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 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 prior ACO before re-entry.
Current start date	Current_Start_Date	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 Re-entering ACOs.
Track in current performance year	Current_Track	Current Performance Year Track: If ACO selected BASIC Level A (one-sided shared savings model) =A; BASIC Level B (one-sided shared savings model) =B; BASIC Level C (two-sided shared savings/losses model) =C; BASIC Level D (two-sided shared savings/losses model) =D; BASIC Level E (two-sided shared savings/losses model); ENHANCED (two-sided shared savings/losses model) =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.
Benchmark minus expenditures	BnchmkMinExp	Total Benchmark Expenditures Minus Assigned Beneficiary Expenditures. If positive, represents total savings. If negative, represents total losses.

Term Name	Variable Name	Definition
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.
Impacted mid-year termination flag	Impact_Mid_Year_Termination	0/1 flag; =1 if ACO is in a two-sided model and terminates its participation agreement under § 425.220 with an effective date of termination after June 30th and prior to December 31st of the performance year and is therefore responsible for a prorated share of any shared losses and is ineligible to receive shared savings; 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 or the alternative quality performance standard. This amount accounts for the application of the ACO's final sharing rate based on quality performance (which can vary based on ACO track and, if applicable, the ACO's health equity adjusted quality performance score), as well as the reduction in performance payment due to sequestration and application of the performance payment limit. This amount equals 0 if ACO is in a two-sided model and terminates its participation agreement under § 425.220 with an effective date of termination after June 30th and prior to December 31st of the performance year. 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 chosen MSR. 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, the EUC adjustment, and any prorating of shared losses for an ACO in a two-sided model that terminates its participation agreement under § 425.220 with an effective date of termination after June 30th and prior to December 31st of the performance year.
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 =0. For PY 2023 all ACOs receive a value of 1 due to the public health emergency (PHE) 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. The quality performance standard is the minimum quality performance score ACOs must achieve to be eligible to share in savings at the maximum rate available for the ACO's track. Meeting the quality performance standard also allows an ACO to avoid maximum shared losses for ACOs participating in the ENHANCED track. Due to the PHE for COVID-19, all ACOs are determined to be affected by an EUC for PY 2023; therefore, all ACOs will automatically meet the quality performance standard. Although the EUC policy applies to all ACOs for PY2023, there are three pathways by which ACOs reporting quality data via the Alternative Payment Model (APM) Performance Pathway (APP) could otherwise meet the quality performance standard: For all ACOs: Achieve a health equity adjusted quality performance score that is equivalent to or higher than the 30th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring; For ACOs that report the 3 electronic clinical quality measures(eCQMs)/Merit-based Incentive Payment System clinical quality measures(MIPS CQMs) and meet the criteria for the eCQM/MIPS CQM reporting incentive: If an ACO reports the 3 eCQMs/MIPS CQMs and meets the MIPS data completeness and case minimum requirements for all 3 eCQMs/MIPS CQMs, then the ACO must achieve a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least 1 of the 4 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 1 of the remaining 5 measures in the APP measure set; or For ACOs in the first performance year of their first agreement period under the Shared Savings Program: Meet the MIPS data completeness and case minimum requirements for each of the 10 CMS Web Interface measures or the 3 eCQMs/MIPS CQMs and administer a CAHPS for MIPS Survey.

Term Name	Variable Name	Definition
Met the alternative quality performance standard	Met_AltQPS	0/1 flag; =1 if ACO met the alternative quality performance standard based on the applicable methodology for a performance year; =0 if ACO did not meet the alternative quality performance standard; =missing, indicated by "-", if ACO met the quality performance standard based on the applicable methodology for a performance year, causing the alternative quality performance standard to be inapplicable. ACOs that do not meet the quality performance standard based on one of the three pathways described above can meet the alternative quality performance standard to be eligible to share in savings at a lower rate that is scaled based on the ACO's quality performance. To meet the alternative quality performance standard, the ACO must report quality data via the APP and achieve 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. Due to the PHE for COVID-19, all ACOs are determined to be affected by an EUC for PY 2023; therefore, all ACOs will automatically meet the quality performance standard. Because of this, all ACOs will receive missing, indicated by "-", for this variable for PY 2023.
Met or exceeded 30th percentile MIPS QPC score	Met_30pctl	0/1 flag; =1 if ACO achieved a health equity adjusted quality performance score that is equivalent to or higher than the 30th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring; otherwise =0. Due to the PHE for COVID-19, all ACOs are determined to be affected by an EUC for PY 2023; therefore, all ACOs will meet or exceed the 30th percentile MIPS Quality performance category score and receive a value of 1 for this variable. Due to the PHE for COVID-19, all Medicare Shared Savings Program ACOs have been determined to have been affected by an EUC and are eligible to have the Shared Savings Program Quality EUC policy applied for PY 2023. Under the Medicare Shared 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 health equity adjusted quality performance score or the equivalent of the 30th percentile MIPS Quality performance category score across all MIPS Quality performance category 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 health equity adjusted quality performance score was set equal to the 30th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring.

Term Name	Variable Name	Definition
Met the eCQM/MIPS CQM reporting incentive	Met_Incentive	0/1 flag; =1 if ACO met the eCQM/MIPS CQM reporting incentive; otherwise =0. For PY 2023, an ACO met the criteria for the eCQM/MIPS CQM reporting incentive if the ACO reports the 3 eCQMs/MIPS CQMs, meets the MIPS data completeness and case minimum requirements for all 3 eCQMs/MIPS CQMs, and achieves a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least 1 of the 4 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 1 of the remaining 5 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 Medicare Shared Savings Program, the ACO reported quality data via the APP and met the MIPS data completeness and case minimum requirements for each of the 10 CMS Web Interface measures or the 3 eCQMs/MIPS CQMs and administered a CAHPS for MIPS Survey; otherwise =0.
Reported CMS Web Interface measure set	Report_WI	0/1 flag; =1 if the ACO reported the CMS Web Interface measures; otherwise =0. In PY 2023, ACOs were required to report the 10 CMS Web Interface measures or the 3 eCQMs/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 Quality performance category score. ACOs that chose to report both the CMS Web Interface measures and eCQMs/MIPS CQMs received a MIPS Quality performance category score based on whichever measure set resulted in a higher score. Note: The ACO health equity adjusted quality performance score and performance rates populated in the public use file (PUF) for an ACO are from the highest scoring reporting option, which was used for financial reconciliation.

Term Name	Variable Name	Definition
Reported eCQMs or MIPS CQMs	Report_eCQM_CQM	0/1 flag; =1 if the ACO reported eCQMs, MIPS CQMs, or both eCQMs/MIPS CQMs; otherwise =0. In PY 2023, ACOs were required to report the 10 CMS Web Interface measures 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 Quality performance category score. ACOs that chose to report both the CMS Web Interface measures and eCQMs/MIPS CQMs received a MIPS Quality performance category score based on whichever measure set resulted in a higher quality score. Note: The ACO health equity adjusted 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 receive a MIPS Quality performance category score under the APP; otherwise =0. ACOs were required to report quality measures under the APP in PY 2023, and they are not scored under the APP if no measures were reported under the APP.
Health equity adjusted quality performance score	QualScore	Health equity adjusted quality performance score: ACO's health equity adjusted quality performance score based on applicable methodology for a performance year. In PY 2023, an ACO's health equity adjusted quality performance score was calculated using the ACO's performance on the quality measures reported under APP, any applicable quality improvement points, and any health equity adjustment bonus points awarded to the ACO. For PY 2023, all Medicare Shared Savings Program ACOs were eligible to have the Medicare 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 health equity adjusted quality performance score was set to the higher of the ACO's health equity adjusted quality performance score or the equivalent of the 30th percentile MIPS Quality performance category score across all MIPS Quality performance category 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 health equity adjusted quality performance score was set equal to the 30th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring. For PY 2023, ACOs that were eligible for health equity adjustment bonus points could receive a maximum of 10 health equity adjustment bonus points and a maximum health equity adjusted quality performance score of 100. An ACO was eligible for health equity adjustment bonus points if its MIPS Quality performance category score was calculated using the eCQM/MIPS CQM measure set, the ACO met the MIPS data completeness requirement for all 3 eCQMs/MIPS CQMs and administered a CAHPS for MIPS Survey, and the ACO had an underserved multiplier greater than or equal to 0.20.

Term Name	Variable Name	Definition
Extreme and uncontrollable circumstance - 30th percentile adjustment-quality	Recvd30p	0/1 flag; =1 if ACO had its health equity adjusted quality performance score set equal to the 30th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, under the Medicare Shared Savings Program Quality EUC policy; otherwise =0
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.
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 Fee-for-Service (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	The percentage of savings an ACO shares if the ACO is eligible for shared savings. 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. If the ACO meets the quality performance standard, equal to 40% for BASIC Track Levels A and B; 50% for BASIC Track Levels C, D, and E; and 75% for ENHANCED Track. If the ACO met the alternative quality performance standard, equal to the applicable percentage specified in the preceding sentence for the ACO's track multiplied by the ACO's health equity adjusted quality performance score. If the ACO does not meet the quality performance standard or the alternative quality performance standard, set to zero. Due to the Public Health Emergency for COVID-19, all ACOs are determined to be affected by an EUC for PY 2023 and therefore all ACOs will automatically meet the quality performance standard.
Final loss rate	FinalLossRate	The percentage of losses an ACO in a two-sided model is liable for if the ACO has losses outside its MLR. If the ACO is in a one-sided model, blank. If the ACO is in a two-sided model, Final Loss Rate is dependent on track. For ACOs in BASIC Track Levels C, D, and E, equal to 30%. For ACOs in ENHANCED Track, if ACO met the quality performance standard or the alternative performance quality standard, one minus the product of 75% and the ACO's health equity adjusted quality performance score, not to exceed 75% or be less than 40%; otherwise, equal to 75%.

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.
Total DUAL person years in performance year	N_AB_Year_Dual_PY	Total number of assigned beneficiaries with DUAL enrollment type in the performance year adjusted for the total number of months that each beneficiary was classified as DUAL (i.e. sum of total ESRD/DUAL person years, total DISABLED/DUAL person years, and total AGED/DUAL person years in the performance year); Number of DUAL person months divided by 12.
Total NON-DUAL person years in performance year	N_AB_Year_NonDual_PY	Total number of assigned beneficiaries with NON-DUAL enrollment type in the performance year adjusted for the total number of months that each beneficiary was classified as NON-DUAL (i.e. sum of total ESRD/NON-DUAL person years, total DISABLED/NON-DUAL person years, and total AGED/NON-DUAL person years in the performance year); Number of NON-DUAL person months divided by 12.

Term Name	Variable Name	Definition
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.
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.

Term Name	Variable Name	Definition
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. Short term acute care hospitals are identified by CMS Certification Number (CCN) where the 3rd through 6th digits is between 0001-0879. CAHs are identified by CCNs where the 3rd through 6th digits is between 1300-1399. Inpatient claims are identified by claim type code 60.
Long term care hospital (LTCH) 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. LTCHs are identified by CCNs where the 3rd through 6th digits is between 2000-2299.
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. IRFs are identified by CCNs where the 3rd through 6th digits is between 3025-3099 or where the 3rd position is equal to R or T.
Inpatient psychiatric facility (IPF) expenditures	CapAnn_INP_Psych	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for inpatient services in a psychiatric hospital or unit for assigned beneficiaries in the performance year. Inpatient claims are identified by claim type code 60. IPFs are identified by CCNs where the 3rd through 6th digits is between 4000-4499 or where the 3rd position 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.
SNF 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 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.

Term Name	Variable Name	Definition
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 claims (claim type codes 71 and 72) by Restructured BETOS Code System (RBCS) codes OA004N, OA002N, OA001N, or OA003N.
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 (DME) expenditures	CapAnn_DME	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for DME for assigned beneficiaries in the performance year. DME claims are identified by claim type codes 81 and 82.
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 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 acute care hospital (IPPS/CAH) 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 is between 0001-0879. CAHs are identified by CCNs where the 3rd through 6th digits is between 1300-1399. Inpatient claims are identified by claim type code 60.
Long-term care hospital (LTCH) discharges	ADM_L_Trm	Total number of LTCH discharges per 1,000 person years in the performance year. A beneficiary is flagged for having a hospitalization in a LTCH 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. 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. LTCHs are identified by CCNs where the 3rd through 6th digits is between 2000-2299.

Term Name	Variable Name	Definition
Inpatient rehabilitation facility (IRF) discharges	ADM_Rehab	Total number of 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. IRFs are identified by CCNs where the 3rd through 6th digits is between 3025-3099 or where the 3rd position is equal to R or T.
Inpatient psychiatric facility (IPF) discharges	ADM_Psych	Total number of 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. IPFs are identified by CCNs where the 3rd through 6th digits is between 4000-4499 or where the 3rd position is equal to M or S.
Outpatient emergency department (ED) visits	P_EDV_Vis	Total number of visits to an outpatient 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 (EDVs) 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 are identified in the hospital inpatient claims with revenue center code values 0450-0459 and 0981. Multiple ED claims on the same date are counted as a single EDV.
Computed tomography (CT) events	P_CT_VIS	Total number of 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.
Magnetic resonance imaging (MRI) events	P_MRI_VIS	Total number of MRI events per 1,000 person years in the performance year. MRI 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 PCP with a CMS specialty code of 1 (general practice), 8 (family practice), 11 (internal medicine), 37 (pediatric medicine), or 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).

Term Name	Variable Name	Definition
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. 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).
SNF discharges	P_SNF_ADM	Total number of discharges from a SNF 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. Adjusted 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.
SNF 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. Adjusted 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.
SNF 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. Adjusted 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 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 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.

Term Name	Variable Name	Definition
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 Tax Identification Numbers (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.
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

Term Name	Variable Name	Definition
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 (MCC). Annual risk-standardized rate of acute, unplanned hospital admissions among Medicare FFS patients aged 65 years and older with 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.
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.

Term Name	Variable Name	Definition
Depression remission at twelve months	QualityID_370	Percentage of adolescent patients 12-17 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: 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.
Diabetes: 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
2023	January 1, 2023-December 31, 2023
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**
2023	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, LTCH discharges, IRF discharges, IPF discharges, Outpatient ED visits, Emergency department visits that lead to a hospitalization, CT events, MRI events, Primary care services, Primary care services with a PCP, Primary care services with a specialist, Primary care services with a NP/PA/CNS, Primary care services with a FQHC/RHC, SNF, SNF length of stay, SNF payment per stay, Percentage duals, Share of Long-term institutionalized beneficiaries.
	All performance year expenditure variables, expenditures used for calculating the ACO's updated benchmark, and expenditure and revenue amounts used for calculating the ACO's revenue status exclude all Medicare Parts A and B payment amounts on Medicare Durable Medical Equipment, Prosthetics, Orthotics & Supplies claims (claim types 72 and 82) associated with HCPCS codes A4352 and A4353 for intermittent urinary catheters in CY 2023. Please reference the final rule entitled "Mitigating the Impact of Significant, Anomalous, and Highly Suspect (SAHS) Billing Activity on Medicare Shared Savings Program Financial Calculations in Calendar Year 2023".
	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 2023.
	For variables beginning with "CAHPS", "QualityID", and "Measure", performance rates are displayed with a dash "-" when missing or otherwise unavailable. If an ACO reported quality data via both CMS Web Interface measures and eCQMs/MIPS CQMs, the performance rates associated with the reporting option that resulted in a lower Quality Performance score are missing and displayed with a dash "-".
	For PY 2023, the CMS Web Interface measures Quality ID #438 and Quality ID #370 and CAHPS_7 do not have benchmarks, and therefore, were not scored.
	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.