustment*

AGREEMENT PERIOD ACO IS SUBJECT TO REGIONAL FFS ADJUSTMENT	WEIGHT USED TO CALCULATE REGIONAL FFS ADJUSTMENT FOR ACOS THAT ARE LOWER SPENDING COMPARED TO THEIR REGION	WEIGHT USED TO CALCULATE REGIONAL FFS 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(f). Refer to the December 2018 Final Rule (83 FR 67908) [Table 6](#) for examples of phase-in of regional adjustment weights based on agreement start date and applicant type.*

**Step 6: Apply BY3 proportions by Medicare enrollment type and sum expenditures across enrollment types.**

CMS multiplies the resulting regionally-adjusted historical benchmark expenditures for each Medicare enrollment type (Step 5(f) above) 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.<sup>106</sup>

<sup>105</sup> Refer to § 425.601(f)(5).

<sup>106</sup> Refer to § 425.601(a)(6).

CMS sums the resulting expenditures across the Medicare enrollment types to determine a single per capita amount of the ACO's adjusted 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 same methodology described in [Section 4.1.2](#) and based on the same 3 benchmark years, to account for the following, as applicable: for the addition and removal of ACO participants or ACO providers/suppliers in accordance with § 425.118(b) (refer to [Section 2.3.1](#)), for a change to the ACO's beneficiary assignment methodology selection under § 425.226(a)(1), and for a change to the beneficiary assignment methodology specified in 42 CFR part 425, subpart E.<sup>107</sup>

To adjust the benchmark, 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.<sup>108</sup>

CMS also 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. Specifically, 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](#).<sup>109</sup> CMS redetermines the regional FFS adjustment amount described in [Section 4.1.2, Step 5](#).<sup>110</sup> CMS also 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 FFS adjustment.<sup>111</sup>

As a result, an ACO may have up to five historical benchmarks for a 5-year agreement period. An ACO with a start date of July 1, 2019, may have up to six historical benchmarks for its 5-year and 6-month agreement period made up of 6 performance years.

An ACO's historical benchmark may also be adjusted to account for any regulatory changes affecting the benchmarking methodologies.<sup>112</sup>

### 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 second or subsequent performance year (as described in [Section 4.1.3](#))—is adjusted and updated at the time of financial reconciliation to reflect certain changes between

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<sup>107</sup> Refer to § 425.601(a)(9).

<sup>108</sup> Refer to § 425.601(a)(9)(i).

<sup>109</sup> Refer to § 425.601(a)(5).

<sup>110</sup> Refer to § 425.601(a)(9)(ii).

<sup>111</sup> Refer to § 425.601(f)(5)(iv).

<sup>112</sup> Refer to § 425.212, and introductory text of section 4.

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<sup>113</sup> and updates the historical benchmark using a blend of national and regional growth rates.<sup>114</sup> The updated historical benchmark is used to determine whether an ACO has shared savings or losses for the relevant performance year.

#### **Step 1: Risk adjust historical benchmark expenditures.**

CMS risk-adjusts the regionally-adjusted historical benchmark expenditures for each Medicare enrollment type (refer to [Section 4.1.2, Step 5](#)) 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 method described in [Section 3.6.2](#).

#### **Step 2: Apply national-regional blend 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 that blends national and regional expenditure growth rates between BY3 and the performance year for each Medicare enrollment type.<sup>115</sup> 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.<sup>116</sup>

The weights used to blend the national and regional components of the update factor would be calculated in the same manner as described in [Section 4.1.2, Step 2](#), except 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 regional growth rate is equal to 1 minus the weight applied to the national growth rate.<sup>117</sup>

#### **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 that would have been assigned to the ACO in any of the 3 most recent

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<sup>113</sup> Refer to § 425.601(a)(10).

<sup>114</sup> Refer to § 425.601(b).

<sup>115</sup> Refer to § 425.601(b)(1).

<sup>116</sup> Refer to § 425.601(b).

<sup>117</sup> Refer to § 425.601(b)(4).

years prior to the start of the new agreement period.<sup>118</sup> For second or subsequent agreement 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) through (d) (refer to [Section 4.1.1-4.1.4](#)) with the following modifications: (1) the weighting of the BYs, and (2) the weight applied to calculate the regional FFS adjustment to the benchmark.

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.<sup>119</sup>

Refer to § 425.601(e)(2)(ii) and [Table 4](#) for further information on the regional FFS adjustment weight 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 example, an ACO that was subject to a weight of 35 or 25 percent in its second agreement period in the Shared Savings Program (according to § 425.603) that enters its third agreement period in the program (second agreement period subject to a regional adjustment) will be subject to a weight of 50 or 25 percent according to § 425.601(f). By contrast, if the same ACO terminated during its second agreement period and subsequently re-enters the program, the ACO would be subject to a weight of 35 or 15 percent until the start of its next 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 83 FR 68024.

## 4.2 MINIMUM SAVINGS RATE AND MINIMUM LOSS RATE

The minimum savings rate (MSR) and minimum loss rate (MLR) are thresholds, calculated as a percentage of the ACO's updated historical benchmark, the ACO must meet or exceed to share in savings or to be liable for shared losses.<sup>120</sup>

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

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<sup>118</sup> Refer to § 425.601(e).

<sup>119</sup> Refer to § 425.601(e)(2)(i).

<sup>120</sup> Refer to § 425.100(b), (c); § 425.605(a)(6), (b)(3), (b)(4); § 425.610(a)(7), (b)(2), (b)(3).

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.<sup>121</sup> We refer to the resulting MSR as a variable MSR based on the ACO’s number of assigned beneficiaries.

[Table 5](#) 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 5](#) below.

**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 5.** 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%

<sup>121</sup> Refer to § 425.605(b)(1).

NUMBER OF ASSIGNED BENEFICIARIES	MSR (LOW END OF ASSIGNED BENEFICIARIES)	MSR (HIGH END OF ASSIGNED BENEFICIARIES)
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:<sup>122</sup>

1. Zero percent MSR/MLR;
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 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.<sup>123</sup>

<sup>122</sup> Refer to §§ 425.605(b)(2)(i), 425.610(b)(1).

<sup>123</sup> Refer to § 425.605(b)(2) introductory text, (b)(2)(ii).



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.<sup>124</sup>

### 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 5](#)) in determining financial performance if the assigned beneficiary population for an ACO participating under a two-sided model falls below 5,000 for the performance year and the ACO selected a fixed MSR/MLR. This policy is applicable to performance years starting on July 1, 2019, and in subsequent years. 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.<sup>125</sup>

## 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.

To qualify for a shared savings payment, an ACO must meet the MSR requirement (refer to [Section 4.2](#)), meet the quality performance standard established under § 425.512, and otherwise maintain its eligibility to participate in the Shared Savings Program under 42 CFR part 425.<sup>126</sup> For performance years beginning on or after January 1, 2021, if an ACO that is otherwise eligible to share in savings meets the quality performance standard established under § 425.512, the ACO will share in savings at the maximum sharing rate according to the applicable financial model, up to the performance payment limit.<sup>127</sup> If the ACO fails to meet the quality performance standard, the ACO will be ineligible to share in savings.

ACOs that operate under a two-sided model and meet or exceed a MLR must share losses with the Medicare program.<sup>128</sup> Once this MLR is met or exceeded, the ACO will share in losses at a rate determined according to the ACO's track/level of participation, up to a loss recoupment limit

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<sup>124</sup> Refer to § 425.605(b)(2), (b)(2)(ii)(A); § 425.610(b)(1).

<sup>125</sup> Refer to § 425.110(b)(3)(iii).

<sup>126</sup> Refer to §§ 425.100(b), 425.604(c), 425.605(c), 425.606(c), 425.610(c).

<sup>127</sup> Refer to § 425.604(d), (e); § 425.605(d); § 425.606(d), (e); § 425.610(d), (e).

<sup>128</sup> Refer to § 425.100(c).

(also referred to as the loss sharing limit).<sup>129</sup> For performance years beginning on or after January 1, 2021, under Track 2 and the ENHANCED track, ACOs that meet the quality performance standard share in losses based on their MIPS Quality performance category score, whereas ACOs that do not meet the quality performance standard owe the maximum amount of shared losses. ACOs in two-sided models of the BASIC track and the Track 1+ Model share in losses at a fixed percentage.

The below steps 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 [Sections 3.1–3.5](#)).<sup>130</sup> 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](#)).

**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 minus the total assigned beneficiary performance year expenditures is less than zero, the ACO

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<sup>129</sup> Refer to § 425.605(d); § 425.606(f), (g); § 425.610(f), (g). Refer to the [Medicare ACO Track 1+ Model Participation Agreement](#).

<sup>130</sup> Refer to § 425.605(a) introductory text; § 425.610(a) introductory text.

is considered to have generated losses, and a two-sided model ACO may be liable to share in losses.<sup>131</sup>

**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.<sup>132</sup> 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.<sup>133</sup> Otherwise, the ACO is ineligible to share in savings.

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 an ACO participating in a two-sided model will be liable for repaying a share of those losses.<sup>134</sup> Otherwise, the ACO does not share in losses.

**Step 6: Calculate final shared savings rate (percentage) and shared loss rate (percentage).**

The quality performance standard for performance years beginning on or after January 1, 2021, is specified in § 425.512. For ACOs meeting the quality performance standard, the final shared savings rate is equal to the maximum sharing rate specific to the ACO's track/level of participation as follows: 40 percent for ACOs participating in Level A or Level B of the BASIC track,<sup>135</sup> 50 percent for ACOs participating in Levels C, D, or E of the BASIC track,<sup>136</sup> and 75 percent for ACOs participating in the ENHANCED track.<sup>137</sup> An ACO that fails to meet the quality performance standard for the performance year will be ineligible for a shared savings payment for the associated performance year.

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.<sup>138</sup>

For ACOs participating in the ENHANCED track, for performance years beginning on or after January 1, 2021, the shared loss rate is determined as follows.

- If an ENHANCED track ACO meets the quality performance standard established in § 425.512, CMS determines the shared loss rate as follows:

<sup>131</sup> Refer to § 425.605(a) introductory text; § 425.610(a) introductory text.

<sup>132</sup> Refer to § 425.605(a)(6), (b)(3), (b)(4); § 425.610(a)(7), (b)(2), (b)(3).

<sup>133</sup> Refer to § 425.100(b); § 425.605(a)(6), (c); § 425.610(a)(7), (c).

<sup>134</sup> Refer to §§ 425.605(b)(4), 425.610(b)(3).

<sup>135</sup> Refer to § 425.605(d)(1)(i)(A)(2), (d)(1)(ii)(A)(2).

<sup>136</sup> Refer to § 425.605(d)(1)(iii)(A)(2), (d)(1)(iv)(A)(2), (d)(1)(v)(A)(2).

<sup>137</sup> Refer to § 425.610(d)(2).

<sup>138</sup> Refer to § 425.605(d)(1)(iii)(C), (d)(1)(iv)(C), (d)(1)(v)(C).

**Step 1:** Calculate the quotient of the MIPS Quality performance category points earned divided by the total MIPS Quality performance category points available.

**Step 2:** Calculate the product of the quotient determined in step 1 and 75 percent.

**Step 3:** Calculate the shared loss rate as 1 minus the product determined in step 2. The shared loss rate may not exceed 75 percent and may not be less than 40 percent.<sup>139</sup>

- If an ENHANCED track ACO fails to meet the quality performance standard established in § 425.512, the ACO will be accountable for shared losses based on the maximum shared loss rate of 75 percent.<sup>140</sup>

For a summary of the shared savings rate and shared loss rate (if applicable) by track/level of participation, refer to [Appendix A, Table 6](#).

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

For ACOs eligible for shared savings, CMS multiplies the final shared savings rate ([Section 4.3, Step 6](#)) 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](#)) by the ACO's losses ([Section 4.3, Step 4](#)). Note that shared savings and shared loss rates are applied on a first dollar basis, not only to savings or losses that exceed the MSR/MLR.<sup>141</sup>

#### **Step 8: Reduce shared savings amount by two percent for sequestration.**

CMS adjusts the shared savings amount for sequestration by reducing by two percent, as required by the Budget Control Act of 2011. This two percent reduction is applied after CMS applies the final shared savings rate to the ACO's savings (refer to [Section 4.3, Step 7](#)) 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](#)) at the applicable performance payment limit for the ACO's track.<sup>142</sup> 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).<sup>143</sup> For a summary of the performance payment limit and loss recoupment limit by track/level of participation, refer to [Appendix A, Table 6](#).

### **BASIC Track**

For ACOs in the BASIC track, the performance payment limit is 10 percent of total updated historical benchmark expenditures.<sup>144</sup> For ACOs in Levels 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

<sup>139</sup> Refer to § 425.610(f)(2)(i).

<sup>140</sup> Refer to § 425.610(f)(2)(ii).

<sup>141</sup> Refer to § 425.605(d)(1)(i)(B)(1), (d)(1)(ii)(B)(1), (d)(1)(iii)(B)(1), (d)(1)(iv)(B)(1), (d)(1)(v)(B)(1); § 425.610(e)(1).

<sup>142</sup> Refer to § 425.605(d)(1)(i)(B)(2), (d)(1)(ii)(B)(2), (d)(1)(iii)(B)(2), (d)(1)(iv)(B)(2), (d)(1)(v)(B)(2); § 425.610(e)(2).

<sup>143</sup> Refer to § 425.605(d)(1)(iii)(D), (d)(1)(iv)(D), (d)(1)(v)(D); § 425.610(g).

<sup>144</sup> Refer to § 425.605(d)(1)(i)(B)(2), (d)(1)(ii)(B)(2), (d)(1)(iii)(B)(2), (d)(1)(iv)(B)(2), (d)(1)(v)(B)(2).

participants in the ACO, not to exceed a percentage of the ACO's updated historical benchmark.<sup>145</sup> 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 3.7](#)). 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.

**If the revenue-based loss sharing limit exceeds the benchmark-based loss sharing limit, apply the benchmark-based loss sharing limit.**

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 percent of the ACO participants' total Medicare FFS revenue.

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

**Calculate benchmark-based loss sharing limit.**

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

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

**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<sup>146</sup> and the loss sharing limit is calculated as 15 percent of the ACO's total updated historical benchmark expenditures.<sup>147</sup>

<sup>145</sup> Refer to § 425.605(d)(1)(iii)(D), (d)(1)(iv)(D), (d)(1)(v)(D).

<sup>146</sup> Refer to § 425.610(e)(2).

<sup>147</sup> Refer to § 425.610(g).

## Step 10: Other adjustments that may apply

### *Withhold shared savings for advance payment recoupment (if applicable)*

Some ACOs participating in the Shared Savings Program also participated in the Advance Payment ACO Model or ACO Investment Model (AIM). Through the Advance Payment ACO Model and the AIM, selected small, rural, or physician-only ACOs received up-front and monthly payments that are considered an advance on future shared savings payments. CMS automatically withholds any shared savings payments earned during the agreement period until the full amount of advance payments to the ACO is offset and thereby repaid by the ACO. For a performance payment to be offset to repay advance payments, an ACO must qualify for a shared savings payment (meet the MSR requirement, meet the quality performance standard, and otherwise maintain its eligibility to participate in the Shared Savings Program).

For ACOs in the Advance Payment ACO Model or the AIM, the advance payment recoupment amount is subtracted after reducing the shared savings amount for sequestration (refer to [Section 4.3, Step 8](#)) and applying the performance payment limit (refer to [Section 4.3, Step 9](#)). In any given performance year, the repayment for advance payments cannot exceed the value of the earned shared savings.

### *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:

- (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.<sup>148</sup> 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.

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<sup>148</sup> Refer to §§ 425.605(f)(2), 425.610(i)(2).



**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.<sup>149</sup>

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.<sup>150</sup> 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](#).

**Example: Calculating Shared Savings for an ACO in Level B of the BASIC Track**

- Track: BASIC track; Level B
- 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%

*Steps in this example correspond with the steps described in the body of the text beginning with Step 4.*

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

$$\begin{aligned} & \text{Total updated benchmark expenditures} - \text{Total performance year expenditures} \\ & \$500M - \$487M = \$13M \text{ Savings} \end{aligned}$$

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.**

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

If savings (*in this example, \$13M*) are  $\geq$  the MSR (*in this example, \$10M*), proceed to next step. If not, the ACO is not eligible for a shared savings payment.

**Step 6: Final shared savings rate (percentage) based on quality performance.**

If the ACO met the quality performance standard, the sharing rate = maximum sharing rate.  
If the ACO failed to meet the quality performance standard, the sharing rate = 0%.

In this example, ACO met the quality performance standard; the ACO may share in savings at the maximum sharing rate of 40%.

**Step 7: Calculate the shared savings amount.**

$$\begin{aligned} & \text{Savings (step 4)} \times \text{Final shared savings rate (step 6)} \\ & \$13M \times 40\% = \$5.2M \text{ Shared savings amount} \end{aligned}$$

<sup>149</sup> Refer to §§ 425.605(e)(1), 425.610(h)(1).

<sup>150</sup> Refer to § 425.605(e)(2), (e)(3); § 425.610(h)(2), (h)(3).

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

$$\begin{aligned} & \text{Shared savings amount (step 7)} \times 2\% \\ & \$5.2M \times 2\% = \$104,000 \text{ Sequestration amount} \\ & \text{Subtract sequestration amount from shared savings amount} \\ & \$5.2M - \$104,000 = \$5,096,000 \end{aligned}$$

**Step 9: Apply the performance payment limit.**

$$\begin{aligned} & \text{Total updated benchmark expenditures} \times \text{Performance payment limit percentage} \\ & \$500M \times 10\% = \$50M \text{ Performance payment limit amount} \end{aligned}$$

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: Withhold shared savings for Advance Payment ACO Model or AIM recoupment, if applicable.**

This example assumes the ACO has not participated in the Advance Payment ACO Model or the AIM.

**Step 11: Determine earned performance payment amount.**

The ACO's earned performance payment = \$5,096,000.

**Example: Calculating Shared Losses for an ACO in the ENHANCED Track**

- 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 quality performance standard
- Maximum sharing rate: 75%
- Shared loss rate: between 40%-75%
- Loss sharing limit (percentage): 15%

Steps in this example correspond with the steps described in the body of the text beginning with Step 4.

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

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

If the difference is > 0, then the ACO may share in savings (refer to previous example for steps). However, 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.

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

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

If the absolute value of the losses (*in this example*, \$2.6M) is  $\geq$  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).**

If the ACO meets the quality performance standard, CMS determines the shared loss rate as follows (representing Steps 1, 2 and 3 described in section 4.3.1, step 6):

$$1 - \left[ \left( \frac{\text{MIPS Quality performance category points earned}}{\text{Total MIPS Quality performance category points available}} \right) \times 75\% \right]$$

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

If the ACO fails to meet the quality performance standard:

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

In this example, the ACO failed to meet the quality performance standard and the maximum shared loss rate of 75% is applied.

**Step 7: Calculate the shared loss amount.**

$$\begin{aligned} & \text{Losses} \times \text{shared loss rate} \\ & -\$2.6M \times 75\% = -\$1.95M \text{ Shared loss amount} \end{aligned}$$

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

**Step 9: Apply the loss sharing limit.**

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

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

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

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

**Step 10: 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: 1%

$$\begin{aligned} & \text{Shared losses} \times \text{percentage of year affected by extreme and uncontrollable circumstance} \\ & \times \text{percentage of assigned beneficiaries in affected counties} \\ & -\$1.95M \times 15\% \times 1\% = -\$2,925 \end{aligned}$$

In this example, shared losses of \$1.95M would be reduced by \$2,925 to adjust for extreme and uncontrollable circumstances.

**Step 11: Pay losses.**

In this example, the ACO must pay CMS the shared losses owed, \$1,947,075, within 90 days of receiving written notification from CMS.

## 4.4 PAYMENT CONSEQUENCES OF TERMINATION

For performance years beginning on July 1, 2019, and in subsequent years, CMS will impose payment consequences for early termination by holding ACOs in two-sided models liable for prorated shared losses. The prorated amount reflects the number of months during the performance year that the ACO was in the program. 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.<sup>151</sup>

The prorated share of losses is calculated as follows in the case of a 12-month performance year: the shared losses incurred during the 12 months of the performance year are multiplied by the quotient equal to the number of months of participation in the program during the performance year, including the month in which the termination was effective, divided by 12.<sup>152</sup>

ACOs will continue to be ineligible to share in savings for a performance year if the effective date of their termination from the program is prior to the last calendar day of the performance year, or if the participation agreement is terminated at any time by CMS, among other factors.<sup>153</sup>

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<sup>151</sup> Refer to § 425.221(b)(2)(ii).

<sup>152</sup> Refer to § 425.221(b)(2)(iii).

<sup>153</sup> Refer to § 425.221(b)(1).

## APPENDIX A: BASIC TRACK AND ENHANCED TRACK CHARACTERISTICS

*Table 6. Comparison of risk and reward under BASIC track and ENHANCED track*

CHARACTERISTIC	BASIC TRACK'S GLIDE PATH				ENHANCED TRACK (RISK/REWARD)
	LEVEL A & LEVEL B (ONE-SIDED MODEL)	LEVEL C (RISK/REWARD)	LEVEL D (RISK/REWARD)	LEVEL E (RISK/REWARD)	
Shared Savings (once MSR met or exceeded) <sup>154</sup>	1 <sup>st</sup> dollar savings at a rate of 40% if quality performance standard is met; not to exceed 10% of updated benchmark	1 <sup>st</sup> dollar savings at a rate of 50% if quality performance standard is met, not to exceed 10% of updated benchmark	1 <sup>st</sup> dollar savings at a rate of 50% if quality performance standard is met, not to exceed 10% of updated benchmark	1 <sup>st</sup> dollar savings at a rate of 50% if quality performance standard is met, not to exceed 10% of updated benchmark	1 <sup>st</sup> dollar savings at a rate of 75% if quality performance standard is met, not to exceed 20% of updated benchmark
Shared Losses (once MLR met or exceeded)	N/A	1 <sup>st</sup> dollar losses at a rate of 30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	1 <sup>st</sup> dollar losses at a rate of 30%, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	1 <sup>st</sup> dollar losses at a rate of 30%, not to exceed 8% of ACO participant revenue in 2019–2024, capped at 4% of updated benchmark. The loss recoupment limit is the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program (QPP) <sup>155</sup> capped at 1 percentage point higher than the benchmark-based nominal risk amount <sup>156</sup>	1 <sup>st</sup> dollar losses at a rate based on quality performance, with minimum shared loss rate of 40% and maximum of 75%, not to exceed 15% of updated benchmark

<sup>154</sup> ACOs that fail to meet the quality performance standard are ineligible to share in savings.

<sup>155</sup> Refer to § 414.1415(c)(3)(i)(A).

<sup>156</sup> Refer to § 414.1415(c)(3)(i)(B).

CHARACTERISTIC	BASIC TRACK'S GLIDE PATH				ENHANCED TRACK (RISK/REWARD)
	LEVEL A & LEVEL B (ONE-SIDED MODEL)	LEVEL C (RISK/REWARD)	LEVEL D (RISK/REWARD)	LEVEL E (RISK/REWARD)	
Annual choice of beneficiary assignment methodology?	Yes	Yes	Yes	Yes	Yes
Annual election to enter higher risk?	Yes, but new, low revenue ACOs may elect an additional year under Level B if they commit to completing the remainder of their agreement under Level E	Yes	No; ACOs will automatically transition to Level E at the start of the next performance year.	No; maximum level of risk/reward under the BASIC track	No; highest level of risk/reward under Shared Savings Program
Advanced APM status under the Quality Payment Program?	No	No	No	Yes	Yes

NOTE: For more information refer to the similar table and related notes at 83 FR 67852 through 67853 (available at <https://www.govinfo.gov/content/pkg/FR-2018-12-31/pdf/2018-27981.pdf#page=37>).



## APPENDIX B: ASSIGNMENT WINDOW AND EXPENDITURES PERIOD DATES

**Table 7.** 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 July 1, 2019, January 1, 2020, or January 1, 2022<sup>157</sup>

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)
July 1, 2019 (Starters and Renewals)	PY4: CY 2022	Jan 1, 2022–Dec 31, 2022	Oct 1, 2020–Sep 30, 2021	Through Sep 30, 2021	Jan 1, 2022–Dec 31, 2022
	PY3: CY 2021	Jan 1, 2021–Dec 31, 2021	Oct 1, 2019–Sep 30, 2020	Through Sep 30, 2020	Jan 1, 2021–Dec 31, 2021
	PY2: CY 2020	Jan 1, 2020–Dec 31, 2020	Oct 1, 2018–Sep 30, 2019	Through Sep 30, 2019	Jan 1, 2020–Dec 31, 2020
	PY1: July 1, 2019–Dec 31, 2019	Jan 1, 2019–Dec 31, 2019	Oct 1, 2017–Sep 30, 2018	Through April 30, 2019	Jan 1, 2019–Dec 31, 2019
	BY3: CY 2018	Jan 1, 2018–Dec 31, 2018	Oct 1, 2016–Sep 30, 2017	Through Oct 31, 2017	Jan 1, 2018–Dec 31, 2018
	BY2: CY 2017	Jan 1, 2017–Dec 31, 2017	Oct 1, 2015–Sep 30, 2016	N/A	Jan 1, 2017–Dec 31, 2017
	BY1: CY 2016	Jan 1, 2016–Dec 31, 2016	Oct 1, 2014–Sep 30, 2015	N/A	Jan 1, 2016–Dec 31, 2016
January 1, 2020 (Starters and Renewals)	PY3: CY 2022	Jan 1, 2022–Dec 31, 2022	Oct 1, 2020–Sep 30, 2021	Through Sep 30, 2021	Jan 1, 2022–Dec 31, 2022
	PY2: CY 2021	Jan 1, 2021–Dec 31, 2021	Oct 1, 2019–Sep 30, 2020	Through Sep 30, 2020	Jan 1, 2021–Dec 31, 2021
	PY1: CY 2020	Jan 1, 2020–Dec 31, 2020	Oct 1, 2018–Sep 30, 2019	Through Sep 30, 2019	Jan 1, 2020–Dec 31, 2020
	BY3: CY 2019	Jan 1, 2019–Dec 31, 2019	Oct 1, 2017–Sep 30, 2018	Through Oct 31, 2018	Jan 1, 2019–Dec 31, 2019

<sup>157</sup> Refer to 425.600(a)(4)(i)(B)(2)(v)

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)
	BY2: CY 2018	Jan 1, 2018– Dec 31, 2018	Oct 1, 2016– Sep 30, 2017	Through Oct 31, 2017	Jan 1, 2018– Dec 31, 2018
	BY1: CY 2017	Jan 1, 2017– Dec 31, 2017	Oct 1, 2015– Sep 30, 2016	N/A	Jan 1, 2017– Dec 31, 2017
January 1, 2022 (Starters and Renewals)	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	Jan 1, 2021– Dec 31, 2021	Oct 1, 2019– Sep 30, 2020	Through Sep 30, 2020	Jan 1, 2021– Dec 31, 2021
	BY2: CY 2020	Jan 1, 2020– Dec 31, 2020	Oct 1, 2018– Sep 30, 2019	Through Sep 30, 2019	Jan 1, 2020– Dec 31, 2020
	BY1: CY 2019	Jan 1, 2019– Dec 31, 2019	Oct 1, 2017– Sep 30, 2018	Through Oct 31, 2018	Jan 1, 2019– Dec 31, 2019

## 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 HCPCS and revenue center codes designated under § 425.400(c). [Table 8](#) lists the primary care service codes (HCPCS and CPT codes), according to § 425.400(c)(1)(vi), for purposes of assigning beneficiaries for the performance year starting on January 1, 2022, 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/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/CPT codes specified in Table 8.

*Table 8. Primary care service codes for purposes of assigning beneficiaries according to § 425.400(c)(1)(vi)*

PRIMARY CARE SERVICE CODES
96160 Administration of Health Risk Assessment
96161 Administration of Health Risk Assessment
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)
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)

## PRIMARY CARE SERVICE CODES

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)

99324 New Patient, brief (patient domiciliary, rest home, or custodial care visit)

99325 New Patient, limited (patient domiciliary, rest home, or custodial care visit)

99326 New Patient, moderate (patient domiciliary, rest home, or custodial care visit)

99327 New Patient, comprehensive (patient domiciliary, rest home, or custodial care visit)

99328 New Patient, extensive (patient domiciliary, rest home, or custodial care visit)

99334 Established Patient, brief (patient domiciliary, rest home, or custodial care visit)

99335 Established Patient, moderate (patient domiciliary, rest home, or custodial care visit)

99336 Established Patient, comprehensive (patient domiciliary, rest home, or custodial care visit)

99337 Established Patient, extensive (patient domiciliary, rest home, or custodial care visit)

99339, brief (patient domiciliary, rest home, or custodial care visit)

99340, comprehensive (patient domiciliary, rest home, or custodial care visit)

99341 New Patient, brief (evaluation and management services furnished in a patient's home for claims identified by place of service modifier 12)

99342 New Patient, limited (evaluation and management services furnished in a patient's home for claims identified by place of service modifier 12)

99343 New Patient, moderate (evaluation and management services furnished in a patient's home for claims identified by place of service modifier 12)

99344 New Patient, comprehensive (evaluation and management services furnished in a patient's home for claims identified by place of service modifier 12)

99345 New Patient, extensive (evaluation and management services furnished in a patient's home for claims identified by place of service modifier 12)

99347 Established Patient, brief (evaluation and management services furnished in a patient's home for claims identified by place of service modifier 12)

99348 Established Patient, moderate (evaluation and management services furnished in a patient's home for claims identified by place of service modifier 12)

99349 Established Patient, comprehensive (evaluation and management services furnished in a patient's home for claims identified by place of service modifier 12)

## PRIMARY CARE SERVICE CODES

99350 Established Patient, extensive (evaluation and management services furnished in a patient's home for claims identified by place of service modifier 12)
99354 Prolonged Services with Direct Patient Contact (prolonged evaluation and management or psychotherapy services beyond the typical service time of the primary procedure)
99355 Prolonged Services with Direct Patient Contact (prolonged evaluation and management or psychotherapy services beyond the typical service time of the primary procedure)
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 (PCM)
99425 Principal Care Management (PCM)
99426 Principal Care Management (PCM)
99427 Principal Care Management (PCM)
99437 Chronic Care Management (CCM)
99439 Non-Complex Chronic Care Management Services
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
99483 Assessment 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 (behavioral health integration services)
99493 Behavioral Health Integration (behavioral health integration services)
99494 Behavioral Health Integration (behavioral health integration services)
99495 Transitional Care Management Services
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)
G0402 Welcome to Medicare Visit
G0438 Annual Wellness Visit
G0439 Annual Wellness Visit

PRIMARY CARE SERVICE CODES
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
G2010 Remote Evaluation of Patient Video/Images
G2012 Virtual Check-In
G2058 Non-Complex Chronic Care Management Service
G2064 Comprehensive Care Management Service (principal care management services)
G2065 Comprehensive Care Management Service (principal care management services)
G2212 Prolonged Office or other Outpatient Evaluation and Management (E/M) Service
G2214 Psychiatric Collaborative Care Model
G2252 Communication Technology-Based Service (CTBS)

*NOTE: Table 8 contains all codes in ranges specified in § 425.400(c)(1)(v) 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)(A)(3), 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 through 99318 are excluded when furnished in a SNF. 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 through 99318, or an FQHC/RHC submits a claim including a qualifier CPT code 99304 through 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/RHC service.*

*According to § 425.400(c)(1)(v)(A)(13), 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. 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 through 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 9](#) 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,<sup>158</sup> 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 9. Physician specialty codes used in assignment*

SPECIALTY CODE	DESCRIPTION	PRIMARY CARE PHYSICIAN (STEP 1)	SPECIALIST (STEP 2)
01	General practice	Yes	No
06	Cardiology	No	Yes
08	Family practice	Yes	No
11	Internal medicine	Yes	No
12	Osteopathic manipulative medicine	No	Yes
13	Neurology	No	Yes
16	Obstetrics/gynecology	No	Yes
23	Sports medicine	No	Yes
25	Physical medicine and rehabilitation	No	Yes
26	Psychiatry	No	Yes
27	Geriatric psychiatry	No	Yes
29	Pulmonary disease	No	Yes
37	Pediatric medicine	Yes	No
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/RHCs participating in an ACO, CMS will use all claims for services furnished by all FQHC/RHC practitioners submitted by the FQHC or RHC, for assignment operations.*

<sup>158</sup> For performance year 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 10](#) lists specialty codes for non-physician practitioners included in claims-based assignment Step 1.

**Table 10.** 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 is limited to outpatient facility claims. As described in this appendix, additional steps are used to identify data on outpatient facility claims. [Table 11](#) 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 National Claims History (NCH) and 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/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” 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/RHCs, CMS treats all services reported on an FQHC/RHC claim as a primary care service performed by a primary care physician.<sup>159</sup> If a beneficiary is eligible for assignment to an ACO, then CMS uses all claims for services furnished by all FQHC/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/RHC.

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<sup>159</sup> 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 Physician Fee Schedule for similar services in the geographic location of the teaching hospital, as a proxy for the amount of the allowed charges for the service. (Refer to 80 FR 32757, 80 FR 71272–71273.)

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.<sup>160</sup> 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 8](#) lists the HCPCS codes that will be used to identify primary care services for ETA institutional claims. However, two codes, G0438 and G0439, are 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 claims are imputed using the formula used by Medicare’s Physician Fee Schedule for calculating allowed charges for each HCPCS code.

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<sup>160</sup> The physician services, per se, are reimbursed during settlement of the annual Medicare Cost Report for ETA hospitals.

**Table 11.** Bill types used for identifying Method II CAH, FQHC/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, and assignment Step 1 or assignment Step 2).	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, and assignment Step 1 or assignment Step 2).	§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).	§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).	§425.404(b)

*NOTE: Refer to Table 9 for physician specialty codes used in claims-based assignment (indicating use in assignment Step 1 or assignment step 2), and Table 10 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/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 Medicare Advantage defines post-graft beneficiaries for purposes of CMS-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).<sup>161</sup> 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 age 18 to 64 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.

### DUALLY 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,<sup>162</sup> including:

- Qualified Medicare Beneficiaries (QMBs) (referred to as having “partial-benefits”) and Qualified Medicare Beneficiaries plus full Medicaid or 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.
- Other full benefit dual eligible/Medicaid-only dual eligible beneficiaries, identified by dual status code 08.

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<sup>161</sup> Refer to [CMS Form 2728](#).

<sup>162</sup> Refer to [“Defining Medicare-Medicaid Enrollees in CMS Data Sources”](#) (Version date: February 16, 2017)



Individuals qualify for Medicare based on age if they are 65 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:

**Assignment List Report** provides ACOs with beneficiary identifiable information on their 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 that received a primary care service from an ACO participant upon whom assignment is based during the most recent 12-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).

**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.

**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 is not risk-adjusted.

**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.

**Non-Claims Based Payment File** provides beneficiary-level data on non-claims based payments for the ACO's assigned population. 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.

**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 summer of the first performance year of their new agreement period, based on finalized data for BY3.

For the second and each subsequent performance year during the term of the agreement period, an ACO's historical benchmark is adjusted annually to account for the following, as applicable: for the addition and removal of ACO participants or ACO providers/suppliers in accordance with § 425.118(b), for a change to the ACO's beneficiary assignment methodology selection under § 425.226(a)(1), and for a change to the beneficiary assignment methodology specified in 42 CFR part 425, subpart E. The ACO's historical benchmark will also be adjusted if there are regulatory changes to the Shared Savings Program's benchmarking methodologies. 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 blend of national and regional growth rates) is provided to all ACOs as part of the with 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.

**Financial Reconciliation Report** specifies the ACO's historical benchmark, updated historical benchmark, and determination of shared savings/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 ACOs under prospective assignment versus ACOs under preliminary prospective assignment with retrospective reconciliation (refer to [Appendix B, Table 7](#)). [Table 12](#) 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 13](#) provides a comparison of the same characteristics for ACOs under prospective assignment.

**Table 12.** 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	Most recent 12 months	Calendar Year	Most recent 12 months	Calendar Year	Calendar Year
Expenditure Completion Factors	N/A	N/A	1.072	1.013	1.013
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 13.** 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 <a href="#">Appendix B, Table 7</a> )	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	Q1 1.349 Q2 1.154 Q3 1.105 Q4 1.072	1.013	1.013
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](#)).

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

## LIST OF ABBREVIATIONS

Acronym	Definition
ACO	Accountable Care Organization
ACO-MS	Accountable Care Organization Management System
APM	Alternative Payment Model
BY	Benchmark Year
CAH	Critical Access Hospital
CCN	CMS Certification Number
CFR	Code of Federal Regulations
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CMS	Centers for Medicare & Medicaid Services
CMS-HCC	CMS Hierarchical Condition Category
COVID-19	Coronavirus disease 2019
CNS	Clinical Nurse Specialist
CPT® <sup>163</sup>	Current Procedural Terminology
CY	Calendar Year
DME	Durable Medical Equipment
DO	Doctor of Osteopathic Medicine
DSH	Disproportionate Share Hospital
EIN	Employer Identification Number
ESRD	End-Stage Renal Disease
ETA	Electing Teaching Amendment
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
IDR	Integrated Data Repository
IFC	Interim Final Rule with Comment Period
IME	Indirect Medical Education
MA	Medicare Advantage
MD	Medical Doctor
MIPS	Merit-based Incentive Payment System
MLR	Minimum Loss Rate
MSP	Medicare Secondary Payer
MSR	Minimum Savings Rate
NCH	National Claims History
NP	Nurse Practitioner
NPI	National Provider Identifier
OACT	CMS Office of the Actuary
OPPS	Outpatient Prospective Payment System
PA	Physician Assistant
PACE	Program of All-Inclusive Care for the Elderly
PECOS	Provider Enrollment, Chain, and Ownership System
PFS	Physician Fee Schedule
PHE	Public health emergency
PY	Performance Year
QMBs	Qualified Medicare beneficiaries
RHC	Rural Health Clinic
SLMBs	Specified Low-Income Medicare beneficiaries
SNF	Skilled Nursing Facility
SSN	Social Security Number
TIN <sup>164</sup>	Taxpayer Identification Number

<sup>163</sup> CPT is copyright 2011 American Medical Association. All rights reserved.

<sup>164</sup> TINs are assigned by the U.S. Internal Revenue Service. There are two types of TINs: Social Security numbers and Employer Identification Numbers.