



Medicare Shared Savings Program

ASSIGNMENT LIST REPORT AND ASSIGNMENT SUMMARY REPORT

User's Guide

April 2024
Version #16

Disclaimer: The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

This communication material was prepared as a service to the public and is not intended to grant rights or impose obligations. It may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of its contents.



MEDICARE
SHARED SAVINGS
PROGRAM

Revision History (from Version 15 to 16)

VERSION	DATE	REVISION/CHANGE DESCRIPTION	AFFECTED AREA
16	2024	Clarified end date of the COVID-19 Public Health Emergency	COVID-19 Public Health Emergency
16	2024	Added new Dual Person Years variable	Section 1.1
16	2024	Added new Reactivated variable	Section 1.8
16	2024	Updated descriptions for dual and non-dual person years	Section 2.2
16	2024	Changed description from use of person years to number of assigned beneficiaries.	Section 2.7
16	2024	Updated descriptions of codes used for assignment in Appendix Table 3	Appendix Table 3
16	2024	Updated to describe Advance Investment Payment Reports	Appendix Table 6
16	2024	Updated to describe Advance Investment Payment Reports	Appendix Table 7

ALR = Assignment List Report; ASR = Assignment Summary Report; CCN = CMS Certification Number; PY = performance year.

Table of Contents

Revision History (from Version 15 to 16)	ii
Introduction	1
COVID-19 Public Health Emergency	3
1 Assignment and Assignment List Report	7
1.1 Table 1-1 File: Assigned Beneficiaries	8
1.2 Table 1-2 File: Assigned Beneficiaries and Number of Primary Care Services at the ACO Participant TIN Level	16
1.3 Table 1-3 File: Assigned Beneficiaries and Number of Primary Care Services at the ACO CCN Level	17
1.4 Table 1-4 File: Top ACO Participant TIN-Individual NPI Combinations (by Number of Primary Care Services) for Assigned Beneficiaries	18
1.5 Table 1-5 File: Beneficiary Turnover Analysis (ACOs Under Preliminary Prospective Assignment Only)	19
1.6 Table 1-6 File: Beneficiaries Assignable to the ACO or Who Selected a Primary Clinician at the ACO (ACOs Under Preliminary Prospective Assignment Only)	20
1.7 Table 1-7 File: Assigned Beneficiaries with COVID-19 Diagnoses and Excluded Months for COVID-19 Episodes	21
1.8 Table 1-8 File: List of CCNs used in beneficiary assignment	25
1.9 Table 1-9 File: List of assigned BENEFICIARIES WITH INDICATORS OF UNDERSERVED POPULATIONS	26
2 Assignment Summary Report	27
2.1 Table 2-1: Beneficiary Assignment Summary	28
2.1.1 Table 2-1A: Voluntarily Aligned Beneficiaries and Exclusions	28
2.1.2 Table 2-1B: Claims-Based Beneficiary Assignment and Exclusions	30
2.2 Table 2-4: Demographic and Eligibility Characteristics of Total Assigned Beneficiaries	33
2.3 Table 2-5: Distribution of Total Assigned Beneficiary Residence by County	35
2.3.1 Table 2-5A: Distribution of Total Assigned Beneficiary Residence by County, Excluding COVID-19 Episodes	35

2.4	Table 2-6: Frequencies and Rates per 10,000 Beneficiaries by Disease Group (CMS-HCC) for Total Assigned Beneficiaries.....	36
2.5	Table 2-7: Prevalence of COVID-19 Among ACO Assigned Beneficiaries	36
2.6	Table 2-8: Utilization of Primary Care Services by Assigned Beneficiaries, Including COVID-19 Episodes	37
2.7	Table 2-9: Distribution of Total Assigned Beneficiaries by Indicators of Underserved Populations	39
Appendix.....		40
	Table 1. Selected Characteristics of Medicare Shared Savings Program Reports for Accountable Care Organizations (ACOs) Under Preliminary Prospective Assignment	40
	Table 2. Selected Characteristics of Medicare Shared Savings Program Reports for ACOs Under Prospective Assignment	40
	Table 3. Primary care service codes for purposes of assigning beneficiaries according to § 425.400(c)(1)(viii)	41
	Table 4. Physician Specialty Codes Used in Assignment.....	45
	Table 5. Specialty Codes for Non-Physician Practitioners Included in the Definition of an ACO Professional.....	46
	Table 6. List of Reports Provided for each Performance Year	47
	Table 7. List of Informational Reports	51
Acronyms		52

Introduction

The Centers for Medicare & Medicaid Services (CMS) periodically provides Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) with aggregate data reports, including reports displaying aggregated metrics on ACOs' assigned beneficiary populations (refer to 42 *Code of Federal Regulations* [CFR] § 425.702(b)(1)). CMS also makes available select beneficiary-identifiable information (the minimum data necessary) for ACOs to conduct health care operations work if the ACO elected to receive data as indicated on the application (refer to § 425.702(c)).¹ The data included in these program reports, referred to as the Assignment List Report (ALR) and Assignment Summary Report (ASR), take into account differences in assignment methodology in the Shared Savings Program:

- For ACOs under preliminary prospective assignment with retrospective reconciliation, CMS determines claims-based beneficiary assignment at the end of the year for each benchmark and performance year using Medicare fee-for-service (FFS) claims.
- For ACOs under prospective assignment, CMS determines claims-based beneficiary assignment prospectively before each benchmark and performance year using Medicare FFS claims.

As a result, reports provided to ACOs under prospective assignment may differ in some ways from reports provided to ACOs under preliminary prospective assignment.

ACOs under preliminary prospective assignment: Before each performance year, CMS will send these ACOs an initial preliminary prospective ALR based on their certified ACO Participant List and an ASR based on these beneficiaries. Several months after the ACO's agreement start date, the ACO will receive a retrospective ASR for each of the 3 benchmark years. Every quarter, these ACOs will receive an updated preliminary prospective ALR and ASR based on a rolling 12 months of data (referred to as quarterly reports). Finally, after each performance year, these ACOs will receive an ALR of retrospectively assigned beneficiaries used for financial reconciliation and an ASR for these beneficiaries (referred to as annual reports).

ACOs under prospective assignment: Before each performance year, these ACOs will receive a list of the beneficiaries prospectively assigned to them for the performance year and an ASR based on these beneficiaries. Several months after the ACO's agreement start date, the ACO will receive an ASR for beneficiaries prospectively assigned to the ACOs for each of the 3 benchmark years. Each quarter, these ACOs will receive updated ALRs that indicate which beneficiaries have been removed from the assignment list as a result of meeting select assignment exclusion criteria. The ACOs

¹ If an ACO elected, on the Shared Savings Program application, to receive beneficiary-identifiable data, CMS will also provide the ACO with a list of beneficiaries assigned to the ACO and information about those beneficiaries in an ALR to accompany the ASR.

will also receive an updated ASR quarterly during the performance year. The ASR will present aggregate metrics on the ACOs' currently assigned beneficiary population, updated to identify exclusions made in the quarterly year-to-date period. After each performance year, the ACOs will receive a year-end report on assigned beneficiaries used for financial reconciliation (similarly indicating beneficiaries excluded from assignment because of select criteria) and an ASR based on the assigned beneficiaries used for financial reconciliation.

An ACO may find these reports helpful for better understanding its assigned beneficiary populations. For example, an ACO could use the reports to help identify priority areas of care to focus on and develop population health management capabilities.

CMS delivers these reports in a static format. ASRs are delivered as Excel files, and ALRs are delivered as CSV files. The organization of this User's Guide follows the format of these static reports. For details on when informational reports are provided to ACOs, as well as descriptions of all report runs, please refer to [Appendix Tables 6](#) and [7](#).

This guide walks through each data field listed on the ALR and ASR and provides additional methodological description and formulas for calculations behind the data. Section 1 describes the assignment process and provides detail on the ALR. Section 2 provides details on the ASR.

[Appendix Tables 1](#) and [2](#) in this guide provide more-detailed information about the characteristics, assignment windows, and sources of certain variables used in the reports for ACOs under preliminary prospective assignment and for ACOs under prospective assignment. An ACO may find this table useful when comparing reports. It is important to note that because of the timing and availability of certain data sources and the differences in data sources, ACOs should use caution when comparing similar variables. For example, for the annual reports, CMS captures claims processed within 3 months after the end of the year when determining assigned beneficiaries. For quarterly reports, CMS captures claims processed up to 7 days after the end of the quarterly report period.

Note: The Participation Options Report, issued to ACOs continuing in or applying to the Shared Savings Program during the annual application and change request cycles, includes preliminary, estimated information on assigned beneficiaries, expenditures, and revenue for each taxpayer identification number (TIN) on the ACOs' proposed Participant List for the next performance year. This report also includes the information for the ACO as a whole. The preliminary, estimated amounts contained in the Participation Options Report are calculated for the purpose of the application and change request cycle only and are not necessarily comparable to the assigned beneficiary and expenditures figures provided in the ASR, ALR, Expenditure/Utilization Report, Beneficiary Expenditure/Utilization Report, Historical Benchmark report, or Financial Reconciliation report. One reason for this is that the amounts in the Participation Options Report are based on proposed ACO Participant Lists, whereas amounts included in the other program reports are based on final ACO Participant Lists and the final set of ACOs participating in the performance year. Please refer to the Participation Options Report Data Dictionary, available at the ACO Management System (ACO-MS) in the Knowledge Library, for details on the methodology used to determine the preliminary, estimated amounts.

COVID-19 Public Health Emergency

CMS amended certain Shared Savings Program regulations in order to address the impact of the Coronavirus Disease 2019 (COVID-19) pandemic and the resulting public health emergency (PHE), as defined in 42 CFR [§ 400.200](#).

Refer to the following:

- The “[Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency](#)” interim final rule with comment period (IFC) appeared in the April 6, 2020, Federal Register ([85 FR 19230, 19267 and 19268](#)) with an effective date of March 31, 2020 (hereafter referred to as the “March 31st COVID-19 IFC”).
- The “[Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program](#)” IFC appeared in the May 8, 2020, Federal Register ([85 FR 27550, 27573 through 27587](#)) with an effective date of May 8, 2020 (hereafter referred to as the “May 8th COVID-19 IFC”).
- The final rule titled “[Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program \(MDPP\) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment \(PPE\) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency \(PHE\) for COVID-19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID-19](#)” was released by CMS on December 1, 2020, and is available at the [Federal Register website](#) (hereafter referred to as the “CY 2021 PFS final rule”).
- The final rule titled “[Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements](#)” was released by CMS on November 19, 2021, and is available at the [Federal Register website](#) (hereafter referred to as the “CY 2022 PFS final rule”).

Expansion of Codes Used in Beneficiary Assignment

Section 425.400(c)(2)(i) specifies that the following additional primary care service codes are used in determining beneficiary assignment when the assignment window (as defined at § 425.20) for a benchmark or performance year includes any months during the COVID-19 PHE defined in § 400.200:

- CPT codes 99421, 99422, and 99423 (online digital evaluation and management services (e-visit));
- CPT codes 99441, 99442, and 99443 (telephone evaluation and management services);
- HCPCS code G2010 (remote evaluation of patient video/images); and
- HCPCS code G2012 (virtual check-in)

Refer to the CY 2021 PFS final rule (Section III.G.5.e.). Under this provision, the CPT codes and HCPCS codes included in the applicable definition of primary care services at § 425.400(c)(1) will continue to apply for purposes of determining beneficiary assignment under § 425.402. For the performance year starting on January 1, 2021, and subsequent performance years, CMS has amended the definition of primary care services to permanently include CPT codes and HCPCS codes: 99421, 99422, 99423, G2010, and G2012.

Refer to the CY 2022 PFS final rule (Section III.J.2.b.). According to § 425.400(c)(2)(i)(A)(2), for the performance year starting on January 1, 2022, and subsequent performance years, CMS will include an exception to the applicability of the expanded definition of primary care services, to extend the timeframe for use of CPT codes 99441, 99442, and 99443 until they are no longer payable under the Medicare FFS payment policies as specified under Section 1834(m) of the Act and §§ 410.78 and 414.65. Refer to Appendix Table 4 for more information on codes used in beneficiary assignment.

Episodes of Care for Treatment of COVID-19

CMS adjusts certain Shared Savings Program calculations to address the impact of the COVID-19 pandemic. As specified in § 425.611, CMS excludes from certain Shared Savings Program calculations all Parts A and B FFS payment amounts for a beneficiary's episode of care for treatment of COVID-19, triggered by an inpatient service, and as specified on Parts A and B claims with dates of service during the episode. According to § 425.611(b), CMS identifies an episode of care for treatment of COVID-19 based on either of the following:

- Discharges for inpatient services eligible for the 20 percent adjustment under Section 1886(d)(4)(C) of the Social Security Act.

- Discharges for acute care inpatient services for treatment of COVID-19 from facilities that are not paid under the inpatient prospective payment system (IPPS), such as Critical Access Hospitals (CAHs), when the date of discharge occurs within the PHE as defined in § 400.200.

As discussed in the CY 2021 PFS final rule (Section III.G.5.d.), CMS will identify inpatient claims that trigger an episode of care for treatment of COVID-19 using all of the following criteria, regardless of whether the claim is submitted by an IPPS or non-IPPS provider. Claims that do not meet these criteria will not trigger an episode of care for treatment of COVID-19.

- Inpatient claims identified by claim type 60;
- Facility type, as identified by the character in the third position of CMS Certification Number (CCN), equal to “T” (Rehabilitation Unit) or “R” (Critical Access Hospital [CAH] Rehabilitation Unit), or by the last four digits of CCN in any of the following ranges:
 - 0001–0879, Short-term (General or Specialty) Hospital
 - 0880–0899, Hospital that participated in an Office of Research and Development demonstration project
 - 1300–1399, CAH
 - 2000–2299, Long-term Care Hospital
 - 3025–3099, Inpatient Rehabilitation Facility
 - 3300–3399, Children’s Hospital;
- Admission date and discharge date both populated; and

Discharge date between January 27, 2020, and March 31, 2020 (inclusive) and diagnosis code equal to B97.29, or discharge date between April 1, 2020, and the expiration date of the PHE for COVID-19, May 11, 2023 (inclusive) and diagnosis code equal to U07.1. (The applicable diagnosis code may be present in any diagnosis code field based on established coding guidelines.) The aforementioned criteria were used in identifying episodes of care for treatment of COVID-19 in Q2 and Q3 2020 program reports provided to ACOs. Prior to preparing the Q4 2020 program reports, CMS incorporated an additional criterion that will ensure that expenditures related to treatment of COVID-19 are not excluded from program calculations when the IPPS provider is not eligible to receive the 20 percent diagnosis-related group (DRG) adjustment, for example, because the provider has specified a billing note NTE02 “No Pos Test” on the electronic claim 837I, or a remark “No Pos Test” on a paper claim. This note or remark on the claim indicates that the beneficiary did not have a positive laboratory test result for COVID-19 documented in the beneficiary’s medical record. This is for consistency with the CMS requirement that there must be a positive

laboratory test result for COVID-19 documented in the beneficiary's medical record in order for an IPPS provider to receive the 20 percent DRG adjustment. This requirement was developed to address potential Medicare program integrity risks, and became effective with admissions occurring on or after September 1, 2020.²

CMS will next identify episode months associated with each triggering inpatient claim. Episode months will include:

- Calendar month of admission;
- Calendar month of discharge;
- Any calendar months between calendar month of admission and calendar month of discharge; and
- Calendar month following calendar month of discharge.

Each episode will start at the beginning of the admission month and end at the end of the month following the discharge month.

Throughout the remainder of this guide, use of the term "COVID-19 episode" refers to episodes of care for treatment of COVID-19 as defined in this section.

COVID-19 ALR and ASR Changes

CMS provides tables in the Assignment List Report (ALR) and the Assignment Summary Report (ASR) that contain data on beneficiaries with a COVID-19 diagnosis or COVID-19 episode. Existing tables have not been altered. The new COVID-19 related tables in the ALR and ASR are the following:

- ALR Table 1-7: Assigned Beneficiaries with COVID-19 Diagnoses and Excluded Months for COVID-19 Episodes. Refer to [Section 1.7](#) for more information.
- ASR Table 2-5A: Distribution of Total Assigned Beneficiary Residence by County, Excluding COVID-19 Episodes. Refer to [Section 2.3.1](#) for more information.
- ASR Table 2-7: Prevalence of COVID-19 Among ACO Assigned Beneficiaries. Refer to [Section 2.5](#) for more information.
- ASR Table 2-8: Utilization of Primary Care Services by Assigned Beneficiaries, Including COVID-19 Episodes. Refer to [Section 2.6](#) for more information.

² For more information, refer to CMS, MLN Matters, "New Waivers for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act" (revised September 11, 2020), available at <https://www.cms.gov/files/document/se20015.pdf>.

1 Assignment and Assignment List Report

Beneficiaries can be assigned to an ACO through two methods: claims-based assignment or voluntary alignment. A beneficiary is eligible for claims-based assignment to the ACO (also referred to as “assignable to the ACO”) if the beneficiary has had at least one primary care service with a qualifying physician in the ACO. A beneficiary is eligible for voluntary alignment if the beneficiary selected a primary clinician that is an ACO professional. Refer to [Appendix Table 3](#) for the list of primary care services codes and [Appendix Table 4](#) for the list of provider specialty codes included in the definition of physician for purposes of claims-based assignment.³ In addition to meeting the above criteria for claims-based assignment and voluntary alignment, the beneficiary must meet the eligibility requirements discussed in detail in the [Medicare Shared Savings Program Shared Savings and Losses and Assignment Methodology Specifications](#).

As a “pre-step” in the claims-based assignment process, CMS identifies all beneficiaries that had at least one primary care service with a physician who is an ACO professional in the ACO and is a primary care physician as defined under § 425.20 or who has one of the primary specialty designations specified in § 425.402(c). CMS treats a service reported on an FQHC/RHC claim as a primary care service performed by a primary care physician, according to § 425.404(b).

Beneficiaries can be assigned through claims using a two-step process, referred to as “claims-based assignment.”

- **Step 1:** In Step 1, the Centers for Medicare & Medicaid Services (CMS) assigns a beneficiary to the ACO if the beneficiary has at least one primary care service furnished by a primary care practitioner within the ACO and has more primary care services (measured by Medicare-allowed charges) furnished by primary care practitioners than the same type of practitioners at any other Shared Savings Program ACO, non-ACO CMS Certification Number (CCN), or non-ACO individual or group taxpayer identification number (TIN) (i.e., a “plurality”). Refer to [Appendix Table 4](#) and [Table 5](#) for lists of codes used to define primary care providers.
- **Step 2:** Step 2 applies only to beneficiaries who have not received any primary care services from any primary care practitioner and were therefore not assigned in assignment Step 1. CMS will assign a beneficiary to a participating ACO in this step if the beneficiary received at least one primary care service from a specialist physician used in assignment at the participating ACO, and more primary care services (measured by Medicare-allowed charges) from specialist physicians used in assignment at the participating ACO than from any other ACO, non-ACO CCN, or

³ Note that the term “assignable beneficiary” as it is used in the ALRs and ASRs covered in this user’s guide refers to a beneficiary that has had a primary care service with a qualifying physician **in a particular ACO**. The June 2016 Final Rule (81 FR 37950) defines “assignable beneficiary” more generally for use in determining national and regional FFS expenditures to be used in calculating ACO benchmarks.

non-ACO individual or group TIN (i.e., a “plurality”). Refer to [Appendix Table 4](#) for the list of codes used to define physician specialists included in Claims-Based Assignment Step 2.

In addition to the two-step claims-based assignment process, beneficiaries have the option of voluntarily aligning to the ACO. Beneficiaries may voluntarily align to an ACO by selecting a practitioner (referred to in this guide as a “primary clinician”) they believe to be responsible for coordinating their overall care. The beneficiary’s selection will take precedence over the claims-based assignment methodology for the Shared Savings Program. To be voluntarily aligned to an ACO, the beneficiary must meet the assignment eligibility criteria. Beneficiaries who select a primary clinician not affiliated with an ACO are excluded from assignment to an ACO, even if the beneficiary would have otherwise been assigned to an ACO through claims-based assignment. Also, beneficiaries must have successfully voluntarily aligned by the voluntary alignment end date in the parameters worksheet of the ASR or ALR.

The remainder of this section describes the tables included in the ALR provided to ACOs. Report packages include a standalone CSV file for each ALR Table. To assist with data analysis, a data dictionary Excel workbook (.xlsx) file will also be included in the report package, providing a description of each of the ALR CSV files and all of the variables, variable formats, and allowable values. ACOs will also receive an Excel file outlining the parameters used in beneficiary assignment. Templates of the workbook files are available through the Shared Savings Program website under the [Program Guidance and Specifications webpage](#) in the Data and Report Sharing section.

An ACO will receive these files if it elected, and is otherwise eligible to receive, beneficiary-identifiable data. All ALRs provided to ACOs before the performance year are based on a 12-month claims-based beneficiary assignment window. Quarterly and annual performance year ALRs provided to ACOs under prospective assignment are based on a report period that does not correspond to the prospective claims-based beneficiary assignment window. For ACOs under prospective assignment, quarterly ALRs are based on year-to-date (YTD) report periods, and the annual performance year ALRs are based on a report period equivalent to the calendar performance year. In addition, ACOs receive benchmark year ALRs and ASRs with claims-based beneficiary assignment windows that correspond with each of the 3 benchmark years before their current agreement period.

1.1 TABLE 1-1 FILE: ASSIGNED BENEFICIARIES

CMS updated the format of Table 1-1 to use a consistent set of columns in all ALR data files sent to ACOs throughout the performance year. Some of the information in Table 1-1 is provided only at certain times during the year. When a variable is not used for a specific report run, the column is present for that variable in the data file; however, the column contains no data.

The CMS-Hierarchical Condition Category (HCC) flags are represented by 90 generic columns that include a variable that indicates the CMS-HCC dependent upon which CMS-HCC version is used in the report. The ALR Data Dictionary provides a crosswalk from the CMS-HCC column position variables to the actual CMS-HCC flags. The ALR Data Dictionary is included in each report package and in the Shared Savings Program Report Templates zip file, which is publicly available on the [Shared Savings Program website](#).

The file includes the following demographic information for each assigned beneficiary:

- Medicare Beneficiary Identifier (MBI).
- Health Insurance Claim Number (HICN) (blank for reports delivered after January 1, 2020).
- First name.
- Last name.
- Sex. Possible values: 0 = unknown; 1 = male; 2 = female.
- Birth date (mm-dd-yyyy).
- Date of death (mm-dd-yyyy).
- County name: County of residence, based on most recent available information in the report period. This field will be blank for prospectively assigned beneficiaries excluded in the report period.
- State name: State of residence, based on most recent available information in the report period. This field will be blank for prospectively assigned beneficiaries excluded in the report period.
- County number: The combination of the two-digit state code and the three-digit county code used by the Social Security Administration. This field will be blank for prospectively assigned beneficiaries excluded in the report period.
- Voluntary Alignment Flag: Indicates whether the beneficiary was prospectively assigned to the ACO through voluntary alignment. Possible values: 1 = voluntarily aligned to ACO; 0 = not voluntarily aligned to ACO. (Note: Measures relating to voluntary alignment are not included in reports prior to PY 2018.)
- Designated Primary Clinician ACO Participant TIN: The TIN of the beneficiary's designated primary clinician. Only provided for beneficiaries assigned to the ACO through voluntary alignment.
- Designated Primary Clinician National Provider Identifier (NPI): The Individual NPI of the beneficiary's designated primary clinician. Only provided for beneficiaries assigned to the ACO through voluntary alignment.

- **Claims-Based Assignment Flag:** Indicates whether the beneficiary was assigned to the ACO through the two-step claims-based assignment process. Possible values: 1 = claims-based assigned to ACO; 0 = not claims-based assigned to ACO. (Note: This field and related fields include only the prefix “Claims-Based” for PY 2018 and subsequent year reports.)
- **Claims-Based Assignment Step Flag:** Possible values: 1 = assigned during Step 1; 2 = assigned during Step 2; 0 = voluntarily aligned only and therefore not assigned through claims. Only populated when the Claims-Based Assignment Flag is 1.
- **Previously Assigned Beneficiary Flag** (included in quarterly reports for ACOs under preliminary prospective assignment only): Indicates if the assigned beneficiary appeared on at least one of the preliminary prospective assignment lists in the previous four quarters, including the preliminary prospective assignment list if the ACO is in its first performance year. Possible values: 1 = appeared on a previous assigned beneficiary list; 0 = did not appear on a previous assigned beneficiary list.
- **Medicare Part D Enrollment Flag:** Indicates the number of months a beneficiary is enrolled in Medicare Part D during the Shared Savings Program ACO Report Period. A beneficiary may be enrolled in Medicare Part D in a given month but be ineligible for ACO assignment if the beneficiary is not enrolled in Medicare Part A and Medicare Part B in that month. Beneficiaries who are not enrolled in Medicare Part D for any report period months will receive a flag of 0. For ACOs under prospective assignment, prospectively assigned beneficiaries who were excluded in the report period will not receive data for this flag.
- **Beneficiary excluded for one or more reasons:** Indicates whether a prospectively assigned beneficiary was excluded during the report period for one or more reasons based on the most recently available data: Beneficiary had a date of death prior to the start of the performance year, , beneficiary had at least 1 month of Part A-only or Part B-only coverage, beneficiary had at least 1 month in a Medicare health plan, beneficiary does not reside in the United States, beneficiary included in other Shared Savings Initiatives, or beneficiary excluded for other reasons.

Possible values: 1 = excluded during the report period for one or more reasons, using the most recently available data; 0 = not excluded. Note that if this field is equal to 1, one or more of the following reason fields will also equal 1:⁴

- **Beneficiary had a date of death before the performance year:** Indicates whether a prospectively assigned beneficiary was excluded during the report period because they had a date of death prior to the start of the performance year, based on most recently available data. Possible values: 1 = Beneficiary excluded

⁴ Note that the individual reason fields will be based on reasons for exclusion during the report period in which the beneficiary is first excluded. This report does not track whether an already excluded beneficiary meets additional criteria for exclusion in subsequent report periods.

because they had a date of death prior to the start of the performance year;
0 = Not excluded (beneficiary is alive or date of death occurred after the start of the performance year).

- Beneficiary excluded for other reasons: Indicates whether a prospectively assigned beneficiary was excluded during the report period because their identifier was missing in CMS records based on most recently available data, or because of other reasons not listed in the ALR. Possible values: 1 = Beneficiary excluded for other reason; 0 = Not excluded.
- Beneficiary had at least one month of Part A-only or Part B-only coverage: Indicates whether a prospectively assigned beneficiary was excluded during the report period because they had at least 1 month of Part A-only, Part B-only, or no months of Part A or Part B coverage during the performance period and is based on the most recently available data. Possible values: 1 = Beneficiary excluded because they had at least 1 month of Part A-only, Part B-only, or no months of Part A and Part B coverage during the report period; 0 = Not excluded (beneficiary had no months of Part A-only, Part B-only, and at least 1 month of Part A and Part B coverage during the report period).
- Beneficiary had at least one month in a Medicare health plan: Indicates whether a prospectively assigned beneficiary was excluded during the report period because they enrolled in a Medicare health plan during the report period based on the most recently available data Medicare health plans include Medicare Advantage (MA) plans, cost plans under Section 1876 of the Social Security Act and Program of All-inclusive Care for the Elderly (PACE) programs. Possible values: 1 = Beneficiary excluded because enrolled in a Medicare health plan for at least 1 month during the report period; 0 = Not excluded because beneficiary was not enrolled in a Medicare health plan for any month during the report period.
- Beneficiary does not reside in the United States: Indicates whether the assigned beneficiary was excluded during the report period because they had non-US residence in the last available month of the performance period. "U.S. resident" is defined by State Codes 01–53, which include the 50 states, District of Columbia, U.S. Virgin Islands, and Puerto Rico, plus 98 or 65 (Guam), 99 with 000 county code or 64 with any county code (American Samoa), and 97 with any county code or 63 with 050 county code (Northern Marianas). Possible values: 1 = Beneficiary excluded because they did not reside in the United States during the last available month of the report period; 0 = Not excluded (beneficiary resided in the United States during the last available month of the report period).
- Beneficiary included in other shared savings initiatives. Indicates whether the assigned beneficiary was excluded during the report period because they were included in other Shared Savings Initiatives during the performance period based

on the most recently available data. Possible values: 1 =Beneficiary excluded because they were included in other Shared Savings Initiatives during the report period; 0 = Not excluded (beneficiary was not included in another Shared Savings Initiative).

- Monthly eligibility flags 1–12: Each month in the report period is represented in a column specified by its numeric indicator. For example, January is Month 1 when the report is based on a calendar year period. Possible values for each of the monthly fields: 4 = Medicare enrollment type is “aged/non-dual”; 3 = Medicare enrollment type is “aged/dual”; 2 = Medicare enrollment type is “disabled”; 1 = Medicare enrollment type is “end-stage renal disease (ESRD)”; 0 = beneficiary was not eligible in the given month. Note that for quarterly reports for ACOs under prospective assignment, only the months corresponding to the YTD report period will be populated for non-excluded beneficiaries. For excluded beneficiaries, monthly eligibility flags will be left blank. For ACOs under preliminary prospective assignment with retrospective reconciliation, the report period refers to the claims-based beneficiary assignment window. For ACOs under prospective assignment, the report period refers to the year-to-date report period.
- CMS-HCC version used in report: The CMS-HCC Column Crosswalk tab of the ALR Data Dictionary along with this variable identifies the CMS-HCC Flag indicated by each column.
- CMS-HCC column positions: As described at the beginning of this section, to maintain a consistent table format throughout the performance year, these generic CMS-HCC column position variables no longer directly indicate the CMS-HCC flags and need to be mapped to the CMS-HCC flags using the crosswalk in the ALR Data Dictionary. The ALR Data Dictionary is included in report packages and in the Shared Savings Program Report Templates zip file, which is publicly available on the [Shared Savings Program website](#). The report includes a subset of CMS-HCCs for a given version. This subset will represent payment HCCs included in the CMS-HCC model used by CMS to adjust Medicare capitation payments to Medicare Advantage health care plans for the health expenditure risk of their enrollees.⁵ For example, as of the 2024 Q2 reports, these flags represent the payment CMS-HCCs included in the V28 CMS-HCC model. Earlier reports represent the payment CMS-HCCs included in the V22 CMS-HCC model or the V24 CMS-HCC model. CMS-HCCs are associated with a particular Medicare Advantage payment year (also referred to as the “risk score year”) and are based on diagnoses from the calendar

⁵ HCC data are included in Shared Savings Program reports for informational purposes. Although CMS only provides data for a single version of HCCs in a given report, in some years, for some beneficiaries, risk scores will be based on a blend of multiple risk score models, which may be based on different CMS-HCC versions. Additionally, ESRD risk score models may be based on a different CMS-HCC version than models used for aged disabled beneficiaries. For more information on the risk score models used for a given year, refer to the [Medicare Advantage Announcement](#) for that year.

year before the payment year (referred to as the “diagnosis year”). Possible values: 1 = beneficiary meets the criteria for the given CMS-HCC according to the most-recently available data; 0 = beneficiary does not meet the criteria for the given CMS-HCC according to the most-recently available data; missing = beneficiary does not have CMS-HCC data or, for ACOs under prospective assignment, beneficiary is excluded in the report period. The report parameters page will indicate the payment and diagnosis years of the CMS-HCC flags included in the report. Refer to the ALR Data Dictionary for the labels corresponding to each payment CMS-HCC flag in the V12, V22, and V24 models.

- CMS-HCC monthly risk scores: The monthly final, prospective risk score based on the applicable risk adjustment model for the Medicare Advantage payment year that corresponds to the report period. Monthly CMS-HCC risk scores are provided in Historical Benchmark and Financial Reconciliation ALRs. These monthly risk scores are renormalized so that the mean national assignable fee-for-service (FFS) risk score for the beneficiary’s enrollment type in that month (as indicated by the corresponding Monthly Eligibility Flag) equals 1.0. To obtain renormalized risk scores, CMS divides the beneficiary’s risk score by the mean national assignable FFS CMS-HCC risk score for the applicable enrollment type. The report parameters file indicates the payment and diagnosis years of the CMS-HCC risk scores included in the report, as well as the mean national assignable FFS CMS-HCC risk scores for each enrollment type used for renormalization. Risk scores for different enrollment categories are renormalized separately; ESRD risk scores are renormalized to the ESRD population, disabled risk scores are renormalized to the disabled population, aged/dual risk scores are renormalized to the aged/dual population, and aged/non-dual risk scores are renormalized to the aged/non-dual population. A very small percentage of beneficiaries are not included in the CMS-HCC risk score file so will not have any CMS-HCC risk score data reported. Beneficiaries in the CMS-HCC risk score file who are missing risk scores for particular months will not have risk scores reported for those months. CMS-HCC risk scores for beneficiaries who are new enrollees (refer to description of New Enrollee flag below) are based on demographic factors only, even if those beneficiaries have CMS-HCC flags. CMS-HCC risk scores based on only demographic factors will still differ from the demographic risk scores included in this table, as they are calibrated on a different population.
- CMS-HCC risk scores by enrollment type: The final, prospective risk score based on the applicable risk adjustment model for the most recently available Medicare Advantage payment year, renormalized so that the mean national assignable FFS risk score equals 1.0. CMS-HCC risk scores by enrollment type are provided in quarterly reports and in the preliminary prospective and prospective reports that ACOs receive before the performance year. To obtain renormalized risk scores, CMS divides the beneficiary’s risk score by the mean national assignable FFS CMS-HCC risk score for the applicable enrollment type. The report parameters file

indicates the payment and diagnosis years of the CMS-HCC risk scores included in the report, as well as the mean national assignable FFS CMS-HCC risk scores for each enrollment type used for renormalization. Risk scores for different enrollment categories are reported in separate columns, with each category renormalized to its own population (e.g., ESRD risk scores are renormalized to the ESRD population, disabled risk scores are renormalized to the disabled population, etc.). Therefore, risk scores for the different enrollment types are not on the same scale and are not comparable. Although there are four columns, CMS will only report beneficiaries' risk score for their enrollment status in their last eligible month of the most recently available Medicare Advantage payment year, which may not correspond to their enrollment type in the report period indicated by the monthly eligibility flags. The three columns for beneficiaries' non-applicable enrollment statuses will be left blank. Beneficiaries who were not included in the most-recent available payment year risk score file, or prospectively assigned beneficiaries who were excluded in the report period, will not have a reported risk score. CMS-HCC risk scores for beneficiaries who are new enrollees (refer to description of New Enrollee flag below) are based on demographic factors only, even if those beneficiaries have CMS-HCC flags. CMS-HCC risk scores based on only demographic factors will still differ from the demographic risk scores included in this table, as they are calibrated on a different population. Note that the risk scores provided in the quarterly reports are for informational purposes and are not the final risk scores that will be used for financial reconciliation; final risk scores are not available until the spring of the following year. The report parameters page indicates the risk score and diagnosis years of the CMS-HCC risk scores included in the report.

- **Beneficiary Demographic Risk Score** (included in quarterly reports and annual reports provided at time of financial reconciliation): Most recently available demographic risk score based on certain demographic attributes that do not vary with the beneficiary's health condition (e.g., age, sex, Medicaid status, original reason for Medicare entitlement). Demographic risk scores for the Shared Savings Program are based on a modified version of the Medicare Advantage demographic models and are calibrated on the entire Medicare FFS population. The demographic risk scores will be different than the CMS-HCC risk scores computed for new enrollees (refer to description of New Enrollee flag below), which are also based on demographic factors but use models calibrated on a different population. CMS renormalizes reported demographic risk scores so the mean national assignable FFS risk score equals 1.0. To obtain renormalized risk scores, CMS divides the beneficiary's risk score by the mean national assignable FFS demographic risk score. The report parameters page will indicate the mean national assignable FFS demographic risk scores for each enrollment type used for renormalization. Risk scores for different enrollment categories are reported in separate columns, with each category renormalized to its own population (e.g., ESRD risk scores are renormalized to the ESRD population, disabled risk scores are renormalized to the

disabled population). Therefore, risk scores for the different enrollment types are not on the same scale and are not comparable. Although there are four columns, each beneficiary will only have the risk score reported for their enrollment status in their last eligible month of the risk score year in quarterly and Initial Assignment Reports, which may not correspond to their Medicare enrollment type in the report period. The three columns for beneficiaries' non-applicable enrollment statuses will be left blank. Prospectively assigned beneficiaries who were excluded in the report period will not have a reported risk score. For Historical Benchmark and Financial Reconciliation reports, each beneficiary will have the risk score reported for any of their enrollment statuses in eligible months from the risk score year, which correspond to their Medicare enrollment type(s) in the report period. These demographic risk scores are provided for informational purposes only.

- **New Enrollee flag:** Indicates whether the beneficiary is a new enrollee for purposes of determining their CMS-HCC risk score(s). New enrollees are beneficiaries who do not have 12 months of Medicare Part B enrollment in the year preceding the Medicare Advantage payment year upon which reported CMS-HCC risk scores are based. Although some new enrollees have CMS-HCC flags populated, the flags may be based on incomplete diagnosis information. The CMS-HCC risk scores for these beneficiaries are based on demographic factors only. Beneficiaries that have 12 months of Medicare Part B enrollment in the year preceding the Medicare Advantage payment year are considered continuing enrollees. CMS-HCC risk scores for these beneficiaries are based on diagnoses (as captured in by CMS-HCC flags) and demographic factors. Possible values: 1 = beneficiary is a new enrollee for purposes of determining the CMS-HCC risk score(s); 0 = beneficiary is not a new enrollee for purposes of determining the CMS-HCC risk score(s); missing = beneficiary does not have sufficient data to indicate whether they are a new enrollee or, for ACOs under prospective assignment, beneficiary is excluded in the report period. The report parameters page will indicate the payment year for which the reported CMS-HCC risk scores are calculated. Note that new enrollees that receive a kidney transplant in the Medicare Advantage payment year are considered new enrollees for this report. CMS-HCC risk scores for months that a beneficiary is in transplant status are based on the same models regardless of whether the beneficiary is a new or continuing enrollee. These models consider transplant factors and do not depend on diagnoses.
- **Long-Term Institutionalized (LTI) flag:** Indicates whether a beneficiary is long-term institutionalized. A beneficiary is considered to be in LTI status if they were classified as long-term institutionalized for at least 1 month during the report period. Monthly LTI status is applicable to beneficiaries who have been in a nursing facility for at least 3 months and is triggered by a quarterly, annual, or significant change in status assessment required for nursing facility residents. Possible values: 1 = Long-term institutionalized; 0 = Not long-term institutionalized; missing = Beneficiary does not

have data to indicate whether they are long-term institutionalized. This flag is only populated in Historical Benchmark and Financial Reconciliation report packages.

- **Beneficiary Race Code:** Indicates the race code of the beneficiary. Possible values: 0 = Unknown; 1 = White; 2 = Black; 3 = Other; 4 = Asian; 5 = Hispanic; 6 = North American Native; missing = Beneficiary does not have data to indicate race.
- **Dual Person Years:** Represents the number of months the beneficiary was dually eligible for Medicare and Medicaid in the 12-month window in the parameters, divided by 12. Dual eligibility is only considered for months in which the beneficiary was alive and eligible for assignment to the Shared Savings Program (per § 425.401).

Details on this and other risk adjustment topics can be found in the webinar held on July 17, 2018, “Risk Adjustment in the Medicare Shared Savings Program,” which is available on the [ACO-MS Knowledge Library](#).

Note that the Medicare Shared Savings Program relies on CMS-HCC risk score data, which are determined by Medicare Advantage. For questions on the methodology used, please refer to the [Medicare Advantage Risk Adjustment website](#).

1.2 TABLE 1-2 FILE: ASSIGNED BENEFICIARIES AND NUMBER OF PRIMARY CARE SERVICES AT THE ACO PARTICIPANT TIN LEVEL

Each record in the file identifies the number of primary care services an assigned beneficiary had at a given ACO participant, identified by TIN, during the report period. Beneficiaries who visited more than one ACO participant TIN will have multiple rows in the table. If a preliminarily prospectively assigned beneficiary had no primary care visits with an ACO participant TIN during the report period (for example, if the beneficiary only received primary care services from a Federally Qualified Health Center [FQHC], Rural Health Clinic [RHC], Method II Critical Access Hospital [CAH], or Electing Teaching Amendment [ETA] outpatient facility), that beneficiary will be included in Table 1-3 and will not be included in Table 1-2 or Table 1-4. Prospectively assigned beneficiaries who did not receive any primary care services during the report period may not appear in either Table 1-2, 1-3, or 1-4 of a quarterly or annual performance year report. Prospectively assigned beneficiaries who are marked as excluded in Table 1-1 will not appear in Table 1-2, 1-3, or 1-4. Also, beneficiaries who are assigned to the ACO only through voluntarily alignment and are not assigned through the two-step claims-based assignment process may not appear in Table 1-2, 1-3, or 1-4. ACOs with assigned beneficiaries who only had primary care services at a CCN or were assigned to the ACO only through voluntary alignment and had no primary care service claims with an ACO participant TIN, will not receive this file. If an ACO participant TIN did not provide any primary care services to assigned beneficiaries during the report period, that

participant TIN will not appear on Table 1-2 or 1-4. The table includes the following information for each assigned beneficiary-TIN combination meeting the above criteria:

- MBI
- HICN (blank for reports delivered after January 1, 2020)
- First name
- Last name
- Sex (Possible values: 0 = unknown; 1 = male; 2 = female)
- Birth date (mm-dd-yyyy)
- Date of death (mm-dd-yyyy)
- ACO participant TIN
- Count of Primary Care Services: Count of primary care services provided by physician and non-physician specialties used in assignment at the ACO participant TIN (refer to [Appendix Table 3](#) for codes that define primary care services, [Appendix Table 4](#) for codes that define physician specialty used in assignment, and [Appendix Table 5](#) for codes that define non-physician practitioners used in assignment)

1.3 TABLE 1-3 FILE: ASSIGNED BENEFICIARIES AND NUMBER OF PRIMARY CARE SERVICES AT THE ACO CCN LEVEL

An ACO may receive this file if the ACO includes Method II CAHs, RHCs, FQHCs, or ETA hospitals, as indicated on the ACO Participant List by their CCN. Each row in the table identifies the number of primary care services an assigned beneficiary received from a given CCN during the report period. Beneficiaries who receive primary care services from more than one CCN during the report period will have multiple rows in this table. Beneficiaries who did not receive any primary care services from a CCN during the report period will not be included in this table. Also, beneficiaries who are assigned to the ACO only through voluntarily alignment and not through the two-step claims-based assignment process may not appear in Table 1-3. If the ACO's assigned beneficiaries did not receive any primary care services from a CCN during the report period, Table 1-3 will not be generated. If a CCN did not provide any primary care services to assigned beneficiaries in the report period, that CCN will not appear on Table 1-3. The table includes the following information for each assigned beneficiary-CCN combination meeting the above criteria:

- MBI
- HICN (blank for reports delivered after January 1, 2020)
- First name

- Last name
- Sex (Possible values: 0 = unknown; 1 = male; 2 = female)
- Birth date (mm-dd-yyyy)
- Date of death (mm-dd-yyyy)
- ACO CCN
- Count of Primary Care Services: Count of primary care services provided by physician and non-physician specialties used in assignment at the ACO CCN (refer to [Appendix Table 3](#) for codes that define primary care services, [Appendix Table 4](#) for codes that define physician specialty used in assignment, and [Appendix Table 5](#) for codes that define non-physician practitioners used in assignment)

1.4 TABLE 1-4 FILE: TOP ACO PARTICIPANT TIN-INDIVIDUAL NPI COMBINATIONS (BY NUMBER OF PRIMARY CARE SERVICES) FOR ASSIGNED BENEFICIARIES

The Table 1-4 file provides the top three ACO participant TIN-Individual NPI combinations for each beneficiary. The ACO TIN-Individual NPI combination that provided the most services is listed first, followed by subsequent ACO TIN-Individual NPI combinations. CMS identifies the top three TIN-Individual NPI combinations by counting the number of primary care services (refer to [Appendix Table 3](#) for codes that define primary care services) assigned beneficiaries had at the ACO participant TIN-Individual NPI level. Beneficiaries who visited fewer than three ACO TIN-Individual NPI combinations during the report period will have fewer than three rows in the table. If two or more ACO TIN-Individual NPI combinations have the same number of primary care service visits for a particular beneficiary, then the combination with the most-recent primary care service date from a primary care physician is included in the list of three. Assigned beneficiaries who only received primary care services from a CCN, as well as prospectively assigned beneficiaries who did not receive any primary care services during the report period, are not included in Table 1-2 or Table 1-4. Also, beneficiaries who are assigned to the ACO only through voluntarily alignment and are not assigned through the two-step claims-based assignment process may not appear in Table 1-2 or Table 1-4. ACOs with assigned beneficiaries who only had primary care services at a CCN or were assigned to the ACO only through voluntary alignment and had no primary care service claims with an ACO participant TIN, will not receive this file. TIN-NPI combinations that did not provide primary care services to assigned beneficiaries in the report period will not appear in this table. The table includes the following information for each assigned beneficiary-ACO participant TIN-Individual NPI combination meeting the above criteria:

- MBI
- HICN (blank for reports delivered after January 1, 2020)
- First name
- Last name
- Sex (possible values: 0 = unknown; 1 = male; 2 = female)
- Birth date (mm-dd-yyyy)
- Date of death (mm-dd-yyyy)
- ACO participant TIN
- Individual NPI
- Count of Primary Care Services: Count of primary care services provided by physician and non-physician specialties used in assignment at the ACO participant TIN-NPI combination (refer to [Appendix Table 3](#) for codes that define primary care services, [Appendix Table 4](#) for codes that define physician specialty used in assignment, and [Appendix Table 5](#) for codes that define non-physician practitioners used in assignment)

1.5 TABLE 1-5 FILE: BENEFICIARY TURNOVER ANALYSIS (ACOS UNDER PRELIMINARY PROSPECTIVE ASSIGNMENT ONLY)

ACOs under preliminary prospective assignment will receive this file. For Q1, this table lists each beneficiary who was assigned to the ACO at the beginning of the performance year (during initial preliminary prospective assignment) but is not assigned in the current (Q1) report period. For Q2 through Q4, this table lists each beneficiary who was assigned to the ACO in the previous quarterly report's report period, but who is not assigned in the current report period. Beginning in PY 2021, this table will also be included in the initial Preliminary Prospective ALR and, in that report, will list beneficiaries assigned in Q4 of the previous Performance Year who are not assigned in the initial Preliminary Prospective ALR.

The table also lists the reason why the beneficiary was not assigned in the current report period. The table includes the following information for each beneficiary who was previously assigned and is not currently assigned:

- MBI
- HICN (blank for reports delivered after January 1, 2020)
- First name

- Last name
- Sex (possible values: 0 = unknown; 1 = male; 2 = female)
- Birth date (mm-dd-yyyy)
- Date of death (mm-dd-yyyy)
- Reason(s) beneficiary is not currently assigned (values equal 1 if the given reason applies to the beneficiary in the current assignment window and equal 0 otherwise; note that a beneficiary can have more than one reason for not being currently assigned to the ACO):
 - Beneficiary did not receive the plurality of primary care services from the ACO (refer to [Appendix Table 3](#) for codes that define primary care services).
 - Beneficiary had at least one month of Part A–only or Part B–only coverage (or no months of Part A and Part B coverage).
 - Beneficiary had at least one month in a Medicare health plan.
 - Beneficiary does not reside in the United States in the last available month of the assignment window.
 - Beneficiary included in other shared savings initiatives during the performance year.
 - Beneficiary did not have a physician visit with an ACO professional or was not assigned for any other reason not listed.

1.6 TABLE 1-6 FILE: BENEFICIARIES ASSIGNABLE TO THE ACO OR WHO SELECTED A PRIMARY CLINICIAN AT THE ACO (ACOS UNDER PRELIMINARY PROSPECTIVE ASSIGNMENT ONLY)

ACOs under preliminary prospective assignment will receive this file. The table includes beneficiaries who received at least one primary care service provided by a qualifying physician in the ACO or who selected a primary clinician at the ACO. A qualifying physician includes primary care physicians, physicians included in Claims-Based Assignment Step 2 (refer to [Appendix Table 4](#)), or a practitioner at an FQHC/RHC in the ACO. The file includes beneficiaries assigned to the ACO during the current assignment window. The file contains the following demographic information for each beneficiary:

- MBI
- HICN (blank for reports delivered after January 1, 2020)
- First name
- Last name

- Sex (possible values: 0 = unknown; 1 = male; 2 = female)
- Birth date (mm-dd-yyyy)
- Date of death (mm-dd-yyyy)
- Voluntary alignment selection only

A beneficiary who was assignable to the ACO during the current claims-based beneficiary assignment window but not assigned may not have been eligible for assignment during that window. A beneficiary who is assignable to the ACO during the current claims-based beneficiary assignment window may also have been eligible for, and potentially assigned to, another Shared Savings Program ACO during the same window through voluntary alignment or claims-based assignment. Additionally, beneficiaries who are assignable to the ACO during the current claims-based beneficiary assignment window and are eligible for assignment may not be assigned to any ACO if they received the plurality of their primary care services with a non-ACO TIN or had a qualifying voluntary alignment selection with a non-ACO TIN. Thus, a single beneficiary may appear in Table 1-6 in reports for multiple ACOs but can only show up as assigned to a single ACO.

1.7 TABLE 1-7 FILE: ASSIGNED BENEFICIARIES WITH COVID-19 DIAGNOSES AND EXCLUDED MONTHS FOR COVID-19 EPISODES

Table 1-7 is a beneficiary-level file that includes assigned beneficiaries who received a COVID-19 diagnosis at an inpatient or outpatient setting. The file identifies COVID-19 episodes and calendar months associated with an episode of care. A beneficiary will have multiple records in this file if they have both a B97.29 diagnosis code and a U07.1 diagnosis code. They will also have multiple records if they have multiple COVID-19 episodes during the report period. Beneficiaries who do not have a COVID-19 diagnosis will not be included in this table. Beneficiaries who have a COVID-19 diagnosis but do not meet the criteria for a COVID-19 episode described in the [COVID-19 PHE](#) section of this guide will be included in the table but will not have any data associated with an episode of care. That is, the columns for admission date (“ADMISSION_DT”) and discharge date (“DISCHARGE_DT”) have a value of “[missing]”, the COVID-19 episode flag (“COVID19_EPISODE”) will have a value equal to “0”, and the columns for monthly COVID-19 episode flag 1 (“COVID19_MONTH01”) through flag 12 (“COVID19_MONTH12”) will have a value equal to “0”. A record identifying a beneficiary with a COVID-19 episode will have a date in the columns for admission date and discharge date; the COVID-19 episode flag will have a value equal to “1”, and calendar months associated with the COVID-19 episode will be indicated by a value of “1” in the corresponding columns for monthly COVID-19 episode (flag 1 through flag 12). As described in the [COVID-19 PHE](#) section of this guide, the calendar months that comprise the COVID-19 episode are

- the calendar month of admission;
- the calendar month of discharge;
- any calendar months between calendar month of admission and calendar month of discharge; and
- the calendar month following calendar month of discharge.

The table includes the following information for each assigned beneficiary meeting the criteria for COVID-19 diagnosis or COVID-19 episode:

- MBI.
- B97.29 Diagnosis: Indicates that the beneficiary had a discharge date or a claim through date between January 27, 2020, and March 31, 2020 (inclusive), and the diagnosis code B97.29. Possible values: 1 = Meets criteria for a COVID-19 diagnosis; 0 = Does not meet the criteria for a COVID-19 diagnosis.
- U07.1 Diagnosis: Indicates that the beneficiary had a discharge date or a claim through date between April 1, 2020 and May 11, 2023 (the expiration date of the PHE) and the diagnosis code U07.1. Possible values: 1 = Meets criteria for a COVID-19 diagnosis; 0 = Does not meet the criteria for a COVID-19 diagnosis.
- COVID-19 Episode: Possible values: 1 = Meets criteria for a COVID-19 episode; 0 = Does not meet the criteria for a COVID-19 episode.
- Admission Date: A missing value indicates that the beneficiary does not meet the criteria for a COVID-19 episode.
- Discharge Date: A missing value indicates that the beneficiary does not meet the criteria for a COVID-19 episode.
- Monthly COVID-19 Episode Flags 1–12: Possible values: 1 = Beneficiary meets criteria for a COVID-19 episode during the report period and is a COVID-19 episode month; 0 = Beneficiary does not meet the criteria for a COVID-19 episode, or meets the criteria for a COVID-19 episode but is not a COVID-19 episode month during the report period. For ACOs under prospective assignment, [Missing] = Not a month within the year-to-date (YTD) report period.
 - For ACOs under prospective assignment, monthly COVID-19 episode flags correspond with the YTD calendar month. For example, for PY 2022 reports, COVID19_MONTH01 corresponds to January 2022, COVID19_MONTH02 corresponds to February 2022, etc.
 - For ACOs under preliminary prospective assignment, monthly COVID-19 episode flags are associated with the months of the rolling 12-month assignment window.

- For PY 2022 Quarter 1 (Q1) reports, COVID19_MONTH01 through COVID19_MONTH12 correspond with April 2021 (Month 1) through March 2022 (Month 12).
- For PY 2022 Q2 reports, COVID19_MONTH01 through COVID19_MONTH12 correspond with July 2021 (Month 1) through June 2022 (Month 12).
- For PY 2022 Q3 reports, COVID19_MONTH01 through COVID19_MONTH12 correspond to October 2021 (Month 1) through September 2022 (Month 12).
- For PY 2022 Q4 reports and financial reconciliation, COVID19_MONTH01 through COVID19_MONTH12 correspond to January 2022 (Month 1) through December 2022 (Month 12).

Beneficiaries may have more than one COVID-19 episode during the report period. Below are examples of how one or multiple COVID-19 episodes are captured in the table:

- Example 1, beneficiary with one COVID-19 episode: For a beneficiary admitted March 15, 2020, and discharged April 17, 2020, monthly flags from March through May will have a value equal to “1.”
 - For an ACO under prospective assignment, in PY 2020 reports, monthly flags COVID19_MONTH03, COVID19_MONTH04, and COVID19_MONTH05 would have values equal to “1,” and the remaining monthly flags would have values equal to “0.”
 - For an ACO under preliminary prospective assignment, in PY 2020 Q2 reports, monthly flags COVID19_MONTH09, COVID19_MONTH10, and COVID19_MONTH11 would have values equal to “1,” and the remaining monthly flags would have values equal to “0.”
- Example 2, beneficiary with two COVID-19 episodes: A beneficiary admitted March 30, 2020; discharged April 8, 2020; admitted again May 8, 2020; and discharged May 10, 2020, would be considered to have two COVID-19 episodes. This beneficiary would have two rows in the table, one for each episode.
 - For the first episode, monthly COVID-19 episode flags from March through May will have a value equal to “1.”
 - For an ACO under prospective assignment, in PY 2020 reports, monthly flags COVID19_MONTH03, COVID19_MONTH04, and COVID19_MONTH05 would have a value equal to “1,” and the remaining monthly flags would have a value equal to “0.”
 - For an ACO under preliminary prospective assignment, in PY 2020 Q2 reports, monthly flags COVID19_MONTH09, COVID19_MONTH10, and

- COVID19_MONTH11 would have a value equal to “1,” and the remaining monthly flags would have a value equal to “0.”
- For the second episode, monthly flags for May and June will have a value equal to “1.”
 - For an ACO under prospective assignment, in PY 2020 reports, monthly flags COVID19_MONTH05 and COVID19_MONTH06 would have a value equal to “1,” and the remaining monthly flags would have a value equal to “0.”
 - For an ACO under preliminary prospective assignment, in PY 2020 Q2 reports, monthly flags COVID19_MONTH11 and COVID19_MONTH12 would have a value equal to “1,” and the remaining monthly flags would have a value equal to “0.”
 - Example 3, beneficiary with COVID-19 episodes that spans multiple calendar year quarters (quarterly reports): A beneficiary admitted May 8, 2020, and discharged June 8, 2020.
 - In the PY 2020 Q2 reports, the incomplete episode will be included, and monthly flags for May and June will have a value equal to “1.”
 - For an ACO under prospective assignment, monthly flags COVID19_MONTH05 and COVID19_MONTH06 will have a value equal to “1,” and the remaining monthly flags will have a value equal to “0.”
 - For an ACO under preliminary prospective assignment, monthly flags COVID19_MONTH11 and COVID19_MONTH12 will have a value equal to “1,” and the remaining monthly flags will have a value equal to “0.”
 - In the PY 2020 Q3 reports, the complete episode will be included, and monthly flags from May through July will have a value equal to “1.”
 - For an ACO under prospective assignment, monthly flags COVID19_MONTH05, COVID19_MONTH06, and COVID19_MONTH07 will have a value equal to “1,” and the remaining monthly flags will have a value equal to “0.”
 - For an ACO under preliminary prospective assignment, monthly flags COVID19_MONTH08, COVID19_MONTH09, and COVID19_MONTH10 will have a value equal to “1,” and the remaining monthly flags will have a value equal to “0.”
 - Example 4, beneficiary with a COVID-19 episode that occurs at the end of the PHE: A beneficiary admitted April 8, 2023, and discharged June 8, 2023.
 - In the PY 2023 Q2 reports, the episode will be included, and monthly flags for April, May, and June will have a value equal to “1.”

- For an ACO under prospective assignment, monthly flags COVID19_MONTH04, COVID19_MONTH05, and COVID19_MONTH06 will have a value equal to “1,” and the remaining monthly flags will have a value equal to “0.”
- For an ACO under preliminary prospective assignment, monthly flags COVID19_MONTH10, COVID19_MONTH11, and COVID19_MONTH12 will have a value equal to “1,” and the remaining monthly flags will have a value equal to “0.”
- In the PY 2023 Q3 reports, the episode will be included, and monthly flags from April through June will have a value equal to “1.” Although the discharge date occurred in June, the PHE ended in May and therefore the month following the discharge date, July, will have a value equal to “0”.
- For an ACO under prospective assignment, monthly flags COVID19_MONTH04, COVID19_MONTH05, and COVID19_MONTH06 will have a value equal to “1,” and the remaining monthly flags will have a value equal to “0.”
- For an ACO under preliminary prospective assignment, monthly flags COVID19_MONTH07, COVID19_MONTH08, and COVID19_MONTH09 will have a value equal to “1,” and the remaining monthly flags will have a value equal to “0.”

1.8 TABLE 1-8 FILE: LIST OF CCNS USED IN BENEFICIARY ASSIGNMENT

An ACO may receive this file if the ACO Participant List includes CCNs that are Method II CAHs, RHCs, FQHCs, or ETA hospitals. Each row in the table identifies a given CCN used in beneficiary assignment during the report period, as well as an identifier that denotes whether the CCN is deactivated or newly enrolled. A CCN that is neither deactivated nor newly enrolled is a CCN that was actively enrolled under a participant TIN as of Initial Assignment prior to the PY. A CCN that is deactivated is a CCN that did not have an active enrollment in PECOS at the time of Initial Assignment prior to the PY but was enrolled under a participant TIN at the ACO as of the CCN’s most recent active enrollment. A CCN that is newly enrolled is a CCN that has no Medicare claims history and was not enrolled in PECOS under the ACO participant TIN as of Initial Assignment prior to the PY but enrolls under the ACO participant TIN during the PY. A CCN may not be both deactivated and newly enrolled. Only ACOs under preliminary prospective assignment will see changes to Table 1-8 throughout the PY to capture newly enrolled CCNs; ACOs under prospective assignment should not see any changes to Table 1-8 after Initial Assignment reports. If a CCN did not provide any primary care services to assigned beneficiaries in the report period, that CCN will not appear on Table 1-3 but will appear in Table 1-8.

CCNs that enroll under an ACO participant TIN during the PY would be reflected in program operations, including, but not limited to, beneficiary assignment, and revenue and expenditure calculations performed quarterly and during financial reconciliation for ACOs under preliminary prospective assignment with retrospective reconciliation. Furthermore, services furnished by a CCN with a deactivated enrollment status prior to that CCN becoming deactivated (that is enrolled under the TIN of an ACO participant at the start of a PY) will be considered in determining beneficiary assignment to the ACO for the applicable PY or benchmark year.

The table includes the following information for each CCN used in assignment:

- ACO participant TIN
- ACO CCN
- CCN Type (up to 50 alpha characters representing the expanded facility description for the CCN type)
- A deactivated flag (possible values: 0 = actively enrolled; 1 = deactivated)
- A newly enrolled flag (possible values: 0 = included in Initial Assignment; 1 = newly enrolled as of Quarter 1; 2 = newly enrolled as of Quarter 2; 3 = newly enrolled as of Quarter 3; 4 = newly enrolled as of Quarter 4). This flag will only populate with non-zero values for ACOs under preliminary prospective assignment.
- A reactivated flag (possible values: 0 = CCNs that were previously deactivated and have not become reactivated, CCNs that are newly enrolled throughout the performance year, and CCNs active as of the initial assignment run for the performance year; 1 = reactivated as of Quarter 1; 2 = reactivated as of Quarter 2; 3 = reactivated as of Quarter 3; 4 = reactivated as of Quarter 4)

1.9 TABLE 1-9 FILE: LIST OF ASSIGNED BENEFICIARIES WITH INDICATORS OF UNDERSERVED POPULATIONS

Table 1-9 is a listing of all assigned beneficiaries with indicators to identify beneficiaries belonging to underserved populations. For annual PY reports, the data provided in this list will be used to calculate the health equity adjustment (HEA) that will be added to the Merit-based Incentive Payment System (MIPS) Quality performance category score for eligible ACOs beginning with PY 2023 (refer to 42 CFR 425.512(b)). See description of Assignment Summary Report Table 2-9 for more information. This table contains the following:

- MBI.
- Area Deprivation Index (ADI) National Percentile Rank: Is based on the beneficiary's applicable census block group (based on most recent address) as of the window in the parameters of the associated report run. Higher percentile rank values are

associated with greater deprivation. A beneficiary can have missing data if their address data are not sufficient to match to an ADI national percentile rank or if the ADI national percentile rank data for the beneficiary's census block group are suppressed. Data will reflect the most recent version of the ADI available in CMS data systems at the time of the report run, as provided in the parameters.

- Low-Income Subsidy (LIS) enrollment flag: Indicates whether the beneficiary had any months in which they were enrolled in the Medicare Part D LIS in the 12-month period provided in the parameters. Possible values: 1 = had one or more months enrolled in the Medicare Part D LIS; 0 = did not have any months enrolled in the Medicare Part D LIS.
- Medicare and Medicaid dual eligibility flag: Indicates whether the beneficiary had any months in which they were dually eligible for Medicare and Medicaid in the 12-month period provided in the parameters. Possible values: 1 = had one or more months dually eligible for Medicare and Medicaid; 0 = did not have any months dually eligible for Medicare and Medicaid.
- Person years enrolled in Medicare Part D LIS or dually eligible for Medicare and Medicaid: Represents the number of months the beneficiary was enrolled in the Medicare Part D LIS or dually eligible for Medicare and Medicaid in the 12-month period provided in the parameters, divided by 12 (i.e., person years are person months divided by 12).
- Total person years: Represents the number of months the beneficiary was alive and eligible for assignment to the Shared Savings Program (per § 425.401) in the 12-month period provided in the parameters, divided by 12 (i.e., person years are person months divided by 12).

For all ACOs, regardless of assignment methodology and regardless of the report run, the 12-month period used to determine the measures in ALR Table 1-9 and provided in the parameters will always correspond to the assignment window used for preliminary prospective ACOs.

2 Assignment Summary Report

This section provides details on the tables included in the ASR provided to ACOs. An ACO will receive these tables if it elected to receive, and is eligible to receive, beneficiary-identifiable data.

The ASR is formatted to have a consistent set of report fields and footnotes sent to ACOs throughout the performance year, separated by ACO assignment methodology. Some of the information in Tables 2-1A and 2-1B is populated only during certain report runs.

2.1 TABLE 2-1: BENEFICIARY ASSIGNMENT SUMMARY

This table contains summary information on the number of beneficiaries assigned to the ACO either through voluntary alignment only, claims-based assignment only, or both voluntary alignment and claims-based assignment. The table includes total assigned beneficiaries, which equals the sum of beneficiaries assigned to the ACO through voluntary alignment only, claims-based assignment only, and both claims-based assignment and voluntary alignment. Voluntarily aligned beneficiaries, as shown in Table 2-1A (Voluntarily Aligned Beneficiaries and Exclusions), equals the sum of voluntarily aligned-only beneficiaries and claims-based assigned and voluntarily aligned beneficiaries from Table 2-1. Claims-based assigned beneficiaries, as shown in Table 2-1B (Claims-Based Assigned Beneficiaries and Exclusions), equals the sum of claims-based assigned-only beneficiaries and claims-based assigned and voluntarily aligned beneficiaries from Table 2-1.

2.1.1 TABLE 2-1A: VOLUNTARILY ALIGNED BENEFICIARIES AND EXCLUSIONS

Table 2-1A includes summary information on beneficiaries assigned to the ACO through voluntary alignment and beneficiaries who selected a primary clinician that is an ACO professional but were excluded from voluntary alignment.

For the initial assignment ASRs, the table identifies the total number of beneficiaries who selected a primary clinician in the ACO. The table also includes summary information on beneficiaries excluded for not meeting assignment eligibility requirements during the prospective assignment window. For quarterly and annual reports, the table identifies the number of prospectively voluntarily aligned beneficiaries and summary information on beneficiaries excluded for not meeting assignment eligibility requirements during the report period.

ASR Table 2-1A is split into two sections: Part I and Part II. Part I contains data for the list of initial prospectively assigned beneficiaries, and Part II contains data for the current list of voluntarily aligned beneficiaries.

ASR Table 2-1A is populated in the following way during the report runs listed:

- ACOs under preliminary prospective assignment:
 - Part I is populated in the Initial ASR and remains static throughout the performance year, including Quarterly and Financial Reconciliation informational reports.
 - Populated for Historical Benchmark informational reports for each benchmark year and reflects the final count of voluntarily aligned beneficiaries for the benchmark year.

- The row *Other reasons* in Part I is not populated in Historical Benchmark informational reports.
- Part II is not populated for the Initial Assignment Summary or Historical Benchmark informational reports. Part II is populated for Quarterly and Financial Reconciliation informational reports using the most recently available data.
- ACOs under prospective assignment:
 - Part I is populated in the Initial ASR and remains static throughout the performance year, including Quarterly and Financial Reconciliation informational reports.
 - The rows Beneficiaries Who Died Prior to Start of the Performance Year and Currently Prospectively Voluntarily Aligned Beneficiaries are only populated for Initial Prospective ASRs.
 - These rows are not populated for Quarterly, Historical Benchmark, and Financial Reconciliation informational reports.
 - The row *Other reasons* is not populated in Historical Benchmark informational reports
 - Part II is not populated for initial prospective ASRs. Part II is populated for Quarterly and Financial Reconciliation reports using the most recently available data.
 - Part I and Part II are populated for Historical Benchmark informational reports for each benchmark year and reflect the final count of voluntarily aligned beneficiaries for the benchmark year.

The assignment eligibility requirements used to exclude beneficiaries during the report period include the following:

- Beneficiary had at least one month of Part A–only or Part B–only coverage. To be eligible for assignment through voluntary alignment, beneficiaries must have both Part A and B coverage for at least one month during the report period and no months of Part A–only or Part B–only.
- Beneficiary had at least one month in a Medicare health plan. Such plans include Medicare Advantage plans, cost plans under Section 1876 of the Social Security Act, and Program of All-Inclusive Care for the Elderly programs. Enrollment is identified using Medicare enrollment records.
- Beneficiary had non-U.S. residence in the last available month of the report period. U.S. residents are defined by State Codes 01–53 (the 50 states, the District of Columbia, the U.S. Virgin Islands, and Puerto Rico), 98 or 65 (Guam), 99 with

000 county code or 64 with any county code (American Samoa), or 97 with any county code or 63 with county code 050 (Northern Marianas).

- Beneficiary is aligned to another Medicare shared savings initiative (e.g., the Financial Alignment Initiative; Vermont All-Payer ACO Model; ACO Realizing Equity, Access, and Community Health (REACH) Model; and Comprehensive Kidney Care Contracting Options).

A beneficiary may be excluded from assignment for more than one reason. Therefore, the sum of the excluded beneficiaries in all categories may not equal the total excluded beneficiaries. The number of beneficiaries with a primary clinician selection minus the number of beneficiaries excluded for any of the reasons listed above equals the total number of prospectively voluntarily aligned beneficiaries.

Voluntarily aligned beneficiaries who died before the report period are excluded from assignment to the ACO.

2.1.2 TABLE 2-1B: CLAIMS-BASED BENEFICIARY ASSIGNMENT AND EXCLUSIONS

Table 2-1B includes summary information on beneficiaries eligible to be assigned through the two-step claims-based assignment process, those actually assigned, and those excluded from assignment to the ACO for the 12-month claims-based beneficiary assignment window. First, the table identifies the total number of beneficiaries eligible for assignment (i.e., beneficiaries assignable to the ACO), who are beneficiaries with at least one primary care service from a qualifying physician. Qualifying physicians must have a specialty used in assignment and be participating in the ACO, as identified by physician specialty codes in [Appendix Table 4](#). Table 1-6 of the ALR, which is made available to ACOs under preliminary prospective assignment, lists assignable beneficiaries.

The table then shows the number of beneficiaries assignable to the ACO who are eligible for assignment under each step, depending on whether or not the beneficiary had a primary care service from a qualifying physician in the 12-month claims-based beneficiary assignment window.

For prospective ACOs, Part I of Table 2-1B shows the number of beneficiaries eligible for assignment who were prospectively claims-based assigned and the number of beneficiaries who were excluded for Step 1, Step 2, and Total. Part II of Table 2-1B shows the number of the beneficiaries who were eligible for final assignment and the number of beneficiaries who were excluded in each step.

For preliminary prospective ACOs, there is no distinction between Part I and Part II. This table shows the claims-based assigned beneficiaries less the beneficiaries excluded for Step 1, Step 2, and Total.

ASR Table 2-1B is populated in the following way during the report runs listed:

- ACOs under preliminary prospective assignment: This table is populated in full for all report runs: Initial ASR, Historical Benchmark informational reports, Financial Reconciliation informational reports, and quarterly reports.
- ACOs under prospective assignment:
 - Part I is populated in the Initial ASR and remains static throughout the performance year, including Quarterly and Financial Reconciliation informational reports.
 - The rows Beneficiaries Who Died Prior to Start of the Performance Year and Currently Prospectively Claims-Based Assigned Beneficiaries are only populated for Initial Prospective ASRs.
 - These rows are not populated for Quarterly, Historical Benchmark and Financial Reconciliation informational reports.
 - Part II is not populated for Initial Prospective ASRs. Part II is populated for Quarterly and Financial Reconciliation informational using the most recently available data.
 - Part I and Part II are populated for Historical Benchmark informational reports for each benchmark year and reflect the final count of claims-based assigned beneficiaries for the benchmark year.

Table 2-1B further breaks down the excluded beneficiaries by criterion:

- The ACO did not provide a plurality (based on allowed charges) of primary care services defined by those HCPCS and/or revenue center codes in [Appendix Table 3](#). CMS applies the plurality rule for claims-based assignment to the ACO using the two-step assignment process described in Section 1 of this guide.
- Beneficiary had at least one month of Part A-only or Part B-only coverage. To be eligible for assignment through claims, beneficiaries must have both Part A and B coverage for at least one month during the claims-based beneficiary assignment window and no months of Part A-only or Part B-only.
- Beneficiary had at least one month in a Medicare health plan. Such plans include Medicare Advantage plans, cost plans under Section 1876 of the Social Security Act, and Program of All-Inclusive Care for the Elderly programs. Enrollment is identified using Medicare enrollment records.
- Beneficiary had non-U.S. residence in the last available month of the claims-based beneficiary assignment window. U.S. residents are defined by State Codes 01–53 (the 50 states, the District of Columbia, the U.S. Virgin Islands, and Puerto Rico), 98 or 65 (Guam), 99 with 000 county code or 64 with any county

code (American Samoa), and 97 with any county code or 63 with county code 050 (Northern Marianas).

- Beneficiary is assigned to a Shared Savings Program ACO under prospective assignment (for ACOs under preliminary prospective assignment only). A beneficiary who is prospectively assigned for a given performance or benchmark year cannot be assigned to an ACO under preliminary prospective assignment in an overlapping performance or benchmark year. For example, a beneficiary prospectively assigned to an ACO under prospective assignment with a January 2023 start date for PY 2023 (Calendar Year 2023, with a claims-based beneficiary assignment window of October 1, 2021–September 30, 2022) cannot also be assigned to an ACO under preliminary prospective assignment for PY 2023 (with a final, retrospective claims-based beneficiary assignment window of January 1, 2023–December 31, 2023).
- Beneficiary is aligned to another Medicare shared savings initiative (e.g., the Financial Alignment Initiative; Vermont All-Payer ACO Model; ACO Realizing Equity, Access, and Community Health (REACH) Model; and Comprehensive Kidney Care Contracting Options).
- Beneficiary had a voluntary alignment selection outside the ACO. Because voluntary alignment takes precedence over claims-based assignment, the beneficiary would not be claims-based assigned to the ACO if the beneficiary had a voluntary alignment selection with another ACO or a non-ACO TIN.
- Beneficiary excluded for any other reason not listed above. Beneficiaries who were previously voluntarily aligned and excluded cannot be reassigned to the ACO through claims-based assignment and may be reflected in this count.

A beneficiary may be excluded from assignment for more than one reason. Therefore, the sum of the excluded beneficiaries in all categories may not equal the total excluded beneficiaries. After excluding these beneficiaries from the total assignable population, CMS reaches the total claims-based assigned population. The claims-based assigned beneficiaries total equals the sum of claims-based assigned–only beneficiaries and claims-based assigned and voluntarily aligned beneficiaries from Table 2-1. Users of the reports can also find a full list of claims-based assigned beneficiaries in Table 1-1 of their ALR; these are beneficiaries with a flag of 1 for claims-based assignment.

For quarterly and annual performance year ASRs for ACOs under prospective assignment, Table 2-1B first identifies the ACO's original number of prospectively claims-based assigned beneficiaries, the number of prospectively assigned beneficiaries who died before the report period, the total number of beneficiaries who were excluded during the quarterly YTD or calendar year report period, the number of beneficiaries excluded because they meet exclusion criteria,⁶ and the number of currently assigned beneficiaries. The number of current claims-based assigned

⁶ As specified under § 425.401(b).

beneficiaries is equal to the number of prospectively assigned beneficiaries minus those who died before the performance year minus the total number excluded during the report period.

2.2 TABLE 2-4: DEMOGRAPHIC AND ELIGIBILITY CHARACTERISTICS OF TOTAL ASSIGNED BENEFICIARIES

This table provides summary demographic and eligibility information on the assigned beneficiary population during the assignment window. CMS provides the number of assigned beneficiaries who died during this period (date of death in the period) and the number of assigned beneficiaries who survived (alive at the end of the period). For ACOs under prospective assignment, prospectively assigned beneficiaries who died before the performance year are already removed from the total number of assigned beneficiaries reported in this table and are thus not included in the count of beneficiaries who died in Table 2-4.

CMS also distinguishes beneficiaries by Medicare enrollment type, specifically ESRD, disabled, and aged. Each enrollment type is broken out by dual eligible status and non-dual eligible status. Dual eligible status and non-dual eligible status are also broken out for all beneficiaries regardless of Medicare enrollment type. CMS derives beneficiary Medicare enrollment type on a monthly basis using Medicare and Medicaid status codes and the “Age” variable from Medicare enrollment records. A beneficiary who has at least one instance of dialysis coverage or kidney transplant coverage within a given current month has “ESRD” status for that month. A beneficiary has “disabled” status in a given month if “Age” is less than 65 and that beneficiary does not have ESRD status for that month. A beneficiary has “aged” status if that beneficiary’s “Age” variable is greater than or equal to 65 in a given month and that beneficiary does not have ESRD status for that month. Dual eligibility status is also derived monthly. Dually eligible beneficiaries are categorized according to CMS’ definitions of Medicare-Medicaid enrollees, including

- Qualified Medicare Beneficiaries (QMBs) (referred to as having “partial benefit”; dual status code 01),
- QMBs plus full Medicaid or QMB-Plus (referred to as having “full benefit”; dual status code 02),
- Specified Low-Income Medicare Beneficiaries (SLMB) Plus full Medicaid or SLMB-Plus (dual status code 04), or
- Other full benefit dual eligible/Medicaid-only dual eligible (dual status code 08).

CMS calculates the ACO’s person years in each enrollment type category (ESRD dual and non-dual, disabled dual and non-dual, and aged dual and non-dual) by summing the number of assigned beneficiary person months in each category for the ACO and dividing by 12. CMS calculates the ACO’s person years for dual status and non-dual

status irrespective of enrollment type category by summing the number of assigned beneficiary person months with dual status (ESRD dual, disabled dual, and aged dual) or non-dual status (ESRD non-dual, disabled non-dual, and aged non-dual) and dividing by 12.

CMS also provides the number of the ACO's assigned beneficiaries in hospice status, determined by whether a beneficiary began hospice coverage during the report period.

CMS provides the number of the ACO's assigned beneficiaries in long-term institutionalized (LTI) status, determined by whether a beneficiary was classified as long-term institutionalized for at least 1 month during the report period. Monthly LTI status is applicable to beneficiaries who have been in a nursing facility for at least 3 months and is triggered by a quarterly, annual, or significant change in status assessment required for nursing facility residents. This field is only populated for historical benchmark and financial reconciliation reports.

The table shows the number of assigned beneficiaries broken out by sex, age, and race. On Table 1 of the ALR, some beneficiaries may have a flag of 0, indicating that their sex is listed as unknown. These beneficiaries are not included in the total for sex listed in ASR Table 2-4, which only includes beneficiaries with "male" and "female" responses.

CMS breaks out age into less than 65 years of age, 65–74 years, 75–84 years, and greater than 85 years of age. For this table, CMS defines age as of the first day of the second month of the report period.

CMS provides the aggregate count of beneficiaries by race. For this table, CMS defines race as Unknown, White, Black, Other, Asian, Hispanic, North American Native, or Missing, using the most recently available data from the Social Security Administration.

For quarterly and annual performance year ASRs for ACOs under prospective assignment, Table 2-4 reflects demographic and eligibility characteristics of currently assigned beneficiaries (refer to [Section 2.1](#)) during the quarterly YTD or calendar year report period.

Table 2-4 also includes the median value for all Shared Savings Program ACOs for each of the categories in this table. The column represents an unweighted median percentage value for all Shared Savings Program ACOs in specified assignment methodologies active at the time the report is run. For this column, the medians for each row are calculated separately. Therefore, totals for each section—including beneficiary person years by enrollment type, hospice status, sex, and age—may not add up to 100 percent.

2.3 TABLE 2-5: DISTRIBUTION OF TOTAL ASSIGNED BENEFICIARY RESIDENCE BY COUNTY

This table provides the distribution of assigned beneficiaries by county and state of residence, determined by the five-digit Social Security Administration code (with the first two digits representing the state code and the last three digits representing the county code). County of residence is based on the most recently available month of data in the report period. The table shows the number and percentage of assigned beneficiaries residing in each county where at least 1 percent of the ACO's assigned beneficiaries reside. The table also shows the total number of assigned beneficiary person years and the number of person years by enrollment type for each of these counties. CMS aggregates the number of beneficiaries residing in counties with fewer than 1 percent of assigned beneficiaries into a single line in the static Excel report the ACO receives. To replicate Table 2-5 including counties with less than one percent of assigned beneficiaries, ACOs may use the data provided in ALR Table 1-1, which includes all beneficiaries assigned to the ACO, to determine the total number of beneficiaries by county and the person years by enrollment type at the county-level. ACOs should use the "STATE_COUNTY_CD" variable in ALR Table 1-1 to determine a beneficiary's county and the monthly eligibility flags ("EnrollFlag1" through "EnrollFlag12") to calculate the person years by enrollment type for each assigned beneficiary. Person years are calculated by taking the sum of months with a particular eligibility flag and dividing by 12 (e.g., 6 months of ESRD eligibility corresponds to 0.5 ESRD person years). ACOs can then aggregate the person years and beneficiaries by county.

For quarterly and annual performance year ASRs for ACOs under prospective assignment, Table 2-5 reflects the distribution of currently assigned beneficiaries (refer to [Section 2.1](#)) by county of residence during the most recently available month of data in the quarterly YTD or calendar year report period.

2.3.1 TABLE 2-5A: DISTRIBUTION OF TOTAL ASSIGNED BENEFICIARY RESIDENCE BY COUNTY, EXCLUDING COVID-19 EPISODES

Table 2-5A provides similar information as [Table 2-5](#), but excludes person months associated with a COVID-19 episode, as defined in the [COVID-19 PHE section](#). Specifically, beneficiary Medicare enrollment type excludes person months for the months associated with a COVID-19 episode from the calculations for the total number of assigned beneficiary person years and for the number of person years by enrollment type for each county where at least 1 percent of the ACO's assigned beneficiaries reside.

2.4 TABLE 2-6: FREQUENCIES AND RATES PER 10,000 BENEFICIARIES BY DISEASE GROUP (CMS-HCC) FOR TOTAL ASSIGNED BENEFICIARIES

This table provides the number of assigned beneficiaries and rate per 10,000 beneficiaries who have a CMS-HCC, as defined in the CMS-HCC model. CMS identifies payment HCCs included in the CMS-HCC model that it then uses to adjust Medicare capitation payments to Medicare Advantage health care plans for the health expenditure risk of their enrollees. The table shows the payment HCCs included in the V24 CMS-HCC model. CMS-HCC diagnostic categories use the most recently available HCCs used for final risk score data. The report parameters page will indicate the payment and diagnosis years of the CMS-HCC flags included in the report. Only assigned beneficiaries who have CMS-HCC flags in the final risk score file will be included in the HCC counts and rates; therefore, the number of beneficiaries in the table may vary from the total number of currently assigned beneficiaries reported in Table 2-1. Some beneficiaries who have CMS-HCC flags may be new enrollees who do not have 12 months of Part B enrollment in the year preceding the Medicare Advantage payment year (i.e., the diagnosis year); for these beneficiaries, the flags may be based on incomplete diagnosis information. A beneficiary with more than one disease within a CMS-HCC disease hierarchy (e.g., diabetes mellitus: CMS-HCCs 17–19) is assigned only to the CMS-HCC for the most severe manifestation of the related diseases. Beneficiaries who are found to have CMS-HCC flags in the risk score file but who have not been diagnosed with conditions included in the CMS-HCC diagnostic categories are indicated under the label “No HCCs.” CMS also provides an unweighted median of values for all Shared Savings Program ACOs in the specified assignment methodologies. Note that the aggregate number of assigned beneficiaries with each CMS-HCC shown in Table 2-6 aligns with the CMS-HCC data provided in ALR Table 1-1.

For quarterly and annual performance year ASRs for ACOs under prospective assignment, Table 2-6 reflects CMS-HCC frequencies and rates among currently assigned beneficiaries (refer to [Section 2.1](#)).

For additional information regarding the CMS-HCC model, please refer to [Medicare Risk Adjustment Information on cms.gov](#).

2.5 TABLE 2-7: PREVALENCE OF COVID-19 AMONG ACO ASSIGNED BENEFICIARIES

This table provides summary information on the total number of beneficiaries assigned to the ACO, total number and percentage of assigned beneficiaries with any COVID-19 diagnosis, and total number and percentage of assigned beneficiaries with a COVID-19 episode. This table also provides the total percentage of assigned beneficiaries with any COVID-19 diagnosis and the total percentage of assigned beneficiaries with a

COVID-19 episode for all Medicare Shared Savings Program ACOs. COVID-19 episodes and the associated diagnoses are described in the [COVID-19 PHE](#) section. Total assigned beneficiaries with a COVID-19 episode are a subset of the total assigned beneficiaries with any COVID-19 diagnosis, which are in turn a subset of the total assigned beneficiaries for the ACO. It should be noted that the fields associated with a COVID-19 diagnosis or COVID-19 episode are blank if the ACO does not have any assigned beneficiaries who meet these criteria.

The “Total Assigned with COVID-19 Diagnosis” number in ASR Table 2-7 corresponds to the number of unique beneficiary MBIs in ALR [Table 1-7](#) (Assigned Beneficiaries with COVID-19 Diagnoses and Excluded Months for COVID-19 Episodes). The “Total Assigned with COVID-19 Episode” number in ASR Table 2-7 corresponds to the number of unique beneficiary MBIs in ALR Table 1-7 where COVID19_EPISODE equals “1.”

2.6 TABLE 2-8: UTILIZATION OF PRIMARY CARE SERVICES BY ASSIGNED BENEFICIARIES, INCLUDING COVID-19 EPISODES

This table describes utilization of primary care services, inclusive of the months associated with COVID-19 episodes (defined in the [COVID-19 PHE](#) section), for the ACO’s assigned beneficiaries and for all Shared Savings Program ACOs during the report period. The values for all Shared Savings Program ACOs represent the unweighted median of values for all currently active Shared Savings Program ACOs under the assignment methodology at the time the report was run. The table includes the utilization rates per 1,000 person years and the total number of primary care services provided during the report period, including the months associated with COVID-19 episodes.

Further detail on total utilization is provided by two subcategories of primary care services:

- Primary care services defined by the following CPT/HCPCS codes:
 - 96160–96161, 99201–99205, 99211–99215, 99304–99306, 99307–99310, 99315–99316, 99318, 99324–99328, 99334–99337, 99339–99340, 99341–99345, 99347–99350, 99354–99355, 99421–99427, 99437, 99439, 99483, 99484, 99487, 99489, 99490, 99491, 99492–99494, 99495–99496, 99497–99498, G0402, G0438, G0439, G0442–G0444, G0463 (for ETA hospitals), G0506, G2010, G2012, G2058, G2064, G2065, G2212, G2214, and G2252.^{7, 8, 9}

⁷ For FQHCs/RHCs, CMS treats a service reported on an FQHC/RHC claim as a primary care service performed by a primary care physician, and these services are included in Claims-Based Assignment Step 1.

⁸ For professional services or services reported on an FQHC or RHC claim, primary care services with codes 99304–99306, 99307–99310, 99315–99316, and 99318 are excluded when furnished in a SNF.

⁹ For professional services, primary care services with codes 99497 and 99498 are excluded when furnished in an inpatient care setting.

- Primary care services that meet the above criteria for CPT/HCPCS codes and are provided via telehealth are also described in the table based on the presence of following telehealth modifiers:
 - Place of Service (POS) 02, POS 10 (effective April 4, 2022), or Modifier 93 or 95 for Part B claims;
 - Modifier 93 or 95 for ETA, Method II CAHs, FQHCs, and RHCs; and
 - HCPCS code G2025 for FQHCs/RHCs.

Refer to the CY 2021 PFS final rule (Section III.G.5.e.). Under this provision, the CPT codes and HCPCS codes included in the applicable definition of primary care services at § 425.400(c)(1) will continue to apply for purposes of determining beneficiary assignment under § 425.402. For the performance year starting on January 1, 2021, and subsequent performance years, CMS has amended the definition of primary care services to permanently include CPT codes and HCPCS codes: 99421, 99422, 99423, G2010, and G2012. Despite this change, CPT/HCPCS codes G2010, G2012, 99421, 99422 and 99423 will continue to be excluded from the counts of “Primary Care Services based on the CPT/HCPCS codes included in the parameters tab” and will instead be presented in “Primary Care Services based on the CPT/HCPCS codes included in the May 8th COVID-19 IFC.” As a result, the rows in this table will remain mutually exclusive and support ACO efforts to monitor telehealth and Primary Care Services specifically associated with the COVID-19 PHE.

Refer to the CY 2022 PFS final rule (Section III.J.2.b.). According to § 425.400(c)(2)(i)(A)(2), when the assignment window (as defined in § 425.20) for a benchmark or performance year includes any month(s) during the COVID-19 Public Health Emergency defined in § 400.200, in determining beneficiary assignment, 99441, 99442, and 99443 (codes for telephone evaluation and management services) are used in determining beneficiary assignment as specified in § 425.400(c)(2)(i) and § 425.400(c)(2)(ii) and until they are no longer payable under Medicare fee-for-service payment policies as specified under Section 1834(m) of the Act and §§ 410.78 and 414.65 of this subchapter.

2.7 TABLE 2-9: DISTRIBUTION OF TOTAL ASSIGNED BENEFICIARIES BY INDICATORS OF UNDERSERVED POPULATIONS

This table provides an ACO-level summary of indicators of underserved populations. This table provides information on data that will be used to calculate the HEA that will be added to the MIPS Quality performance category score for eligible ACOs, beginning PY 2023 (refer to 42 CFR 425.512[b]). Specifically, the HEA includes an underserved multiplier based on the ACO's assigned beneficiary population for the PY, which is considered underserved based on the highest of (1) the proportion of the ACO's assigned beneficiaries residing in a census block group with an ADI national percentile rank of at least 85, or (2) the proportion of the ACO's assigned beneficiaries.

Table 2-9 shows the distribution of assigned beneficiaries residing in a census block group with ADI national percentile rank of at least 85 or in a census block group with ADI national percentile rank below 85. Beneficiaries who have missing or suppressed national percentile rank data are excluded from the counts and percentages presented in this table.

This table also shows the distribution of assigned beneficiaries based on enrollment in the Medicare Part D LIS or dual eligibility for Medicare and Medicaid. Enrolled in LIS or Dual Eligible is the number of beneficiaries that were enrolled in Medicare Part D LIS or dually eligible for Medicare and Medicaid in the 12-month period provided in the parameters. Not Enrolled in LIS or Dual Eligible is the number of beneficiaries that were not enrolled in Medicare Part D LIS and not dually eligible for Medicare and Medicaid.

Beneficiary-level information on the ADI national percentile rank, Medicare Part D LIS enrollment, and dual eligibility for Medicare and Medicaid that underlie this table are provided in Assignment List Report Table 1-9.

Appendix

Preliminary Prospective Assignment

Table 1. Selected Characteristics of Medicare Shared Savings Program Reports for Accountable Care Organizations (ACOs) Under Preliminary Prospective Assignment

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	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

NOTE: Preliminary historical benchmark reports use less than 3 months of run-out for the 3rd benchmark year. Depending on the run-out time, CMS uses a completion factor of 1.013 or 1.072. N/A = not applicable. Expenditures and utilization are not included in all reports, and a completion factor is not used for utilization rates.

Prospective Assignment

Table 2. Selected Characteristics of Medicare Shared Savings Program Reports for ACOs Under Prospective Assignment

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 window	Prospective assignment window	Prospective assignment window	Prospective assignment window	Prospective assignment window
Assignment exclusion dates of service	Calendar YTD	Calendar year	Calendar YTD	Calendar year	Calendar year
Expenditure completion factors	N/A	N/A	Q1: 1.349 Q2: 1.154 Q3: 1.105 Q4: 1.072	1.013	1.013
Medicare enrollment type determined	Monthly	Monthly	Monthly	Monthly	Monthly

NOTE: Beneficiaries are excluded from the prospective assignment lists on a quarterly basis and annually prior to financial reconciliation based on select assignment exclusion criteria. The 3 months claims run-out is used for prospective ACOs when determining financial reconciliation and historical benchmark expenditures, eligibility, and utilization, whereas assignment for prospective ACOs is based on the latest data available at the time of the assignment run prior to the start of the performance year. N/A = not applicable. Expenditures and utilization are not included in all reports, and a completion factor is not used for utilization rates.

Primary Care and Specialty Codes Used in Assignment

According to § 425.20, “primary care services” means the set of services identified by the HCPCS and revenue center codes designated under § 425.400(c). Table 3 lists the primary care service codes (HCPCS and CPT codes), according to § 425.400(c)(1)(viii), for purposes of assigning beneficiaries for the performance year starting on January 1, 2024, and subsequent performance years. According to § 425.404(b), for performance years starting on January 1, 2019, and subsequent performance years, a service reported on an FQHC/RHC claim is treated as a primary care service performed by a primary care physician. For services billed under the Physician Fee Schedule (including by Method II CAHs, and ETA hospitals), “primary care services” as defined according to § 425.20, include services identified by the HCPCS/CPT codes specified in Table 3.

Table 3. Primary care service codes for purposes of assigning beneficiaries according to § 425.400(c)(1)(viii)

PRIMARY CARE SERVICE CODES
96160 Administration of Health Risk Assessment
96161 Administration of Health Risk Assessment
96202 Caregiver Behavior Management Training
96203 Caregiver Behavior Management Training
97550 Caregiver Training Services
97551 Caregiver Training Services
97552 Caregiver Training Services
99201 New Patient, brief (office or other outpatient visit for the evaluation and management of a patient)
99202 New Patient, limited (office or other outpatient visit for the evaluation and management of a patient)
99203 New Patient, moderate (office or other outpatient visit for the evaluation and management of a patient)
99204 New Patient, comprehensive (office or other outpatient visit for the evaluation and management of a patient)
99205 New Patient, extensive (office or other outpatient visit for the evaluation and management of a patient)
99211 Established Patient, brief (office or other outpatient visit for the evaluation and management of a patient)
99212 Established Patient, limited (office or other outpatient visit for the evaluation and management of a patient)
99213 Established Patient, moderate (office or other outpatient visit for the evaluation and management of a patient)
99214 Established Patient, comprehensive (office or other outpatient visit for the evaluation and management of a patient)
99215 Established Patient, extensive (office or other outpatient visit for the evaluation and management of a patient)
99304 New or Established Patient, brief (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99305 New or Established Patient, moderate (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99306 New or Established Patient, comprehensive (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)

PRIMARY CARE SERVICE CODES

99307 New or Established Patient, brief (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99308 New or Established Patient, limited (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99309 New or Established Patient, comprehensive (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99310 New or Established Patient, extensive (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99315 New or Established Patient, brief (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99316 New or Established Patient, comprehensive (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99318 New or Established Patient (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99324 New Patient, brief (patient domiciliary, rest home, or custodial care visit)
99325 New Patient, limited (patient domiciliary, rest home, or custodial care visit)
99326 New Patient, moderate (patient domiciliary, rest home, or custodial care visit)
99327 New Patient, comprehensive (patient domiciliary, rest home, or custodial care visit)
99328 New Patient, extensive (patient domiciliary, rest home, or custodial care visit)
99334 Established Patient, brief (patient domiciliary, rest home, or custodial care visit)
99335 Established Patient, moderate (patient domiciliary, rest home, or custodial care visit)
99336 Established Patient, comprehensive (patient domiciliary, rest home, or custodial care visit)
99337 Established Patient, extensive (patient domiciliary, rest home, or custodial care visit)
99339, brief (patient domiciliary, rest home, or custodial care visit)
99340, comprehensive (patient domiciliary, rest home, or custodial care visit)
99341 New Patient, brief (evaluation and management services furnished in a patient's home)
99342 New Patient, limited (evaluation and management services furnished in a patient's home)
99343 New Patient, moderate (evaluation and management services furnished in a patient's home)
99344 New Patient, comprehensive (evaluation and management services furnished in a patient's home)
99345 New Patient, extensive (evaluation and management services furnished in a patient's home)
99347 Established Patient, brief (evaluation and management services furnished in a patient's home)
99348 Established Patient, moderate (evaluation and management services furnished in a patient's home)
99349 Established Patient, comprehensive (evaluation and management services furnished in a patient's home)
99350 Established Patient, extensive (evaluation and management services furnished in a patient's home)
99354 Prolonged Services with Direct Patient Contact (prolonged evaluation and management or psychotherapy services beyond the typical service time of the primary procedure)
99355 Prolonged Services with Direct Patient Contact (prolonged evaluation and management or psychotherapy services beyond the typical service time of the primary procedure)
99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

PRIMARY CARE SERVICE CODES	
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
99422	Online Digital Evaluation and Management Service, 11-20 minutes (online digital evaluation and management)
99423	Online Digital Evaluation and Management Service, 21 or more minutes (online digital evaluation and management)
99424	Principal Care Management (PCM) Services
99425	Principal Care Management (PCM) Services
99426	Principal Care Management (PCM) Services
99427	Principal Care Management (PCM) Services
99437	Chronic Care Management (CCM) Services
99439	Non-Complex Chronic Care Management Services
99441	Telephone Evaluation and Management Service, 5-10 minutes of Medical Discussion
99442	Telephone Evaluation and Management Service, 11-20 minutes of Medical Discussion
99443	Telephone Evaluation and Management Service, 21-30 minutes of Medical Discussion
99483	Assessment and Care Planning for Patients with Cognitive Impairment
99484	General Behavioral Health Integration Care Management (behavioral health integration services)
99487	Complex Chronic Care Management Service
99489	Complex Chronic Care Management Service
99490	Non-Complex Chronic Care Management Service
99491	Non-Complex Chronic Care Management Service
99492	Behavioral Health Integration (behavioral health integration services)
99493	Behavioral Health Integration (behavioral health integration services)
99494	Behavioral Health Integration (behavioral health integration services)
99495	Transitional Care Management Services
99496	Transitional Care Management Services
99497	Advance Care Planning (professional services identified by this code furnished in an inpatient care setting are excluded)
99498	Advance Care Planning (professional services identified by this code furnished in an inpatient care setting are excluded)
G0019	Community Health Integration Services
G0022	Community Health Integration Services
G0023	Principal Illness Navigation Services
G0024	Principal Illness Navigation Services
G0101	Cervical or Vaginal Cancer Screening
G0136	Social Determinants of Health Risk Assessment Services
G0317	Prolonged Nursing Facility Evaluation and Management Service
G0318	Prolonged Home or Residence Evaluation and Management Service
G0402	Welcome to Medicare Visit
G0438	Annual Wellness Visit

PRIMARY CARE SERVICE CODES

G0439 Annual Wellness Visit
G0442 Annual Alcohol Misuse Screening Service
G0443 Annual Alcohol Misuse Counseling Service
G0444 Annual Depression Screening Service
G0463 Hospital Outpatient Clinic Visit (for services furnished in ETA hospitals; refer to note below)
G0506 Chronic Care Management
G2010 Remote Evaluation of Patient Video/Images
G2012 Virtual Check-In
G2058 Non-Complex Chronic Care Management Service
G2064 Comprehensive Care Management Service (principal care management services)
G2065 Comprehensive Care Management Service (principal care management services)
G2086 Office-Based Opioid Use Disorder Services, at least 70 minutes in the first calendar month
G2087 Office-Based Opioid Use Disorder Services, at least 60 minutes in a subsequent calendar month
G2088 Office-Based Opioid Use Disorder Services, each additional 30 minutes above 120 minutes
G2211 Complex Evaluation and Management Services Add-on
G2212 Prolonged Office or Other Outpatient Evaluation and Management Services
G2214 Psychiatric Collaborative Care Model
G2252 Communication Technology-Based Services (CTBS)
G3002 Chronic Pain Management and Treatment
G3003 Chronic Pain Management and Treatment (additional 15 minutes)

NOTE: Table 3 contains all codes in ranges specified in § 425.400(c)(1)(v) that are currently in use. G0463 has been used by hospital outpatient departments covered by Outpatient Prospective Payment System (OPPS) (bill type 13X) since January 1, 2014; for Shared Savings Program assignment purposes, it is used only for ETA hospitals.

According to § 425.400(c)(1)(v)(A)(3), for the performance year starting on January 1, 2021, and subsequent performance years, professional services or services reported on an FQHC or RHC claim identified by CPT codes 99304 through 99318 are excluded when furnished in a SNF. Operationally, the exclusion occurs when the following conditions are met (85 FR 84755 and 84756):

- (1) Either a professional service is billed under CPT codes 99304 through 99318 or an FQHC/RHC submits a claim including a qualifier CPT code 99304 through 99318; and*
- (2) A SNF facility claim is in our claims files with dates of service that overlap with the date of service for the professional service or FQHC/RHC service.*

According to § 425.400(c)(1)(v)(A)(13), for the performance year starting on January 1, 2021, and subsequent performance years, CMS excludes from use in the assignment methodology advance care planning services claims billed under CPT codes 99497 and 99498 when such services identified by these codes are furnished in an inpatient care setting. Operationally, CMS will exclude advance care planning services claims billed under CPT codes 99497 and 99498 from use in the assignment methodology when there is an inpatient facility claim in CMS claims files with dates of service that overlap with the date of service for the professional service billed under CPT code 99497 or add-on code 99498 (85 FR 84754).

According to § 425.400(c)(2)(i)(A)(2), when the assignment window (as defined in § 425.20) for a benchmark or performance year includes any month(s) during the COVID-19 Public Health Emergency defined in § 400.200, in determining beneficiary assignment, 99441, 99442, and 99443 (codes for telephone evaluation and management services) are used in determining beneficiary assignment as specified in § 425.400(c)(2)(i) and § 425.400(c)(2)(ii) and until they are no longer payable under Medicare fee-for-service payment policies, as specified under Section 1834(m) of the Act and §§ 410.78 and 414.65 of this subchapter.

Physician Specialty Codes

Table 4. Physician Specialty Codes Used in Assignment

SPECIALTY CODE	DESCRIPTION	PRIMARY CARE PHYSICIAN (STEP 1)	PHYSICIAN SPECIALTIES USED IN ASSIGNMENT (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	No	Yes
70	Multispecialty clinic or group practice	No	Yes
79	Addiction medicine	No	Yes
82	Hematology	No	Yes
83	Hematology/oncology	No	Yes
84	Preventive medicine	No	Yes
86	Neuropsychiatry	No	Yes
90	Medical oncology	No	Yes
98	Gynecology/oncology	No	Yes

Non-Physician Specialty Codes

Table 5. 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

NOTE: Specialties included in this table are considered primary care providers for purposes of assignment and are included in Assignment Step 1.

Performance Year Reports

Table 6 provides a description of every report run provided to ACOs throughout the course of a given performance year. For each report run, Table 6 also provides details on the timing of the run, as well as the individual reports included in that run.

Table 6. List of Reports Provided for each Performance Year

REPORT	DESCRIPTION	TIMING ¹⁰	REPORTS PROVIDED	NAMING CONVENTION OF ZIP PACKAGES
Initial Assignment Reports (Preliminary Prospective / Prospective Assignment Reports)	Initial assignment list delivered to ACOs prior to the start of the new Performance Year (PY). These reports provide a list of the initially assigned beneficiary population to ACOs. ACOs under preliminary prospective assignment with retrospective reconciliation receive an assignment list that includes beneficiaries preliminarily prospectively assigned beneficiaries via claims-based assignment based on most recent data available and prospectively assigned beneficiaries as a result of voluntary alignment. These beneficiaries may not appear in subsequent assignment lists for report Runs later in the PY, because they can be excluded from assignment after the initial assignment run. For ACOs under prospective assignment, claims-based beneficiary assignment is determined prospectively at the beginning of each benchmark and PY based on the beneficiary's use of primary care services in the most recent 12 months for which data are available. Near the start of the PY, ACOs receive an assignment list that includes beneficiaries prospectively assigned via claims-based assignment and prospectively assigned beneficiaries as a result of voluntary alignment. Only ACOs receiving Advance Investment Payments for the PY will receive Beneficiary Advance Investment Payments (BAIP) and Advance Investment Payment Summary Reports (AIPSR).	Prior to the start of the Performance Year	- ALR - ASR - BAIP (if applicable) - AIPSR (if applicable)	HASSGN

¹⁰ Please consult the Shared Savings Program report schedule available on the [ACO-MS Knowledge Library](#) for more specific information on when reports will be released during the calendar year.

REPORT	DESCRIPTION	TIMING ¹⁰	REPORTS PROVIDED	NAMING CONVENTION OF ZIP PACKAGES
Preliminary and Adjusted Historical Benchmark Reports	CMS establishes an ACO's historical benchmark at the start of its first agreement period and resets (or rebases) the benchmark at the start of each subsequent agreement period (AP). The benchmark, whether initial or rebased, is based on the most recent three calendar years prior to the start of the ACO's current agreement period. The Historical Benchmark Reports show an ACO's calculated benchmark based on these three aforementioned years and all relevant data related to this calculation. CMS provides Preliminary Historical Benchmark Reports near the start of the first PY of the ACO's AP. Due to the timing of reports, certain data needed to calculate values for BY3 are not yet available and certain calculations for BY3 do not include the full 3 months of claims run out. Because of this, any ACO that receives a Preliminary Historical Benchmark will also receive a Final Historical Benchmark later in the year. The Final Historical Benchmark Report is described in a separate row of this table. For the second and each subsequent PY during the term of the AP, an ACO's historical benchmark is adjusted annually to account for the following, as applicable: 1) the addition and removal of ACO participants and ACO providers; 2) changes in CMS Certification Number (CCN) for a FQHC, RHC, Method II CAH, or ETA hospital enrolled under the TIN of an ACO participant (including all CCNs with a deactivated enrollment status); or 3) a change to the ACO's beneficiary assignment methodology selection, and for a change to the Shared Savings Program beneficiary assignment methodology. The ACO's historical benchmark may also be adjusted if there are regulatory changes to the Shared Savings Program's benchmarking methodologies. If there are no changes, the benchmark will not be adjusted. Informational reports are included as supplementary information that show the ACO's assigned populations, per capita expenditures, and utilization rates for each BY.	March of the Performance Year	▪ Informational Reports: ○ ALR for each BY ○ ASR for each BY ○ EXPU for each BY ○ BEUR for each BY ○ NCBP data files for each BY, if available ▪ Preliminary or Adjusted Historical Benchmark Report	BNMRK

REPORT	DESCRIPTION	TIMING ¹⁰	REPORTS PROVIDED	NAMING CONVENTION OF ZIP PACKAGES
Quarterly Reports	These reports are informational only and serve to provide ACOs with a snapshot of their beneficiary population and their associated expenditures and utilization rates. Only ACOs receiving Advance Investment Payments for the PY will receive BAIP and AIPSR reports. These files will only be present in Quarter 1 and Quarter 2 report packages.	After the end of every quarter	▪ ALR ▪ ASR ▪ EXPU ▪ BEUR ▪ NCBP data files ▪ BAIP (if applicable) ▪ AIPSR (if applicable)	QEXPU
Preliminary and Final Historical Benchmark Reports	ACOs who received Preliminary Historical Benchmark Reports in the spring of the PY (ACOs in the first PY of their AP) will receive Preliminary and Final Historical Benchmark Reports in the summer. ACOs that did not participate in their BY3 will receive a Final Historical Benchmark which contains a full 3 months of claims run out and all relevant data inputs. ACOs that participated in their BY3 will receive a Preliminary Historical Benchmark that contains a full 3 months of claims run out but will not contain all relevant data inputs for the Prior Savings Adjustment. Final Historical Benchmarks for these ACOs will be delivered in the fall and are described more fully below. Informational reports are included as supplementary information that show the ACO's assigned populations and per capita expenditures and utilization rates for each BY. All benchmark years are provided, although BY1 and BY2 informational reports match reports delivered during the Preliminary Historical Benchmark Reports run.	June of the PY	▪ Informational Reports: ○ ALR for each BY ○ ASR for each BY ○ EXPU for each BY ○ BEUR for each BY ○ NCBP data files for each BY, if available ▪ Final Historical Benchmark Report	BNMRK

REPORT	DESCRIPTION	TIMING ¹⁰	REPORTS PROVIDED	NAMING CONVENTION OF ZIP PACKAGES
Financial Reconciliation Settlement and Quality Performance Reports	The Financial Reconciliation Settlement and Quality Performance Report packages contain a Financial Reconciliation Settlement Report and a Quality Performance Report. The Financial Reconciliation Settlement report shows the ACO's historical benchmark, updated benchmark, and shared savings or losses calculation. The Quality Performance Report includes information on the Shared Savings Program Quality Performance Standard Score (30th percentile MIPS Quality Performance Category [QPC] Score) and the ACO Quality Performance Score used in financial reconciliation. This report is based on the final MIPS QPC Score from the MIPS Final Score preview period, prior to any MIPS targeted reviews or data suppression results. Informational reports are included as supplementary information that show the ACO's final assigned population and per capita expenditures and utilization rates. There are two versions of reports: the Embargoed report package and the Unembargoed report package. The embargoed report package contains all the reports listed under the "Reports Provided" column and are not publicly releasable. The Unembargoed Report Package contains the Unembargoed Financial Reconciliation Settlement Report and the Unembargoed Quality Performance Report.	Embargoed reports: late summer of the following calendar year. Unembargoed reports: late summer/early fall of the following calendar year.	▪ Informational Reports: ○ ALR ○ ASR ○ EXPU ○ BEUR ○ NCBP Data File ▪ Financial Reconciliation Settlement Report ▪ Quality Performance Report	STLMT
Final Historical Benchmark Report	Only ACOs who received a Preliminary Historical Benchmark Report in the summer will receive a Final Historical Benchmark Report in October. This Final Historical Benchmark Report will contain all relevant data inputs used to calculate an ACO's Prior Savings Adjustment.	October of the PY	▪ Final Historical Benchmark Report	BNMRK

Informational Reports for ACOs

Table 7 provides details on the informational reports provided to ACOs. For each informational report, Table 7 provides a reference to a detailed description of the report, the report runs that include the report, as well as the naming convention for the informational report based on the report run.

Table 7. List of Informational Reports

REPORT	DESCRIPTION OF REPORT	PROVIDED WITH	NAMING CONVENTION WITHIN ZIP PACKAGES
Assignment List Report (ALR)	See Section 1 of ALR/ASR User's Guide	Annual and quarterly report packages, except Unembargoed Financial Reconciliation	- Annual Reports (Initial Assignment, HBs, Financial Reconciliation): AALR - Quarterly: QALR
Assignment Summary Report (ASR)	See Section 2 of ALR/ASR User's Guide	Annual and quarterly report packages, except Unembargoed Financial Reconciliation	- Annual Reports (Initial Assignment, HBs, Financial Reconciliation): AASR - Quarterly: QASR
Expenditure and Utilization Report (EXPU)	See Section 2 of EXPU/BEUR/NCBP User's Guide	Annual and quarterly report packages, except Unembargoed Financial Reconciliation	- Annual Reports (HBs and Financial Reconciliation): AEXPU - Quarterly: QEXPU
Beneficiary Expenditure Utilization Report (BEUR)	See Section 3 of EXPU/BEUR/NCBP User's Guide	Annual and quarterly report packages, except Unembargoed Financial Reconciliation	- Annual Reports (HBs and Financial Reconciliation): ABEUR - Quarterly: QBEUR
Non-Claims Based Payments Data File (NCBP)	See Section 4 of EXPU/BEUR/NCBP User's Guide	Annual and quarterly report packages, except Unembargoed Financial Reconciliation	- Annual Reports (HBs and Financial Reconciliation): ANCBP - Quarterly: QNCBP
Advance Investment Payment Summary Report (AIPSR)	See AIP User's Guide	Initial Assignment, Quarter 1, and Quarter 2 report packages (if applicable)	Initial Assignment and Quarterly Reports: QAIPSR
Beneficiary Advance Investment Payment Report (BAIP)	See AIP User's Guide	Initial Assignment, Quarter 1, and Quarter 2 report packages (if applicable)	Initial Assignment and Quarterly Reports: QBAIP

Acronyms

Acronym	Definition
ACO	Accountable Care Organization
AIPSR	Advance Investment Payment Summary Report
ALR	Assignment List Report
ASR	Assignment Summary Report
BAIP	Beneficiary Advance Investment Payment
CAH	Critical Access Hospital
CCN	CMS Certification Number
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CPT	Current Procedural Terminology
CY	Calendar Year
ESRD	End-Stage Renal Disease
ETA	Electing Teaching Amendment
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
FR	Federal Register
HCC	Hierarchical Condition Categories
HCPSC	Healthcare Common Procedure Coding System
HICN	Health Insurance Claim Number
IFC	Interim Final Rule with Comment Period
IPPS	Inpatient Prospective Payment System
MBI	Medicare Beneficiary Identifier
NPI	National Provider Identifier
PFS	Physician Fee Schedule
PHE	Public Health Emergency
PY	Performance Year
QMB	Qualified Medicare Beneficiaries
RHC	Rural Health Clinic
SLMB	Specified Low-Income Medicare Beneficiaries
TIN	Taxpayer Identification Number
YTD	Year to Date