Performance Year Financial and Quality Results PUF Data Dictionary

Term Name	Variable Name	Definition
ACO ID	ACO_ID	Unencrypted ACO Identifier. This identifier can be linked to the encrypted ACO identifier used for prior performance years (PY) using the ACO ID Crosswalk available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-data.
ACO name	ACO_Name	ACO Doing Business As (DBA) or Legal Business Name (LBN). Listed name is DBA unless DBA is not available, in which case LBN is used.
Agreement type	Agree_Type	Indicates whether an ACO is "Initial", participating in an initial agreement period; "Renewal", in a second or subsequent agreement period; or "Re-entering", in an agreement period not defined as a renewal. If a Re-entering ACO subsequently renews, the ACO is flagged as a Renewal.
Agreement period number	Agreement_Period_Num	Numerical indicator of agreement period; =1 if ACO is in first agreement period; =2 if ACO is in second agreement period; etc. For Re-entering ACOs, agreement period number is determined at the time of re-entry based on the number of agreement periods completed by the by the same ACO prior to re-entry based on the number of agreement periods completed by the prior ACO.
Current start date	Current_Start_Date	Agreement start date of current agreement period. This will be the start date of the second or subsequent agreement period for ACOs classified as a Renewal. This will be the start date of the current agreement period for ACOs classified as Re-entering.
Track in current performance year	Current_Track	If ACO selected BASIC Level A (one-sided shared savings model) for current performance year= A; BASIC Level B (one-sided shared savings model) for current performance year= B; BASIC Level C (two-sided shared savings / losses model) for current performance year= C;BASIC Level D (two-sided shared savings / losses model) for current performance year = D; BASIC Level E (two-sided shared savings / losses model) for current performance year; ENHANCED (two-sided shared savings / losses model) for current performance year= EN.
Risk Model	Risk_Model	Indicates whether an ACO is "One-Sided", participating in a one-sided shared savings model; or "Two-Sided", participating in a two-sided shared savings/losses model for the performance year.
Assignment Methodology	Assign_Type	Indicates whether an ACO is "Prospective", under Prospective Assignment; "Retrospective", under Preliminary Prospective Assignment with Retrospective Reconciliation.
Participate in Skilled Nursing Facility (SNF) 3-Day Rule Waiver	SNF_Waiver	0/1 flag; =1 if ACO participates in SNF 3-day waiver; otherwise =0.
Total Assigned Beneficiaries	N_AB	Number of assigned beneficiaries, performance year.
Savings Rate	Sav_rate	Total Benchmark Expenditures Minus Assigned Beneficiary Expenditures as a percent of Total Benchmark Expenditures.
Minimum Savings Rate (%)	MinSavPerc	If ACO is in a one-sided model, the Minimum Savings Rate is determined on a sliding scale based on the number of assigned beneficiaries. If ACO is in a two-sided model, the Minimum Savings Rate (MSR) / Minimum Loss Rate (MLR) selected by the ACO at the time of application to a two-sided model applies for the duration of the ACO's agreement period. For such ACOs, the MSR and MLR can be set to: zero percent; symmetrical MSR/MLR in a 0.5 percent increment between 0.5-2.0 percent; or symmetrical MSR/MLR determined on a sliding scale based on the number of assigned beneficiaries.

Term Name	Variable Name	Definition
Benchmark Minus Expenditures	BnchmkMinExp	Total Benchmark Expenditures Minus Assigned Beneficiary Expenditures. If positive, represents total savings. If negative, represents total losses.
Generated Total Savings/Losses	GenSaveLoss	Generated savings: Total savings (measured as Benchmark Minus Expenditures, from first to last dollar) for ACOs whose savings rate equaled or exceeded their MSR. This amount does not account for the application of the ACO's final sharing rate based on quality performance, reduction due to sequestration, application of performance payment limit, or repayment of advance payments. Generated losses: Total losses (measured as Benchmark Minus Assigned Expenditures, from first to last dollar) for ACOs in two-sided models whose losses rate equaled or exceeded their MLR. This amount does not account for the application of the ACO's final sharing rate based on quality performance or the loss sharing limit.
Extreme and Uncontrollable Circumstance Adjustment - Financial	DisAdj	If ACO is in one-sided model, blank (–). If ACO is in two-sided model with losses outside their MLR, equal to shared losses after applying the loss sharing limit, multiplied by percentage of beneficiaries in counties affected by an extreme and uncontrollable circumstance (EUC) and share of year affected by an EUC. For PY 2022 all counties in the United States were affected by the public health emergency for COVID-19 for the entirety of the year.
Proration of Shared Losses Flag	Prorate_Shared_Losses	0/1 flag; =1 if ACO is in a two-sided risk model and terminated after 6/31 and prior to 12/31 and is therefore responsible for a prorated share of losses if applicable; otherwise = 0.
Earned Shared Savings Payments/Owed Losses	EarnSaveLoss	Total earned shared savings: The ACO's share of savings for ACOs whose savings rate equaled or exceeded their MSR, and who were eligible for a performance payment because they met the program's quality performance standard. This amount accounts for the application of the ACO's final sharing rate based on quality performance (based on ACO track), as well as the reduction in performance payment due to sequestration and application of the performance payment limit. This amount does not account for repayment of advance payments. Total earned shared losses: The ACO's share of losses for ACOs in two-sided tracks whose losses rate equaled or exceeded their MLR, which is the negative of the MSR chosen. This amount accounts for the application of the ACO's final loss sharing rate based on quality performance (based on ACO track), the loss sharing limit, and the EUC adjustment.
Extreme and Uncontrollable Circumstance Affected - Quality	DisAffQual	0/1 flag; = 1 if at least 20% of assigned beneficiaries (based on Q3 assignment for the performance year) reside in a county affected by an EUC or ACO legal entity is located in such a county. Otherwise, equal to 0. For PY 2022 all ACOs receive value of 1 due to the public health emergency for COVID-19.

Term Name	Variable Name	Definition
Met the Quality Performance Standard	Met_QPS	0/1 flag; =1 if ACO met the quality performance standard based on the applicable methodology for a performance year; otherwise =0. For PY 2022, an ACO that reports quality data via the Alternative Payment Model (APM) Performance Pathway (APP) can meet the quality performance standard via one of three pathways: (1) achieving a quality performance score that is equivalent to or higher than the 30th percentile across all MIPS Quality performance category (QPC) scores, excluding entities/providers eligible for facility-based scoring; (2) meeting the criteria for the electronic clinical quality measure (eCQM)/Merit-based Incentive Payment System clinical quality measure (MIPS CQM) reporting incentive; or (3) meeting the quality reporting criteria as a 1st year ACO. An ACO must meet the quality performance standard to be eligible to share in savings at the maximum sharing rate and avoid maximum shared losses under certain payment tracks.
Met or exceeded 30th percentile MIPS QPC score	Met_30pctl	0/1/ flag; =1 if ACO achieved a quality performance score that is equivalent to or higher than the 30th percentile across all MIPS QPC scores, excluding entities/providers eligible for facility-based scoring; otherwise =0. For PY 2022, all Shared Savings Program ACOs were determined to have been affected by an EUC and were eligible to have the Shared Savings Program Quality EUC policy applied. Under the Savings Program Quality EUC policy, if the ACO was able to report quality data via the APP and met the MIPS data completeness and case minimum requirements, the ACO's quality performance score was set to the higher of the ACO's quality performance score or the equivalent of the 30th percentile MIPS QPC score across all MIPS QPC scores, excluding entities/providers eligible for facility-based scoring. If the ACO was unable to report quality data and meet the MIPS data completeness and case minimum requirements, the ACO's quality performance score was set equal to the 30th percentile MIPS QPC score across all MIPS QPC scores, excluding entities/providers eligible for facility-based scoring.
Met the eCQM/CQM Reporting Incentive	Met_Incentive	0/1 flag; =1 if ACO met the eCQM/MIPS CQM reporting incentive; otherwise =0. In PY 2022, an ACO meets the eCQM/MIPS CQM reporting incentive by reporting the three eCQMs/MIPS CQMs, meeting the MIPS data completeness and case minimum requirements for all three measures and by achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set and a quality performance score equivalent to or higher than the 30th percentile of the performance benchmark on at least one of the five remaining measures in the APP measure set.
ACO is 1st Year ACO that met reporting criteria	Met_FirstYear	0/1 flag; =1 if for the first performance year of an ACO's first agreement period under the Shared Savings Program, the ACO reported the ten CMS Web Interface measures or the three eCQMs/MIPS CQMs and administered a Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey under the APP and met MIPS data completeness and case minimum requirements for all of the measures; otherwise =0.

Term Name	Variable Name	Definition
Reported CMS Web Interface Measure Set	Report_WI	0/1 flag; 1 = if the ACO reported quality by the CMS Web Interface reporting option; otherwise = 0. In PY 2022, ACOs were required to report the 10 measures under the CMS Web Interface or the 3 eCQM/MIPS CQMs. ACOs were also required to administer the CAHPS for MIPS survey. CMS calculated the Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups and Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC) measures using administrative claims data. Based on the ACO's chosen reporting option, either 6 or 10 measures were included in calculating the ACO's MIPS QPC score. ACOs that chose to report both the CMS Web Interface measures and eCQM/MIPS CQMs received a MIPS QPC score based on whichever measure set resulted in a higher score. Note: The ACO quality performance score and performance rates populated in the PUF for an ACO are from the highest scoring reporting option, which was used for financial reconciliation.
Reported eCQMs or MIPS CQMs	Report_eCQM_CQM	0/1 flag; 1 = if the ACO reported quality by eCQMs, MIPS CQMs, or both eCQMs/MIPS CQMs; otherwise = 0. In PY 2022, ACOs were required to report the 10 measures under the CMS Web Interface or the 3 eCQMs/MIPS CQMs. ACOs were also required to administer the CAHPS for MIPS survey. CMS calculated the HWR and MCC measures using administrative claims data. Based on the ACO's chosen reporting option, either 6 or 10 measures were included in calculating the MIPS QPC score. ACOs that chose to report both the CMS Web Interface measures and eCQMs/MIPS CQMs received a MIPS QPC score based on whichever measure set resulted in a higher quality score. Note: The ACO quality performance score and performance rates populated in the PUF for an ACO are from the highest scoring reporting option, which was used for financial reconciliation.
Incomplete Reporting	Report_Inc	0/1 flag; 1 = if the ACO did not report any of the 10 CMS Web Interface measures or any of the 3 eCQMs/MIPS CQMs under the APP; otherwise = 0. In PY 2022, ACOs were required to report the 10 measures under the CMS Web Interface or the 3 eCQMs/MIPS CQMs. ACOs were also required to administer the CAHPS for MIPS survey. CMS calculated the HWR and MCC measures using administrative claims data. Based on the ACO's chosen reporting option, either 6 or 10 measures were included in calculating the MIPS QPC score.

Term Name	Variable Name	Definition
Quality Performance Score	QualScore	Quality performance score: ACO's quality performance score based on applicable methodology for a performance year. In PY 2022, an ACO's quality performance score was calculated using the ACO's performance on the quality measures reported under APP and any applicable quality improvement points. For PY 2022, all Shared Savings Program ACOs were eligible to have the Shared Savings Program Quality EUC policy applied. Under the Savings Program Quality EUC policy, if the ACO was able to report quality data via the APP and met the MIPS data completeness and case minimum requirements, the ACO's quality performance score was set to the higher of the ACO's quality performance score or the equivalent of the 30th percentile MIPS QPC score across all MIPS QPC scores, excluding entities/providers eligible for facility-based scoring. If the ACO was unable to report quality data and meet the MIPS data completeness and case minimum requirements, the ACO's quality performance score was set equal to the 30th percentile MIPS QPC score across all MIPS QPC scores, excluding entities/providers eligible for facility-based scoring.
Extreme and Uncontrollable Circumstance- 30th Percentile Adjustment-Quality	Recvd30p	0/1 flag; =1 if ACO had its quality performance score set equal to the 30th percentile MIPS QPC score across all MIPS QPC scores, excluding entities/providers eligible for facility-based scoring, under the Shared Savings Program Quality EUC policy. =0 if ACO received its own MIPS QPC score as its quality performance score rather than the 30th percentile MIPS QPC score.
Positive Regional Adjustment	PosRegAdj	Value of the aggregate regional adjustment applied to the historical benchmark. The regional adjustment is computed separately by enrollment type and is determined by the difference in the ACO's spending relative to its regional service area. This value represents the weighted average of these enrollment type specific adjustments. A positive value indicates the ACO had lower spending than its regional service area while a negative value indicates the ACO had higher spending than its regional service area.
Updated benchmark expenditures	UpdatedBnchmk	Updated benchmark is compared to ACO performance year expenditures and is used to determine ACO savings/losses in the performance year. As part of updating benchmark, benchmark expenditures are risk-adjusted in the historical benchmark period and performance period to account for changes in the ACO's assigned populations over time. Updated benchmark also includes the blended national-regional update factor (for all ACOs that entered an agreement period beginning on or after July 1, 2019).
Historical benchmark	HistBnchmk	Single per capita historical benchmark value reflecting ACO's applicable benchmarking methodology. For ACOs that entered an agreement period on or after July 2019, the benchmark is calculated using a blend of national and regional assignable FFS expenditure trend factors and incorporates a regional adjustment subject to a cap.
Total benchmark expenditures	ABtotBnchmk	Per capita benchmark (UpdatedBnchmk) multiplied by total person years (N_AB_Year).
Total expenditures	ABtotExp	Per capita performance year expenditures (Per_Capita_Exp_TOTAL) multiplied by total person years (N_AB_Year).
Final sharing rate	FinalShareRate	Equal to maximum sharing rate, which is the maximum percentage of savings an ACO can share based on the ACO's track, before accounting for quality performance. Set to 40% for BASIC Track Levels A and B, 50% for BASIC Track Levels C, D, and E, and 75% for ENHANCED Track. The percentage of savings an ACO shares if the ACO is eligible for shared savings. Will equal zero if ACO failed to meet quality performance standard.

Term Name	Variable Name	Definition
Indicates whether a high or low revenue ACO	Rev_Exp_Cat	If ACO participant total Medicare Parts A and B FFS revenue for the performance year is less than 35% of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries for the performance year, "Low Revenue". If ACO participant total Medicare Parts A and B FFS revenue for the performance year is 35% or more of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries for the performance year, "High Revenue".
Per capita ESRD expenditures in benchmark year 1	Per_Capita_Exp_ALL_ESRD_BY1	Annualized, truncated, weighted mean total expenditures per ESRD assigned beneficiary person years in benchmark year 1.
Per capita DISABLED expenditures in benchmark year 1	Per_Capita_Exp_ALL_DIS_BY1	Annualized, truncated, weighted mean total expenditures per DISABLED assigned beneficiary person years in benchmark year 1.
Per capita AGED/DUAL expenditures in benchmark year 1	Per_Capita_Exp_ALL_AGDU_BY1	Annualized, truncated, weighted mean total expenditures per AGED/DUAL assigned beneficiary person years in benchmark year 1.
Per capita AGED/NON-DUAL expenditures in benchmark year 1	Per_Capita_Exp_ALL_AGND_BY1	Annualized, truncated, weighted mean total expenditures per AGED/NON-DUAL assigned beneficiary person years in benchmark year 1.
Per capita ESRD expenditures in benchmark year 2	Per_Capita_Exp_ALL_ESRD_BY2	Annualized, truncated, weighted mean total expenditures per ESRD assigned beneficiary person years in benchmark year 2.
Per capita DISABLED expenditures in benchmark year 2	Per_Capita_Exp_ALL_DIS_BY2	Annualized, truncated, weighted mean total expenditures per DISABLED assigned beneficiary person years in benchmark year 2.
Per capita AGED/DUAL expenditures in benchmark year 2	Per_Capita_Exp_ALL_AGDU_BY2	Annualized, truncated, weighted mean total expenditures per AGED/DUAL assigned beneficiary person years in benchmark year 2.
Per capita AGED/NON-DUAL expenditures in benchmark year 2	Per_Capita_Exp_ALL_AGND_BY2	Annualized, truncated, weighted mean total expenditures per AGED/NON-DUAL assigned beneficiary person years in benchmark year 2.
Per capita ESRD expenditures in benchmark year 3	Per_Capita_Exp_ALL_ESRD_BY3	Annualized, truncated, weighted mean total expenditures per ESRD assigned beneficiary person years in benchmark year 3.
Per capita DISABLED expenditures in benchmark year 3	Per_Capita_Exp_ALL_DIS_BY3	Annualized, truncated, weighted mean total expenditures per DISABLED assigned beneficiary person years in benchmark year 3.
Per capita AGED/DUAL expenditures in benchmark year 3	Per_Capita_Exp_ALL_AGDU_BY3	Annualized, truncated, weighted mean total expenditures per AGED/DUAL assigned beneficiary person years in benchmark year 3.
Per capita AGED/NON-DUAL expenditures in benchmark year 3	Per_Capita_Exp_ALL_AGND_BY3	Annualized, truncated, weighted mean total expenditures per AGED/NON-DUAL assigned beneficiary person years in benchmark year 3.
Per capita ESRD expenditures in performance year	Per_Capita_Exp_ALL_ESRD_PY	Annualized, truncated, weighted mean total expenditures per ESRD assigned beneficiary person years in the performance year.
Per capita DISABLED expenditures in performance year	Per_Capita_Exp_ALL_DIS_PY	Annualized, truncated, weighted mean total expenditures per DISABLED assigned beneficiary person years in the performance year.

Term Name	Variable Name	Definition
Per capita AGED/DUAL expenditures in performance year	Per_Capita_Exp_ALL_AGDU_PY	Annualized, truncated, weighted mean total expenditures per AGED/DUAL assigned beneficiary person years in the performance year.
Per capita AGED/NON-DUAL expenditures in performance year	Per_Capita_Exp_ALL_AGND_PY	Annualized, truncated, weighted mean total expenditures per AGED/NON-DUAL assigned beneficiary person years in the performance year.
Per capita ALL expenditures in performance year	Per_Capita_Exp_TOTAL_PY	Annualized, truncated, weighted mean total expenditures per assigned beneficiary person years in the performance year.
Average ESRD HCC risk score in benchmark year 1	CMS_HCC_RiskScore_ESRD_BY1	Final, mean prospective CMS-HCC risk score for ESRD enrollment type in benchmark year 1.
Average DISABLED HCC risk score in benchmark year 1	CMS_HCC_RiskScore_DIS_BY1	Final, mean prospective CMS-HCC risk score for DISABLED enrollment type in benchmark year 1.
Average AGED/DUAL HCC risk score in benchmark year 1	CMS_HCC_RiskScore_AGDU_BY1	Final, mean prospective CMS-HCC risk score for AGED/DUAL enrollment type in benchmark year 1.
Average AGED/NON-DUAL HCC risk score in benchmark year 1	CMS_HCC_RiskScore_AGND_BY1	Final, mean prospective CMS-HCC risk score for AGED/NON-DUAL enrollment type in benchmark year 1.
Average ESRD HCC risk score in benchmark year 2	CMS_HCC_RiskScore_ESRD_BY2	Final, mean prospective CMS-HCC risk score for ESRD enrollment type in benchmark year 2.
Average DISABLED HCC risk score in benchmark year 2	CMS_HCC_RiskScore_DIS_BY2	Final, mean prospective CMS-HCC risk score for DISABLED enrollment type in benchmark year 2.
Average AGED/DUAL HCC risk score in benchmark year 2	CMS_HCC_RiskScore_AGDU_BY2	Final, mean prospective CMS-HCC risk score for AGED/DUAL enrollment type in benchmark year 2.
Average AGED/NON-DUAL HCC risk score in benchmark year 2	CMS_HCC_RiskScore_AGND_BY2	Final, mean prospective CMS-HCC risk score for AGED/NON-DUAL enrollment type in benchmark year 2.
Average ESRD HCC risk score in benchmark year 3	CMS_HCC_RiskScore_ESRD_BY3	Final, mean prospective CMS-HCC risk score for ESRD enrollment type in benchmark year 3.
Average DISABLED HCC risk score in benchmark year 3	CMS_HCC_RiskScore_DIS_BY3	Final, mean prospective CMS-HCC risk score for DISABLED enrollment type in benchmark year 3.
Average AGED/DUAL HCC risk score in benchmark year 3	CMS_HCC_RiskScore_AGDU_BY3	Final, mean prospective CMS-HCC risk score for AGED/DUAL enrollment type in benchmark year 3.
Average AGED/NON-DUAL HCC risk score in benchmark year 3	CMS_HCC_RiskScore_AGND_BY3	Final, mean prospective CMS-HCC risk score for AGED/NON-DUAL enrollment type in benchmark year 3.
Average ESRD HCC risk score in performance year	CMS_HCC_RiskScore_ESRD_PY	Final, mean prospective CMS-HCC risk score for ESRD enrollment type in the performance year.
Average DISABLED HCC risk score in performance year	CMS_HCC_RiskScore_DIS_PY	Final, mean prospective CMS-HCC risk score for DISABLED enrollment type in the performance year.

Term Name	Variable Name	Definition
Average AGED/DUAL HCC risk score in performance year	CMS_HCC_RiskScore_AGDU_PY	Final, mean prospective CMS-HCC risk score for AGED/DUAL enrollment type in the performance year.
Average AGED/NON-DUAL HCC risk score in performance year	CMS_HCC_RiskScore_AGND_PY	Final, mean prospective CMS-HCC risk score for AGED/NON-DUAL enrollment type in the performance year.
ESRD person years in benchmark year 3	N_AB_Year_ESRD_BY3	Number of assigned beneficiaries with ESRD enrollment type in benchmark year 3 adjusted for the total number of months that each beneficiary was classified as ESRD; Number of ESRD person-months divided by 12.
DISABLED person years in benchmark year 3	N_AB_Year_DIS_BY3	Number of assigned beneficiaries with DISABLED enrollment type in benchmark year 3 adjusted for the total number of months that each beneficiary was classified as DISABLED; Number of DISABLED person-months divided by 12.
AGED/DUAL person years in benchmark year 3	N_AB_Year_AGED_Dual_BY3	Number of assigned beneficiaries with AGED/DUAL enrollment type in benchmark year 3 adjusted for the total number of months that each beneficiary was classified as AGED/DUAL; Number of AGED/DUAL person-months divided by 12.
AGED/NON-DUAL person years in benchmark year 3	N_AB_Year_AGED_NonDual_BY3	Number of assigned beneficiaries with AGED/NON-DUAL enrollment type in benchmark year 3 adjusted for the total number of months that each beneficiary was classified as AGED/NON-DUAL; Number of AGED/NON-DUAL person-months divided by 12.
Total person years in performance year	N_AB_Year_PY	Number of assigned beneficiaries in the performance year adjusted downwards for beneficiaries with less than a full 12 months of eligibility; Number of person-months divided by 12.
ESRD person years in performance year	N_AB_Year_ESRD_PY	Number of assigned beneficiaries with ESRD enrollment type in the performance year adjusted for the total number of months that each beneficiary was classified as ESRD; Number of ESRD person-months divided by 12.
DISABLED person years in performance year	N_AB_Year_DIS_PY	Number of assigned beneficiaries with DISABLED enrollment type in the performance year adjusted for the total number of months that each beneficiary was classified as DISABLED; Number of DISABLED person-months divided by 12.
AGED/DUAL person--years in performance year	N_AB_Year_AGED_Dual_PY	Number of assigned beneficiaries with AGED/DUAL enrollment type in the performance year adjusted for the total number of months that each beneficiary was classified as AGED/DUAL; Number of AGED/DUAL person-months divided by 12.
AGED/NON-DUAL person years in performance year	N_AB_Year_AGED_NonDual_PY	Number of assigned beneficiaries with AGED/NON-DUAL enrollment type in the performance year adjusted for the total number of months that each beneficiary was classified as AGED/NON-DUAL; Number of AGED/NON-DUAL person-months divided by 12.
Beneficiaries assigned through voluntary alignment only	N_Ben_VA_Only	Number of assigned beneficiaries assigned through voluntary alignment only.
Beneficiaries assigned through claims-based assignment only	N_Ben_CBA_Only	Number of assigned beneficiaries assigned through claims-based assignment only.
Beneficiaries assigned through claims-based assignment and voluntary alignment	N_Ben_CBA_and_VA	Number of assigned beneficiaries assigned through claims-based assignment and voluntary alignment.
Total assigned beneficiaries, age 0-64	N_Ben_Age_0_64	Total number of assigned beneficiaries, age 0-64 in the calendar year; age calculated as of February 1 of the calendar year. Based on most current date of birth in Medicare records.

Term Name	Variable Name	Definition
Total assigned beneficiaries, age 65-74	N_Ben_Age_65_74	Total number of assigned beneficiaries, age 65-74 in the calendar year; age calculated as of February 1 of the calendar year. Based on most current date of birth in Medicare records.
Total assigned beneficiaries, age 75-84	N_Ben_Age_75_84	Total number of assigned beneficiaries, age 75-84 in the calendar year; age calculated as of February 1 of the calendar year. Based on most current date of birth in Medicare records.
Total assigned beneficiaries, age 85+	N_Ben_Age_85plus	Total number of assigned beneficiaries, age 85+ in the calendar year age calculated as of February 1 of the calendar year. Based on most current date of birth in Medicare records.
Total assigned beneficiaries, female	N_Ben_Female	Total number of assigned beneficiaries, female (Gender=2) in the calendar year. Based on most current gender in Medicare records.
Total assigned beneficiaries, male	N_Ben_Male	Total number of assigned beneficiaries, male (Gender=1) in the calendar year. Based on most current gender in Medicare records.
Total assigned beneficiaries, Non-Hispanic White	N_Ben_Race_White	Total number of assigned beneficiaries, Non-Hispanic White (Race=1) in the calendar year. Based on most current race in Medicare records.
Total assigned beneficiaries, Black	N_Ben_Race_Black	Total number of assigned beneficiaries, Black (Race=2) in the calendar year. Based on most current race in Medicare records.
Total assigned beneficiaries, Asian	N_Ben_Race_Asian	Total number of assigned beneficiaries, Asian (Race=4) in the calendar year. Based on most current race in Medicare records.
Total assigned beneficiaries, Hispanic	N_Ben_Race_Hisp	Total number of assigned beneficiaries, Hispanic (Race=5) in the calendar year. Based on most current race in Medicare records.
Total assigned beneficiaries, North American Native	N_Ben_Race_Native	Total number of assigned beneficiaries, North American Native (Race=6) in the calendar year. Based on most current race in Medicare records.
Total assigned beneficiaries, Other	N_Ben_Race_Other	Total number of assigned beneficiaries, Other (Race= 3) in the calendar year. Based on most current race in Medicare records.
Total assigned beneficiaries, Unknown	N_Ben_Race_Unknown	Total number of assigned beneficiaries, Unknown (Race=0) and Missing (Race=~) in the calendar year. Based on most current race in Medicare records.
Total Inpatient expenditures	CapAnn_INP_All	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for inpatient services for assigned beneficiaries in the performance year. Includes all hospital provider types including but not limited to short term acute care hospital, long term care hospital, rehabilitation hospital or unit, and psychiatric hospital or unit. Because total hospital inpatient facility expenditures and expenditures by hospital provider type are each truncated at the same level as total expenditures, expenditures by hospital provider type may not sum to total hospital inpatient facility expenditures. Inpatient claims are identified by claim type code 60.
Short term acute care hospital (IPPS/CAH) expenditures	CapAnn_INP_S_trm	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for acute care inpatient services in a short term acute care (Inpatient Prospective Payment System (IPPS) or Critical Access Hospital (CAH) setting for assigned beneficiaries in the performance year. Inpatient claims are identified by claim type code 60. Short term acute care hospitals are identified by CMS Certification Number (CCN) where the 3rd through 6th digits are between 0001 - 0879. CAHs are identified by CCNS where the 3rd through 6th digits are between 1300 - 1399.
Long term care hospital expenditures	CapAnn_INP_L_trm	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for inpatient services in a long term care setting for assigned beneficiaries in the performance year. Inpatient claims are identified by claim type code 60. Long term care hospitals are identified by CCNs where the 3rd through 6th digits are between 2000 - 2299.

Term Name	Variable Name	Definition
Inpatient rehabilitation facility (IRF) expenditures	CapAnn_INP_Rehab	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for inpatient services in a rehabilitation facility or unit for assigned beneficiaries in the performance year. Inpatient claims are identified by claim type code 60. Inpatient rehabilitation facilities are identified by CCNs where the 3rd through 6th digits are between 3025 - 3099 or where the 3rd byte is equal to R or T.
Inpatient psychiatric hospital expenditures	CapAnn_INP_Psych	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for inpatient services in a psychiatric hospital facility or unit for assigned beneficiaries in the performance year. Inpatient claims are identified by claim type code 60. Psychiatric hospitals are identified by CCNs where the 3rd through 6th digits are between 4000 - 4499 or where the 3rd byte is equal to M or S.
Hospice expenditures	CapAnn_HSP	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for hospice services for assigned beneficiaries in the performance year. Hospice claims are identified by claim type code 50.
Skilled nursing facility or unit expenditures	CapAnn_SNF	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for services in a SNF setting for assigned beneficiaries in the performance year. SNF claims are identified by claim type codes 20 and 30).
Outpatient expenditures	CapAnn_OPD	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for outpatient services for assigned beneficiaries in the performance year. Includes all outpatient facility types including, but not limited to, hospital outpatient departments, outpatient dialysis facilities, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), outpatient rehabilitation facilities, and community mental health centers. Outpatient claims are identified by claim type code 40.
Physician/supplier expenditures	CapAnn_PB	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for Part B physician/supplier (Carrier) services for assigned beneficiaries in the performance year. Includes all Part B physician/supplier services including, but not limited to, evaluation and management, procedures, imaging, laboratory and other test, Part B drugs, and ambulance services. In addition to physician and other practitioner services, includes free-standing ambulatory surgery centers, independent clinical laboratories, and other suppliers. Includes physician/practitioner services provided in either an inpatient or outpatient setting. Physician/supplier claims are identified by claim type codes 71 and 72.
Ambulance expenditures	CapAnn_AmbPay	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for ambulance services for assigned beneficiaries in the performance year. Ambulance services are identified in the Part B physician/supplier (Carrier) claims (claim type codes 71 and 72) by Restructured BETOS Code System (RBCS) codes OA004N, OA002N, OA001N, or OA003N..[PA1]
Home health expenditures	CapAnn_HHA	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for home health agency services for assigned beneficiaries in the performance year. Home health claims are identified by claim type code 10.
Durable medical equipment expenditures	CapAnn_DME	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for durable medical equipment (DME) for assigned beneficiaries in the performance year. DME claims are identified by claim type codes 81 and 82.

Term Name	Variable Name	Definition
Inpatient hospital discharges	ADM	Total number of inpatient hospital discharges per 1,000 person years in the performance year. A beneficiary is flagged for having a hospitalization if the beneficiary had at least one inpatient claim during the performance year. Each hospitalization is defined as a set of claims with the same Medicare Beneficiary Identifier (MBI), same admission date, and same provider number. Adjusted for short-term acute-care transfers by combining two admissions into one when the second admission was within one day of the discharge date of the first admission. Inpatient claims are identified by claim type code 60. Hospitals are identified on inpatient claims through the last four characters of the CMS Certification Number (CCN). The relevant ranges for the last four characters of the CCN on the claims are: 0001-0899; 9800-9899; 1225-1299; 1300-1399; 2000-2299; 3025-3099; T001-T899; R225-R399; 4000-4499; S001-S899; M225-M399; 1990-1999; 3300-3399.
Short term hospital discharges	ADM_S_Trm	Total number of short term hospital discharges per 1,000 person years in the performance year. A beneficiary is flagged for having a hospitalization if the beneficiary had at least one inpatient claim during the performance year. Each hospitalization is defined as a set of claims with the same MBI, same admission date, and same provider number. Short term acute care hospitals are identified by CCNs where the 3rd through 6th digits are between 0001 - 0879. CAHs are identified by CCNs where the 3rd through 6th digits are between 1300 - 1399. Inpatient claims are identified by claim type code 60
Long-term hospital discharges	ADM_L_Trm	Total number of long-term care hospital (LTCH) discharges per 1,000 person years in the performance year. A beneficiary is flagged for having a hospitalization in a long-term hospital if the beneficiary had at least one inpatient claim during the performance year. Each hospitalization is defined as a set of claims with the same MBI, same admission date, and same provider number[PA2] . CMS adjusts for transfers by combining two admissions into one when the second admission was within one day of the discharge date of the first admission. Inpatient claims are identified by claim type code 60. Long term care hospitals are identified by CCNs where the 3rd through 6th digits are between 2000 - 2299.
Rehabilitation hospital or unit discharges	ADM_Rehab	Total number of inpatient rehabilitation facility (IRF) discharges per 1,000 person years in the performance year. A beneficiary is flagged for having a hospitalization in a rehabilitation hospital or unit if the beneficiary had at least one inpatient claim during the performance year. Each hospitalization is defined as a set of claims with the same MBI, same admission date, and same provider number. Inpatient claims are identified by claim type code 60. Inpatient rehabilitation facilities are identified by CCNs where the 3rd through 6th digits are between 3025 - 3099 or where the 3rd byte is equal to R or T.
Psychiatric hospital or unit discharges	ADM_Psych	Total number of inpatient psychiatric facility (IPF) discharges per 1,000 person years in the performance year. A beneficiary is flagged for having a hospitalization in a psychiatric hospital or unit if the beneficiary had at least one inpatient claim during the performance year. Each hospitalization is defined as a set of claims with the same MBI, same admission date, and same provider number. Inpatient claims are identified by claim type code 60. Psychiatric hospitals are identified by CCNs where the 3rd through 6th digits are between 4000 - 4499 or where the 3rd byte is equal to M or S.

Term Name	Variable Name	Definition
Outpatient ED visits	P_EDV_Vis	Total number of visits to an outpatient emergency department (ED) per 1,000 person years in the performance year. An Emergency Department Visit (EDV) is defined using both Inpatient & Outpatient claims and using the Revenue Center Code field on the claims: EDVs in the hospital inpatient and hospital outpatient claims with revenue center code values 0450-0459 and 0981. The restriction is imposed that a beneficiary could have a maximum of one EDV on a specific date.
Emergency Department Visits that lead to a Hospitalization	P_EDV_Vis_HOSP	Total number of visits to an ED that result in an inpatient stay per 1,000 person years in the performance year. EDVs that Lead to Hospitalizations is identified in the hospital inpatient claims with revenue center code values 0450-0459 and 0981[PA3] . Multiple emergency department claims on the same date are counted as a single EDV.
CT events	P_CT_VIS	Total number of computed tomography (CT) events per 1,000 person years in the performance year. CT imaging events are defined based on claim type codes 71 or 72 and RBCS codes IC000N, IC003N, IC006N, IC007N, and IC021N.
MRI events	P_MRI_VIS	Total number of magnetic resonance imaging (MRI) events per 1,000 person years in the performance year. MRI imaging events are defined based on claim type codes 71 or 72 and RBCS codes IM009N, IM010N, IM020N, IM022N, and IM023N.
Primary care services	P_EM_Total	Total number of primary care services per 1,000 person years in the performance year. Primary care services are counted regardless of physician specialty.
Primary care services with a primary care physician (PCP)	P_EM_PCP_Vis	Total number of primary care services provided by a PCP per 1,000 person years in the performance year. Defined as a qualifying visit with a primary care physician with a CMS specialty code of 1 (general practice), 8 (family practice), 11 (internal medicine), 37 (pediatric medicine), or [PA4] 38 (geriatric medicine). This includes primary care services provided at Method II CAHs.
Primary care services with a specialist	P_EM_SP_Vis	Total number of primary care services provided by a specialist per 1,000 person years in the performance year.
Primary care services with a NP/PA/CNS	P_Nurse_Vis	Total number of primary care services provided by a nurse practitioner (NP), physician's assistant (PA), or clinical nurse specialist (CNS) per 1,000 person years in the performance year. Defined as a qualifying visit with practitioner with a CMS specialty code of 50 (NP), 89 (CNS), and 97 (PA).
Primary care services with a FQHC/RHC	P_FQHC_RHC_Vis	Total number of primary care services provided at a FQHC or RHC per 1,000 person years in the performance year[PA5] [WK6] . Bill types are used to identify classes of claims from these providers: RHC claims are 71x bill types. FQHC claims are 73x (for dates of service before April 1, 2010) and 77x (for dates of service on or after April 1, 2010).
Skilled nursing facility discharges	P_SNF_ADM	Total number of discharges from a skilled nursing facility per 1,000 person years in the performance year. Each SNF stay is defined as a set of claims with the same MBI, same admission date, and same provider number. We adjust for transfers by combining two stays into one when the second admission was within one day of the discharge date of the first admission, or when the second admission was at the same SNF and was within three days of the discharge date of the first admission.

Term Name	Variable Name	Definition
Skilled nursing facility length of stay	SNF_LOS	Average number of Medicare covered utilization days for entire SNF stay for stays with a discharge date in the performance year. Each SNF stay is defined as a set of claims with the same MBI, same admission date, and same provider number. We adjust for transfers by combining two stays into one when the second admission was within one day of the discharge date of the first admission, or when the second admission was at the same SNF and was within three days of the discharge date of the first admission.
Skilled nursing facility payment per stay	SNF_PayperStay	Average Medicare expenditure per SNF stay. Includes entire facility payment for stays with discharge date in the performance year. Each SNF stay is defined as a set of claims with the same MBI, same admission date, and same provider number. We adjust for transfers by combining two stays into one when the second admission was within one day of the discharge date of the first admission, or when the second admission was at the same SNF and was within three days of the discharge date of the first admission.
Number of CAHs	N_CAH	Total number of Critical Access Hospitals (CAHs) participating in the ACO in the performance year. Based on the ACO's certified participant list used in financial reconciliation and information in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).
Number of FQHCs	N_FQHC	Total number of FQHCs participating in the ACO in the performance year. Based on the ACO's certified participant list used in financial reconciliation and information in PECOS.
Number of RHCs	N_RHC	Total number of RHCs participating in the ACO in the performance year. Based on the ACO's certified participant list used in financial reconciliation and information in PECOS.
Number of Elected Teaching Amendment (ETA) hospitals	N_ETA	Total number of ETA hospitals participating in the ACO in the performance year. Based on the ACO's certified participant list used in financial reconciliation and information in PECOS.
Number of short-term acute care hospitals	N_Hosp	Total number of short-term acute care hospitals (excluding CAHs and ETA hospitals) participating in the ACO in the performance year. Based on the ACO’s certified participant list used in financial reconciliation and information in PECOS.
Number of other facility types	N_Fac_Other	Total number of other facilities participating in the ACO in the performance year. Based on the ACO's certified participant list used in financial reconciliation and information in PECOS.
Number of participating PCPs	N_PCP	Total number of primary care physicians (PCPs) that reassigned billing rights to an ACO participant in the performance year. Based on the ACO's certified participant list used in financial reconciliation and information in PECOS. PCPs include the following specialties: General Practice, Family Practice, Internal Medicine, Pediatric Medicine and Geriatric Medicine.
Number of participating specialists	N_Spec	Total number of physician specialists that reassigned billing rights to an ACO participant in the performance year. Based on the ACO's certified participant list used in financial reconciliation and information in PECOS and claims submitted through ACO participant TINs.
Number of participating nurse practitioners	N_NP	Total number of nurse practitioners that reassigned billing rights to an ACO participant in the performance year. Based on the ACO's certified participant list used in financial reconciliation and information in PECOS and claims submitted through ACO participant TINs.
Number of participating physician assistants	N_PA	Total number of physician assistants that reassigned billing rights to an ACO participant in the performance year. Based on the ACO's certified participant list used in financial reconciliation and information in PECOS and claims submitted through ACO participant TINs.

Term Name	Variable Name	Definition
Number of participating clinical nurse specialists	N_CNS	Total number of clinical nurse specialists that reassigned billing rights to an ACO participant in the performance year. Based on the ACO's certified participant list used in financial reconciliation and information in PECOS and claims submitted through ACO participant TINs.
Proportion of Dual Beneficiaries	Perc_Dual	The percentage of an ACO's assigned beneficiaries that have dual eligibility status (e.g. were simultaneously enrolled in both Medicare and Medicaid for at least one month during the performance year)
Share of Beneficiaries with COVID-19 Diagnosis	Perc_CovDiag	The percentage of an ACO's assigned beneficiaries that had a COVID-19 diagnosis during the performance year.
Share of Beneficiaries with COVID-19 Episode	Perc_CovEpisode	The percentage of an ACO's assigned beneficiaries that had a COVID-19 episode during the performance year.
Share of Long-Term Institutionalized Beneficiaries	Perc_LTI	The percentage of an ACO's assigned beneficiaries that are a long-term resident of an institution.
CAHPS: Getting Timely Care, Appointments, and Information	CAHPS_1	CAHPS: Getting Timely Care, Appointments, and Information
CAHPS: How Well Your Providers Communicate	CAHPS_2	CAHPS: How Well Your Providers Communicate
CAHPS: Patients' Rating of Provider	CAHPS_3	CAHPS: Patients' Rating of Provider
CAHPS: Access to Specialists	CAHPS_4	CAHPS: Access to Specialists
CAHPS: Health Promotion and Education	CAHPS_5	CAHPS: Health Promotion and Education
CAHPS: Shared Decision Making	CAHPS_6	CAHPS: Shared Decision Making
CAHPS: Health Status/Functional Status	CAHPS_7	CAHPS: Health Status/Functional Status
CAHPS: Stewardship of Patient Resources	CAHPS_11	CAHPS: Stewardship of Patient Resources
CAHPS: Courteous and Helpful Office Staff	CAHPS_9	CAHPS: Courteous and Helpful Office Staff
CAHPS: Care Coordination	CAHPS_8	CAHPS: Care Coordination
Hospital-Wide 30-day Readmission Rate	Measure_479	Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible clinician Groups. Risk-adjusted percentage of ACO assigned beneficiaries who were hospitalized and readmitted to a hospital within 30 days of discharge from the index hospital admission. Note that a lower performance rate is indicative of better quality.
All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Measure_484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions. Annual risk-standardized rate of acute, unplanned hospital admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with multiple chronic conditions (MCCs). Note that a lower performance rate is indicative of better quality.
Falls: Screening for Future Fall Risk	QualityID_318	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.

Term Name	Variable Name	Definition
Preventive Care and Screening: Influenza Immunization	QualityID_110	Percentage of patients aged six months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	QualityID_226	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.
Preventive Care and Screening: Screening for Depression and Follow-up Plan, WI	QualityID_134_WI	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.
Preventive Care and Screening: Screening for Depression and Follow-up Plan, eCQM	QualityID_134_eCQM	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.
Preventive Care and Screening: Screening for Depression and Follow-up Plan, MIPS CQM	QualityID_134_MIPSCQM	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.
Colorectal Cancer Screening	QualityID_113	Percentage of adults 50 - 75 years of age who had appropriate screening for colorectal cancer.
Breast Cancer Screening	QualityID_112	Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	QualityID_438	Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period: · Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR · Adults aged ≥ 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >190 mg/dL or were previously diagnosed with or currently have a diagnosis of familial or pure hypercholesterolemia; OR · Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL
Depression Remission at Twelve Months	QualityID_370	Percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event.
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), WI	QualityID_001_WI	Percentage of patients 18 - 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. Note that a lower performance rate is indicative of better quality.
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), eCQM	QualityID_001_eCQM	Percentage of patients 18 - 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. Note that a lower performance rate is indicative of better quality.

Term Name	Variable Name	Definition
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), MIPS CQM	QualityID_001_MIPSCQM	Percentage of patients 18 - 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. Note that a lower performance rate is indicative of better quality.
Controlling High Blood Pressure, WI	QualityID_236_WI	Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.
Controlling High Blood Pressure, eCQM	QualityID_236_eCQM	Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.
Controlling High Blood Pressure, MIPS CQM	QualityID_236_MIPSCQM	Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.

Parameters

File year	Performance year period
2022	January 1, 2022-December 31, 2022
2021	January 1, 2021-December 31, 2021
2020	January 1, 2020-December 31, 2020
2019A	July 1, 2019-December 31, 2019
2019	January 1, 2019-December 31, 2019
2018	January 1, 2018-December 31, 2018
2017	January 1, 2017-December 31, 2017
2016	January 1, 2016-December 31, 2016
2015	January 1, 2015-December 31, 2015
2014	January 1, 2014-December 31, 2014
2013	21-month (April 1, 2012-December 31, 2013) or 18-month (July 1, 2012-December 31, 2013) period for ACOs with 2012 start dates, and a 12-month (January 1, 2013-December 31, 2013) period for ACOs with 2013 start dates

Notes

For details on the Medicare Shared Savings Program, refer to:	Shared Savings Program on CMS.gov
For details on the methodology used to determine shared savings and losses, refer to:	Medicare Shared Savings Program Guidance & Specifications Medicare Shared Savings Program Statutes & Regulations
For details on COVD-19 adjustments, refer to:	Medicare Shared Savings Program Shared Savings and Losses and Assignment Methodology Specifications of Policies to Address the Public Health Emergency for COVID-19
File year	**Notes**
2022	All performance year expenditure, risk score, and person year variables, and variables related to savings and loss calculations that are derived from these variables, unless otherwise noted, are calculated excluding months associated with episodes of care for the treatment of COVID-19 episodes. Please reference the Medicare Shared Savings Program Shared Savings and Losses and Assignment Methodology Specifications of Policies to Address the Public Health Emergency for COVID-19.
	Months associated with episodes of care for the treatment of COVID-19 have been included in the calculations for the following variables: Inpatient hospital discharges, Short term hospital discharges, Long-term hospital discharges, Rehabilitation hospital or unit discharges, Psychiatric hospital or unit discharges, Outpatient ED visits, Emergency department visits that lead to a hospitalization, CT events, MRI events, Primary care services, Primary care services with a primary care physician (PCP), Primary care services with a specialist, Primary care services with a NP/PA/CNS, Primary care services with a FQHC/RHC, Skilled nursing facility discharges, Skilled nursing facility length of stay, Skilled nursing facility payment per stay, Percentage Duals, Share of Long-Term Institutionalized Beneficiaries
	The definition for Met the Quality Performance Standard is specific to calendar year 2022.
	DisAffQual is equal to 1 for all ACOs as a result of the COVID-19 pandemic which occurred during the quality reporting period, affecting all U.S. counties and triggering the extreme and uncontrollable circumstances policy for quality reporting for 2022.
	Quality performance rates are displayed with a dash "-" when missing or unreported. If an ACO reported quality measure performance via both CMS Web Interface measures and eCQMs/MIPS CQMs, the quality performance rates associated with the reporting option that resulted in a lower Quality Performance score are displayed as missing.
	For PY 2022, the CMS Web Interface measures Quality ID #438 and Quality ID #370 do not have benchmarks, and therefore, were not scored. CAHPS_7 did not have a benchmark and was not scored. For PY 2022, the eCQM collection type for Quality ID #236 and Quality ID #134 were subject to measure suppression for the eCQM collection type, and therefore, these eCQMs do not have benchmarks. Thus, if these measures were only reported as an eCQM, the measure is suppressed. If these measures were reported as both an eCQM and a MIPS CQM, the measure is suppressed for both collection types. If these measures were reported as a MIPS CQM only, the measure may be included if data completeness and case minimum requirements were met.
	CAHPS for MIPS, Quality ID# 321, is a composite measure that includes several summary survey measures (SSMs); there is no composite performance rate to report for this measure. The individual CAHPS measures or SSMs that are part of CAHPS for MIPS are CAHPS_1, CAHPS_2, CAHPS_3, CAHPS_4, CAHPS_5, CAHPS_6, CAHPS_7, CAHPS_8, CAHPS_9, and CAHPS_11.
	The CMS cell size suppression policy sets minimum thresholds for the display of CMS data. The policy stipulates that no cell (e.g., admissions, discharges, patients, services, etc.) containing a value of 1 to 10 can be reported directly. A value of zero does not violate the minimum cell size policy. In addition, no cell can be reported that allows a value of 1 to 10 to be derived from other reported cells or information. For example, the use of percentages or other mathematical formulas that, in combination with other reported information, result in the display of a cell containing a value of 1 to 10 are prohibited. As a result, cells in this data set are suppressed with an "*" if displaying them would violate the CMS cell size suppression policy. For more information on this policy, refer to https://www.hhs.gov/guidance/document/cms-cell-suppression-policy.