

**Table 2-6**  
**Medicare Shared Savings Program**  
**Frequencies and Rates per 10,000 Beneficiaries by Disease Group (CMS-HCC) for Assigned Beneficiaries**  
**ACO A#### [ACO Name]**  
**Year 20XX, Quarter X**  
[Table of Contents](#)

Assigned beneficiaries, total  
Assigned beneficiaries without HCC data<sup>1</sup>  
Assigned beneficiaries with HCC data (sample for this table)<sup>2</sup>

CMS-HCC <sup>4</sup>	CMS-HCC Label	ACO-Specific Assigned Beneficiaries		All MSSP ACOs <sup>3</sup>
		Beneficiaries <sup>5</sup>	Rate per 10,000	Rate per 10,000
--	No HCCs			
HCC1	HIV/AIDS			
HCC2	Septicemia/Shock			
HCC5	Opportunistic Infections			
HCC7	Metastatic Cancer and Acute Leukemia			
HCC8	Lung, Upper Digestive Tract, and Other Severe Cancers			
HCC9	Lymphatic, Head and Neck, Brain, and Other Major Cancers			
HCC10	Breast, Prostate, Colorectal and Other Cancers and Tumors			
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation			
HCC16	Diabetes with Neurologic or Other Specified Manifestation			
HCC17	Diabetes with Acute Complications			
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation			
HCC19	Diabetes without Complication			
HCC21	Protein-Calorie Malnutrition			
HCC25	End-Stage Liver Disease			
HCC26	Cirrhosis of Liver			
HCC27	Chronic Hepatitis			
HCC31	Intestinal Obstruction/Perforation			
HCC32	Pancreatic Disease			
HCC33	Inflammatory Bowel Disease			
HCC37	Bone/Joint/Muscle Infections/Necrosis			
HCC38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease			
HCC44	Severe Hematological Disorders			
HCC45	Disorders of Immunity			
HCC51	Drug/Alcohol Psychosis			
HCC52	Drug/Alcohol Dependence			
HCC54	Schizophrenia			
HCC55	Major Depressive, Bipolar, and Paranoid Disorders			
HCC67	Quadriplegia, Other Extensive Paralysis			
HCC68	Paraplegia			
HCC69	Spinal Cord Disorders/Injuries			
HCC70	Muscular Dystrophy			
HCC71	Polyneuropathy			
HCC72	Multiple Sclerosis			
HCC73	Parkinsons and Huntingtons Diseases			
HCC74	Seizure Disorders and Convulsions			
HCC75	Coma, Brain Compression/Anoxic Damage			
HCC77	Respirator Dependence/Tracheostomy Status			
HCC78	Respiratory Arrest			
HCC79	Cardio-Respiratory Failure and Shock			
HCC80	Congestive Heart Failure			
HCC81	Acute Myocardial Infarction			
HCC82	Unstable Angina and Other Acute Ischemic Heart Disease			
HCC83	Angina Pectoris/Old Myocardial Infarction			
HCC92	Specified Heart Arrhythmias			
HCC95	Cerebral Hemorrhage			
HCC96	Ischemic or Unspecified Stroke			
HCC100	Hemiplegia/Hemiparesis			
HCC101	Cerebral Palsy and Other Paralytic Syndromes			
HCC104	Vascular Disease with Complications			
HCC105	Vascular Disease			
HCC107	Cystic Fibrosis			
HCC108	Chronic Obstructive Pulmonary Disease			
HCC111	Aspiration and Specified Bacterial Pneumonias			
HCC112	Pneumococcal Pneumonia, Empyema, Lung Abscess			
HCC119	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage			
HCC130	Dialysis Status			

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**ACO A#### [ACO Name]**  
**Year 20XX, Quarter X**  
[Table of Contents](#)

Assigned beneficiaries, total  
Assigned beneficiaries without HCC data<sup>1</sup>  
Assigned beneficiaries with HCC data (sample for this table)<sup>2</sup>

CMS-HCC <sup>4</sup>	CMS-HCC Label	ACO-Specific Assigned Beneficiaries		All MSSP ACOs <sup>3</sup>
		Beneficiaries <sup>5</sup>	Rate per 10,000	Rate per 10,000
HCC131	Renal Failure			
HCC132	Nephritis			
HCC148	Decubitus Ulcer of Skin			
HCC149	Chronic Ulcer of Skin, Except Decubitus			
HCC150	Extensive Third-Degree Burns			
HCC154	Severe Head Injury			
HCC155	Major Head Injury			
HCC157	Vertebral Fractures without Spinal Cord Injury			
HCC158	Hip Fracture/Dislocation			
HCC161	Traumatic Amputation			
HCC164	Major Complications of Medical Care and Trauma			
HCC174	Major Organ Transplant Status <sup>6</sup>			
HCC176	Artificial Openings for Feeding or Elimination			
HCC177	Amputation Status, Lower Limb/Amputation Complications			

**NOTES:**

See note regarding HCCs in the Parameters Worksheet.

<sup>1</sup>Assigned beneficiaries without complete diagnosis information for the year in which the HCC diagnoses were based, that is, who do not have 12 months of both Part A and Part B Medicare enrollment, or who were not in the diagnoses file for the year in which the HCC diagnoses were based.

<sup>2</sup>Assigned beneficiaries who have complete diagnoses information for the year in which the HCC diagnoses were based.

<sup>3</sup>All MSSP ACOs column represents an unweighted median of values for all MSSP ACOs active at the time this report was run.

<sup>4</sup>A beneficiary with more than one disease within a CMS-HCC disease hierarchy (e.g., diabetes mellitus: HCCs 15–19) is assigned only to the CMS-HCC for the most severe manifestation of the related diseases. Diagnoses are the most recent available HCCs. The year of the HCCs and the year of the diagnoses on which the HCCs are based are shown in the Parameters Worksheet.

<sup>5</sup>Frequencies are the number of beneficiaries with each CMS-HCC, among assigned beneficiaries with HCC data. Beneficiaries may be counted in more than one CMS-HCC.

<sup>6</sup>Does not include kidney transplants.

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**ACO A#### [ACO Name]  
Report Period: Year XXX, Quarter X  
Aggregate Expenditure/Utilization Report  
Medicare Shared Savings Program  
Agreement Start Date: [Month], 1, 20XX  
Performance Year X**

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## Table of Contents

Glossary

Parameters

Table 1: Aggregate Expenditure/Utilization Report

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## Glossary

### Table of Contents

ACO	Accountable Care Organization
BETOS	Berenson-Eggers Type of Service
CMS	Centers for Medicare and Medicaid Services
DSH	Disproportionate Share Hospital
DO	Doctor of Osteopathy
Dual-eligible	Medicare beneficiaries whose Part B premium and cost-sharing amounts are paid by their states' Medicaid program (Qualified Medicare Beneficiaries or QMBs), including those who also have full Medicaid benefits including Rx coverage (QMB plus)
ESRD	End Stage Renal Disease
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
HCPCS	Healthcare Common Procedure Coding System
IME	Indirect Medical Education
Method II CAH	Method II Critical Access Hospital
MSSP	Medicare Shared Savings Program
OACT	CMS Office of the Actuary
Pass-throughs	For short-term, acute-care hospitals paid under Medicare's Inpatient Prospective Payment System (IPPS), some items are reimbursed on a pass-through basis instead of being included in their standard IPPS payments. Pass-throughs include, but are not limited to, direct medical education costs, kidney acquisition costs, and bad debts.
PY	Performance Year
RHC	Rural Health Clinic
UCC	Uncompensated care payments from Medicare paid to Medicare DSH hospitals

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## Parameters

### Table of Contents

#### Current Quarterly Report Period

Beneficiary Assignment Period	XX/XX/XXXX - XX/XX/XXXX
Claims Processed as of	XX/XX/XXXX
Claims Completion Factor	1.072
Date Produced	XX/XX/XXXX

This report is based on the Performance Year X ACO Participant List.

In determining expenditures for ACOs, Part A and B expenditures for services provided from April 1, 2013 onward will be adjusted to include the amount of payment withheld due to sequestration (e.g., 2 percent of the paid amount).

#### Annualized Expenditure Truncation Thresholds

ESRD	
Disabled	
Aged/Dual	
Aged/Non-Dual	

#### Definitions of Primary Care Services

The following HCPCS and/or revenue center codes identify primary care services:

99201–99205, 99211–99215; 99304–99306; 99307–99310; 99315–99316; 99318; 99324–99328, 99334–99337; 99339–99340; 99341–99345, 99347–99350; G0402, G0438, G0439.

For FQHC services furnished prior to 01/01/2011, includes HCPCS code G0402 or revenue center codes 0521, 0522, 0524, 0525.

For RHC services, includes HCPCS code G0402, G0438, G0439 or revenue center codes 0521, 0522, 0524, 0525.

#### Definitions of Providers

ACO Physician is defined as a MD/DO with CMS specialty codes 01–14; 16–18; 20–30; 33–34; 36–40; 44; 46; 66; 70; 72; 76–79; 81–86; 90–94; 98–99; C0.

ACO Professional is defined as an ACO physician or nurse practitioner, physician assistant, or clinical nurse specialist with CMS specialty codes: 50 (nurse practitioner), 89 (clinical nurse specialist), 97 (physician assistant).

#### Definitions of (Berenson-Eggers) Type of Service (BETOS) Categories for Part B Physician/Supplier Expenditures

Evaluation and Management includes BETOS codes M1A, M1B, M2A, M2B, M2C, M3, M4A, M4B, M5A, M5B, M5C, M5D, and M6. Procedures includes BETOS codes P0, P1A, P1B, P1C, P1D, P1E, P1F, P1G, P2A, P2B, P2C, P2D, P2E, P2F, P3A, P3B, P3C, P3D, P4A, P4B, P4C, P4D, P4E, P5A, P5B, P5C, P5D, P5E, P6A, P6B, P6C, P6D, P7A, P7B, P8A, P8B, P8C, P8D, P8E, P8F, P8G, P8H, P8I, P9A, and P9B. Imaging includes BETOS codes I1A, I1B, I1C, I1D, I1E, I1F, I2A, I2B, I2C, I2D, I3A, I3B, I3C, I3D, I3E, I3F, I4A, and I4B. Laboratories and other tests includes BETOS codes T1A, T1B, T1C, T1D, T1E, T1F, T1G, T1H, T2A, T2B, T2C, and T2D. Part B Drugs includes BETOS codes O1D and O1E. Ambulance includes BETOS code O1A.

Please see <http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/BETOS.html> for definitions of the BETOS codes, the crosswalk from HCPCS codes to BETOS codes, and more information about the BETOS classification.

Please refer to the “Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology Specifications” document, which is available on the CMS Medicare Shared Savings Program Web site, for descriptions of Specialty Codes and HCPCS and revenue center codes.

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**Table 1**  
**Medicare Shared Savings Program**  
**Aggregate Expenditure/Utilization Report**  
**ACO A#### [ACO Name]**  
**Year 20XX, Quarter X**  
Table of Contents

	ACO-Specific Assigned		
	Beneficiaries <sup>1</sup>	All MSSP ACOs <sup>1</sup>	National FFS <sup>2</sup>
	Quarterly	Quarterly	Quarterly
<b>Number of ACOs</b>	1	#	-
<b><u>Person-Years per Assigned Beneficiary Medicare Enrollment Type<sup>3</sup></u></b>			
Total			
End Stage Renal Disease			
Disabled			
Aged/Dual			
Aged/Non-Dual			
<b><u>Total Expenditures per Assigned Beneficiary Medicare Enrollment Type<sup>4,5</sup></u></b>			
Total			
End Stage Renal Disease			
Disabled			
Aged/Dual			
Aged/Non-Dual			
<b><u>Assigned Beneficiaries Who Declined Data Sharing<sup>6</sup></u></b>			
Person-Years			
Total Expenditures per Assigned Beneficiary			
<b><u>Component Expenditures per Assigned Beneficiary<sup>7</sup></u></b>			
Hospital Inpatient Facility, Total <sup>5,8</sup>			
Short-Term Stay Hospital			
Long-Term Stay Hospital			
Rehabilitation Hospital or Unit			
Psychiatric Hospital or Unit			
Skilled Nursing Facility or Unit			
Institutional (Hospital) Outpatient Facility <sup>9</sup>			
Part B Physician/Supplier (Carrier) <sup>10</sup>			
Evaluation and Management			
Procedures			
Imaging			
Laboratory and Other Tests			
Part B Drugs			
Ambulance			
Home Health Agency			
Durable Medical Equipment			
Hospice			
<b><u>Transition of Care/Care Coordination Utilization</u></b>			
30-Day All-Cause Readmissions Per 1,000 Discharges <sup>11</sup>			
30-Day Post-Discharge Provider Visits Per 1,000 Discharges			
Ambulatory Care Sensitive Conditions Discharge Rates Per 1,000 Beneficiaries <sup>11</sup>			
Chronic Obstructive Pulmonary Disease or Asthma			
Congestive Heart Failure			
Bacterial Pneumonia			
<b><u>Additional Utilization Rates (Per 1,000 Person-Years)</u></b>			
Hospital Discharges, Total <sup>12</sup>			
Short-Term Stay Hospital			
Long-Term Stay Hospital			
Rehabilitation Hospital or Unit			
Psychiatric Hospital or Unit			
Skilled Nursing Facility or Unit Discharges			
Skilled Nursing Facility or Unit Utilization Days <sup>13</sup>			
Emergency Department Visits			
Emergency Department Visits that Lead to Hospitalizations			
Computed Tomography (CT) Events			
Magnetic Resonance Imaging (MRI) Events			
Primary Care Services <sup>14</sup>			
With a Primary Care Physician			
With a Specialist Physician			
With a Nurse Practitioner/Physician Assistant/Clinical Nurse Specialist			
With a FQHC/RHC			

**Table 1**  
**Medicare Shared Savings Program**  
**Aggregate Expenditure/Utilization Report**  
**ACO A#### [ACO Name]**  
**Year 20XX, Quarter X**  
Table of Contents

	ACO-Specific Assigned Beneficiaries <sup>1</sup>	All MSSP ACOs <sup>1</sup>	National FFS <sup>2</sup>
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**NOTES:**

The single average claims completion factor listed in the Parameters worksheet accounting for all expected remaining Parts A and B claims run-out is reflected in the reported total expenditures per assigned beneficiary person-years, expenditures per assigned beneficiary person-years by Medicare enrollment type, and component expenditures.

All beneficiary annualized expenditures are truncated by setting expenditures that are greater than the truncation threshold equal to the truncation threshold.

For each Medicare enrollment type, the expenditure truncation threshold is the national unweighted 99<sup>th</sup> percentile of annualized Part A and Part B expenditures (excluding IME/DSH, UCC, and pass-through payments) for national FFS beneficiaries, calculated by OACT. See the annualized expenditure truncation thresholds on the Parameters worksheet.

Risk adjustment is not applied in any of these calculations.

Expenditures are not standardized for geographic variations in Medicare prices (i.e., arising from the Area Wage Index or the Geographic Practice Cost Index).

<sup>1</sup>SSP expenditures exclude IME/DSH, UCC, and pass-through payments. The All MSSP ACOs column represents an un-weighted median of values for all currently active MSSP ACOs at the time this report was run. Medians for components do not sum or aggregate to totals because medians are taken separately for each component variable across all ACOs. For example, the sum of median person-years by enrollment type does not equal median total person-years.

<sup>2</sup>The National FFS column represents mean expenditures for all Medicare FFS beneficiaries (those enrolled in both Parts A and B, residing in the US, not enrolled in a Medicare Group Health Plan, and alive at the beginning of the assignment period), including care management fees. National FFS expenditures exclude IME/DSH, UCC, and pass-through payments. Expenditures are annualized and truncated separately by Medicare enrollment type at the 99<sup>th</sup> percentile of national FFS expenditures for that enrollment type. The national FFS population includes beneficiaries without any evaluation and management services, who therefore could not be assigned to any ACO. This differs slightly from the data used by the OACT to calculate the national trend factors used for reconciliation. The OACT calculation, as required in statute, does not restrict only to months of both Part A and B enrollment and does not truncate expenditures.

<sup>3</sup>Beneficiary Medicare enrollment type is determined on a monthly basis. Person-years is the number of assigned beneficiaries in a given Medicare enrollment type adjusted for the total number of months that each beneficiary was classified in the particular Medicare enrollment type, i.e., person-years is the number of person-months in an enrollment type divided by 12.

<sup>4</sup>Total expenditures and total expenditures by Medicare enrollment type are annualized, weighted for months of beneficiary ACO eligibility, and truncated. Total expenditures are calculated as a weighted average of the expenditures by Medicare enrollment type, with person-years in each enrollment type as weights. Reported expenditures are the beneficiary expenditures per month amount multiplied by 12. Total expenditures take into account individually identifiable payments made for beneficiaries under a demonstration, pilot or time-limited program, if available.

<sup>5</sup>IME, DSH, UCC, and pass-through payments are excluded from total and hospital inpatient facility expenditures for SSP ACOs.

<sup>6</sup>Includes person-years and expenditures for assigned beneficiaries who declined or "opted out" of data sharing. Expenditures for beneficiaries who declined data sharing are calculated in the same way as expenditures for beneficiaries by enrollment type (see footnote 4). Data on beneficiaries who have declined data sharing are included in all statistics presented in this report, and have always been included in the Expenditure/Utilization Reports, but were not shown separately until 2015 Q1. If the number of person-years of beneficiaries who declined or opted out of data sharing is 10 or fewer, expenditures are not reported separately to protect confidentiality.

<sup>7</sup>Quarterly component expenditures (inpatient, outpatient, etc.) are calculated in the same manner as total expenditures (see footnote 4). Because component expenditures are also truncated at the same truncation threshold as total expenditures, the sum of component expenditures will not add to total expenditures. Expenditure thresholds are imposed on annualized expenditures for each beneficiary for each Medicare enrollment type. Please note that a beneficiary can have more than one expenditure threshold applied because they may have months in more than one Medicare enrollment type.

<sup>8</sup>Includes hospital provider types not separately listed. For this reason, and because total hospital inpatient facility expenditures and expenditures by hospital provider type are each truncated at the same level as total expenditures, expenditures by hospital provider type do not sum to total hospital inpatient facility expenditures.

<sup>9</sup>In addition to hospital outpatient department claims, this category includes claims from FQHCs, RHCs and Method II CAHs. The hospital outpatient claims contain facility payments. FQHC and RHC claim payments are a combination of facility and professional payments—these two components cannot be separately identified. In addition to facility payments Method II CAH claims can also include separately identified professional payments. Also includes claims from renal dialysis facilities, outpatient rehabilitation facilities, community mental health centers, and other institutional outpatient providers.

<sup>10</sup>Includes Part B expenditure types of service not separately listed. For this reason, and because total Part B expenditures and expenditures by type of service are each truncated at the same level as total expenditures, expenditures by type of service do not sum to total Part B expenditures. See Parameters worksheet for type of service codes that comprise each category. In addition to physician and other practitioner services, includes free-standing ambulatory surgery centers, independent clinical laboratories, and other suppliers. Includes physician/practitioner services provided in either an inpatient or outpatient setting.

<sup>11</sup>This measure specification differs from the measure specification used for the quality performance standard (e.g., it is not risk adjusted).

<sup>12</sup>Includes hospital provider types not listed separately. For this reason, discharges by hospital provider type may not sum to total hospital discharges.

<sup>13</sup>The number of covered days of care that are chargeable to Medicare facility utilization that includes full days, coinsurance days, and lifetime reserve days. It excludes any days classified as non-covered, leave of absence days, and the day of discharge or death. Includes all Medicare-covered days of stays that end in the reporting period (based on claim thru date), including days prior to the start of the reporting period. Does not include any days of stays that start in the reporting period but end after the reporting period.

<sup>14</sup>See Parameters worksheet for definitions of primary care services and the providers of those services. Primary care visits with a primary care physician, specialist physician and nurse practitioners/physician assistants/clinical nurse specialists include services received at Method II CAHs.

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