Performance Year 2024 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://data.cms.gov/.
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. For ACOs that started an agreement period on or after January 1, 2024, the calculation of this variable accounts for the application of the guardrail policy (see definition for "Guardrail policy applies").

Term Name	Variable Name	Definition
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 For ACOs that started an agreement period on or after January 1, 2024, the calculation of this variable accounts for the application of the guardrail policy (see definition for "Guardrail policy applies").
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, or met criteria for opportunities for low revenue ACOs to share in savings. 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 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. For ACOs that started an agreement period on or after January 1, 2024, the calculation of this variable accounts for the application of the guardrail policy (see definition for "Guardrail policy applies").
Extreme and Uncontrollable Circumstance Adjustment - Financial	DisAdj	If ACO is in one-sided model, blank (represented by a "-"). 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 42 CFR 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 losses and is ineligible to receive shared savings; otherwise =0.

Term Name	Variable Name	Definition
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, or met criteria for opportunities for low revenue ACOs to share in savings, 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 quality 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. For ACOs that started an agreement period on or after January 1, 2024, the calculation of this variable accounts for the application of the guardrail policy (see definition for "Guardrail policy applies").
Extreme and Uncontrollable Circumstance Affected - Quality	DisAffQual	0/1 flag; =1 if 20 percent or more of the ACO's Quarter four list assigned beneficiaries reside in an area identified under the Quality Payment Program (QPP) as being affected by an EUC; or the ACO's legal entity is located in an area identified under the QPP as being affected by an EUC; otherwise =0.

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 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 ACOs participating in the ENHANCED track to avoid maximum shared losses. For PY 2024, ACOs that report quality data on the APP quality measure set can meet the quality performance standard via one of three pathways: • For all ACOs: Achieve a quality score that is equivalent to or higher than the 40th percentile across all MIPS quality performance category scores, excluding entities/providers eligible for facility-based scoring; • For ACOs that report the three eCQMs/MIPS CQMs and meet the MIPS data completeness requirement for all three eCQMs/MIPS CQMs (eCQM/MIPS CQM reporting incentive): 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 quality measure set and a quality performance score equivalent to or higher than the 40th percentile of the performance benchmark on at least one of the remaining five measures in the APP quality measure set. This reporting incentive does not apply to Medicare CQMs. Eligibility for the eCQM/MIPS CQM reporting incentive is determined independently of the quality measures that contribute to an ACO's quality score; or • For ACOs in the first performance year of their first agreement period under the Shared Savings Program (first year ACOs): Meet the MIPS data completeness requirement for each of the ten CMS Web Interface measures or the three eCQMs/MIPS CQMs/Medicare CQMs, administer the CAHPS for MIPS Survey (if the ACO meets the sample size required to administer the survey), and receive a MIPS quality performance category score.

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; equal to blank (represented by "-") if the ACO met the quality performance standard based on the applicable methodology for a performance year, indicating the alternative quality performance standard does not apply. ACOs that do not meet the quality performance standard based on one of the three pathways described in the Met the Quality Performance Standard row 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. The ACO's quality score (expressed as a percentage is multiplied by the maximum sharing rate for the ACO's track to determine its final shared savings rate. A similar approach is applied to ENHANCED track ACOs to determine shared losses. The alternative quality performance standard is available to all ACOs, regardless of how they report quality data. To meet the alternative quality performance standard, ACOs must report quality data on the APP quality measure set 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 quality measure set.
Met or exceeded 40th percentile MIPS quality performance category score	Met_40pctl	0/1 flag; =1 if ACO achieved a quality score that is equivalent to or higher than the 40th percentile across all MIPS quality performance category scores, excluding entities/providers eligible for facility-based scoring; otherwise =0.
Met criteria for the eCQM/MIPS CQM Reporting Incentive	Met_Incentive	0/1 flag; =1 if ACO met the criteria for the eCQM/MIPS CQM reporting incentive; otherwise =0. For PY 2024, an ACO can meet the criteria for the eCQM/MIPS CQM reporting incentive if the ACO reports the three eCQMs/MIPS CQMs, meets the MIPS data completeness requirement for all three eCQMs/MIPS CQMs, and achieves 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 quality measure set and a quality performance score equivalent to or higher than the 40th percentile of the performance benchmark on at least one of the remaining five measures in the APP quality measure set. This reporting incentive does not apply to Medicare CQMs. Eligibility for the eCQM/MIPS CQM reporting incentive is determined independently of the quality measures that contribute to an ACO's quality score.

Term Name	Variable Name	Definition
ACO is First Year ACO that met reporting criteria	Met_FirstYear	0/1 flag; =1 if the ACO is a first year ACO that met the reporting criteria; otherwise =0. An ACO in the first performance year of its first agreement period under the Shared Savings Program can meet the reporting criteria if the ACO reports quality data on the APP quality measure set, meets the MIPS data completeness requirement for each of the ten CMS Web Interface measures or the three eCQMs/MIPS CQMs/Medicare CQMs, administers the CAHPS for MIPS Survey (if the ACO meets the sample size required to administer the survey), and receives a MIPS quality performance category score.
Reported CMS Web Interface Measure Set	Report_WI	0/1 flag; =1 if the ACO reported the CMS Web Interface measures; otherwise =0. ACOs that reported both the CMS Web Interface measures and eCQMs/MIPS CQMs/Medicare CQMs received a MIPS quality performance category score based on whichever measure set resulted in a higher score. Note: The ACO's quality score and performance rates populated in the public use file (PUF) for an ACO are based on the highest scoring measure set , which represents the ACO's quality score (used in financial reconciliation to determine any shared savings or shared losses (if applicable)).
Reported eCQMs, MIPS CQMs or Medicare CQMs	Report_eCQM_CQM_MedicareCQM	0/1 flag; =1 if the ACO reported any eCQMs, MIPS CQMs, Medicare CQMs, or a combination of these measures on the APP quality measure set; otherwise =0. ACOs reported both the CMS Web Interface measures and eCQMs/MIPS CQMs/Medicare CQMs received a MIPS quality performance category score based on whichever measure set resulted in a higher quality score. Note: The ACO's quality score and performance rates populated in the PUF for an ACO are based on the highest scoring measure set, which , represents the ACO's quality score (used in financial reconciliation to determine any shared savings or shared losses (if applicable).

Term Name	Variable Name	Definition
Met SSP Quality Reporting Requirements	Met_SSP_quality_reporting_requirements	0/1 flag; =1 if the ACO met the Shared Savings Program quality reporting requirements described below; otherwise =0. For PY 2024, Shared Savings Program ACOs were required to report quality data on the APP quality measure set to meet the quality performance standard used to determine shared savings and shared losses (if applicable). ACO were required to report the ten CMS Web Interface measures or the three eCQMs/MIPS CQMs/Medicare CQMs; administer a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for MIPS Survey (if the ACO meets the sample size required to administer the survey); and be scored on two administrative claims measures that are calculated by CMS using administrative claims data (if the ACO meets the MIPS case minimum requirement).
Quality Score	QualScore	The quality score is the ACO's MIPS quality performance category score after any applicable Population and Income Adjustment bonus points are applied, and after the Shared Savings Program Quality EUC Policy and Shared Savings Program Scoring Policy for Excluded APP Measures and APP Measures that Lack a Benchmark are applied, if applicable.
Extreme and Uncontrollable Circumstance- 40th Percentile Adjustment-Quality	Recvd40p	0/1 flag; =1 if an ACO is determined to be affected by an EUC in PY 2024, the ACO's quality score will be set to the higher of its quality score or the equivalent of the 40th percentile MIPS quality performance category score across all MIPS quality performance category scores, excluding entities/providers eligible for facility-based scoring; otherwise =0.
Received Advance Investment Payments (AIP)	AIP	0/1 flag; =1 if the ACO received AIP; otherwise =0.
AIP recoupment for the performance year, maximum	AIPBalance	Maximum amount of AIP available for recoupment at the time of financial reconciliation for the performance year. If the ACO received AIP, and no amount of AIP is available for recoupment at the time of financial reconciliation for the performance year, equal to $0. If the ACO did not receive AIP, blank (represented by "-").
AIP recoupment for the performance year, actual	AIPRecoup	Actual amount of AIP recouped by CMS at performance year settlement. If the ACO received AIP, and no amount of AIP is recouped by CMS at performance year settlement, equal to $0. If the ACO did not receive AIP, blank (represented by "-").
AIP balance still owed to CMS after recoupment	AIPOwe	AIP amount of the performance year eligible balance still owed to CMS after recoupment process. If the ACO received AIP, and no balance is owed, equal to $0. If the ACO did not receive AIP, blank (represented by "-").

Term Name	Variable Name	Definition
Regional Adjustment	RegAdj	The ACO's per capita regional adjustment, expressed as a single value. In establishing historical benchmarks, CMS calculates an adjustment, by Medicare enrollment type, that is equal to a percentage of the difference between the average per capita expenditure amount for the ACO's regional service area for BY3 and the ACO's historical benchmark amount. This value represents the weighted average of these Medicare 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. ACOs that started an agreement period on or after July 1, 2019, and before January 1, 2024, can have a negative regional adjustment applied to their historical benchmark and the cap on their negative regional adjustment will not change. For ACOs that started an agreement period on or after January 1, 2024, the cap on negative Medicare enrollment type specific regional adjustments is reduced from 5 percent to 1.5 percent of national per capita expenditures for Parts A and B services under the original Medicare Fee-for-Service (FFS) Program in the third benchmark year. Additionally, if the regional adjustment, when expressed as a single value, is negative, then no regional adjustment is applied to the ACO's historical benchmark. For additional details on the methodology that CMS uses to compute the regional adjustment for PY 2024, including details on how the methodology differs based on agreement period start date, refer to Shared Savings and Losses, Assignment, and Quality Performance Standard Methodology Specifications Version 12.

Term Name	Variable Name	Definition
Prior Savings Adjustment	PriorSavAdj	The ACO's per capita prior savings adjustment, if eligible; otherwise, blank (represented by "-"). For ACOs that started an agreement period on or after January 1, 2024 in establishing historical benchmarks, CMS calculates an adjustment to account for savings generated in the three years prior to the start of an ACO's current agreement period for renewing or re-entering ACOs that were reconciled for one or more performance years in the Shared Savings Program during this period. Eligibility for a prior savings adjustment is determined by whether the simple average of an ACO's per capita savings or losses during the three years prior to the start of the ACO's current agreement period is positive (eligible) or either negative or equal to zero (ineligible). For additional detail on the methodology that CMS uses to compute the prior savings adjustment, refer to Shared Savings and Losses, Assignment, and Quality Performance Standard Methodology Specifications Version 12. ACOs that started an agreement period prior to January 1, 2024, are not eligible for a prior savings adjustment.
Adjustment applied to historical benchmark	FinalAdjCat	The type of adjustment (regional or prior savings), if any, applied to the ACO's historical benchmark. For ACOs that started an agreement period on or after July 1, 2019, and before January 1, 2024: Equal to "Regional Adjustment", pursuant to § 425.601(a)(8). For ACOs that started an agreement period on or after January 1, 2024: Equal to "Regional Adjustment", "Prior Savings Adjustment", or "No Adjustment", as applicable, pursuant to § 425.652(a)(8). For additional detail on the methodology that CMS uses to determine which adjustment, if any, to apply to the ACO's historical benchmark, refer to Shared Savings and Losses, Assignment, and Quality Performance Standard Methodology Specifications Version 12.

Term Name	Variable Name	Definition
Updated benchmark expenditures	UpdatedBnchmk	Value of the ACO's updated per capita historical benchmark expenditures. CMS calculates an updated historical benchmark for each performance year during annual financial reconciliation. For ACOs that started an agreement period on or after July 1, 2019, and before January 1, 2024: The updated benchmark includes the annual risk adjustment to the historical benchmark according to § 425.601(a)(10), as well as the annual update to the historical benchmark, which is calculated using a two-way blend of national and regional growth rates according to § 425.601(b) and § 425.652(a)(10). For ACOs that started an agreement period on or after January 1, 2024: The updated benchmark includes the annual risk adjustment to the historical benchmark according to § 425.652(a)(10), as well as the annual update to the historical benchmark, which is calculated using a three-way blend calculated as a weighted average of a two-way blend of national and regional growth rates and the Accountable Care Prospective Trend (ACPT; except in cases where a two-way blend is applied under a guardrail policy) according to § 425.652(b) and § 425.660. For additional detail on the methodology that CMS uses to compute updated benchmark expenditures for PY 2024, including details on how the methodology differs based on agreement period start date, refer to Shared Savings and Losses, Assignment, and Quality Performance Standard Methodology Specifications Version 12. For additional detail on the methodology that CMS uses to compute and apply the ACPT, refer to Shared Savings and Losses, Assignment and Quality Performance Standard Methodology, Specifications of the Accountable Care Prospective Trend (ACPT) and Three-Way Blended Benchmark Update Factor, Version 4.

Term Name	Variable Name	Definition
Guardrail policy applies	Guardrail	For ACOs that started an agreement on or after January 1, 2024, 0/1 flag; =1 if guardrail policy applies; otherwise =0. For ACOs that started an agreement period on or after July 1, 2019 and before January 1, 2024, blank (represented by "-") A "guardrail" policy ensures that the use of the three-way blended update factor (see definition for updated benchmark expenditures) will not result in lower benchmarks than the two-way national-regional blended update factor in a way that poses higher financial risk for ACOs under two-sided models, and/or that could jeopardize an ACO's continued participation in the Shared Savings Program under the financial performance monitoring policy. If an ACO generates losses for a performance year that meet or exceed its MLR (for two-sided model ACOs) or negative MSR (for one-sided model ACOs) under the three-way blended update factor, CMS will recalculate the ACO's updated benchmark using the two-way national-regional blended update factor. If the ACO generates a smaller number of losses using the two-way blend, CMS will use this smaller number to determine the ACO's responsibility for shared losses, if applicable, and in determining the ACO's financial performance for monitoring purposes. If an ACO generates savings using the two-way blend to update its benchmark but does not generate savings under the three-way blend, the ACO will neither be responsible for shared losses (if in a two-sided model) nor be eligible for shared savings for the applicable performance year, even if the savings generated exceed the ACO's MSR. For additional detail on the guardrail policy, including illustrative examples, refer to: Shared Savings and Losses, Assignment and Quality Performance Standard Methodology, Specifications of the Accountable Care Prospective Trend (ACPT) and Three-Way Blended Benchmark Update Factor, Version 4.
Historical benchmark	HistBnchmk	Single per capita historical benchmark value reflecting ACO's applicable benchmarking methodology. For additional details on the methodology that CMS uses to establish historical benchmark expenditures for PY 2024, including details on how the methodology differs based on agreement period start date, refer to Shared Savings and Losses, Assignment, and Quality Performance Standard Methodology Specifications Version 12.
Total benchmark expenditures	ABtotBnchmk	Per capita benchmark (UpdatedBnchmk) multiplied by total person years (N_AB_Year). For ACOs that started an agreement period on or after January 1, 2024, the calculation of this variable accounts for the application of the guardrail policy (see definition for "Guardrail policy applies").

Term Name	Variable Name	Definition
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. For ACOs meeting the applicable quality performance standard established under § 425.512(a)(2) or § 425.512(a)(5)(i), equal to the maximum sharing rate specific to the ACO's track or level of participation as follows: 40 percent for BASIC Track Levels A and B; 50 percent for BASIC Track Levels C, D, and E; and 75 percent for ENHANCED track. If the ACO fails to meet the applicable quality performance standard but meets the alternative quality performance standard established under § 425.512(a)(5)(ii), equal to the applicable percentage specified in the preceding sentence for the ACO's track multiplied by the ACO's quality score. If the ACO does not meet the quality performance standard or the alternative quality performance standard, set to zero. For agreement periods beginning on or after January 1, 2024, ACOs that do not meet or exceed the MSR but do meet certain eligibility criteria (see definition for "met criteria for opportunities for low revenue ACOs to share in savings") may share in savings equal to one half of the rate determined when the MSR is met or exceeded. That is, for eligible ACOs meeting the applicable quality performance standard established under § 425.512(a)(2) or § 425.512(a)(5)(i), equal to one half of the maximum sharing rate for the ACO's level of participation as follows: 20 percent for BASIC Track Levels A and B; and 25 percent for BASIC Track Levels C, D, and E; For eligible ACOs that do not meet the quality performance standard but do meet the alternative quality performance standard as established under § 425.512(a)(5)(ii), the final sharing rate is equal to the applicable percentage in the preceding sentence multiplied by the ACO's quality score. For eligible ACO that do not meet the quality performance standard or the alternative quality performance standard, set to zero.

Term Name	Variable Name	Definition
Met criteria for opportunities for low revenue ACOs to share in savings	ReducedSS	0/1 flag; =1 if the ACO is eligible for reduced shared savings; otherwise =0 For agreement periods beginning on or after January 1, 2024, BASIC track ACOs whose savings did not meet or exceed the MSR may be eligible to qualify for a shared savings payment, in which the ACO shares in savings at a reduced sharing rate, if all of the following criteria are met: 1. The ACO has average per capita Medicare Parts A and B FFS expenditures for the performance year below the updated benchmark. 2. The ACO is a low-revenue ACO as defined in § 425.20 as determined at the time of financial reconciliation for the performance year. 3. The ACO has at least 5,000 assigned beneficiaries for the relevant performance year as determined at the time of financial reconciliation for the performance year. 4. The ACO is participating in an agreement period beginning on January 1, 2024, or in subsequent years.
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 (represented by "-") 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 quality performance standard, one minus the product of 75% and the ACO's quality score, not to exceed 75% or be less than 40%; otherwise, equal to 75%.
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.

Term Name	Variable Name	Definition
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.
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.

Term Name	Variable Name	Definition
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.

Term Name	Variable Name	Definition
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.
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.
Average ESRD demographic risk score in performance year	Demog_RiskScore_ESRD_PY	Final, mean demographic risk score for ESRD enrollment type in the performance year.
Average DISABLED demographic risk score in performance year	Demog_RiskScore_DIS_PY	Final, mean demographic risk score for DISABLED enrollment type in the performance year.
Average AGED/DUAL demographic risk score in performance year	Demog_RiskScore_AGDU_PY	Final, mean demographic risk score for AGED/DUAL enrollment type in the performance year.
Average AGED/NON-DUAL demographic risk score in performance year	Demog_RiskScore_AGND_PY	Final, mean demographic risk score for AGED/NON-DUAL enrollment type in the performance year.
Average ESRD demographic risk score in benchmark year 3	Demog_RiskScore_ESRD_BY3	Final, mean demographic risk score for ESRD enrollment type in benchmark year 3.
Average DISABLED demographic risk score in benchmark year 3	Demog_RiskScore_DIS_BY3	Final, mean demographic risk score for DISABLED enrollment type in benchmark year 3.
Average AGED/DUAL demographic risk score in benchmark year 3	Demog_RiskScore_AGDU_BY3	Final, mean demographic risk score for AGED/DUAL enrollment type in benchmark year 3.
Average AGED/NON-DUAL demographic risk score in benchmark year 3	Demog_RiskScore_AGND_BY3	Final, mean demographic risk score for AGED/NON-DUAL enrollment type in benchmark year 3.

Term Name	Variable Name	Definition
Weight applied to the growth in ESRD risk scores	RR_weight_ESRD_PY	Weight applied to the growth in risk score for ESRD enrollment type for calculating weighted average growth in demographic risk scores or prospective HCC risk scores. Equal to the product of the ACO's historical benchmark expenditures, adjusted in accordance with § 425.652(a)(8), for ESRD enrollment type and the ACO's performance year assigned beneficiary person years for ESRD enrollment type. Used for calculating the cap on positive adjustments to prospective HCC risk scores when adjusting the benchmark for changes in severity and case mix in the assigned beneficiary population between BY3 and the performance year.
Weight applied to the growth in DISABLED risk scores	RR_weight_DIS_PY	Weight applied to the growth in risk score for DISABLED enrollment type for calculating weighted average growth in demographic risk scores or prospective HCC risk scores. Equal to the product of the ACO's historical benchmark expenditures, adjusted in accordance with § 425.652(a)(8), for DISABLED enrollment type and the ACO's performance year assigned beneficiary person years for DISABLED enrollment type. Used for calculating the cap on positive adjustments to prospective HCC risk scores when adjusting the benchmark for changes in severity and case mix in the assigned beneficiary population between BY3 and the performance year.
Weight applied to the growth in AGED/DUAL risk scores	RR_weight_AGDU_PY	Weight applied to the growth in risk score for AGED/DUAL enrollment type for calculating weighted average growth in demographic risk scores or prospective HCC risk scores. Equal to the product of the ACO's historical benchmark expenditures, adjusted in accordance with § 425.652(a)(8), for AGED/DUAL enrollment type and the ACO's performance year assigned beneficiary person years for AGED/DUAL enrollment type. Used for calculating the cap on positive adjustments to prospective HCC risk scores when adjusting the benchmark for changes in severity and case mix in the assigned beneficiary population between BY3 and the performance year.
Weight applied to the growth in AGED/NON-DUAL risk scores	RR_weight_AGND_PY	Weight applied to the growth in risk score for AGED/NON-DUAL enrollment type for calculating weighted average growth in demographic risk scores or prospective HCC risk scores. Equal to the product of the ACO's historical benchmark expenditures, adjusted in accordance with § 425.652(a)(8), for AGED/NON-DUAL enrollment type and the ACO's performance year assigned beneficiary person years for AGED/NON-DUAL enrollment type. Used for calculating the cap on positive adjustments to prospective HCC risk scores when adjusting the benchmark for changes in severity and case mix in the assigned beneficiary population between BY3 and 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.

Term Name	Variable Name	Definition
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.
Beneficiaries assigned through voluntary alignment only	N_Ben_VA_Only	Number of assigned beneficiaries assigned through voluntary alignment only.

Term Name	Variable Name	Definition
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 (sex=2) in the calendar year. Based on most current sex in Medicare records.
Total assigned beneficiaries, male	N_Ben_Male	Total number of assigned beneficiaries, male (sex=1) in the calendar year. Based on most current sex 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.

Term Name	Variable Name	Definition
Total Inpatient expenditures	CapAnn_INP_All	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for inpatient services for assigned beneficiaries in the performance year. Includes all hospital provider types including but not limited to short term acute care hospital, long term care hospital, rehabilitation hospital or unit, and psychiatric hospital or unit. Because total hospital inpatient facility expenditures and expenditures by hospital provider type are each truncated at the same level as total expenditures, expenditures by hospital provider type may not sum to total hospital inpatient facility expenditures. Inpatient claims are identified by claim type code 60.
Short term acute care hospital (IPPS/CAH) expenditures	CapAnn_INP_S_trm	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for acute care inpatient services in a short-term acute care (Inpatient Prospective Payment System (IPPS) or Critical Access Hospital (CAH) setting for assigned beneficiaries in the performance year. Inpatient claims are identified by claim type code 60. Short term acute care hospitals are identified by CMS Certification Number (CCN) where the 3rd through 6th digits are between 0001 - 0879. CAHs are identified by CCNS where the 3rd through 6th digits are between 1300 - 1399.
Long term care hospital (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 are 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 are between 3025 - 3099 or where the 3rd byte 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 facility 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 are between 4000 - 4499 or where the 3rd byte is equal to M or S.
Hospice expenditures	CapAnn_HSP	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for hospice services for assigned beneficiaries in the performance year. Hospice claims are identified by claim type code 50.
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).

Term Name	Variable Name	Definition
Outpatient expenditures	CapAnn_OPD	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for outpatient services for assigned beneficiaries in the performance year. Includes all outpatient facility types including, but not limited to, hospital outpatient departments, outpatient dialysis facilities, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), outpatient rehabilitation facilities, and community mental health centers. Outpatient claims are identified by claim type code 40.
Physician/supplier expenditures	CapAnn_PB	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for Part B physician/supplier (Carrier) services for assigned beneficiaries in the performance year. Includes all Part B physician/supplier services including, but not limited to, evaluation and management, procedures, imaging, laboratory and other test, Part B drugs, and ambulance services. In addition to physician and other practitioner services, includes free-standing ambulatory surgery centers, independent clinical laboratories, and other suppliers. Includes physician/practitioner services provided in either an inpatient or outpatient setting. Physician/supplier claims are identified by claim type codes 71 and 72.
Ambulance expenditures	CapAnn_AmbPay	Annualized, truncated, weighted mean expenditures per assigned beneficiary person years for ambulance services for assigned beneficiaries in the performance year. Ambulance services are identified in the Part B physician/supplier (Carrier) claims (claim type codes 71 and 72) by Restructured BETOS Code System (RBCS) codes OA004N, OA002N, OA001N, or OA003N.
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.

Term Name	Variable Name	Definition
Inpatient hospital discharges	ADM	Total number of inpatient hospital discharges per 1,000 person years in the performance year. A beneficiary is flagged for having a hospitalization if the beneficiary had at least one inpatient claim during the performance year. Each hospitalization is defined as a set of claims with the same Medicare Beneficiary Identifier (MBI), same admission date, and same provider number. Adjusted for short-term acute-care transfers by combining two admissions into one when the second admission was within one day of the discharge date of the first admission. Inpatient claims are identified by claim type code 60. Hospitals are identified on inpatient claims through the last four characters of the 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 (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 are between 0001 - 0879. CAHs are identified by CCNs where the 3rd through 6th digits are between 1300 - 1399. Inpatient claims are identified by claim type code 60.
Long-term 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. Long-term care hospitals are identified by CCNs where the 3rd through 6th digits are between 2000 - 2299.
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 are between 3025 - 3099 or where the 3rd byte is equal to R or T.

Term Name	Variable Name	Definition
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 are 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 is identified in the hospital inpatient claims with revenue center code values 0450-0459 and 0981 Multiple emergency department 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 imaging events are defined based on claim type codes 71 or 72 and RBCS codes IM009N, IM010N, IM020N, IM022N, and IM023N.
Primary care services	P_EM_Total	Total number of primary care services per 1,000 person years in the performance year. Primary care services are counted regardless of physician specialty.
Primary care services with a primary care physician (PCP)	P_EM_PCP_Vis	Total number of primary care services provided by a PCP per 1,000 person years in the performance year. Defined as a qualifying visit with a 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 bill type 71x and FQHC claims are bill type 77x.
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.

Term Name	Variable Name	Definition
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.
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 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

Term Name	Variable Name	Definition
CAHPS: Shared Decision Making	CAHPS_6	CAHPS: Shared Decision-Making
CAHPS: Health Status/Functional Status	CAHPS_7	CAHPS: Health Status/Functional Status
CAHPS: Stewardship of Patient Resources	CAHPS_11	CAHPS: Stewardship of Patient Resources
CAHPS: Courteous and Helpful Office Staff	CAHPS_9	CAHPS: Courteous and Helpful Office Staff
CAHPS: Care Coordination	CAHPS_8	CAHPS: Care Coordination
Hospital-Wide 30-day Readmission Rate	Measure_479	Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible clinician Groups. Risk-adjusted percentage of ACO assigned beneficiaries who were hospitalized and readmitted to a hospital within 30 days of discharge from the index hospital admission. Note that a lower performance rate is indicative of better quality.
All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Measure_484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCCs). 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. Patients are excluded if they were attributed to Qualifying Alternative Payment Model (APM) Participants (QPs). Most providers participating in Track E and ENHANCED track ACOs are QPs, and so performance rates for Track E and ENHANCED track ACOs may not be representative of the care provided by these ACOs' providers overall. Additionally, many of these ACOs do not have a performance rate calculated due to not meeting the minimum of 18 beneficiaries attributed to non-QP providers.
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 during the measurement period 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 12 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.

Term Name	Variable Name	Definition
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.
Preventive Care and Screening: Screening for Depression and Follow-up Plan, Medicare CQM	QualityID_134_MedicareCQM	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 45 - 75 years of age who had appropriate screening for colorectal cancer.
Breast Cancer Screening	QualityID_112	Percentage of women –40 - 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 who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR · Adults aged 20 - 75 years who have ever had a low-density lipoprotein cholesterol (LDL-C) level >=190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; OR · Adults aged 40-75 years with a diagnosis of diabetes; OR · Adults aged 40-75 with a 10-year ASCVD risk score of >= 20 percent
Depression Remission at Twelve Months	QualityID_370	Percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event.
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), WI	QualityID_001_WI	Percentage of patients 18 - 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. Note that a lower performance rate is indicative of better quality.
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), eCQM	QualityID_001_eCQM	Percentage of patients 18 - 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. Note that a lower performance rate is indicative of better quality.
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), MIPS CQM	QualityID_001_MIPSCQM	Percentage of patients 18 - 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. Note that a lower performance rate is indicative of better quality.

Term Name	Variable Name	Definition
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), Medicare CQM	QualityID_001_MedicareCQM	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.
Controlling High Blood Pressure, Medicare CQM	QualityID_236_MedicareCQM	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
2024	January 1, 2024-December 31, 2024
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

File year	Notes
2024	All benchmark 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. The PHE for COVID-19 was in effect starting in January 2020 and expired on May 11, 2023. Therefore, performance year expenditures calculations are not impacted.
	In accordance with § 425.670, to mitigate the impact of SAHS billing activity for selected intermittent urinary catheter supplies in calendar year 2023, all Parts A and B payment amounts on Medicare Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) claims (claim types 72 and 82) associated with Healthcare Common Procedure Coding System (HCPCS) codes A4352 and A4353 and dates of service in calendar year 2023 are excluded from the following calculations: calculation of Medicare Parts A and B FFS expenditures for setting the ACO's historical benchmark; and calculation of FFS expenditures for assignable beneficiaries as used in determining county-level FFS expenditures and national Medicare FFS expenditures.
	In accordance with § 425.672, to mitigate the impact of SAHS billing activity for selected services in calendar year 2024, all Parts A and B payment amounts on claim types 72 and 82 associated with HCPCS codes A4353 and A5057 and dates of service during the performance year or benchmark years are excluded from the following calculations: calculation of Medicare Parts A and B FFS expenditures for setting the ACO's historical benchmark; calculation of FFS expenditures for assignable beneficiaries as used in determining county-level FFS expenditures and national Medicare FFS expenditures; and calculation of Medicare Parts A and B FFS revenue of ACO participants for purposes of calculating the ACO's loss recoupment limit under the BASIC track and for purposes of identifying whether an ACO is a high revenue ACO or low revenue ACO.
	In addition to these adjustments, CMS made adjustments for the calendar year corresponding to BY3 in projecting per capita growth in Parts A and B FFS expenditures for purposes of calculating the ACPT for agreement periods beginning on January 1, 2024, and in subsequent years.
	For additional detail on the policy context for these exclusions, refer to the link below:
	eCFR :: 42 CFR 425.672 -- Adjustments to mitigate the impact of significant, anomalous, and highly suspect billing activity on Shared Savings Program financial calculations involving calendar year 2024 or subsequent calendar years.
	For ACOs that started agreement periods on January 1, 2024, all variables that are based on the updated benchmark are calculated having accounted for the application of the guardrail policy. For every such variable, this is also noted in the definitions above.

File year	Notes
2024	Please note that in the CY 2026 Medicare Physician Fee Schedule (PFS) proposed rule, CMS is proposing to revise the terminology used to describe the health equity adjustment and other related terms in the Shared Savings Program regulations for performance year 2024. The terms used in the ACO PUF Data Dictionary reflect the proposed terminology described in the CY 2026 PFS Proposed Rule, which is accessible via the link below:
	Federal Register: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program
	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/Medicare CQMs, the performance rates associated with the highest scoring measure set are missing and displayed with a dash "-".
	For PY 2024, the CMS Web Interface measures Quality ID #438 and Quality ID #370 do not have benchmarks, and therefore, were not scored. CAHPS_7 did not have a benchmark and was not scored.
	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, refer to the link below:
	CMS Cell Size Suppression Policy | ResDAC