Medicare Shared Savings Program

SHARED SAVINGS AND LOSSES, ASSIGNMENT AND QUALITY PERFORMANCE STANDARD METHODOLOGY

Specifications of the Accountable Care Prospective Trend (ACPT) and Three-Way Blended Benchmark Update Factor

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
MEDICARE SHARED SAVINGS PROGRAM

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Executive Summary

This document describes specifications for certain Medicare Shared Savings Program (Shared Savings Program) benchmarking calculations applicable to Accountable Care Organizations (ACOs) entering agreement periods beginning on January 1, 2024, and in subsequent years as specified in 42 Code of Federal Regulations (CFR) §§ 425.650 through 425.660. This document focuses on describing the calculation of a prospective, external factor—the Accountable Care Prospective Trend (ACPT)—as a component of a three-way blended update factor to the historical benchmark as specified in §§ 425.652(b) and 425.660. This document includes the following:

- Description of regulatory background (Section 1).
- Description of select calculations of the benchmarking methodology applicable to ACOs entering agreement period beginning on January 1, 2024, and in subsequent years (Section 2).
- Description of terminology used to refer to inputs used to calculate the ACPT (Section 3).
- Description and examples of steps to calculate the ACPT (Section 4).
- Description of the calculation of the ACPT/national-regional three-way blended benchmark update factor (Section 5).
- Description of the guardrail policy to protect ACOs from larger shared losses (or potentially from the negative implications of financial monitoring) based on an updated benchmark computed using the three-way blend, rather than under the two-way national-regional blend (Section 6).
- Description of the Centers for Medicare & Medicaid Services' (CMS's) discretion to reweight the components of the three-way blend in the event of unforeseen circumstances (Section 7).

1 Regulatory Background

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 finalized modifications to the Shared Savings Program benchmarking policies for ACOs in agreement periods beginning on January 1, 2024, and in subsequent years, through the final rule titled "Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use

Package Drugs To Provide Refunds With Respect to Discarded Amounts; and COVID-19 Interim Final Rules," which appeared in the November 18, 2022, *Federal Register* (see 87 FR 69404) (hereafter referred to as the "CY 2023 PFS final rule") and is available on the *Federal Register* website. Refer to 87 FR 69875 through 69958.

2 Summary of Select Calculations of the Benchmarking Methodology

The benchmarking methodology applicable to ACOs entering agreement periods beginning on January 1, 2024, and in subsequent years, is specified in 42 CFR §§ 425.650 through 425.660. We refer readers to the Shared Savings Program regulations for further information on historical benchmark calculations. To follow is a brief summary of select calculations of the benchmarking methodology.

CMS establishes an ACO's historical benchmark near the start of an ACO's first agreement period. For ACOs entering second or subsequent agreement periods, CMS resets (or rebases) the historical benchmark near the start of each new agreement period. For the second and each subsequent performance year during the term of the agreement period, an ACO's historical benchmark is adjusted annually (i.e., adjusted historical benchmark) to account for certain changes, as applicable.

The historical benchmark calculation involves historical expenditures for the ACO's assigned beneficiaries as well as expenditures CMS calculates for assignable fee-for-service (FFS) beneficiaries in the ACO's regional service area.

In establishing an ACO's historical benchmark for its first agreement period under the Shared Savings Program, or in resetting (or rebasing) the benchmark for an ACO that renews its agreement for a second or subsequent agreement period, CMS determines the per capita Parts A and B FFS expenditures for beneficiaries who would have been assigned to the ACO in the 3 most recent years (i.e., benchmark years) prior to the start of the agreement period using the ACO participant Taxpayer Identification Numbers identified before the start of the agreement period and the beneficiary assignment methodology selected by the ACO for the first performance year (PY) of the agreement period.[1] CMS makes separate expenditure calculations for each of the following populations of beneficiaries (based on Medicare enrollment type): end-stage renal disease (ESRD), disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries. For each ACO, CMS calculates the annualized, truncated per capita expenditures for each of the three benchmark years (BY1–BY3) for each Medicare enrollment type.[2]

CMS trends forward expenditures for each benchmark year (BY1 and BY2) to BY3 dollars, using a blend of national and regional growth rates, and makes separate

[1] Refer to § 425.652(a) introductory text, and § 425.652(c) (resetting the benchmark).
[2] Refer to § 425.652(a)(4).

calculations for each Medicare enrollment type.[3] CMS adjusts the historical benchmark based on the ACO's regional service area expenditures (as specified under § 425.656) (referred to as the regional adjustment), or for savings generated by the ACO, if any, in the 3 most recent years prior to the start of the agreement period, if applicable (as specified under § 425.658) (referred to as the prior savings adjustment), or a combination of these two adjustments.[4] CMS risk-adjusts benchmark year expenditures for changes in severity and case mix using prospective CMS-Hierarchical Condition Category (HCC) risk scores for each Medicare enrollment type.[5]

CMS calculates an updated historical benchmark for each performance year during annual financial reconciliation. An ACO's historical benchmark—either the 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—is adjusted and updated at the time of financial reconciliation to reflect certain changes between BY3 and the performance year.[6]

In the calendar year (CY) 2023 Physician Fee Schedule (PFS) final rule, CMS finalized modifications to the methodology for annually updating the ACO's historical benchmark during the ACO's agreement period (refer to 87 FR 69881 through 69898). For agreement periods beginning on January 1, 2024, and in subsequent years, CMS will incorporate a fixed projected growth rate determined at the beginning of the ACO's agreement period called the ACPT into the blended update factor (described in § 425.652(b) when updating an ACO's benchmark for each performance year of the agreement period.[7] Under this approach, we will use a three-way blend calculated as the weighted average of the ACPT (one-third) and the existing two-way blend of national and regional growth rates ("two-way blend") (two-thirds) in updating an ACO's historical benchmark between BY3 and the performance year. Refer to § 425.660 specifying the determination of the ACPT, and § 425.652(b) specifying the calculation of the updated benchmark including provisions on the calculation of the two-way blend,[8] determining the weight placed on the two-way blend and the ACPT, and circumstances in which CMS will recalculate the updated benchmark using the two-way blend instead of the three-way blend.

[3] Refer to § 425.652(a)(5).
[4] Refer to § 425.652(a)(8).
[5] Refer to § 425.652(a)(3).
[6] Refer to §§ 425.652(a)(10) and 425.652(b).
[7] Refer to § 425.660(a).
[8] For agreement periods beginning on January 1, 2024, and in subsequent years, the calculation of the two-way blend is specified in § 425.652(b)(2). For additional detail on the two-way blend, particularly as applicable for earlier agreement periods, refer to the discussion of background in the CY 2023 PFS final rule (87 FR 69881–69882), and Medicare Shared Savings Program Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Version 11 Specifications.

This document focuses on describing the calculation of a prospective, external factor—the ACPT as a component of a three-way blended update factor to the historical benchmark.

3 Terminology

The methodology under which CMS uses the ACPT as a component of a three-way blended update factor (also referred to as the "three-way blend") introduced new inputs to the calculation of the benchmark update. Discussions in the CY 2023 PFS final rule generally used the term ACPT to refer to various inputs. For clarity and ease of reference, the following terminology is used to refer to the inputs used to calculate the ACPT within this document.

- **United States Per Capita Costs (USPCC)**. The CMS Office of the Actuary (OACT) provides projections of Medicare program spending for various recurring deliverables, including the Medicare Trustees Report and the Advance Notice and Announcement of Medicare Advantage capitation rates and Part C and Part D payment policies. These publications include both historical and projected future Medicare spending amounts expressed on a per capita basis. These amounts published in the Advance Notice and the Announcement are labeled the FFS USPCCs.[9]
- **Modified USPCC Annualized Growth Rates**. OACT will use a modification of the existing FFS USPCC growth trend projections used annually for establishing Medicare Advantage rates, to reflect the following: (1) exclusion of payments for indirect medical education and disproportionate share hospitals, and the supplemental payment for Indian Health Service/Tribal hospitals and Puerto Rico hospitals; and (2) inclusion of payments associated with hospice claims.[10] OACT will produce separate Modified USPCCs for the ESRD population and the non-ESRD aged/disabled ("Aged/Disabled") population.[11] OACT will calculate one or more Modified USPCC annualized growth rates for the ESRD population (herein referred to as ESRD Modified USPCC Annualized Growth Rates) and one or more annualized growth rates for the Aged/Disabled population (herein referred to as Aged/Disabled Modified USPCC Annualized Growth Rates) (collectively referred to Modified USPCC Annualized Growth Rates). These annualized growth rates will remain fixed over the ACO's agreement period.[12]
- **Cumulative Modified USPCC Growth Rates**. OACT calculates Cumulative Modified USPCC Growth Rates for the performance years within an agreement period from the Modified USPCC Annualized Growth Rates—for the ESRD

[9] Refer to 87 FR 69882. FFS trend data can be accessed at https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/ffs-trends.
[10] Refer to § 425.660(b)(1) and 87 FR 69882.
[11] Refer to § 425.660(b)(2) and 87 FR 69882–69883.
[12] Refer to § 425.660(b)(2).

population (herein referred to as ESRD Cumulative Modified USPCC Growth Rate) and for the non-ESRD aged/disabled population (herein referred to as Aged/Disabled Cumulative Modified USPCC Growth Rate).

- **Flat Dollar Amount**. CMS generates separate flat dollar amounts for each of four Medicare enrollment types. The ESRD Cumulative Modified USPCC Growth Rate is used in calculating the flat dollar amount for the ESRD population.[13] The Aged/Disabled Cumulative Modified USPCC Growth Rate is used in calculating the flat dollar amounts for the following populations: disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries.[14]
- **ACO Risk-Adjusted Flat Dollar Amount**. The ACO Risk-Adjusted Flat Dollar Amount represents the Flat Dollar Amount for each performance year and each Medicare enrollment type, risk-adjusted based on the ACO's renormalized, BY3 prospective CMS-HCC risk score for that enrollment type.[15]
- **ACPT**. The ACPT refers to the final input that is blended with the two-way blend to produce the three-way blended update factor. The ACPT represents the ACO Risk-Adjusted Flat Dollar Amount re-expressed on a relative basis by dividing by an ACO's historical benchmark expenditures for each Medicare enrollment type.[16]

Additional details on how these inputs are calculated are provided in Section 4 of this document.

4 Calculating the ACPT

This section outlines the steps for the calculation of the ACPT and includes examples, using hypothetical values, to illustrate the calculation steps.

Step 1: Calculation of Annualized Growth Rate(s) for Agreement Period

OACT will calculate one or more Modified USPCC annualized growth rates for the ESRD population and one or more annualized growth rates for the Aged/Disabled population (herein referred to as Modified USPCC Annualized Growth Rates). These annualized growth rates will remain fixed over the ACO's agreement period.[17] The Modified USPCC Annualized Growth Rate is an annual rate of growth in projected expenditures during the ACO's 5-year agreement period relative to BY3, calculated as follows:

[13] Refer to § 425.660(b)(3)(i).
[14] Refer to § 425.660(b)(3)(ii).
[15] Refer to § 425.660(b)(4).
[16] Refer to § 425.660(b)(5).
[17] Refer to § 425.660(b)(2). See also 87 FR 69883.

- Using a uniform annualized projected rate of growth over each of the 5 performance years of the 5-year agreement period; or
- If annualization as specified earlier is determined not to reasonably fit the anticipated growth curve, CMS will apply an alternative annualization technique using two or more annualized growth rates reflecting the projected rates of growth during the 5 performance years comprising the 5-year agreement period.[18]

Tables 1A and 1B summarize the projected ESRD Modified USPCC Annualized Growth Rates and Aged/Disabled Modified USPCC Annualized Growth Rates, respectively, simulated for Shared Savings Program agreement periods.

Table 1A. *Summary of projected ESRD Modified USPCC Annualized Growth Rates, simulated for periods of five, 12-month PYs corresponding to agreement period start dates between 2014 and 2024*

AGREEMENT PERIOD START YEAR	PROJECTED MODIFIED USPCC ANNUALIZED GROWTH RATES				
	PY1	PY2	PY3	PY4	PY5
2014	0.6%	2.3%	4.4%	4.4%	5.0%
2015	2.4%	2.4%	3.6%	4.3%	3.6%
2016	0.9%	2.6%	2.6%	3.3%	3.3%
2017	2.5%	2.5%	4.2%	4.2%	4.2%
2018	7.3%	3.3%	3.3%	4.3%	4.3%
2019	2.2%	3.0%	4.0%	4.0%	4.0%
2020	2.6%	2.6%	2.6%	3.4%	3.4%
2021	7.3%	7.3%	2.2%	3.8%	10.3%*
2022	7.5%	4.2%	4.2%	10.2%*	4.5%
2023	8.1%	6.8%	14.2%*	7.4%	5.3%
2024[1]	5.1%†	7.5%*	5.5%	5.5%	8.0%

** Growth in ESRD spending in 2025 is expected to be significantly higher than that in neighboring years because phosphate binder medications are scheduled to be included in the Prospective Payment System bundle starting January 1, 2025.*

† CMS has recalculated the projected modified USPCC annualized growth rate for agreement periods starting January 1, 2024, and for PY1 CMS performed an adjustment to effectively remove COVID-19 episode expenditures for January through May 2023 that were included in version 2 of this document, 2023 is the base year for the agreement period start year 2024 PY1 USPCC calculation.

[1] CMS has made adjustments for payments associated with some HCPCS codes for BY3 in projecting per capita growth in Parts A and B FFS expenditures. For more details, refer to § 425.670(e).

Source: Projections were simulated using archived OACT projection data corresponding to the USPCCs released in the spring of the respective PY1 for each listed agreement period start date. In certain years, adjustments necessitated reliance on internal data archived from Medicare Trustees Reports published the same year.

[18] Refer to § 425.660(b)(2).

Table 1B. *Summary of projected Aged/Disabled Modified USPCC Annualized Growth Rates, simulated for periods of five, 12-month PYs corresponding to agreement period start dates between 2014 and 2024*

AGREEMENT PERIOD START YEAR	PROJECTED MODIFIED USPCC ANNUALIZED GROWTH RATES				
	PY1	PY2	PY3	PY4	PY5
2014	1.0%	2.0%	2.6%	3.9%	4.7%
2015	2.1%	2.1%	4.4%	4.4%	4.4%
2016	1.3%	3.4%	3.4%	4.8%	4.8%
2017	2.7%	2.7%	4.9%	4.9%	4.9%
2018	2.9%	4.1%	4.1%	4.8%	4.8%
2019	4.2%	4.2%	5.0%	5.0%	5.0%
2020	5.6%	4.6%	4.6%	4.6%	4.6%
2021	11.5%	10.3%	3.0%	5.1%	5.1%
2022	9.4%	5.3%	5.3%	5.3%	5.3%
2023	8.7%	4.4%	4.4%	4.4%	5.8%
2024[1]	4.9%[†]	4.3%	4.4%	5.8%	4.3%

[†] CMS has recalculated the projected modified USPCC annualized growth rate for agreement periods starting January 1, 2024, and for PY1 CMS performed an adjustment to effectively remove COVID-19 episode expenditures for January through May 2023 that were included in version 2 of this document, 2023 is the base year for the agreement period start year 2024 PY1 USPCC calculation.

[1] CMS has made adjustments for payments associated with some HCPCS codes for BY3 in projecting per capita growth in Parts A and B FFS expenditures. For more details, refer to § 425.670(e).

Source: Projections were simulated using archived OACT projection data corresponding to the USPCCs released in the spring of the respective PY1 for each listed agreement period start date. In certain years, adjustments necessitated reliance on internal data archived from Medicare Trustees Reports published the same year.

CMS uses the Modified USPCC Annualized Growth Rates to calculate cumulative growth rates for each population for each performance year within an agreement period (herein Cumulative Modified USPCC Growth Rates). Example 1 illustrates the calculation of Cumulative Modified USPCC Growth Rates.

Example 1: Calculating Cumulative Modified USPCC Growth Rates

For example, using values from **Table 1B**, the Aged/Disabled Cumulative Modified USPCC Growth Rates for ACOs that began an agreement period on January 1, 2022, would hypothetically be as follows for PY1 through PY5 (CYs 2022 through 2026, respectively):[19]

- $PY1\ Cumulative\ Modified\ USPCC\ Growth\ Rate = 1 + Projected\ Modified\ USPCC\ Annualized\ Growth\ Rate_{PY1} = 1 + 9.4\% = \mathbf{1.094}$
- $PY2\ Cumulative\ Modified\ USPCC\ Growth\ Rate = Cumulative\ Modified\ USPCC\ Growth\ Rate_{PY1} \times (1 + Projected\ Modified\ USPCC\ Annualized\ Growth\ Rate_{PY2}) = 1.094 \times (1 + 5.3\%) = \mathbf{1.152}$
- $PY3\ Cumulative\ Modified\ USPCC\ Growth\ Rate = Cumulative\ Modified\ USPCC\ Growth\ Rate_{PY2} \times (1 + Projected\ Modified\ USPCC\ Annualized\ Growth\ Rate_{PY3}) = 1.152 \times (1 + 5.3\%) = \mathbf{1.213}$
- $PY4\ Cumulative\ Modified\ USPCC\ Growth\ Rate = Cumulative\ Modified\ USPCC\ Growth\ Rate_{PY3} \times (1 + Projected\ Modified\ USPCC\ Annualized\ Growth\ Rate_{PY4}) = 1.213 \times (1 + 5.3\%) = \mathbf{1.277}$
- $PY5\ Cumulative\ Modified\ USPCC\ Growth\ Rate = Cumulative\ Modified\ USPCC\ Growth\ Rate_{PY4} \times (1 + Projected\ Modified\ USPCC\ Annualized\ Growth\ Rate_{PY5}) = 1.277 \times (1 + 5.3\%) = \mathbf{1.345}$

Note that these Cumulative Modified USPCC Growth Rates would be applicable for the following Shared Savings Program Medicare enrollment types: disabled, aged/dual eligible, and aged/non-dual eligible.

Step 2: Express the Cumulative Modified USPCC Growth Rates for Each Performance Year as Flat Dollar Amounts by Medicare Enrollment Type

For each performance year, CMS will multiply the applicable Cumulative Modified USPCC Growth Rates described in Step 1 by BY3 truncated national per capita FFS Medicare expenditures for assignable beneficiaries for each Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries) identified for the 12-month calendar year corresponding to BY3 to express the annualized growth rate as flat dollar amounts (see Example 2).[20] The ESRD Cumulative Modified USPCC Growth Rate is used in calculating the flat dollar amount for the ESRD population.[21] The Aged/Disabled Cumulative Modified USPCC Growth Rate is used in calculating the flat dollar amounts

[19] The example calculations in this document are based on annualized growth rates projected for an agreement period beginning on January 1, 2022. However, note that the three-way blended benchmark update factor is applicable to agreement periods beginning on January 1, 2024, and in subsequent years.
[20] Refer to § 425.660(b)(3).
[21] Refer to § 425.660(b)(3)(i).

for the following populations: disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries.[22,23]

Example 2: Expressing the Cumulative Modified USPCC Growth Rates for Each Performance Year as Flat Dollar Amounts by Medicare Enrollment Type

The following formula specifies the calculation for expressing the Cumulative Modified USPCC Growth Rates for each performance year as a flat dollar amount.

$$Flat\ dollar\ amount = BY3\ truncated\ national\ assignable\ expenditure\ amount\ for\ enrollment\ type \times (projected\ PY\ Cumulative\ Modified\ USPCC\ Growth\ Rate - 1)$$

Example calculation inputs:

Assume for the same population of hypothetical ACOs that began an agreement period on January 1, 2022, as in Example 1.

BY3 truncated national per capita expenditures for assignable beneficiaries for the aged/dual eligible enrollment type = **$16,000**.

For instance, the flat dollar amounts for PY1 and PY5 would be calculated as follows:

- $PY1\ Flat\ Dollar\ Amount = \$16{,}000 \times (1.094 - 1) = \$1{,}504.$
- $PY5\ Flat\ Dollar\ Amount = \$16{,}000 \times (1.345 - 1) = \$5{,}520.$

Step 3: Risk Adjust the Flat Dollar Amounts

CMS will adjust the flat dollar amounts for each performance year and for each Medicare enrollment type, described in Step 2, for differences in severity and case mix between the ACO's BY3 assigned beneficiary population and the national assignable FFS population for each Medicare enrollment type identified for the 12-month calendar year corresponding to BY3.[24] CMS will multiply the flat dollar amounts for each performance year, for each enrollment type, by the ACO's renormalized, mean BY3 prospective CMS-HCC risk score for that enrollment type to obtain an ACO specific flat dollar amount (herein ACO Risk-Adjusted Flat Dollar Amount) (see Example 3). Risk adjusting the flat dollar amounts will allow for a higher update for ACOs serving a population that is more medically complex than the national average.[25]

[22] Refer to § 425.660(b)(3)(ii).
[23] See also 87 FR 69884.
[24] Refer to § 425.660(b)(4). For consistency with other Shared Savings Program risk adjustment calculations, the risk score used will first be renormalized by dividing by the national mean risk score for the assignable FFS population for that enrollment type identified for the calendar year corresponding to BY3. See 87 FR 69884.
[25] Refer to 87 FR 69884.

Example 3: Risk Adjusting the Flat Dollar Amounts

The following formula specifies the calculation for risk adjusting the flat dollar amounts for a particular Medicare enrollment type.

$$PYx\ ACO\ Risk\text{-}Adjusted\ Flat\ Dollar\ Amount = Flat\ Dollar\ Amount\ for\ PY_{x\ and\ enrollment\ type} \times ACO's\ renormalized, mean\ BY3\ prospective\ CMS\text{-}HCC\ risk\ score_{enrollment\ type}$$

Example calculation inputs:

- Continuing with the calculations from Example 2, for the aged/dual eligible enrollment type, the PY1 flat dollar amount = **$1,504**, and the PY5 flat dollar amount = **$5,520**.
- ACO's renormalized, mean BY3 risk score for the aged/dual eligible enrollment type = **1.025**.

For instance, the ACO risk-adjusted flat dollar amounts for PY1 and PY5 would be calculated as follows:

- $PY1\ ACO\ Risk\text{-}Adjusted\ Flat\ Dollar\ Amount = \$1{,}504 \times 1.025 = \$1{,}542.$
- $PY5\ ACO\ Risk\text{-}Adjusted\ Flat\ Dollar\ Amount = \$5{,}520 \times 1.025 = \$5{,}658.$

Step 4: Re-Express the ACO Risk-Adjusted Flat Dollar Amounts as Relative Factors—the ACPT

The fourth and final step before calculating the three-way blended update factor is to re-express the ACO risk-adjusted flat dollar amount for each enrollment type on a relative basis such that it can be combined in a weighted average with the two-way blend.[26]

To do so, CMS will divide the ACO risk-adjusted flat dollar amounts described in Step 3 for a given enrollment type by the ACO's historical benchmark expenditures described in § 425.652(a) for each Medicare enrollment type to calculate the percent increase to be included in the three-way blended update factor described in § 425.652(b)(4).[27] See Example 4.

The resulting amount will represent the final ACPT portion of the blended update factor for that enrollment type.

[26] Refer to 87 FR 69884–69885.
[27] Refer to § 425.660(b)(5).

Example 4: Re-Expressing the ACO Risk-Adjusted Flat Dollar Amounts as Relative Factors by Medicare Enrollment Type to Compute the ACPT

The following formula specifies the calculation for re-expressing the ACO risk-adjusted flat dollar amount as a relative factor by Medicare enrollment type.

$$PY_x\ final\ ACPT\ portion\ of\ blended\ update\ factor_{enrollment\ type} = \left(\frac{PYx\ ACO\ Risk-Adjusted\ Flat\ Dollar\ Amount_{enrollment\ type}}{ACO's\ historical\ benchmark\ expenditure\ amount_{enrollment\ type}}\right) + 1$$

Example calculation inputs:

- ACO's historical benchmark expenditures for the aged/dual eligible enrollment type = **$15,000**.
- Continuing with the calculations from Example 3, PY1 ACO risk-adjusted flat dollar amount = **$1,542**, and PY5 ACO risk-adjusted flat dollar amount = **$5,658**.

For instance, the final ACPT for the aged/dual eligible enrollment type for PY1 and PY5 would be calculated as follows:

- $PY1\ final\ ACPT\ portion\ of\ the\ blended\ update\ factor_{aged\ /dual\ eligible\ enrollment\ type} = \left(\$1{,}542/\$15{,}000\right) + 1 = 1.103$
- $PY5\ final\ ACPT\ portion\ of\ the\ blended\ update\ factor_{aged\ /dual\ eligible\ enrollment\ type} = \left(\$5{,}658/\$15{,}000\right) + 1 = 1.377.$

Note that the addition of 1 in the calculation is to express the ACO risk-adjusted flat dollar amount on a relative basis so it can be combined in a weighted average with the current two-way blend.

5 Calculating the Three-Way Blended Update Factor

For all agreement periods beginning on January 1, 2024, and in subsequent years, CMS updates the historical benchmark annually for each year of the agreement period using a three-way blend calculated as a weighted average of a two-way blend of national and regional growth rates determined after the end of each performance year and a fixed projected growth rate determined at the beginning of the ACO's agreement period called the ACPT.[28]

The two-way blend, calculated in accordance with § 425.652(b)(2), and the ACPT, calculated in accordance with § 425.660 (and as described in Section 4 of this document) are blended together by taking the weighted average of the two.[29] Absent unforeseen circumstances (as described in Section 7), the weight applied to the

[28] Refer to § 425.652(b).
[29] Refer to § 425.652(b)(4).

components of the blend is as follows: two-way blend is equal to two-thirds, and ACPT is equal to one-third (see Example 5).[30]

Example 5: Calculating the Three-Way Blend

Example calculation inputs for the aged/dual eligible enrollment type for a hypothetical ACO:

- ACO's historical benchmark expenditures for the aged/dual eligible enrollment type = **$15,000.**
- Regional expenditure growth between BY3 and PY1 = **2.5 percent.**
- National assignable FFS expenditure growth = **3 percent**.
- ACO's assigned beneficiaries represent **20 percent** of the assignable population in the ACO's regional service area.[31]
- ACO risk ratio = **1.0** (assumed for simplicity).
- PY1 final ACPT portion of the blended update factor for aged/dual eligible enrollment type = **1.103** (Section 4, Step 4, Example 4).

Calculation of the two-way blended update factor for PY1 for the aged/dual eligible enrollment type:[32]

$Two\text{-}way\ blend = (National\ Update\ Factor \times National\ Weight) + (Regional\ Update\ Factor \times (1 - National\ Weight))$; or

$Two\text{-}way\ blend = (1.030 \times 20\ percent) + \left(1.025 \times (1 - 20\ percent)\right) = 1.026$

Updating the ACO's benchmark for the aged/dual eligible enrollment type with the two-way blended update factor alone would yield a value of: $\$15{,}000 \times 1.026 = \$\mathbf{15,390}$.

Calculation of the three-way blended update factor for PY1 for the aged/dual eligible enrollment type:

$Three\text{-}way\ blend = \left[PY1\ ACPT \times \left({}^{1}/_{3}\right)\right] + \left[PY1\ Two\text{-}Way\ Blend \times \left({}^{2}/_{3}\right)\right]$; or

$Three\text{-}way\ blend = \left[1.103 \times \left({}^{1}/_{3}\right)\right] + \left[1.026 \times \left({}^{2}/_{3}\right)\right] = 1.052$

Updating the ACO's benchmark for the aged/dual eligible enrollment type with the three-way blended update factor would yield an updated benchmark of: $\$15{,}000 \times 1.052 = \$\mathbf{15,780}$.

[30] Refer to 87 FR 69885.
[31] 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. Refer to § 425.652(b)(2)(iii)(A).
[32] Refer to 87 FR 69885. For additional detail about the calculation of the national-regional blend, refer to Medicare Shared Savings Program Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Version 11 Specifications.

In Example 5, as a result of applying the three-way blend instead of the two-way blend to the historical benchmark, the ACO's updated benchmark for the enrollment type increases by 2.5 percentage points, corresponding to an increase of $390 per capita.[33]

The three-way blended update factor is multiplied by each enrollment type's risk-adjusted historical benchmark expenditures. This allows for risk score growth changes between BY3 and the performance year to be included when applying the three-way blend in the updated historical benchmark.

6 Guardrail Policy

Including the ACPT as a component of a three-way blend could provide a degree of certainty that benchmarks would not be lowered as a result of ACOs reducing FFS spending growth, and thereby increase the incentive for such savings and strengthen incentives for ACOs to enter and remain in the Shared Savings Program. However, incorporating the ACPT into a three-way blended update factor may have the potential for mixed effects. For example, it may also lower an ACO's benchmark relative to the two-way blend if external factors lead to higher program spending growth than originally projected at the start of an ACO's agreement period.[34]

A "guardrail" policy ensures that the use of the three-way blended update factor will not result in lower benchmarks than the two-way national-regional blended update factor in a way that poses higher financial risk for ACOs under two-sided models, or that could jeopardize an ACO's continued participation in the Shared Savings Program under the financial performance monitoring policy described in § 425.316(d), or both.[35]

If an ACO generates losses for a performance year that meet or exceed its minimum loss rate (MLR) (for two-sided model ACOs) or negative minimum savings rate (MSR) (for one-sided model ACOs) under the three-way blended update factor, CMS will recalculate the ACO's updated benchmark using the two-way national-regional blended update factor. If the ACO generates a smaller number of losses using the two-way blend, CMS will use this smaller number to determine the ACO's responsibility for shared losses, if applicable, and in determining the ACO's financial performance for monitoring purposes under § 425.316(d).[36]

If an ACO generates savings using the two-way blend to update its benchmark but does not generate savings under the three-way blend, the ACO will neither be responsible for shared losses (if in a two-sided model) nor be eligible for shared savings for the applicable performance year, even if the savings generated exceed the ACO's MSR.[37] Example 6 illustrates how the guardrail will be applied.

[33] Refer to 87 FR 69885.
[34] Refer to 87 FR 69885.
[35] Refer to 87 FR 69885.
[36] Refer to 87 FR 69885 and § 425.652(b)(5).
[37] Refer to 87 FR 69885 and § 425.652(b)(5)(ii).

Example 6: Application of the Guardrail Policy[38]

Consider a hypothetical ACO participating at Level E of the BASIC track for which the updated benchmark calculated using the three-way blend was **$12,760**. Assume that the ACO's per capita performance year expenditures were **$12,980** and that the ACO had selected a symmetrical MSR/MLR of **1.5 percent**.

Using the three-way blend, the ACO would have per capita losses of **-$220**, or **-1.7 percent** of its updated benchmark, which would be above the ACO's selected MLR of **-1.5 percent**. A fixed shared loss rate of **30 percent** under Level E would be applied for this ACO, resulting in shared losses (on a per capita basis) of **-$66**.

In applying the guardrail policy, CMS would reassess the ACO's performance using the two-way blend. If the two-way blend produced an updated benchmark of **$12,804**, the ACO's new per capita loss amount would be **-$176**, or **-1.4 percent** of its updated benchmark, which would be within the ACO's selected MLR of **-1.5 percent**.

This ACO would therefore not be responsible for shared losses for the performance year and would not face any negative consequences under the financial performance monitoring policy.

If the two-way blend instead produced an updated benchmark of **$13,183**, the ACO would have measured per capita savings of **$203**, or **1.54 percent** of its updated benchmark. However, although the savings amount would exceed the ACO's MSR of **1.5 percent**, the ACO would not be eligible for shared savings under the guardrail policy.

7 Reducing the Weight Applied to the ACPT in the Three-Way Blend Due to Unforeseen Circumstances

CMS has sole discretion to determine whether an unforeseen circumstance exists that warrants a reduction to the weight of the ACPT and the reduced weight that will apply to the ACPT.[39] As described in the CY 2023 PFS final rule, if it is determined that expenditure growth has differed significantly from projections made at the start of the agreement period due to unforeseen circumstances, such as an economic recession, pandemic, or other factors, a reduction in the weight placed on the ACPT may be considered.[40]

Absent unforeseen circumstances, CMS will weight the two-way blend as two-thirds and the ACPT as one-third in calculating the three-way blend. However, if CMS determines an unforeseen circumstance has occurred that warrants adjustment to these weights,

[38] Refer to 87 FR 69885 and 69886.
[39] Refer to § 425.652(b)(4)(ii).
[40] Refer to 87 FR 69886.

then CMS will modify the three-way blend to reduce the weight that will apply to the ACPT and increase the weight of the two-way blend.[41]

However, given that external factors that cause deviations from projected trends would continue to be reflected in the two-way blend component of the update factor, the impacts from unforeseen circumstances that increase or decrease the two-way blend component would also then increase or decrease the three-way blend. This will likely mitigate the need to adjust the weight of the ACPT used in the three-way blend.[42]

[41] Refer to 87 FR 69886.
[42] Refer to 87 FR 69886.