Performance Year Financial and Quality Results PUF Data Dictionary				
Term Name	**Variable Name**	**Definition**	**Footnotes**	**Applicable Performance Year(s)**
ACO Number	ACO_Num	Encrypted ACO Identifier. Identifier is consistent across performance years.	NA	2014 - 2017
ACO ID	ACO_ID	Unencrypted ACO Identifier. This identifier can be linked to the encrypted ACO identifier used for prior performance years.	NA	2013 - present
ACO name	ACO_Name	ACO Doing Business As (DBA) or Legal Business Name (LBN).	NA	2013 - present
State(s) where beneficiaries reside	ACO_State	Assigned beneficiary state(s) of residence. Includes only states that include counties where at least 1% of ACO's assigned beneficiaries reside. States are sorted by descending number of assigned beneficiaries.	NA	2013 - present
Agreement type	Agree_Type	Indicates whether an ACO is "Initial", participating in an initial agreement period; "Renewal", in a second or subsequent agreement period Renewal; 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.	NA	2016 - present
Participating for 6-Months	Participation_Six_Months	0/1 flag; =1 if ACO participated in a 6-month performance year (or performance period) from January 1, 2019, through June 30, 2019; =0 if ACO participated in a 12-month performance year Indicates whether an ACO was involved in a six or a 12-month performance year (PY) for PY 2019.	NA	2019
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 prior ACO.	NA	2016 - present
Initial start date	Initial_Start_Date	Agreement start date of first agreement period. For re-entering ACOs, initial start date is the start date of the agreement period for which the ACO re-entered the program.	NA	2016 - present
Track 1 in initial agreement period	Initial_Track_1	0/1 flag; =1 if ACO selected Track 1 (one-sided shared savings model) for initial agreement period; otherwise =0.	NA	2016 - 2019A
Track 2 in initial agreement period	Initial_Track_2	0/1 flag; =1 if ACO selected Track 2 (two-sided shared savings / losses model) for initial agreement period; otherwise =0.	NA	2016 - 2019A
Track 3 in initial agreement period	Initial_Track_3	0/1 flag; =1 if ACO selected Track 3 (two-sided shared savings / losses model) for initial agreement period; otherwise =0.	NA	2016 - 2019A
Track 1+ Model in initial agreement period	Initial_Track_1_Plus	0/1 flag; =1 if ACO selected Track 1+ Model (two-sided shared savings / losses model) for initial agreement period; otherwise =0.	NA	2018 - 2019A
BASIC Level A in initial agreement period	Initial_BASIC_A	0/1 flag; =1 if ACO selected BASIC Level A (one-sided shared savings model) for initial agreement period; otherwise =0.	NA	2019A
BASIC Level B in initial agreement period	Initial_BASIC_B	0/1 flag; =1 if ACO selected BASIC Level B (one-sided shared savings model) for initial agreement period; otherwise =0.	NA	2019A
BASIC Level C in initial agreement period	Initial_BASIC_C	0/1 flag; =1 if ACO selected BASIC Level C (two-sided shared savings / losses model) for initial agreement period; otherwise =0.	NA	2019A
BASIC Level D in initial agreement period	Initial_BASIC_D	0/1 flag; =1 if ACO selected BASIC Level D (two-sided shared savings / losses model) for initial agreement period; otherwise =0.	NA	2019A
BASIC Level E in initial agreement period	Initial_BASIC_E	0/1 flag; =1 if ACO selected BASIC Level E (two-sided shared savings / losses model) for initial agreement period; otherwise =0.	NA	2019A
ENHANCED in initial agreement period	Initial_ENHANCED	0/1 flag; =1 if ACO selected ENHANCED (two-sided shared savings / losses model) for initial agreement period; otherwise =0.	NA	2019A

Current start date	Current_Start_Date	Agreement start date of current agreement period. This will be the start date of the second or subsequent start date for ACOs classified as a Renewal. This will be the start date of the current agreement period for ACOs classified as re-entering.	NA	2013 - present
Track 1 in current performance year	Current_Track_1	0/1 flag; =1 if ACO selected Track 1 (one-sided shared savings model) for current performance year; otherwise =0.	NA	2013 - present
Track 2 in current performance year	Current_Track_2	0/1 flag; =1 if ACO selected Track 2 (two-sided shared savings / losses model) for current performance year; otherwise =0.	NA	2013 - present
Track 3 in current performance year	Current_Track_3	0/1 flag; =1 if ACO selected Track 3 (two-sided shared savings / losses model) for current performance year; otherwise =0.	NA	2016 - present
Track 1+ Model in current performance year	Current_Track_1_Plus	0/1 flag; =1 if ACO selected Track 1+ Model (two-sided shared savings / losses model) for current performance year; otherwise =0.	NA	2018 - present
BASIC Level A in current performance year	Current_BASIC_A	0/1 flag; =1 if ACO selected BASIC Level A (one-sided shared savings model) for current performance year; otherwise =0.	NA	2019A - present
BASIC Level B in current performance year	Current_BASIC_B	0/1 flag; =1 if ACO selected BASIC Level B (one-sided shared savings model) for current performance year; otherwise =0.	NA	2019A - present
BASIC Level C in current performance year	Current_BASIC_C	0/1 flag; =1 if ACO selected BASIC Level C (two-sided shared savings / losses model) for current performance year; otherwise =0.	NA	2019A - present
BASIC Level D in current performance year	Current_BASIC_D	0/1 flag; =1 if ACO selected BASIC Level D (two-sided shared savings / losses model) for current performance year; otherwise =0.	NA	2019A - present
BASIC Level E in current performance year	Current_BASIC_E	0/1 flag; =1 if ACO selected BASIC Level E (two-sided shared savings / losses model) for current performance year; otherwise =0.	NA	2019A - present
ENHANCED in current performance year	Current_ENHANCED	0/1 flag; =1 if ACO selected ENHANCED (two-sided shared savings / losses model) for current performance year; otherwise =0.	NA	2019A - present
Risk Model	Risk_Model	Indicates participation in a one-sided shared savings model or a two-sided shared savings/losses model for the performance year.	NA	2019 - present
Participate(d) in Advance Payment Model	Adv_Pay	0/1 flag; =1 if ACO participates or participated in Advance Payment Model; otherwise =0.	NA	2013 - present
Participate(d) in ACO Investment Model	AIM	0/1 flag; =1 if ACO participates or participated in ACO Investment Model (AIM); otherwise =0.	NA	2016 - present
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.	NA	2018 - present
Total Assigned Beneficiaries	N_AB	Number of assigned beneficiaries, performance year.	NA	2013 - present
Savings Rate	Sav_rate	Total Benchmark Expenditures Minus Assigned Beneficiary Expenditures as a percent of Total Benchmark Expenditures.	NA	2013 - present
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.	NA	2013 - present
Benchmark Minus Expenditures	BnchmkMinExp	Total Benchmark Expenditures Minus Assigned Beneficiary Expenditures. If positive, represents total savings. If negative, represents total losses.	NA	2013 - present

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. Note that in the PY 2018, 2019, and 2019A files, Generated losses was calculated as: 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 and the negative of the MSR (for ACOs in one-sided models).	NA	2013 - present
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 and share of year affected by an Extreme and Uncontrollable Circumstance.	NA	2017 - present
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 Extreme and Uncontrollable Circumstance adjustment.	NA	2013 - present
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 Extreme and Uncontrollable Circumstance or ACO legal entity is located in such a county. Otherwise equal to 0. In 2019 and 2020, all ACOs receive value of 1 due to the public health emergency for COVID-19.	NA	2018 - present

Met the Quality Performance Standard	Met_QPS	0/1 flag; =1 if ACO met the quality performance standard; otherwise =0. An ACO must meet the quality performance standard to be eligible to share in any savings generated. Any ACO that did not completely report quality data did not meet the quality performance standard unless the ACO was determined to be impacted by an Extreme and Uncontrollable Circumstance. The quality performance standard for ACOs in their first performance year is based on complete and accurate reporting of all required quality measures. ACOs beyond the first performance year of their first agreement period must also meet minimum attainment (which is the 30th percentile benchmark for pay-for-performance measures and complete reporting for pay-for-reporting measures) on at least one measure in each domain. For ACOs determined to have been affected by an Extreme and Uncontrollable Circumstance, the ACO will automatically meet the quality performance standard.	NA	2016 - present
Quality Score	QualScore	Quality score: In Performance Year 1 of an ACO's first agreement period, the quality score is 100% if all measures were completely reported and less than 100% if one or more measures were not completely reported. Beyond Performance Year 1 of an ACO's first agreement period, the quality score will be determined not only by whether all measures were completely reported but also on their performance against established benchmarks and on quality improvement. For ACOs determined to have been affected by an Extreme and Uncontrollable Circumstance, the quality score is the higher of the ACO's calculated initial quality score or the national mean quality score across all Shared Savings Program ACOs who met the quality performance standard before application of the Extreme and Uncontrollable Circumstances policy.	NA	2016 - present
Extreme and Uncontrollable Circumstance-Adjustment-Quality	RecvdMean	0/1 flag; =1 if ACO was affected by an Extreme and Uncontrollable Circumstance and had a quality score equal to the national mean quality score across all Shared Savings Program ACOs. =0 if ACO was either not affected by an Extreme and Uncontrollable Circumstance or was affected by an Extreme and Uncontrollable Circumstance and did not receive the mean quality score.	NA	2018 - present

Per Capita Prior Savings Adjustment (Prorated)	Prior_Sav_Adj	Per Capita Prior Savings Adjustment (Prorated): This applies only to ACOs with 2012 or 2013 start dates that renewed for a second agreement period in 2016; value is blank for all other ACOs. If average per capita savings (simple average of Total Historical Benchmark minus Total Expenditures, not to exceed the performance payment limit for the ACO's track, divided by assigned beneficiary person years for each performance year in the first agreement period) in the first agreement period is greater than zero, then multiply average per capita savings by average final sharing rate from first agreement period (simple average of Final Sharing Rate based on quality performance for each performance year in first agreement period). The additional per capita amount will be applied to the ACOs rebased historical benchmark for a number of assigned beneficiaries (expressed as person years) not to exceed the average number of assigned beneficiaries (expressed as person years) under the ACO's first agreement period.	NA	2016 - 2019
Regional Trend and Update Factors	RegTrndUpdt	0/1 flag; =1 if benchmark trend and update factors are based on regional expenditures; otherwise =0.	NA	2017 - present
Positive Regional Adjustment	PosRegAdj	0/1 flag; =1 if ACO received a positive regional adjustment to its historical benchmark (meaning ACO had lower spending than its region); otherwise =0 indicating ACO received a negative regional adjustment to its historical benchmark (meaning the ACO had higher spending than its region). This applies only to ACOs that renewed for a second agreement period in 2017, 2018, or 2019, and to ACOs that entered an agreement period beginning on or after July 1, 2019; value is blank for all other ACOs.	NA	2017 - present
Updated benchmark expenditures	UpdatedBnchmk	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 projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original fee-for-service program (for ACOs in a first agreement period from PY 1 - PY 2019 and for ACOs that entered a second agreement period in 2016), a regional update factor (for ACOs that entered a second agreement period in 2017, 2018, or 2019), or a blended national-regional update factor (for all ACOs that entered an agreement period beginning on or after July 1, 2019).	NA	2013 - present
Historical benchmark	HistBnchmk	Single per capita historical benchmark value reflecting ACO's applicable benchmarking methodology. For ACOs that entered a first agreement in 2018 or prior years, the benchmark is calculated using national assignable fee-for-service (FFS) expenditure trend factors. For ACOs that entered a second agreement period in 2017, 2018 or January 2019, the benchmark iscalculated using regional assignable FFS expenditure trend factors and incorporates a regional adjustment. 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.	NA	2013 - present

Total benchmark expenditures	ABtotBnchmk	Per capita benchmark (UpdatedBnchmk) multiplied by total person years (N_AB_Year).	NA	2013 - present
Total expenditures	ABtotExp	Per capita performance year expenditures (Per_Capita_Exp_TOTAL) multiplied by total person years (N_AB_Year).	NA	2013 - present
Advance payment amount	Adv_Pay_Amt	Maximum amount of advance payment/AIM available for recoupment at the time of financial reconciliation.	NA	2013 - present
Advance payment recoupment	Adv_Pay_Recoup	Amount of advance payment/AIM actually recouped at the time of financial reconciliation. Populated for advance payment/AIM ACOs that shared savings and is no greater than the maximum amount owed.	NA	2013 - present
Quality sharing rate	QualPerfShare	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 Track 1, Track 1+ Model and BASIC Track Levels C, D, and E, 60% for Track 2, and 75% for Track 3/ENHANCED Track.	NA	2013 - present
Final sharing rate	FinalShareRate	Quality performance sharing rate (QualPerfShare) multiplied by quality score (QualScore). 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.	NA	2013 - present
Revenue-based loss sharing limit	RevLossLimit	0/1 flag; =1 if ACO is subject to a revenue-based loss sharing limit; Otherwise =0. A Track 1+ Model is subject to a revenue-based loss sharing limit if none of the following criteria are met: the ACO includes an ACO participant that is an inpatient prospective payment system (IPPS) hospital, cancer center, or a rural hospital with more than 100 beds, or is owned or operated by, in whole or in part, such a hospital or by an organization that owns or operates such a hospital. If any of these criteria are met, the Track 1+ Model ACO is subject to a benchmark-based loss sharing limit. ACOs in BASIC Track Level C, Level D, and Level E are subject to a revenue-based loss sharing limit.	NA	2018 - present
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".	NA	2018 - present
Per capita ESRD expenditures in benchmark year 1	Per_Capita_Exp_ALL_ESRD_BY1	Annualized, truncated, weighted mean total expenditures per End-Stage Renal Disease (ESRD) assigned beneficiary person years in benchmark year 1.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present

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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
Average ESRD HCC risk score in benchmark year 1	CMS_HCC_RiskScore_ESRD_BY1	Final, mean prospective CMS- Hierarchical Condition Category (HCC) risk score forESRD enrollment type in benchmark year 1.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present

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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present

Total assigned beneficiaries, age 0-64	N_Ben_Age_0_64	Total number of assigned beneficiaries, age 0-64 in the calendar year (CY); age calculated as of February 1 of the calendar year. Based on mostcurrent date of birth in Medicare records.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
Total assigned beneficiaries, Other	N_Ben_Race_Other	Total number of assigned beneficiaries, Other (Race= 0,3,~) in the calendar year. Based on most current race in Medicare records.	NA	2013 - present
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.	NA	2013 - present

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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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).	NA	2013 - present
Other inpatient expenditures	CapAnn_INP_Other	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for other inpatient services in a short-term acute care setting for assigned beneficiaries in the performance year. Inpatient claims are identified by claim type code 60.	NA	2013 - 2019
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.	NA	2013 - present

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.	NA	2013 - present
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 Berenson-Eggers Type of Service (BETOS) code O1A.	NA	2013 - present
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.	NA	2013 - present
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.	NA	2013 - present
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 Health Insurance Claim Number (HICN), 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.	NA	2013 - present
Short term acute care hospital discharges	ADM_S_Trm	Total number of short-term acute care hospital discharges per 1,000 person years in the performance year. A beneficiary is flagged for having a hospitalization in a short-term acute-care 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 HICN, 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 or 61.	NA	2013 - present

LTCH 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 HICN, same admission date, and same provider number. 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.	NA	2013 - present
IRF 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 HICN, 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.	NA	2013 - present
IPF 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 HICN, 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.	NA	2013 - present
CHF discharges	chf_adm	Total number of discharges for congestive heart failure (CHF) per 1,000 person years in the performance year. Measure specifications are based on Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators Technical Specifications—Version 6.0. This metric differs from the measure used for the quality performance standard. It is not risk-adjusted. For annual quality measurement, CMS will use the risk-adjusted AHRQ Prevention Quality Indicator #8. Denominator: Number of beneficiaries assigned to the ACO during the measurement period (measured as person years). Numerator: All patients discharged with a principal diagnosis of CHF from a short-term acute-care hospital (including CAHs).	NA	2013 - present
COPD/Asthma discharges	copd_adm	Total number of discharges for chronic obstructive pulmonary disease (COPD) or asthma per 1,000 person years in the performance year. Measure specifications are based on AHRQ Prevention Quality Indicators Technical Specifications—Version 6.0. Denominator: Number of beneficiaries assigned to the ACO during the measurement period (measured as person years). Numerator: All discharges with a principal diagnosis of COPD or asthma from a short-term acute-care hospital (including CAHS).	NA	2013 - present

Post-discharge provider visits (30 day)	prov_Rate_1000	Rate of provider visits within 30 days of discharge from a short-term acute-care hospital (including critical access hospitals) per 1,000 discharges among eligible beneficiaries assigned to the ACO in the performance year. In the event there is no more than one day between a discharge and the next admission, then the two hospital visits will be combined and considered as a single stay (contiguous admissions). For example, if there are contiguous admissions the earliest admission date and the latest discharge date will be used for the below calculations. Adjusted for transfers by combining two admissions into one when the second admission was within one day of the discharge date of the first admission. Denominator: Number of qualifying discharges from a short-term acute care hospital (including CAHs) among an ACO's assigned beneficiaries. To be considered a qualifying discharge, the hospitalization must occur in the first 11 months the performance year and the beneficiary must be alive at the time of discharge. Numerator: Includes all of the qualifying discharges in the denominator that were followed by at least one provider visit made by the assigned beneficiary within 30 days of the discharge or prior to readmission (if the readmission occurs within 30 days of the discharge).	NA	2013 - present
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.	NA	2013 - present
Inpatient ED visits	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.	NA	2013 - present
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 BETOS codes I2A (advanced imaging-CAT: head) and I2B (advanced imaging-CAT: other).	NA	2014 - present
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 BETOS codes I2C (advanced imaging-MRI: brain) and I2D (advanced imaging-MRI: other).	NA	2013 - present
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.	NA	2013 - present
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), or 38 (geriatric medicine). This includes primary care services provided at Method II CAHs.	NA	2013 - present

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.	NA	2013 - present
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).	NA	2013 - present
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.	NA	2013 - present
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 HICN, 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.	NA	2013 - present
Acute composite discharges	acute_adm	Total number of discharges for dehydration, bacterial pneumonia, and urinary tract infections per 1,000 person years in the performance year. Measure specifications are based on AHRQ Prevention Quality Indicators Technical Specifications—Version 6.0. This measure differs from the measure used for the quality performance standard. It is not risk-adjusted. For annual quality measurement, CMS will use the risk-adjusted AHRQ Prevention Quality Indicator #91. Denominator: Number of beneficiaries assigned to the ACO during the measurement period (measured as person years). Numerator: All discharges with a principal diagnosis of bacterial pneumonia, dehydration, or urinary tract infection, or a secondary diagnosis of dehydration accompanying a principal diagnosis of hyperosmolarity and/or hypernatremia, gastroenteritis, or acute kidney injury, from a short-term acute-care hospital (including critical access hospitals).	NA	2017

Short term acute care readmissions (all-cause 30 day)	readm_Rate_1000	Rate of short-term acute-care hospital readmissions within 30 days of discharge from a short-term acute-care hospital (including critical access hospitals) per 1,000 discharges among eligible beneficiaries assigned to the ACO in the performance year. When identifying an initial admission, all overlapping and contiguous hospital bills submitted to Medicare are considered as single hospital stays if there are no breaks greater than one day. For example, in the event there are contiguous stays the earliest admission date and latest discharge date will be used for the below calculation. Adjusted for transfers by combining two admissions into one when the second admission date was no more than one day after the discharge date of the first admission. This measure differs from the readmission measure used for the quality performance standard. It is not risk-adjusted. For annual quality measurement, CMS uses the risk-standardized Yale hospital wide readmission (HWR) measure. Denominator: Number of qualifying discharges from a short-term acute care hospital (including critical access hospitals) among an ACO's assigned beneficiaries. To be considered a qualifying discharge, the hospitalization must occur in the first 11 months the performance year and the beneficiary must be alive at the time of discharge. Numerator: The number of hospital readmissions to a short-term acute-care hospital within 30 days of a qualifying discharge.	NA	2014 - 2017
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 HICN, 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.	NA	2018
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 HICN, 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.	NA	2018
Number of CAHs	N_CAH	Total number of Critical Access Hospitals 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).	NA	2013 - present
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 the PECOS.	NA	2013 - present
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 the PECOS.	NA	2013 - present
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 the PECOS.	NA	2013 - present

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 the PECOS.	NA	2013 - present
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 the PECOS.	NA	2013 - present
Number of participating PCPs	N_PCP	Total number of 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 the PECOS.	NA	2013 - present
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 the PECOS.	NA	2013 - present
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 the PECOS.	NA	2013 - present
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 the PECOS.	NA	2013 - present
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 the PECOS.	NA	2013 - present
CAHPS: Getting Timely Care, Appointments, and Information	ACO1	Consumer Assessment of Healthcare Providers and Systems (CAHPS): Getting Timely Care, Appointments, andInformation	NA	2016 – present
CAHPS: How Well Your Providers Communicate	ACO2	CAHPS: How Well Your Providers Communicate	NA	2016 - present
CAHPS: Patients' Rating of Provider	ACO3	CAHPS: Patients' Rating of Provider	NA	2016 - present
CAHPS: Access to Specialists	ACO4	CAHPS: Access to Specialists	NA	2016 - present
CAHPS: Health Promotion and Education	ACO5	CAHPS: Health Promotion and Education	NA	2016 - present
CAHPS: Shared Decision Making	ACO6	CAHPS: Shared Decision Making	NA	2016 - present
CAHPS: Health Status/Functional Status	ACO7	CAHPS: Health Status/Functional Status	NA	2016 - present
CAHPS: Stewardship of Patient Resources	ACO34	CAHPS: Stewardship of Patient Resources	NA	2016 - present
CAHPS: Courteous and Helpful Office Staff	ACO45	CAHPS: Courteous and Helpful Office Staff	NA	2019 - present
CAHPS: Care Coordination	ACO46	CAHPS: Care Coordination	NA	2019 - present
Risk Standardized, All Condition Readmission	ACO8	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.	NA	2016 - present
Skilled Nursing Facility 30-day All-Cause Readmission measure (SNFRM)	ACO35	Risk-adjusted rate of all-cause, unplanned, hospital readmissions within 30 days for ACO assigned beneficiaries who had been admitted to a SNF after discharge from their prior proximal hospitalization. Note that a lower performance rate is indicative of better quality.	NA	2016 - 2018

All-Cause Unplanned Admissions for Patients with Diabetes	ACO36	Rate of risk-standardized acute, unplanned hospital admissions among FFS beneficiaries 65 years and older with diabetes who are assigned to the ACO. Note that a lower performance rate is indicative of better quality.	NA	2016 - 2018
All-Cause Unplanned Admissions for Patients with Heart Failure	ACO37	Rate of risk-standardized acute, unplanned hospital admissions among FFS beneficiaries 65 years and older with heart failure who are assigned to the ACO. Note that a lower performance rate is indicative of better quality.	NA	2016 - 2018
All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	ACO38	Rate of risk-standardized acute, unplanned hospital admissions among Medicare FFS beneficiaries 65 years and older with multiple chronic conditions (MCCs) who are assigned to the ACO. Note that a lower performance rate is indicative of better quality.	NA	2016 - present
Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (AHRQ Prevention Quality Indicator (PQI) #5)	ACO9	All discharges with an ICD-10-CM principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO assigned or aligned beneficiaries with COPD or asthma, with risk-adjusted comparison of observed discharges to expected discharges for each ACO. This is a ratio of observed to expected discharges. Note that a lower performance rate is indicative of better quality.	NA	2016
Ambulatory Sensitive Conditions Admissions: Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8)	ACO10	All discharges with an ICD-10-CM principal diagnosis code for HF in adults ages 18 years and older, for ACO assigned or aligned beneficiaries with HF, with risk-adjusted comparison of observed discharges to expected discharges for each ACO. This is a ratio of observed to expected discharges. Note that a lower performance rate is indicative of better quality.	NA	2016
Use of Imaging Studies for Low Back Pain	ACO44	The percentage of ACO assigned beneficiaries with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, or CT scan) within 28 days of diagnosis.	NA	2017 - 2018
Ambulatory Sensitive Condition Acute Composite (AHRQ* Prevention Quality Indicator (PQI #91))	ACO43	Risk-adjusted rate of hospital discharges for acute PQI conditions with a principal diagnosis of, community-acquired bacterial pneumonia, or urinary tract infection among ACO assigned Medicare FFS beneficiaries 18 years and older. Note that a lower performance rate is indicative of better quality. In PY 2020 the measure was updated and the principal diagnosis of dehydration was removed.	NA	2017 - present
Use of Certified electronic health record (EHR) Technology	ACO11	Percentage of Merit-Based Incentive Payment System (MIPS) Eligible Clinicians participating in the ACO (regardless of track) who successfully meet the Advancing Care Information Base Score requirements.	NA	2016 - 2018
Medication Reconciliation Post-Discharge	ACO12	The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years of age and older of age seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record.	NA	2017 - 2018

Documentation of Current Medications in the Medical Record	ACO39	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	NA	2016
Falls: Screening for Future Fall Risk	ACO13	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	NA	2016 - present
Preventive Care and Screening: Influenza Immunization	ACO14	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.	NA	2016 – present
Pneumococcal Vaccination Status for Older Adults	ACO15	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	NA	2016 - 2018
Preventive Care and Screening: Body MassIndex (BMI) Screeningand Follow-Up Plan	ACO16	Percentage of patients aged 18 years and older with a Body Mass Index (BMI) documented during the current encounter or during the previous 12 months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous 12 months of the current encounter.	NA	2016 - 2018
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	ACO17	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	NA	2016 - present
Pneumococcal Vaccination Status for Older Adults	ACO15	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	NA	2016 - 2018

Preventive Care and Screening: Screening for Depression and Follow-up Plan	ACO18	Percentage of patients aged 12 years and older screened for depression on 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 positive screen.	NA	2016 - present
Colorectal Cancer Screening	ACO19	Percentage of adults 50 - 75 years of age whohad appropriate screening for colorectal cancer.	NA	2016 - present
Breast Cancer Screening	ACO20	Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer.	NA	2016 - present
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	ACO21	Percentage of patients aged 18 years and olderseen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	NA	2016
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	ACO42	Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statintherapy during the measurement period: · Adults aged ≥ 21 years who were previously diagnosed with or currently have anactive diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR · Adults aged ≥ 21 years who were previously diagnosed with or currently have anactive diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR · Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL	NA	2016 - present
Depression Remission at Twelve Months	ACO40	The 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.	NA	2016 - present
Diabetes Composite (All or Nothing Scoring)	DM_Comp	Percentage of patients who meet the numerator criteria of ACO-41 and do not meet the numerator criteria of ACO-27.	NA	2016 - 2018
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	ACO27	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.	NA	2016 - present
Diabetes: Eye Exam	ACO41	Percentage of patients 18 - 75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal (no evidence of retinopathy) in the 12 months priorto the measurement period.	NA	2016 - 2018
Controlling High Blood Pressure	ACO28	Percentage of patients 18 - 85 years of age whohad a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.	NA	2016 - present

Parameters

File year	Performance year period
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

Notes

For details on the Medicare Shared Savings Program, see:

Shared Savings Program on CMS.gov

For details on the methodology used to determine shared savings and losses, see:

Medicare Shared Savings Program Guidance & Specifications

Medicare Shared Savings Program Statutes & Regulations

For details on COVD-19 adjustments, see:

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
2020	All performance year expenditure, risk score, and person year variables, and variables related to savings and loss calculations that are derived from these variables, are calculated excluding months associated with episodes of care for the treatment of coronavirus disease 2019 (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 Total Person Years Including the following utilization variables: Inpatient hospital discharges, Short-term acute-care hospital discharges, LTCH discharges, IRF discharges, IPF discharges, CHF discharges, COPD/Asthma discharges, Post-discharge provider visits (30 day), Outpatient ED visits, Inpatient ED visits, CT events, MRI events, Primary care services, Primary care services with a primary care physician, 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.
	The definition for Met the Quality Performance Standard is specific to calendar year 2020 and may not be applicable to performance periods outside of PY 2020.
	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 2020.
	For CMS Web Interface measures ACO-13 through ACO-42, if no beneficiaries were eligible for this measure due to the measure's inclusion/exclusion criteria, then a "N/A" (Not Applicable) will appear in place of a performance rate.
	CMS waived the CAHPS for ACOs reporting requirement for Performance Year 2020 and ACOs were assigned automatic credit for each of the CAHPS survey measures within the patient/caregiver experience domain and these will have a "^" in place of performance rate data.
	ACOs that did not successfully report CMS Web Interface measures will have a dash "-" displayed for performance rates.
	Two of the three claims-based measures in the quality measure set for 2020 (ACO-8 and ACO-38) were reverted to pay-for-reporting for PY 2020 given the impact of the COVID-19 public health emergency (PHE) on these measures and their performance data will be suppressed as indicated by "~".
2019A	For ACOs being reconciled for the 6-month performance year from July 1, 2019, through December 31, 2019, performance year assigned beneficiaries, person years, per capita expenditures, assigned beneficiary proportions, quality performance, total Medicare Parts A and B FFS revenue for ACO participants, share of beneficiaries in counties affected by an extreme and uncontrollable circumstance, and share of year affected by an extreme and uncontrollable circumstance reported in this table are for CY 2019.
	Participating for 6-Months is equal to 1 for all ACOs in PY 2019A.
	Final Sharing Rate has been rounded to the nearest percent value. Note that Earned Performance Payments and Payment due to CMS have been calculated with a more precise value for Final Sharing Rate than presented here.
	For PY 2019A, the following variables are prorated: Total Assigned Beneficiary Expenditures, Total Benchmark Expenditures, Total Benchmark Minus Assigned Beneficiary Expenditures, Earned Performance Payment, Payment due to CMS.
	The definition for Met the Quality Performance Standard is specific to calendar year 2019 and may not be applicable to performance periods outside of PY 2019 and PY 2019A.
	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 2019.
	For variable Earned Shared Savings Payments/Owe Losses, the final sharing rate is not to exceed 40% for BASIC Track Level A, 40% for BASIC Track Level B, 50% for BASIC Track Level C, 50% for BASIC Track Level D, 50% for BASIC Track Level E, and 75% for ENHANCED Track ACOs
	For CMS Web Interface measures ACO-13 through ACO-42, if no beneficiaries were eligible for this measure due to the measure's inclusion/exclusion criteria, then a "N/A" (Not Applicable) will appear in place of a performance rate.
	ACOs that did not successfully report CAHPS measures will have a dash "-" displayed for CAHPS measures (ACO-1 through ACO-7, ACO-34, ACO-45, and ACO-46). ACOs that did not successfully report CMS Web Interface measures will have a dash "-" displayed for performance rates.
	Per CMS policy, ACO Quality Measures with cell sizes <11, or any combination of information that would allow cell sizes of <11 to be calculated, are not publicly reported. Such measures will have a "*" displayed if the sample size is sufficiently small.
	A "/" indicates a reporting error occurred for the ACO Quality Measure and the performance rate will not be displayed.
2019	For ACOs being reconciled in both PY 2019 and PY 2019A, Advance Payment Recoupment shows the maximum amount of Advance Payment or AIM available for recoupment at performance year settlement. This is the total amount not repaid as of Advance Payment or AIM Recoupment Date and not recouped from performance payment earned, if any, for PY 2019. Recoupment is considered for the calendar year and thus PY 2019A recoupment will be net of whatever has already been repaid in PY 2019.
	For ACOs being reconciled for the 6-month performance year or performance period from January 1, 2019 through June 30, 2019, performance year assigned beneficiaries, person years, per capita expenditures, assigned beneficiary proportions, quality performance, total Medicare Parts A and B FFS revenue for ACO participants, share of beneficiaries in counties affected by an extreme and uncontrollable circumstance, and share of year affected by an extreme and uncontrollable circumstance are for calendar year 2019.
	Participating for 6-Months is only applicable to ACOs in PY 2019.
	Final Sharing Rate has been rounded to the nearest percent value. Note that Earned Performance Payments and Payment due to CMS have been calculated with a more precise value for Final Sharing Rate than presented here.
	For PY 2019, the following variables are prorated for ACOs Participating for 6-Months: Total Assigned Beneficiary Expenditures, Total Benchmark Expenditures, Total Benchmark Minus Assigned Beneficiary Expenditures, Earned Performance Payment, Payment due to CMS.
	The definition for Met the Quality Performance Standard is specific to calendar year 2019 and may not be applicable to performance periods outside of PY 2019 and PY 2019A.

	For Met_QPS, as finalized in the March 31st COVID-19 IFC, all 2019 and 2019A ACOs are determined to be impacted by an extreme and uncontrollable circumstance for calendar year 2019 and therefore all ACOs will automatically meet the quality performance standard and are eligible to share in savings.
	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 2019.
	For variable Earned Shared Savings Payments/Owe Losses, the final sharing rate is not to exceed 50% for Track 1 and Track 1+, 60% for Track 2, 75% for Track 3
	For CMS Web Interface measures ACO-13 through ACO-42, if no beneficiaries were eligible for this measure due to the measure's inclusion/exclusion criteria, then a "N/A" (Not Applicable) will appear in place of a performance rate.
	ACOs that did not successfully report CAHPS measures will have a dash "-" displayed for CAHPS measures (ACO-1 through ACO-7, ACO-34, ACO-45, and ACO-46). ACOs that did not successfully report CMS Web Interface measures will have a dash "-" displayed for performance rates.
2018	Per CMS policy, ACO Quality Measures with cell sizes <11, or any combination of information that would allow cell sizes of <11 to be calculated, are not publicly reported. Such measures will have a "*" displayed if the sample size is sufficiently small.
2017	A "/" indicates a reporting error occurred for the ACO Quality Measure and the performance rate will not be displayed.
	For measures ACO-12 through ACO-30, ACO-40 through ACO-42, and the Diabetes Composite, if no beneficiaries were eligible for this measure due to the measure's inclusion/exclusion criteria, then a "N/A" (Not Applicable) will appear in the place of a performance rate.
	Note, ACO-11 Use of Certified EHR Technology measure performance rates have been updated. ACOs' quality scores were not impacted since the measure is pay-for-reporting.
	ACOs that did not successfully report CAHPS measures in 2017 will have a dash "-" displayed for CAHPS measures (ACO-1 through ACO-7 and ACO-34). ACOs that did not successfully report CMS Web Interface measures in 2017 will have a dash "-" displayed for
2016	CMS Web Interface measures (ACO-12 through ACO-30 and ACO-40 through ACO-42). These measure fields may appear as blank cells in the downloaded file (the dash is not displayed).
	For measures ACO-12 through ACO-30 and ACO-40 through ACO-42, if no beneficiaries were eligible for this measure due to the measure's inclusion/exclusion criteria, then a "N/A" (Not Applicable) will appear in the place of a performance rate.
	ACOs that did not successfully report CAHPS measures in 2016 will have a dash "-" displayed for CAHPS measures (ACO-1 through ACO-7 and ACO-34). ACOs that did not successfully report GPRO Web Interface measures in 2016 will have a dash "-" displayed.
	GPRO Web Interface measures (ACO-13 through ACO-33 and ACO-39 through ACO-41). These measure fields appear as blank cells in the downloaded file (the dash is not displayed).
	For measures ACO-13 through ACO-33 and ACO-39 through ACO-42, if no beneficiaries were eligible for this measure due to the measure's inclusion/exclusion criteria, then a "N/A" (Not Applicable) will appear in the place of a performance rate.