Medicare Shared Savings Program

Shared Savings and Losses and Assignment Methodology

Specifications

Applicable beginning Performance Year 2016

Version 4

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4	Provided clarifying details on MLR and shared losses	Executive Summary, 5, 5.1, 5.2, 6.6
4	Added options for MSR/MLR in two-sided models	Executive Summary, 5.2
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EXECUTIVE SUMMARY

This report describes the specifications for beneficiary assignment and the shared savings and losses calculations under the Medicare Shared Savings Program (Shared Savings Program) pursuant to policies established by the Shared Savings Program's November 2011 final rule (76 FR 67802) and as amended by the June 2015 final rule (80 FR 32692), and codified at 42 CFR part 425. Within the Shared Savings Program, we enter into agreements with Accountable Care Organizations (ACOs). We'll reward ACOs when they're able to lower growth in Medicare Parts A and B fee-for-service costs (relative to their unique target) while, at the same time, they meet performance standards on quality of care. ACOs can choose to participate under a Track 1 shared savings only model (one-sided model), or under Track 2 or Track 3 which are shared savings and losses models (two-sided models). ACOs that choose to become accountable for shared losses under Track 2 or Track 3 will have the opportunity to get a greater portion of shared savings.

Beneficiary Assignment

For Tracks 1 and 2, we use preliminary prospective beneficiary assignment with final retrospective beneficiary assignment. For Track 3, we use prospective beneficiary assignment. As described in the final rule, if a beneficiary gets at least one primary care service from a physician utilized in assignment (as defined in the program's regulations under § 425.20 and § 425.402(c)) within the ACO, the beneficiary may be assigned to the ACO based on a 2-step process. Note that for beneficiaries receiving primary care services at a FQHC/RHC, the physician (NPI) must be included on the ACO Participant List's attestation list.[1]

- The first step assigns a beneficiary to an ACO if the beneficiary receives the plurality of his or her primary care services from primary care practitioners (primary care physicians, nurse practitioners, clinical nurse specialists, physician assistants, or ACO professionals providing services at a FQHC/RHC) within the ACO. We define primary care physicians as physicians with 1 of 5 specialty designations: internal medicine, general practice, family practice, pediatric medicine, or geriatric medicine.

- The second step only considers beneficiaries who have not received a primary care service from a primary care physician or non-physician inside or outside the ACO. Under this

[1] ACOs that include FQHCs and RHCs are required to identify, through an attestation process (see § 425.404(a)), the physicians (M.D./D.O.) who provide direct patient primary care services in their ACO participant FQHCs or RHCs. The attestation list refers to the reporting mechanism used to identify these providers.

second step, we assign a beneficiary to an ACO if the beneficiary receives the plurality of his or her primary care services from certain ACO professionals within the ACO.

A plurality means a greater proportion of primary care services as measured in allowed charges within the ACO than from services outside the ACO (such as from other ACOs, individual providers, or provider organizations). The plurality can be less than a majority of total services.

Establishing and Updating the Benchmark

First Agreement Period

For each ACO in its first agreement period, we'll calculate a benchmark using risk-adjusted average per capita expenditures for Parts A and B services for original Medicare fee-for-service (FFS) beneficiaries. The benchmark includes beneficiaries who would have been assigned to the ACO in each of the 3 calendar years prior to the start of the agreement period. We trend forward each of the first 2 benchmark years' (BY1 and BY2) per capita risk-adjusted expenditures to third benchmark year (BY3) dollars based on the national average growth rate in Parts A and B per capita FFS expenditures verified by the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary (OACT). The first benchmark year is weighted 10%, the second benchmark year is weighted 30%, and the third benchmark year is weighted 60%. In creating an updated benchmark we account for changes in beneficiary characteristics and update the benchmark by an OACT-verified projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original fee-for-service program. In trending forward, accounting for changes in beneficiary characteristics, and updating the benchmark, we'll make calculations for populations of beneficiaries in each of the following Medicare enrollment types: ESRD, disabled, aged/dual eligible and aged/non-dual eligible. Further, to minimize variation from catastrophically large claims, we'll truncate an assigned beneficiary's total annual Parts A and B FFS per capita expenditures at a threshold.

Second and Subsequent Agreement Periods

For each ACO in its second and subsequent agreement periods, we'll calculate a rebased benchmark according to the methodology used to calculate the first agreement period benchmark, with the following differences. The three benchmark years are weighted equally. We'll also account for savings generated under the ACO's prior agreement period, if we determine the ACO generated net savings across the three performance years under its first agreement period. For an ACO determined to have generated net savings, we make an adjustment to its rebased benchmark to reflect the average per

capita amount of savings earned by the ACO in its prior agreement period, reflecting the ACO's financial and quality performance, and number of assigned beneficiaries, during that prior agreement period.

Risk Adjustment

We'll use the CMS-HCC (Hierarchical Condition Category) prospective risk adjustment models to calculate beneficiary risk scores and to adjust the benchmark years used for the historical benchmark. CMS won't risk-adjust the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original FFS program used to update the benchmark. We'll add this flat dollar amount of growth to the risk-adjusted benchmark expenditures. Each year we'll adjust the benchmark for changes during the performance period in health status and demographic factors of assigned beneficiaries. An ACO's updated CMS-HCC prospective risk scores will take into account changes in severity and case mix for newly-assigned beneficiaries. We'll use demographic factors to adjust for these changes in severity and case mix for beneficiaries continuously assigned to the ACO's population. However, if the continuously assigned population shows a decline in its CMS-HCC prospective risk scores, we'll lower the risk score for this population.

Calculating Shared Savings and Losses

The shared savings methodology used under the one- and two-sided models is largely the same. CMS will compare the updated historical benchmark to the ACO's assigned beneficiaries' per capita expenditures during the performance year to see whether the ACO may share in savings or losses. To qualify for shared savings, an ACO must meet or exceed a prescribed Minimum Savings Rate (MSR), meet the minimum quality performance standards, and otherwise maintain eligibility to participate in the Shared Savings Program. ACOs meeting these requirements may share in savings at a rate determined by their quality performance up to a performance payment limit. The structure and features of the shared losses and shared savings methodologies are similar to each other. To be liable for shared losses, an ACO must meet or exceed a prescribed Minimum Loss Rate (MLR). Once this MLR is met or exceeded, the ACO will share in losses at a rate determined by its quality performance up to a loss recoupment limit (also referred to as a loss sharing limit). The MSR and MLR are expressed as a percentage of the ACO's updated historical benchmark, and serve as thresholds the ACO must meet or exceed before sharing in savings and losses (respectively).

Shared Savings

Under the one-sided model, Track 1 ACOs that meet or exceed the MSR will be eligible to share in savings at a rate of up to 50% based on their quality performance. The one-sided model MSR is a

percent of the ACO's updated benchmark calculated on a sliding scale based on the size of its assigned beneficiary population. Savings are calculated as the difference between the updated benchmark and actual expenditures, with savings payments capped at 10% of total benchmark expenditures each year.

Under the two-sided models, ACOs must choose from one of the following options for the MSR/MLR: (1) zero percent MSR/MLR, (2) symmetrical MSR/MLR in a 0.5 percent increment between 0.5 - 2 percent, or (3) symmetrical MSR/MLR that varies based on the number of beneficiaries assigned to the ACO, as used for Track 1. Track 2 ACOs that meet or exceed the MSR will be eligible to share in savings at a rate of up to 60% based on their quality performance. Savings are calculated as the difference between the updated benchmark and actual expenditures, with payments for Track 2 ACOs capped at 15% of total benchmark expenditures each year. Track 3 ACOs that meet or exceed the MSR will be eligible to share in savings at a rate of up to 75% based on their quality performance. Savings are calculated as the difference between the updated benchmark and actual expenditures, with payments for Track 3 ACOs capped at 20% of total benchmark expenditures each year.

Shared savings payments made through the Medicare Shared Savings Program are subject to the mandatory reductions in federal budgetary resources known as sequestration, required by the Budget Control Act of 2011. Under these mandatory reductions, shared savings payments made to ACOs will be reduced by 2%. When performing ACO financial reconciliation, we will account for the impact of sequestration by adjusting performance year expenditures and the national update amount. This approach ensures that sequestration applies only once to ACO shared savings payments. In determining performance year expenditures for ACOs, we will adjust Part A and B expenditures from April 1, 2013 onward to include the amount of payment withheld due to sequestration. Likewise, the national update amount used to update the historical benchmark also will be adjusted to include the amount of payment withheld due to sequestration.

Shared Losses

Under the two-sided models, ACOs may also incur a loss if actual expenditures exceed the updated benchmark equal to or greater than the minimum loss rate. An ACO will share losses, on a first dollar basis, at a rate of one minus its final sharing rate. For Track 2 ACOs, the shared loss rate may not be less than 40% or exceed 60%. For Track 3 ACOs, the shared loss rate may not be less than 40% or exceed 75%. An ACO will owe a payment equal to its loss rate multiplied by the difference between its actual expenditures and its updated benchmark. Losses under Track 2 are capped at 5% of the ACO's updated benchmark in the first performance year, 7.5% in the second performance year, and 10% in the

third or subsequent performance year. Under Track 3, losses are capped at 15% of the ACO's updated benchmark.

Repayment Mechanism

ACOs choosing a two-sided model (Track 2 or 3) must show they have a repayment mechanism in place that can repay at least 1% of its total per capita Medicare FFS Parts A and B expenditures for its assigned beneficiaries based on expenditures used to establish the historical benchmark. CMS will determine whether this repayment mechanism is adequate when looking at an ACO's application to participate in the program. ACOs participating under the program's two-sided models must show that this repayment mechanism is adequate once at the beginning of a 3-year agreement period, and provide for timely replenishment of repayment mechanism funds used to repay CMS shared losses.

Data Sharing/Reports

We'll give ACOs aggregate information on their assigned population and financial performance at the start of the agreement period and quarterly during the course of the performance year, as well as following the conclusion of each performance year.

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SECTION 1: INTRODUCTION

This document is subject to periodic change. Any substantive changes to this document will be noted in a section on revision history.

1.1 Statutory & Regulatory Background and Program Context

The Shared Savings Program rewards ACOs that improve the quality and cost efficiency of health care. The Shared Savings Program was mandated by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010. These public laws are collectively known as the Affordable Care Act. The Affordable Care Act states that the Secretary may enter into an agreement with the ACO to participate in the Shared Savings Program, for a period not less than three years. CMS published a notice of proposed rulemaking for the program on April 7, 2011 followed by a public comment period. The final rule was published on November 2, 2011.[2] CMS published another notice of proposed rulemaking for the program on December 8, 2014 followed by a public comment period. The final rule was published on June 9, 2015.[3] This program will reward ACOs that lower growth in health care expenditures while meeting performance standards on quality of care.

1.2 Overview of the Shared Savings Program's Financial Models

The Shared Savings Program gives financial incentives to ACOs that proactively coordinate beneficiary care; invest in new care management programs; and redesign care processes to improve the quality, efficiency, and effectiveness of care delivered to Medicare beneficiaries in the fee-for-service (FFS) program. If these investments generate savings for the Medicare program, ACOs may share in a portion of the savings based on financial and quality performance. However, ACOs may also be required to repay Medicare for shared losses. For their first agreement period, ACOs will have an option between 3 tracks. Track 1 ACOs follow a one-sided model. Tracks 2 and 3 ACOs follow a two-sided model for their first agreement period. Those Track 1 ACOs that wish to continue participating in the Shared Savings Program beyond the first agreement period may enter one additional 3-year agreement under Track 1 if they meet eligibility requirements for continued participation. ACOs may operate under the one-sided model for a maximum of two agreement periods. ACOs that enter an agreement with the Shared Savings Program under a two-sided model (Track 2 or Track 3) must remain under a two-sided

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[2] Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67802 (Nov. 2, 2011) (Amending 42 CFR Chapter IV by adding part 425).

[3] Medicare Shared Savings Program: Accountable Care Organizations, 80 Fed. Reg. 32692 (Jun. 9, 2015) (Amending 42 CFR Part 425).

model for the term of their agreement and any subsequent agreements. Although the 3 models share many common features, such as eligibility requirements, quality measures and shared savings methodology, under the two-sided models ACOs are accountable for shared losses but also have the opportunity for a greater percentage of shared savings.

1.3 Agreement Period and Benchmark Data

CMS accepts applications annually for the agreement period start date of January 1 of each year. The term of the agreement is 3 calendar years. Regardless of an ACO's start date, we determine the benchmark based on the 3 calendar years prior to the ACO's agreement period start date. Table 1 presents the relevant dates for both the assignment periods and expenditures periods for Tracks 1, 2, and 3 ACOs with a performance year in calendar year 2016 (CY2016). For example, ACOs that started in the program on January 1, 2014, January 1, 2015, or January 1, 2016 are participating in their first agreement period. Organizations that started in the program on April 1 or July 1, 2012 or January 1, 2013 will be in the first performance year of their second agreement period during CY2016. The benchmark years remain the same for all performance years during the agreement period. When an ACO renews its agreement for a second or subsequent agreement period, the benchmark is based on 3 calendar years immediately preceding the start of the new agreement period.

For example, the timeline for the program for those organizations that start on January 1, 2016 is:

- Three Benchmark Years: 3 calendar years for January 1, 2013–December 31, 2015
- Performance Year 1: January 1, 2016–December 31, 2016
- Performance Year 2: January 1, 2017–December 31, 2017
- Performance Year 3: January 1, 2018–December 31, 2018

The subsequent sections of this report describe program procedures and the underlying programming methods in more detail. Section 2 describes the Medicare data files used to calculate shared savings and shared losses. Section 3 explains the method for assigning beneficiaries to an ACO. Section 4 explains how per capita expenditures are calculated and how we use risk adjustment to account for case mix changes from year to year. Section 5 describes the minimum savings rates for the one- and two-sided models. Section 6 gives details on how we calculate shared savings and shared losses. Finally, Section 7 describes aggregate reports provided to ACOs.

Table 1. Relevant assignment period and expenditures period dates for Tracks 1, 2, and 3 ACOs with a performance year in calendar year 2016

Agreement Period Start Year	Benchmark or Performance Period	Tracks 1 & 2 Assignment Period	Track 3 Assignment Period	Expenditures Period (All ACOs)
2014	PY 3: CY 2016	Jan 1, 2016 – Dec 31, 2016	NA	Jan 1, 2016 – Dec 31, 2016
2014	BY3: CY 2013	Jan 1, 2013 – Dec 31, 2013	NA	Jan 1, 2013 – Dec 31, 2013
2014	BY2: CY 2012	Jan 1, 2012 – Dec 31, 2012	NA	Jan 1, 2012 – Dec 31, 2012
2014	BY1: CY 2011	Jan 1, 2011 – Dec 31, 2011	NA	Jan 1, 2011 – Dec 31, 2011
2015	PY 2: CY 2016	Jan 1, 2016 – Dec 31, 2016	NA	Jan 1, 2016 – Dec 31, 2016
2015	BY3: CY 2014	Jan 1, 2014 – Dec 31, 2014	NA	Jan 1, 2014 – Dec 31, 2014
2015	BY2: CY 2013	Jan 1, 2013 – Dec 31, 2013	NA	Jan 1, 2013 – Dec 31, 2013
2015	BY1: CY 2012	Jan 1, 2012 – Dec 31, 2012	NA	Jan 1, 2012 – Dec 31, 2012
2016 (New Starters and Renewals)	PY 1: CY 2016	Jan 1, 2016 – Dec 31, 2016	Oct 1, 2014 – Sep 30, 2015	Jan 1, 2016 – Dec 31, 2016
2016 (New Starters and Renewals)	BY3: CY 2015	Jan 1, 2015 – Dec 31, 2015	Oct 1, 2013 – Sep 30, 2014	Jan 1, 2015 – Dec 31, 2015
2016 (New Starters and Renewals	BY2: CY 2014	Jan 1, 2014 – Dec 31, 2014	Oct 1, 2012 – Sep 30, 2013	Jan 1, 2014 – Dec 31, 2014
2016 New Starters and Renewals)	BY1: CY 2013	Jan 1, 2013 – Dec 31, 2013	Oct 1, 2011 – Sep 30, 2012	Jan 1, 2013 – Dec 31, 2013

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SECTION 2: MEDICARE DATA USED TO CALCULATE SHARED SAVINGS AND LOSSES

This Section describes the Medicare data used to calculate the shared savings and losses for each ACO participating in the program. Acquiring and processing program data for shared savings and losses calculations are discussed in Section 2.2.

2.1 Data Used in Program

We primarily use Medicare enrollment information (Section 2.1.1) and claims data (2.1.2) to assign beneficiaries and calculate shared savings and losses for the program.

2.1.1 Medicare Enrollment Information

We use Medicare enrollment information for beneficiaries entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment.

2.1.2 Claims Data

We use Medicare fee-for-service (FFS) claims data to make benchmark and performance year financial calculations.

Claims have seven components:

- Inpatient
- Outpatient
- Carrier (Physician/Supplier Part B)
- Skilled Nursing Facility (SNF)
- Home Health Agency (HHA)
- Durable Medical Equipment (DME)
- Hospice Claims

Based on historical trends, we expect generally to have between 98% and 99% of complete claims data 3 months after the end of the calendar year. CMS will calculate the payment amounts

included in Parts A and B FFS claims using a 3-month claims run out with a completion factor provided by the CMS Office of the Actuary (OACT). CMS will also use these claims data and other sources to find individually identifiable payments made from the Medicare Trust Funds for beneficiaries under a demonstration, pilot or time limited program, such as care coordination fees.

For Annual Reports, CMS uses a 3-month claims run out when determining assigned beneficiaries. For Quarterly Reports, CMS runs assignment data in the month following every calendar year quarter using a rolling 12 months of data and at most a seven days claim run out. To control for claim variability we set the claims effective date and an Integrated Data Repository (IDR) load date when calculating expenditures.

2.2 Acquiring and Processing Program Data

Before we can start analyzing the data, claims files used to calculate beneficiary expenditures must accumulate at the CMS data center. Therefore, for each benchmark and performance year in the program, we'll gather and process final program data starting 3 months after the end of the performance year. Note that we'll use a 3-month claims run out both for benchmark and performance years, to make sure Shared Savings Program financial calculations stay consistent internally. After waiting these 3 months, we'll start the steps to gather and process data for calculating benchmarks or shared savings payments, and OACT will provide a completion factor to estimate the expenditures that would result if claims data were 100% complete. CMS may use data based on less than a complete 3-month run out for quarterly and other preliminary reports.

2.2.1 Data Steps to Establish the Historical Benchmark

There are many data steps involved in calculating the historical benchmarks, including:

- Retrospectively assigning beneficiaries to a Track 1 or Track 2 ACO in each benchmark year for purposes of establishing the historical benchmark.
- Prospectively assigning beneficiaries to a Track 3 ACO in each benchmark year for purposes of establishing the historical benchmark.
- Calculating annualized, truncated, weighted Part A and B FFS per capita expenditures in each benchmark year.[4]

[4] Annualization and weighting adjusts for months of beneficiary eligibility.

- Applying a completion factor to all benchmark year expenditures.
- Risk-adjusting and trending forward ACO historical benchmark years BY1 and BY2 to benchmark year BY3, and then applying benchmark year weights.

2.2.2 Data Steps to Establish the Performance Year Shared Savings and Losses

There are many data steps involved in calculating shared savings and losses, including:

- Retrospectively assigning beneficiaries to Track 1 and 2 ACOs at the end of each performance year for purposes of determining shared savings and losses.
- Prospectively assigning beneficiaries to Track 3 ACOs at the beginning of each performance year for purposes of determining shared savings and losses.
- Annualizing and truncating performance year expenditures.
- Applying a completion factor to all performance year expenditures.
- Adjusting the benchmark each year annually for changes in the risk profile of assigned beneficiaries.
- Updating the benchmark annually based on the flat dollar update amount.
- Determining eligibility for and the amount of shared savings or losses.

Note that we'll use a 3-month claims run out for quarterly and other preliminary reports.

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SECTION 3: BENEFICIARY ASSIGNMENT FOR MEDICARE SHARED SAVINGS PROGRAM

The first step in calculating ACO shared savings or losses is to assign beneficiaries to the ACO. For Track 1 and 2 ACOs, beneficiary assignment is determined retrospectively at the end of the year for each benchmark and performance year. For Track 3 ACOs, beneficiary assignment is determined prospectively prior to the start of each benchmark and performance year. Although beneficiaries will be assigned prospectively to Track 3 ACOs, the assignment methodology itself will be the same as is used to assign beneficiaries to ACOs participating under Track 1 and Track 2, with limited exceptions that are described below. A beneficiary assigned to an ACO in one year may not have been assigned to that ACO for the preceding years.

In addition to retrospective assignment for Tracks 1 and 2 ACOs, preliminary prospective assignment is performed for two types of occasions. One is during the pre-screening (or application) phase when applications submitted by potential ACOs are assessed by CMS. The other is for the quarterly reports that are based on the most recent four quarters of claims and eligibility data and include lists of preliminary prospective assigned beneficiaries.

During retrospective assignment to a Track 1 or Track 2 ACO for the benchmark and performance year financial reconciliation, the most recent claims are used with a 3-month claims run out period. For preliminary prospective assignment, the claims are used with, at most, a 7-day claims run out period. Lists of prospectively assigned beneficiaries are provided to each ACO.

In addition to prospective assignment to a Track 3 ACO for the benchmark and performance year financial reconciliation, prospective assignment is also used during the pre-screening (or application) phase when applications submitted by potential ACOs are assessed by CMS. Prospective assignment to Track 3 ACOs uses an offset assignment period (see Table 1) in order to generate the list of prospectively assigned beneficiaries prior to the start of the year. The most recent claims are used with up to three months claims run out, as available. Once a beneficiary is prospectively assigned to a Track 3 ACO for a benchmark or performance year, the beneficiary will not be eligible for assignment to a different ACO, even if the beneficiary obtains a plurality of his or her primary care services from ACO professionals in that ACO during the relevant benchmark or performance year.

While a beneficiary who is prospectively assigned to a Track 3 ACO for a benchmark or performance year is not eligible for assignment to another ACO, prospectively assigned beneficiaries who meet exclusion criteria at the end of a performance or benchmark year will be excluded from the

prospective assignment list prior to calculating the historical benchmark or financial reconciliation. In addition, CMS will also perform this exclusion on a quarterly basis during each performance year, and incorporate these exclusions into quarterly reports provided to Track 3 ACOs. The remaining exclusion criteria applied to prospectively assigned beneficiaries match the assignment criteria B, C and E included in Section 3.1 below. Also note, that in producing the Track 3 ACO's prospective assignment list for the performance year, we will remove beneficiaries who, although assigned using the offset assignment window (October – September), have died following the end of the assignment window and production of the assignment list. However, we do not make a similar exclusion for deceased beneficiaries in determining benchmark year assignment for Track 3 ACOs. ACOs are accountable for the cost and quality of care for prospectively assigned beneficiaries who die during the course of the performance year.

In performing beneficiary assignment, we determine whether ACO professionals participating in an ACO have provided the plurality of a beneficiary's primary care services as compared to ACO professionals in all other ACOs and individual practitioners or groups of practitioners identified by taxpayer identification numbers (TINs) that are not participating in an ACO. We treat ACOs as a collection of TINs for the purpose of determining whether the ACO provided the plurality of the beneficiary's primary care services. The ACO's Participant List that identifies these TINs is therefore important to beneficiary assignment and all related program operations. An ACO participant must agree to participate in the ACO and comply with program regulations in order for the ACO to include the entity on its ACO Participant List. As part of the application cycle, an ACO submits its ACO Participant List, and certifies a finalized Participant List as part of entering the program. CMS engages in a process of screening ACO Participant Lists to confirm the eligibility of Medicare enrolled TINs to participate in the program.

Under the participation agreement, the ACO is required to tell CMS of changes in the composition of its ACO participants and ACO providers/suppliers. The ACO must report to CMS within 30 days of adding or removing ACO participants and ACO providers/suppliers and must update its ACO participant and ACO provider/supplier list at the beginning of each performance year and at other such times as we specify. Annually, an ACO may add TINs vetted through CMS' screening process or delete participants, resulting in a certified ACO participant list which is the basis for beneficiary assignment used in program operations for the ACO's next performance year. Specifically, the ACO's updated certified participant list is used to: (i) recalculate the ACO's historical benchmark based on the 3 years prior to the start of its agreement period (herein adjusted historical benchmark); (ii) determine the ACO's quality sample; (iii) determine performance year expenditures (shared savings/losses); and (iv) produce

quarterly and annual feedback reports. As a result, an ACO may have up to three historical benchmarks for an agreement period if it makes revisions to its participant list prior to the start of its second and third performance years.

Section 3 describes the steps used for assignment for the Shared Savings Program.

3.1 Assignment Criteria

Using Medicare claims, we'll assign beneficiaries to an ACO in a 2-step process if they get at least 1 primary care service from a physician utilized in assignment within the ACO. For each year, a beneficiary will be assigned to a participating ACO if the following criteria are met:

A) Beneficiary must have a record of enrollment

Medicare must have information about the beneficiary's Medicare enrollment status and other information which is needed to determine if the beneficiary meets other criteria below.[5]

B) Beneficiary must have at least 1 month of Part A and Part B enrollment, and cannot have any months of Part A only or Part B only enrollment

Because the purpose of this program is to align incentives between Part A and Part B, beneficiaries who have coverage under only 1 of these parts are not included.

C) Beneficiary cannot have any months of Medicare group (private) health plan enrollment

Only beneficiaries enrolled in traditional Medicare FFS under Parts A and B are eligible to be assigned to an ACO participating in the Shared Savings Program. Those enrolled in a group health plan—including beneficiaries enrolled in Medicare Advantage (MA) plans under Part C, eligible organizations under section 1876 of the Social Security Act, and Program of All Inclusive Care for the Elderly (PACE) programs under section 1894—are not eligible.

D) Beneficiaries will be assigned to only one Medicare shared savings initiative

Beneficiaries can't be assigned to more than 1 Medicare shared savings initiative. For example, beneficiaries can't be assigned to a Shared Savings Program ACO if they're associated with another Medicare shared savings initiative before the start of the Shared Savings Program ACO's agreement start

[5] Please note that Medicare Secondary Payer (MSP) status doesn't exclude a beneficiary from assignment to an ACO.

date. Consequently, we'll also exclude beneficiaries aligned to another Medicare shared savings initiative from each of the benchmark and performance years.

E) Beneficiary must live in the United States or U.S. territories and possessions

We exclude beneficiaries whose permanent residence is outside the United States or U.S. territories and possessions in the last month of the benchmark or performance year, as they may have gotten care outside of the United States and therefore Medicare claims aren't available. If the beneficiary was a U.S. resident in the last month of the benchmark or performance year, we consider the beneficiary to be a U.S. resident for the entire period. We use the same method (residency in the last month of the assignment period) for quarterly preliminary prospective assignments for Tracks 1 and 2 ACOs. Similarly, we look at residency in the last month of the quarter when performing quarterly exclusions for Track 3 ACOs. United States residence includes the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Marianas.

F) Beneficiary must have a primary care service with a physician at the ACO

To be eligible for assignment to an ACO, a beneficiary must have had at least 1 primary care service furnished by a physician, included in the definition of an ACO professional, utilized in assignment.[6] Note that for beneficiaries receiving primary care services at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), the physician NPI must be included on the ACO Participant List. These and other special cases are described below. Tables 2 through 5 below define key terms for the assignment process, such as "primary care service."

G) Beneficiary must have gotten the largest share of his/her primary care services from the participating ACO

If a beneficiary meets the screening criteria in A through F, then the beneficiary is eligible to be assigned to an ACO. There are up to 2 steps in this process:

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[6] Physicians utilized in assignment are: primary care physicians specified under § 425.20 (internal medicine, general practice, family practice, geriatric medicine, or pediatric medicine), and physicians with primary specialty designations specified under § 425.402(c). These specialty designations are: (1) Cardiology, (2) Osteopathic manipulative medicine, (3) Neurology, (4) Obstetrics/gynecology, (5) Sports medicine, (6) Physical medicine and rehabilitation, (7) Psychiatry, (8) Geriatric psychiatry, (9) Pulmonary disease, (10) Nephrology, (11) Endocrinology, (12) Multispecialty clinic or group practice, (13) Addiction medicine, (14) Hematology, (15) Hematology/oncology, (16) Preventive medicine, (17) Neuropsychiatry, (18) Medical oncology, (19) Gynecology/oncology.

Assignment Policy Step (1): We'll assign a beneficiary to a participating ACO when the beneficiary has at least one primary care service furnished by a primary care practitioner (primary care physician, nurse practitioner, physician assistant, clinical nurse specialist at the participating ACO or an ACO professional providing services at a FQHC/RHC) within the ACO (Tables 3, 4, and 5), and more primary care services (measured by Medicare allowed charges) furnished by primary care practitioners at the participating ACO than from the same types of providers at any other Shared Savings Program ACO or non-ACO individual or group taxpayer identification number (TIN).[7]

Assignment Policy Step (2): This step applies only for beneficiaries who haven't gotten any primary care services from a primary care practitioner. We'll assign the beneficiary to the participating ACO in this step if the beneficiary got at least 1 primary care service from a specialist physician utilized in assignment (see § 425.402(c)) at the participating ACO, and more primary care services (measured by Medicare allowed charges) from specialist physicians utilized in assignment at a participating ACO than from any other ACO or non-ACO individual or group TIN.

We'll include TINs from the physician/supplier carrier claims file, and other identifiers discussed below for Method II Critical Access Hospitals (CAHs), FQHCs, RHCs, and Electing Teaching Amendment (ETA) hospitals in the assignment algorithm in both Assignment Policy Steps 1 and 2 using claims from the outpatient (institutional) file loaded in the Integrated Data Repository (IDR). Sections 3.3, 3.4, and 3.5 contain details on how these other organization types will be identified in the outpatient claims. These organizations may be either: independent ACOs; a participant in an ACO; or a non-ACO organization. If one of these organizations is an independent ACO (i.e., an ACO with only one participant) or a participant of an ACO that has more than one participant, we'll treat it just like any other ACO participant in the assignment algorithm. If it is part of an ACO, we'll group it with that ACO's other TINs and consider it as part of that ACO just like the TINs for the ACO's other participants. If it is not an ACO participant, we'll include it in the assignment algorithm just like any other non-ACO TIN because it could be the plurality provider of primary care services to a beneficiary, which would preclude assignment of that beneficiary to an ACO. In summary, we perform the assignment process simultaneously including all eligible organizations using both carrier (physician/supplier Part B) and outpatient claims together in each step.

[7] As assigned by the U.S. Internal Revenue Service. There are two types of TINs: Social Security Numbers (SSNs) and Employer Identification Numbers (EINs).

3.2 Programming Steps in Assigning Beneficiaries to ACOs

There are 5 programming steps involved in assigning beneficiaries to an ACO:

Programming Step 1: Identify only those beneficiaries who have a primary care service with a physician at the ACO (3.1 F).

We identify all Part B claims that have at least one line item with a primary care code furnished by an ACO, based on the ACO's TINs (Employer Identification Numbers or Social Security Numbers). We'll use a participating ACO's TINs to identify beneficiaries who had a Part B claim that includes at least one primary care service (identified by the Healthcare Common Procedure Coding System (HCPCS) and/or revenue center codes listed in Table 2) furnished by a physician at the ACO utilized in assignment (see Table 3) within the year—this includes RHC, FQHC, and method II CAH professional services claims, which are Part B claims billed on institutional forms. Note that RHCs, FQHCs, and method II CAHs will be identified on claims by their CMS Certification Number (CCN). For claims for services provided by an ACO's FQHC/RHC participants, beneficiaries are identified if they had at least one primary care service at the ACO from a physician NPI (M.D./D.O.) listed on the Participant List.

Programming Step 2: Create finder file for beneficiaries identified in Step 1.

We'll create a "finder file" for each ACO of the beneficiaries identified in Programming step 1. The finder file includes the beneficiary identifier for each beneficiary who was furnished at least one primary care service by the ACO's physicians utilized in assignment within the assignment window. We'll drop beneficiaries from the finder file who don't meet general eligibility requirements described in Section 3.1.

Programming Step 3: Obtain selected claims, enrollment and demographic information for beneficiaries.

We'll use the finder file from step 2 to get enrollment information for each beneficiary who had a primary care service from physicians utilized in assignment at the ACO. Eligibility information includes Medicare Parts A and B enrollment, enrollment in a group health plan, primary payer code, and other enrollment information for these beneficiaries.

Programming Step 4: Assign beneficiaries to ACOs using Assignment Policy Step 1 (3.1 G).

We'll use the finder file in Step 3 to identify beneficiaries who got at least one primary care service from a primary care practitioner at the participating ACO during the assignment window. We'll

assign beneficiaries who meet this condition to an ACO if the allowed charges for primary care services given to the beneficiary by primary care practitioners at the participating ACO are greater than the allowed charges for primary care services furnished by primary care practitioners in any other ACO, and greater than the allowed charges for primary care services from the same types of providers in each non-ACO individual or group TIN or CCN for FQHC, RHC, or method II CAH, as noted in Sections 3.3 and 3.4 below.

For each ACO, we'll sum allowed charges for primary care services by beneficiary identifier. We include the primary care allowed charges for each beneficiary at each ACO participant (TINs and CCNs) identified as associated with the ACO's organizational ID.[8] Note that the CCN is used for FQHC, RHC, method II CAH and ETA hospital claims as indicated in Sections 3.3, 3.4, and 3.5 below. We'll sum primary care allowed charges by the "Line HCPCS Code" on Part B, FQHC,[9] and method II CAH claims, and by revenue codes on claims from RHCs. See Table 2 for a list of the primary care HCPCS codes and revenue codes we include in beneficiary assignment. We'll use allowed charges for assignment because, unlike expenditures, they include the Medicare deductible, the first dollars of Medicare Part B payments by a beneficiary within the year (for example, $147 in 2014). By using allowed charges rather than a simple service count, we also reduce the likelihood that there would be ties. To determine where a beneficiary got the plurality of his or her primary care services, we compare the allowed charges for each beneficiary for primary care services provided by the ACO (in total for all ACO participants) to the allowed charges for primary care services provided by other ACOs and non-ACO providers.

As stated in the final rule, it's unlikely that allowed charges by 2 different entities would be equal, and the final rule doesn't include a detailed discussion of a tie-breaker method. We have established the following policy in the event of such an occurrence: the tie breaker will be the ACO or non-ACO individual or group TIN or other organizational identifier (for FQHCs, RHCs, method II CAHs and ETA hospitals) that gave the most recent primary care service by a primary care physician. If there's still a tie, then the tie breaker will be the ACO or non-ACO individual or group TIN or other organizational identifier (for FQHCs, RHCs, method II CAHs and ETA hospitals) that gave the most recent primary care service by a physician utilized in assignment. If there is still a tie, the beneficiary is randomly assigned.

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[8] All ACOs will have special identifiers in the form of **Axxxx** (with the x's being a 4-digit number).

[9] For claims prior to January 1, 2011, revenue center codes on FQHC claims were used to identify primary care services. For FQHC claims on or after January 1, 2011, the "line HCPCS codes" are used.

Programming Step 5: Apply Assignment Policy Step 2 to beneficiaries who weren't assigned in Assignment Policy Step 1.

This step applies only to beneficiaries who haven't received any primary care services from a primary care physician, nurse practitioner, physician assistant, clinical nurse specialist or ACO professional providing services at an FQHC/RHC at the participating ACO, or the same type of providers outside of the ACO. In other words, it applies to beneficiaries in the finder file from step 2 who, after step 4, remain unassigned to any ACO, or non-ACO individual or group TIN or FQHC, RHC, method II CAH or ETA hospitals. We'll assign each of these beneficiaries to an ACO if (1) the allowed charges for primary care services given to the beneficiary by all other ACO physicians utilized in assignment (including physician specialists as indicated in Table 3) are greater than the allowed charges for primary care services furnished by all ACO physician specialists used in assignment in each other ACO, and (2) the allowed charges are greater than the allowed charges for primary care services furnished by physician specialists used in assignment in each non-ACO individual or group TIN or method II CAH or ETA hospitals.

Table 3 lists all specialty codes included in the definition of a physician. Note that the definition of a physician for purposes of the Shared Savings Program includes only M.D./D.O. physicians. Table 4 lists specialty codes for ACO non-physician practitioners (nurse practitioner, clinical nurse specialist, or physician assistant) included in the definition of ACO professional under § 425.20.

If there's a tie, the tie breaker will be the ACO that provided the most recent primary care service by a professional. If there is still a tie, the beneficiary is randomly assigned.

3.3 Special Policy for Processing Method II CAH Claims for Professional Services

Method II CAH professional services are billed on institutional claim form 1450, bill type 85X, with the presence of one or more of the following revenue center codes: 096x, 097x, and/or 098x. These services require special processing for purposes of the Shared Savings Program. In general, ACOs are identified by TIN(s). However, the TINs for method II CAHs aren't included in the National Claims History (NCH) and IDR claims files. These CAHs submit line item bills using HCPCS. The rendering physician/practitioner isn't reported for each line item. In addition, unlike for FQHCs and RHCs, no attestation (as required for processing FQHC and RHC claims under Section 3.4 below) is required for CAH services.

- We'll use the CCN as the unique identifier for an individual method II CAH.

- To obtain the rendering physician/practitioner for method II CAH claims, we'll use the "rendering NPI" field. In the event the rendering NPI field is blank, we'll use the "other provider" NPI field. If the other provider NPI field is also blank on a claim, we'll use the attending NPI field.

- We'll use PECOS (the Provider Enrollment, Chain and Ownership System) to get the CMS specialty for method II CAH claims.

3.4 Special Rules for Processing FQHC and RHC Claims

FQHC and RHC services are billed on an institutional claim form (see Table 5 for bill types) and require special handling to incorporate them into the beneficiary assignment process. In general, ACO participants are identified through their TIN(s). However, the TINs for FQHCs and RHCs aren't included in the NCH and IDR claims files. Note that the definition of a primary care service or a primary care physician depends on the bill type and date of service.

- A primary care physician is any physician NPI included in an attestation by the FQHC or RHC as part of the ACO Participant List. (All M.D. and D.O. physicians are considered primary care physicians. Note that statutory regulations require that the provider be a physician) CMS will use FQHC/RHC physician attestation information only for purposes of determining whether a beneficiary is eligible to be assigned to an ACO. If a beneficiary is identified as "assignable" then we'll use claims for primary care services furnished by all FQHC/RHC ACO professionals submitted by the FQHC or RHC to determine whether the beneficiary received a plurality of his or her primary care services from the ACO under Step 1.

- For FQHCs/RHCs that are participants in an ACO, we treat a FQHC or RHC service reported on an institutional claim as a primary care service if the claim includes a HCPCS or revenue center code that meets the definition of a primary care service.

- For FQHCs/RHCs that are NOT participants in an ACO, we treat a FQHC or RHC service reported on an institutional claim as a primary care service if the claim includes a HCPCS or revenue center code that meets the definition of a primary care service. That is, for these non-ACO FQHCs and RHCs, we assume a primary care physician performed all their primary care services. This will help make sure we don't disrupt established relationships between beneficiaries and FQHCs/RHCs.

- We use the CCN as the unique identifier for an individual FQHC/RHC.

The ACO Participant List includes the CCN, the TIN, and the organizational and individual NPIs for the FQHC/RHC providers affiliated with the ACO.

3.5 Special Rules for Processing ETA Institutional Claims

ETA hospitals are hospitals that have voluntarily elected to receive payment on a reasonable cost basis for the direct medical and surgical services of their physicians in lieu of Medicare fee schedule payments that might otherwise be made for these services.

ETA institutional claims are identified with claim type code equal to 40, bill type equal to 13 and require that the CCN on the claim is on a list of CMS-recognized ETA hospitals. The line item HCPCS codes on the ETA institutional claims are used to identify whether a primary care service was provided. The reason for this is that physician services provided at ETA hospitals don't otherwise appear in either outpatient or physician claims.[10] ETA hospitals, however, do bill CMS to recover facility costs incurred when ETA hospital physicians provide services. The HCPCS code, thus, will provide identification that a primary care service was rendered to a beneficiary. However, we won't scan revenue center codes. Table 2 lists the HCPCS codes that will be used to identify primary care services for ETA institutional claims, except for 2: G0438 and G0439 are not included in the list of HCPCS codes for ETA hospitals in 2009 and 2010.

- To obtain the rendering physician/practitioner for ETA institutional claims, we'll use the "other provider" NPI field. If this field is blank on a claim, we'll use the attending NPI field.
- We'll use PECOS to obtain the CMS specialty for ETA institutional claims.
- Allowed charges for ETA claims are imputed using the formula used by Medicare's Physician Fee Schedule for calculating allowed charges for each HCPCS code.

3.6 Tables for Section 3

- Table 2 lists the primary care codes (HCPCS and Revenue Center Codes) included in beneficiary assignment criteria.

[10] The physician services, per se, are reimbursed during settlement of the annual Medicare Cost Report for ETA hospitals.

- Table 3 lists specialty codes used to identify physicians who are the basis for beneficiary assignment. Specialty is identified by the specialty code associated with each line item on a claim. The table includes the specialty codes used to define a primary care physician (used in Assignment Step 1 and specified under § 425.20), specialist (used in Assignment Step 2 and specified under § 425.402(c)). Note that the definition of a physician for purposes of the Shared Savings Program includes only MD/DO physicians.

- Table 4 lists specialty codes for non-physician practitioners included in the definition of an ACO professional.

- Table 5 lists the bill types for selecting Carrier (Physician/Supplier Part B), method II CAH, FQHC, RHC, and ETA institutional claims.

Table 2. Primary care codes included in beneficiary assignment criteria

Primary Care Codes and Services
For services billed under the physician fee schedule (including method II CAHs), and for FQHC services furnished after 1/1/2011, primary care services include services identified by the following HCPCS/CPT©[11] codes:
Office or Other Outpatient Services
99201 New Patient, brief
99202 New Patient, limited
99203 New Patient, moderate
99204 New Patient, comprehensive
99205 New Patient, extensive
99211 Established Patient, brief
99212 Established Patient, limited
99213 Established Patient, moderate
99214 Established Patient, comprehensive
99215 Established Patient, extensive
Initial Nursing Facility Care
99304 New or Established Patient, brief
99305 New or Established Patient, moderate
99306 New or Established Patient, comprehensive
Subsequent Nursing Facility Care
99307 New or Established Patient, brief
99308 New or Established Patient, limited
99309 New or Established Patient, comprehensive
99310 New or Established Patient, extensive
Nursing Facility Discharge Services
99315 New or Established Patient, brief
99316 New or Established Patient, comprehensive
Other Nursing Facility Services
99318 New or Established Patient
Domiciliary, Rest Home, or Custodial Care Services
99324 New Patient, brief
99325 New Patient, limited
99326 New Patient, moderate

(continued)

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Table 2. Primary care codes included in beneficiary assignment criteria (continued)

Primary Care Codes and Services
99327 New Patient, comprehensive
99328 New Patient, extensive
99334 Established Patient, brief
99335 Established Patient, moderate
99336 Established Patient, comprehensive
99337 Established Patient, extensive
Domiciliary, Rest Home, or Home Care Plan Oversight Services
99339, brief
99340, comprehensive
Home Services
99341 New Patient, brief
99342 New Patient, limited
99343 New Patient, moderate
99344 New Patient, comprehensive
99345 New Patient, extensive
99347 Established Patient, brief
99348 Established Patient, moderate
99349 Established Patient, comprehensive
99350 Established Patient, extensive
99490 Chronic Care Management Service, 20 minutes
99495 Transitional Care Management Services within 14 days of discharge
99496 Transitional Care Management Services within 7 days of discharge
Wellness Visits
G0402 Welcome to Medicare visit
G0438 Annual wellness visit
G0439 Annual wellness visit
New G code for Outpatient Hospital Claims
G0463 Hospital outpatient clinic visit (see note below)
For FQHC services furnished prior to 1/1/2011, primary care services include services identified by HCPCS code G0402 (effective 1/1/2009) or the following revenue center codes:
0521 Clinic visit by member to RHC/FQHC
0522 Home visit by RHC/FQHC practitioner
0524 Visit by RHC/FQHC practitioner to a member, in a covered Part A stay at the SNF
0525 Visit by RHC/FQHC practitioner to a member in an SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility

(continued)

Table 2. Primary care codes included in beneficiary assignment criteria (continued)

Primary Care Codes and Services
For RHC services, primary care services include services identified by HCPCS code G0402 (effective 1/1/2009) or G0438 (effective 1/1/2011), G0439 (effective 1/1/2011) or the following revenue center codes:
0521 Clinic visit by member to RHC/FQHC
0522 Home visit by RHC/FQHC practitioner
0524 Visit by RHC/FQHC practitioner to a member, in a covered Part A stay at the SNF
0525 Visit by RHC/FQHC practitioner to a member in an SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility

NOTE: 42 CFR Part 425 defines primary care services as the set of services identified by the following HCPCS codes: 99201 through 99215; 99304 through 99340; 99341 through 99350; G0402; G0438; G0439; and G0463. Revenue center codes 0521, 0522, 0524, and 0525. Table 2 contains all codes in that range that are currently in use. While G0463 is used by hospital outpatient departments covered by OPPS system (bill type 13x) since January 1, 2014, for assignment purposes it is used only for ETA hospitals. The Shared Savings Program assignment algorithm ignores claims with bill type 13x except for ETA hospitals. That is, only CCNs belonging to ETA hospitals are allowed to use G0463 during the assignment process.

Table 3. Use of physician specialty codes in assignment

Specialty Code	Description	Primary Care Physician *(Step 1)*	Specialist *(Step 2)*
01	General practice	**Yes**	No
06	Cardiology	No	**Yes**
08	Family practice	**Yes**	No
11	Internal medicine	**Yes**	No
12	Osteopathic manipulative medicine	No	**Yes**
13	Neurology	No	**Yes**
16	Obstetrics/gynecology	No	**Yes**
23	Sports medicine	No	**Yes**
25	Physical medicine and rehabilitation	No	**Yes**
26	Psychiatry	No	**Yes**
27	Geriatric Psychiatry	No	**Yes**
29	Pulmonary disease	No	**Yes**
37	Pediatric medicine	**Yes**	No
38	Geriatric medicine	**Yes**	No
39	Nephrology	No	**Yes**
46	Endocrinology (eff. 5/1992)	No	**Yes**
70	Multispecialty clinic or group practice	No	**Yes**
79	Addiction medicine (eff. 5/1992)	No	**Yes**
82	Hematology (eff. 5/1992)	No	**Yes**
83	Hematology/oncology (eff. 5/1992)	No	**Yes**
84	Preventive medicine (eff. 5/1992)	No	**Yes**
86	Neuropsychiatry (eff. 5/1992)	No	**Yes**
90	Medical oncology (eff. 5/1992)	No	**Yes**
98	Gynecologist/oncologist (eff. 10/1994)	No	**Yes**

NOTE: All specialties listed in this table are used to create the finder file. In Assignment Step 1 for ACOs with one or more FQHC/RHCs, we include any M.D./D.O. that appears on the attestation list, including those with specialties not listed in the above table.

Table 4. Specialty codes for Non-Physician Practitioners included in the definition of an ACO professional

Specialty Code	Description
50	Nurse practitioner
89	Clinical nurse specialist
97	Physician assistant

Table 5. Bill types used for identifying method II CAH, FQHC/RHC, and ETA institutional claims

Specialty code	Specialty code name
Method II CAH claims	Type of bill 85X with the presence of one or more of the following revenue center codes: 096x, 097x, and/or 098x
RHC claims	71x bill types
FQHC claims	73x (for dates of service prior to 4/1/10) and 77x (for dates of service on or after 4/1/10)
ETA claims	13x bill types (from ETA hospitals)

SECTION 4: ACO PER CAPITA EXPENDITURES AND RISK ADJUSTMENT

In this section we'll describe how we'll calculate per capita expenditures and risk scores for a participating ACO. This process starts once we complete beneficiary assignment, as described in Section 3. We perform separate calculations for each benchmark year, quarterly aggregate report, and performance year.

4.1 Calculating ACO Assigned Beneficiary Expenditures

After we complete ACO beneficiary assignment, we calculate expenditures for ACO assigned beneficiaries separately for the following populations based on their Medicare enrollment type:

- ESRD—eligibility for Medicare as a result of end stage renal disease
- Disabled—eligibility for Medicare by disability
- Aged/dual eligible Medicare and Medicaid beneficiaries—eligibility for Medicare by age, and eligibility for both Medicare and Medicaid
- Aged/non-dual eligible beneficiaries—eligibility for Medicare by age, but not eligible for Medicaid

We'll allocate eligible beneficiary months to each of these Medicare enrollment types, applying a hierarchy when determining monthly enrollment categories for each beneficiary. We'll use Medicare paid amounts to calculate the ACO's benchmark and performance year expenditures. We'll assign beneficiary expenditures separately in the following hierarchical order of Medicare enrollment type by month: (1) ESRD; (2) Disabled; (3) Aged/dual eligible Medicare and Medicaid beneficiaries; or (4) Aged/non-dual eligible beneficiaries.

The Shared Savings Program identifies ESRD status based on Medicare enrollment/eligibility files. Beneficiaries meet the Medicare ESRD entitlement definition as ESRD. Diagnosis codes on Medicare claims are not used as an indicator of whether or not a beneficiary is entitled to Medicare ESRD status. We do not use the 72x bill types to determine whether a beneficiary is an ESRD beneficiary. Beneficiaries who are on short-term dialysis are not defined as ESRD for Medicare eligibility purposes or in the Medicare Shared Savings Program. Additionally, beneficiaries greater than 3 months post-graft are not categorized as ESRD beneficiaries under the Shared Savings Program. This aligns with how

Medicare Advantage defines ESRD beneficiaries for purposes of HCC risk adjustment and how the CMS Office of the Actuary defines ESRD beneficiaries.

The Shared Savings Program identifies dually eligible beneficiaries as those categorized according to CMS' definitions of Medicare-Medicaid enrollees,[12] including:

- Qualified Medicare Beneficiaries or QMBs (referred to as having "partial-benefit") and Qualified Medicare Beneficiaries plus full Medicaid or QMB-plus (referred to as having "full benefit"), identified in CMS data systems by dual status code 01 and 02, respectively.

- Specified Low-Income Medicare Beneficiaries plus full Medicaid or SLMB-plus, identified by dual status code 04.

- Other full benefit dual eligible / Medicaid only dual eligibles, identified by dual status code 08.

We distinguish between the aged/dual eligible and aged/non-dual eligible populations because our models suggest these populations have significantly different expenditures. However, the ESRD and disabled categories include both dual eligible and non-dual eligible beneficiaries because our models suggest these populations don't have significantly different levels of cost.

Step 1: Calculate total Medicare expenditures for each beneficiary assigned to the ACO.

For each beneficiary we assign to the ACO, we'll calculate total Medicare Parts A and B FFS expenditures (payments) for Shared Savings Program-eligible months from the Inpatient, SNF, Outpatient, Carrier (Physician/Supplier Part B), DME, HHA, and Hospice claims for each Medicare enrollment type. To calculate total Medicare FFS expenditures for each beneficiary for each Medicare enrollment type, we'll sum expenditures (paid amounts) from all of the beneficiary's Inpatient, SNF, Hospital Outpatient, Carrier (Part B), DME, HHA, and Hospice claims at any provider. We'll exclude denied payments and line items from the calculation.

In determining expenditures for quarterly and annual reports, we'll adjust Part A and B expenditures from April 1, 2013 onward to include the amount of payment withheld due to sequestration. Table 6 contains a list of the variables we'll use to determine the expenditure amount and denied line

[12] See "Defining Medicare-Medicaid Enrollees in CMS Data Sources" (Version date: January 9, 2013), available online at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Definition_of_Dual_Eligible.pdf.

items or denied claims for the various claims. We'll also include individually identifiable payments made for beneficiaries under a demonstration, pilot or time-limited program (e.g., care coordination payments) in financial reconciliation. We'll remove Indirect Medical Education (IME) payments and Disproportionate Share Hospital (DSH) payments, including uncompensated care payments, from total expenditures. Since Maryland hospitals receive payment outside the inpatient prospective payment system, these hospitals do not directly receive IME and DSH payments from Medicare. Therefore, the Shared Savings Program does not adjust for IME/DSH payments to Maryland hospitals. Pass-through payments are also excluded from expenditures. Pass-through payments include, but are not limited to, graduate medical education, kidney acquisition costs, and bad debt.

In calculating expenditures, we'll allow 3 months after the end of the performance year for claims to run out. We'll apply a completion factor provided by OACT to complete claims to 100% because generally claims will be approximately 98% complete at this time. For the quarterly aggregate reports, we'll use up to a 7-day claims run out depending on data availability and apply a completion factor we get from OACT.

4.2 Annualizing Assigned Beneficiary Expenditures

After we sum an ACO's assigned beneficiaries' expenditures for each Medicare enrollment type, we'll annualize the expenditures by dividing them by the fraction of months in the year each beneficiary was enrolled in each Medicare enrollment type. All further analyses weight the annualized expenditures by this same fraction. Annualization and weighting ensures that payments are correctly adjusted for months of beneficiary eligibility, including new Medicare enrollees and beneficiaries who die, and also enables us to truncate outlier expenditures.

Table 6. Variables used in total beneficiary expenditure calculations

Expenditure component	Payment is equal to	Claim denied if left justified value is	Line item denied if	Through date
SNF (Claim type = 20, 30)	Claim payment amount	Any non-blank value for 'Claim Medicare Non-Payment reason code'	Not applicable	Claim through date
Inpatient (Claim type = 60)	Claim payment amount-(excluding capital and operating IME and DSH amounts)	Any non-blank value for 'Claim Medicare Non-Payment reason code'	Not applicable	Claim through date

(continued)

Table 6. Variables used in total beneficiary expenditure calculations (continued)

Expenditure component	Payment is equal to	Claim denied if left justified value is	Line item denied if	Through date
Outpatient (Claim type= 40)	Claim payment amount	Any non-blank value for 'Claim Medicare Non-Payment reason code' Claim Billing Facility Type Code in (4, 5)	Not applicable	Claim through date
Home health (Claim type = 10)	Claim payment amount	Any non-blank value for 'Claim Medicare Non-Payment reason code' Claim Billing Facility Type Code in (4, 5)	Not applicable	Claim through date
Carrier (physician/ supplier Part B) (Claim type = 71, 72)	Line NCH payment amount	'Carrier Claim Payment Denial Code' = '0' or 'D through Y'	Line processing indicator code ≠ A, R, or S	Line latest expense date
DME (Claim type = 81, 82)	Line NCH payment amount	'Carrier Claim Payment Denial Code' = '0' or 'D through Y'	Line processing indicator code ≠ A, R, or S	Line latest expense date
Hospice (Claim type = 50)	Claim payment amount	Any non-blank value for 'Claim Medicare Non-Payment reason code'	Not applicable	Claim through date

NOTE: You can find details on variables at the Research Data Assistance Center website, http://www.resdac.org/.

Step 2: Calculate the fraction of the year that each assigned beneficiary is enrolled in Medicare in each Medicare enrollment type.

In this step, we calculate the number of months the beneficiary was enrolled in Medicare Parts A and B for each Medicare enrollment type. A beneficiary is enrolled in Medicare Parts A and B when the Medicare entitlement/Buy-in Indicator for the month in the Medicare enrollment files is equal to 3 (3=Medicare Parts A and B both) or C (C=Medicare Parts A and B, and State Buy-In). We'll then take the number of months the beneficiary is enrolled in each Medicare enrollment type and divide it by 12 (the number of months in a calendar year). We'll use this fraction to annualize beneficiary expenditures in the next step. When we sum the fraction of the year enrolled in Medicare for all the beneficiaries assigned to the ACO, the result is the total "person years" for the ACO's assigned beneficiaries within the year. Person years are used to calculate the ACO's shared savings or losses.

Step 3: Calculate annualized expenditures.

We'll calculate annualized expenditures for each beneficiary assigned to the ACO for his or her Shared Savings Program-eligible months in each Medicare enrollment type. To annualize a beneficiary's expenditures, we'll divide the total expenditures in the applicable months by the fraction of the year the beneficiary is enrolled in each Medicare enrollment type.

4.3 Truncating Assigned Beneficiary Expenditures and Applying a Completion Factor

Step 4: Truncate annualized expenditures and apply completion factor.

We'll then truncate all annualized expenditures by setting those expenditures greater than a threshold equal to the threshold. We'll do this to prevent a small number of extremely costly beneficiaries from significantly affecting the ACO's per capita expenditures. For all beneficiaries, the threshold will be the national unweighted 99th percentile of annualized expenditures by Medicare enrollment type, verified by OACT. The 99th percentile for ESRD beneficiaries is typically much higher than that of aged and disabled beneficiaries.

Similarly, we'll truncate all annualized negative expenditures. A negative payment amount may occur in two situations: when a beneficiary is charged the full Medicare deductible during a short inpatient stay and the deductible exceeds the amount Medicare pays, or when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount plus deductible exceeds the amount Medicare pays. For a relatively low weight DRG, the deductible plus coinsurance can exceed the Medicare DRG payment amount. Medicare records the payment as a negative number on the claim and deducts the amount from the provider payment at the time it is sent. The beneficiary does not receive the excess. Negative annualized expenditures will be truncated at the negative of the applicable truncation threshold (i.e., the negative of the national un-weighted 99th percentile of annualized expenditures).

We'll truncate annualized expenditures and annualized negative expenditures at the 99th percentile of FFS per capita expenditures for the applicable enrollment type (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible).

Once expenditures are annualized and truncated, the appropriate completion factor is applied to expenditures. For example, if an aged/dual beneficiary had annualized expenditures of $20,000 in 2013, then after adjustment for the completion factor with 3-month run out it would be ($20,000)*(1.013) = $20,260. To take another example, if an aged/dual beneficiary had annualized expenditures of $200,000 in 2013, then since the 2013 applicable nominal expenditure truncation threshold for the aged/dual

population is $163,780.92, the beneficiary's truncated expenditures would be $163,780.92. Then after adjustment for the completion factor with 3-month run out, the effective expenditure truncation threshold would be ($163,780.92)*(1.013) = $165,910.07.

OACT calculates the nominal annualized expenditure truncation thresholds based on uncompleted claims. To be consistent for the annualized expenditures, the uncompleted claims are truncated, and then the truncated claims are completed.

4.4 ACO Per Capita Expenditures for Assigned Beneficiaries

Once we have annualized and truncated expenditures for each assigned beneficiary's months in each Medicare enrollment type, we calculate weighted mean annualized expenditures. This yields per capita expenditures for the ACO for each Medicare enrollment type. As described in step 5 below, we'll weight ACO per capita expenditures for each Medicare enrollment type by the fraction of the year the beneficiary is enrolled in Medicare in each enrollment type, so beneficiaries for whom we have less than a year's worth of expenditures don't contribute equally to ACO per capita expenditures as beneficiaries for whom we do have a full year of expenditure data.

Step 5: Calculate weighted average of truncated annualized expenditures for the ACO by Medicare enrollment type, weighting by the fraction of the year that each beneficiary is enrolled in Medicare enrollment type.

We'll calculate the per capita expenditures for the ACO according to the following methodology. We use truncated annualized Medicare expenditures as determined in steps 3 and 4 for each beneficiary for their Shared Savings Program-eligible months in each Medicare enrollment type and multiply by each beneficiary's fraction of the year enrolled in each Medicare enrollment type. For example, we would assign a value of $1,250 to a disabled beneficiary with $2,500 annualized expenditures enrolled in Medicare on the basis of disability for 6 months. We calculate this value across all beneficiaries in the disabled population assigned to the ACO, and then sum all these values and divide by the total number of person years in the disabled population assigned to the ACO. The beneficiary above would count as half of a person year for purposes of this calculation. We'll use these ACO per capita expenditures to calculate shared savings and losses.

4.5 Risk Adjustment

When establishing the historical benchmark, we'll use the CMS-HCC prospective risk adjustment model to calculate beneficiary risk scores to adjust for changes in the health status of the population

assigned to the ACO. These adjustments will account for changes in case mix between the first and third benchmark years and between the second and third benchmark years. CMS maintains the CMS-HCC prospective risk adjustment models for the Medicare Advantage (MA) program. CMS calculates CMS-HCC risk scores for all Medicare beneficiaries, including FFS beneficiaries. CMS uses separate models for Aged/Disabled beneficiary subpopulations, including models for community-residing beneficiaries, long-term institutional beneficiaries, new Medicare enrollees, and functioning graft (post-kidney-transplant) beneficiaries. CMS also uses separate models for ESRD beneficiary subpopulations, including models for dialysis beneficiaries and kidney transplant beneficiaries. For the benchmark and performance years we'll apply the MA risk adjustment model that exists for the current applicable year. We'll remove the MA coding intensity adjustment in the applicable years. Risk scores will be normalized by Medicare enrollment type for each year to ensure that the mean national FFS risk score equals 1.0. This adjustment ensures consistency in the FFS risk score year to year. Note also that data used for the quarterly reports will not be risk-adjusted.

A "newly assigned" beneficiary is a beneficiary assigned in the current performance year who was neither assigned to nor got a primary care service from any of the ACO's participants during the assignment window for the most recent prior benchmark or performance year. A "continuously assigned" beneficiary is one assigned to the ACO in the current performance year who was either assigned to or got a primary care service from any of the ACO's participants during the assignment window for the most recent prior benchmark or performance year. We'll categorize beneficiaries as ESRD, disabled, aged/dual eligible and aged/non-dual eligible based on eligibility on a monthly basis. In each performance year, we'll adjust the ACO's benchmark to account for changes in health status and demographic factors for newly assigned beneficiaries, and for continuously assigned beneficiaries. We'll make these adjustments separately for each Medicare enrollment type. We'll restate the ACO's updated benchmark in the appropriate performance year risk to recognize changes in the level of risk among the ACO's assigned beneficiaries.

For each performance year, we'll use separate methodologies to risk-adjust the benchmark for newly assigned and continuously assigned beneficiaries. For newly assigned beneficiaries we'll recalculate the ACO's CMS-HCC prospective risk scores to adjust for changes in severity and case mix arising from this population's risk scores. The MA coding intensity adjustment will be removed in the applicable years. The risk scores will be renormalized by Medicare enrollment type for each year to ensure that the mean national FFS risk score equals 1.0. We'll use demographic factors to adjust for changes in severity and case mix for beneficiaries continuously assigned to the ACO's population. We'll renormalize demographic risk scores by Medicare enrollment type for each year to ensure that the mean

national FFS risk score equals 1.0. However, if the continuously assigned population shows a decline in its CMS-HCC prospective risk scores, we'll lower the risk score for this population.

For the ACO's continuously assigned beneficiaries we'll recalculate:

1. CMS-HCC prospective risk scores, and
2. Demographic scores

We'll then determine whether a prospective HCC or demographic risk adjustment will be used for the continuously assigned population at the aggregate level (rather than within each Medicare enrollment type). To do this we'll compare risk ratios for each continuously assigned beneficiary population in each Medicare enrollment type based on their CMS-HCC scores and demographic risk scores for the performance interval relative to Benchmark Year 3 (BY3). We'll weight the risk ratios for each Medicare enrollment type relative to their respective person years and per capita benchmark dollars to obtain an overall dollar weighted average risk ratio. If the overall risk ratio is less than one, thereby indicating the average HCC score for the continuously assigned beneficiaries has fallen relative to BY3, we apply HCC ratios to the continuously assigned population within each Medicare enrollment type. Alternatively, if the overall risk ratio is greater-than-or-equal-to one, then the demographic ratios are applied to the continuously assigned population within each Medicare enrollment type.

We'll then update the ACO's historical benchmark risk scores for the continuously and newly assigned populations within each Medicare enrollment type based on the ratio of HCC or a combination of HCC and demographic scores in the performance period relative to BY3.

On a year-to-year basis, this risk adjustment methodology would account for changes in total risk due to beneficiaries who are assigned in the prior year but who aren't assigned in the current performance year (patients who leave the ACO or "leavers"). However, we'll monitor HCC scores for leavers, to see if we notice a trend in how the health status changes for this population.

SECTION 5: MINIMUM SAVINGS RATE AND MINIMUM LOSS RATE

Under both the one-sided and two-sided models of the Shared Savings Program, ACOs must meet or exceed a minimum savings rate (MSR) to get a shared savings payment.

The MSR is designed to provide a level of confidence that Medicare is rewarding true cost savings (efficiency) on the part of the ACO rather than paying for normal expenditure fluctuations. There's "normal" variation in the incidence and severity of illness in patient populations, so there's variation in medical expenditures. Variation in annual per capita medical care expenditures (claims costs) for the patients assigned to an ACO creates uncertainty in determining savings. The question then arises as to whether observed (measured) savings are the result of the ACO, or the result of normal fluctuations in medical expenditures for the assigned beneficiary population. A similar issue arises with respect to shared losses and therefore a minimum loss rate (MLR) is applied to protect against losses resulting from random variation.

As described in this section, the MSR and MLR reflect a percent of the ACO's updated benchmark.

5.1 One-Sided Model (Track 1)

Under the one-sided model, we'll base an ACO's MSR on the ACO's number of assigned beneficiaries in the performance year. Table 7 shows the MSR as a function of the number of beneficiaries annually assigned to the ACO. For example, the minimum (floor) MSR is set at 2% for ACOs with 60,000 or more beneficiaries and the MSR is set at 3.9% for ACOs with 5,000 beneficiaries.

MSRs which are in between the stated endpoints are calculated by the below specified equation, which is a weighted average of the stated endpoints in Table 7. For example, if an ACO has 5,333 beneficiaries, its MSR would be 3.8%:

$$3.9\% \times (5{,}999 - 5{,}333)/(5{,}999 - 5{,}000) + 3.6\% \times (5{,}333 - 5{,}000)/(5{,}999 - 5{,}000)$$

Table 7. Minimum Savings Rate by number of assigned beneficiaries (one-sided model)

Number of assigned beneficiaries	MSR (low end of assigned beneficiaries)	MSR (high end of assigned beneficiaries)
5,000–5,999	3.9%	3.6%
6,000–6,999	3.6%	3.4%
7,000–7,999	3.4%	3.2%
8,000–8,999	3.2%	3.1%
9,000–9,999	3.1%	3.0%
10,000–14,999	3.0%	2.7%
15,000–19,999	2.7%	2.5%
20,000–49,999	2.5%	2.2%
50,000–59,999	2.2%	2.0%
60,000 +	2.0%	2.0%

If an ACO's number of retrospectively assigned beneficiaries used for performance year reconciliation falls below 5,000, the ACO's MSR will be set to a level consistent with the number of assigned beneficiaries (as specified under § 425.110); in these cases the ACO's MSR will be increased above 3.9%, based on its number of assigned beneficiaries.

Since ACOs participating under the one-sided model are not accountable for shared losses, there is no corresponding MLR that is applied.

5.2 Two-Sided Models (Track 2 and 3)

ACOs participating in Track 2 and 3 must choose from one of the following options for the MSR/MLR: (1) zero percent MSR/MLR, (2) symmetrical MSR/MLR in a 0.5 percent increment between 0.5 - 2 percent, or (3) symmetrical MSR/MLR that varies, based on the number of beneficiaries assigned to the ACO, as used for Track 1.

This selection, made at the time of their application to the program, applies for the duration of the ACO’s agreement period. These MSR/MLR options give ACOs flexibility in setting the threshold they must meet before being eligible to share in savings or being accountable for losses. By selecting a higher MSR/MLR, an ACO will have the protection of a higher threshold before liability for losses, although they will in turn have a higher threshold to meet before being eligible to share in savings. By selecting a lower MSR/MLR, an ACO will have less protection against liability for losses although they will benefit

from a corresponding lower threshold for sharing in savings. By choosing the option for a MSR/MLR to vary according to the size of the ACO's population, a smaller ACO will have a relatively higher threshold to meet before being accountable for losses and therefore greater protection against performance-based risk, although they will have a corresponding higher threshold to meet before sharing in savings.

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SECTION 6: SHARED SAVINGS AND LOSSES CALCULATIONS

This section describes how we'll calculate an ACO's initial benchmark, updated benchmark, performance year expenditures, and annual ACO shared savings and shared losses during a Shared Savings Program agreement period. Sections 6.1, 6.2, 6.3, and 6.4 which discuss the methodology for determining the initial benchmark the rebased benchmark, the adjusted benchmark (based on participant list changes), and updated benchmark, respectively, apply to both the one-sided and two-sided models. We use "PY1, PY2, and PY3" to denote the 3 performance years of the Shared Savings Program agreement period, and in discussing ACO performance we refer to the corresponding performance period to be clear. For instance, we would refer to the performance year ending December 31, 2016 as "Performance Year 2016" We use "BY1, BY2, and BY3" for the 3 years we use to calculate the ACO's historical benchmark, which is updated benchmark for each performance year during the agreement period. Sections 6.5 and 6.6 will focus on the calculation of PY1–PY3 shared savings and losses for one-sided and two-sided models, respectively.

6.1 Calculating 3-Year Average Historical Benchmark (for ACOs in their first Agreement Period)

The first step in calculating annual shared savings and losses for a performance year in an ACO's first agreement period is to calculate the 3-year historical average benchmark expenditures for assigned beneficiaries, according to the steps in Sections 4.1–4.5.

First, we calculate the ACO's BY1–BY3 assigned beneficiary annualized per capita expenditures for the ESRD, disabled, aged/dual eligible and aged/non-dual eligible populations by summing Parts A and B FFS expenditures for months in each Medicare enrollment type and dividing by the fraction of the year in the Medicare enrollment type. As noted in Section 2.1.2, we'll include individually identifiable payments from the Medicare Trust Funds made for beneficiaries under a demonstration, pilot or time limited program, such as care coordination fees, in the ACO's benchmark. As noted in Section 4.3, we'll truncate expenditures at the national unweighted 99th percentile of annualized expenditures.

We'll trend forward the per capita dollars of expenditures for beneficiaries assigned in the first and second benchmark years BY1 and BY2 to BY3 dollars based on the national average growth rate in Parts A and B fee-for-service expenditures verified by OACT. We'll identify the OACT national FFS expenditures by ESRD, disabled, aged/dual eligible and aged/non-dual eligible populations and will calculate separate growth factors for each Medicare enrollment type.

Second, to risk-adjust the benchmark expenditures, we'll obtain the mean FFS normalized CMS-HCC risk scores for the ESRD, disabled, aged/dual eligible and aged/non-dual eligible assigned populations. We restate the BY1 and BY2 expenditures in BY3 assigned beneficiary level of risk by calculating and applying risk ratios of the BY3 risk score divided by each year's risk score.

Third, we'll apply the benchmark year weights to the trended, risk-adjusted expenditures for the ESRD, disabled, aged/dual eligible, and aged/non-dual eligible populations. BY1 has a weight of 10%, BY2 has a weight of 30%, and BY3 has a weight of 60%. This will give us weighted average annual per capita expenditures for each population.

We'll then weight the final benchmark to reflect the BY3 proportions of the ACO assigned beneficiary populations that are ESRD, disabled, aged/dual eligible and aged/non-dual eligible beneficiaries. We'll state the ACO's historical benchmark as a single per capita amount.

6.2 Calculating the Rebased Benchmark

The first step in calculating annual shared savings and losses for a performance year in an ACO's second or subsequent agreement periods is to rebase the 3-year historical average benchmark expenditures for assigned beneficiaries, according to the steps in Sections 4.1–4.5. If the ACO chooses to renew its agreement at the end of 3 years, we'll reset the ACO's historical benchmark at the start of the new agreement period, based on its most recent 3 calendar years prior to the start of the new agreement period.

First, we calculate the ACO's BY1–BY3 assigned beneficiary annualized per capita expenditures for the ESRD, disabled, aged/dual eligible and aged/non-dual eligible populations by summing Parts A and B FFS expenditures for months in each Medicare enrollment type and dividing by the fraction of the year in the Medicare enrollment type, where BY1-BY3 represent the 3 calendar years prior to the start of the current agreement period. As noted in Section 2.1.2, we'll include individually identifiable payments from the Medicare Trust Funds made for beneficiaries under a demonstration, pilot or time limited program, such as care coordination fees, in the ACO's benchmark. As noted in Section 4.3, we'll truncate expenditures at the national unweighted 99th percentile of annualized expenditures.

We'll trend forward the per capita dollars of expenditures for beneficiaries assigned in the first and second benchmark years BY1 and BY2 to BY3 dollars based on the national average growth rate in Parts A and B fee-for-service expenditures verified by OACT. We'll identify the OACT national FFS expenditures by ESRD, disabled, aged/dual eligible and aged/non-dual eligible populations and will calculate separate growth factors for each Medicare enrollment type.

Second, to risk-adjust the benchmark expenditures, we'll obtain the mean FFS normalized CMS-HCC risk scores for the ESRD, disabled, aged/dual eligible and aged/non-dual eligible assigned populations. We restate the BY1 and BY2 expenditures in BY3 assigned beneficiary level of risk by calculating and applying risk ratios of the BY3 risk score divided by each year's risk score.

Third, we'll apply equal weights to the benchmark years' trended, risk-adjusted expenditures for the ESRD, disabled, aged/dual eligible, and aged/non-dual eligible populations. That is, each BY will be weighted one-third. This will give us weighted average annual per capita expenditures for each population.

We'll then weight the final benchmark to reflect the BY3 proportions of the ACO assigned beneficiary populations that are ESRD, disabled, aged/dual eligible and aged/non-dual eligible beneficiaries. We'll state the ACO's historical benchmark as a single per capita amount.

Finally, we will use data from the ACO's finalized financial reconciliation report for the performance year which corresponds to the benchmark year for the prior agreement period to calculate the adjustment for savings generated in the prior agreement period. The calculation will include the following steps (as illustrated in Table 8 below):

Step 1. Determine whether the ACO generated net savings.

For each performance year we will determine an average per capita amount reflecting the quotient of the ACO's total updated benchmark expenditures minus total performance year expenditures divided by performance year assigned beneficiary person years. However, the ACO's total updated benchmark expenditures minus total performance year expenditures may not exceed the performance payment limit for the relevant track. If the sum of the 3 performance year per capita amounts is positive, the ACO would be determined to have net savings and we would proceed with Steps 2 and 3. If the sum of the 3 performance year per capita amounts is zero or negative, we will not make any adjustment to the ACO's rebased benchmark to account for any savings the ACO may have generated under its prior agreement period.

Step 2. Calculate an average per capita amount of savings reflecting the ACO's final sharing rates based on quality performance.

We will average the performance year per capita amounts determined in Step 1 to determine the average per capita amount for the agreement period. We will also determine the ACO's average final sharing rate, based on an average of the ACO's quality performance in each performance year of the

agreement period. Therefore, the average per capita amount of savings will account for those situations where an ACO's sharing rate for a performance year is set equal to zero (based on the ACO's failure to meet the quality performance requirements in that year). We will then calculate an average per capita amount of savings which is the product of the average performance year per capita amount and the average sharing rate based on quality performance.

Step 3. Add the average per capita amount of savings determined in Step 2 to the ACO's rebased historical benchmark.

The additional per capita amount will be applied to the ACO's rebased historical benchmark for a number of assigned beneficiaries (expressed as person years) not to exceed the average number of assigned beneficiaries (expressed as person years) under the ACO's first agreement period. Imposing this limit will help ensure that the adjustment does not exceed the amount of net savings generated by the ACO during the prior agreement period due to ACO participant list changes that may increase the number of assigned beneficiaries in the current agreement period.

Note that ACOs with April 1, 2012 and July 1, 2012 agreement start dates had a first performance year spanning a 21-month or 18-month period (respectively), concluding in December 31, 2013. In calculating the average per capita amount of savings for these ACOs, we will use calendar year 2013 data from the performance year 1 final financial reconciliation for these ACOs, to align with the same 12-month period for the corresponding benchmark year under their second agreement.

Table 8. Hypothetical performance data—Incorporating savings into rebased benchmark

	PY1	PY2	PY3	Average
A. Person Years	31,024	32,579	32,463	32,022 (average of A for PY1, PY2, PY3)
B. Total benchmark expenditures minus total expenditures	$19,265,778.00	($48,470,676.00)	$21,824,075.00	—
C. Per capita total benchmark minus total expenditures (C = B/A)	$621.00	($260.00)	$672.28	$344.42 (average of C for PY1 , PY2, PY3)
D. Final Sharing Rate	50%	0.0%	40%	30% (average of D for PY1, PY2, PY3)
E. Average per capita amount to add to Rebased Historical Benchmark	—	—	—	$103.33 (E = average C * average D)

6.3 Calculating the Adjusted Benchmark (based on Participant List changes)

Under the participation agreement, the ACO is required to tell CMS of changes in the composition of its ACO participants and ACO providers/suppliers. The ACO must report to CMS within 30 days of adding or removing ACO participants and ACO providers/suppliers and must update its ACO participant and ACO provider/supplier list at the beginning of each performance year and at other such times as we specify. We'll recalculate an ACO's historical benchmark based on the same 3 benchmark years (prior to the start of its agreement period) to account for changes in ACOs participants, resulting in an "adjusted" historical benchmark. An ACO may have up to three historical benchmarks for an agreement period if it makes revisions to its participant list prior to the start of its second and third performance years. The finalized historical benchmark, either the benchmark issued during the ACO's first performance year, or adjusted benchmark (in the event the ACO finalizes Participant List changes effective for the performance year), will be used to produce the updated historical benchmark for determining shared savings/losses for the relevant performance year. Otherwise, throughout the ACO's agreement period, the historical benchmark and adjusted historical benchmark (if any are produced for the ACO) are based on the three years prior to the start of the ACO's agreement period. The adjusted historical benchmark is not based on more current years. If an ACO does not make participant list changes, they will not have an adjusted benchmark.

6.4 Calculating the Updated Benchmark

We calculate the updated benchmark expenditures for each performance year as the sum of risk-adjusted historical benchmark expenditures plus the flat dollar amount equal to the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original FFS program from the benchmark to the performance year.

To calculate the updated benchmark, we determine the national projected absolute amount of growth in per capita expenditures for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible). We'll add this flat dollar amount to the risk-adjusted historical benchmark expenditures that were calculated in Section 6.1. For example, we would add the aged/dual eligible national amount of growth from historical benchmark to performance year (PY) to the aged/dual eligible risk-adjusted portion of the historical benchmark.

The overall updated benchmark for a PY is the weighted average of per capita expenditures for each of the Medicare enrollment types. To get the updated benchmark for a PY, we'll take a weighted average of ESRD, disabled, aged/dual eligible and aged/non-dual eligible benchmarks, using the PY ACO

assigned beneficiary proportions of ESRD, disabled, aged/dual eligible and aged/non-dual eligible person years.

We'll calculate updated benchmarks for each performance year in a similar manner, adding to the historical benchmark expenditures the most recent flat dollar equivalents of the national expenditure growth amounts for ACO assigned beneficiary proportions of ESRD, disabled, aged/dual eligible and aged/non-dual eligible beneficiaries. The benchmark will be updated each performance year to account for changes in beneficiary health status and demographic factors, and updated by the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original FFS program. The updated benchmark will be provided in the financial reconciliation report, showing the calculation of shared savings eligibility.

The updated benchmark is adjusted relative to the risk profile of the PY, as described in Section 4.5.

6.5 Annual Financial Reconciliation Calculations—One-Sided Model

This section details how we'll perform the annual financial reconciliation calculations under the one-sided model. First, we'll calculate the per capita updated benchmark as described above. We'll then rerun our assignment algorithm at the end of each PY and calculate per capita assigned beneficiary PY expenditures. For both the benchmark and the applicable PY, we'll multiply each ACO's per capita expenditures by the assigned beneficiary person years in the PY.

Next, we'll calculate total savings or losses for the PY. First, we determine if the total updated benchmark minus the total assigned beneficiary PY expenditures is greater than zero (potential savings). If so, we then determine whether or not the savings generated by the ACO are greater than or equal to the MSR, which is based on the number of assigned beneficiaries. The MSR is the minimum threshold necessary to share savings. Note: for the one-sided model, the ACO's MSR is based on a sliding scale relative to the size of its assigned beneficiary population, ranging from 2.0% to 3.9% of the ACO's updated benchmark. If total savings are greater than or equal to the MSR, then savings occurred. Otherwise, there are neither shared savings nor shared losses since ACOs participating under the one-sided model are not responsible for any losses.

We'll then calculate the shared savings percentage. The maximum quality performance sharing rate percentage is 50% under the one-sided model (with the remaining percent going to the Medicare program). We'll base the quality sharing rate on the ACO's quality performance. The final sharing rate

is equal to the product of the ACO's quality score and the maximum sharing rate of 50%. In PY1 of the Shared Savings Program, an ACO can earn the maximum 50% of shareable savings for quality performance based on full and accurate reporting of quality measures (known as pay for reporting). Following the first performance year, an ACO must continue to report completely and accurately on all measures; but in addition, its performance will be assessed relative to performance benchmarks for a specified set of measures in each performance year (known as pay for performance). If the ACO does not meet the quality performance standard for the performance year, it will not be eligible for any shared savings.

The final savings rate will apply to an ACO's savings on a first dollar basis. Under the one-sided model, shared savings are subject to a cap equal to 10% of total updated benchmark expenditures in each performance year. If an ACO is eligible to receive shared savings, we will reduce the shared savings amount paid to the ACO by 2% due to sequestration. This 2% reduction will be applied after all other calculations for shared savings are complete and prior to applying the cap. For those ACOs that are participating in the Advance Payment Model or the ACO Investment Model, sequestration is applied to the gross payment amount and then the advance payment withhold is subtracted.

6.6 Annual Financial Reconciliation Calculations—Two-Sided Models

This section describes how we'll perform the annual financial reconciliation calculations under the two-sided model. First, we'll calculate the per capita updated benchmark as described above. For Track 2 ACOs, we'll then rerun our assignment algorithm at the end of each PY and calculate per capita assigned beneficiary PY expenditures. For Track 3 ACOs, we'll determine the final list of prospectively assigned beneficiaries, having removed excluded beneficiaries that match the assignment criteria B, C and E described in Section 3 above. To determine total expenditures, we'll multiply each ACO's per capita updated benchmark and performance year expenditures by the assigned beneficiary person years in the PY.

Next, we'll calculate total savings or losses for the PY. First we determine if the total updated benchmark minus the total assigned beneficiary PY expenditures is greater than zero (potential savings) or less than zero (potential losses). We then determine whether or not the savings or losses generated by the ACO are equal to or greater than the MSR or the MLR, expressed as a percentage of the ACO's updated historical benchmark. The MSR is the minimum threshold necessary to share savings. The MLR is the minimum threshold to share losses. The choices of symmetrical MSR and the MLR under the two-sided models are described in Section 5. For example, with a MSR of 2%, the total updated benchmark

expenditures multiplied by 2% is the MSR ($). Likewise, if the MLR percentage is set at −2%, the MLR dollar amount is equal to the total updated benchmark expenditures multiplied by −2%.

If total savings are equal to or greater than the MSR, then the ACO is eligible to receive a share of these savings. If total losses are equal to or greater than the MLR, then the ACO will be accountable for repaying a share of those losses. Otherwise, there are neither shared savings nor shared losses.

We'll then calculate the shared savings percentage. Under the two-sided models the maximum quality performance sharing rate percentage is 60% for Track 2 and 75% for Track 3 (with the remaining percent going to the Medicare program). We'll base the quality sharing rate on the ACO quality performance. In PY1, a Track 2 ACO can earn the maximum 60% while a Track 3 ACO can earn the maximum of 75% of shareable savings for quality performance based on full and accurate reporting of quality measures (known as pay for reporting). Following the first performance year, an ACO must continue to report completely and accurately on all measures; but in addition, its performance will be assessed relative to performance benchmarks for a specified set of measures in each performance year (known as pay for performance). If the ACO does not meet the quality performance standard for the performance year, it will not be eligible for any shared savings and will be accountable for shared losses based on the highest shared loss rate.

The final sharing rate is equal to the product of the ACO's quality score and the maximum sharing rate of 60% for Track 2 or 75% for Track 3. The final loss rate is equal to one minus the final sharing rate. The final loss rate will not be less than 40% for either two-sided model and will not exceed 60% for Track 2 or 75% for Track 3. The final savings and loss rates will apply to an ACO's savings or losses on a first dollar basis.

Under the two-sided models, shared savings are subject to a cap equal to 15% (for Track 2) or 20% (for Track 3) of total updated benchmark expenditures in each year. Track 2 shared losses are subject to a limit equal to 5% of total updated benchmark expenditures in PY1, 7.5% of total updated benchmark expenditures in PY2, and 10% of total updated benchmark expenditures in PY3 and any subsequent year. Track 3 shared losses are subject to a limit equal to 15% of total updated benchmark expenditures for each performance year.

If an ACO is eligible to receive shared savings, we will reduce the shared savings amount paid to the ACO by 2% due to sequestration. This 2% reduction will be applied after all other calculations for shared savings are complete and prior to applying the cap. For those ACOs that are participating in the

Advance Payment Model or the ACO Investment Model, sequestration is applied to the gross payment amount and then the advance payment withhold is subtracted.

If an ACO has shared losses, the ACO must make payment in full to CMS within 90 days of receipt of notification. CMS shall draw upon the repayment mechanism established by the ACO as a condition of eligibility to participate in the two-sided model at the request of the ACO during the 90 day repayment period, and if the ACO fails to make payment in full within this time. If an ACO's self-executing repayment mechanism is not adequate to pay for all of the losses in the current year, the unpaid amount and any accrued interest are due in full.

6.7 Repayment Mechanism

ACOs choosing a two-sided model (Tracks 2 or 3) must show they have a repayment mechanism in place that can repay at least 1% of its total per capita Medicare FFS Parts A and B expenditures for its assigned beneficiaries based on expenditures used to establish the historical benchmark. ACOs must select from one or more of the following 3 types of repayment arrangements: (1) funds placed in escrow, (2) a line of credit as evidenced by a letter of credit, or (3) surety bond. CMS will determine whether this repayment mechanism is adequate when looking at an ACO's application to participate in the program. Beginning with the 2016 performance year, ACOs participating under the program's two-sided models must show that this repayment mechanism is adequate once at the beginning of a 3-year agreement period.[13] ACOs must demonstrate that they would be able to repay shared losses incurred at any time within the agreement period, and for a reasonable period of time after the end of each agreement period (the "tail period"). If any portion of the repayment mechanism is used to repay shared losses owed to CMS, the ACO is required to replenish the amount of its repayment mechanism within 90 days. For additional details, see the Shared Savings Program's Repayment Mechanism Arrangements Guidance, available online at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Repayment-Mechanism-Guidance.pdf.

6.8 Advance Payment ACO Model and ACO Investment Model

Some ACOs participating in the Shared Savings Program also participate in the Advance Payment ACO Model or ACO Investment Model implemented by the Center for Medicare and Medicaid Innovation. Through the Advance Payment ACO Model and ACO Investment Model, selected small,

[13] The June 2015 final rule finalized changes to the program's repayment mechanism requirements. ACOs with repayment mechanisms already established are expected to maintain their existing repayment mechanism in accordance with the terms set forth in the repayment mechanism.

rural or physician only ACOs receive upfront and monthly payments. CMS will automatically withhold any shared savings payments earned during the agreement period until the full amount of advance payments paid to the ACO as of the date of the financial reconciliation is offset and thereby repaid by the ACO. For a performance payment to be offset to repay advance payments, an ACO must earn a performance payment (generate shared savings that meet or exceed its MSR) and otherwise qualify for a performance payment (e.g., through adequate quality reporting). In any given performance year, the repayment for advance payments cannot exceed the value of the earned shared savings.

SECTION 7: REPORTS PROVIDED TO ACOS

We'll provide ACOs with information on their assigned population and financial performance at the start of the agreement period and routinely during the course of the performance year. We'll provide:

- Assignment list reports with beneficiary identifiable information on the ACO's assigned population and identifying select ACO participants (TINs) and ACO providers/suppliers (NPIs, CCNs) who treat assigned beneficiaries.
  - Track 1 and 2: at the start of the agreement period and with each adjusted historical benchmark, ACO receives a report on the beneficiaries assigned for the most recent benchmark year to serve as an initial preliminary prospective assignment list for the performance year; quarterly reports on the ACO's preliminary prospectively assigned population; and a year-end report on retrospectively assigned beneficiaries used for financial reconciliation.
  - Track 3: ACO receives a prospective assignment list close to the start of each performance year; quarterly list of beneficiaries who have been removed from the ACO's assignment list as a result of meeting select assignment exclusion criteria; and a year-end report on assigned beneficiaries used for financial reconciliation (similarly excluding beneficiaries determined to be excluded from assignment based on select criteria).
- Assignment summary reports on beneficiaries assigned for each benchmark year (Tracks 1, 2 and 3), preliminarily prospectively assigned (Tracks 1 and 2) each quarter, and a year-end report on beneficiaries retrospectively assigned (Track 1 and 2) for financial reconciliation.
- Aggregate expenditure and utilization reports provided each quarter during the agreement period, and provided for each benchmark year and annually for each performance period.
- Historical benchmark report specifying the calculation of the ACO's 3-year average per capita benchmark value. Preliminary historical benchmark report provided within several months following the ACO's agreement start date. Final historical benchmark provided with each financial reconciliation, and typically provided in advance for informational purposes. Adjusted historical benchmarks provided annually (only to ACOs finalizing Participant List changes effective for the performance year) several months after the start of the performance year.

- Financial reconciliation reports specifying the calculation of the ACO's historical benchmark, updated benchmark and determination of shared savings/losses.

Table 9 (Selected characteristics of Shared Savings Program ACO reports for Tracks 1 & 2 ACOs) below provide a comparison of characteristics and data sources for the above mentioned ACO Reports. Table 10 provides the same information for Track 3 ACOs. These tables illustrate the differences between reports produced on a quarterly basis and those reports produced on an annual basis. For reports produced annually a 3-month claims run out is used, whereas, a 7-day claims run out is used for reports produced quarterly. In order to get real-time data to the ACOs during each quarter, a smaller claims run out must be used. Consequently, the expenditure completion factors must be larger for quarterly data to account for this shorter claims run out. Lastly, payments withheld due to sequestration will be added into expenditures in 2013 Q4 reports and all quarterly reports moving forward. Payments withheld due to sequestration were not included in the quarterly reports produced before 2013 Q4. Table 11 provides a data and report schedule for 2016.

Table 9. Selected characteristics of Shared Savings Program ACO reports for Tracks 1 & 2 ACOs

Characteristic	Assignment Summary Report (Quarterly)	Assignment Summary Report (Annual)	Expenditure /Utilization Report (Quarterly)	Expenditure /Utilization Report (Annual)	Historical Benchmark Report
Claims Run Out	$\leq$ 7 days	3 months	$\leq$ 7 days	3 months	3 months
Assignment Dates of Service	Most recent 12 months	Calendar Year	Most recent 12 months	Calendar Year	Calendar Year
Expenditure Completion Factors	N/A	N/A	1.072	1.013	1.013
Medicare Enrollment Type Determined	Monthly	Monthly	Monthly	Monthly	Monthly

N/A = "not applicable". Expenditures and utilization are not included in all reports, and a completion factor is not used for utilization rates.

Table 10. Selected characteristics of Shared Savings Program ACO reports for Track 3 ACOs

Characteristic	Assignment Summary Report (Quarterly)	Assignment Summary Report (Annual)	Expenditure /Utilization Report (Quarterly)	Expenditure /Utilization Report (Annual)	Historical Benchmark Report
Claims Run Out	≤ 7 days	3 months	≤ 7 days	3 months	3 months
Assignment Dates of Service	Prospective Assignment Period	Prospective Assignment Period	Prospective Assignment Period	Prospective Assignment Period	Prospective Assignment Period
Assignment Exclusion Dates of Service	Calendar Year to Date	Calendar Year	Calendar Year to Date	Calendar Year	Calendar Year
Expenditure Completion Factors	N/A	N/A	1.072	1.013	1.013
Medicare Enrollment Type Determined	Monthly	Monthly	Monthly	Monthly	Monthly

Prospective Assignment Period uses data from October 1 two years prior to the start of the performance or benchmark year through September 30 of the year prior to the performance or benchmark year. Beneficiaries are removed from the prospective assignment lists on a quarterly basis and annually prior to financial reconciliation based on select assignment exclusion criteria. N/A = "not applicable". Expenditures and utilization are not included in all reports, and a completion factor is not used for utilization rates.

Table 11. 2016 Shared Savings Program Data and Report Schedule

Month	CMS Report	2014/2015 Starters Tracks 1 and 2	2016 New Starters Tracks 1 and 2	2016 New Starters Track 3	2016 Renewals Tracks 1 and 2	2016 Renewals Track 3
December	2016 Preliminary Prospective Assigned Beneficiary List	X	X		X	
December	2016 Prospective Assigned Beneficiary List			X		X
January	2015 Group Practice Reporting Option (GPRO) Patient Ranking file	X			X	X
February	Claim and Claim Line Feeds	X	X	X	X	X
February	2015 Quarter 4 Aggregate Expenditure/Utilization Report	X			X	X
February	2015 Quarter 4 Assignment Summary Reports	X			X	X

(continued)

Table 11. 2016 Shared Savings Program Data and Report Schedule (continued)

Month	CMS Report	2014/2015 Starters Tracks 1 and 2	2016 New Starters Tracks 1 and 2	2016 New Starters Track 3	2016 Renewals Tracks 1 and 2	2016 Renewals Track 3
February	2015 Quarter 4 Preliminary Prospective Assigned Beneficiary List	X			X	X
March	Claim and Claim Line Feeds	X	X	X	X	X
March	Adjusted Historical Benchmark Reports	X*				
March	Preliminary Historical Benchmark Report		X	X	X	X
March	Preliminary Historical Assignment Summary Report		X	X	X	X
March	Preliminary Historical Expenditure/Utilization Report		X	X	X	X
April	Claim and Claim Line Feeds	X	X	X	X	X
May	Claim and Claim Line Feeds	X	X	X	X	X
May	2016 Quarter 1 Aggregate Expenditure/Utilization Report	X	X	X	X	X
May	2016 Quarter 1 Assignment Summary Reports	X	X	X	X	X
May	2016 Quarter 1 Preliminary Prospective Assigned Beneficiary List	X	X		X	
May	2016 Quarter 1 Prospective Assigned Beneficiary List			X		X
June	Claim and Claim Line Feeds	X	X	X	X	X
June	Final Historical Benchmark Report		X	X		
June	Final Historical Assignment Summary Report		X	X		
June	Final Historical Expenditure/Utilization Report		X	X		
July	Claim and Claim Line Feeds	X	X	X	X	X
July	2015 Financial Reconciliation Report & 2015 ACO Quality Performance Report	X			X	X
August	Claim and Claim Line Feeds	X	X	X	X	X
August	2016 Quarter 2 Aggregate Expenditure/Utilization Report	X	X	X	X	X
August	2016 Quarter 2 Assignment Summary Reports	X	X	X	X	X

(continued)

Table 11. 2016 Shared Savings Program Data and Report Schedule (continued)

Month	CMS Report	2014/2015 Starters Tracks 1 and 2	2016 New Starters Tracks 1 and 2	2016 New Starters Track 3	2016 Renewals Tracks 1 and 2	2016 Renewals Track 3
August	2016 Quarter 2 Preliminary Prospective Assigned Beneficiary List	X	X		X	
August	2016 Quarter 2 Prospective Assigned Beneficiary List			X		X
August	Final Historical Benchmark Report				X	X
August	Final Historical Assignment Summary Report				X	X
August	Final Historical Expenditure/Utilization Report				X	X
September	Claim and Claim Line Feeds	X	X	X	X	X
September	2015 CAHPS Survey Detailed Performance Report	X			X	X
October	Claim and Claim Line Feeds	X	X	X	X	X
November	Claim and Claim Line Feeds	X	X	X	X	X
November	2016 Quarter 3 Aggregate Expenditure/Utilization Report	X	X	X	X	X
November	2016 Quarter 3 Assignment Summary Reports	X	X	X	X	X
November	2016 Quarter 3 Preliminary Prospective Assigned Beneficiary List	X	X		X	
November	2016 Quarter 3 Prospective Assigned Beneficiary List			X		X
December	Claim and Claim Line Feeds	X	X	X	X	X
December	2017 Preliminary Prospective Assigned Beneficiary List	X**	X**		X**	
December	2017 Prospective Assigned Beneficiary List			X		X

* For performance year 2016, all existing ACOs receive adjusted historical benchmark based on regulatory changes to the Shared Savings Program's assignment methodology. These adjusted benchmarks will account for modifications ACOs made to their 2016 ACO Participant List.

** ACOs who modified their 2017 ACO Participant List

Note: This is the planned report delivery schedule. Active ACOs should refer to Program Announcements and the Report Schedule available on the Shared Savings Program portal for current information.

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LIST OF ABBREVIATIONS

Acronym	Spelled-out meaning
ACO	Accountable Care Organization
BY	Benchmark Year
CAH	Critical Access Hospital
CCN	CMS Certification Number
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CMS-HCC	CMS Hierarchical Condition Category
CPT	Current Procedural Terminology
CY	Calendar Year
DME	Durable Medical Equipment
DO	Doctor of Osteopathic Medicine
DSH	Disproportionate Share Hospital
EIN	Employer Identification Number
ESRD	End Stage Renal Disease
ETA	Electing Teaching Amendment Hospital
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
FR	Federal Register
GPRO	Group Practice Reporting Option
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
IDR	Integrated Data Repository
IME	Indirect Medical Education
MA	Medicare Advantage
MD	Medical Doctor
MLR	Minimum Loss Rate
MSR	Minimum Savings Rate
NCH	National Claims History
NPI	National Provider Identifier
OACT	CMS Office of the Actuary
OPPS	Outpatient Prospective Payment System
PACE	Program of All Inclusive Care for the Elderly
PECOS	Provider Enrollment, Chain and Ownership System
PY	Performance Year
QMBs	Qualified Medicare beneficiaries
RHC	Rural Health Clinic
SNF	Skilled Nursing Facility
SSN	Social Security Number
TIN	Taxpayer Identification Number