Next Generation ACO Welcome Packet

October 15, 2015

Welcome to the Next Generation ACO Model! CMS looks forward to working with you to advance higher quality care at lower costs for beneficiaries.

This welcome packet provides you with general information regarding your participation in the Next Generation ACO Model and important documents for you to review. Please review the documents enclosed carefully. Some of them note a deadline by which we need a response from you. If you have any questions on the contents of this packet please do not hesitate to contact the Next Generation ACO team through the following means:

Phone Inquiries: Next Generation ACOs can contact Accountable Care Organization Information Center by calling 1-888-734-6433 between the hours of 8:30 a.m. to 7:30 p.m. Eastern Time Monday through Friday.

Electronic Inquiries: Next Generation ACOs can email NextGenerationACOModel@cms.hhs.gov and will receive confirmation that their email was received within 24 hours.

Sincerely,

The Next Generation ACO Model Team

Next Generation ACO Welcome Packet

1. **Welcome Letter**
2. **Content Explanation**
3. **Helpdesk Information**
    - This document provides detailed information about contacting the Accountable Care Organization Information Center, which is the Single-Point-of-Contact for ACO inquiries. It also provides reminders about the required process for encrypting Personally Identifiable Information (PII) Data.

4. **Next Generation ACO Model Timeline**
    - This timeline shows important dates for Next Generation ACO Performance Year 1.

5. **CMMI Incidence Response Processes**
    - This document details important information about protecting CMS data and responding to potential violations of Federal security/privacy laws and/or CMS security/privacy policies.

6. **Next Generation ACO Learning System Introduction**
    - This document provides an introduction to the Next Generation ACO learning system, and details some of the upcoming activities.

7. **Beneficiary Notification Template**
    - This document provides a beneficiary notification letter template to alert beneficiaries of your participation in the Next Generation ACO model. Additional guidance will be forthcoming, but ACOs letters will be expected to be sent in mid-December after the signing of the participation agreement.

8. **Quality Resources**
    - This document provides resources for programs including CAHPS, GPRO, the EHR incentive program, MSSP's quality requirements, Physician Compare, PQRS and the Value Based Payment Modifier.

9. **Payment Document**

    This document provides information about CMS Demonstration Payment Policies and forms that must be returned to CMS.
    - 588 Form: This is a payment setup form that is necessary to set up electronic fund transfers to pay monthly payments (both PBP and infrastructure payments) and to pay shared savings. This form should be completed by all NGACOs (regardless of planned payment mechanism) according to the instructions included with the form.

- ACTION REQUIRED: Due to CMS no later than November 13, 2015.

- W-9: This is a common tax form that is required on file for recoupment purposes. It can be found here: https://www.irs.gov/pub/irs-pdf/fw9.pdf This form can be submitted via e-mail to the NGACO Questions inbox.
  - ACTION REQUIRED: Due to CMS no later than November 13, 2015.

10. Next Generation ACO File Transfer FAQs

- This provides answers to Frequently Asked Questions about the Next Generation ACO file transfer process.

11. Next Generation ACO User Guide – Pull

- This document serves as a user guide for the Next Generation ACOs using the Secure Hypertext Transfer Protocol (HTTPS) Web interface of TIBCO Managed File Transfer (MFT) Internet Server to exchange data with CMS, a process that National Government Services (NGS) coordinates and provides to CMS.

12. Next Generation ACO User Guide – Push

- This document serves as a user guide for the Next Generation ACOs using Secure File Transfer Protocol (SFTP) to exchange data with CMS, a process that National Government Services (NGS) coordinates and provides to CMS.

13. NGACO Alignment List Report (ALR) Information Packet (IP)

The ALR IP contains instructions on use and detailed information about the Initial Alignment Report:

- The NGACO Initial Alignment Report is a list of prospectively aligned beneficiaries generated once at the beginning of each performance year for each ACO. The report includes beneficiary demographic information, alignment eligibility, if they have Part D coverage, and risk scores for each of the alignment years.

The NGACO Initial Alignment Report will be delivered as a text file for instructions on how to open the text files in Excel and report format please refer pg. 2 and 6 (Table 1) of the attached NGACO ALR IP.

14. Claim and Claim Line Feed (CCLF) IP

The CCLF IP contains instructions on the use and detailed information about Accountable Care Organization (ACO) Program Claim and Claim Line Feed (CCLF):

- The CCLF will include claims for all services covered by Part A (Hospital Insurance) and Part B (Supplemental Medical Insurance) that were provided to beneficiaries who agreed to data sharing and were processed during the prior month. Claims data will also include prescriptions covered by a Prescription Drug Program in which the beneficiary is enrolled.

For reference you will find the Pioneer/SSP CCLF IP attached that can be used as a guide with regards to file layouts. An updated CCLF IP with NGACO information incorporated will be forthcoming.

15. NGACO ACOs and ACO-OS Interface Control Document (ICD)

This ICD describes the relationship between the Accountable Care Organization - Operational System (ACO-OS) and Accountable Care Organizations (ACOs). This ICD provides the following information:

- A general interface description
- Assumptions, where appropriate
- A description of the data exchange format and exchange protocol
- Estimated data exchange size and frequency

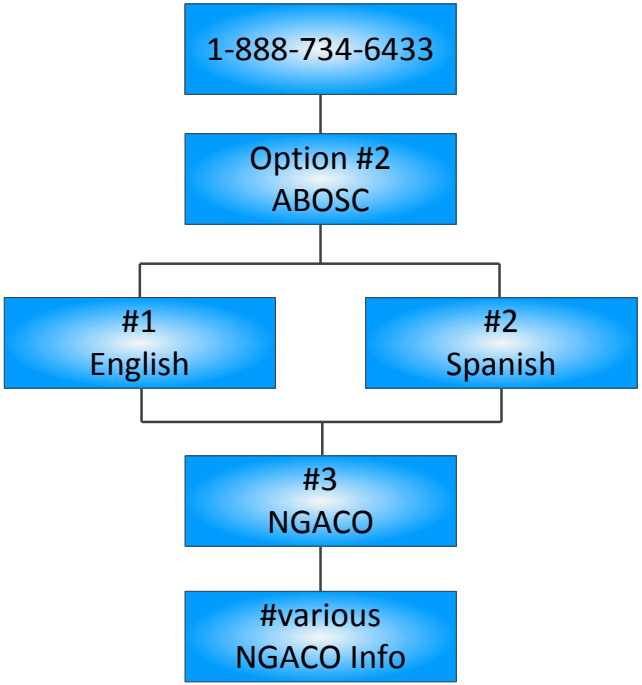
Beginning April 1, 2016 the following data exchanges will be performed between ACOs and ACO-OS. The Pioneer ACO to ACO-OS ICD is provided as a guide for file layouts. An NGACO-specific ACO to ACO-OS ICD will be forthcoming.

- ACOs may begin sending the following files to ACO-OS:
  - Alcohol and substance abuse data sharing preferences – for current file layout please refer Table 7 – 9 (pg. 14-16) of Pioneer ACOs and ACO-OS ICD.
  - Participant list updates – refer Table 16 - 19 (pg. 30-32) of Pioneer ACO and ACO-OS ICD.
- The ACO-OS sends the following to ACOs:
  - A monthly data sharing status file for all aligned beneficiaries – refer Table 10 - 12 (pg. 19-22) of Pioneer ACOs and ACO-OS ICD.
  - Pass-through files received from CMS supporting systems. The pass-through file details are provided in Appendix C of the attached Pioneer ACOs and ACO-OS ICD**Error! Reference source not found.**
  - A quarterly participant status file – refer Table 10 - 12 (pg. 19-22) of Pioneer ACO and ACO-OS ICD.
  - Response files for each incoming data.

Getting Help and Reporting a Problem

Any question or issue can be handled by the Accountable Care Organization Information Center (ACOIC). They are the Single-Point-of-Contact for ACO inquiries.

- Users can call 1-888-734-6433, option #2, between the hours of 8:30am ET to 7:30pm ET.
  - User may choose to speak to a Customer Service Representative (CSR) or get "self-help" through the telephone menu options.
- Users can email *NextGenerationACOModel@cms.hhs.gov* 24 hours a day with response the next business day.



Encrypting Files Containing Personal Information

Personally Identifiable Information Reminder: When emailing files, forms or other documents that contain any health or personal information (name, SSN, DOB, TIN and NPI), remember to encrypt the document before emailing it. Encryption helps protect the privacy and security of that information for you and your beneficiaries. Transmission of unencrypted data would be considered a PHI or PII breach and would need to be reported to the CMS IT Services Desk as a PHI or PII security incident.

Encrypted emails or files require a password to be opened and read. Do NOT email the password. To increase the security of your information, please contact the ACO Information Center (ACOIC) for the password at 1-888-734-6433, option #2.

If you require any additional information regarding the encryption of sensitive information, please contact the CMS IT Service Desk via E-mail: CMS_IT_Services_Desk@cms.hhs.gov or by phone: 1-800-562-1963.

Note: Please ensure you have the proper software installed when attempting to open an encrypted file. Examples of software that will assist you in extracting compressed files include WinZip and 7-Zip. Your IT department should be consulted should you have questions when installing any software program.

Next Generation ACO Model Timeline - Performance Year 1		
Task	**Date**	**Notes**
ACOs to send Benefit Enhancement Implementation Plan	October 30, 2015	via e-mail to nextgenerationacomodel@cms.hhs.gov
ACOs to send Preferred Provider Lists	October 30, 2015	via ENCRYPTED e-mail to nextgenerationacomodel@cms.hhs.gov.
Send Baseline Report to ACOs	Early-Mid December, 2015	Will include following components of benchmark calculation: • Baseline (2014 expenditures) • Trend (including national projected trend and regional price adjustment) • Efficiency adjustments (regional and national components) • Preliminary prospective benchmark (baseline adjusted by trend and efficiency-adjusted discount) – benchmark provided in this report does not include baseline-to-performance-year risk adjustment (performance year risk scores not yet known) or quality adjustment to the standard discount (performance on pay-for-reporting in Performance Year 1 not yet known)
ACOs sign Participation Agreement	Mid-December, 2015	
Beneficiary Alignment Lists to ACOs	Mid-December, 2015	via EFT. Will be sent once Participation Agreements are signed.
ACOs to send Beneficiary Notification Letters	Mid-December	Notification that the beneficiary has been aligned to your ACO. All ACOs are required to send once Participation Agreements are signed
Performance Year 1 Begins	January 1, 2016	
First Monthly Payment to ACOs	Early January, 2016	For ACOs receiving infrastructure payments or PBP.
CMS to produce Alignment Summary Reports	Mid-January, 2016	
CMS to produce and send Historical CCLFs to ACOs	Mid-January, 2016	Please note that ACOs should set up their own IT systems to store CCLFs (or any reports) prior to this date.
Date by which ACOs can Withdraw without Financial Reconciliation	April 1, 2016	
Send 1st Quarter Baseline-Benchmark Report to ACOs	End of April, 2016	Includes components of baseline report, plus: • ACO's 2016 Quarter 1 year-to-date expenditures (with no claims run-out and completion factor) • ACO Performance Year 1 population incorporates OEP exclusions (exclusion of beneficiaries enrolling in Medicare Advantage during the CY2016 open enrollment period)

ACOs to register for EIDM	Early June, 2016	For GPRO Web Interface. ACOs MUST register for a new EIDM account for the Next Generation ACO Model. Your old Pioneer/SSP account will not work.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
7500 Security Blvd
Baltimore, MD 21244-1850

CMS INFORMATION SECURITY
CMMI Incidence Response (IR)

Version 1.5
May 13, 2014

TABLE OF CONTENTS

This Review Log is maintained to record the reviews that have taken place over a three year period. The Review Log is provided below.

REVIEW LOG

DATE OF THE REVIEW	INITIALS OF THE REVIEWER	STAFF NAME OF THE REVIEWER	STAFF REVIEWER'S ORGANIZATION	VERSION REVIEWED	VERSION CREATED
May 8, 2014	SG	Sidney Gibson	MITRE		1.0
May 9, 2014	WJY	Bill Yurcik	CMS/OEM/OEB/IBSG	1.0	1.1
May 9, 2014	SG	Sidney Gibson	MITRE	1.1	1.2
May 12, 2014	WJY	Bill Yurcik	CMS/OEM/OEB/IBSG	1.2	1.3
May 12, 2014	SG	Sidney Gibson	MITRE	1.3	1.4
May 12, 2014	WJY	Bill Yurcik	CMS/OEM/OEB/IBSG	1.4	1.5
		Michael Reinhold	CMS/OEM/OEB/IBSG	1.5	

1. INTRODUCTION

The Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS) must be able to respond to computer security-related and/or privacy-related incidents in a manner that protects its own information and helps to protect the information of others that might be affected by the incident.[1] All individuals assigned to CMMI (whether government employees or contractor) or supporting an information system containing CMS information has a responsibility to protect CMS information and to report any observed activities that may lead to a compromise of CMS information. This document identifies and describes the roles, responsibilities, and process flows assigned to support Incidence Response (IR).

[1] CMS Risk Management Handbook (RMH), Vol III, Incident Handling and Breach Notification, V1.0, Dec 6, 2012

1.1 PURPOSE

All individuals assigned to CMMI have a responsibility to protect CMS information wherever it resides and regardless of how it is represented (either in hardcopy or electronic/digital form). This document describes the CMMI roles and responsibilities for detecting, reporting and supporting the resolution of potential and actual security incidents. By Federal Law (FISMA, HIPAA and others), OMB Policy (to include OMB Circular A-130 and various Memorandums) and CMS Policy (PISP), information hosted by, processed by and transmitted between information systems supporting federal programs must be protected. Proper and timely reporting of both potential and actual security incidents are paramount to maintaining the approved security posture of CMS information systems.

1.2 SCOPE

This document applies to CMMI employees, CMMI contractors, or anyone affiliated with a CMMI program. It is vital that users with authorized access to information systems processing, storing or transmitting CMS information are vigilant, along with the individuals involved with the acquisition, design, deployment and operation of the information system. These individuals, and all authorized users, are responsible for reporting suspicious events involving these information systems and the CMS information these information systems process, store, and/or transmit.

The goal of incidence response is limiting the scope and magnitude of security/privacy incidents. Incidence response is typically coordinated and directed at the enterprise-level within an organization due to specialized training requirements for effectiveness (knowledge of incidence response), optimizing resources for efficiency (one response group for entire organization instead of many), and the need to maintain an enterprise level perspective on risks and impact of an incident. What is described here is the general CMS enterprise-level Incidence Response Process with specific details highlighted for the CMMI component.

1.3 DOCUMENT ORGANIZATOIN

This document is organized in the following manner:

- Section 1: Introduction
- Section 2: Definitions
- Section 3: Roles and Responsibilities
- Section 4: Approach
- Appendix A: CMMI Incidence Response Tracking
- Appendix B: CMMI Incidence Response Process Flows

2. DEFINITIONS

The primary source for the following definitions is the "CMS Risk Management Handbook." The following terms are used throughout this document:

- **A Security Event** - an observable occurrence of any behavior that could potentially violate Federal security/privacy laws and/or CMS security/privacy policies.

- **A Security Incident** - a "Reportable Event[2]" that meets one or more set criteria as decided upon by the CMS Incidence Response Team (CSIRT). One criterion is the violation of Federal security/privacy laws and/or CMS security/privacy policies. A second criterion is violation of confidentiality, integrity, and/or availability of an information system or the information the system processes, stores, and/or transmits.

- **Privacy** - the right of an individual to control their own personal information, and not have it disclosed or used by others without permission. CMS employees, to include contractors, are charged with protecting other people's private information as subsequently defined (e.g. PII, PHI).

- **Personally Identifiable Information (PII**) - information which can be used to distinguish or trace an individual's identify, such as their name, social security number, biometric records, etc. alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.[3]

  Two specific types of PII include:

  - **Federal Tax Information (FTI):** Internal Revenue Code (IRC), Section 6103 (p)(4)(D) requires that agencies receiving FTI, which includes the combined definitions of the terms "Return", "Return Information", and "Taxpayer Return Information", provide appropriate safeguard measures to ensure the confidentiality of the FTI.

  - **Protected Health Information (PHI**): is individually identifiable health information, which includes a subset of health information (examples include information created or received by a healthcare provided, health plan, employer, or healthcare clearinghouse) held or transmitted by a covered entity or tis business associates, in any form or media, whether electronic, paper or oral.

- **A Privacy Incident** - a "Security Incident" that involves PII or PHI where there is a loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situation where persons other than authorized

[2] See Section 1.1.2 Reportable Event of RMH
[3] PII is defined in OMB M-07-16, Safeguarding Against and Responding to the Breach of Personally Identifiable Information

users, and for an other than authorized purpose, have access or potential access to PII/PHI in usable form, whether physical or electronic.

- **A Privacy Breach** - a privacy incident that poses a reasonable risk of harm (the likelihood that an individual may experience a substantial harm, embarrassment, inconvenience, or unfairness to any individual or whom information is maintained) to applicable individuals. For any CMS privacy incident, the determination of whether it may rise to the level of a "Breach" is made by the CMS Breach Analysis Team (BAT), which determines whether the privacy incident poses a significant risk of financial, reputational, or other harm to the individuals.

3. ROLES AND RESPONSIBILITIES

All CMMI staff and contractors must be aware of their expected actions in the event of a security event which may or may not become an actual security incident and/or privacy incident and/or privacy breach. The roles and responsibilities involved with incidence response are summarized in the following table on the following pages.

Roles	Responsibilities
CMMI Staff and CMMI Contractors	Responsibilities of CMMI Staff and CMMI Contractors are as follows: • Immediately report any suspected security events, including the loss of control of PII and PHI in any form, immediately to the CMS IT Service Desk 410-786-2580 • In addition to reporting any suspected security event, clearly identify to the CMS IT Service Desk the following: o CMS Unit – which is "CMMI" o CMMI Project Name o CMMI Project Officer (PO) o ISSO for CMMI Project • After reporting, notify the following: o CMMI PO o ISSO for CMMI Project • Support data-gathering for suspected security events reported
CMS IT SERVICE DESK	Responsibilities of CMS IT Service Desk are listed but not limited to the following: • Act as the first point-of-contact for suspicious security events • Gather detailed information on suspicious security events • Refer potential security events to the CSIRT • Coordinate and support dissemination of information between stakeholders to include CSIRT and CMMI BO, SD/M, PO, and ISSO
CMMI Project Officer (PO)	Responsibilities of PO are listed but not limited to the following: • Confirm all reported information about their project is accurate • Notify the CMMI ISSO of suspected security events • Coordinate with the CMMI ISSO, SD/M, CMMI BO and CSIRT • Support CMMI data-gathering for suspected security events
CMMI BUSINESS OWNER (BO)	Responsibilities of BO are listed but not limited to the following: • Confirm all reported information about their IT System is complete and correct. • Notify the CMMI ISSO of suspected security events • Coordinate with the CMMI ISSO, SD/M, CMMI PO and CSIRT • Form an event-specific Incidence Response Team-IRT (when necessary) • Support CMMI data-gathering for suspected security events • Create post-IR resolution solutions (when necessary)
CMMI SYSTEM DEVELOPER / MAINTAINER (SD/M)	Responsibilities of CMMI SD/M are listed but not limited to the following: • When requested, provide change/configuration management information • Notify CMMI ISSO of suspicious security events • Support CMMI data-gathering for suspected security events/incidents • Support CMMI BO in creating post-IR resolution solutions

Roles	Responsibilities
CMMI ISSO	Responsibilities of a CMMI ISSO include but are not limited to the following: • Serve as focal point for coordinating each CMMI IR security event • Support the CMMI Business Owner in all tasks • Support CMMI data-gathering for suspected security events • Record all reported CMMI security events/incidents
CMS Computer Security Incidence Response Team (CSIRT)	Responsibilities of the CMS Computer System Incidence Response Team (CSIRT) are listed but not limited to the following: • Serve as the primary entity in CMS responsible for maintaining CMS-wide operational informational security situational awareness and determine the overall information security risk posture of CMS • Receives all security events reported to the CMS IT Service Desk • Determine if any reported security event rises to the level of an incident, assign the initial categorization, and document actions taken • Act as lead organization for IT system forensic evidence handling and collection • Contact and support affected BOs • Notify appropriate officials such as immediate supervisors, corresponding BO, SD/M, ISSO, and HHS CSIRC • Coordinate response activities with the affected ISSO(s) • For Privacy Incidents, notify the Pre-Breach Analysis Team o Coordinate tracking, updating, and reporting PHI and/or PHI related incidents o Coordinate with HHS Privacy Incidence Response Team (PIRT)
CMS Breach Analysis Team (BAT)	Responsibilities of CMS BAT are listed but not limited to the following: • Determine if the incident qualifies as a breach under the HITECH provisions • Advise the applicable CMS organization on notifying affected individuals in accordance with HITECH requirements • Ensure reporting of a privacy incident to any other affected business or system owner • Provide BAT findings, including recommendations on whether to notify CMS Senior Core Leadership

4. APPROACH

CMMI operates in accordance with Federal privacy and information security requirements (see guidance from the Privacy Act, HIPPA, FISMA, OMB, NIST, HHS and CMS) as both a federal agency and as a health care component of HHS. The Privacy Act is the primary authority under which CMS, as a federal agency, may collect, use, and/or disclose PII necessary to accomplish program purposes and operations. These requirements are extended to CMS business associates, via provisions in their award agreements/contracts with CMS, and must report PII/PHI incidents to the CMS IT Service Desk.

CMMI IR roles and their corresponding responsibilities have been defined in the previous section. All CMMI staff should be aware of their IR responsibilities and act accordingly.

For additional clarification, the procedures CMMI staff shall use to respond to security events is described in a narrative fashion in this section with sub-sections entitled: "Reporting and Preliminary Review", "Identifying", "Resolving", and "Privacy Breach Post-Incidence Response". The Business Process Management (BPM) flow diagrams matching the narrative in this section can be found in Appendix B.

4.1 REPORTING AND PRELIMINARY REVIEW

If a CMMI employee, contractor, or anyone affiliated with a CMMI program encounters suspicious behavior involving misuse of CMS data or the potential compromise of a CMMI IT system, they must report it to the CMS IT Service Desk (hereafter referred to as "Service Desk") at 410-786-2580.

The Service Desk acts as the first point-of-contact for reporting any suspicious security event. When individuals report suspected security events, members of the Service Desk shall generate a CMS Incident Ticket that includes who reported the incident/anomaly, their CMS Unit (which is "CMMI"), CMMI project name, CMMI Project Officer, the observed behavior, corresponding CMMI BO and CMMI SD/M (if an IT System is involved), and assigned CMMI ISSO. The Service Desk performs a preliminary review of the potential security incident. If the Service Desk determines the reported security incident does not fit the approved criteria for a security incident, the incident ticket is closed. If the Service Desk cannot close the ticket, the corresponding incident is referred to the CMS CSIRT (CMS Computer Security Incidence Response Team) for further identification.

Preliminary IR review by the CSIRT involves analyzing the facts of the incident, triaging the incident to stop additional compromise of data and/or additional IT system damage, and determining the causal factors. Subsequent IR review is aimed at improving defenses, eliminating vulnerabilities, and removing the cause of the incident to eliminate recurrence. Efficient, accurate, and timely communication are essential to successful incidence response and adhering to legal/policy requirements for reporting and notification. IR may also involve coordinating with and supporting law enforcement, system backup, changing access controls, and activating contingency plans.

4.2 IDENTIFYING

The CSIRT takes the lead for resolving security incidents referred by the Service Desk. The CSIRT reviews the reported information to determine categorization of reported security events. If an event is determined by the CSIRT to be an actual security incident, the CSIRT must determine if it is a IT system security incident (involving an IT system or IT system component) and/or a privacy incident (involving information mandated by law [such as the Privacy Act, HIPAA, or FISMA] to be protected). If a reported suspicious security event is determined to by the CSIRT to be both a security incident and a privacy incident, this security/privacy incident is processed by both the CSIRT and the BAT. A ticket is updated and closed if a reported security event is determined not to have been an incident violating any Federal laws or relevant CMS security policies.

4.3 RESOLVING

If the CSIRT identifies an IT system security incident, the CSIRT initiates a security incident investigation. The CSIRT shall identify and assemble the necessary resources to properly conduct the investigation. The CSIRT formally notifies the affected CMMI BO and assumes control of the system/application to conduct the investigation. The CMMI BO is expected to notify and coordinate with individuals knowledgeable of the operation of the information system (such as the CMMI SD/M and other support personnel) and the assigned CMMI ISSO in support of the investigation. The CSIRT shall use the investigation to resolve the incident by recommending corrective actions, mitigating actions, or some combination of the two.

If the CSIRT identifies a privacy incident and/or privacy breach may have occurred, the incident is referred to the BAT which follows a defined process (see RMH, Incident Handling and Breach Notification and Appendix B). The CSIRT reconvenes as the pre-BAT and reviews the reported incident. If the pre-BAT determines the reported incident is not privacy-related, the determination is noted on the ticket and the ticket is closed. If the pre-BAT determines a privacy-related incident occurred that meets the criteria of a Breach, it begins an investigation, notifies corresponding CMMI PO and/or CMMI BO (if a CMMI IT System is involved) and determines when to convene the BAT – consisting of selected senior leaders.

The pre-BAT operates as a CMS privacy working group gathering information, identifying corrective/mitigating actions, and directing corrective/mitigating actions while the BAT is the CMS decision-making body for privacy breaches. Privacy incident investigation activities includes conducting a risk assessment, identifying corrective and mitigation actions, implementing corrective and mitigation activities, and developing the Corrective Action Plan (CAP).

When appropriate, the BAT is convened and determines if the privacy incident qualifies as a Breach. Only the BAT has the authority to designate a privacy incident a Breach. If the BAT determines a Breach has occurred, it shall inform the CMS Senior Leadership, coordinate the notification of affected parties (such as notification letters) in the proper manner and the required timeframe. When the BAT declares a specific privacy breach closed, the Service Desk ticket is also closed.

The need for an event-specific Incidence Response Team (IRT) is determined by the CMMI PO and/or CMMI BO if an incident requires technical and policy support. The CMMI PO and/or CMMI BO may be requested to form an IRT by the CMS CSIRT. The CMMI ISSO should be contacted for support in the decision whether or not to create an IRT as well as the composition of an IRT if the decision is made for an IRT to be organized.

An IRT is an ad hoc logical group assembled by the CMMI PO and/or CMMI BO that will vary in nature for each reported security event depending on the nature of the security event. Staff typically considered for the IRT includes the CMMI ISSO(s), the CMMI SD/M, CMMI application developers, and CMMI contractor Security Officer(s) and CMMI system

administrator(s) for the IT system(s) under investigation. There is typically the need to establish and oversee the on-site Incidence Response (IR) authority role (section 2.4.3 of RMH-II). Normally this is a contractor with formal responsibility (typically a CMMI Contractor Security Officer) who works with their federal counterpart (CMMI ISSO).

For advance planning purposes, the CMMI PO and/or CMMI BO may assign initial IRT members for their CMMI Project and/or CMMI IT System when creating the required Contingency Plan security artifact for the CMMI IT System. When a security incident occurs, the previously organized IRT for CMMI Projects and CMMI IT systems can be more quickly convened as well as modified with supplemental staff as appropriate.

Lastly, a designated CMMI ISSO tracks all security/privacy incidents involving CMMI. A sample CMMI Incidence Response tracking sheet is provided in Appendix A.

4.4 PRIVACY BREACH POST-INCIDENCE RESPONSE

If PII and/or PHI is potentially involved in a reported security event, the CMMI Business Owner and/or CMMI Project Officer will be contacted when a Pre-Breach Analysis Team (Pre-BAT) or Breach Analysis Team (BAT) is convened for input but may not be requested to take any action. However, the CMMI Business Owner and/or CMMI Project Officer may be asked to participate in a risk assessment with the Pre-BAT and a BAT. In this case the CMMI Business Owner and/or CMMI Project Officer along with the pre-BAT and BAT assess PII/PHI breach incidents according to CMS Rules of Behavior, CMS Minimum Security Requirements (CMSRs), ARRA/HITECH Notification requirements and OMB directives.

The CSIRT identifies High Profile PII/PHI risks that should be notified to the CMS Chief Information Security Officer (CISO). CSIRT also reports all PII incidents to the HHS Computer Security Incidence Response Team (CSIRT) regardless of risk either in an immediate report or a monthly summary report.

In the case where there is a confirmed PII/PHI breach requiring notification, the CMS Office of E-Health Standards and Services (OESS) will coordinate with the CMMI Business Owner and/or CMMI Project Officer on a case-by-case basis. OESS will provide (via Email) a draft template breach notification letters in plain language containing some information tailored for the specific instance to the CMMI PO and/or CMMI BO. After OESS approval of a notification letter from the CMMI PO and/or CMMI BO, OESS forwards the notification letter to the Department of Health and Human Services (HHS) for Department level review and approval. After approval of the notification letter from HHS, a copy of the letter is provided to the Office of External Affairs and Beneficiary Services (OEABS) for call center customer service representatives to supplement the general script the call center service representatives normally use. This letter can be used as a reference for specific inquiries about a particular Breach.

If it is determined by the BAT that a contractor is responsible for losing data, then the contractor may be responsible for paying for credit protection. If a CMS is responsible for losing data, then CMS may be responsible for paying for credit protection and CMMI may have to coordinate with other CMS units to establish and implement a credit protection monitoring program for those at risk of financial harm.

For PII complaint notifications involving more than 500 residents of a State or jurisdiction, OESS notifies prominent media outlets serving the State or jurisdiction. For State Medicaid data, under Public Law 104-191 known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), each state must have a process to report PII breaches. In addition to this HIPAA requirement, a State should immediately report a PII Breach to the Director of the Division of State Systems at CMS.

5. APPENDICES

The appendices are listed below:

- Appendix A – CMMI Incidence Response Tracking
- Appendix B – CMMI Incidence Response Process Flows
    - Overview of CMMI IR Process
    - CMMI IR Intake Process
    - CMMI IR Investigation Process
    - CMMI IR Resolution Process
    - CMMI Privacy Breach Investigation Process (Post-Incident)
    - CMMI Privacy Breach Resolution Process (Post-Incident)

APPENDIX A – CMMI INCIDENCE RESPONSE TRACKING

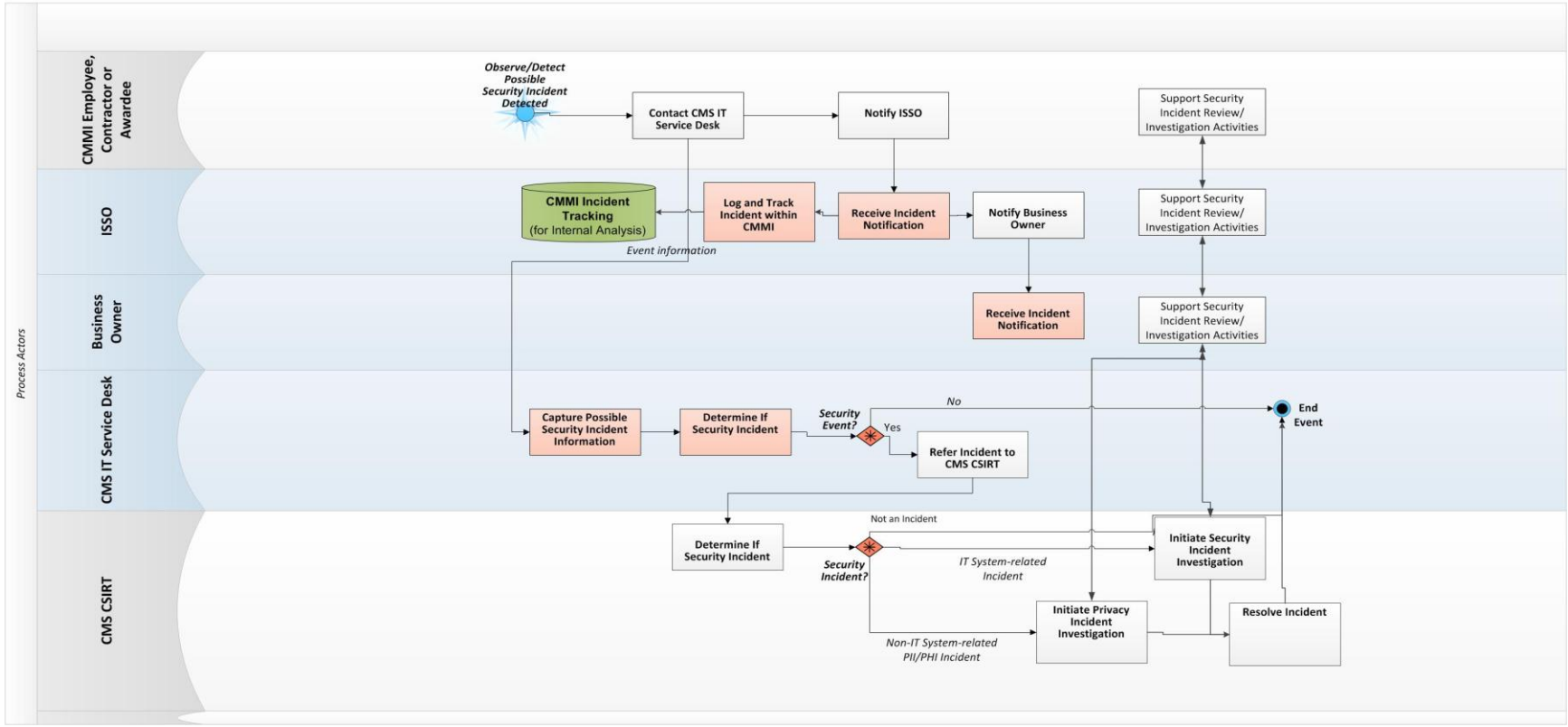
CMMI tracks CMMI security incidents involving CMMI Projects, CMMI CMS data breaches, and CMMI IT Systems. The following is a tracking sheet which will be maintained electronically and in hard copy by one CMMI ISSO.

STATUS	INCIDENT PRIORITY	INCIDENT CATEGORY	CMS TRACKING NUMBER	CMMI PROJECT NAME	CMMI PROJECT OFFICER	CMMI IT SYSTEM NAME	CMMI BUSINESS OWNER	CMMI SD/M	CMMI ISSO	DATE/TIME OCCURRED AND REPORTED	PHYSICAL LOCATION	INCIDENT DESCRIPTION AND COMMENTS

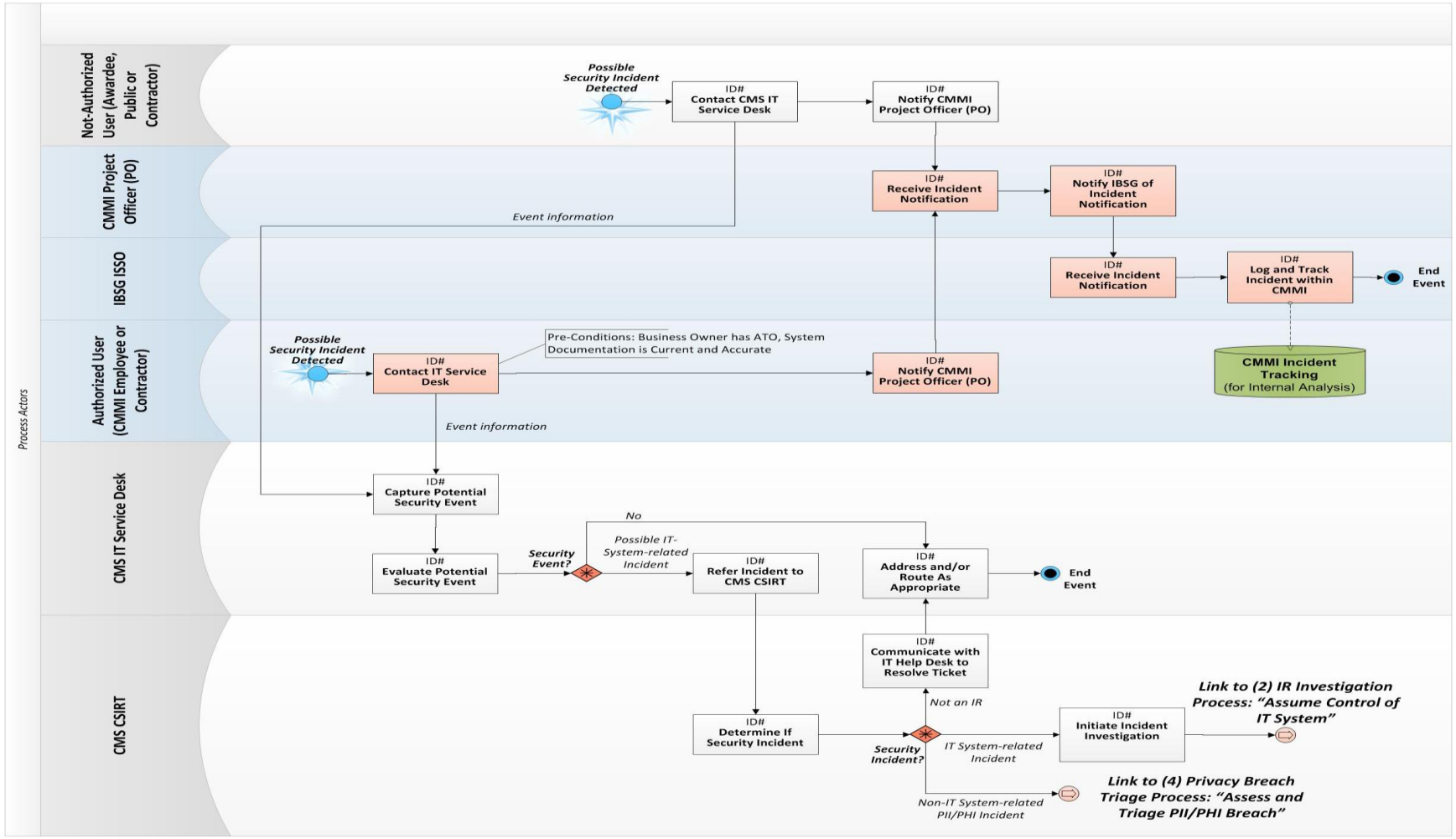
- **Status:** Open or closed (if closed, please provide the date)
- **Incident Priority**: Provided by CMMI, in sequential numerical order from 1.
- **Incident Category:** Category – type of incident.
- **CMS Tracking Number:** Provide the CMS Tracking Number assigned by CMS IT Service Desk
- **CMMI Project Name:** self-explanatory
- **CMMI Project Officer:** CMMI Project Officer, COR, or delegated Project Lead
- **Name of CMMI IT System:** Provide the name of the IT system if an IT System is associated with incident.
- **Business Owner, SD/M. & ISSO:** If associated CMMI IT Systems then names of CMMI IT System Business Owner and CMMI System Developer/Maintainer
- **CMMI ISSO:** ISSO assigned for this CMMI project
- **Date/Time Occurred and Reported:** Insert the date the incident occurred and when it was reported to the CMS IT Service Desk
- **Physical Location:** include complete postal mailing address with zip code.
- **Incident Description and Comments:** Describe what occurred. What type of information was compromised if any? What resources are being used to resolve the incident? When is the incident expected to be resolved?

APPENDIX B – CMMI INCIDENCE RESPONSE PROCESS FLOWS

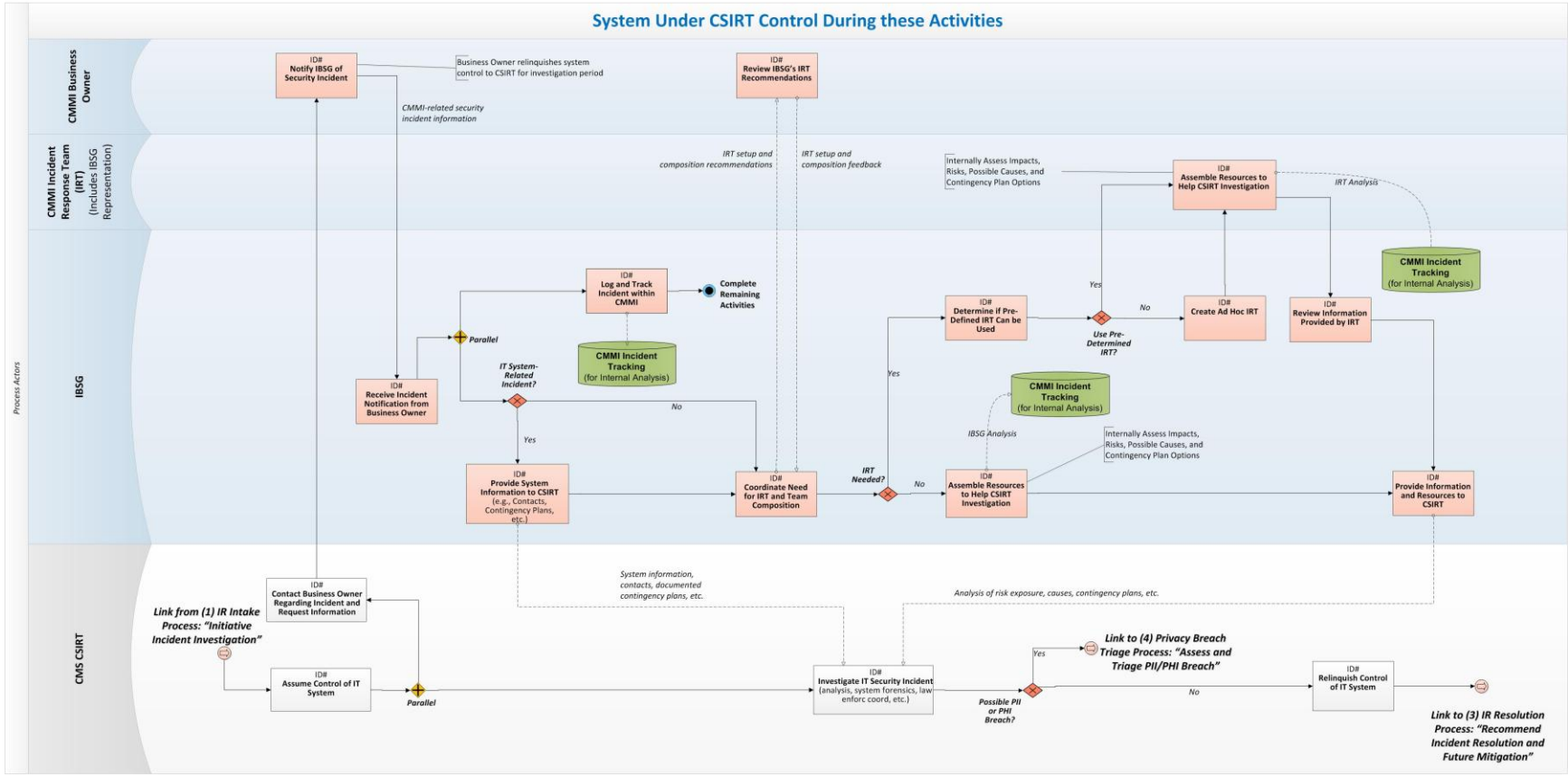
Overview of CMMI IR Process



CMMI IR INTAKE PROCESS



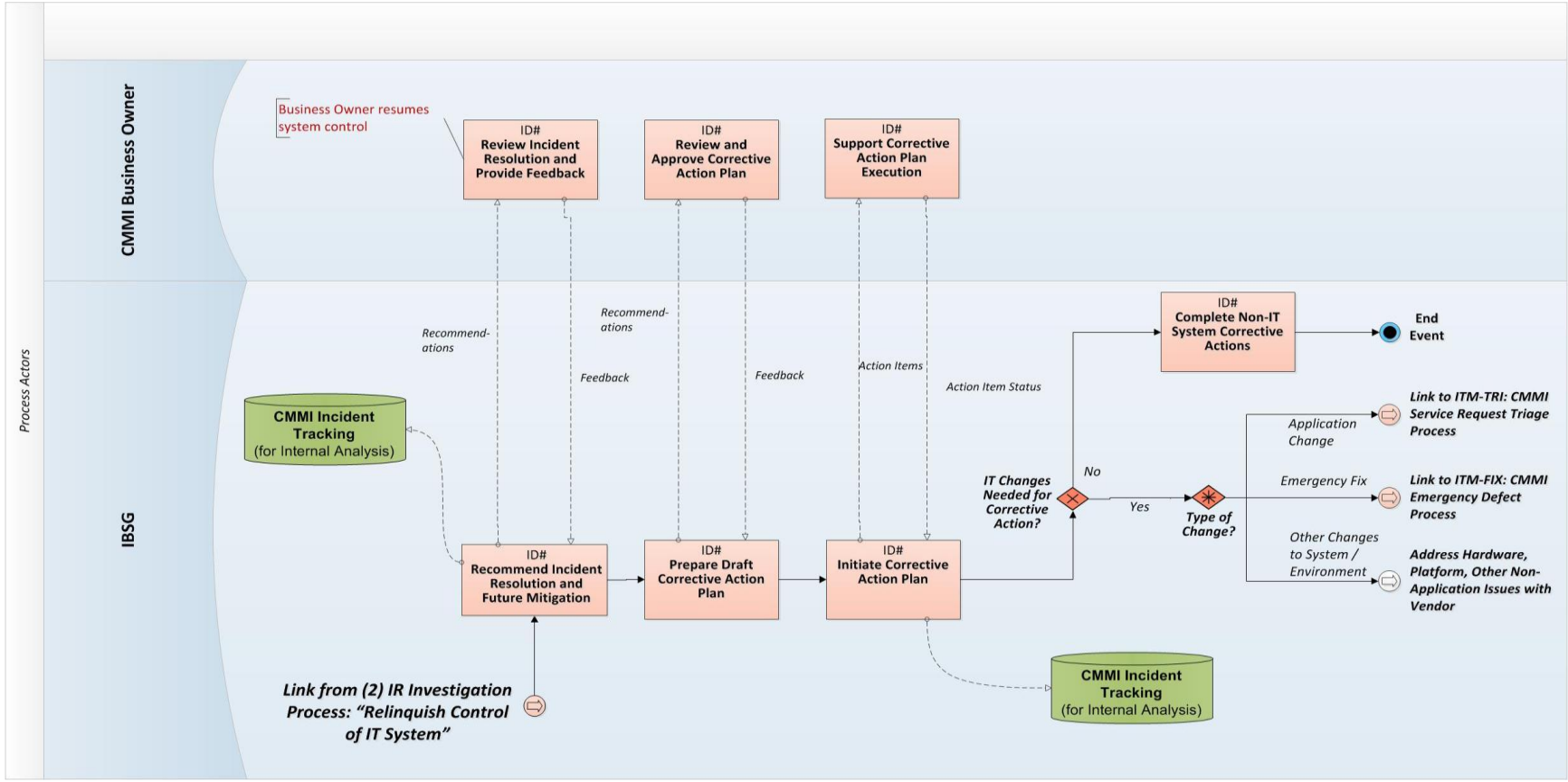
CMMI IR INVESTIGATION PROCESS



CMMI IR RESOLUTION PROCESS

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

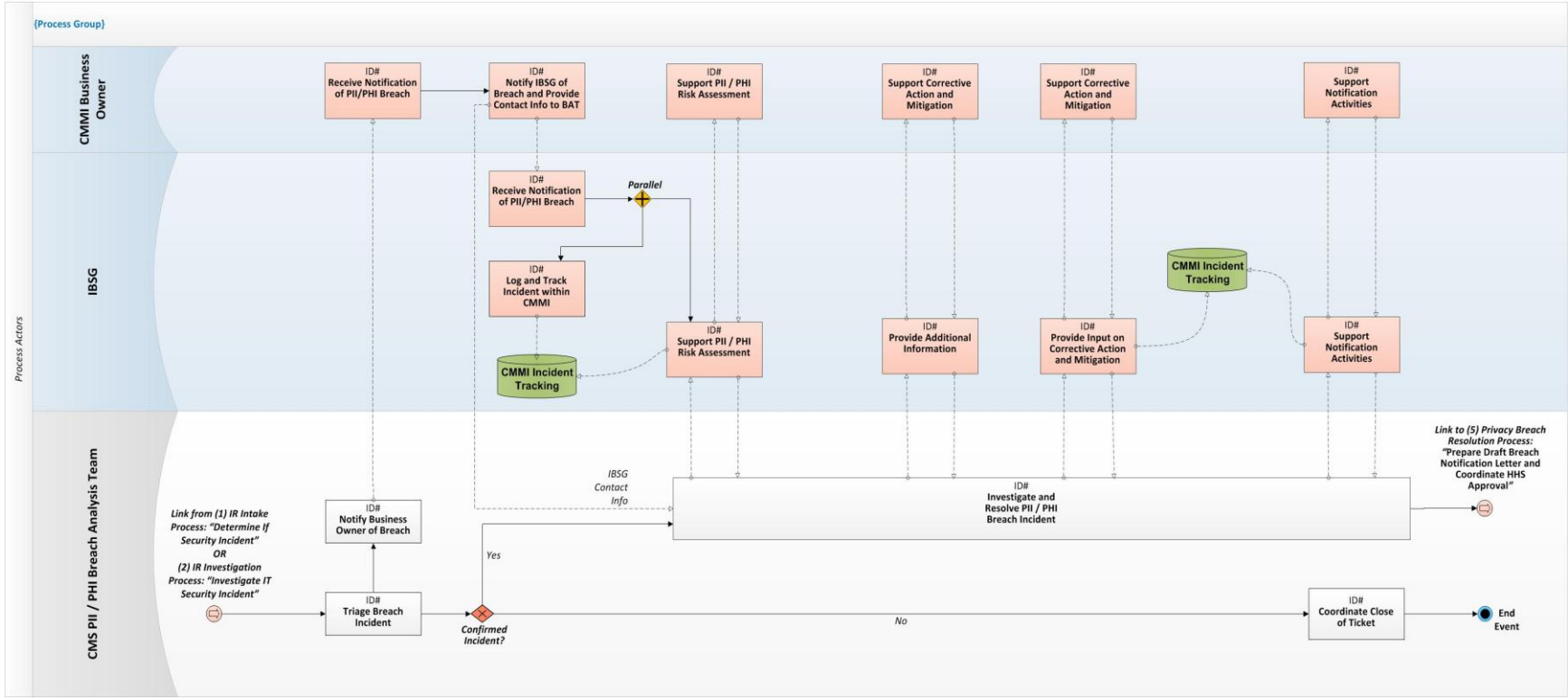
CMMI IR Resolution Process



CMMI PRIVACY BREACH INVESTIGATION PROCESS (POST-INCIDENT)

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

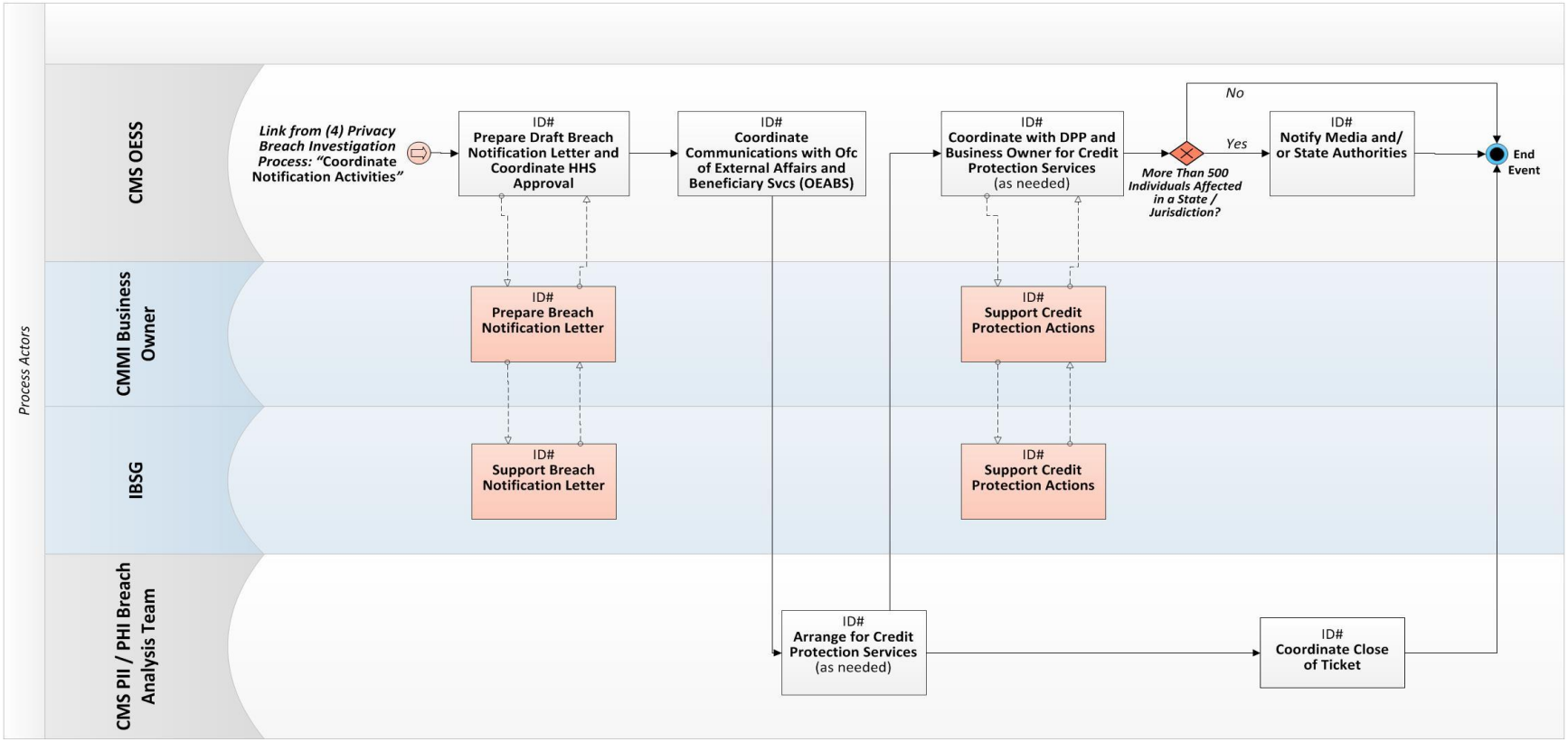
CMMI Privacy Breach Investigation Process



CMMI PRIVACY BREACH RESOLUTION PROCESS (POST-INCIDENT)

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

CMMI Privacy Breach Resolution Process



Learning Systems
for Accountable Care Organizations

Next Generation ACO Learning System

The Center for Medicare & Medicaid Innovation (CMMI) has contracted with Mathematica Policy Research to support a learning system for multiple Medicare ACO models, including Next Generation Model ACOs. The learning system creates a structure for peer-to-peer learning to support ACOs in the provision of better care for patients, better health for populations, and lower health care costs. Mathematica and its partner, Premier Inc., will assist CMMI design and initiate learning activities for the Next Generation ACO model, beginning in late 2015.

The learning system provides opportunities for continuous, collaborative learning and data-driven decision-making through a variety of activities, such as:

- Webinars that feature discussion among ACOs implementing innovative strategies, presentations about a recent data analysis from an external speaker with unique insight in a subject area, or technical assistance on use of a new data source to inform decision-making
- In-person meetings, such as an annual face-to-face meeting in the Washington, DC area and regional In-Person Learning Collaboratives
- Case studies or narrative reports that explore ACOs' innovative approaches to address common challenges
- Interactive dashboard that ACOs may use to track cost and quality performance and for comparing your results to peers

To inform learning system activities and materials, the learning system team will stay abreast of the ACOs' key concerns and objectives through a combination of an annual assessment survey, ACOs' driver diagrams, site visits, planning groups, and other informal data collection activities.

In the coming weeks, you will see emails with details about upcoming activities and learning opportunities from NGLearningActivities@mathematica-mpr.com, some of which are described below. Please forward these emails to others within your organization as appropriate. To submit questions, comments, or suggestions for learning system activities at any point, please use either NGLearningActivities@mathematica-mpr.com or the CMMI email address of NextGenerationACOModel@cms.hhs.gov with "NG Learning System" in the subject line.

Welcome to the Next Generation ACO model! We look forward to meeting you, and working with you to provide educational programs and tools that help you achieve your goals. Below is a listing of upcoming activities.

The Mathematica/Next Generation Learning System Team

Upcoming Activities

I. Assessment Survey

The first learning system activity will be an annual assessment of Next Generation ACOs' implementation activities and learning interests. The survey is designed to accomplish three main goals: (1) provide ACOs with an understanding of implementation progress in key operational areas, (2) inform the development of learning activities to address ACOs' current challenges and highlight recent successes, and (3) facilitate continuous improvement in the value of learning systems activities.

The assessment will be a web-based survey targeted toward ACOs' organizational leadership (e.g., Chief Medical Officer, Director of Care Management, and Director of Health Information Technology). Each ACO will submit one survey response which reflects the collective insight and experience of your organization. We anticipate releasing the

survey in November and will provide additional information about the survey in a separate email. We expect the survey to take approximately 30 minutes to complete.

II. Orientation Webinar Series

Starting in December 2015, Next Generation ACOs will be invited to participate in a series of orientation webinars. The topics and timeframes are listed below. Additional details will be shared at a later date.

- Introduction to the Next Generation ACO Model: Mid-December 2015
- Implementation and Benefit Enhancements: Mid-January 2016
- Attribution Methodology and Benchmarking: Late-January 2016
- Quality Reporting Strategies and Planning: Mid-February 2016

III. Driver Diagram

In January 2016, Next Generation ACOs will be asked to develop a driver diagram. A driver diagram is a structured logic model that allows an organization to state the overall vision or aim, describe the factors that influence the achievement of those aims (also called "drivers"), and specify the causal pathway to promote key drivers. A driver diagram helps an organization define which aspects of a system should be measured and monitored, to see if the changes/interventions are effective, and if the underlying causal theories are correct. A driver diagram will help ACOs remain focused on a particular aim when it is used as regular reference for improvement work. To facilitate completion of the diagrams, Mathematica will provide guidance to develop your ACO's driver diagram, including the following:

- Suggestions on strategies to identify key drivers
- CMMI's Next Generation ACO model diagram as an example
- Template driver diagrams to complete

IV. Cross-model ACO Face-to-Face Meeting

Please save the date for the first annual CMMI Cross-Model ACO Face-to-Face Meeting! The event is planned for May 23 and 24, 2016, in Arlington, VA at the Sheraton Pentagon City. The meeting will be a cross-model forum for Pioneer, ESRD Seamless Care Organization, and Next Generation ACO representatives to discuss and share strategies for improving health care delivery and quality while reducing costs.

This first annual cross-model event will provide ACOs with opportunities to interact with each other, CMS and CMMI leadership, and other federal stakeholders to give them deeper insights into the ACO models, their challenges, and their achievements. The meeting will include keynote speakers from HHS leadership, presentations from panels of ACOs, and guided networking sessions designed for the cross-fertilization of successful initiatives and ideas.

ACO staff will leave with a better understanding of CMS programs and policies, actionable strategies that you can try out in your own settings, and a host of new contacts for your peers around the country to inspire ongoing collaboration.

Registration and location information to follow. For questions or more information please contact NextGenerationACOModel@cms.hhs.gov, with subject line "Face to Face."

<ADDRESS>
<CITY> <STATE> <ZIP>

<ACO Name>
<Dr. Name>

<BENEFICIARY FULL NAME>
<ADDRESS1>
<ADDRESS2>
<CITY> <STATE> <ZIP>

Dear <BENEFICIARY FULL NAME>,

Your doctor has chosen to participate in <ACO NAME>**,** a Medicare Next Generation Model Accountable Care Organization (ACO). An ACO is a group of doctors, hospitals, and other health care providers who come together voluntarily to coordinate high quality care for Medicare patients, like you, to better meet your individual needs and preferences. Coordinated care helps patients get the right care at the right time and avoid getting the same service repeated unnecessarily.

If you are in Original Medicare, your relationship with ACO providers will NOT limit your benefits and you still have the right to use any doctor or hospital that accepts Medicare, at any time.*

Coordinated Care Reward

Medicare would like to reward you for care you receive through doctors and hospitals associated with your ACO. <ACO NAME> can give you a list of these doctors and hospitals. If you receive at least 75% of certain health care services within a calendar year through the doctors, hospitals, and providers affiliated with <ACO NAME>, Medicare will send you a reward check in the mail. To help you know when you receive this care, your Medicare Summary Notice (MSN) will now indicate when you receive health care services from your Next Generation ACO health care providers.

New Features

[Insert applicable Beneficiary Enhancements. See the Appendix A for these inserts.]

About <ACO NAME>

[ACO can insert their own CMS approved language here]

Questions or Concerns?

- If you have any questions about <ACO NAME> or the Next Generation ACO Model, you can ask your doctor, contact your ACO by calling <ACO NUMBER>, contact your local State Health Insurance Assistance Program (SHIP), or contact Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also get more information online at the websites below:
    - <ACO NAME & WEB SITE ADDRESS>

* If you enrolled in a Medicare Advantage Plan during Open Enrollment, you can disregard this letter.

- Centers for Medicare & Medicaid Services: http://www.medicare.gov/manage-your-health/coordinating-your-care/accountable-care-organizations.html
- Next Generation ACO Model: http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/

- To find contact information for your local State Health Insurance Assistance Program (SHIP) visit https://shipnpr.shiptalk.org/ or look on the back of your *Medicare and You 2016 Handbook.*

You can hear this information in your primary language by calling 1-800-633-4227 and asking about Accountable Care Organizations.

ARABIC	لقراءة هذه المعلومات لك عبر الهاتف ، دعوة 1-800-633-4227 ويسأل عن منظمات الرعاية للمساءلة لاستلام هذه المعلومات باللغة العربية، اتصل بالرقم 1-800 MEDICARE
SPANISH	“Para que le proporcionen esta información por teléfono en [español], llame al 1-800-633-4227 y pregunte por las Organizaciones Responsables por la Atención Médica.”
HINDI	"यह जानकारी आपको फोन पर हिंदी में पढ़ कर सुनाए जाने के लिए, 1-800 633-4227 पर कॉल करें और अकाउंटेबल केयर ऑर्गेनाइजेशन्स के बारे में पूछें"

Appendix A

- 3-day Skilled Nursing Facility (SNF) Rule Waiver: Under current Medicare law, Medicare only covers care in a SNF if a patient has a prior three-day inpatient hospital stay. This new feature may allow you to get Medicare covered SNF services at a participating SNF without a mandatory three-day inpatient hospital stay. For a list of participating SNFs, please visit our website at: [Insert link to page on ACO's website that lists this information].

- Post-Discharge Home Visits: <ACO NAME> is expanding its post-discharge service to provide more comprehensive follow-up care at home after discharge from a hospital to help with the sometimes challenging transition between the hospital and home. For a list of participating physicians, please visit our website at: [Insert link to page on ACO's website that lists this information].

- Telehealth Expansion: Telehealth services allow you to receive some health care services using real-time communication between you and your primary care doctor or specialist. For a list of participating physicians, please visit our website at: [Insert link to page on ACO's website that lists this information].

  You can learn more about these initiatives by visiting the following web page: http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/ or by contacting any of the resources listed at the end of this letter.

Quality Resources

CAHPS

- **Website:** http://acocahps.cms.gov/Content/Default.aspx
- **Help Desk:**
  E-mail: ACOCAHPS@hcqis.org
  Phone: 1-855-472-4746 (toll free)

Group Practice Reporting Option

- **Website:** https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html
- **Help Desk:** contact the QualityNet Help Desk
  Phone: 1-866-288-8912 TTY: 1-877-715-6222
  Phone: 1-888-734-6433 (TTY 888-734-6563) for Electronic Reporting Using an Electronic Health Record (EHR)
  Email: Qnetsupport@hcqis.org

Medicare Electronic Health Record (EHR) Incentive Program

- **Website:** https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

Medicare Shared Savings Program

- **Website:** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html

Physician Compare

- **Website:** https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/index.html
- **Help Desk:** E-mail- PhysicianCompare@Westat.com

Physician Quality Reporting System

- **Website**: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html
- **Help Desk:** Contact the QualityNet Help Desk
  Phone: 1-866-288-8912 TTY: 1-877-715-6222
  Email: Qnetsupport@hcqis.org

Value-Based Payment Modifier

- **Website:** https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeedbackprogram/valuebasedpaymentmodifier.html
- **Help Desk**
  E-mail: pvhelpdesk@cms.hhs.gov
  Phone: 1 (888) 734-6433, press option 3 (TTY 888-734-6563)

Attention: Demonstration Participants

Re: CMS Demonstration Payment Policy

In order to receive payment, demonstration payees must submit a completed CMS Form 588 Electronic Funds Transfer (EFT) Authorization Agreement. CMS uses the banking information, business address, and TIN/EIN supplied on this form to establish vendor accounts for demonstration payees in our Healthcare Integrated General Ledger Accounting System (HIGLAS); this payment system interfaces with the US Department of Treasury which EFT deposits funds to the vendor accounts established for the payees in HIGLAS. In order to verify the banking information provided on the CMS Form 588, payees must also submit either a bank printed voided check **(NO starter checks or handwritten information)** or a signed letter from their bank/financial institution that includes the account and routing numbers.

Importantly, we require that all payees possess an active checking account to receive the EFT deposit; **savings accounts and escrow accounts are not accepted**. Please make sure that all requested information is included on your CMS Form 588; also ensure that banking information on the form corresponds with the voided check or signed letter from the bank.

CMS pre-notes the banking information before the EFT deposits are executed; if there are pre-note errors, CMS will notify the contact person on the CMS Form 588 and request corrected information. Demonstration participants without a successfully pre-noted vendor account will not receive payments.

Finally, payees will receive the IRS Form 1099 which will be mailed to the address provided on the CMS Form 588; please make sure the legal name and mailing address are correct. Payees must indicate whether their firm is profit or non-profit by writing **"P" or "NP"** on the top right-hand corner of the form; also make sure to indicate which demonstration you are participating in on the top left hand corner of the form.

Please forward the completed the CMS form 588 http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS588.pdf. with the **ORIGINAL (wet)** signature using an overnight mail that can be tracked (FedEx, UPS, etc.) to:

Centers for Medicare and Medicaid Services
7500 Security Blvd
Mail Stop WB-06-05
Baltimore, MD 21244-1850
Attention: Phoebe Ramsey (WB-07-07)

Thank you for your cooperation.

Phoebe R. Ramsey, J.D. (410) 786-4015
Social Science Research Analyst, Next Generation ACO Team, Center for Medicare and Medicaid Innovation

NGACO File Transfer Frequently Asked Questions

Contents

Next Generation ACOs will utilize either the Push (SFTP – Secure File Transfer Protocol) or Pull (MFTP – Managed File Transfer Protocol) mechanisms for receiving or submitting your electronic file transfers.

Pull (MFT) Configuration FAQs

The Pull or MFT process refers to the process by which users download, or pull, files from the MFT Internet Server webpage.

Users apply for an Enterprise Identity Management (EIDM) ID. An EIDM ID is assigned to the individual and requires the user's social security number during application. EIDM IDs should not be used with automation scripts. With their EIDM IDs, users log into the MFT Internet Server webpage. On the webpage, users will see virtual directories where they will upload and download their files. Using this method requires the users' firewalls to allow file transfer through port 11443.

Q1. Why does the logon prompt return when I enter my user ID and password?

A1. The logon screen returns after entry when the Internet Server is unable to authenticate the user ID and password combination that you entered. Please Call 1-800-562-1963 and select option 1 to request a password reset. Selecting this option will direct you to a technician that can reset the password to the default. Please be sure to request that you need your CMS user id password reset.

Once the help desk resets your password, please log into EUA to reset your password to something unique. The URL for the EUA site is https://eua.cms.gov/identityiq/login.jsf.

Q2. We are having issues downloading files via the MFT site.

A2. Please ensure you have Internet Explorer version 7, 8 or 9, or Firefox 10 and above installed before accessing MFT. Please add the MFT URL, https://eftp2.cms.hhs.gov:11443/browser to your Exception Site List.

Once you have met the MFT browser requirements and added MFT to your Exception Site List, please reboot your machine before attempting to access the MFT site.

Note: Your organization's firewall must allow your computer/laptop to navigate to the Internet Protocol (IP) address xx.xxx.183.162 on Port 11443. You may be required to respond to Secure Sockets Layer (SSL) certificate requests and Java code certificate requests. NTLM authentication does not support the recent cryptology methods used by MFT Internet Server.

Q3. I am having issues using Java to access the MFT website.

A3. In the event you have issues using the HTML Mode, access the MFT website via the following link. https://eftp2.cms.hhs.gov:11443. This will log you in using JAVA mode.

Q4. How do additional ACO contacts obtain access to the MFT site?

A4. If the individual they wish to add to the MFT account already has an existing CMS User ID.

You may contact the Next Generation ACO Model via email to add this user to your MFT account. Please send the email to NextGenerationACOModel@cms.hhs.gov

Include the following information in the subject line of the email:

- Attn: Additional MFT access

Include the following information in the body of the email:

- The ACO ID (V###)
- The individual's name you wish to add
- The individual's CMS User ID

Please note: It may take a few weeks to process your request.

Q5. Can ACOs use other environments other than Microsoft (MS) Windows?

A5. The MFT environment has been established with the expectation that the ACO environment being used is a Microsoft (MS) Windows-based environment. If you are using another environment (e.g., Linux), contact the Accountable Care Organization Information Center (ACOIC) at 1-888-734-6433, Option 2 CMS, to have your configuration changed to allow proper file transfer capability.

Q6. What are the file naming conventions?

A6. EFT uses file-naming conventions to facilitate automatic file exchanges. These conventions are crucial for proper transfer of files. For detailed information, please refer to the Next Generation User Guide – Pull that can be found on the collaboration site at https://collaboration.cms.gov/?q=user

Q7. How do I download and upload files?

A7. For detailed instructions on how to download and upload files, please review section 7 (File Transfer Operations) of the Next Generation User Guide – Pull that can be found on the collaboration site at https://collaboration.cms.gov/?q=user

Q8. Is there a way to test connectivity for file transfers?

A8. For detailed instructions on how to test connectivity, please review section 6 of the Next Generation User Guide – Pull that can be found on the collaboration site at https://collaboration.cms.gov/?q=user

Note: If you are assigned to support multiple ACO ID numbers (for example, V***), you must test the text transfers for each ACO ID number.

A successful test includes both an upload and download of a test file for the text transfer. Both actions are required for a complete test.

Q9. Why am I receiving a "Page Not Displayed" error?

A9. This message may be received when attempting to navigate to https://eftp2.cms.hhs.gov:11443/. Your organization's firewall may be blocking the IP address xx.xxx.232.162 on Port 11443. Check your permissions to navigate to this IP address and port with your organization's firewall point of contact.

Q10. Why do I receive the error message "RACROUTE AUTH fail-User not authorized" error?

A10. This error may be received when attempting to upload a file and indicates that you do not have permission to upload a file with the file name that you are using. Double-check that you are selecting the correct MFT Internet Server directory/folder and verify that the filename follows the proper naming convention outlined in section 5.4 I the Next Generation User Guide – Pull that can be found on the collaboration site at https://collaboration.cms.gov/?q=user.

If you believe that your file name is correct and you still receive this error message, contact the CMS Service Desk at 1-800-562-1963 or via e-mail CMS_IT_Service_Desk@cms.hhs.gov.

Q11. Why am I receiving the error message "Session ID has expired"?

A11. A "Session ID has expired" error indicates that you are no longer logged into the MFT Internet Server. You may have logged out manually by clicking the Logout link or – after a period of inactivity – the MFT Internet Server may have automatically terminated your session. To log in again, begin a new browser session before navigating to the MFT Web interface page. To open a new session in Internet Explorer, click File> New Session.

Q12. Why do I receive the error message "User not authorized"?

A12. This error may be received when attempting to upload a file and indicates that you do not have permission to upload a file with the file name that you are using. Double-check your file name to ensure that it follows the proper naming convention. If you believe that your file name is correct and you still receive this error message, contact the Accountable Care Organization Information Center (ACOIC) at 1-888-734-6433, Option 2.

Q13. Why does the "File transfer in progress" window "hang"?

A13. The "File transfer in progress" window may "hang" when attempting to transfer a File and indicates your organization's firewall might be blocking the user's ability to accept SSL certificates, Java code certificate requests, or the IP address xx.xxx.232.162 on Port 11443, or using NTLM authentication. Check with your network administrator. If your firewall is not blocking the IP, certificates or Java code certificate requests, attempt to access the site with https://eftp2.cms.hhs.gov:11443/browser.

Push (SFTP) Configuration FAQs

The Push or SFTP process refers to the process by which an organization receives files from CMS via an SSH transfer to their SSH server. Setting up a push transfer typically requires more time and effort from the organization (vs. Pull) to setup the necessary SSH server and SFTP client.

To upload files to CMS, organizations apply for a Secure Point of Entry ID. The SPOE ID is assigned to the organization and may be used with automation scripts. Users connect to MFT Internet Server with an SFTP client using their SPOE ID, password and a password protected SSH2 key. Users upload files to virtual directories. Using this method requires the users' firewalls to allow file transfer through port 11222.

To receive files from CMS, organizations will need an SSH server. Organizations provide the EFT team with the necessary account information to push files to their server. This requires the users' organization to allow file transfer through port 22 or 11022.

Q1. How do I obtain a user ID?

A1. You will need to apply for an EIDM ID with Internet Server access using the Next Generation EIDM User Guide. Completed applications should be sent to NextGenerationACOModel@cms.hhs.gov.

Q2. Why do I receive invalid user ID or password when I logon to my SFTP Client?

A2. This message appears when the Internet Server is unable to authenticate the user ID and password combination that you entered. For assistance with issues regarding your password, contact the Accountable Care Organization Information Center (ACOIC) at 1-888-734-6433, Option 2.

Q3. What are the file naming conventions?

A3. EFT uses file-naming conventions to facilitate automatic file exchanges. These conventions are crucial for proper transfer of files. For detailed information, please refer to section 5.3 of the Next Generation User Guide – Push that can be found on the collaboration site at https://collaboration.cms.gov/?q=user

Q4. Is there a way to test connectivity for file transfers?

A4. For detailed instructions on how to test connectivity, please review section 7 of the Next Generation User Guide – Push that can be found on the collaboration site at https://collaboration.cms.gov/?q=user

Q5. How do I upload the SSH2 key to the MFT internet server?

A5. For detailed instructions on how to upload the SSH2 Key, please review section 6 of the Next Generation User Guide – Push that can be found on the collaboration site at https://collaboration.cms.gov/?q=user

Q6. Why am I receiving a "Page Not Displayed" error?

A6. Please ensure you are navigating to the correct URL https://eftp2.cms.hhs.gov:11442/. If you are using the correct URL and still receiving this error message, your organization's firewall may be blocking the IP address xx.xxx.163.162 or Port 11442. Check your permissions to navigate to this IP address and port with your organization's firewall point of contact.

Q7. Why do I receive the error message "RACROUTE AUTH fail-User not authorized"?

A7. This error may occur when attempting to upload a file and indicates that you do not have permission to upload a file with the file name that you are using. Double-check you are selecting the correct MFT Internet Server directory/folder and verify that the filename follows the proper naming convention outlined in section 4.0. If you believe that your file name is correct and you still receive this error message, contact the CMS Service Desk at 1-800-562-1963 or via e-mail (CMS_IT_Service_Desk@cms.hhs.gov).

Q8. Why do I receive the error message "Data would be Truncated"?

A8. This error may occur when attempting to upload a file and indicates that a record in the file is larger than the attributes specified for this file. This message typically displays when a user attempts to transfer a file that is better-suited for binary transfer through the text upload transfer.

- Examples of files that are better-suited to binary transfer are Microsoft (MS) Word documents, MS Excel worksheets, Adobe .PDF files, etc.
- Files that are better-suited to text transfer are text files and comma separated value files.

If you are testing connectivity, use a text editor application (for example, Windows Notepad, Linux VI,Mac TextEdit, etc.) to create your text file.

Q9. Why am I having trouble uploading a zip file?

A9. ZIP files end WITH the ZIP extension (i.e. *.zip). Do not upload zipped files with a zip extension. MFT will not transfer ZIP files to the CMS mainframe.

Next Generation ACO User Guide - Pull

Version:	1.0
Owner:	Nicole Mister
Location:	NGS
Publication Date:	8/17/2015
Document Control Number	9014

Table of Contents

List of Figures

1.0 OBJECTIVE

This document serves as a user guide for the Next Generation Accountable Care Organizations (ACOs) using the Secure Hypertext Transfer Protocol (HTTPS) Web interface of TIBCO Managed File Transfer (MFT) Internet Server to exchange data with CMS, a process that National Government Services (NGS) coordinates and provides to the Centers for Medicare & Medicaid Services (CMS).

2.0 SCOPE

This document addresses only transfers through HTTPS using a Web browser.

3.0 BACKGROUND

The Enterprise File Transfer (EFT) facility provides secure automated file transfer services for the CMS inter-agency data transfers, and for external organizations that are required to exchange data with CMS as part of doing business with the agency. The EFT Team establishes and maintains these connections between CMS and external organizations.

Procedures for preparing to transfer files are described in Section 5.0. The process for connectivity testing is described in Section 6.0. File transfer operations are described in Section 7.0, as well as how to review your transfer history. Section 8.0 provides answers to frequently asked questions about use of managed file transfers. Section 9.0 provides information on support and technical assistance available in the use of the HTTP MFT Internet Server system.

4.0 TERMINOLOGY

ACAIC – Affordable Care Act Information Center

ACO – Accountable Care Organization

CMS – Centers for Medicare & Medicaid Services

CMCS – Center for Medicaid, CHIP and Survey & Certification

EFT - Enterprise File Transfer

EFT Admin - Refers to any member of the EFT team

EIDM – Enterprise Identity Management

HTTPS – Secure Hypertext Transfer Protocol

MFT – Managed File Transfer (TIBCO product)

MS – Microsoft

NGS – National Government Services

SFTP – Secure File Transfer Protocol

SSH – Secure Shell

5.0 PREPARATION FOR EXECUTING FILE TRANSFERS

5.1 Managed File Transfer Internet Server

To securely exchange files over the Internet, CMS utilizes the MFT Internet Server, a TIBCO product. The HTTPS Web interface of MFT Internet Server allows external organizations to exchange data with CMS using a Web browser.

5.2 Access Requirements

To access MFT Internet Server, you must use either the 4-character user ID and password assigned to you by the Center for Medicaid, CHIP and Survey & Certification (CMCS) or a 7-character Enterprise Identity Management (EIDM) ID and password.

You may need to check with your network administrator regarding network settings that could prevent you from transferring using HTTPS MFT Internet Server. Your organization's firewall must allow your computer/laptop to navigate to the Internet Protocol (IP) address xx.xxx.183.162 on Port 11443. You may be required to respond to Secure Sockets Layer (SSL) certificate requests and Java code certificate requests.

Your organization will not be able to use Windows NT LAN Manager (NTLM) authentication while transferring to CMS. NTLM authentication does not support the recent cryptology methods used by MFT Internet Server.

5.3 Access Environment Assumption

The MFT environment has been established with the expectation that the ACO environment being used is a Microsoft (MS) Windows-based environment. If you are using another environment (e.g., Linux), contact the the Affordable Care Act Information Center (ACAIC) at 1-888-734-6433, Option 2 CMS, to have your configuration changed to allow proper file transfer capability.

5.4 File-naming Conventions

EFT uses file-naming conventions to facilitate automatic file exchanges. These conventions are crucial for proper transfer of files. Below is an example of a file name retrieved by an ACO from CMS:

*P.V***.NGALIGN.RP.Dyymmdd.Thhmmsst*

Files retrieved by an ACO include six qualifiers separated by a dot (.) as a delimiter.

The first qualifier indicates if the file is a Test file or a Production file, with a “P” for Production or “T” for Test.

The second qualifier indicates the ACO ID number.

The third and fourth qualifiers indicate the type of file.

The fifth and sixth qualifiers are the date-time stamp. The date is indicated by a “D” followed by the date in the format of a two-digit year, two-digit month, and two-digit day. The time is indicated by a “T” followed by a two-digit hour, two-digit minute, two-digit second, and one-digit tenth of a second.

Files submitted to CMS by an ACO should also follow a naming convention, as shown in the following example:

*P#EFT.ON.ACO.V***.NGVLALGN*

The first qualifier is either a “P#EFT” for Production files or a “T#EFT” for test files.

The second and third qualifiers are always “ON.ACO.”.

The fourth qualifier indicates the ACO plan number.

The fifth qualifier indicates the type of file.

The date-time stamp is automatically appended to files inbound to CMS. The following is an example of a file name when it arrives at CMS.

*P#EFT.ON.ACO.V***. NGVLALGN.Dyymmdd.Thhmmsst*

Because the date-time stamp is automatically appended, you do not need to include a date-time stamp in your CMS inbound file names.

6.0 CONNECTIVITY TESTING

To verify that you are able to submit and receive files, review the File Transfer Operations (see Section 7.0). Then complete the actions described in the subsections below to test your ability to upload (see Section 6.1) and download (see Section 6.2) files to CMS.

NOTE:

- If you are assigned to support multiple ACO ID numbers (for example, V***), you must test the text transfers for each ACO ID number.
- A successful test includes both an upload and download of a test file for the text transfer. Both actions are required for a complete test.

6.1 Upload Test (to send files to CMS)

1. Create a test file named:

*T#EFT.ON.NG.V***.TST*

a. Use a text editor application (such as Windows Notepad, Linux VI, and Mac TextEdit) to create a test file. Insert a few lines of text (such as "This is a test.") in the body of the file.

b. Save the file with the name shown above, replacing the asterisks with your plan number. ***Do not use the .txt extension in the file name.***

NOTE: The file-naming convention for this particular test file does not follow the standard for inbound file names.

2. Follow the instructions in Section 7.1 to log onto MFT.
3. Follow the instructions in Section 7.2 to upload your file to the "V***UT" virtual directory.
4. Perform the applicable action:

- If you are ***not successful*** uploading your test file, review Section 8.0 for possible solutions to frequently asked questions. If you are still experiencing difficulties, contact the Affordable Care Act Information Center (ACAIC) at 1-888-734-6433, Option 2.
- If you are ***successful*** uploading your test file, continue to the download test procedure described in Section 6.2.

6.2 Download Test (to receive files from CMS)

1. The file that you uploaded will be routed back to you. Wait for the file, as this internal process could take a few minutes.
2. Follow the instructions in Section 7.3 to download your file from the "V***DT" virtual directory. When your file has been routed back to you, you will see a file name in the T.V***.TST.Dyymmdd.Dyymmdd.Thhmmsst format available for download. Select this file.

NOTE: The file-naming convention for this particular test file does not follow the standard for outbound file names.

3. Perform the applicable action:

- If you are ***successful*** downloading your test file, your connectivity test is complete; no further action is required for connectivity testing.

- If you are ***not successful*** downloading your test file, review Section 8.0 for possible solutions to frequently asked questions. If you are still experiencing difficulties, contact the Affordable Care Act Information Center (ACAIC) at 1-888-734-6433, Option 2.

7.0 FILE TRANSFER OPERATIONS

This section describes how to execute file transfers. The Web interface offers two options for transfers: HTML mode and Java mode. By default, the landing page is in HTML mode. The guide will cover the steps for HTML.

All transfer operations are executed from the Transfers page (see Figure 1).

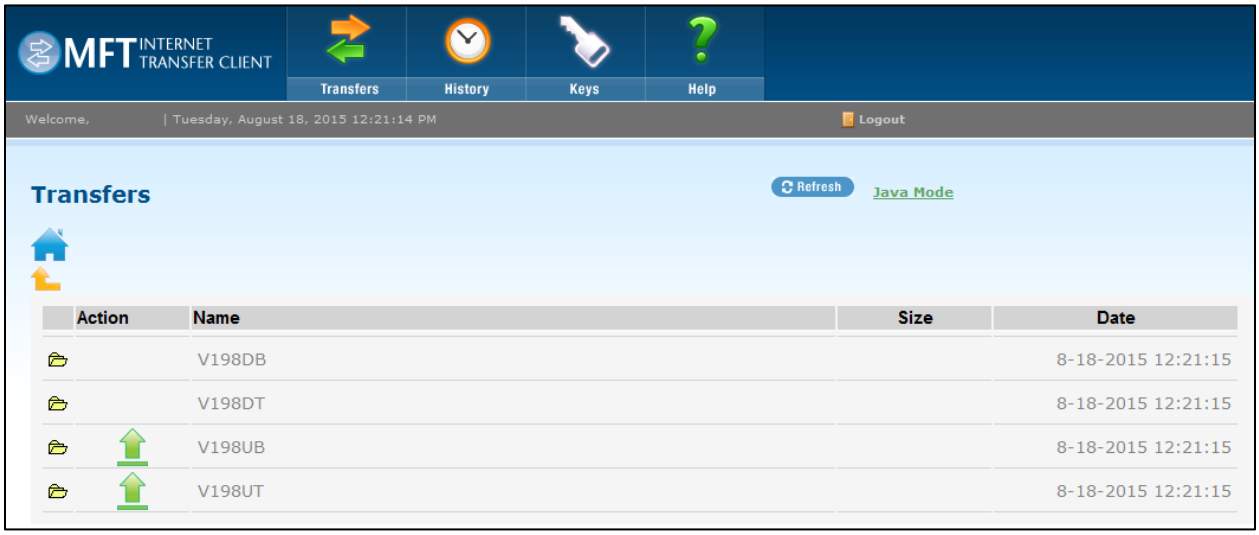


Figure 1- Transfers page

This page displays all of the virtual transfer directories to which you have access: download text (V***DT), download binary (V***DB), upload text (V***UT), and upload binary (V***UB).

Text transfers are used for text-based files such as Extensible Markup Language (XML), comma-separated values (CSV), and text. Some extensions for files that should be transferred as text data include .xml, .csv, and .txt.

Binary transfers are used for data type transfers such as files with formatting and graphics. Some extensions for files that should be transferred as binary data include .pdf, .xls, .xlsx, and .jpg.

- To log on to the system, see Section 7.1.
- To upload a file, see Section 7.2.
- To download a file, see Section 7.3.

- To review your file transfer history, see Section 7.4.
- To log off (exit) the system, see Section 7.5.

7.1 Logging On

To log on for transferring files:

1. Open your Web browser.
2. Navigate to the Uniform Resource Locator (URL) for executing HTTPS transfers, https://eftp2.cms.hhs.gov:11443/. If a security warning appears for this URL (see Figure 2), click the **Continue to this website** link.

Figure 2—Security Warning message

A logon window displays (see Figure 3).

Figure 3- Logon window

3. In the *User name* and *Password* fields, respectively, enter your **user name** and **password**.

7.2 Upload a File

Perform the following steps to select files for upload (e.g. to transfer files to CMS):

1. From the Transfers page, double-click the green arrow button for the desired file transfer. A small overlay will display.
2. Click the **Browse…** button. The **Choose file to Upload** window displays, with your computer drives, directories/folders, and files shown.

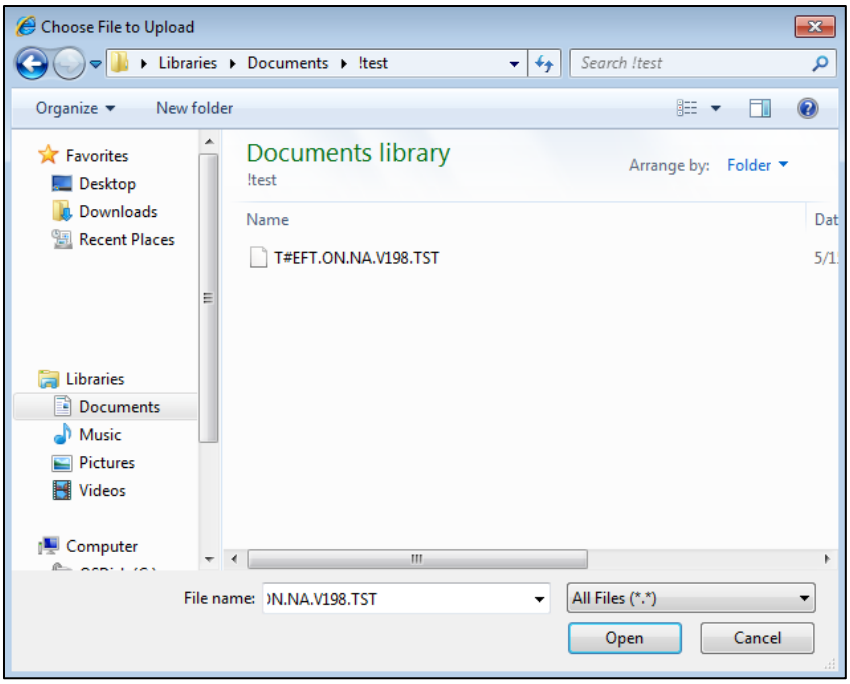


Figure 4 - Choose file for upload window

3. Select the desired folder/directory, and then select the desired file to upload.
4. Click the **Open** button. The file selection window closes, and the Transfers page redisplays with the filename.

Figure 5 - Transfers page with selected file to upload

5. Click **Upload** to Upload the file.

7.3 Download a File

Perform the following steps to select files for download (e.g. to retrieve files from CMS):

1. From the Transfers page, double-click the yellow folder button for the desired file(s) transfer.
2. Then select the file to download by double-clicking the blue download button (see
3. Figure 6).

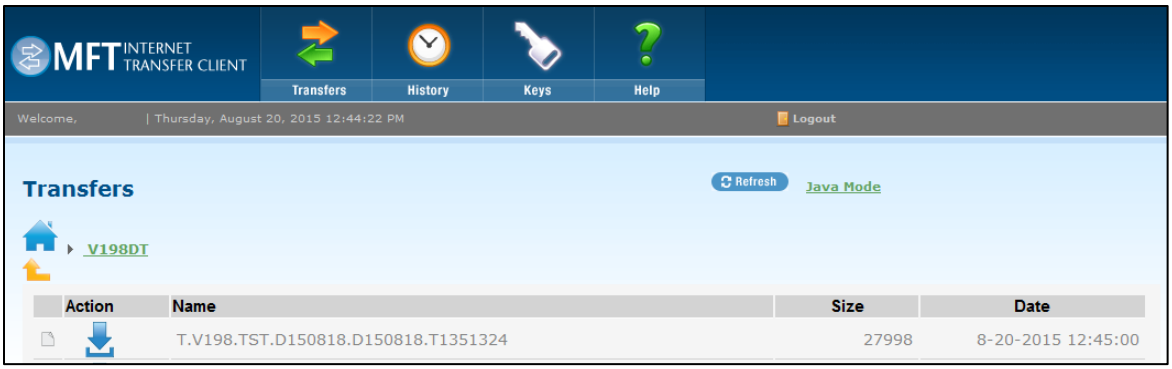


Figure 6 - Select files to download window

4. Click the **Save** button. Select the location and click **Save** again.

7.4 Review your File Transfer History

To review your file transfer history:

1. From the Transfers page, click the **History** button (located along the top of the Transfers page). The History page displays (see Figure 7).

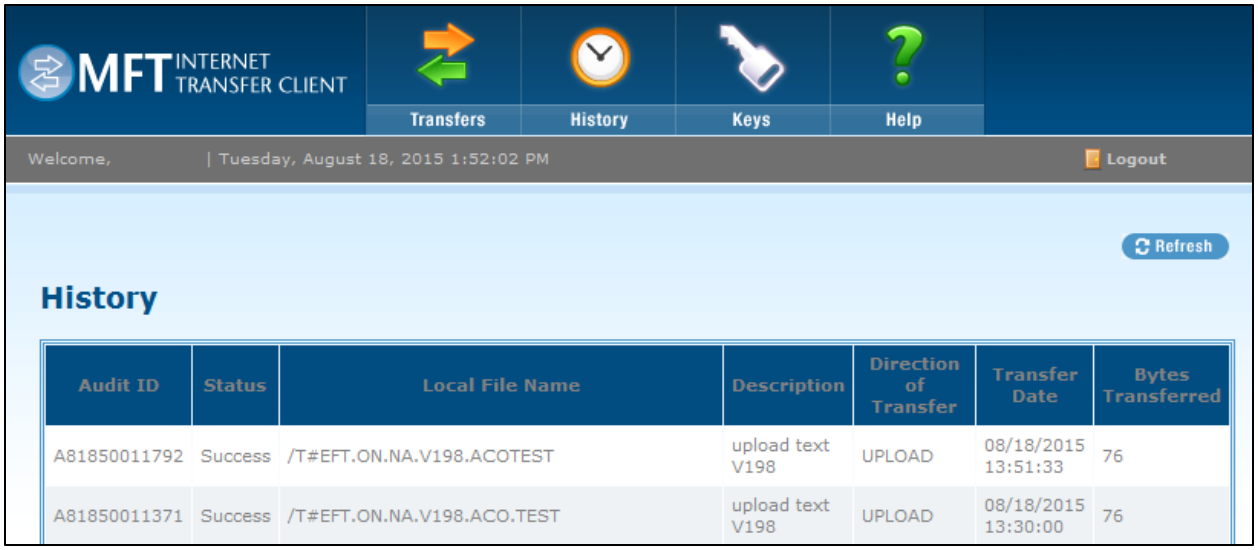


Figure 7 - History window

2. From this page, you may review the audit ID, status, local file name, description, direction of transfer, transfer date, and bytes transferred data for all files processed under your account.

   NOTE: The Keys function (located along the top of the Transfers page) is not used for HTTPS file transfers at this time.

7.5 Logging Off

To log out:

1. Click the **Logout** button located in the upper right area of the page.
2. Close your Web browser.

8.0 FREQUENTLY ASKED QUESTIONS

8.1 Page Not Displayed

Why am I receiving a "Page Not Displayed" error when I attempt to navigate to ***https://eftp2.cms.hhs.gov:11443/****?*

Your organization's firewall may be blocking the IP address xx.xxx.232.162 on Port 11443. Check your permissions to navigate to this IP address and port with your organization's firewall point of contact.

8.2 Logon Prompt Return

Why does the logon prompt return when I enter my user ID and password?

The logon screen returns after entry when the Internet Server is unable to authenticate the user ID and password combination that you entered. For assistance with issues regarding your password, contact the Affordable Care Act Information Center (ACAIC) at 1-888-734-6433, Option 2.

8.3 RACFROUTE Auth Fail-User Not Authorized

Why do I receive the error message "RACROUTE AUTH fail-User not authorized" when I attempt to upload a file?

This error indicates that you do not have permission to upload a file with the file name that you are using. Double-check that you are selecting the correct MFT Internet Server directory/folder and verify that the filename follows the proper naming convention outlined in section 4.0. If you believe that your file name is correct and you still receive this error message, contact the CMS Service Desk at 1-800-562-1963 or via e-mail (CMS_IT_Service_Desk@cms.hhs.gov).

8.4 Session ID has Expired

Why am I receiving the error message "Session ID has expired"?

A "Session ID has expired" error indicates that you are no longer logged into the MFT Internet Server. You may have logged out manually by clicking the Logout link or – after a period of inactivity – the MFT Internet Server may have automatically terminated your session. To log in again, begin a new browser session before navigating to the MFT Web interface page. To open a new session in Internet Explorer, click **File> New Session**.

8.5 User Not Authorized

Why do I receive the error message "User not authorized" when I attempt to upload a file?

This error indicates that you do not have permission to upload a file with the file name that you are using. Double-check your file name to ensure that it follows the proper naming convention. If you believe that your file name is correct and you still receive this error message, contact the Affordable Care Act Information Center (ACAIC) at 1-888-734-6433, Option 2.

8.6 File Transfer in Progress

Why does the "File transfer in progress" window "hang" when I attempt to transfer a file?

Your organization's firewall might be blocking the user's ability to accept SSL certificates, Java code certificate requests, or the IP address xx.xxx.232.162 on Port 11443, or using NTLM authentication. Check with your network administrator.

If your firewall is not blocking the IP, certificates or Java code certificate requests, attempt to access the site with **https://eftp2.cms.hhs.gov:11443/browser.**

9.0 SUPPORT & TECHNICAL ASSISTANCE

For assistance, including issues with account passwords and the MFT Web browser interface, contact the Affordable Care Act Information Center (ACAIC) at 1-888-734-6433, Option 2.

10.0 ACTIVITY HISTORY

Version[1]	Activity Type	Details	Activity Owner	Owner Role	Date
V1.0	Creation	Document Created	Nicole Mister	EFT Analyst	8/17/2015

[1] Assign whole numbers to major revisions, such as 1.0, 2.0, 3.0, etc.

Next Generation User ACO Guide - Push

Version:	1.0
Owner:	Nicole Mister
Location:	NGS
Publication Date:	8/17/2015
Document Control Number	9013

Table of Contents

List of Figures

1.0 OBJECTIVE

This document serves as a user guide for the Next Generation Accountable Care Organizations (ACOs) using Secure File Transfer Protocol (SFTP) to exchange data with CMS, a process that National Government Services (NGS) coordinates and provides to the Centers for Medicare & Medicaid Services (CMS).

2.0 SCOPE

This document addresses only transfers using Secure File Transfer Protocol (SFTP). To use the SFTP capability, your organization will need an SFTP client to send files to CMS and a Secure Shell (SSH) server to receive files from CMS.

3.0 BACKGROUND AND PURPOSE

The Enterprise File Transfer (EFT) facility provides secure automated file transfer services for the CMS inter-agency data transfers, and for external organizations that are required to exchange data with CMS as part of doing business with the agency. The EFT Team establishes and maintains these connections between CMS and external organizations.

Procedures for preparing to exchange files to CMS and uploading an SSH2 public key are described in Sections 5.0 and 6.0. The process for connectivity testing is described in Section 7.0. Section 8.0 provides answers to frequently asked questions about use of Managed File Transfers (MFT). Section 9.0 provides information on support and technical assistance available in the use of the SFTP MFT Internet Server system.

4.0 TERMINOLOGY

ACAIC – Affordable Care Act Information Center

ACO – Accountable Care Organization

CMS – Centers for Medicare & Medicaid Services

CMCS – Center for Medicaid, CHIP and Survey & Certification

EFT - Enterprise File Transfer

EFT Admin- Refers to any member of the EFT team

HTTPS – Secure Hypertext Transfer Protocol

Gentran – IBM Sterling file transfer product

IACS – Individuals Authorized Access to CMS Computer Services

IS – Internet Server (part of TIBCO MFT)

MFT – Managed File Transfer (TIBCO product)

MS – Microsoft

NGS – National Government Processes

SFTP – Secure File Transfer Protocol

SSH – Secure Shell

5.0 PREPARATION FOR EXECUTING FILE TRANSFERS

5.1 Managed File Transfer Internet Server

To securely exchange files using Secure File Transfer Protocol (SFTP), CMS utilizes the Managed File Transfer (MFT) Internet Server, a TIBCO product. The Secure File Transfer Protocol (SFTP) of MFT Internet Server allows external organizations to exchange data with CMS using a Secure Shell (SSH) server.

5.2 Access Requirements

In order to transfer files to CMS via SFTP, customers must provide their own SFTP client which is capable of supporting the protocols outlined in this document. Internet access must be provided by the customer.

To access MFT Internet Server via SFTP, you must use a Secure Point Of Entry SPOE ID and password. The SPOE ID is a 7-character user ID assigned to you by the IACS Engineering team.

5.2.1 SFTP CLIENT AUTHENTICATION PROTOCOL

SFTP clients used to connect to MFT Internet Server must support **SSH2 keys or x.509 certificates**. SSH2 keys are most commonly used. SSH2 key pairs must be **1024-bit RSA SSH2 with a passphrase**. The public key will need to be provided to EFT (see Section 6.0).

As an alternative to using an SSH2 key, you may obtain from EFT an X.509 certificate and passphrase, which is compatible with some SFTP clients.

5.2.2 CONNECTION CONFIGURATIONS

To connect, the following configurations must be set in the SFTP client:

- Host name: eftp2.cms.hhs.gov
- Port number: **11222**
- Authentication method: key and password
- ID entered as **SYSIDLDAP-GIS####**
- RSA SSH2 private key and passphrase or X.509 private certificate and passphrase
- Compression: zlib (optional)

MFT Internet Server uses both password and key authentication. Please make sure you use your key and enable password authentication in your SFTP client.

5.2.3 SSH SERVER

To receive files from CMS, your site will need an SSH server. You will be provided the EFT Partner Server form. The following information is requested on the form:

- IP Address
- Port Number: 22 or 11022
- Username
- Directory
- Password expiration procedures
- SSH DSA Host Key

If you need assistance, direct any questions to your EFT contact.

5.3 File-naming Conventions

EFT uses file-naming conventions to facilitate automatic file exchanges. These conventions are crucial for proper transfer of files. Below is an example of a file name retrieved by an ACO from CMS:

*P.V***.NGALIGN.RP.Dyymmdd.Thhmmsst*

Files retrieved by an ACO include six qualifiers separated by a dot (.) as a delimiter.

The first qualifier indicates if the file is a Test file or a Production file, with a “P” for Production or “T” for Test.

The second qualifier indicates the ACO ID number.

The third and fourth qualifiers indicate the type of file.

The fifth and sixth qualifiers are the date-time stamp. The date is indicated by a “D” followed by the date in the format of a two-digit year, two-digit month, and two-digit day. The time is indicated by a “T” followed by a two-digit hour, two-digit minute, two-digit second, and one-digit tenth of a second.

Files submitted to CMS by an ACO should also follow a naming convention, as shown in the following example:

*P#EFT.ON.ACO.V***.NGVLALGN*

The first qualifier is either a “P#EFT” for Production files or a “T#EFT” for test files.

The second and third qualifiers are always “ON.ACO.”.

The fourth qualifier indicates the ACO plan number.

The fifth qualifier indicates the type of file.

The date-time stamp is automatically appended to files inbound to CMS. The following is an example of a file name when it arrives at CMS.

*P#EFT.ON.ACO.V***. NGVLALGN.Dyymmdd.Thhmmsst*

Because the date-time stamp is automatically appended, you do not need to include a date-time stamp in your CMS inbound file names.

6.0 UPLOAD KEY TO MFT INTERNET SERVER

This section describes how to upload the SSH2 public key from your SFTP client to MFT Internet Server.

1. Generate an SSH2 RSA or DSA 1024-bit key pair with a passphrase with your SFTP client. **NOTE**: MFT Internet Server does not support PGP keys.
2. Open your Web browser.
3. Navigate to the Uniform Resource Locator (URL) for executing HTTPS transfers https://eftp2.cms.hhs.gov:11442/. If a security warning appears for this URL (see Figure 1), click the **Continue to this website** link.

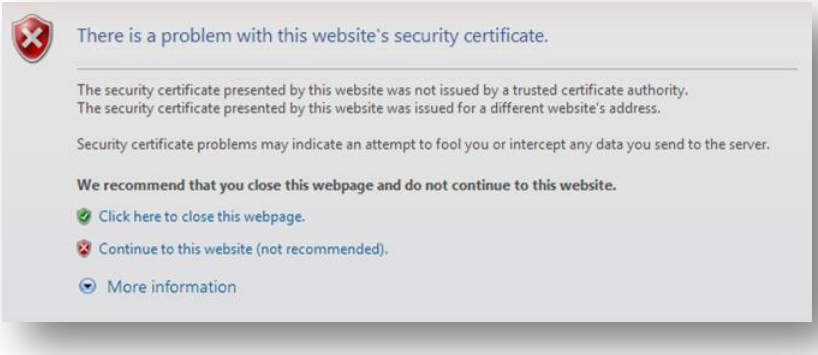


Figure 1 - Security Warning message

A logon window displays. In the User name and Password fields, respectively, enter your GIS#### and password. Click the OK button when ready.

4. After you login to the website, please select the Keys link (see Figure 2).

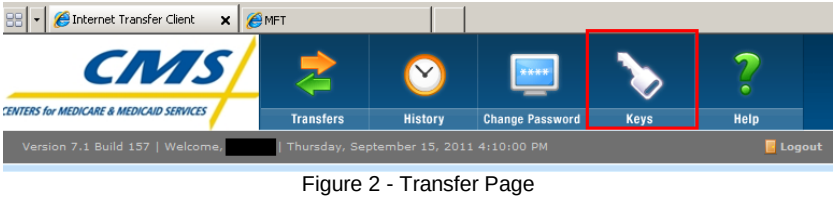


Figure 2 - Transfer Page

5. Expend the **SSH Public Key view** (see Figure 3). Please make sure that you copy your entire public key and enter it as shown below.

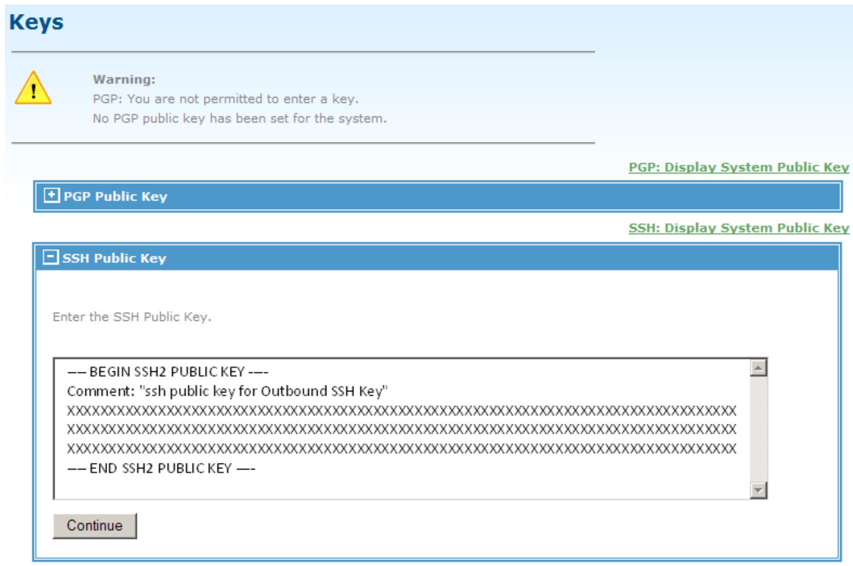


Figure 3 - Upload SSH Key

6. Click the **Continue** button.

Figure 4 - Click Continue

7. Click the **Continue** button.

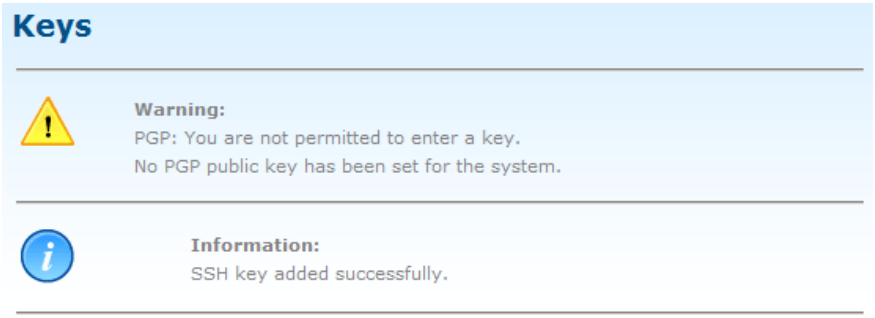


Figure 5 - SSH Key Confirmation

8. Log out of the web interface of MFT Internet Server and notify the EFT representative you are working with that you are ready to proceed.

   NOTE: You will not use the MFT web interface after successful addition of your key.

7.0 CONNECTIVITY TESTING

To verify that you are able to submit and receive files, complete the actions described in the subsections below to test your ability to upload files to CMS (see Section 7.1) and receive files from CMS (see Section 7.2).

NOTE:

- If you are assigned to support multiple ACO ID numbers (for example, V***), you must test the text transfers for each ACO ID number.
- A successful test includes both an upload and download of a test file for the text transfer. Both actions are required for a complete test.

7.1 Test to Send Files to CMS

1. Create a test file named:

   *T#EFT.ON.NG.V***.TST*

   a. Use a text editor application (such as Windows Notepad, Linux VI, and Mac TextEdit) to create a test file. Insert a few lines of text (such as “This is a test.”) in the body of the file.

   b. Save the file with the name shown above, replacing the asterisks with your plan number. ***Do not use the .txt extension in the file name.***

      NOTE: The file-naming convention for this particular test file does not follow the standard for inbound file names.

2. Logon to your SFTP client and upload your test file to the "V***UT" virtual directory.
3. Perform the applicable action:
   - If you are ***not successful*** uploading your test file, review Section 8.0 for possible solutions to frequently asked questions. If you are still experiencing difficulties, notify your EFT contact.
   - If you are ***successful*** uploading your test file, continue to the download test procedure described in Section 7.2.

7.2 Test to receive files from CMS

1. The file that you transferred to CMS will be routed back to you. Wait for the file, as this internal process could take a few minutes.
2. Your test file will be transferred to your server. Verify that the file arrives in the destination directory with the expected formatting.

   NOTE : The file-naming convention for this particular test file does not follow the standard for outbound file names.
3. Perform the applicable action:
   - If the transfer to your server is ***not successful*** downloading your test file, notify your EFT contact.
   - If the transfer to your server is ***successful***, your connectivity test is complete; provide confirmation to your EFT contact. No further action is required for connectivity testing.

8.0 FREQUENTLY ASKED QUESTIONS

8.1 Page Not Displayed

Why am I receiving a "Page Not Displayed" error when I attempt to navigate to **https://eftp2.cms.hhs.gov:11442/***?*

Your organization's firewall may be blocking the IP address xx.xxx.232.162 or Port 11442. Check your permissions to navigate to this IP address and port with your organization's firewall point of contact.

8.2 Invalid User ID/Password

Why do I receive invalid user ID or password when I logon to my SFTP Client with my SYSIDLDAP-GISXXXX ID?

This message appears when the Internet Server is unable to authenticate the user ID and password combination that you entered. For assistance with issues regarding your password, contact the Affordable Care Act Information Center (ACAIC) at 1-888-734-6433, Option 2.

8.3 RACFROUTE Auth Fail-User Not Authorized

Why do I receive the error message "RACROUTE AUTH fail-User not authorized" when I attempt to upload a file?

This error indicates that you do not have permission to upload a file with the file name that you are using. Double-check that you are selecting the correct MFT Internet Server directory/folder and verify that the filename follows the proper naming convention outlined in section 4.0. If you believe that your file name is correct and you still receive this error message, contact the CMS Service Desk at 1-800-562-1963 or via e-mail (CMS_IT_Service_Desk@cms.hhs.gov).

8.4 Data would be Truncated

Why do I receive the error message "Data would be Truncated" when I attempt to upload a file?

This error indicates that a record in the file is larger than the attributes (e.g., record length, record format, etc.) specified for this file. This message typically displays when a user attempts to transfer a file that is better suited for binary transfer through the text upload transfer.

- Examples of files that are better suited to binary transfer are Microsoft (MS) Word documents, MS Excel worksheets, Adobe .PDF files, etc.
- Files that are better suited to text transfer are text files and comma separated value files.

If you are testing connectivity, use a text editor application (for example, Windows Notepad, Linux VI, Mac TextEdit, etc.) to create your text file.

9.0 SUPPORT & TECHNICAL ASSISTANCE

For assistance, including issues with account passwords and the MFT Web browser interface, contact the Affordable Care Act Information Center (ACAIC) at 1-888-734-6433, Option 2.

10.0 ACTIVITY HISTORY

Version1	Activity Type	Details	Activity Owner	Owner Role	Date
V1.0	Creation		Nicole Mister	EFT Analyst	8/17/2015

[1] Assign whole numbers to major revisions, such as 1.0, 2.0, 3.0, etc.

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Accountable Care Organization – Operational System (ACO-OS)

Next Generation Accountable Care Organization (NGACO) Alignment List Report (ALR) Information Packet (IP)

Version 2.0

06/24/2015

Document Number: NGC.ICDA.0302.2.0.0615

Contact Number: NGC-HHSM-500-2007-00014I/HHSM-500-T0006

Prepared for:
Centers for Medicare & Medicaid Services (CMS)
Office of Technology Solutions
7500 Security Boulevard, N2-13-16
Baltimore, MD 21244-1850

Prepared by:
Northrop Grumman Corporation (NGC)
Information Systems
2810 Lord Baltimore Drive
Baltimore, MD 21244

Approvals

The undersigned acknowledge that they have reviewed this document and agree with the information presented within this document. Changes to this document will be coordinated with, and approved by, the undersigned, or their designated representatives.

Signature: Date:

Print Name: Vince Mashek

Title: ACO-OS Program Manager

Role: Submitting Organization's Approving Authority

Signature: Date:

Print Name: Joshua Sopher

Title: OTS/ISDDG/DND – CMS ICD&A Government Task Lead (GTL)

Role: CMS' Approving Authority

Signature: Date:

Print Name: Michael Reinhold

Title: OEM/OEB/IBSG – Director

Role: CMS Business Owner

Record of Changes

Version	Date	Author/Owner	Description of Change
0.1	05/08/2015	Nima Eslami/Northrop Grumman	Initial draft for June 2015 release based on CR 225.
1.0	06/02/2015	Geoff Cummings/ Northrop Grumman	Baselined as Final for June 2015 Release.
1.1	06/19/2015	Nima Eslami/Northrop Grumman	Updated Data Format information on pages three and four; Table 1 based on comments received from Kristine Maenner.
2.0	06/24/2015	Nima Eslami/Northrop Grumman	Removed the bulleted list of 13 elements in section 2.1, step 13. Baselined as Final for June 2015 Release.

Table of Contents

List of Figures

List of Tables

1 Overview

The purpose of this information packet (IP) is to provide instructions for basic operations in the Next Generation Accountable Care Organization (NGACO) Alignment List Report (NGACO ALR) and to document the decisions made in building the NGACO ALR process. NGACO ALR consists of one report:

- NGACO Initial Alignment Report (Report 1-1)

The Patient Protection and Affordability Act was signed into law in March 2010. Section 1899 was added to the Social Security Act requiring the establishment of a Shared Savings Program. The Final Rule for Shared Savings Program ACOs was published on November 2, 2011.

ACOs are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high quality care to the Medicare patients they serve. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

Medicare offers several ACO programs, including the NGACO Model, which is a population-based payment initiative for health care organizations and providers experienced in coordinating care for patients across care settings.

Organizations across the country have already transformed the way they deliver care, in ways similar to the ACOs supported by Medicare.

ACOs are aimed at specifically improving value in the Medicare program – both higher quality and lower total cost. The goal of the NGACO Model is better health for populations, better care for individuals, and lower growth in expenditures.

The annual report for the NGACOs is based on actual, prospectively aligned beneficiaries, and is calculated with a three-month claims run-out that is performed before the beginning of each performance year.

2 NGACO Alignment List Report

The following section provides information on the NGACO ALR report:

- NGACO Initial Alignment Report (Report 1-1)

The NGACO Initial Alignment Report is generated once at the beginning of each performance year to create a list of prospectively aligned beneficiaries for a specific NGACO. The Integrated Data Repository (IDR) data is used for gathering the alignment list data. The report includes beneficiary demographic information, indicators specifying their alignment eligibility, if they have Part D coverage and risk scores for each of the alignment years. The specific data elements with their descriptions can be found in Section 2.2 of this document. The ACO will receive the report data in a text file.

2.1 Opening the NGACO Initial Alignment Report

The NGACO Initial Alignment Report is delivered to the ACOs as text files. The following instructions address how to open these text files in Excel.

1. Copy or save the file to your computer or a secure network drive as a text file.
2. Open Excel.
3. Select **File**, then **Open.**
4. Select the location of the file saved/copied in Step 1.
5. The first Import Wizard pop-up displays, as represented in **Error! Reference source not found.**.
6. Select the **Delimited** radio button under **Original data type**.
7. Select **Next**.

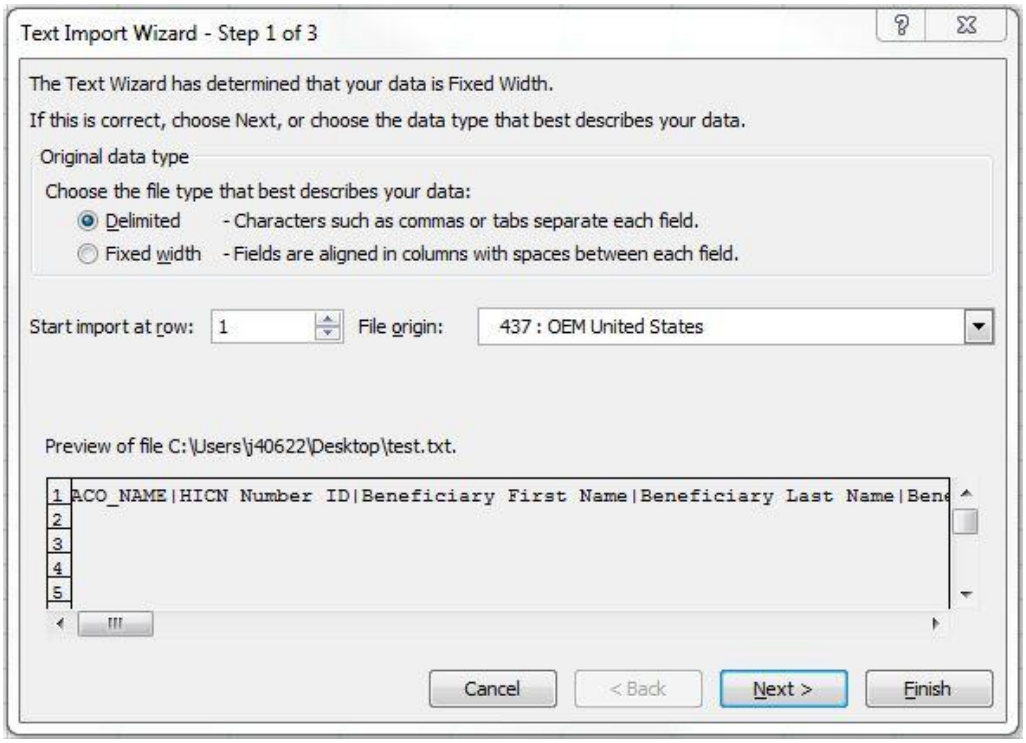


Figure 1: Text Import Wizard Step 1

8. The second Import Wizard pop-up displays, as represented in **Error! Reference source not found.**.
9. Select the **Other** checkbox.

   NOTE: If the **Tab** checkbox is already selected, de-select it.
10. Enter the pipe symbol in the text box next to the **Other** checkbox.

    NOTE: To enter the pipe symbol, press the **Shift** key on the keyboard and select the backward slash **(\)** key at the same time.
11. Select **Next**.

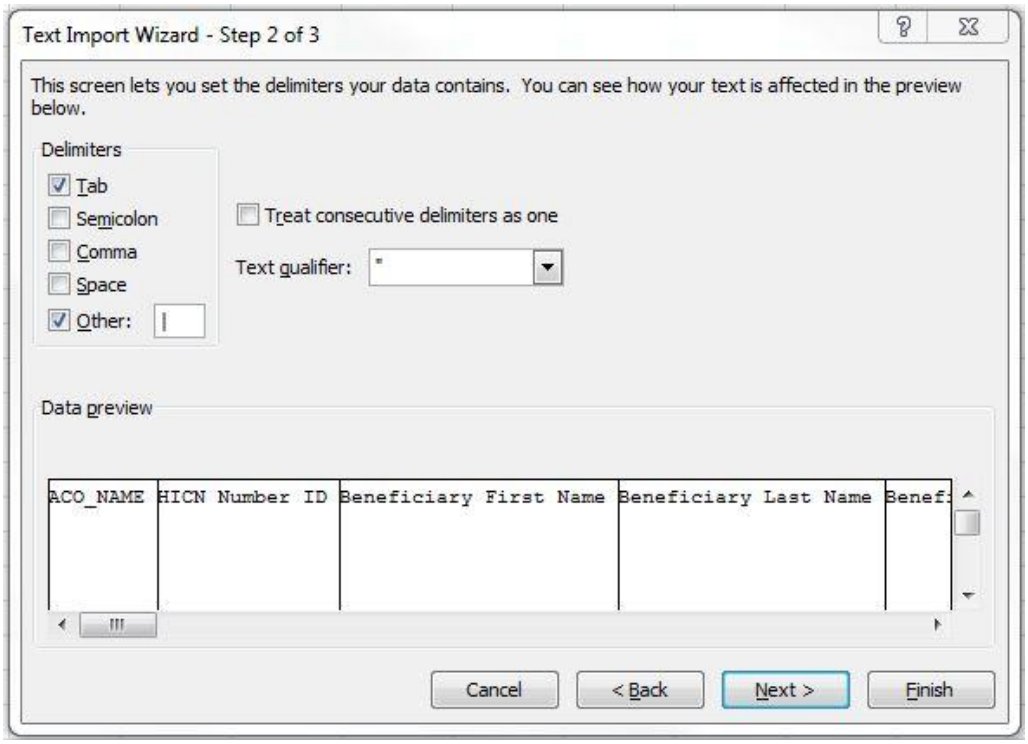


Figure 2: Text Import Wizard Step 2

12. The third Import Wizard pop-up displays, as represented in **Error! Reference source not found.**.
13. Change the data format from **General** to **Text** for all columns identified in Table 1.

    NOTE: This ensures that the data is correctly identified by Excel and displays properly in the worksheet file.
14. Select **Finish**.

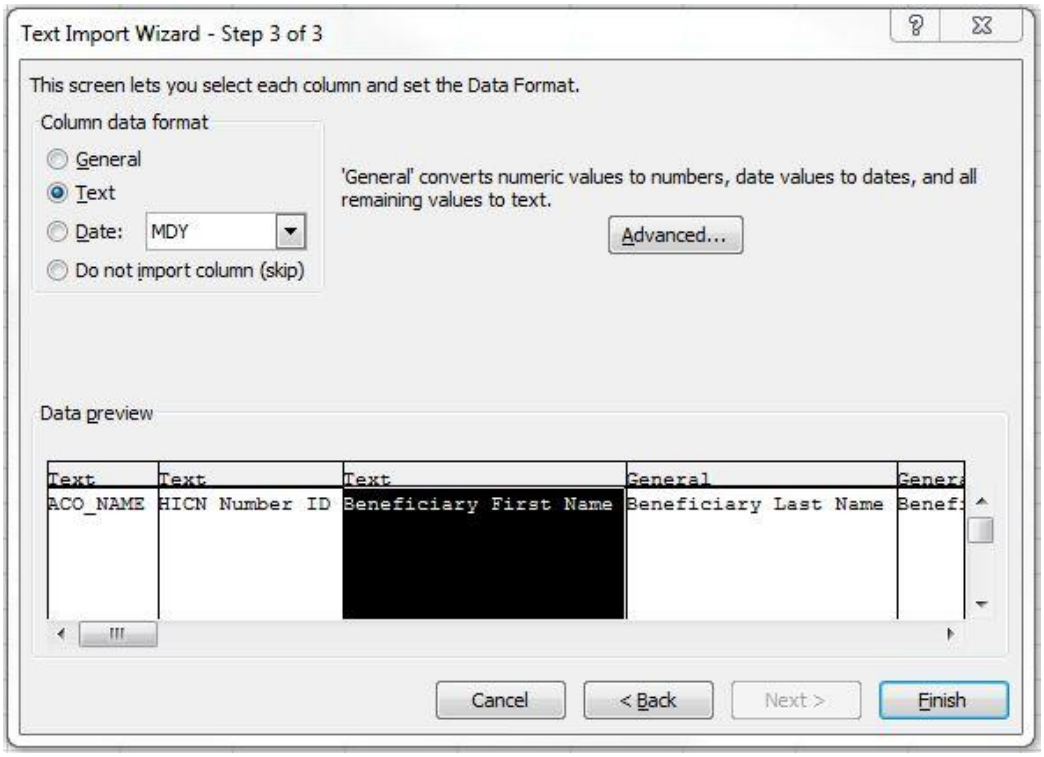


Figure 3: Text Import Wizard Step 3

15. The open spreadsheet displays with data for the ACO.
16. Resize the columns in the spreadsheet as needed.

2.2 NGACO Initial Alignment Report Format

The following table details the pipe-delimited text file for the report.

Table 1: NGACO Alignment List Format

Element #	Element Name	Data Description	Data Length	Format	Comments
1	ACO_NAME	ACO Name	100	VARCHAR(100)	NGACO's name; this must contain a value.
2	BENE_HIC_NUM	Current HIC NUM	12	VARCHAR(12)	Beneficiary's current HIC NUM; this must contain a value. It can start with {, a letter, or a number.
3	BENE_1ST_NAME	First Name	30	VARCHAR(30)	Beneficiary's first name; this must contain a value.
4	BENE_LAST_NAME	Last Name	40	VARCHAR(40)	Beneficiary's last name; this must contain a value.
5	BENE_LINE_1_ADR	Address Line 1	45	VARCHAR(45)	First line of the beneficiary's address; this must contain a value.
6	BENE_LINE_2_ADR	Address Line 2	45	VARCHAR(45)	Second line of the beneficiary's address; this value can be blank.
7	BENE_LINE_3_ADR	Address Line 3	40	VARCHAR(40)	Third line of the beneficiary's address; this value can be blank.
8	BENE_LINE_4_ADR	Address Line 4	40	VARCHAR(40)	Fourth line of the beneficiary's address; this value can be blank.
9	BENE_LINE_5_ADR	Address Line 5	40	VARCHAR(40)	Fifth line of the beneficiary's address; this value can be blank.
10	BENE_LINE_6_ADR	Address Line 6	40	VARCHAR(40)	Sixth line of the beneficiary's address; this value can be blank.
11	GEO_ZIP_PLC_NAME	City	100	VARCHAR(100)	City's name for a beneficiary; this value can be blank if outside the United States.

Element #	Element Name	Data Description	Data Length	Format	Comments
12	GEO_USPS_STATE_CD	USPS State Code	2	CHAR(2)	State abbreviation code for a beneficiary; this can be blank if outside the United States.
13	GEO_ZIP5_CD	5 digit zip code	5	CHAR(5)	Beneficiary's 5 digit Zip code; the value can contain blank or a tilde (~), primarily for addresses outside the United States.
14	GEO_ZIP4_CD	4 digit zip code	4	CHAR(4)	Beneficiary's +4 digit Zip code; the value can contain blank or a tilde (~), primarily for addresses outside the United States.
15	BENE_SEX_CD_DESC	Gender	100	VARCHAR(100)	Beneficiary's gender; there may be instances where the data value contains "UNKNOWN."
16	BENE_BRTH_DT	Birth Date	10	MM/DD/YYYY	Beneficiary's birth date.
17	BENE_AGE	Calculated Age	3	INTEGER	Beneficiary's calculated age at the time of alignment or time of death. BENE AGE is calculated based on current system date or death date as follows: (CASE WHEN BENE_DEATH_DT is not null THEN CAST((BENE_DEATH_DT - BENE_BRTH_DT)/365 as Integer) ELSE CAST ((DATE - BENE_BRTH_DT)/365 as integer) END) BENE_AGE
18	BENE_ELGBL_ALGNMNT_YR_1_IND	Beneficiary Eligibility Alignment Year 1	1	CHAR(1)	Identifies if a beneficiary was alignment-eligible based on the AY1 with either a "Y" (Yes) or "N" (No).

Element #	Element Name	Data Description	Data Length	Format	Comments
19	BENE_ELGBL_ALGNMNT_YR_2_IND	Beneficiary Eligibility Alignment Year 2	1	CHAR(1)	Identifies if a beneficiary was alignment-eligible based on the AY2 with either a “Y” (Yes) or “N” (No).
20	BENE_PTD_CVRG_ALGNMNT_YR_1_IND	Beneficiary Part D Coverage Alignment Year 1	1	CHAR(1)	Identifies if a beneficiary had Pharmacy Coverage for Part D during alignment year with either a “Y” (Yes) or “N” (No).
21	BENE_PTD_CVRG_ALGNMNT_YR_2_IND	Beneficiary Part D Coverage Alignment Year 2	1	CHAR(1)	Identifies if a beneficiary had Pharmacy Coverage for Part D during alignment year with either a “Y” (Yes) or “N” (No).
22	BENE_ALGNMNT_YR_1_HCC_SCRE_NUM	Final Community Hierarchical Condition Categories Year 1 Indicator	7	DECIMAL(6,4)	The beneficiary’s Part C Final HCC Score for the calendar year in which AY1 starts.
23	BENE_ALGNMNT_YR_2_HCC_SCRE_NUM	Final Community Hierarchical Condition Categories Year 2 Indicator	7	DECIMAL(6,4)	The beneficiary’s Part C Final HCC Score for the calendar year in which AY2 starts.
24	PRVDR_ACO_NEW_ALGN_BENE_SW	Newly Aligned Beneficiary Flag	1	CHAR(1)	Identifies if a beneficiary is newly aligned with a “Y” (Yes) or if aligned to the same ACO as the last performance year an “N” (No).
25	PRVDR_NGACO_ALGN_BY_ATSTTN_SW	Voluntary Alignment Flag	1	CHAR(1)	Default value is ‘N’. The voluntary preference will be updated to ‘Y’ if BENE is QEM qualified.

Glossary

Term	Definition
Accountable Care Organization	ACO is a health system model with the ability to provide, and manage for patients a continuum of care across different institutional settings, including at least ambulatory (outpatient) and inpatient hospital care, and possibly post-acute care.
Cumulative report through [mmm dd, yyyy]	The report includes cumulative information for the calendar year up until the date the report was generated.
Fee-for-Service	FFS is the traditional method of reimbursing physicians, hospitals and other health care providers for their services.
Healthcare Common Procedure Coding System	HCPCS is a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (Commonly pronounced Hick-Picks).
Integrated Data Repository	The IDR is a single source database system containing CMS beneficiary, claim, and provider data.
NGACO Alignment List Report	NGACO ALR consists of a list report delivered to ACOs that details valuable information about their aligned population.
Shared Savings Program	Section 3022 of the Affordable Care Act requires the CMS to establish a Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare FFS beneficiaries and reduce unnecessary costs.
Social Security Administration	The SSA is an independent government agency responsible for the Social Security system.

Acronyms

Acronym	Description
ACO	Accountable Care Organization
ACO-OS	Accountable Care Organization – Operational System
AY	Alignment Year
BENE	Beneficiary
CHAR	Character
CMS	Centers for Medicare & Medicaid Services
FFS	Fee-for-Service
HCC	Hierarchical Condition Categories
HCPCS	Healthcare Common Procedure Coding System
HIC NUM	Health Insurance Claim Number
HICN	Health Insurance Claim Number
IDR	Integrated Data Repository
IP	Information Packet
NGACO	Next Generation Accountable Care Organization
OEP	Open Enrollment Period
NGACO ALR	Next Generation Accountable Care Organization Alignment List Report
SSA	Social Security Administration
USPS	U.S. Postal Service
XLC	eXpedited Life Cycle
ZIP	Zone Improvement Plan

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Accountable Care Organization – Operational System (ACO-OS) Claim and Claim Line Feed (CCLF)

Information Packet (IP)

Version 11.0

08/28/2015

DRAFT

Document Number: NGC.ICDA.0301.11.0.0815
Contact Number: NGC-HHSM-500-2007-00014I/HHSM-500-T0006

Prepared for:
Centers for Medicare & Medicaid Services (CMS)
Office of Technology Solutions
7500 Security Boulevard, N2-13-16
Baltimore, MD 21244-1850

Prepared by:
Northrop Grumman Corporation
Information Systems
2810 Lord Baltimore Drive
Baltimore, MD 21244

Notices and Disclaimers

CPT only copyright 2013 American Medical Association. All rights reserved.

CPT is a registered trademark of the American Medical Association.

Applicable FARS\DFARS Restrictions Apply to Government Use.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

DRAFT

Approvals

The undersigned acknowledge that they have reviewed the Information Packet and agree with the information presented within this document. Changes to this Information Packet will be coordinated with, and approved by, the undersigned or their designated representatives.

Signature: Date:

Print Name: Vince Mashek

Title: ACO-OS Program Manager

Role: Submitting Organization's Approving Authority

Signature: Date:

Print Name: Joshua Sopher

Title: OTS/ISDDG/DND – CMS ICD&A Government Task Lead (GTL)

Role: CMS' Approving Authority

Signature: Date:

Print Name: Pauline Lapin

Title: Group Director, Seamless Care Models Group

Role: CMS Business Owner

Signature: Date:

Print Name: John Pilotte

Title: CM/Performance-based Payment Policy Group – ACO Shared Savings Program Business Owner

Role: CMS Business Owner

DRAFT

Record of Changes

Version	Date	Description of Change
1.0	03/07/2012	BIETL096_Pioneer_CCLF_IP_v1_0_F_20120307
2.0	11/06/12	In Table 3, Element 3, corrected the format to X(06) because Online Survey Certification and Report System (OSCAR) numbers contain both letters and numbers. Edited and renamed the document (removed the word "Pioneer," etc.) so that it applies to the entire ACO program. Added additional Appendix to include Substance Abuse Codes. Added the AMA copyright disclaimer to Table 4 – CPT Codes. Added the Summary Statistics file. Updated Appendix B – File Layouts Updated Sections 2, 3, 4, and 5 to incorporate the change to the Debit/Credit version of the data feed. Additional Section: Section 7. Deleted extra space between section 5.4 and 5.5.
3.0	02/25/2013	Final baselined version by NG.

DRAFT

Version	Date	Description of Change
4.0	07/29/2013	March 2013: Revised to add new and additional fields and information as requested by CMS. Updated Appendix B for the March 2013 release. Updated and baselined versioning per customer's request and added change records from Maricom. Updated and baselined versioning per CM/P3's request and removed duplicate rows in Table 16. June 2013: Updated the "Description of Change" to be more descriptive of changes for the June 2013 release. Section 2.6: Addition of text stating the file will be sent to SSP and Pioneer Part A Claims Revenue Center Detail File Addition of "CLM_LINE" to Claim Field Label element 7 and 9 Part B Physicians File Addition of "RNDRG" to Claim Field Label element 18 Finalized updates for the June 2013 release: Changes to section 2.1.1 based on comments from CM received on June 26, 2013. Minor edits to section 3.3 to improve readability. Changes to section 2.1.1 based on comments from CM received on July 17, 2013.
5.0	02/26/2014	Updated Section 2.5.2. Updated the format column of elements 23 and 24 in Appendix B, Table 6. Revised Section 2.5.2 Updated Provider Specialty Codes hyperlink for Element #9 in Table 10. Baselined as Final for March 2014.
6.0	05/14/2014	Added Table 6: ICD-10-PCS Inpatient Procedure Codes. Added Table 7: ICD-10-CM Diagnosis Codes. Baselined as final for June 2014 release.
7.0	06/24/2014	Added additional Substance Abuse codes. Baselined as final for June 2014 release.

DRAFT

Version	Date	Description of Change
8.0	09/30/2014	Changes to the CCLF format effective October 2014. Updated based on the September 2014 release: Updated Table 9, Element #14-20. Updated Table 12, Element #28-42. Updated Table 14, Element #10-19. Added additional fields for Table 15: Beneficiary Demographics File. Updated based on customer. Updated Table 14, Element #12 added “DEA” in Claim Field Description. Updated Table 15, Elements #17 and #18. Highlighted changes in Appendix B: CCLF File Layouts, including Tables 9, 12, 14, and 15.
9.0	12/23/2014	Added Notices and Disclaimers. Updated Section 1. Updated the Format column in Tables 8, 9, 12, 13, 14, and 19. Update the Part B Physician File Table 18 Element 7 to include additional Provider Type Codes.
10.0	07/17/2015	Reworded the two lead-in paragraphs in Appendix A: Alcohol and Substance Abuse Codes. Appendix A: Removed SA codes based on coordination with SAMHSA. Updated the following sections to include the ICD codes of 9, 10, and “U”: 2.2.1, 2.2.3, 2.2.4, 2.3.1, and Appendix B: CCLF File Layouts. Updated Table 13: ICD-10-CM-Diagnosis Codes with the updated list of ICD9/10 codes. Updated Section 2.6.

DRAFT

Version	Date	Description of Change
11.0	08/28/2015	Updated Section 2.5.1 – Provided further information regarding the Beneficiary Demographics File. Updated Section 3.2 – Clarified blank vs. non-blank value of the variable CCLFs. Updated Section 4.0 and 4.1 – Revised text for clarity. Updated Section 5.2.1 – Provided further information regarding the Natural Keys. Updated typos on “BENE_EQTBL_BIC_HICN_NUM” where applicable. Added Section 8: Best Practices for Protecting Beneficiary-Level Data. Updated Appendix B – Added CCLF file number after each file name. Updated Acronyms List.

DRAFT

Table of Contents

DRAFT

DRAFT

List of Figures

List of Tables

DRAFT

1 Overview

The purpose of this information packet is to provide instructions for basic operations in the Accountable Care Organization (ACO) Program Claim and Claim Line Feed (CCLF).

The ACOs will request that the Centers for Medicare & Medicaid Services (CMS) gather a data feed for beneficiaries who have been notified of the possibility for data sharing and who have not declined to allow CMS to share their claims data with the ACO. The data feed provided to the ACO will include claims for all services covered by Part A (Hospital Insurance) and Part B (Supplemental Medical Insurance) that were provided to beneficiaries who agreed to data sharing and were processed during the prior month. Claims data will also include prescriptions covered by a Prescription Drug Program in which the beneficiary is enrolled. Medicare Claims are submitted by a broad range of facilities (institutional providers), professionals, and suppliers, including hospitals (both inpatient and outpatient claims); physicians; home health agencies (HHA); skilled nursing facilities (SNFs); hospices; and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) providers. Some of these provide services that are covered by Part A and/or Part B (e.g., hospitals and SNFs); others provide services that are covered only by Part B.

Medicare Administrative Contractors (MAC) (formerly Fiscal Intermediaries [FI] and Carriers) are responsible for processing Medicare claims. Different payment methods and claims processing systems are used depending upon the type of facility where services are received. For example, the inpatient prospective payment system (IPPS) is used to price acute hospital inpatient services, the Physician Fee Schedule is used to price physician office visits, and the outpatient prospective payment system (OPPS) is used to price outpatient services received in an outpatient setting. Medicare claims processing entities are responsible for following the rules of the various payment systems and pricing the claims.

The data files the ACOs will receive consist of four Part A files, two Part B files, one Part D file, one beneficiary demographics file, and one beneficiary Health Insurance Claim Number (HICN) cross-reference file. These files are described in Section 2: Structure and Content. For Pioneer ACOs, the Alignment Report, which provides identifying information (including names and contact information) for each of the ACO's assigned beneficiaries, is an important source of information that will be used in conjunction with the data contained in these files. The data files the ACOs will receive will include beneficiaries who are not entitled to Medicare, and this is primarily because those beneficiaries are deceased.

The term "claim" refers to a bill that is submitted by a provider for services rendered to a Medicare beneficiary over a period of time. A single claim can be associated with multiple services provided on one or more dates. Individual services are reported on the claim form as separate claim lines. Some data files will be at the claim level, and some will be at the line level.

This document includes the following appendices:

- Appendix A: Alcohol and Substance Abuse Code Tables
- Appendix B: CCLF File Layouts

DRAFT

2 Structure and Content

This section provides a brief set of directions for users to get started using the CCLF.

2.1 High-Level Relationships among the Claim Files

Figure 1 shows, at a very high level, the relationships among the nine files that the ACOs will receive.

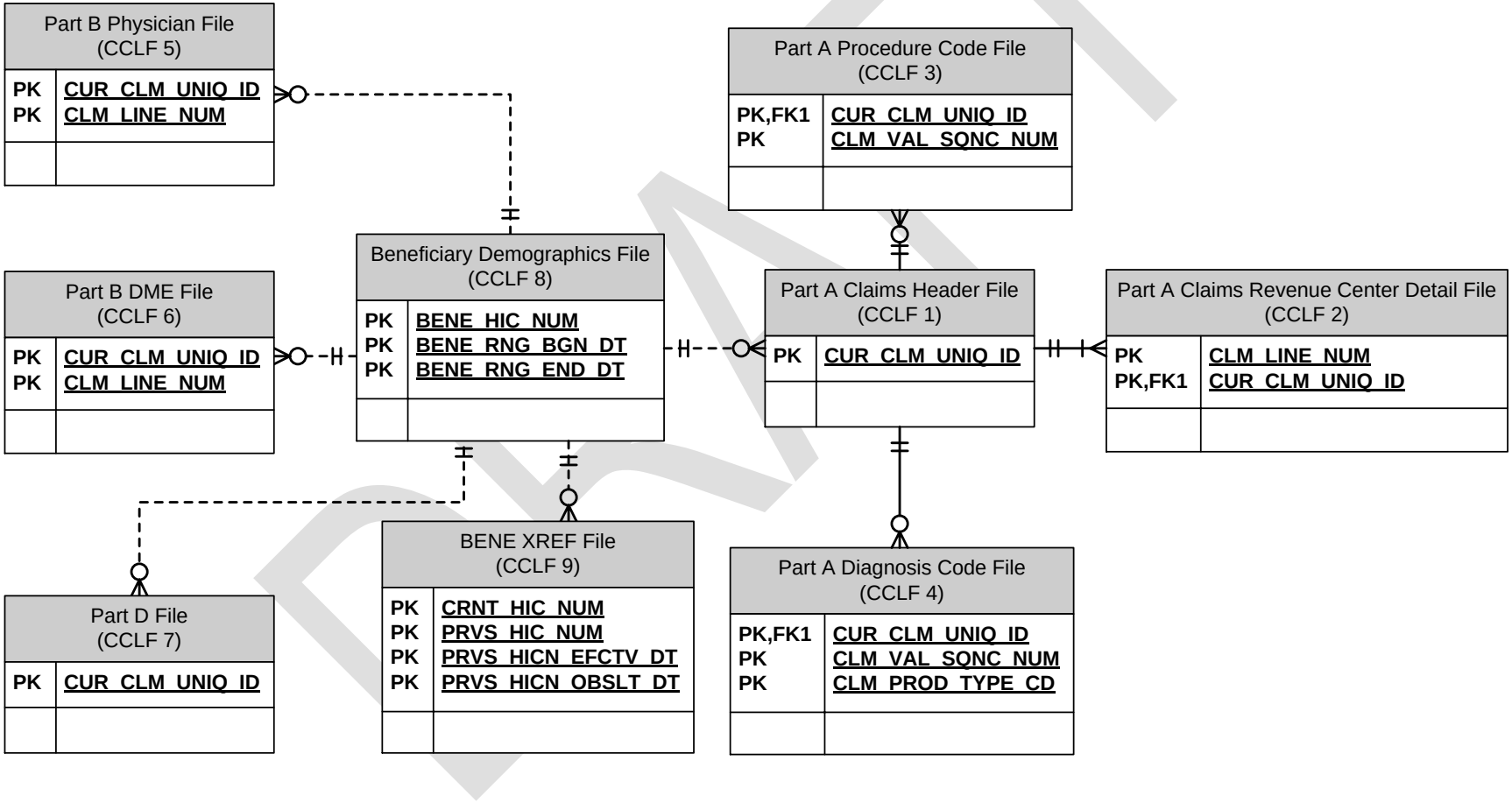


Figure 1: Entity Relationship Diagram

DRAFT

2.1.1 Keys

The Beneficiary Demographic File is the starting point of Figure 1. A record in a given file (i.e., a row from the file) can be uniquely identified by the use of a Primary Key (PK); that is, a PK consists of exactly enough information to uniquely identify a row from a file. Depending upon the nature/structure of a data file, a PK can consist of multiple variables. For the Beneficiary Demographics File, the PK consists of BENE_HIC_NUM, BENE_RNG_BGN_DT, and BENE_RNG_END_DT. Using these three fields, an ACO can go to the Beneficiary Demographic File and identify a record.

A Primary Key with a singular value is a primary key that can be identified by just one column in a table. The primary key for Part A claims header is CUR_CLM_UNIQ_ID. Each row in this file can be identified by just one column value. Each claim header is uniquely identified by a different CUR_CLM_UNIQ_ID value.

The Foreign Key (FK) signals that the variable is used as a PK in another file. For example, BENE_HIC_NUM is a FK in the Part D File, signaling that it is a PK in another file (i.e., the Beneficiary Demographics File).

2.1.2 Defining Relationships between Files

In Figure 1, the lines connecting the files define the relationships between the files (i.e., entities). There are two types of relationships in the diagram.

- Zero-or-more: A dotted line that ends in a circle with three lines indicates a zero-to-one relationship. An example of this relationship is the line connecting the Beneficiary Demographics File and the Part B Physician File. This means that each row in the Beneficiary Demographic File is associated with zero or more rows in the Part B Physician File.
- One-or-more: A dotted line that splits into three lines indicates a one-or-more relationship. An example of this relationship is the line connecting the Part A Claims Header File and the Part A Claims Revenue Center Detail File. This means that each row in the Part A Claims Header File is associated with at least one row from the Part A Claims Revenue Center Detail File.

2.2 Part A Claim Data

Part A claim files contain claims submitted by facilities such as hospitals, SNFs, HHAs, rehabilitation facilities, and dialysis facilities. These files are referred to as institutional or facility files. The Part A claim file contains claims for services that are covered under Part A as well as claims for some services that are covered under Part B of Medicare. An example of a Part B covered service appearing in the Part A file would be a visit to the emergency department of an acute care hospital that did not result in an admission. In this situation, the hospital would file a Part A claim form for a Part B covered service. As a result, the Part B covered service would be included in the Part A claim record.

2.2.1 Part A Claim Header File

The Part A Claims Header File contains summary claims from HHAs, SNFs, acute care hospitals (inpatient and outpatient claims), and hospice facilities. This file is at the summary claim level and does NOT contain line item information. From this file, you can obtain beneficiary level spending on facility services (overall, by diagnostic related group [DRG], or by

DRAFT

principal diagnosis), the national provider identifier (NPI) corresponding to the provider and/or facility associated with the claim, and the beneficiary's identification number, which is referred to as a HICN. This file can also be used to calculate the proportion of services (as measured by payment amount) for the ACO's beneficiaries that are provided by the ACO versus at non-ACO providers.

Institutional providers are identified in the Part A claim header file by both the facility NPI (FAC_PRVDR_NPI_NUM) and the older Online Survey Certification and Reporting System (OSCAR) number (also referred to as the CMS Certification Number or CCN). Data describing the individual or organization identified by the NPI may be obtained from the National Plan and Provider Enumeration System (NPPES).

The Part A claim header file also provides the NPI of the attending, operating, and other provider.

The International Classification of Diseases (ICD) Version Indicator can be found in the Claim Header File. This indicator is a single character denotation of whether the codes received derived from ICD-9 (9) or ICD-10 (0). The value of "U" indicates an unknown indicator from source data.

For more information, refer to Table 14: Part A Claims Header File.

2.2.2 Part A Claim Revenue Center Detail File

The Part A Claim Revenue Center Detail File contains line-item level detail for each claim from the Part A Claims Header File. This file contains codes from the healthcare common procedure coding system (HCPCS) for each service received as well as the date the service was received. For outpatient claims, the file contains the payment amount and allowed charge amount for individual services. The file can be used to obtain the proportion of the ACO's beneficiaries that received a particular service.

For more information, refer to Table 15: Part A Claims Revenue Center Detail File.

2.2.3 Part A Procedure Code File

The Part A Procedure Code File contains detailed information regarding the claims from the Part A Claims Header File, such as the type of surgical procedure performed and the date it was performed. This file can be used in conjunction with the Part A Claims Header File to identify and compare the surgical procedures that are associated with a given principal diagnosis for both ACO and non-ACO providers. For example, for a beneficiary diagnosed with X, a beneficiary is more likely to receive surgical procedure Y from an ACO provider, whereas surgical procedure Z is more likely to be performed by a non-ACO provider.

The ICD Version Indicator can be found in the Part A Procedure Code File. This indicator is a single character denotation of whether the codes received derived from ICD-9 (9) or ICD-10 (0). The value of "U" indicates an unknown indicator from source data. For more information, refer to Table 16: Part A Procedure Code File.

2.2.4 Part A Diagnosis Code File

The Part A Diagnosis Code File contains the diagnosis codes for the principal diagnosis as well as all secondary diagnoses that correspond with a given claim from the Part A Claims Header File. For a given claim, the associated secondary diagnoses can be distinguished from one another by the use of the variables CLM_VAL_SQNC_NUM and CLM_PROD_TYPE_CD. This

DRAFT

file can be used in conjunction with the Part A Claims Header File to identify secondary diagnoses that are associated with a given principal diagnosis.

The ICD Version Indicator can be found in the Part A Diagnosis Code File. This indicator is a single character denotation of whether the codes received derived from ICD-9 (9) or ICD-10 (0). The value of "U" indicates an unknown indicator from source data.

For more information, refer to Table 17: Part A Diagnosis Code File.

2.3 Part B Claim Data

The following subsections provide information on the Part B Claim Data Files.

2.3.1 Part B Physician File

The Part B Physician File contains information on services delivered by physicians, practitioners, and suppliers. The file contains both claim level and line level information. At the claim level, the file contains date of service, HICN, header level diagnosis codes, disposition code, and type of claim (DMEPOS or non-DMEPOS). At the line level, the file contains provider specialty, date of service, HCPCS code, HCPCS modifier codes, payment amount, allowed charge amount, line-level diagnosis code (i.e., the "pointer" to the header level diagnosis), units of service, primary payer, provider Taxpayer Identification Number (TIN), and rendering NPI number. This information allows you to identify the proportion of total Part B services (or a particular type of Part B service) being supplied to your beneficiaries by the ACO versus non-ACO providers.

The ICD Version Indicator can be found in the Part B Physicians File. This indicator is a single character denotation of whether the codes received derived from ICD-9 (9) or ICD-10 (0). The value of "U" indicates an unknown indicator from source data. For more information, refer to Table 18: Part B Physicians File.

2.3.2 Part B DME File

The Part B DME file consists of claim-line records, but includes both claim-level and line-level information. Claim-level information includes date of service, disposition code, and type of claim submitted (DMEPOS versus non-DMEPOS). Line-level information includes date of service, HCPCS code, payment amount, allowed charge amount, ordering NPI number, and paid to NPI number.

For more information, refer to Table 19: Part B DME File.

2.4 Part D Claim Data

The Part D File contains prescription drug information at the beneficiary level. Some of the data elements in this file include the National Drug Code (NDC), quantity dispensed, days supplied, prescribing provider ID, service provider ID, and patient payment amount.

For more information, refer to Table 20: Part D File.

DRAFT

2.5 Beneficiary Data

The following subsections provide information on the beneficiary data files.

2.5.1 Beneficiary Demographics File

The Beneficiary Demographics file (CCLF8) contains the list of beneficiaries for whom the ACO is qualified to receive claims data. This will be based off the data requests submitted by the ACO (DTRQT.A####), but will be limited to only those beneficiaries who have consented to share their claims information and have not been excluded by CMS or have died prior to the ACO's agreement date.

This file contains the beneficiary's current HICN, first/middle/last name, ZIP code, date of birth, sex, race, age, Medicare Status Code, dual eligibility status, hospice begin/end dates, and date of death if a decedent.

The Beneficiary Demographics File may contain multiple rows for the same beneficiary. This is because the beneficiary may have services with varying BENE_RNG_BGN_DT and BENE_RNG_END_DT dates. In this case, each row will have its own relationship to the rows of the CCLF 1, CCLF 5, CCLF 6, and CCLF 7. This is represented in Figure 1: Entity Relationship Diagram as each row in the Beneficiary Demographic File having association with zero or more rows of each of the four other CCLF files.

For more information, refer to Table 21: Beneficiary Demographics File.

2.5.2 HICN Crosswalk - Bene XREF File

The Bene cross-reference (XREF) File contains the beneficiary's current HICN and any previous HICNs, along with their associated start/end dates. This file will be used to link a given beneficiary's files over time. Note that the Bene XREF file is a full replacement file (meaning that, for a given performance year, the most recent Bene XREF file supersedes any and all previously received Bene XREF files). Also, the Bene XREF file includes HICNs only for beneficiaries who have had at least one change in their HICN.

For example, if a beneficiary becomes a widow or widower or remarries, the beneficiary's HICN is likely to change. Any claims submitted after that change occurs will carry the new HICN. The cross-reference file can be used to identify the historical claims that should be linked to the new HICN or vice versa.

The Bene XREF file provides the Retirement Board (RRB) number for the reported beneficiary when the beneficiary's current HICN is in the RRB format. If the beneficiary's current HICN is based on an SSN, this field will be blank. For more information, refer to Table 22: Beneficiary XREF File.

2.6 Summary Statistics Data

The Summary Statistics File contains the record count for each of the nine CCLF files. You can use this file to verify that all of the records per file were received. This file is implemented for Shared Savings Program and Pioneer ACOs.

The file is delivered to the user as a pipe-delimited text file, which can be downloaded into a Microsoft Excel spreadsheet, as shown in Table 1.

Note: The total record count varies each month for the files in Table 1.

DRAFT

Table 1: Summary Statistics File in Microsoft Excel Spreadsheet Format

File Number	File Description	Total Record Count	Record Length
CCLF1	Part A Claims Header File	xxxxxxxxx	xxx
CCLF2	Part A Claims Revenue Center Detail File	xxxxxxxxx	xxx
CCLF3	Part A Procedure Code File	xxxxxxxxx	xxx
CCLF4	Part A Diagnosis Code File	xxxxxxxxx	xxx
CCLF5	Part B Physicians File	xxxxxxxxx	xxx
CCLF6	Part B DME File	xxxxxxxxx	xxx
CCLF7	Part D File	xxxxxxxxx	xxx
CCLF8	Beneficiary Demographics File	xxxxxxxxx	xxx
CCLF9	BENE XREF File	xxxxxxxxx	xxx
CCLF0	Summary Statistics Header Record	xxxxxxxxx	xxx

For more information, refer to Table 23: Summary Statistics Header Record and Table 24: Summary Statistics Detail Records.

DRAFT

3 Limitations and Cautions

This section describes limitations and cautions for ACOs using the CCLF.

3.1 Matching HICNs

All data files contain the beneficiary's current HICN. While the beneficiary's HICN is unique to that beneficiary, the HICN can change over time. Therefore, when you are combining records from multiple months, you will need to use the Bene XREF file.

For example, you must perform the following steps to merge data from the January 2012 and February 2012 datasets.

1. Use the current HICN (from the February data set) to identify any previous HICNs that may be associated with each current HICN (using the BENE XREF File).
2. Go to the January dataset and locate any previous HICNs that are in this dataset.
3. Replace the previous HICNs in the January dataset with the current HICNs from the February dataset. The file will now have only one unique HICN per beneficiary across time (over January and February).

3.2 Dropping Denied Claims

Depending on your use of the data, you may want to drop denied and corrected claims. Part B claims need to be dropped depending upon the value of the variable CLM_CARR_PMT_DNL_CD, whereas Part B line-items would need to be dropped depending upon the value of the variable CLM_PRCSG_IND_CD. That is, for Part B Physician/DME claims, some individual line-items can be denied, whereas other line-items are not denied. If the value of the variable is not blank, then the claim has been denied. For Part A claims, the variable CLM_MDCR_NPMT_RSN_CD identifies claims that have been denied. Unlike Part B claims, Part A claims are either accepted in their entirety or denied in their entirety.

3.3 Part D Data Limitations

The Part D data file will only include records for beneficiaries who are enrolled in a Prescription Drug Plan (PDP). Many beneficiaries have Part D prescription drug coverage through an employer-sponsored retiree drug plan. Part D data does not include prescription data for these beneficiaries due to differences in the data that are required to be submitted by a PDP and a retiree drug plan. Furthermore, Part D data only reflect expenditures for filled prescriptions.

The Part D claims contained in the CCLF are "final action" claims, unlike the other claims related files in the CCLF, which are debit/credit claims. In any given set of monthly CCLF files, only "final action" claims will be contained in the Part D file. Furthermore, the Part D cancelation claims (i.e., delete claims) always are submitted with a $0 payment amount. As you create a claims record over time by combining many monthly CCLF data feeds for Part D claims, you will need to identify for any given set of Related Claims (i.e., claims that all represent the same event) the most recent claim and delete/ignore all of the previous related claims for that event. That is, you need to identify the "final action" claims.

Lastly, note that the NDC code is not populated for "delete" prescription drug events (PDEs); all cancelation claims in the Part D file will have blank values for the NDC code field.

DRAFT

3.4 Claims Run-out

Monthly claims processing will include claims that have a date-of-service within either the historical claims period or the performance year. Generally, this means that claims that are included in a given month's feed will include both claims for services provided during the specified month as well as claims for services provided in an earlier month.

Monthly claims data will not include claims for services provided either during the month or in a prior month but that have not yet been submitted to the MAC by the provider. Similarly, monthly claims data will not include claims received by the MAC but were still being processed at the time the claims feed was generated.

Two variables are used to control claims run-out: CLM_EFCTV_DT and CLM_IDR_LD_DT.

- The CLM_EFCTV_DT is the date that the claim was processed by National Claims History (NCH). The CLM_EFCTV_DT is alternatively referred to as the NCH Weekly Processing Date. The CLM_EFCTV_DT is generally a Friday.
- The CLM_IDR_LD_DT is the date the claim was loaded into the Integrated Data Repository (IDR), the CMS data warehouse or repository. The CLM_IDR_LD_DT is generally a Monday. The CLM_IDR_LD_DT will always be *later* than the CLM_EFCTV_DT.

It is typically the case that for a given claim, there is a gap of a few days between the CLM_EFCTV_DT and the CLM_IDR_LD_DT. However, in some cases, a claim is "pended" (i.e., held back) and not loaded into the IDR immediately. As a result, some claims loaded into the IDR on a given Monday (from CLM_IDR_LD_DT) will actually include claims whose CLM_EFCTV_DT is weeks or even, in a small number of cases, months in the past. Therefore, to control claims run-out, both of these variables may be needed. For example, if you want to capture all of the claims that were paid during CY2012 as of the current date, you would use only the CLM_EFCTV_DT. If, however, you wanted to capture all of the claims that were *known* to have been paid as of a given date in the past (e.g., as of March 31, 2013), you would need to restrict your analysis to claims that had been appended to the IDR by March 31, 2013. Specifically, you would need to specify the following:

1. CLM_IDR_LD_DT on or before March 31, 2013.
2. CLM_EFCTV_DT within CY2012.

3.5 Other Limitations/Cautions

The Medicare dataset supplied to you is a subset of the full set of Medicare data. The variables were chosen because they were deemed to be the most useful information for you.

The data does not reflect the use and expenditures for beneficiaries who have not given permission for their data to be shared with ACOs. In addition, substance abuse data is not shared. As a result, this data may not include 100% of the claims data for every beneficiary.

DRAFT

4 Fields in the CCLF Data Files

4.1 Additional Fields and Descriptive Text Added to Version 3.0 of the Claims Line Feed

4.1.1 Fields Added to the Part A Header File

- CLM_ADMSN_TYPE_CD
- CLM_ADMSN_SRC_CD
- CLM_BILL_FREQ_CD
- CLM_QUERY_CD

4.1.2 Fields Added to the Part A Revenue Center File

- CLM_LINE_ALOWD_UNIT_QTY
- CLM_LINE_CVRD_PD_AMT
- HCPCS_1_MDFR_CD
- HCPCS_2_MDFR_CD
- HCPCS_3_MDFR_CD
- HCPCS_4_MDFR_CD
- HCPCS_5_MDFR_CD

4.1.3 Fields Added to the Part A Procedure Code File

- No fields were added to this file.

4.1.4 Fields Added to the Part A Diagnosis Code File

- CLM_POA_IND

4.1.5 Fields Added to the Part B Physician File

- CLM_LINE_ALOWD_CHRG_AMT
- CLM_LINE_ALOWD_UNIT_QTY
- HCPCS_1_MDFR_CD
- HCPCS_2_MDFR_CD
- HCPCS_3_MDFR_CD
- HCPCS_4_MDFR_CD
- HCPCS_5_MDFR_CD
- CLM_DISP_CD
- CLM_DGNS_1_CD

DRAFT

- CLM_DGNS_2_CD
- CLM_DGNS_3_CD
- CLM_DGNS_4_CD
- CLM_DGNS_5_CD
- CLM_DGNS_6_CD
- CLM_DGNS_7_CD
- CLM_DGNS_8_CD

4.1.6 Fields Added to the Part B DME File

- CLM_LINE_ALOWD_CHRG_AMT
- CLM_DISP_CD

4.1.7 Fields Added to the Part D File

No fields were added to this file. However, note that the source for the field CLM_EFCTV_DT has been revised:

- Previously, CLM_EFCTV_DT was populated with the date the PDE data was transmitted by the PDP to CMS (i.e., the claim transmission date).
- Going forward, CLM_EFCTV_DT will be populated with the date the PDP indicates the claim was paid (i.e., claim scheduled payment date).
- **Note:** This change affects only the Part D file. It does not affect the field CLM_EFCTV_DT in any of the other files.

4.1.8 Fields Added to the Beneficiary Demographic File

- BENE_RNG_BGN_DT
- BENE_RNG_END_DT
- BENE_1ST_NAME
- BENE_MIDL_NAME
- BENE_LAST_NAME

4.1.9 Fields Added to the Beneficiary XREF File

- BENE_RRB_NUM

4.2 Description of the Additional Fields

- CLM_ADMSN_TYPE_CD: Claim admission type code (e.g., emergency, urgent and elective).
- CLM_ADMSN_SRC_CD: Claim admission source code (e.g., clinic referral, transfer from another healthcare facility, and emergency room).

DRAFT

- CLM_BILL_FREQ_CD: Claim Frequency Code (e.g., non-payment, admit through discharge, interim, and adjustment of prior claim).
- CLM_QUERY_CD: Claim Query Code (e.g., credit adjustment, interim bill, and final bill).
- CLM_LINE_ALOWD_CHRG_AMT: Line-level allowed charge amount. This amount includes beneficiary-paid amounts (i.e., deductible and coinsurance).
- CLM_LINE_ALOWD_UNIT_QTY: Count of total units, at the line-item level, associated with services needing unit reporting (e.g., anesthesia time units and blood units).
- CLM_LINE_CVRD_PD_AMT: The amount of payment made by Medicare.
- HCPCS_1_MDFR_CD- HCPCS_5_MDFR_CD: HCPCS modifier codes.
- CLM_POA_IND: Present on admission indicator (e.g., Y and N).
- CLM_DISP_CD: Code indicating the disposition or outcome of the processing of the claim record (e.g., debit accepted and cancel accepted).
- CLM_DGNS_1_CD-CLM_DGNS_8_CD: Claim level diagnosis codes.
- BENE_RNG_BGN_DT: Hospice enrollment begin date.
- BENE_RNG_END_DT: Hospice enrollment end date.
- BENE_1ST_NAME: Beneficiary first name.
- BENE_MIDL_NAME: Beneficiary middle name.
- BENE_LAST_NAME: Beneficiary last name.
- BENE_RRB_NUM: External (to Medicare) HICN for RRB beneficiaries.

4.3 Beneficiary Equitable BIC Health Insurance Claim Number vs. Health Insurance Claim Number

The Health Insurance Claim Number (BENE_HIC_NUM) has two elements: a nine-byte field called Beneficiary Claim Account Number (CAN) and a two-byte field called the Beneficiary Identification Code (BIC). The CAN is a number that represents the person who earned the Medicare benefits by working and paying Medicare taxes (i.e., the wage earner), and is often a Social Security Number (SSN). A spouse who is entitled to Medicare benefits under their wife's/husband's work history would have the same CAN as their wife/husband. The BIC identifies the relationship of the beneficiary and the wage earner. For example, the "first wife" of a CAN-owner would be identified by a BIC of "B." If the husband dies, then the "first wife" changes to the BIC of "first widow." The CAN for the wife/widow does not change in this example.

The Beneficiary Equitable BIC Health Insurance Claim Number (BENE_EQTBL_BIC_HICN_NUM) is an "umbrella" HICN, meaning that it groups certain HICNs together, at the beneficiary level. Whenever the CAN for a beneficiary changes, then the BENE_EQTBL_BIC_HICN_NUM will change. However, whenever the BIC changes (holding the CAN constant) for a beneficiary, the BENE_EQTBL_BIC_HICN_NUM will NOT change. For example, the beneficiary cited above, whose status changed from a "first wife" to a "first widow"

DRAFT

upon the death of her husband, would have the same value for BENE_EQTBL_BIC_HICN_NUM before and after this life event.

4.4 Debit/Credit Method and the Identification of Cancelation/Adjustment Claims

The Debit/Credit method gives a full account/history of the claims processed over time. This means that the universe of claims is included in the claims line feed, including adjustment and cancelation claims. The variable CLM_ADJSMT_TYPE_CD identifies which of the following categories that any individual claim falls into:

1. CLM_ADJSMT_TYPE_CD= 0 signifies an Original Claim.
2. CLM_ADJSMT_TYPE_CD= 1 signifies a Cancelation Claim.
3. CLM_ADJSMT_TYPE_CD= 2 signifies an Adjustment Claim (claim that is an adjustment to an original claim).

DRAFT

5 Application Notes

The following subsections provide application notes.

5.1 Identification of Related Claims Using the Natural Key

5.1.1 Natural Keys

Related Claims refer to all of the claims associated with a single episode of service (i.e., event). This includes the original claim(s) and any corresponding cancelation and adjustment claims. A natural key allows you to identify/group Related Claims. The natural key for each of the files is as follows:

Part A Claim Header File/Revenue Center/Procedure/Diagnosis files:

- PRVDR_OSCAR_NUM
- CLM_FROM_DT
- CLM_THRU_DT
- BENE_EQTBL_BIC_HICN_NUM.

Part B Physician/DME files:

- CLM_CNTL_NUM
- BENE_EQTBL_BIC_HICN_NUM

Part D File:

- CLM_LINE_FROM_DT, PRVDR_SRVC_ID_QLFYR_CD
- CLM_SRVC_PRVDR_GNRC_ID_NUM
- CLM_DSPNSNG_STUS_CD
- CLM_LINE_RX_SRVC_RFRNC_NUM
- CLM_LINE_RX_FILL_NUM

5.1.2 Example: Linking Related Claims in the Part A Header File Using the Natural Key

Suppose you are looking at a claim with CUR_CLM_UNIQ_ID=3589734591235. To identify all related claims, first find the values for the natural key that are associated with CUR_CLM_UNIQ_ID=3589734591235 (i.e., find the values for PRVDR_OSCAR_NUM, CLM_FROM_DT, CLM_THRU_DT, and BENE_EQTBL_BIC_HICN_NUM when CUR_CLM_UNIQ_ID=3589734591235). Suppose that, for this claim, the values for the natural key are as follows:

- PRVDR_OSCAR_NUM=654321
- CLM_FROM_DT= 07/01/12
- CLM_THRU_DT= 7/04/12
- BENE_EQTBL_BIC_HICN_NUM= 123456789B

DRAFT

Using these values for the natural key, we can now identify all claims in the Part A Header file that have the same values for the natural key. Suppose we obtain the following from Table 2:

Table 2: Part A Header File

CUR_CLM_UNIQ_ID	PRVDR_OSCAR_NUM	CLM_FROM_DT	CLM_THRU_DT	BENE_EQTBL_BIC_HICN_NUM
2222222222222	654321	07/01/12	7/04/12	123456789B
3589734591235	654321	07/01/12	7/04/12	123456789B
1313274894021	654321	07/01/12	7/04/12	123456789B
1111111111111	654321	07/01/12	7/04/12	123456789B
3333333333333	654321	07/01/12	7/04/12	123456789B

This group of claims consists of five records that are all related to one another. Specifically, they all involve a claim for services provided to a beneficiary by a single Part A provider during the time period July 1, 2012, through July 4, 2012. Further information is needed to distinguish among the claims and identify the "final action" claim(s). In this particular example, it will be useful to obtain information on the claim effective date and the claim adjustment type code. In the Table 3, this additional information is added. (The primary key is dropped to reduce the number of columns displayed; however, one can assume that those columns shown in the above table are simply not displayed here.)

Table 3: Claim Effective Date and the Claim Adjustment Type Code

ROW	BENE_HIC_NUM	CUR_CLM_UNIQ_ID	CLM_EFCTV_DT	CLM_ADJSMT_TYPE_CD
1	123456789B	2222222222222	07/30/12	0 (original claim)
2	123456789B	3589734591235	08/01/12	1 (cancelation claim)
3	123456789B	1313274894021	08/01/12	2 (adjustment claim)
4	123456789D	1111111111111	08/07/12	1 (cancelation claim)
5	123456789D	3333333333333	08/07/12	2 (adjustment claim)

In the above table, you will find that the record in Row 2 cancels the record in Row 1. Likewise, the record in Row 4 cancels the record in Row 3. The remaining record in Row 5 is the "final action" claim. Note that in this example, sorting by CLM_EFCTV_DT and then by CLM_ADJSMT_TYPE_CD, yields the final action claim as the last record in this sort. This is a unique example, and it is NOT always true that related claims sorted in this way will yield the "final action" claim(s). As detailed in Section 5.2 below, there is variation across the claims-related files (Part A, Part B, Part D) in the appropriate use of the variables CLM_EFCTV_DT and CLM_ADJSMT_TYPE_CD in distinguishing among related claims.

5.2 Occurrences of Related Claims in the Various Claims-Related Files

5.2.1 Related Claims in the Part A Header File

In the Part A Header file, you will find original claims, cancelation claims, and adjustment claims (i.e., claims with CLM_ADJSMT_TYPE_CD=0, 1, or 2 respectively). Related claims found in the Part A Header file may exhibit a number of patterns, including (but not limited to), the following:

1. An original claim with no other related claims.
2. An adjustment claim with no other related claims.
3. A set of related claims consisting of an original claim and a cancelation claim.

DRAFT

4. A set of related claims including two original claims (and no other related claims).
5. A set of related claims including an original claim, a cancelation claim, and an adjustment claim.

The timing of the processing of the related claims is not always straightforward. In all instances, an original claim will be processed before its corresponding adjustment and cancelation claim. In many instances, the cancelation claim is processed at the same time as the adjustment claim. However, in some instances, the cancelation claim is processed weeks (or even months) *after* the adjustment claim is processed. In other instances, the cancelation claim is processed weeks (or even months) *before* the adjustment claim. As a result, it is not always straightforward (or even possible) to distinguish among all of the beneficiary's related claims.

In order to identify the "final action" or "non-canceled" claims in a related set of claims, it is necessary to match each cancelation claim with one of the following:

- An original claim
- An adjustment claim

All original/cancelation and adjustment/cancelation matched pairs should be removed/ignored, yielding only final action claim(s). It is possible that there is more than one final action claim among a related set of claims.

In the event a Claim Through Date (CLM_THRU_DT) is submitted incorrectly and must be revised, the following will happen:

1. A cancellation claim will be generated identical to the original claim, and will have the same incorrect through date.
2. An adjustment claim will be submitted with the correct Claim Through Date. In this instance, the natural key cannot be used to link the related claims together. When one of the fields of the natural key changes, it makes the natural key no longer useful in linking together the related claims.

5.2.2 Related Claims in the Part B Physician File

In the Part B Physician file, you will find original claims and cancelation claims. You will not find any adjustment claims in these files. A variety of related claims are found in the Part B Physician file, including (but not limited to) the following:

1. An original claim with no other related claims.
2. A set of related claims consisting of an original claim and a cancelation claim.
3. A set of related claims consisting of two original claims and one cancelation claim.
4. A set of related claims consisting of three original claims and two cancelation claims.

5.2.3 Related Claims in the Part B DME File

In the Part B DME file, you will find original claims and cancelation claims. You will not find any adjustment claims in these files. A variety of related claims are found in the Part B DME file, including (but not limited to) the following:

1. An original claim with no other related claims.
2. A set of related claims consisting of one original claim and one cancelation claim.
3. A set of related claims consisting of two original claims and one cancelation claim.

DRAFT

4. A set of related claims consisting of three original claims and two cancelation claims.

5.2.4 Related Claims in the Part D File

In the Part D file, you will find original claims, cancelation claims, and adjustment claims. A variety of related claims are found in the Part D file, including (but not limited to) an original claim with no other related claims.

5.3 Calculating Beneficiary-Level Expenditures

5.3.1 Calculating Total Part A and B Expenditures

Calculating total expenditures for a beneficiary using the debit/credit data is conceptually a simple process of adding up all of the debit and credit amounts associated with the claims incurred by the beneficiary during the time period of interest.

However, it is slightly more complicated for two reasons: First, the payment amounts on each record are not "signed" to indicate whether the payment amount is a payment to the provider or a recovery from the provider. Therefore, it is necessary to use the CLM_ADJSMT_TYPE_CD to determine whether to "add" or "subtract" the payment amount from the running total. Second, different HICNs may appear on the claims for a single beneficiary at different points in time.

To correctly "sign" the payment amounts follow the steps below to identify beneficiary level expenditures for Part A and Part B services.

1. Identify the canceled claims in the Part A Header file. These claims are identified by CLM_ADJSMT_TYPE_CD=1. Change the "sign" of the variable CLM_PMT_AMT for each of these cancelation claims (i.e., multiply the CLM_PMT_AMT by -1). For example, if on a given cancelation claim the value for CLM_PMT_AMT=$30.18, then change this to equal -$30.18.
2. Identify all the canceled records (line items) in the Part B Physician file. The canceled line items are identified by CLM_ADJSMT_TYPE_CD=1. Change the "sign" of the variable CLM_LINE_CVRD_PD_AMT for each of these canceled line items.
3. Identify all the canceled records (line items) in the Part B DME file. The canceled line items are identified by CLM_ADJSMT_TYPE_CD=1. Change the "sign" of the variable CLM_LINE_CVRD_PD_AMT for each of these canceled line items.

To identify all claims incurred by a single beneficiary regardless of changes in the beneficiary's HICN, follow the steps below.

1. Replace all old HICNs in the previous datasets (if any) with the current HICN using information from the Bene XREF File.
2. For each current HICN (after making the changes from step 4), identify the Part A claims from the Part A Claims Header File. Identify total Part A Header level expenditures for each HICN after accounting for the potential "sign" changes in Step 1.
3. For each current HICN (after making the changes from step 4), identify the Part B Physician line-items. Identify the total Part B Physician expenditures (summing across line-items) for each HICN after accounting for the potential "sign" changes in Step 2.

DRAFT

4. For each current HICN (after making the changes from Step 4), identify the Part B DME line-items. Identify the total Part B DME expenditures (summing across line-items) for each HICN after accounting for the potential "sign" changes in Step 3.
5. Sum the values in 2, 3, and 4 above to get total Part A and B expenditures at the beneficiary-level (year-to-date or for whatever time period you prefer).

5.3.2 Example of Calculating Total Part A and Part B Expenditures

1. Starting from your initial assignment list, suppose you have a beneficiary with a current HICN of 123123123B. Going to the XREF file, you find the beneficiary does not have any previous HICNs. Suppose also that the beneficiary's BENE_EQTBL_BIC_HICN_NUM=123123123B.
2. For this beneficiary, suppose you finds claims in the Part A Header File and the Part B Physician File, but no claims in the Part B DME file.
3. Calculating total Part A Expenditures: Table 4 contains the full set of Part A Header Records for the beneficiary.

Table 4: Part A Header Records

CLM#	CCN	FROM	THRU	EQ_HICN	PAID	ADJ_TYPE	EFCTV_DT
1	654321	7/1/12	7/8/12	123123123B	$200	0	7/20/12
2	654321	7/1/12	7/8/12	123123123B	$0	2	9/20/12
3	654321	7/1/12	7/8/12	123123123B	$200	1	8/7/12
4	654321	7/1/12	7/8/12	123123123B	$210	2	9/20/12
5	654321	7/1/12	7/8/12	123123123B	$0	2	8/7/12
6	654321	7/1/12	7/8/12	123123123B	$0	1	10/7/12
7	654321	8/20/12	8/29/12	123123123B	$50	0	9/20/12

Many of the variables' names were shortened in order to make the table fit better. The following contains a list of the variables' names that were changed, with their "new" names in parentheses: CUR_CLM_UNIQ_ID (CLM#), PRVDR_OSCAR_NUM (CCN), CLM_FROM_DT (FROM), CLM_THRU_DT (THRU), BENE_EQTBL_BIC_HICN_NUM (EQ_HICN), CLM_PMT_AMT (PAID), CLM_ADJSMT_TYPE_CD (ADJ_TYPE), and CLM_EFCTV_DT (EFCTV_DT).

Changing the sign for CLM_PMT_AMT on all cancelation claims (i.e., those claims with CLM_ADJSMT_TYPE_CD=1) yields the following:

Table 5: Part A Header Records

CLM#	CCN	FROM	THRU	EQ_HICN	PAID	ADJ_TYPE	EFCTV_DT
1	654321	7/1/12	7/8/12	123123123B	$200	0	7/20/12
2	654321	7/1/12	7/8/12	123123123B	$0	2	9/20/12
3	654321	7/1/12	7/8/12	123123123B	-$200	1	8/7/12
4	654321	7/1/12	7/8/12	123123123B	$210	2	9/20/12
5	654321	7/1/12	7/8/12	123123123B	$0	2	8/7/12
6	654321	7/1/12	7/8/12	123123123B	-$0	1	10/7/12
7	654321	8/20/12	8/29/12	123123123B	$50	0	9/20/12

Summing across the values of the variable CLM_PMT_AMT yields: $200 + $0 + -$200 +$210 + $0 + -$0 + $50=$260. Note that Claim #3 (i.e., claim where CLM#=3) cancels

DRAFT

Claim #1. It is unclear which claim (Claim #2 or Claim #5) that Claim #6 is canceling. However, if there are any data elements contained in the claims line feed that vary between Claim #2 and Claim #5, then these data elements could potentially be used to identify which claim is being canceled by Claim #6. This may not always be possible, and hence you will not know which claim (#2 or #5) should be canceled; you will simply need to pick one in this case. Lastly, note that Claims #1-#6 are a set of Related Claims (i.e., they all have the same natural key), whereas Claim #7 is a separate un-related claim.

For utilization measurement purposes, you may want to identify the claims that represent the most recent (i.e., final action) data. In this instance, this would include three Part A claims: Claim #4, Claim #7, and either Claim #2 or Claim #5, but not both.

4. Calculating Part B Physician Expenditures: The following table contains the full set of Part B Physician records for the beneficiary:

Table 6: Part B Line-Item Records

CLM#	LINE_NUM	CNTL_NUM	EQ_HICN	PAID	ADJ_TYPE	EFCTV_DT
1	3	7	123123123B	$0	1	9/2/12
1	1	7	123123123B	$380	1	9/2/12
1	2	7	123123123B	$227	1	9/2/12
2	1	7	123123123B	$380	0	9/2/12
2	2	7	123123123B	$227	0	9/2/12
2	3	7	123123123B	$100	0	9/2/12
3	3	7	123123123B	$0	0	8/15/12
3	1	7	123123123B	$380	0	8/15/12
3	2	7	123123123B	$227	0	8/15/12

Some variables have been renamed in a similar fashion as in the Part A Header record table from Part 3. The following additional variable renaming was done to conserve space in the table, where the “new” names are in parentheses: CLM_LINE_CVRD_PD_AMT (PAID), CLM_LINE_NUM (LINE_NUM), and CLM_CNTL_NUM (CNTL_NUM).

Changing the sign for CLM_LINE_CVRD_PD_AMT on all cancelation claims (i.e., those claims with CLM_ADJSMT_TYPE_CD=1) yields the following:

Table 7: Part B Line-Item Records

CLM#	LINE_NUM	CNTL_NUM	EQ_HICN	PAID	ADJ_TYPE	EFCTV_DT
1	3	7	123123123B	-$0	1	9/2/12
1	1	7	123123123B	-$380	1	9/2/12
1	2	7	123123123B	-$227	1	9/2/12
2	1	7	123123123B	$380	0	9/2/12
2	2	7	123123123B	$227	0	9/2/12
2	3	7	123123123B	$100	0	9/2/12
3	3	7	123123123B	$0	0	8/15/12
3	1	7	123123123B	$380	0	8/15/12
3	2	7	123123123B	$227	0	8/15/12

DRAFT

Summing across the values of the variable CLM_LINE_CVRD_PD_AMT yields the following:

$0 + -$380 + -$227 + $380 + $227 + $100 + $0 + $380 + $227 = $100 + $380 + $227

= $707.

5. To calculate total Part A and B expenditures, sum the amount from steps 3 and 4. Total Part A and B expenditures=$260+$707=$967.

5.4 Part A vs. Part B Claims

To identify the total expenditure incurred and paid under the Hospital Insurance (Part A) program and the Supplemental Medical Insurance (Part B) program, it is important to know that the Part A claims files will include Medicare provider payments for some services covered under both Part A and Part B.

To distinguish Part A claims that are covered and paid under the Hospital Insurance program from those covered under the Supplemental Medical Insurance program, you must use the Claim Facility Type Code and the Claim Service Classification Code.

All claims in the Part B physician and Part B DMEPOS files are covered under the Supplemental Medical Insurance program.

5.5 Identifying Sources of Care for the Assigned Population

Follow the steps below to determine the percentage of care being provided by your ACO, as measured by number of Part A line items, for the beneficiaries included in your CCLF.

1. Use the Part A Claim Revenue Center Detail File to identify the number of line items for a beneficiary. Each row in this table represents a separate line item.
2. Identify the rows in the file that correspond to each beneficiary (using the current BENE_HIC_NUM). For a given beneficiary-claim combination, each row (line-item) can be distinguished by the claim line number (CLM_LINE_NUM). For a given claim (and its associated line items), the determination of who provided the service (ACO or non-ACO) provider can be determined by looking at the claim facility NPI (FAC_PRVDR_NPI_NUM) and the operating physician NPI (OPRTG_PRVDR_NPI_NUM) from the Part A Claims Header File.
3. Calculate the total line items for Part A services, line items for Part A services provided by the ACO, and line items for Part A services provided by non-ACO providers.

DRAFT

6 Combining Claims Data with Other Data Sources

The monthly claims data feed provides data on Medicare expenditures for services covered by Parts A, B, and D. It also provides a limited set of demographic variables for each beneficiary. Additional useful data sources that might be merged into the claims data are listed below.

6.1 Assignment Report/Table Data

The Assignment Report provided to your ACO includes identifying information for each beneficiary. These data are also updated each quarter. This report is the source of beneficiary identifying information for the claims data.

6.2 Provider Data

The claims data identifies providers by NPI (or in some cases the OSCAR number or CCN). Information to identify providers by name must be merged with the claims data. One source for this information is the public-use NPPES file that can be downloaded from http://nppes.viva-it.com/NPI_Files.html.

DRAFT

7 Useful Resources

7.1 Useful Resources Regarding Medicare Claims Data

The ResDAC website (http://www.resdac.org) is a useful source of information regarding Medicare claims data. Another useful source of information is the National Claims History documentation available at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/DataAdmin/Downloads/NCH_RIF090211.zip.

DRAFT

8 Best Practices for Protecting Beneficiary-Level Data

CMS takes protecting the data for millions of Medicare beneficiaries very seriously. It is important to ensure that necessary steps are taken to keep the data secure. By implementing the below listed best practices, we can all help to better protect the beneficiary data:

1. Do not click on a link or attachment until you have talked to the sender or are expecting the attachment.
2. Never share your password.
3. Avoid sharing Personally Identifiable Information (PII), Protected Health Information (PHI), or sensitive data by email. If you must share, encrypt it, and do not send the password through email.
4. Never send work information to or from your personal account.
5. Forward suspicious email to your organization's IT administrator. If you believe Medicare beneficiary (or provider) data has been compromised, report the incident to the CMS IT Service Desk at 1-800-562-1963.

More information on CMS security, privacy guidance, and best practices are available at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/index.html?redirect=/informationsecurity/.

DRAFT

Appendix A: Alcohol and Substance Abuse Code Tables

Table 8, Table 9, Table 10, Table 11, Table 12, and Table 13 contain codes for alcohol and substance abuse-related diagnoses, which CMS will exclude from Shared Savings Program Claims Line Feeds.

Table 8, Table 9, Table 10, Table 11, Table 12, and Table 13 substance abuse codes will be excluded from the Pioneer Model Claims Line Feeds for an ACO if a beneficiary elects not to opt-in to Alcohol and Substance Abuse sharing with that ACO.

Table 8: MS-DRGs

MS-DRGs	Description
MS-DRG 522	Alcohol/drug abuse or dependence w rehabilitation therapy w/o CC
MS-DRG 523	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o CC
MS-DRG 895	Alcohol/drug abuse or dependence w rehabilitation therapy
MS-DRG 896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC
MS-DRG 897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC

Table 9: CPT Codes

CPT Codes	Description
4320F	Patient counseled regarding psychosocial and pharmacologic treatment options for alcohol dependence
H0005	Alcohol and/or drug services; Group counseling by a clinician
H0006	Alcohol and/or drug services; case management
H0007	Alcohol and/or drug services; crisis intervention (outpatient)
H0008	Alcohol and/or drug services; sub-acute detox (hospital inpatient)
H0009	Alcohol and/or drug services; Acute detox (hospital inpatient)
H0010	Alcohol and/or drug services; Sub-acute detox (residential addiction program inpatient)
H0011	Alcohol and/or drug services; acute detox (residential addiction program inpatient)
H0012	Alcohol and/or drug services; Sub-acute detox (residential addiction program outpatient)
H0013	Alcohol and/or drug services; acute detox (residential addiction program outpatient)
H0014	Alcohol and/or drug services; ambulatory detox
H0015	Alcohol and/or drug services; intensive outpatient
H0050	Alcohol and/or Drug Service, Brief Intervention, per 15 minutes
99408	Alcohol and substance (other than tobacco) abuse structure screening (e.g., AUDIT, DAST) and brief intervention (SBI) services; 15-30 minutes
99409	Alcohol and substance (other than tobacco) abuse structure screening (e.g., AUDIT, DAST) and brief intervention (SBI) services; Greater than 30 minutes
H0034	Alcohol and/or drug abuse halfway house services, per diem
H0047	Alcohol and/or Drug abuse services, not otherwise specified
H2035	Alcohol and/or drug treatment program, per hour
H2036	Alcohol and/or drug treatment program, per diem

DRAFT

CPT Codes	Description
H0020	Alcohol and/or drug services; methadone administration and/or service (provisions of the drug by a licensed program)
S9475	Ambulatory Setting substance abuse treatment or detoxification services per diem
T1006	Alcohol and/or substance abuse services, family/couple counseling
T1007	Alcohol and/or substance abuse services, treatment plan development and or modification
T1008	Day Treatment for individual alcohol and/or substance abuse services
T1009	Child sitting services for children of individuals receiving alcohol and/or substance abuse services
T1010	Meals for individuals receiving alcohol and/or substance abuse services (when meals are not included in the program
T1011	Alcohol and/or substance abuse services not otherwise classified
T1012	Alcohol and/or substance abuse services, skill development

Table 10: ICD-9-CM Procedure Codes

ICD-9-CM Procedure Codes	Description
94.45	Drug Addict Counseling
94.46	Alcoholism Counseling
94.53	Referral Alcohol Rehab
94.54	Referral for Drug Rehab
94.6	Alcohol and drug rehabilitation and detoxification
94.61	Alcohol rehabilitation
94.62	Alcohol detoxification
94.63	Alcohol rehabilitation and detoxification
94.64	Drug rehabilitation
94.65	Drug detoxification
94.66	Drug rehabilitation and detoxification
94.67	Combined alcohol and drug rehabilitation
94.68	Combined alcohol and drug detoxification
94.69	Combined alcohol and drug rehabilitation and detoxification

Table 11: ICD-9-CM Diagnosis Codes

ICD-9-CM Diagnosis Codes	Description
291	Alcohol-induced mental disorders
291.0	Alcohol withdrawal delirium
291.1	Alcohol-induced persisting amnestic disorder
291.2	Alcohol-induced persisting dementia
291.3	Alcohol-induced psychotic disorder with hallucinations
291.4	Idiosyncratic alcohol intoxication
291.5	Alcohol-induced psychotic disorder with delusions

DRAFT

ICD-9-CM Diagnosis Codes	Description
291.81	Alcohol withdrawal
291.82	Alcohol induced sleep disorders
291.89	Other alcohol-induced mental disorders
291.9	Unspecified alcohol-induced mental disorders
292	Drug-induced mental disorders
292.0	Drug withdrawal
292.1	Drug-induced psychotic disorders
292.11	Drug-induced psychotic disorder with delusions
292.12	Drug-induced psychotic disorder with hallucinations
292.2	Pathological drug intoxication
292.8	Other specified drug-induced mental disorders
292.81	Drug-induced delirium
292.82	Drug-induced persisting dementia
292.83	Drug-induced persisting amnestic disorder
292.84	Drug-induced mood disorder
292.85	Drug induced sleep disorders
292.89	Other specified drug-induced mental disorders
292.9	Unspecified drug-induced mental disorder
303	Alcohol dependence syndrome
303.0	Acute alcoholic intoxication
303.00	Acute alcoholic intoxication in alcoholism, unspecified
303.01	Acute alcoholic intoxication in alcoholism, continuous
303.02	Acute alcoholic intoxication in alcoholism, episodic
303.03	Acute alcoholic intoxication in alcoholism, in remission
303.9	Other and unspecified alcohol dependence
303.90	Other and unspecified alcohol dependence, unspecified
303.91	Other and unspecified alcohol dependence, continuous
303.92	Other and unspecified alcohol dependence, episodic
303.93	Other and unspecified alcohol dependence, in remission
304	Drug Dependence
304.0	Opioid type dependence
304.00	Opioid type dependence, unspecified
304.01	Opioid type dependence, continuous
304.02	Opioid type dependence, episodic
304.03	Opioid type dependence, in remission
304.1	Sedative, hypnotic or anxiolytic dependence
304.10	Sedative, hypnotic or anxiolytic dependence, unspecified
304.11	Sedative, hypnotic or anxiolytic dependence, continuous
304.12	Sedative, hypnotic or anxiolytic dependence, episodic
304.13	Sedative, hypnotic or anxiolytic dependence, in remission
304.2	Cocaine dependence
304.20	Cocaine dependence, unspecified
304.21	Cocaine dependence, continuous
304.22	Cocaine dependence, episodic
304.23	Cocaine dependence, in remission
304.3	Cannabis dependence

ICD-9-CM Diagnosis Codes	Description
304.30	Cannabis dependence, unspecified
304.31	Cannabis dependence, continuous
304.32	Cannabis dependence, episodic
304.33	Cannabis dependence, in remission
304.4	Amphetamine and other psychostimulant dependence
304.40	Amphetamine and other psychostimulant dependence, unspecified
304.41	Amphetamine and other psychostimulant dependence, continuous
304.42	Amphetamine and other psychostimulant dependence, episodic
304.43	Amphetamine and other psychostimulant dependence, in remission
304.5	Hallucinogen dependence
304.50	Hallucinogen dependence, unspecified
304.51	Hallucinogen dependence, continuous
304.52	Hallucinogen dependence, episodic
304.53	Hallucinogen dependence, in remission
304.6	Other specified drug dependence
304.60	Other specified drug dependence, unspecified
304.61	Other specified drug dependence, continuous
304.62	Other specified drug dependence, episodic
304.63	Other specified drug dependence, in remission
304.7	Combinations of opioid type drug with any other drug dependence
304.70	Combinations of opioid type drug with any other drug dependence, unspecified
304.71	Combinations of opioid type drug with any other drug dependence, continuous
304.72	Combinations of opioid type drug with any other drug dependence, episodic
304.73	Combinations of opioid type drug with any other drug dependence, in remission
304.8	Combinations of drug dependence excluding opioid type drug
304.80	Combinations of drug dependence excluding opioid type drug, unspecified
304.81	Combinations of drug dependence excluding opioid type drug, continuous
304.82	Combinations of drug dependence excluding opioid type drug, episodic
304.83	Combinations of drug dependence excluding opioid type drug, in remission
304.9	Unspecified drug dependence
304.90	Unspecified drug dependence, unspecified
304.91	Unspecified drug dependence, continuous
304.92	Unspecified drug dependence, episodic
304.93	Unspecified drug dependence, in remission
305	Nondependent abuse of drugs
305.0	Alcohol abuse
305.00	Alcohol abuse, unspecified
305.01	Alcohol abuse, continuous
305.02	Alcohol abuse, episodic
305.03	Alcohol abuse, in remission
305.2	Cannabis abuse
305.20	Cannabis abuse, unspecified
305.21	Cannabis abuse, continuous
305.22	Cannabis abuse, episodic
305.23	Cannabis abuse, in remission
305.3	Hallucinogen abuse

ICD-9-CM Diagnosis Codes	Description
305.30	Hallucinogen abuse, unspecified
305.31	Hallucinogen abuse, continuous
305.32	Hallucinogen abuse, episodic
305.33	Hallucinogen abuse, in remission
305.4	Sedative, hypnotic or anxiolytic abuse
305.40	Sedative, hypnotic or anxiolytic abuse, unspecified
305.41	Sedative, hypnotic or anxiolytic abuse, continuous
305.42	Sedative, hypnotic or anxiolytic abuse, episodic
305.43	Sedative, hypnotic or anxiolytic abuse, in remission
305.5	Opioid abuse
305.50	Opioid abuse, unspecified
305.51	Opioid abuse, continuous
305.52	Opioid abuse, episodic
305.53	Opioid abuse, in remission
305.6	Cocaine abuse
305.60	Cocaine abuse, unspecified
305.61	Cocaine abuse, continuous
305.62	Cocaine abuse, episodic
305.63	Cocaine abuse, in remission
305.7	Amphetamine or related acting sympathomimetic abuse
305.70	Amphetamine or related acting sympathomimetic abuse, unspecified
305.71	Amphetamine or related acting sympathomimetic abuse, continuous
305.72	Amphetamine or related acting sympathomimetic abuse, episodic
305.73	Amphetamine or related acting sympathomimetic abuse, in remission
305.8	Antidepressant type abuse
305.80	Antidepressant type abuse, unspecified
305.81	Antidepressant type abuse, continuous
305.82	Antidepressant type abuse, episodic
305.83	Antidepressant type abuse, in remission
305.9	Other, mixed, or unspecified drug abuse
305.90	Other, mixed, or unspecified drug abuse, unspecified
305.91	Other, mixed, or unspecified drug abuse, continuous
305.92	Other, mixed, or unspecified drug abuse, episodic
305.93	Other, mixed, or unspecified drug abuse, in remission
790.3	Excessive blood level of alcohol
V65.42	Counseling on substance use and abuse

Table 12: ICD-10-PCS Inpatient Procedure Codes

ICD-10-PCS Codes	Description
HZ2ZZZZ	Detoxification Services for Substance Abuse Treatment
HZ30ZZZ	Individual Counseling for Substance Abuse Treatment, Cognitive
HZ31ZZZ	Individual Counseling for Substance Abuse Treatment, Behavioral
HZ32ZZZ	Individual Counseling for Substance Abuse Treatment, Cognitive-Behavioral
HZ33ZZZ	Individual Counseling for Substance Abuse Treatment, 12-Step

ICD-10-PCS Codes	Description
HZ34ZZZ	Individual Counseling for Substance Abuse Treatment, Interpersonal
HZ35ZZZ	Individual Counseling for Substance Abuse Treatment, Vocational
HZ36ZZZ	Individual Counseling for Substance Abuse Treatment, Psychoeducation
HZ37ZZZ	Individual Counseling for Substance Abuse Treatment, Motivational Enhancement
HZ38ZZZ	Individual Counseling for Substance Abuse Treatment, Confrontational
HZ39ZZZ	Individual Counseling for Substance Abuse Treatment, Continuing Care
HZ3BZZZ	Individual Counseling for Substance Abuse Treatment, Spiritual
HZ40ZZZ	Group Counseling for Substance Abuse Treatment, Cognitive
HZ41ZZZ	Group Counseling for Substance Abuse Treatment, Behavioral
HZ42ZZZ	Group Counseling for Substance Abuse Treatment, Cognitive-Behavioral
HZ43ZZZ	Group Counseling for Substance Abuse Treatment, 12-Step
HZ44ZZZ	Group Counseling for Substance Abuse Treatment, Interpersonal
HZ45ZZZ	Group Counseling for Substance Abuse Treatment, Vocational
HZ46ZZZ	Group Counseling for Substance Abuse Treatment, Psychoeducation
HZ47ZZZ	Group Counseling for Substance Abuse Treatment, Motivational Enhancement
HZ48ZZZ	Group Counseling for Substance Abuse Treatment, Confrontational
HZ49ZZZ	Group Counseling for Substance Abuse Treatment, Continuing Care
HZ4BZZZ	Group Counseling for Substance Abuse Treatment, Spiritual
HZ50ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Cognitive
HZ51ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Behavioral
HZ52ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Cognitive-Behavioral
HZ53ZZZ	Individual Psychotherapy for Substance Abuse Treatment, 12-Step
HZ54ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Interpersonal
HZ55ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Interactive
HZ56ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Psychoeducation
HZ57ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Motivational Enhancement
HZ58ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Confrontational
HZ59ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Supportive
HZ5BZZZ	Individual Psychotherapy for Substance Abuse Treatment, Psychoanalysis
HZ5CZZZ	Individual Psychotherapy for Substance Abuse Treatment, Psychodynamic
HZ5DZZZ	Individual Psychotherapy for Substance Abuse Treatment, Psychophysiological
HZ63ZZZ	Family Counseling for Substance Abuse Treatment
HZ80ZZZ	Medication Management for Substance Abuse Treatment, Nicotine Replacement
HZ81ZZZ	Medication Management for Substance Abuse Treatment, Methadone Maintenance
HZ82ZZZ	Medication Management for Substance Abuse Treatment, Levo-alpha-acetyl-methadol (LAAM)
HZ83ZZZ	Medication Management for Substance Abuse Treatment, Antabuse
HZ84ZZZ	Medication Management for Substance Abuse Treatment, Naltrexone
HZ85ZZZ	Medication Management for Substance Abuse Treatment, Naloxone
HZ86ZZZ	Medication Management for Substance Abuse Treatment, Clonidine

ICD-10-PCS Codes	Description
HZ87ZZZ	Medication Management for Substance Abuse Treatment, Bupropion
HZ88ZZZ	Medication Management for Substance Abuse Treatment, Psychiatric Medication
HZ89ZZZ	Medication Management for Substance Abuse Treatment, Other Replacement Medication
HZ90ZZZ	Pharmacotherapy for Substance Abuse Treatment, Nicotine Replacement
HZ91ZZZ	Pharmacotherapy for Substance Abuse Treatment, Methadone Maintenance
HZ92ZZZ	Pharmacotherapy for Substance Abuse Treatment, Levo-alpha-acetyl-methadol (LAAM)
HZ93ZZZ	Pharmacotherapy for Substance Abuse Treatment, Antabuse
HZ94ZZZ	Pharmacotherapy for Substance Abuse Treatment, Naltrexone
HZ95ZZZ	Pharmacotherapy for Substance Abuse Treatment, Naloxone
HZ96ZZZ	Pharmacotherapy for Substance Abuse Treatment, Clonidine
HZ97ZZZ	Pharmacotherapy for Substance Abuse Treatment, Bupropion
HZ98ZZZ	Pharmacotherapy for Substance Abuse Treatment, Psychiatric Medication
HZ99ZZZ	Pharmacotherapy for Substance Abuse Treatment, Other Replacement Medication

Table 13: ICD-10-CM Diagnosis Codes

ICD-10-CM Diagnosis Codes	Description
F10.10	Alcohol abuse, uncomplicated
F10.14	Alcohol abuse with alcohol-induced mood disorder
F10.19	Alcohol abuse with unspecified alcohol-induced disorder
F10.20	Alcohol dependence, uncomplicated
F10.21	Alcohol dependence, in remission
F10.24	Alcohol dependence with alcohol-induced mood disorder
F10.26	Alcohol dependence with alcohol-induced persisting amnestic disorder
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.29	Alcohol dependence with unspecified alcohol-induced disorder
F10.94	Alcohol use, unspecified with alcohol-induced mood disorder
F10.96	Alcohol use, unspecified with alcohol-induced persisting amnestic disorder
F10.97	Alcohol use, unspecified with alcohol-induced persisting dementia
F10.99	Alcohol use, unspecified with unspecified alcohol-induced disorder
F10.120	Alcohol abuse with intoxication, uncomplicated
F10.121	Alcohol abuse with intoxication delirium
F10.129	Alcohol abuse with intoxication, unspecified
F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions
F10.151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
F10.159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10.180	Alcohol abuse with alcohol-induced anxiety disorder
F10.181	Alcohol abuse with alcohol-induced sexual dysfunction
F10.182	Alcohol abuse with alcohol-induced sleep disorder
F10.188	Alcohol abuse with other alcohol-induced disorder
F10.220	Alcohol dependence with intoxication, uncomplicated

DRAFT

ICD-10-CM Diagnosis Codes	Description
F10.221	Alcohol dependence with intoxication delirium
F10.229	Alcohol dependence with intoxication, unspecified
F10.230	Alcohol dependence with withdrawal, uncomplicated
F10.231	Alcohol dependence with withdrawal delirium
F10.232	Alcohol dependence with withdrawal with perceptual disturbance
F10.239	Alcohol dependence with withdrawal, unspecified
F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions
F10.251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
F10.259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.280	Alcohol dependence with alcohol-induced anxiety disorder
F10.281	Alcohol dependence with alcohol-induced sexual dysfunction
F10.282	Alcohol dependence with alcohol-induced sleep disorder
F10.288	Alcohol dependence with other alcohol-induced disorder
F10.920	Alcohol use, unspecified with intoxication, uncomplicated
F10.921	Alcohol use, unspecified with intoxication delirium
F10.929	Alcohol use, unspecified with intoxication, unspecified
F10.950	Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions
F10.951	Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations
F10.959	Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
F10.980	Alcohol use, unspecified with alcohol-induced anxiety disorder
F10.981	Alcohol use, unspecified with alcohol-induced sexual dysfunction
F10.982	Alcohol use, unspecified with alcohol-induced sleep disorder
F10.988	Alcohol use, unspecified with other alcohol-induced disorder
F11.10	Opioid abuse, uncomplicated
F11.14	Opioid abuse with opioid-induced mood disorder
F11.19	Opioid abuse with unspecified opioid-induced disorder
F11.20	Opioid dependence, uncomplicated
F11.21	Opioid dependence, in remission
F11.23	Opioid dependence with withdrawal
F11.24	Opioid dependence with opioid-induced mood disorder
F11.29	Opioid dependence with unspecified opioid-induced disorder
F11.90	Opioid use, unspecified, uncomplicated
F11.93	Opioid use, unspecified with withdrawal
F11.94	Opioid use, unspecified with opioid-induced mood disorder
F11.99	Opioid use, unspecified with unspecified opioid-induced disorder
F11.120	Opioid abuse with intoxication, uncomplicated
F11.121	Opioid abuse with intoxication delirium
F11.122	Opioid abuse with intoxication with perceptual disturbance
F11.129	Opioid abuse with intoxication, unspecified
F11.150	Opioid abuse with opioid-induced psychotic disorder with delusions
F11.151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
F11.159	Opioid abuse with opioid-induced psychotic disorder, unspecified

DRAFT

ICD-10-CM Diagnosis Codes	Description
F11.181	Opioid abuse with opioid-induced sexual dysfunction
F11.182	Opioid abuse with opioid-induced sleep disorder
F11.188	Opioid abuse with other opioid-induced disorder
F11.220	Opioid dependence with intoxication, uncomplicated
F11.221	Opioid dependence with intoxication delirium
F11.222	Opioid dependence with intoxication with perceptual disturbance
F11.229	Opioid dependence with intoxication, unspecified
F11.250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11.281	Opioid dependence with opioid-induced sexual dysfunction
F11.282	Opioid dependence with opioid-induced sleep disorder
F11.288	Opioid dependence with other opioid-induced disorder
F11.920	Opioid use, unspecified with intoxication, uncomplicated
F11.921	Opioid use, unspecified with intoxication delirium
F11.922	Opioid use, unspecified with intoxication with perceptual disturbance
F11.929	Opioid use, unspecified with intoxication, unspecified
F11.950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions
F11.951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
F11.959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
F11.981	Opioid use, unspecified with opioid-induced sexual dysfunction
F11.982	Opioid use, unspecified with opioid-induced sleep disorder
F11.988	Opioid use, unspecified with other opioid-induced disorder
F12.10	Cannabis abuse, uncomplicated
F12.19	Cannabis abuse with unspecified cannabis-induced disorder
F12.20	Cannabis dependence, uncomplicated
F12.21	Cannabis dependence, in remission
F12.29	Cannabis dependence with unspecified cannabis-induced disorder
F12.90	Cannabis use, unspecified, uncomplicated
F12.99	Cannabis use, unspecified with unspecified cannabis-induced disorder
F12.120	Cannabis abuse with intoxication, uncomplicated
F12.121	Cannabis abuse with intoxication delirium
F12.122	Cannabis abuse with intoxication with perceptual disturbance
F12.129	Cannabis abuse with intoxication, unspecified
F12.150	Cannabis abuse with psychotic disorder with delusions
F12.151	Cannabis abuse with psychotic disorder with hallucinations
F12.159	Cannabis abuse with psychotic disorder, unspecified
F12.180	Cannabis abuse with cannabis-induced anxiety disorder
F12.188	Cannabis abuse with other cannabis-induced disorder
F12.220	Cannabis dependence with intoxication, uncomplicated
F12.221	Cannabis dependence with intoxication delirium
F12.222	Cannabis dependence with intoxication with perceptual disturbance
F12.229	Cannabis dependence with intoxication, unspecified

DRAFT

ICD-10-CM Diagnosis Codes	Description
F12.250	Cannabis dependence with psychotic disorder with delusions
F12.251	Cannabis dependence with psychotic disorder with hallucinations
F12.259	Cannabis dependence with psychotic disorder, unspecified
F12.280	Cannabis dependence with cannabis-induced anxiety disorder
F12.288	Cannabis dependence with other cannabis-induced disorder
F12.920	Cannabis use, unspecified with intoxication, uncomplicated
F12.921	Cannabis use, unspecified with intoxication delirium
F12.922	Cannabis use, unspecified with intoxication with perceptual disturbance
F12.929	Cannabis use, unspecified with intoxication, unspecified
F12.950	Cannabis use, unspecified with psychotic disorder with delusions
F12.951	Cannabis use, unspecified with psychotic disorder with hallucinations
F12.959	Cannabis use, unspecified with psychotic disorder, unspecified
F12.980	Cannabis use, unspecified with anxiety disorder
F12.988	Cannabis use, unspecified with other cannabis-induced disorder
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F13.14	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder
F13.19	Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F13.21	Sedative, hypnotic or anxiolytic dependence, in remission
F13.24	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder
F13.26	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F13.27	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.29	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13.90	Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
F13.94	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder
F13.96	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F13.97	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.99	Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13.120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F13.121	Sedative, hypnotic or anxiolytic abuse with intoxication delirium
F13.129	Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
F13.150	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.151	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations

ICD-10-CM Diagnosis Codes	Description
F13.159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.181	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.182	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disorder
F13.188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder
F13.220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13.221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium
F13.229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified
F13.230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13.231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
F13.232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
F13.239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
F13.250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.281	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.282	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder
F13.288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder
F13.920	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, uncomplicated
F13.921	Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium
F13.929	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, unspecified
F13.930	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, uncomplicated
F13.931	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal delirium
F13.932	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal with perceptual disturbances
F13.939	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, unspecified
F13.950	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions

DRAFT

ICD-10-CM Diagnosis Codes	Description
F13.951	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.959	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.980	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.981	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.982	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sleep disorder
F13.988	Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic or anxiolytic-induced disorder
F14.10	Cocaine abuse, uncomplicated
F14.14	Cocaine abuse with cocaine-induced mood disorder
F14.19	Cocaine abuse with unspecified cocaine-induced disorder
F14.20	Cocaine dependence, uncomplicated
F14.21	Cocaine dependence, in remission
F14.23	Cocaine dependence with withdrawal
F14.24	Cocaine dependence with cocaine-induced mood disorder
F14.29	Cocaine dependence with unspecified cocaine-induced disorder
F14.90	Cocaine use, unspecified, uncomplicated
F14.94	Cocaine use, unspecified with cocaine-induced mood disorder
F14.99	Cocaine use, unspecified with unspecified cocaine-induced disorder
F14.120	Cocaine abuse with intoxication, uncomplicated
F14.121	Cocaine abuse with intoxication with delirium
F14.122	Cocaine abuse with intoxication with perceptual disturbance
F14.129	Cocaine abuse with intoxication, unspecified
F14.150	Cocaine abuse with cocaine-induced psychotic disorder with delusions
F14.151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
F14.159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified
F14.180	Cocaine abuse with cocaine-induced anxiety disorder
F14.181	Cocaine abuse with cocaine-induced sexual dysfunction
F14.182	Cocaine abuse with cocaine-induced sleep disorder
F14.188	Cocaine abuse with other cocaine-induced disorder
F14.220	Cocaine dependence with intoxication, uncomplicated
F14.221	Cocaine dependence with intoxication delirium
F14.222	Cocaine dependence with intoxication with perceptual disturbance
F14.229	Cocaine dependence with intoxication, unspecified
F14.250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14.251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14.259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14.280	Cocaine dependence with cocaine-induced anxiety disorder
F14.281	Cocaine dependence with cocaine-induced sexual dysfunction
F14.282	Cocaine dependence with cocaine-induced sleep disorder

ICD-10-CM Diagnosis Codes	Description
F14.288	Cocaine dependence with other cocaine-induced disorder
F14.920	Cocaine use, unspecified with intoxication, uncomplicated
F14.921	Cocaine use, unspecified with intoxication delirium
F14.922	Cocaine use, unspecified with intoxication with perceptual disturbance
F14.929	Cocaine use, unspecified with intoxication, unspecified
F14.950	Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions
F14.951	Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations
F14.959	Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified
F14.980	Cocaine use, unspecified with cocaine-induced anxiety disorder
F14.981	Cocaine use, unspecified with cocaine-induced sexual dysfunction
F14.982	Cocaine use, unspecified with cocaine-induced sleep disorder
F14.988	Cocaine use, unspecified with other cocaine-induced disorder
F15.10	Other stimulant abuse, uncomplicated
F15.14	Other stimulant abuse with stimulant-induced mood disorder
F15.19	Other stimulant abuse with unspecified stimulant-induced disorder
F15.20	Other stimulant dependence, uncomplicated
F15.21	Other stimulant dependence, in remission
F15.23	Other stimulant dependence with withdrawal
F15.24	Other stimulant dependence with stimulant-induced mood disorder
F15.29	Other stimulant dependence with unspecified stimulant-induced disorder
F15.90	Other stimulant use, unspecified, uncomplicated
F15.93	Other stimulant use, unspecified with withdrawal
F15.94	Other stimulant use, unspecified with stimulant-induced mood disorder
F15.99	Other stimulant use, unspecified with unspecified stimulant-induced disorder
F15.120	Other stimulant abuse with intoxication, uncomplicated
F15.121	Other stimulant abuse with intoxication delirium
F15.122	Other stimulant abuse with intoxication with perceptual disturbance
F15.129	Other stimulant abuse with intoxication, unspecified
F15.150	Other stimulant abuse with stimulant-induced psychotic disorder with delusions
F15.151	Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations
F15.159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
F15.180	Other stimulant abuse with stimulant-induced anxiety disorder
F15.181	Other stimulant abuse with stimulant-induced sexual dysfunction
F15.182	Other stimulant abuse with stimulant-induced sleep disorder
F15.188	Other stimulant abuse with other stimulant-induced disorder
F15.220	Other stimulant dependence with intoxication, uncomplicated
F15.221	Other stimulant dependence with intoxication delirium
F15.222	Other stimulant dependence with intoxication with perceptual disturbance
F15.229	Other stimulant dependence with intoxication, unspecified

DRAFT

ICD-10-CM Diagnosis Codes	Description
F15.250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions
F15.251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations
F15.259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15.280	Other stimulant dependence with stimulant-induced anxiety disorder
F15.281	Other stimulant dependence with stimulant-induced sexual dysfunction
F15.282	Other stimulant dependence with stimulant-induced sleep disorder
F15.288	Other stimulant dependence with other stimulant-induced disorder
F15.920	Other stimulant use, unspecified with intoxication, uncomplicated
F15.921	Other stimulant use, unspecified with intoxication delirium
F15.922	Other stimulant use, unspecified with intoxication with perceptual disturbance
F15.929	Other stimulant use, unspecified with intoxication, unspecified
F15.950	Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions
F15.951	Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations
F15.959	Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified
F15.980	Other stimulant use, unspecified with stimulant-induced anxiety disorder
F15.981	Other stimulant use, unspecified with stimulant-induced sexual dysfunction
F15.982	Other stimulant use, unspecified with stimulant-induced sleep disorder
F15.988	Other stimulant use, unspecified with other stimulant-induced disorder
F16.10	Hallucinogen abuse, uncomplicated
F16.14	Hallucinogen abuse with hallucinogen-induced mood disorder
F16.19	Hallucinogen abuse with unspecified hallucinogen-induced disorder
F16.20	Hallucinogen dependence, uncomplicated
F16.21	Hallucinogen dependence, in remission
F16.24	Hallucinogen dependence with hallucinogen-induced mood disorder
F16.29	Hallucinogen dependence with unspecified hallucinogen-induced disorder
F16.90	Hallucinogen use, unspecified, uncomplicated
F16.94	Hallucinogen use, unspecified with hallucinogen-induced mood disorder
F16.99	Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder
F16.120	Hallucinogen abuse with intoxication, uncomplicated
F16.121	Hallucinogen abuse with intoxication with delirium
F16.122	Hallucinogen abuse with intoxication with perceptual disturbance
F16.129	Hallucinogen abuse with intoxication, unspecified
F16.150	Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions
F16.151	Hallucinogen abuse with hallucinogen-induced psychotic disorder with hallucinations
F16.159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified

ICD-10-CM Diagnosis Codes	Description
F16.180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
F16.183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)
F16.188	Hallucinogen abuse with other hallucinogen-induced disorder
F16.220	Hallucinogen dependence with intoxication, uncomplicated
F16.221	Hallucinogen dependence with intoxication with delirium
F16.229	Hallucinogen dependence with intoxication, unspecified
F16.250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
F16.251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
F16.259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16.283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
F16.288	Hallucinogen dependence with other hallucinogen-induced disorder
F16.920	Hallucinogen use, unspecified with intoxication, uncomplicated
F16.921	Hallucinogen use, unspecified with intoxication with delirium
F16.929	Hallucinogen use, unspecified with intoxication, unspecified
F16.950	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with delusions
F16.951	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with hallucinations
F16.959	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified
F16.980	Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder
F16.983	Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks)
F16.988	Hallucinogen use, unspecified with other hallucinogen-induced disorder
F18.10	Inhalant abuse, uncomplicated
F18.14	Inhalant abuse with inhalant-induced mood disorder
F18.17	Inhalant abuse with inhalant-induced dementia
F18.19	Inhalant abuse with unspecified inhalant-induced disorder
F18.20	Inhalant dependence, uncomplicated
F18.21	Inhalant dependence, in remission
F18.24	Inhalant dependence with inhalant-induced mood disorder
F18.27	Inhalant dependence with inhalant-induced dementia
F18.29	Inhalant dependence with unspecified inhalant-induced disorder
F18.90	Inhalant use, unspecified, uncomplicated
F18.94	Inhalant use, unspecified with inhalant-induced mood disorder
F18.97	Inhalant use, unspecified with inhalant-induced persisting dementia
F18.99	Inhalant use, unspecified with unspecified inhalant-induced disorder
F18.120	Inhalant abuse with intoxication, uncomplicated
F18.121	Inhalant abuse with intoxication delirium
F18.129	Inhalant abuse with intoxication, unspecified

DRAFT

ICD-10-CM Diagnosis Codes	Description
F18.150	Inhalant abuse with inhalant-induced psychotic disorder with delusions
F18.151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations
F18.159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified
F18.180	Inhalant abuse with inhalant-induced anxiety disorder
F18.188	Inhalant abuse with other inhalant-induced disorder
F18.220	Inhalant dependence with intoxication, uncomplicated
F18.221	Inhalant dependence with intoxication delirium
F18.229	Inhalant dependence with intoxication, unspecified
F18.250	Inhalant dependence with inhalant-induced psychotic disorder with delusions
F18.251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
F18.259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F18.280	Inhalant dependence with inhalant-induced anxiety disorder
F18.288	Inhalant dependence with other inhalant-induced disorder
F18.920	Inhalant use, unspecified with intoxication, uncomplicated
F18.921	Inhalant use, unspecified with intoxication with delirium
F18.929	Inhalant use, unspecified with intoxication, unspecified
F18.950	Inhalant use, unspecified with inhalant-induced psychotic disorder with delusions
F18.951	Inhalant use, unspecified with inhalant-induced psychotic disorder with hallucinations
F18.959	Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified
F18.980	Inhalant use, unspecified with inhalant-induced anxiety disorder
F18.988	Inhalant use, unspecified with other inhalant-induced disorder
F19.10	Other psychoactive substance abuse, uncomplicated
F19.14	Other psychoactive substance abuse with psychoactive substance-induced mood disorder
F19.16	Other psychoactive substance abuse with psychoactive substance-induced persisting amnestic disorder
F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
F19.19	Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder
F19.20	Other psychoactive substance dependence, uncomplicated
F19.21	Other psychoactive substance dependence, in remission
F19.24	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
F19.26	Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.29	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder
F19.90	Other psychoactive substance use, unspecified, uncomplicated

DRAFT

ICD-10-CM Diagnosis Codes	Description
F19.94	Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder
F19.96	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting amnestic disorder
F19.97	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia
F19.99	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder
F19.120	Other psychoactive substance abuse with intoxication, uncomplicated
F19.121	Other psychoactive substance abuse with intoxication delirium
F19.122	Other psychoactive substance abuse with intoxication with perceptual disturbances
F19.129	Other psychoactive substance abuse with intoxication, unspecified
F19.150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions
F19.151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations
F19.159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified
F19.180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder
F19.181	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction
F19.182	Other psychoactive substance abuse with psychoactive substance-induced sleep disorder
F19.188	Other psychoactive substance abuse with other psychoactive substance-induced disorder
F19.220	Other psychoactive substance dependence with intoxication, uncomplicated
F19.221	Other psychoactive substance dependence with intoxication delirium
F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19.229	Other psychoactive substance dependence with intoxication, unspecified
F19.230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19.231	Other psychoactive substance dependence with withdrawal delirium
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19.239	Other psychoactive substance dependence with withdrawal, unspecified
F19.250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
F19.251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
F19.259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
F19.280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19.281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction

DRAFT

ICD-10-CM Diagnosis Codes	Description
F19.282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
F19.288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F19.920	Other psychoactive substance use, unspecified with intoxication, uncomplicated
F19.921	Other psychoactive substance use, unspecified with intoxication with delirium
F19.922	Other psychoactive substance use, unspecified with intoxication with perceptual disturbance
F19.929	Other psychoactive substance use, unspecified with intoxication, unspecified
F19.930	Other psychoactive substance use, unspecified with withdrawal, uncomplicated
F19.931	Other psychoactive substance use, unspecified with withdrawal delirium
F19.932	Other psychoactive substance use, unspecified with withdrawal with perceptual disturbance
F19.939	Other psychoactive substance use, unspecified with withdrawal, unspecified
F19.950	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions
F19.951	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations
F19.959	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder, unspecified
F19.980	Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder
F19.981	Other psychoactive substance use, unspecified with psychoactive substance-induced sexual dysfunction
F19.982	Other psychoactive substance use, unspecified with psychoactive substance-induced sleep disorder
F19.988	Other psychoactive substance use, unspecified with other psychoactive substance-induced disorder
F55.0	Abuse of antacids
F55.1	Abuse of herbal or folk remedies
F55.2	Abuse of laxatives
F55.3	Abuse of steroids or hormones
F55.4	Abuse of vitamins
F55.8	Abuse of other non-psychoactive substances
R78.0	Finding of alcohol in blood
Z71.41	Alcohol abuse counseling and surveillance of alcoholic
Z71.51	Drug abuse counseling and surveillance of drug abuser

DRAFT

Appendix B: CCLF File Layouts

Following is the list of data elements present on the CCLF Reports. The records in the text file are fixed width. The File Name Convention is listed prior to each table.

The File Name Convention for Table 14 is *P#EFT.ON.ACOT.<ACOID>.CCLF1.Dyymmdd.Thhmmsst*.

Table 14: Part A Claims Header File (CCLF1)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2	PRVDR_OSCAR_NUM	Provider OSCAR Number	14	19	6	X(06)	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
3	BENE_HIC_NUM	Beneficiary HIC Number	20	30	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
4	CLM_TYPE_CD	Claim Type Code	31	32	2	X(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient “Full-Encounter” claim
5	CLM_FROM_DT	Claim From Date	33	42	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as “Statement Covers From Date.”

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
6	CLM_THRU_DT	Claim Thru Date	43	52	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers Through Date."

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	CLM_BILL_FAC_TYPE_CD	Claim Bill Facility Type Code	53	53	1	X(01)	The first digit of the type of bill (TOB1) is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1=Hospital 2=SNF 3=HHA 4=Religious non-medical (hospital) 5=Religious non-medical (extended care) 6=Intermediate care 7=Clinic or hospital-based renal dialysis facility 8=Specialty facility or Ambulatory Surgical Center (ASC) surgery 9=Reserved

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
8	CLM_BILL_CLSFCTN_CD	Claim Bill Classification Code	54	54	1	X(01)	The second digit of the type of bill (TOB2) is used to indicate with greater specificity where the service was provided (e.g., a department within a hospital). Find Claim Service Classification Codes here: http://www.resdac.org/cms-data/variables/Claim-Service-classification-Type-Code
9	PRNCPL_DGNS_CD	Principal Diagnosis Code	55	61	7	X(07)	The ICD-9/10 diagnosis code identifies the beneficiary's principal illness or disability.
10	ADMTG_DGNS_CD	Admitting Diagnosis Code	62	68	7	X(07)	The ICD-9/10 diagnosis code identifies the illness or disability for which the beneficiary was admitted.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
11	CLM_MDCR_NPMT_RSN_CD	Claim Medicare Non-Payment Reason Code	69	70	2	X(02)	Indicates the reason payment on an institutional claim is denied. Find Medicare Non-Payment Reason Codes here: http://www.resdac.org/cms-data/variables/claim-medicare-non-payment-reason-code
12	CLM_PMT_AMT	Claim Payment Amount	71	87	17	X(17)	Amount that Medicare paid on the claim.
13	CLM_NCH_PRMRY_PYR_CD	Claim NCH Primary Payer Code	88	88	1	X(01)	If a payer other than Medicare has primary responsibility for payment of the beneficiary's health insurance bills, this code indicates the responsible primary payer. If this field is blank, Medicare is the primary payer for the beneficiary. Find NCH Primary Payer Codes here: http://www.resdac.org/cms-data/variables/NCH-Primary-Payer-Code

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
14	PRVDR_FAC_FIPS_ST_CD	Federal Information Processing Standards (FIPS) State Code	89	90	2	X(02)	Identifies the state where the facility providing services is located.
15	BENE_PTNT_STUS_CD	Beneficiary Patient Status Code	91	92	2	X(02)	Indicates the patient's discharge status as of the Claim Through Date. For example, it may indicate where a patient was discharged to (e.g., home, another facility) or the circumstances of a discharge (e.g., against medical advice, or patient death). Find Patient Discharge Status Codes here: http://www.resdac.org/cms-data/variables/patient-discharge-status-code
16	DGNS_DRG_CD	Diagnosis Related Group Code	93	96	4	X(04)	Indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
17	CLM_OP_SRVC_TYPE_CD	Claim Outpatient Service Type Code	97	97	1	X(01)	Indicates the type and priority of outpatient service. Claim Outpatient Service Type Codes are: 0=Blank 1=Emergency 2=Urgent 3=Elective 5-8=Reserved 9=Unknown
18	FAC_PRVDR_NPI_NUM	Facility Provider NPI Number	98	107	10	X(10)	Identifies the facility associated with the claim. Each facility is assigned its own unique NPI.
19	OPRTG_PRVDR_NPI_NUM	Operating Provider NPI Number	108	117	10	X(10)	Identifies the operating provider associated with the claim. Each provider is assigned its own unique NPI.
20	ATNDG_PRVDR_NPI_NUM	Attending Provider NPI Number	118	127	10	X(10)	Identifies the attending provider associated with the claim. Each provider is assigned its own unique NPI.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
21	OTHR_PRVDR_NPI_NUM	Other Provider NPI Number	128	137	10	X(10)	Identifies the other providers associated with the claim. Each provider is assigned its own unique NPI.
22	CLM_ADJSMT_TYPE_CD	Claim Adjustment Type Code	138	139	2	X(02)	Indicates whether the claim is an original, cancelation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Cancelation Claim 2=Adjustment claim
23	CLM_EFCTV_DT	Claim Effective Date	140	149	10	YYYY-MM-DD	Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date.
24	CLM_IDR_LD_DT	Claim IDR Load Date	150	159	10	YYYY-MM-DD	When the claim was loaded into the IDR.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
25	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	160	170	11	X(11)	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event, using the natural key.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
26	CLM_ADMSN_TYPE_CD	Claim Admission Type Code	171	172	2	X(2)	Indicates the type and priority of inpatient services. Claim Admission Type Codes are: 0=Blank 1=Emergency 2=Urgent 3=Elective 4=Newborn 5=Trauma Center 6-8=Reserved 9=Unknown
27	CLM_ADMSN_SRC_CD	Claim Admission Source Code	173	174	2	X(2)	Indicates the source of the beneficiary's referral for admission or visit (e.g., a physician or another facility). Find Admission Source Codes here: http://www.resdac.org/cms-data/variables/Claim-Source-Inpatient-Admission-Code

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
28	CLM_BILL_FREQ_CD	Claim Bill Frequency Code	175	175	1	X(1)	The third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Find Claim Frequency Codes here: http://www.resdac.org/cms-data/variables/Claim-Frequency-Code.
29	CLM_QUERY_CD	Claim Query Code	176	176	1	X(1)	Indicates the type of claim record being processed with respect to payment (e.g., debit/credit indicator or interim/final indicator). Claim Query Codes are: 0=Credit adjustment 1=Interim bill 2=HHA benefits exhausted 3=Final bill 4=Discharge notice 5=Debit adjustment

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
30	DGNS_PRCDR_ICD_IND	ICD Version Indicator	177	177	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than “9” or “0” in the source data.

DRAFT

The File Name Convention for Table 15 is P#EFT.ON.ACOT.<ACOID>.CCLF2.Dyymmdd.Thhmmsst.

Table 15: Part A Claims Revenue Center Detail File (CCLF2)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim
2	CLM_LINE_NUM	Claim Line Number	14	23	10	9(10)	A sequential number that identifies a specific claim line
3	BENE_HIC_NUM	Beneficiary HIC Number	24	34	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
4	CLM_TYPE_CD	Claim Type Code	35	36	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient “Full-Encounter” claim
5	CLM_LINE_FROM_DT	Claim Line From Date	37	46	10	YYYY-MM-DD	The date the service associated with the line item began.
6	CLM_LINE_THRU_DT	Claim Line Thru Date	47	56	10	YYYY-MM-DD	The date the service associated with the line item ended.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	CLM_LINE_PROD_REV_CTR_CD	Product Revenue Center Code	57	60	4	X(04)	The number a provider assigns to the cost center to which a particular charge is billed (e.g., accommodations or supplies). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). Find Revenue Center Codes here: http://www.resdac.org/sites/resdac.org/files/Revenue%20Center%20Table.txt Revenue center code 0001 represents the total of all revenue centers included on the claim.
8	CLM_LINE_INSTNL_REV_CTR_DT	Claim Line Institutional Revenue Center Date	61	70	10	YYYY-MM-DD	The date that applies to the service associated with the Revenue Center code.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
9	CLM_LINE_HCPCS_CD	HCPCS Code	71	75	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
10	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	76	86	11	X(11)	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
11	PRVDR_OSCAR_NUM	Provider OSCAR Number	87	92	6	X(6)	A facility's Medicare/Medicaid identification number, also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services.
12	CLM_FROM_DT	Claim From Date	93	102	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers From Date."
13	CLM_THRU_DT	Claim Thru Date	103	112	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers Through Date."

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
14	CLM_LINE_SRVC_UNIT_QTY	Claim Line Service Unit Quantity	113	136	24	X(24)	Count of total units, at the line-item level, associated with services needing unit reporting (e.g., anesthesia time units and blood units).
15	CLM_LINE_CVRD_PD_AMT	Claim Line Covered Paid Amount	137	153	17	X(17)	The amount Medicare reimbursed the provider for covered services associated with the claim-line.
16	HCPCS_1_MDFR_CD	HCPCS First Modifier Code	154	155	2	X(2)	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
17	HCPCS_2_MDFR_CD	HCPCS Second Modifier Code	156	157	2	X(2)	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
18	HCPCS_3_MDFR_CD	HCPCS Third Modifier Code	158	159	2	X(2)	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
19	HCPCS_4_MDFR_CD	HCPCS Fourth Modifier Code	160	161	2	X(2)	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
20	HCPCS_5_MDFR_CD	HCPCS Fifth Modifier Code	162	163	2	X(2)	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.

DRAFT

The File Name Convention for Table 16 is *P#EFT.ON.ACOT.<ACOID>.CCLF3.Dyymmdd.Thhmmsst*.

Table 16: Part A Procedure Code File (CCLF3)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2	BENE_HIC_NUM	Beneficiary HIC Number	14	24	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim.
3	CLM_TYPE_CD	Claim Type Code	25	26	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient "Full-Encounter" claim

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
4	CLM_VAL_SQNC_NUM	Claim Value Sequence Number	27	28	2	9(2)	An arbitrary sequential number that uniquely identifies a procedure code record within the claim.
5	CLM_PRCDR_CD	Procedure Code	29	35	7	X(07)	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
6	CLM_PRCDR_PRFRM_DT	Procedure Performed Date	36	45	10	YYYY-MM-DD	The date the indicated procedure was performed.
7	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	46	56	11	X(11)	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary’s spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
8	PRVDR_OSCAR_NUM	Provider OSCAR Number	57	62	6	X(6)	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services.
9	CLM_FROM_DT	Claim From Date	63	72	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as "Statement Covers From Date."
10	CLM_THRU_DT	Claim Thru Date	73	82	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers Through Date."
11	DGNS_PRCDR_ICD_IND	ICD Version Indicator	83	83	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than "9" or "0" in the source data.

DRAFT

The File Name Convention for Table 17 is P#EFT.ON.ACOT.<ACOID>.CCLF4.Dyymmdd.Thhmmsst.

Table 17: Part A Diagnosis Code File (CCLF4)

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2	BENE_HIC_NUM	Beneficiary HIC Number	14	24	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim.
3	CLM_TYPE_CD	Claim Type Code	25	26	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient "Full-Encounter" claim

DRAFT

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
4	CLM_PROD_TYPE_CD	Claim Product Type Code	27	27	1	X(01)	Codes classifying the diagnosis category: E=Accident diagnosis code 1=First diagnosis E code D=Other diagnosis codes
5	CLM_VAL_SQNC_NUM	Claim Value Sequence Number	28	29	2	9(2)	An arbitrary sequential number that uniquely identifies a procedure code record within the claim.
6	CLM_DGNS_CD	Diagnosis Code	30	36	7	X(07)	The ICD-9/10 diagnosis code identifying the beneficiary's illness or disability.
7	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	37	47	11	X(11)	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.

DRAFT

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
8	PRVDR_OSCAR_NUM	Provider OSCAR Number	48	53	6	X(6)	The OSCAR is a facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services.
9	CLM_FROM_DT	Claim From Date	54	63	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers From Date."
10	CLM_THRU_DT	Claim Thru Date	64	73	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers Through Date."

DRAFT

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
11	CLM_POA_IND	Claim Present-on-Admission Indicator	74	80	7	X(7)	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility. Find Present-on-Admission values here: http://www.resdac.org/cms-data/variables/claim-diagnosis-code-i-diagnosis-present-admission-indicator-code
12	DGNS_PRCDR_ICD_IND	ICD Version Indicator	81	81	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than “9” or “0” in the source data.

The File Name Convention for Table 18 is P#EFT.ON.ACOT.<ACOID>.CCLF5.Dyymmdd.Thhmmsst.

Table 18: Part B Physicians File (CCLF5)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
2	CLM_LINE_NUM	Claim Line Number	14	23	10	9(10)	A sequential number that identifies a specific claim line within a given claim.
3	BENE_HIC_NUM	Beneficiary HIC Number	24	34	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim
4	CLM_TYPE_CD	Claim Type Code	35	36	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs Claim type codes are: 71=RIC O local carrier non-DMEPOS claim 72=RIC O local carrier DMEPOS claim
5	CLM_FROM_DT	Claim From Date	37	46	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers From Date."

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
6	CLM_THRU_DT	Claim Thru Date	47	56	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers Through Date."

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	RNDRG_PRVDR_TYPE_CD	Rendering Provider Type Code	57	59	3	X(03)	Indicates the type of provider who provided the service associated with this line item on the claim. Provider Type Codes are: 0=Clinics, groups, associations, partnerships, or other entities 1=Physicians or suppliers reporting as solo practitioners 2=Suppliers (other than sole proprietorship) 3=Institutional provider 4=Independent laboratories 5=Clinics (multiple specialties) 6=Groups (single specialty) 7=Other entities UI= UPIN Identification N2= National Council for Prescription Drug Programs D= National Supplier Clearinghouse BP= PIN Individual BG= PIN Group A= Online Survey, Certification and Reporting

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
8	RNDRG_PRVDR_FIPS_ST_CD	Rendering Provider FIPS State Code	60	61	2	X(02)	Identifies the state that the provider providing the service is located in.
9	CLM_PRVDR_SPCLTY_CD	Claim-Line Provider Specialty Code	62	63	2	X(02)	Indicates the CMS specialty code associated with the provider of services. CMS used this number to price the service on the line-item. Find Provider Specialty Codes here: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf
10	CLM_FED_TYPE_SRVC_CD	Claim Federal Type Service Code	64	64	1	X(01)	Indicates the type of service (e.g., consultation, surgery) provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual. Find Types of Service Codes here: http://www.resdac.org/sites/resdac.org/files/CMS%20Type%20of%20Service%20Table.txt

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
11	CLM_POS_CD	Claim Place of Service Code	65	66	2	X(02)	Indicates the place where the indicated service was provided (e.g., ambulance, school). Places of service are defined in the Medicare Carrier Manual. Find Place of Service Codes here: http://www.resdac.org/sites/resdac.org/files/Place%20of%20Service%20Table.txt
12	CLM_LINE_FROM_DT	Claim Line From Date	67	76	10	YYYY-MM-DD	The date the service associated with the line item began.
13	CLM_LINE_THRU_DT	Claim Line Thru Date	77	86	10	YYYY-MM-DD	The date the service associated with the line item ended.
14	CLM_LINE_HCPCS_CD	HCPCS Code	87	91	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
15	CLM_LINE_CVRD_PD_AMT	Claim Line Covered Paid Amount	92	106	15	X(15)	The amount of payment made by Medicare on behalf of the beneficiary for the indicated service after deductible and coinsurance amounts have been paid.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
16	CLM_PRMRY_PYR_CD	Claim Primary Payer Code	107	107	1	X(01)	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer. This field is also known as the Line Beneficiary Primary Payer Code. If this field is blank, Medicare is the primary payer for the beneficiary. Find Primary Payer Codes here: http://www.resdac.org/cms-data/variables/Line-Beneficiary-Primary-Payer-Code
17	CLM_LINE_DGNS_CD	Diagnosis Code	108	114	7	X(07)	The ICD-9/10 diagnosis code identifying the beneficiary's principal illness or disability.
18	CLM_RNDRG_PRVDR_TAX_NUM	Claim Provider Tax Number	115	124	10	X(10)	The SSN or Employee Identification Number (EIN) of the provider of the indicated service. This number identifies who receives payment for the indicated service.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
19	RNDRG_PRVDR_NPI_NUM	Rendering Provider NPI Number	125	134	10	X(10)	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI.
20	CLM_CARR_PMT_DNL_CD	Claim Carrier Payment Denial Code	135	136	2	X(02)	Indicates to whom payment was made (e.g., physician, beneficiary), or if the claim was denied. Find Carrier Payment Denial Codes here: http://www.resdac.org/sites/resdac.org/files/Carrier%20Claim%20Payment%20Denial%20Table.txt
21	CLM_PRCSG_IND_CD	Claim-Line Processing Indicator Code	137	138	2	X(02)	Indicates whether the service indicated on the claim line was allowed or the reason it was denied. Find Processing Indicator Codes here: http://www.resdac.org/sites/resdac.org/files/Line%20Processing%20Indicator%20Table.txt

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
22	CLM_ADJSMT_TYPE_CD	Claim Adjustment Type Code	139	140	2	X(02)	Indicates whether the claim an original, cancelation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Cancelation Claim 2=Adjustment claim
23	CLM_EFCTV_DT	Claim Effective Date	141	150	10	YYYY-MM-DD	The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date.
24	CLM_IDR_LD_DT	Claim IDR Load Date	151	160	10	YYYY-MM-DD	When the claim was loaded into the IDR.
25	CLM_CNTL_NUM	Claim Control Number	161	200	40	X(40)	A unique number assigned to a claim by the Medicare carrier. This number allows CMS to associate each line item with its respective claim.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
26	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	201	211	11	X(11)	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.
27	CLM_LINE_ALOWD_CHRG_AMT	Claim Line Allowed Charges Amount	212	228	17	X(17)	The amount Medicare approved for payment to the provider.
28	CLM_LINE_SRVC_UNIT_QTY	Claim Line Service Unit Quantity	229	252	24	X(24)	Count of total units, at the line-item level, associated with services needing unit reporting (e.g., anesthesia time units and blood units).

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
29	HCPCS_1_MDFR_CD	HCPCS First Modifier Code	253	254	2	X(2)	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
30	HCPCS_2_MDFR_CD	HCPCS Second Modifier Code	255	256	2	X(2)	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
31	HCPCS_3_MDFR_CD	HCPCS Third Modifier Code	257	258	2	X(2)	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
32	HCPCS_4_MDFR_CD	HCPCS Fourth Modifier Code	259	260	2	X(2)	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
33	HCPCS_5_MDFR_CD	HCPCS Fifth Modifier Code	261	262	2	X(2)	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
34	CLM_DISP_CD	Claim Disposition Code	263	264	2	X(2)	Information regarding payment actions on the claim. Claim Disposition Codes are: 01=Debit accepted 02=Debit accepted (automatic adjustment) 03=Cancel accepted
35	CLM_DGNS_1_CD	Claim Diagnosis First Code	265	271	7	X(7)	The first of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
36	CLM_DGNS_2_CD	Claim Diagnosis Second Code	272	278	7	X(7)	The second of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
37	CLM_DGNS_3_CD	Claim Diagnosis Third Code	279	285	7	X(7)	The third of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
38	CLM_DGNS_4_CD	Claim Diagnosis Fourth Code	286	292	7	X(7)	The fourth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
39	CLM_DGNS_5_CD	Claim Diagnosis Fifth Code	293	299	7	X(7)	The fifth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
40	CLM_DGNS_6_CD	Claim Diagnosis Sixth Code	300	306	7	X(7)	The sixth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
41	CLM_DGNS_7_CD	Claim Diagnosis Seventh Code	307	313	7	X(7)	The seventh of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
42	CLM_DGNS_8_CD	Claim Diagnosis Eighth Code	314	320	7	X(7)	The eighth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
43	DGNS_PRCDR_ICD_IND	ICD Version Indicator	321	321	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than “9” or “0” in the source data.

DRAFT

The File Name Convention for Table 19 is P#EFT.ON.ACOT.<ACOID>.CCLF6.Dyymmdd.Thhmmsst.

Table 19: Part B DME File (CCLF6)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2	CLM_LINE_NUM	Claim Line Number	14	23	10	9(10)	A sequential number that identifies a specific claim line.
3	BENE_HIC_NUM	Beneficiary HIC Number	24	34	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim.
4	CLM_TYPE_CD	Claim Type Code	35	36	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 81=RIC M DMERC non-DMEPOS claim 82=RIC M DMERC DMEPOS claim

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
5	CLM_FROM_DT	Claim From Date	37	46	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as the “Statement Covers From Date.”
6	CLM_THRU_DT	Claim Thru Date	47	56	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the “Statement Covers Through Date.”
7	CLM_FED_TYPE_SRVC_CD	Claim Federal Type Service Code	57	57	1	X(01)	Indicates the type of service (e.g., consultation, surgery), provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual. Find Types of Service Codes here: http://www.resdac.org/sites/resdac.org/files/CMS%20Type%20of%20Service%20Table.txt

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
8	CLM_POS_CD	Claim Place of Service Code	58	59	2	X(02)	Indicates place where the indicated service was provided (e.g., ambulance, school). Find Place of Service Codes here: http://www.resdac.org/sites/resdac.org/files/Place%20of%20Service%20Table.txt
9	CLM_LINE_FROM_DT	Claim Line From Date	60	69	10	YYYY-MM-DD	The date the service associated with the line item began.
10	CLM_LINE_THRU_DT	Claim Line Thru Date	70	79	10	YYYY-MM-DD	The date the service associated with the line item ended.
11	CLM_LINE_HCPCS_CD	HCPCS Code	80	84	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
12	CLM_LINE_CVRD_PD_AMT	Claim Line Covered Paid Amount	85	99	15	X(15)	The amount of payment made by Medicare on behalf of the beneficiary for the indicated service after deductible and coinsurance amounts have been paid.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
13	CLM_PRMRY_PYR_CD	Claim Primary Payer Code	100	100	1	X(01)	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer. This field is also known as the Line Beneficiary Primary Payer Code. If this field is blank, Medicare is the primary payer for the beneficiary. Find Primary Payer Codes here: http://www.resdac.org/cms-data/variables/Line-Beneficiary-Primary-Payer-Code
14	PAYTO_PRVDR_NPI_NUM	Pay-to Provider NPI Number	101	110	10	X(10)	A number that identifies the provider billing for the indicated service on the claim line. Each provider is assigned its own unique NPI.
15	ORDRG_PRVDR_NPI_NUM	Ordering Provider NPI Number	111	120	10	X(10)	A number that identifies the provider ordering the indicated service on the claim line. Each provider is assigned its own unique NPI.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
16	CLM_CARR_PMT_DNL_CD	Claim Carrier Payment Denial Code	121	122	2	X(02)	Indicates to whom payment was made (e.g., physician, beneficiary) or if the claim was denied Find Carrier Payment Denial Codes here: http://www.resdac.org/sites/resdac.org/files/Carrier%20Claim%20Payment%20Denial%20Table.txt
17	CLM_PRCSG_IND_CD	Claim Processing Indicator Code	123	124	2	X(02)	Indicates whether the service indicated on the claim line was allowed or the reason it was denied. Find Processing Indicator Codes here: http://www.resdac.org/sites/resdac.org/files/Line%20Processing%20Indicator%20Table.txt

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
18	CLM_ADJSMT_TYPE_CD	Claim Adjustment Type Code	125	126	2	X(02)	Indicates whether the claim an original, cancelation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Cancelation Claim 2=Adjustment claim
19	CLM_EFCTV_DT	Claim Effective Date	127	136	10	YYYY-MM-DD	The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date.
20	CLM_IDR_LD_DT	Claim IDR Load Date	137	146	10	YYYY-MM-DD	When the claim was loaded into the IDR.
21	CLM_CNTL_NUM	Claim Control Number	147	186	40	X(40)	A unique number assigned to a claim by the Medicare carrier. This number allows CMS to associate each line item with its respective claim.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
22	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	187	197	11	X(11)	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary’s spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.
23	CLM_LINE_ALOWD_CHRG_AMT	Claim Line Allowed Charges Amount	198	214	17	-9(14)V99	The amount Medicare approved for payment to the provider.
24	CLM_DISP_CD	Claim Disposition Code	215	216	2	X(2)	Contains information regarding payment actions on the claim. Claim Disposition Codes are: 01=Debit accepted 02=Debit accepted (automatic adjustment) 03=Cancel accepted

DRAFT

The File Name Convention for Table 20 is P#EFT.ON.ACOT.<ACOID>.CCLF7.Dyymmdd.Thhmmsst.

Table 20: Part D File (CCLF7)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2	BENE_HIC_NUM	Beneficiary HIC Number	14	24	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim.
3	CLM_LINE_NDC_CD	NDC Code	25	35	11	X(11)	A universal unique product identifier for human drugs.
4	CLM_TYPE_CD	Claim Type Code	36	37	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 01=Part D - Original without resubmitted PDE 02=Part D - Adjusted PDE 03=Part D - Deleted Claims 04=Part D - Resubmitted PDE

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
5	CLM_LINE_FROM_DT	Claim Line From Date	38	47	10	YYYY-MM-DD	The date the service associated with the line item began (i.e., the date upon which the prescription was filled).
6	PRVDR_SRVC_ID_QLFYR_CD	Provider Service Identifier Qualifier Code	48	49	2	X(02)	Indicates the type of number used to identify the pharmacy providing the services: 01= NPI Number 06=Unique Physician Identification Number (UPIN) 07=National Council for Prescription Drug Programs (NCPDP) Number 08=State License Number 11=TIN 99=Other mandatory for Standard Data Format
7	CLM_SRVC_PRVDR_GNRC_ID_NUM	Claim Service Provider Generic ID Number	50	69	20	X(20)	The number associated with the indicated code in the Provider Service Identification Qualifier Code field.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
8	CLM_DSPNSNG_STUS_CD	Claim Dispensing Status Code	70	70	1	X(01)	Indicates the status of prescription fulfillment. Dispensing Codes are: P=Partially filled C=Completely filled

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
9	CLM_DAW_PROD_SLCTN_CD	Claim Dispense as Written (DAW) Product Selection Code	71	71	1	X(01)	Indicates the prescriber's instructions regarding generic substitution or how those instructions were followed. DAW Product Selection Codes are: 0=No product selection indicated 1=Substitution not allowed by prescriber 2=Substitution allowed – Patient requested that brand be dispensed 3=Substitution allowed – Pharmacist selected product dispensed 4=Substitution allowed – Generic not in stock 5=Substitution allowed – Brand drug dispensed as generic 6=Override 7=Substitution not allowed – Brand drug mandated by law 8=Substitution allowed – Generic drug not available in marketplace 9=Other

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
10	CLM_LINE_SRVC_UNIT_QTY	Claim Line Service Unit Quantity	72	95	24	X(24)	Count of total units, at the line-item level, associated with services needing unit reporting (e.g., anesthesia time units and blood units).
11	CLM_LINE_DAYS_SUPLY_QTY	Claim Line Days' Supply Quantity	96	104	9	9(09)	The number of days the supply of medication dispensed by the pharmacy will cover.
12	PRVDR_PRSBNG_ID_QLFYR_CD	Provider Prescribing ID Qualifier Code	105	106	2	X(02)	Indicates the type of number used to identify the prescribing provider: 01= NPI Number 06= UPIN 07= NCPDP Number 08=State License Number 11=TIN 12=DEA 99=Other mandatory for Standard Data Format
13	CLM_PRSBNG_PRVDR_GNRC_ID_NUM	Claim Prescribing Provider Generic ID Number	107	126	20	X(20)	The number associated with the indicated code in the Provider Prescribing Service Identification Qualifier Code field.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
14	CLM_LINE_BENE_PMT_AMT	Claim Line Beneficiary Payment Amount	127	139	13	-9(9).99	The dollar amount paid by the beneficiary that is not reimbursed by a third party (e.g., copayments, coinsurance, deductible or other patient pay amounts).
15	CLM_ADJSMT_TYPE_CD	Claim Adjustment Type Code	140	141	2	X(02)	Indicates whether the claim an original, cancelation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Cancelation Claim 2=Adjustment claim
16	CLM_EFCTV_DT	Claim Effective Date	142	151	10	YYYY-MM-DD	The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date.
17	CLM_IDR_LD_DT	Claim IDR Load Date	152	161	10	YYYY-MM-DD	When the claim was loaded into the IDR.
18	CLM_LINE_RX_SRVC_RFRNC_NUM	Claim Line Prescription Service Reference Number	162	173	12	X(12)	Identifies a prescription dispensed by a particular service provider on a particular service date.

DRAFT

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
19	CLM_LINE_RX_FILL_NUM	Claim Line Prescription Fill Number	174	182	9	X(09)	Assigned to the current dispensed supply by the pharmacy. It designates the sequential order of the original fill or subsequent refills of a prescription.

The File Name Convention for Table 21 is P#EFT.ON.ACOT.<ACOID>.CCLF8.Dyymmdd.Thhmmsst.

Table 21: Beneficiary Demographics File (CCLF8)

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
1	BENE_HIC_NUM	Beneficiary HIC Number	1	11	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim.
2	BENE_FIPS_STATE_CD	Beneficiary FIPS State Code	12	13	2	9(02)	Identifies the state where the beneficiary receiving services resides.
3	BENE_FIPS_CNTY_CD	Beneficiary FIPS County Code	14	16	3	9(03)	Identifies the county where the beneficiary receiving services resides.
4	BENE_ZIP_CD	Beneficiary ZIP Code	17	21	5	X(05)	The beneficiary's ZIP code as indicated in their Medicare enrollment record.

DRAFT

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
5	BENE_DOB	Beneficiary Date of Birth	22	31	10	YYYY-MM-DD	The month, day, and year of the beneficiary's birth.
6	BENE_SEX_CD	Beneficiary Sex Code	32	32	1	X(01)	The beneficiary's sex: 1=Male 2=Female 0=Unknown
7	BENE_RACE_CD	Beneficiary Race Code	33	33	1	X(01)	The beneficiary's race: 0=Unknown 1=White 2=Black 3=Other 4=Asian 5=Hispanic 6=North American Native
8	BENE_AGE	Beneficiary Age	34	36	3	9(03)	The beneficiary's current age, as calculated by subtracting the beneficiary's date of birth from the current date.

DRAFT

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
9	BENE_MDCR_STATUS_CD	Beneficiary Medicare Status Code	37	38	2	X(02)	Indicates the reason for a beneficiary's entitlement to Medicare benefits as of a particular date, broken down by the following categories: Old Age & Survivors Insurance (OASI), Disabled, and End Stage Renal Disease (ESRD), and by appropriate combinations of these categories: 10=Aged without ESRD 11=Aged with ESRD 20=Disabled without ESRD 21=Disabled with ESRD 31=ESRD only
10	BENE_DUAL_STATUS_CD	Beneficiary Dual Status Code	39	40	2	X(02)	Identifies the most recent entitlement status of beneficiaries eligible for a program(s) in addition to Medicare (e.g., Medicaid). Find Dual Status Codes here: http://www.resdac.org/cms-data/variables/Dual-Status-Code-occurs-12-times
11	BENE_DEATH_DT	Beneficiary Death Date	41	50	10	YYYY-MM-DD	The month, day, and year of a beneficiary's death.

DRAFT

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
12	BENE_RNG_BGN_DT	Date beneficiary enrolled in Hospice	51	60	10	YYYY-MM-DD	The date the beneficiary enrolled in Hospice.
13	BENE_RNG_END_DT	Date beneficiary ended Hospice	61	70	10	YYYY-MM-DD	The date the beneficiary is-enrolled in hospice.
14	BENE_1ST_NAME	Beneficiary First Name	71	100	30	X(30)	The first name of the beneficiary.
15	BENE_MIDL_NAME	Beneficiary Middle Name	101	115	15	X(15)	The middle name of the beneficiary.
16	BENE_LAST_NAME	Beneficiary Last Name	116	155	40	X(40)	The last name of the beneficiary.
17	BENE_ORGNL_ENTLMT_RSN_CD	Beneficiary Original Entitlement Reason Code	156	156	1	X(01)	The reason for the beneficiary's original entitlement to medicare benefits. 0 - Old Age and Survivors Insurance (Oasi) 1 - Disability Insurance Benefits (DIB) 2 - ESRD 3 - Both DIB and ESRD 4 - Unknown

DRAFT

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
18	BENE_ENTLMT_BUYIN_IND	Beneficiary Entitlement Buy-in Indicator	157	157	1	X(01)	Indicates for each month of the denominator reference year, the entitlement of the beneficiary to Medicare Part A, Medicare Part B, or Medicare Parts A and B both, as well as whether or not the beneficiary's state of residence was liable and paid for the beneficiary's Medicare Part B monthly premiums. 0 Not Entitled 1 Part A Only 2 Part B Only 3 Part A and Part B A Part A, State Buy-In B Part B, State Buy-In C Parts A and B, State Buy-In

DRAFT

The File Name Convention for Table 22 is P#EFT.ON.ACOT.<ACOID>.CCLF9.Dyymmdd.Thhmmsst.

Table 22: Beneficiary XREF File (CCLF9)

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
1	CRNT_HIC_NUM	Current HIC Number	1	11	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim
2	PRVS_HIC_NUM	Previous HIC Number	12	22	11	X(11)	The HICN that appears in this field is the beneficiary's previous HICN.
3	PRVS_HICN_EFCTV_DT	Previous HICN Effective Date	23	32	10	YYYY-MM-DD	The date the previous HICN became active.
4	PRVS_HICN_OBSLT_DT	Previous HICN Obsolete Date	33	42	10	YYYY-MM-DD	The date the previous HICN ceased to be active.
5	BENE_RRB_NUM	Beneficiary Railroad Board Number	43	54	12	X(12)	The external (to Medicare) HICN for beneficiaries that are RRB members.

DRAFT

The File Name Convention for Table 23 and Table 24 is P#EFT.ON.ACOT.<ACOID>.CCLF0.Dyymmdd.Thhmmsst.

Table 23: Summary Statistics Header Record (CCLF0)

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
1	Column Title 1	Title	1	11	11	X(11)	Field will contain “File Number.”
2	Filler	Filler	12	15	4	X(4)	N/A
3	Column Title 2	Title	16	31	16	X(16)	Field will contain “File Description.”
4	Filler	Filler	32	36	5	X(5)	N/A
5	Column Title 3	Title	37	54	18	X(18)	Field will contain “Total Records Count.”
6	Filler	Filler	55	56	2	X(2)	N/A
7	Column Title 4	Title	57	69	13	X(13)	Field will contain “Record Length.”
8	Filler	Filler	70	73	4	X(14)	N/A

DRAFT

Table 24: Summary Statistics Detail Records

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
1	File Type	Title	1	11	11	X(11)	Field will contain either “CCLF1”, “CCLF2”, “CCLF3”, “CCLF4”, “CCLF5”, “CCLF6”, “CCLF7”, “CCLF8”, or “CCLF9.”
2	Filler	Filler	12	14	3	X(3)	N/A

DRAFT

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
3	File Name	Title	15	54	40	X(40)	For file CCLF 1, this field will contain “Part A Claims Header File.” For file CCLF 2, this field will contain “Part A Claims Revenue Center Detail File.” For file CCLF 3, this field will contain “Part A Procedure Code File.” For file CCLF 4, this field will contain “Part A Diagnosis Code File.” For file CCLF 5, this field will contain “Part B Physicians File.” For file CCLF 6, this field will contain “Part B DME File.” For file CCLF 7, this field will contain “Part D File.” For file CCLF 8, this field will contain “Beneficiary Demographics File.” For file CCLF 9, this field will contain “BENE XREF File.”
4	Filler	Filler	55	58	4	X(4)	N/A

DRAFT

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
5	Number of records	Contains the number of records in the file	59	67	9	X(9)	N/A
6	Filler	Filler	68	72	5	X(5)	N/A
7	Length of record	Contains the length of the record in the file.	73	75	3	X(3)	N/A
8	Filler	Filler	76	79	4	X(4)	N/A

DRAFT

Glossary

Term	Definition
Accountable Care Organization	ACOs are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to the Medicare patients they serve.
Centers for Medicare & Medicaid Services	CMS is a Federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program, and health insurance portability standards.
Electronic File Transfer	EFT is the act of transmitting files over a computer network or the Internet.
End Stage Renal Disease	ESRD is an irreversible decline in kidney function that is severe enough to be fatal without dialysis or transplantation.
Healthcare Common Procedure Coding System	HCPCS is a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (Commonly pronounced Hick-Picks).
Integrated Data Repository	The IDR is a single source database system containing CMS beneficiary and claim data.
Shared Savings Program	The Shared Savings Program promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Participating entities that meet quality and performance standards, referred to as Medicare ACOs, are eligible to receive payments for shared savings.

DRAFT

Acronyms

Acronym	Description
ACO	Accountable Care Organization
ACO-OS	Accountable Care Organization – Operational System
ASC	Ambulatory Surgical Center
BENE	Beneficiary
BIC	Beneficiary Identification Code
CAN	Claim Account Number
CCLF	Claim and Claim Line Feed
CCN	CMS Certification Number
CMS	Centers for Medicare & Medicaid Services
DAW	Dispense As Written
DIB	Disability Insurance Benefits
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMERC	Durable Medical Equipment Regional Carrier
DRG	Diagnostic Related Group
EFT	Electronic File Transfer
EIN	Employer Identification Number
ESRD	End Stage Renal Disease
FI	Fiscal Intermediaries
FIPS	Federal Information Processing Standards
FK	Foreign Key
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HICN	Health Insurance Claim Number
ICD	International Classification of Diseases
IDR	Integrated Data Repository
IP	Information Packet
IPPS	Inpatient Prospective Payment System

DRAFT

Acronym	Description
MAC	Medicare Administrative Contractors
NCH	National Claims History
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NGC	Northrop Grumman Corporation
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OASI	Old Age & Survivors Insurance
OPPS	Outpatient Prospective Payment System
OSCAR	Online Survey Certification and Reporting System
PDE	Prescription Drug Event
PDP	Prescription Drug Plan
PHI	Protected Health Information
PII	Personally Identifiable Information
PK	Primary Key
RRB	Railroad Retirement Board
SNF	Skilled Nursing Facility
SSN	Social Security Number
TIN	Taxpayer Identification Number
TOB	Type Of Bill
UPIN	Unique Physician Identification Number
XLC	eXpedited Life Cycle
XREF	Cross-Reference

DRAFT

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Pioneer Accountable Care Organizations (ACOs) Accountable Care Organization – Operational System (ACO-OS)

Interface Control Document

Version 10.1

10/02/2015

Document Number: NGC.ICDA.1502.10.1.1015
Contact Number: 500-2007-00014I/0008

Prepared for:
Centers for Medicare & Medicaid Services (CMS)
Office of Technology Solutions
7500 Security Boulevard, N2-13-16
Baltimore, MD 21244-1850

Prepared by:
Northrop Grumman Corporation (NGC)
Information Systems
2810 Lord Baltimore Drive
Baltimore, MD 21244

Approvals

The undersigned acknowledge that they have reviewed this document and agree with the information presented within this document. Changes to this document will be coordinated with, and approved by, the undersigned, or their designated representatives.

Signature: Date:
Print Name: Vince Mashek
Title: ACO-OS Program Manager
Role: Submitting Organization's Approving Authority

Signature: Date:
Print Name: Joshua Sopher
Title: OTS/ESSG/DADS – CMS ICD&A Government Task Lead (GTL)
Role: CMS' Approving Authority

Signature: Date:
Print Name: Pauline Lapin
Title: Group Director, Seamless Care Models Group
Role: CMS Business Owner

Revision History

Version	Date	Organization Point of Contact (POC)	Changes
DRAFT	08/02/2011	NGC/Mussie Estifanos	Initial working draft
DRAFT	08/09/2011	NGC/Mussie Estifanos	Updates from review meeting 08/04/2011
DRAFT	08/15/2011	NGC/Mussie Estifanos	Updates from review meeting 08/10/2011
DRAFT	08/26/2011	NGC/Mussie Estifanos	Minor updates
DRAFT	09/01/2011	NGC/Mussie Estifanos	Updated with comments from CMS
1.0	12/02/2011	NGC/Vinod Panicker	Updated document based on comments from CMS and included Pioneer pass-through file already sent to ACOs
1.0	12/7/2011	NGC/Lora L. Hammer	QA reviewed and document number assigned
1.1	12/12/2011	NGC/Vinod Panicker	Merged the sections for Data Sharing Request and Data Sharing Preference files and made changes to other sections as per feedback from CMS
1.2	12/14/2011	NGC/Vinod Panicker	Made changes to the document based on feedback from CMS/Business Owners
1.3	12/16/2011	NGC/Vinod Panicker	Updated to include the response filename
1.4	12/27/2011	NGC/Vinod Panicker	Made changes to the document based on feedback from CMS/Business Owners
1.5	01/25/12	NGC/Karl Greninger	Made changes to the document based on feedback from CMS/Business Owners
1.6	02/13/2012	NGC/Karl Greninger	Made changes to the document based on feedback from CMS/Business Owners Added sample XML files to Appendix A.
1.7	02/21/2012	NGC/Karl Greninger	Created Appendix G for Pioneer/Shared Savings Program Historical/Monthly Claims and Claims line feed data layout
1.8	02/24/2012	NGC/Karl Greninger	Made changes to the document based on feedback from CMS/Business Owners
1.9	03/05/2012	NGC/Karl Greninger	Made changes to the document based on feedback from CMS/Business Owners. Updated list of pass-through files in Appendix C.
1.10	03/13/2012	NGC/Karl Greninger	Made changes to the document based on feedback from CMS/Business Owners.
1.11	04/02/2012	NGC/Shemie James	Updated the XML Error File Layout, Pass-through Files and Report Layouts.
1.12	04/13/2012	NGC/Shemie James	Updated the titles of Appendices E, F, G, and H per the customer's request.

Version	Date	Organization Point of Contact (POC)	Changes
1.13	04/16/2012	NGC/Shemie James	Updated file layouts for the ACO Claims Line Feed Reports in Appendix K per the customer's request.
1.14	05/18/2012	NGC/Shemie James	Amended Appendix section to incorporate BIETL reports added to Appendices I and J per the customer's request.
1.15	06/19/2012	NGC/Shemie James	Updated valid values for Beneficiary Data Sharing Decision Mechanism Code and Beneficiary Alcohol and Substance Abuse Data Sharing Decision Mechanism Code per ACO_0022.
1.16	07/25/2012	NGC/Shemie James	Added valid value of "W" to the Beneficiary Alcohol and Substance Abuse Data Sharing Decision Mechanism Code per the customer's request. Added Maricom Report Layouts (Appendices N-R). Annotated Mechanism Code values used by Pioneer.
1.17	08/01/2012	NGC/Shemie James	Added verbiage to Table 11 to annotate valid values for Pioneer and Shared Savings Program decision mechanism codes per CMS request.
1.18	08/10/2012	NGC/Shemie James/Sanjay Agarwal	Updated Tables 4-12 and added Section 6.5 and 6.6 as part of ACO_0020D related changes.
1.19	09/20/2012	NGC/Shemie James	Incorporated customer comments. Added Appendix S per ACO_0040. Updated notes following Table 17. Noted Section 6.5 and 6.6 are out of scope until March 2013. Added two new pass-through files per ACO_0057.
1.20	02/11/2013	NGC/Shemie James	Updated based on feedback from CMS and the following Change Requests for the March 2013 release: • ACO_0015E (Section 6.1) (Appendix A). • ACO_0020E (Section 6.5 and Section 6.6) (Appendix A). • ACO_0040, Appendix S. • Several wording changes were updated in Section 6.2 (Table 7 & Table 8). • Added new response codes per above CR's (Appendix B). • Updated report and CCLF file formats to most recent versions (Appendix E – J) (Appendix M – P).

Version	Date	Organization Point of Contact (POC)	Changes
1.21	03/15/2013	NGC/Shemie James	Updated based on feedback from CMS and the following Change Requests (CRs) for the June 2013 release: • Revised verbiage to clarify that RTI only sends updates to the Participant List to the ACO-OS. (Section 3, Section 5.4 and Section 6.5.1). • Removed third bullet following Table 17. • Removed the fourth bullet following Table 17 as it is now covered by Error Code 38. • Changed the frequency of the Participant List Update file from “weekly” to “as needed” per customer comments. (Section 6.5.5.1). • Corrected references to the header, record detail and trailer records in Section 6.5.4.1 and 6.6.4.1. • Added the Quarterly Participant Status XSD/XML. (Appendix A) • Updated description for Error Code 38 per ACO_0020. (Appendix B) • Added CCLF 0 to Appendix C per ACO_0080.
1.22	05/08/2013	NGC/Shemie James	Updated based on feedback from CMS: • Updated “Project Overview” to include ACO_0020E per customer’s request. (Section 1.1) • Revised verbiage for the Quarterly Participant Status file XSD and Sample XML. (Section 6.6.3) • Updated CCLF file formats to reflect most recent version per ACO_0048D. (Appendix M) • Updated report templates 2-1 and 6-1 to reflect most recent version. (Appendix I & Appendix N) • Added note following Table 17 to specify required timeframes related to the ACO termination date. (Section 6.5)

Version	Date	Organization Point of Contact (POC)	Changes
1.23	06/03/2013	NGC/Shemie James	Updated based on feedback from CMS and the following CRs: • Updated Appendix C to reflect ACO_0080 and ACO_0107 • Updated Appendix C to reflect the report file layout locations within the document • Updated ACO submission/scheduled job timeframes (Sections 6.1.5.1, 6.2.5.1 and 6.3.5.1) • Updated "Scheduled Date" column for CCLF pass-through files (Appendix C)
2.0	06/07/2013	NGC/Cara Chang	Updated dates and signature page for final version
2.1	08/07/2013	NGC/Shemie James	• Updated Report 1-1 per ACO_0041C. (Appendix K) • Re-ordered Appendix N (Report 1-2) and Appendix O (Report 2-2) to maintain chronological order of report templates. • Removed asterisks in the response files as all required files are based on incoming data. (Table 4 and Table 8) • Updated the frequency of the Beneficiary Attestation file to the Friday before the first Monday of each month. (Section 6.1.5.1) • Added "Blank" as a valid value to the "Beneficiary Data Sharing Source Code" data element. (Table 11) • Specified "Participant TIN" as a required data element. (Table 17)
2.2	08/16/2013	NGC/Shemie James	• Updated verbiage in Report 1-1 per CMS feedback (ACO_0041C). (Appendix K) • Updated column name for entry #27. (Appendix K) • Updated column name for entry #7 in CCLF 5 – Table 29 (Appendix M). • Replaced all instances of "MSSP" with "Shared Savings Program" throughout. • Updated verbiage for error code 40 definition. (Appendix B) • Updated additional columns for step 13. (Appendix L)
2.3	08/21/2013	NGC/Shemie James	• Updated verbiage in Report 1-1 per CMS feedback (CR 41C). (Appendix K)

Version	Date	Organization Point of Contact (POC)	Changes
3.0	09/04/2013	NGC/Shemie James	• Updated to Final version. • Updated filename for the Historical Claims Line Feed (Summary Statistics) Pass-through file. (Appendix C)
3.1	10/03/2013	NGC/Shemie James	Updated based on feedback from CMS and the following CRs for the December 2013 Release: • Updated the Beneficiary Alignment and Exclusions Summary Report Template. (ACO_0150) (Appendix F). • Numerically reorganized Report Templates in the Appendices section.
3.2	10/22/2013	NGC/James Ternyila	Updated based on feedback from CMS: • Updated the Beneficiary Alignment and Exclusions Summary Report Template. (ACO_0150) (Appendix F).
4.0	11/14/2013	NGC/Kristina Kriss	Updated dates for Final delivery for December 2013 release.
4.1	04/10/2014	NGC/Shemie James/Subhaker Chigurula	• Updated Table 1: Referenced Documents. • Updated Sections 4.1, Assumptions and 4.3, Risks. • Updated Table 11: Removed “Beneficiary Substance Abuse Data Sharing Source Code” data field to match with current sample production XML and XSD files. • Updated Appendix A. • Updated SA Data Sharing Scenarios to reflect ACO_0154. (Appendix S)
4.2	05/07/2014	NGC/Shemie James/Subhaker Chigurula	• Updated Table 1: Referenced Documents. • Updated Appendix K to current. • Updated SA Data Sharing Scenarios for Pioneer and Shared Savings Program to reflect ACO_0154. (Appendix S) • Updated Medical Claims Usage Scenarios for Pioneer and Shared Savings Program. (Appendix S)
5.0	6/12/2014	NGC/Kristina Kriss	Final baseline for June 2014 release.

Version	Date	Organization Point of Contact (POC)	Changes
5.1	6/13/2014	NGC/Shemie James	Updated based on the following CRs for the September 2014 Release: • ACO_0175 – Added the TINHICN Report as a new pass-through file. (Appendix C) • RT #INC000002879974/CR186 - Disabled Beneficiary Attestation file and revised all associated verbiage throughout. (Section 1, Section 3, Section 5, Section 6.1, Section 8.1, Appendix A and Appendix B) • Updated Shared Savings Program and Pioneer Medical Claims User Scenarios (Appendix G)
5.2	08/15/2014	NGC/Shemie James/Hema Parasuramuni	Updated Table 1: Referenced Documents. Corrected Length column for ACO Program Code in Table 6: Beneficiary Alcohol and Substance Abuse Data Sharing Preferences File Header. Corrected File Layout column of Appendix C: Pass-Through Files based on feedback from CMS. Updated per ACO_0197: • Added a foot note for Appendix C to identify files supplied separately by CMS partners • Deleted Benchmark Reports
6.0	09/16/2014	NGC/Kristina Kriss	Baselined as Final for September 2014.
6.1	10/01/2014	NGC/James Ternyila/Hema Parasuramuni/Chris Zahn	For December 2014: Updated Table 1: Referenced Documents. Updated per ACO_0200: • Table 7: ACO to ACO-OS Beneficiary Alcohol and Substance Abuse Data Sharing Preferences Record Detail • Table 8: ACO-OS to ACO Beneficiary Alcohol and Substance Abuse Data Sharing Preferences Response Record Detail • Table 11: ACO-OS to ACO Beneficiary Monthly Data Sharing Status Record Detail Updated section 6.2 • Updated Appendix A: XML Schema Definitions and Samples Updated per ACO_0187: • Table 27: Part A Claims Revenue Center Detail File • Table 30: Part B Physicians File • Table 32: Part D File • Table 33: Beneficiary Demographics File

Version	Date	Organization Point of Contact (POC)	Changes
7.0	10/17/2014	NGC/Chris Zahn/Hema Parasuramuni	• Revised language in sections 3 and 5 to include alcohol and substance abuse data sharing preferences. • Updated Appendix B: Removed error code 58, “Encounter Date later than File Receipt Date.” Pioneer functionality does not support this error code. • Updated the Explanation of Appendix B for Error Code 36 and added Error Code 37. • Baselined as Final for December 2014 release.
7.1	10/28/2014	NGC/Hema Parasuramuni	• Deleted a note on page 13, Table 7: ACO to ACO-OS Beneficiary Alcohol and Substance Abuse Data Sharing Preferences Record Detail. • Updated Acronyms section.
8.0	12/11/2014	NGC/Kristina Kriss	Baselined as Final for December 2014.
8.1	12/17/2014	NGC/Shemie James	Updated per RT# INC000003162978. Added default Substance Abuse scenarios to Appendix P, Table 35: Pioneer Alcohol and Substance Abuse User Scenarios.
9.0	01/05/2015	NGC/Kristina Kriss	Baselined as Final for March 2015 Off-Cycle Release.
9.1	06/16/2015	NGC/Hema Parasuramuni	September 2015 Release per ACO_0224 • Updated sections 6.3 with addition of Beneficiary Claims Sharing Code. • Updated the Sample XML for Monthly Data Sharing Status File
9.2	07/14/2015	NGC/Subhaker Chigurula/Shemie James/Aftaan White	September 2015 Release Added Sample Monthly Beneficiary Data Sharing Status XML when the Beneficiary Claims Sharing Code is neither ‘R’ nor ‘S’ in Appendix A. ACO_0230 • Updated Appendix D: Pioneer ACO Quarterly Report on Excluded Beneficiaries ACO_0179 • Updated Appendix N: BI/ETL ACO Pioneer/Claim Line Feed Data Mapping ACO_0224 • Updated Section III Monthly Beneficiary Data Sharing Status XSD in Appendix A

Version	Date	Organization Point of Contact (POC)	Changes
9.3	08/11/2015	NGC/Subhaker Chigurula/Chris Zahn/Hema Parasuramuni/Nima Eslami	Added/Updated Report Templates: • ACO_0212: Modify Report 6.3 (Monthly PSP Reduction Report), Appendix L: File format – Pioneer ACO Model Provider Specific Payment Reduction Report • ACO_0216: Monthly Beneficiary Entitlement Category Report, Appendix M: File format – Pioneer ACO Model Monthly Beneficiary Entitlement Category Report • ACO_0230: Update Report 1.2 Header, Appendix D: Pioneer ACO Quarterly Report on Excluded Beneficiaries Added Appendix S: Post Final Rule Data Sharing Preferences: • ACO_0200: Medical Claims Sharing Preferences Collection, Appendix S: Medical Data Sharing Preferences User Scenarios – Effective FINAL RULE Go-Live Date Table 1: Referenced Documents: • Added relevant September CRs • Added current Alignment Requirement RD Section 4.2 – removed "…project completion…" Section 5.1 – removed "monthly" from "a monthly participant status update file" Section 5.2 – Added DATAPREF RSP file Section 5.3 – Added DATAPREF RSP file to diagram Appendix C – updated the Logical Record Length Defect # 885 Appendix A – updated Sample Monthly Data Sharing Status XSD from "Bene_Sup_Res_Cd" to "Bene_Supp_Res_Cd" Appendix P – updated table names to include the CCLF file numbers. Section 6.3 – added clarity to 'Note' in response to the comment from OTS
9.4	09/03/2015	NGC/Aftaan White	Updated Appendix A • Item V: Participant List XSD. Updated XSD file contents. INC000003551849 Updated Appendix B • Response Codes and Explanations: Response Code 75 description added to the table. RT000003552042

Version	Date	Organization Point of Contact (POC)	Changes
10.0	09/21/2015	NGC/Kristina Kriss	Baselined as Final for September 2015 Release.
10.1	10/02/2015	NGC/Nima Eslami/Aftaan White	For December 2015 Release: ACO_0220: Updated Appendix C: Pass-Through Files and removed the Alignment and Exclusions Summary Report. Removed Appendix E: Beneficiaries Alignment and Exclusions Summary Report. ACO_0217: Added Appendix M: Monthly Reference Population Expenditure Report, and updated subsequent Appendices numbers. Updated Appendix C: Pass-Through Files and added file name for the Monthly Reference Population Expenditure Report. Updated Appendix I: Pioneer ACO Model Monthly Expenditure Report Updated Appendix C: Pass-Through Files for the current file name for the Pioneer ACO Monthly Expenditure Report Updated Pioneer 6-1 report template

Table of Contents

List of Figures

List of Tables

1 Introduction

This Interface Control Document (ICD) describes the relationship between the Accountable Care Organization - Operational System (ACO-OS) and Accountable Care Organizations (ACOs).

The ACO-OS handles the data collection and exchange required to manage the ACO Pioneer Program. ACO-OS must effectively incorporate data that the Centers for Medicare and Medicaid Services (CMS) currently manage with new data that ACOs produce. The system must help CMS and these organizations manage, track, and report data so that the ACOs understand the totality of care provided to their beneficiaries.

This ICD specifies interface requirements that participants in the system, ACO-OS and ACOs, must meet. It describes the interface concept of operations (ConOps), defines the message structure and protocols that govern data interchange, and identifies the communication paths along which data are expected to flow.

1.1 Project Overview

The ACO program calls for a new system that brings data together across programs to ensure that beneficiaries are apportioned and/or assigned in coordination with all programs. ACO-OS integrates beneficiary, healthcare provider, and care organization data to provide this information to ACOs participating in the ACO Pioneer program. ACO-OS needs to interface with other CMS systems, such as the Common Medicare Environment (CME)/Medicare Beneficiary Database (MBD), Coordination of Beneficiary Data (COB), Integrated Data Repository (IDR), 1-800-Medicare (NGD), and Research Triangle Institute (RTI). This system also provides Receipt and Control service for the various files that move from and to the ACO entities as well as between CMS supporting systems.

Pioneer ACOs send the following monthly files:

- Pioneer attestation lists (through PY3)
- Alcohol and substance abuse data sharing preferences
- Participant list updates

ACO-OS sends a monthly beneficiary data sharing status file for all beneficiaries aligned to the ACO. This file includes changes to beneficiary data sharing preferences received from ACOs and the 1-800-Medicare system. ACO-OS also sends pass-through files received from CMS supporting systems to the ACOs as well as a participant list update response file and a quarterly participant status file.

This ICD provides the following information:

- A general interface description
- Assumptions, where appropriate
- A description of the data exchange format and exchange protocol
- Estimated data exchange size and frequency

2 Referenced Documents

The following documents provided information for this ICD:

Table 1: Referenced Documents

Title	Document Number	Issued
Change Requests: ACO_015E: New Attestation Process Requirements ACO_020D: Updating Participant List ACO_0040: SSP CCLF Priority Rules – Usage Scenarios ACO_048D: Add Fields to Pioneer/ SSP Claim Line Feeds ACO_057B: Additional Files Sent and Received Through MFT ACO_0080: Pioneer CCLF Summary Statistics ACO_0107: ACO Pioneer Settlement Report ACO_0150: Alignment and Exclusions Summary Table 2-1 ACO_0154: Substance Abuse Data Sharing Preference Tracking ACO_0175: Transmission of Annual Pioneer TIN-NPI-CCN-HICN report through RACS and EFT ACO_0179: ACO-OS ICD-10 Codes Transition ACO_0186: Revised Pioneer Alignment Process Flow ACO_0187: CCLF Changes for the September 2014 Release RT #INC000002879974 ACO_0200: Medical Claims Sharing Preferences Collection RT# INC000003162978 ACO_0224: Bene Opt-In Out for Provider Term, Part 2 ACO_0230: Update Report 1.2 Header	Change Requests ACO_0015E, ACO_0020D, ACO_0040, ACO_0041C, ACO_0048D, ACO_0057B, ACO_0080, ACO_0107, ACO_0150, ACO_0154, ACO_0175, ACO_0179, ACO_0187, RT #INC000002879974/ ACO_0186, ACO_0200, and RT# INC000003162978, ACO_0224, ACO_0230	11/06/2012 to 07/24/2015
CME Data Dictionary	NGC_CME Data Dictionary 20100715.xlsx	07/05/2011
CMS Problem Management Tracking Process	PRJ.PMM.0201.05.0.0111	01/03/2011
Alignment Requirements Document v12.0 March 2015 Release - 12/22/2014	HHSM-5000-2014-000082U	12/22/2014
ACO-OS Functional Requirements Document	NGC.ICDA.3401.08.0.0615	06/12/2015
ACO-OS RACS System Design Document (SDD)	NGC.ICDA.1603.04.0.0915	09/03/2015
ACO Logical Data Model	None	02/21/2014

Title	Document Number	Issued
ACO Logical Data Model Attribute Dictionary	None	02/05/2014
ACO-OS Claim and Claim Line Feed (CCLF) Information Packet (IP)	NGC.ICDA.0301.11.0.0815	08/28/2015

3 ICD Overview

The ACO-OS receives the following files from ACOs:

1. Pioneer attestation list (Through PY3)
2. ACO beneficiary alcohol and substance abuse data sharing preferences
3. Participant list updates

The ACO-OS sends the following to ACOs:

1. A monthly data sharing status file based on changes to beneficiary alcohol and substance abuse data sharing preferences from ACOs and 1-800-Medicare combined for all aligned beneficiaries.
2. Pass-through files received from CMS supporting systems. The pass-through file details are provided in Appendix C:
3. A quarterly participant status file.
4. A participant list updated response file.

4 Assumptions, Constraints, and Risks

This section describes assumptions, constraints, and risks associated with the interface.

4.1 Assumptions

The following assumptions apply to the project:

- ACOs data is delivered per the agreed Interface Initiation as documented in Section 6.
- ACOs have the expertise and resources to pull the requested data and send it to the ACO-OS.

4.2 Constraints

N/A

4.3 Risks

There are no significant risks pertaining to this interface.

5 General Interface Requirements

This section describes general interface requirements.

5.1 Interface Overview

The ACO-OS receives the attestation list from the Pioneer ACOs through PY3. Pioneer ACOs also send beneficiary alcohol and substance abuse data sharing preferences and Participant List Update file. ACOs are only required to send any active changes in a beneficiary's attestations through PY3 or alcohol and substance abuse data sharing preferences (i.e., the delta). The ACO-OS sends compiled data sharing preferences and pass-through files received from CMS supporting systems to ACOs via a Receipt and Control System (RACS).

5.2 Functional Allocation

ACOs create a data file and send it to the ACO-OS. The ACO-OS updates its database with the attestation data through PY3, alcohol and substance abuse data sharing preferences, and monthly participant status. The ACO-OS sends the current beneficiary data sharing status, pass-through files received from CMS supporting systems, quarterly participant status, participant list update response, and beneficiary alcohol and substance abuse data sharing preferences response containing each record received along with a response code, and sends each file back to the ACOs.

5.3 Data Transfer

The following diagram (Figure 1) shows the data flow for the ACO to ACO-OS file transfers.

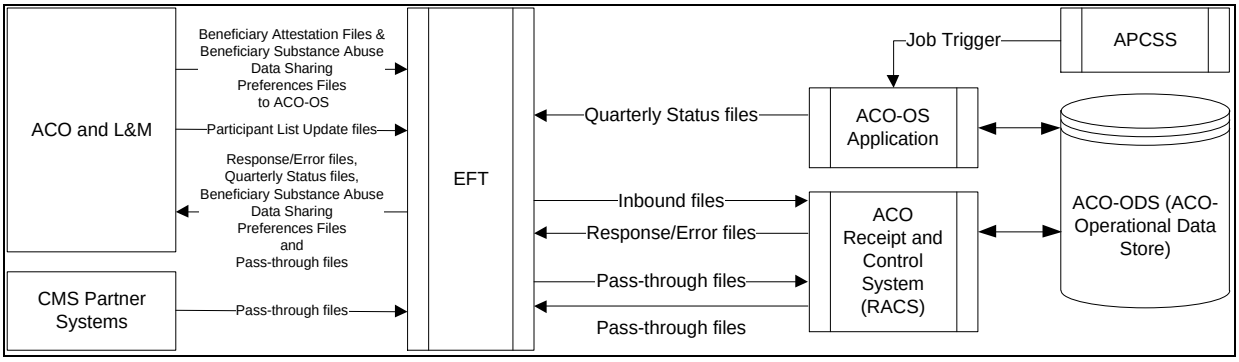


Figure 1: ACO Data Flow

5.4 Transactions

1. The ACO sends the following files to the ACO-OS:
    - Pioneer attestation list (Through PY3)
    - ACO beneficiary alcohol and substance abuse data sharing preferences
    - ACO participant list update files

2. The RACS sends response files back to ACO for each of the files received from the ACO after successful validation against the Extensible Markup Language (XML) Schema Definition (XSD) document.
3. The RACS sends error files in case the data file is not successfully validated against the XSD.
4. The ACO-OS application sends the monthly data sharing status files and the quarterly participant status files to the ACOs.
5. The CMS Partner systems send pass-through files to the RACS periodically.
6. The RACS logs the receipt of the pass-through file and then forwards the pass-through file to the ACO.

5.5 Security and Integrity

Files are transmitted using the CMS Electronic File Transfer (EFT) process over a secure connection.

6 Detailed Interface Requirements

This section describes detailed interface requirements.

6.1 Beneficiary Attestation File (through PY3)

This section describes information that needs to be present in the data file received from Pioneer ACOs with the beneficiary attestation information.

6.1.1 General Processing

Pioneer ACOs send beneficiary attestation data to the ACO-OS on a monthly basis. After the ACO-OS receives data files from the ACOs, the system updates the ACO-OS database and generates a response file containing each record received from the ACO, along with a response code, and sends it back to the ACOs.

6.1.2 Interface Processing Time Requirements

Data is processed immediately after the EFT process receives the file from the ACOs and transfers it to the ACO-RACS application.

6.1.3 Message Format (or Record Layout) & Required Protocols

Each file is coded in XML. Please refer to Appendix A: XML Schema Definitions and Samples for the Pioneer attestation list XSD and sample XML.

6.1.4 File Layout

Each ACO-provided file and corresponding ACO-OS response file has a header, record details, and trailer, as described in Section 6.1.4.2.

6.1.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see Section 6.1.4.2.

6.1.4.2 Field/Element Definitions

All tables briefly describe a file transaction from the ACOs and a response by the ACO-OS. The description column describes basic file elements. The response file provides back exact field values submitted by the ACO, with the addition of a response code.

Table 2: Beneficiary Attestation File Header

Data Field	Description	Length	Format	Valid Values
Header Code	Code to show that the line entry is header information for the Attestation file	10	CHAR	HDR_ATTEST
Header Description	Description of the file	55	CHAR	Beneficiary attestation file for the month of <MM>, <CCYY> Example: Beneficiary attestation file for the month of 12, 2011
File Creation Date	Date the file is created	8	CHAR	CCYYMMDD
ACO Program Code	Code indicating the program type	2	CHAR	07 = Pioneer

Table 3: ACO to ACO-OS Beneficiary Attestation Record Detail

Data Field	Description	Length	Format	Valid Values
Beneficiary HICN*	Beneficiary Health Insurance Claim Number (HICN)	11	CHAR	
Beneficiary First Name	Beneficiary first name	30	CHAR	
Beneficiary Middle Name	Beneficiary middle name	30	CHAR	
Beneficiary Last Name	Beneficiary last name	40	CHAR	
Beneficiary Date of Birth*	Beneficiary date of birth (DOB)	8	CHAR	CCYYMMDD
Beneficiary Gender*	Beneficiary gender	1	CHAR	M – Male F – Female U – Unknown
Organization Identifier*	Unique identifier for Pioneer ACO	5	CHAR	P<nnn>

Data Field	Description	Length	Format	Valid Values
Beneficiary Attestation Submission Date*	The date the beneficiary submitted the attestation	8	CHAR	CCYYMMDD
Beneficiary Attestation Switch*	A switch indicating if the beneficiary attestation should be effective (Y) or terminated (N)	1	CHAR	Y = Yes N = No

Note: All fields marked with an asterisk (*) are required.

Table 4: ACO-OS to ACO Beneficiary Attestation Response Record Detail

Data Field	Description	Length	Format	Valid Values
Beneficiary HICN	Beneficiary HICN	11	CHAR	As received on Inbound Files
Beneficiary First Name	Beneficiary first name	30	CHAR	As received on Inbound Files
Beneficiary Middle Name	Beneficiary middle name	30	CHAR	As received on Inbound Files
Beneficiary Last Name	Beneficiary last name	40	CHAR	As received on Inbound Files
Beneficiary Date of Birth	Beneficiary DOB	8	CHAR	As received on Inbound Files
Beneficiary Gender	Beneficiary gender	1	CHAR	As received on Inbound Files
Organization Identifier	Unique identifier for Pioneer ACO	5	CHAR	As received on Inbound Files
Beneficiary Attestation Submission Date	The date the beneficiary submitted the attestation	8	CHAR	As received on Inbound Files
Beneficiary Attestation Switch	A switch indicating if the beneficiary attestation should be effective (Y) or terminated (N)	1	CHAR	As received on Inbound Files
Response Code	Response code indicating if the record was processing successfully or not	2	CHAR	Valid values are documented and explained in Appendix B:

Table 5: Beneficiary Attestation File Trailer

Data Field	Description	Length	Format	Valid Values
Trailer Code	Code to indicate that the line entry is a trailer for the Attestation file	10	CHAR	TRL_ATTEST
Trailer Description	Description of the file	55	CHAR	Beneficiary attestation file for the month of <MM>, <CCYY> Example: Beneficiary attestation file for the month of 12, 2011
File Creation Date	Date when the file was created	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent to ACO-OS	10	NUMERIC	

6.1.4.3 Filenames

The file naming convention for the Attestation list sent by an ACO to the ACO-OS will be **P#EFT.ON.ACO.P***.ATTEST.Dyymmdd.Thhmmsst**. For example, an incoming file for December 15, 2011, at 10:00 AM from a Pioneer ACO with ID "P123" would be **P#EFT.ON.ACO.P123.ATTEST.D111215.T1000000**.

The local file created by the EFT process for the RACS would follow the naming convention ATTEST.P***.Dyymmdd.Thhmmsst

The file naming convention for the Attestation response file sent by the ACO-OS to an ACO will be **P.P***.ATTEST.RSP.Dyymmdd.Thhmmsst**. For example, an outbound file from the ACO-OS corresponding to the above file from a Pioneer ACO with ID "P123" would be **P.P123.ATTEST.RSP.D111215.T1000000**.

6.1.5 Communication Methods

This section describes communication methods the interface uses, as well as error recovery.

6.1.5.1 Interface Initiation

ACOs send the beneficiary attestation file to the ACO-OS by 9:00 PM ET the Friday before the first Monday of each month.

6.1.5.2 Flow Control

ACO data files are transferred to the ACO-OS using EFT. If there are any problems transferring data from an ACO, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

6.1.6 Security Requirements

For information on security requirements, see Section 5.5, Security and Integrity.

6.2 Beneficiary Alcohol and Substance Abuse Data Sharing Preferences File

This section describes information that needs to be present in the data file received from Pioneer ACOs with the beneficiary data sharing preferences.

6.2.1 General Processing

ACOs send beneficiary alcohol and substance abuse data sharing preferences to the ACO-OS on a monthly basis. After the ACO-OS receives data files from the ACOs, the system updates the ACO-OS database and generates a response file containing each record received along with a response code and sends it back to the ACOs.

Each Beneficiary Alcohol and Substance Abuse Data Sharing Preference File received from an ACO includes codes used to identify the mechanism that the ACO used to record their data sharing preference decision. The valid values, as outlined in this ICD, for the Pioneer ACO beneficiary alcohol and substance abuse data sharing decision mechanism codes are:

- E = Electronically
- W = Written

6.2.2 Interface Processing Time Requirements

Data is processed immediately after the EFT process receives the file from the ACOs and transfers it to the ACO-RACS application.

6.2.3 Message Format (or Record Layout) & Required Protocols

Each file is coded in XML. Please refer to Appendix A: XML Schema Definitions and Samples for the Pioneer beneficiary data sharing preferences XSD and sample XML.

6.2.4 File Layout

Each ACO provided file and corresponding ACO-OS response file has a header, record details, and trailer as described in Section 6.2.4.2.

6.2.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see Section 6.2.4.2.

6.2.4.2 Field/Element Definitions

All tables briefly describe a file transaction from an ACO and a response by the ACO-OS. The description column describes basic file elements. The response file provides back exact field values submitted by the ACO with the addition of a response code.

Table 6: Beneficiary Alcohol and Substance Abuse Data Sharing Preferences File Header

Data Field	Description	Length	Format	Valid Values
Header Code	Code to show that the line entry is header information for beneficiary data sharing preferences	11	CHAR	HDR_DATAPRF
Header Description	Description of the file	55	CHAR	Beneficiary Alcohol and Substance Abuse Data Sharing Preference File for <MM>, <CCYY> Example: Beneficiary Alcohol and Substance Abuse Data Sharing Preferences File for 12,2011
File Creation Date	Date the file is created	8	CHAR	CCYYMMDD
ACO Program Code	Code indicating the program type	2	CHAR	07 = Pioneer

Table 7: ACO to ACO-OS Beneficiary Alcohol and Substance Abuse Data Sharing Preferences Record Detail

Data Field	Description	Length	Format	Valid Values
Beneficiary HICN*	HICN	11	CHAR	
Beneficiary First Name	Beneficiary first name	30	CHAR	
Beneficiary Middle Name	Beneficiary middle name	30	CHAR	
Beneficiary Last Name	Beneficiary last name	40	CHAR	
Beneficiary Date of Birth*	DOB	8	CHAR	CCYYMMDD
Beneficiary Gender*	Beneficiary gender	1	CHAR	M – Male F – Female U – Unknown

Data Field	Description	Length	Format	Valid Values
Organization Identifier*	Unique identifier for Pioneer ACO	5	CHAR	P<nnn>
Beneficiary Encounter Date*	Date beneficiary visited or communicated with the ACO	8	CHAR	CCYYMMDD
Beneficiary Alcohol and Substance Abuse Data Sharing Preference Code	Preference of beneficiary for sharing claims level data on alcohol and substance abuse data with the ACO	1	CHAR	Y – Beneficiary has agreed to substance abuse data sharing N – Beneficiary does not agree to substance abuse data sharing
Beneficiary Alcohol and Substance Abuse Data Sharing Decision Mechanism Code*	Code identifying the mechanism with which the beneficiary recorded their opt in/out decision for alcohol and substance abuse data sharing; required if beneficiary alcohol and substance abuse data sharing preference code is received	1	CHAR	E = Electronically W = Written

Note: All fields marked with an asterisk (*) are required.

Table 8: ACO-OS to ACO Beneficiary Alcohol and Substance Abuse Data Sharing Preferences Response Record Detail

Data Field	Description	Length	Format	Valid Values
Beneficiary HICN	HICN	11	CHAR	As received on Inbound Files
Beneficiary First Name	Beneficiary first name	30	CHAR	As received on Inbound Files
Beneficiary Middle Name	Beneficiary middle name	30	CHAR	As received on Inbound Files
Beneficiary Last Name	Beneficiary last name	40	CHAR	As received on Inbound Files
Beneficiary Date of Birth	DOB	8	CHAR	As received on Inbound Files
Beneficiary Gender	Beneficiary gender	1	CHAR	As received on Inbound Files
Organization Identifier	Unique identifier for Pioneer ACO	5	CHAR	As received on Inbound Files

Data Field	Description	Length	Format	Valid Values
Beneficiary Encounter Date	Date beneficiary visited or communicated with the ACO	8	CHAR	As received on Inbound Files
Beneficiary Substance Abuse Data Sharing Preference Code	Preference of beneficiary for sharing claims level data on alcohol and substance abuse data with the ACO	1	CHAR	As received on Inbound Files
Beneficiary Alcohol and Substance abuse Data Sharing Decision Mechanism Code	Code identifying the mechanism with which the beneficiary recorded their opt in/out decision for alcohol and substance abuse data sharing; required if beneficiary alcohol and substance abuse data sharing preference code is received	1	CHAR	As received on Inbound Files
Response Code	Response code indicating if the record was processing successfully or not	2	CHAR	Valid values are documented and explained in Appendix B:

Table 9: Beneficiary Alcohol and Substance Abuse Data Sharing Preferences File Trailer

Data Field	Description	Length	Format	Valid Values
Trailer Code	Code to indicate that the line entry is a trailer for beneficiary data sharing preferences	11	CHAR	TRL_DATAPRF
Trailer Description	Description of the file	55	CHAR	Beneficiary Alcohol and Substance Abuse Data Sharing Preference File for <MM>, <CCYY> Ex. Beneficiary Alcohol and Substance Abuse Data Sharing Preferences File for 12,2011
File Creation Date	Date the file was created	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent to ACO-OS	10	NUMERIC	

6.2.4.3 Filenames

The file naming convention for the Alcohol and Substance Abuse Data Sharing Preferences File sent by an ACO to the ACO-OS will be **P#EFT.ON.ACO.P***.DATAPRF.Dyymmdd.Thhmmsst**. For example, an incoming file for December 15, 2011, at 10:00 AM from a Pioneer ACO with ID "P123" would be **P#EFT.ON.ACO.P123.DATAPRF.D111215.T1000000**.

The local file created by the EFT process for the RACS would follow the naming convention DATAPRF.P***.Dyymmdd.Thhmmsst.

The file naming convention for the Alcohol and Substance Abuse Data Sharing Preferences Response File sent by the ACO-OS to an ACO will be **P.P***.DATAPRF.RSP.Dyymmdd.Thhmmsst**. For example, an outbound file from the ACO-OS corresponding to the above file from a Pioneer ACO with ID "P123" would be **P.P123.DATAPRF.RSP.D111215.T1000000**.

6.2.5 Communication Methods

This section describes communication methods the interface uses, as well as error recovery.

6.2.5.1 Interface Initiation

ACOs send beneficiary Alcohol and Substance Abuse Data Sharing Preferences File to the ACO-OS by 9:00 PM ET the Friday before the first Monday of each month.

6.2.5.2 Flow Control

ACO data files are transferred to the ACO-OS using EFT. If there are any problems transferring data from an ACO, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

6.2.6 Security Requirements

For information on security requirements, see Section 5.5, Security and Integrity.

6.3 Monthly Beneficiary Data Sharing Status File

This section describes information that needs to be present in the data file sent by the ACO-OS to Pioneer ACOs with the current beneficiary data sharing preferences. The beneficiaries who are actively aligned one month prior to the Monthly Beneficiary Data Sharing Status File will be included in the file with the current beneficiary data sharing preferences. The actively aligned beneficiaries are the adjusted beneficiaries who remain aligned to the ACO after the Quarterly Exclusion Process.

***NOTE**: Depending on the day of the month the Beneficiary Data Sharing Status File is generated, the quarterly excluded beneficiaries may appear in the Beneficiary Data Sharing Status File for the first month after the month in which they were excluded; however, they will not appear in the Monthly Beneficiary Data Sharing File from the second month following the month in which they were excluded.*

6.3.1 General Processing

The ACO-OS sends current aligned beneficiary data sharing status file to ACOs on a monthly basis.

6.3.2 Interface Processing Time Requirements

Data files are generated as soon as the Automated Production Control & Scheduling System (APCSS) Job trigger is received by the ACO-OS application.

6.3.3 Message Format (or Record Layout) & Required Protocols

Each file is coded in XML. Please refer to Appendix A: XML Schema Definitions and Samples for the Monthly beneficiary data sharing status XSD and sample XML.

6.3.4 File Layout

Each file has a header, record details, and trailer as described in Section 6.3.4.2.

6.3.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see Section 6.3.4.2.

6.3.4.2 Field/Element Definitions

All tables briefly describe a file transaction to the ACOs from the ACO-OS. The description column describes basic file elements.

Table 10: Beneficiary Monthly Data Sharing Status File Header

Data Field	Description	Length	Format	Valid Values
Header Code	Code to show that the line entry is header information for the beneficiary monthly data sharing status	9	CHAR	HDR_DPREF
File Creation Date	Date the file is created	8	CHAR	CCYYMMDD

Table 11: ACO-OS to ACO Beneficiary Monthly Data Sharing Status Record Detail

Data Field	Description	Length	Format	Valid Values
Beneficiary HICN	HICN	11	CHAR	
Beneficiary First Name	Beneficiary first name	30	CHAR	
Beneficiary Middle Name	Beneficiary middle name	30	CHAR	
Beneficiary Last Name	Beneficiary last name	40	CHAR	
Beneficiary Date of Birth	DOB	8	CHAR	CCYYMMDD
Beneficiary Gender	Beneficiary gender	1	CHAR	M – Male F – Female U – Unknown
Organization Identifier	Unique identifier for Pioneer ACO	5	CHAR	P<nnn>
Beneficiary Data Sharing Effective Date	The most recent date the beneficiary changed their data sharing preference	8	CHAR	CCYYMMDD

Data Field	Description	Length	Format	Valid Values
Beneficiary Data Sharing Termination Date	Date when the beneficiary terminated the data sharing preference	8	CHAR	CCYYMMDD
Beneficiary Data Sharing Source Code	Source of the data sharing information	5	CHAR	ACO † 1-800
Beneficiary Substance Abuse Effective Date	Date when the beneficiary opted into the sharing of substance abuse data with an ACO	8	CHAR	CCYYMMDD
Beneficiary Data Sharing Decision Mechanism Code	Code identifying the mechanism with which the beneficiary recorded their opt in/out decision	1	CHAR	E = Electronically O = Office R = Response N = No Response T = Telephone W = Written Blank (Blank is used by the ACOs-OS to identify default Beneficiary Data Sharing Preference Indicator) Valid values submitted by Pioneer ACOs for the beneficiary data sharing decision mechanism code are “E,” “T,” and “W.” Valid values submitted by Shared Savings Program ACOs for the beneficiary data sharing decision mechanism code are “E,” “O,” “R” and “N.”

† *Note: ACO applies only to the data sharing information received prior to January 1, 2015.*

Data Field	Description	Length	Format	Valid Values
Beneficiary Alcohol and Substance Abuse Data Sharing Decision Mechanism Code	Code identifying the mechanism with which the beneficiary recorded their opt in/out decision	1	CHAR	O = Office R = Response N = No Response T = Telephone E= Electronically W = Written Blank (Blank is used by the ACOs-OS to identify default Beneficiary Substance Abuse Data Sharing Preference Indicator) Valid values submitted by Pioneer ACOs for the beneficiary alcohol and substance abuse data sharing decision mechanism code are “E” and “W.” Valid values submitted by Shared Savings Program ACOs for the beneficiary alcohol and substance abuse data sharing decision mechanism code are “O,” “R,” and “N.”
Beneficiary Data Sharing Preference Code	Preference of beneficiary for sharing claims level data with the ACO excluding alcohol and substance abuse data	1	CHAR	Y – Beneficiary has agreed to sharing claims data N – Beneficiary does not agree to sharing claims data Blank – no update

Data Field	Description	Length	Format	Valid Values
Beneficiary Substance Abuse Data Sharing Preference Code	Preference of beneficiary for sharing claims level data on alcohol and substance abuse with the ACO	1	CHAR	Y – Beneficiary has agreed to substance abuse data sharing N – Beneficiary does not agree to substance abuse data sharing Blank – no update
Beneficiary Claims Sharing Code	Code representing the beneficiaries whose claims are suppressed or resumed as determined during recent Quarterly Claims Data Sharing check.	1	CHAR	S- Beneficiary's claims are suppressed. R- Beneficiary's claims are resumed after a most recent quarterly suppression. Blank –Beneficiary claims are neither currently suppressed nor resumed.

Table 12: Beneficiary Monthly Data Sharing Status File Trailer

Data Field	Description	Length	Format	Valid Values
Trailer Code	Code to indicate that the line entry is a trailer	9	CHAR	TRL_DPREF
File Creation Date	Date the file was created	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent to ACO-OS	10	NUMERIC	

6.3.4.3 Filenames

The file naming convention for the monthly data sharing status file will be **P.P***.DPREF.LIST.Dyymmdd.Thhmmsst**.
For example, an outbound file for December 15, 2011, at 10:00 AM for a Pioneer ACO with ID "P123" would be **P.P123.DPREF.LIST.D111215.T1000000**.

6.3.5 Communication Methods

This section describes communication methods the interface uses, as well as error recovery.

6.3.5.1 Interface Initiation

This process is automated and a part of the Tivoli Workload Scheduler (TWS) schedule. A scheduled job converts the database records to conform to the layout described in the previous section. The job will be triggered to execute on the first Monday of each month.

6.3.5.2 Flow Control

The monthly beneficiary data sharing status file is created in the mid-tier environment and transferred to the mainframe. The CMS EFT process then sweeps the file and sends it to the ACOs.

If a transmission failure should occur at any point in the process within CMS, the CMS Consolidated Information Technology Infrastructure Contractor (CITIC) contractor will work with the system maintainers to address errors. Any delays in schedule will be communicated to the CMS GTL. The CMS GTL will communicate status to the Centers for Medicare and Medicaid Innovations (CMMI) team and impacted ACO per operational procedures established externally to this ICD.

The APCSS production control documentation provides the CMS data center with additional recovery details as well as exchange-related jobs, processes, filenames, error codes, and handling procedures.

6.3.6 Security Requirements

For information on security requirements, see Section 5.5, Security and Integrity.

6.4 ACO-OS to ACO Error File

This section describes information present in the data file sent by the ACO-OS to Pioneer ACOs when an error is encountered while processing any of the XML files sent by ACOs to the ACO-OS. This is different from the response file that is generated if the XML file is read properly and the system is able to process the records in the XML file.

6.4.1 General Processing

The ACO-OS sends this file only when there is an error in processing any of the XML files sent by ACOs to ACO-OS.

6.4.2 Interface Processing Time Requirements

N/A

6.4.3 Message Format (or Record Layout) & Required Protocols

Each file is coded in XML. Please refer to Appendix A: XML Schema Definitions and Samples for the Error file sample XML.

6.4.4 File Layout

Each file has a header, record details, and a trailer as described in Section 6.4.4.2.

6.4.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see Section 6.4.4.2.

6.4.4.2 Field/Element Definitions

All tables briefly describe a file transaction to ACOs from the ACO-OS. The description column describes basic file elements.

Table 13: ACO-OS to ACO Error File Header

Data Field	Description	Length	Format	Valid Values
Header Code	Code to show that the line entry is header information	11	CHAR	As received from the incoming file
Header Description	Description of the file	55	CHAR	As received from the incoming file
Filename	Filename of the error file being generated	44	CHAR	
File Creation Date	Date the file is created	20	CHAR	The format for the date will be YYYY-MM-DDTHH:MI:SS
File Control Number	CMS internally generated file control number for the file that was processed with errors If the entire file is unable to be read due to XSD validation error, the file control number will be set to 0	10	NUMERIC	

Table 14: ACO-OS to ACO Error Record Detail

Data Field	Description	Length	Format	Valid Values
Batch Information	This contains the Batch Filename and Batch Records Processed Count elements	N/A	N/A	
Batch Filename	The name of the file that was processed with errors. The name of the file corresponds to the information stored on the header record. If the entire file is unable to be read due to XSD validation error, the filename will correspond to the local filename.	44	CHAR	As received from the incoming file Please refer to the filenames section for the corresponding inbound file to identify the local filename format used.
Batch Records Processed Count	This is the total number of batch level errors encountered while processing the file	7	NUMERIC	
Batch Error Details	This contains the Batch Level Error Code, Batch Level Error Description and Batch Level Error Message elements	N/A	N/A	
Batch Level Error Code	This is the error code corresponding to the file validation process	10	CHAR	CM01 – XML did not pass XSD schema validation CM09 – Number of records does not match trailer record count
Batch Level Error Description	This is the error description corresponding to the file validation error	120	CHAR	
Batch Level Error Message	This is a detailed explanation for the error encountered	500	CHAR	

Table 15: ACO-OS to ACO Error File Trailer

Data Field	Description	Length	Format	Valid Values
Trailer Code	Code to indicate that the line entry is a trailer	11	CHAR	As received from the incoming file
Trailer Description	Description of the file	55	CHAR	As received from the incoming file
Filename	The name of the error file that is produced	44	CHAR	
File Creation Date	Date the file was created	20	CHAR	The format for the date will be YYYY-MM-DDTHH:MI:SS
File Control Number	CMS internally generated file control number for the file that was processed with errors If the entire file is unable to be read due to XSD validation error, the file control number will be set to 0	10	NUMERIC	
Detail Record Count	Number of rows or records sent to ACO-OS	10	NUMERIC	
File Transmission Date	The date the error file is being generated	20	CHAR	The format for the date will be YYYY-MM-DDTHH:MI:SS

6.4.4.3 Filenames

The file naming convention for the error file follows the same naming conventions as the response file for that particular file exchange.

6.4.5 Communication Methods

This section describes communication methods the interface uses, as well as error recovery.

6.4.5.1 Interface Initiation

The ACO-OS generates an error file only in case of an error in reading the XML file sent by ACOs to the ACO-OS.

6.4.5.2 Flow Control

The error data files are transferred from the ACO-OS to the ACOs using EFT process.

6.4.6 Security Requirements

For information on security requirements, see Section 5.5, Security and Integrity.

6.5 Participant List

This section describes information that needs to be present in the data file received from the Pioneer ACOs with Participant List information.

6.5.1 General Processing

An ACO sends updated Participant List data for any participants who have dropped out of their ACO or have had Taxpayer Identification Number (TIN) changes to the ACO-OS. These updates will change ACO/Participant relationships for Pioneer by changing the TIN, terminating the relationship, or reversing a terminated relationship. After the ACO-OS receives the updated Participant List data file from an ACO, the system updates the ACO-OS database and sends a Response file back to an ACO.

6.5.2 Interface Processing Time Requirements

Data is processed immediately after the EFT process receives the file from the Pioneer ACOs and transfers it to the ACO-OS RACS application.

6.5.3 Message Format (or Record Layout) & Required Protocols

Each file is coded in XML. Please refer to Appendix A: XML Schema Definitions and Samples for the Participant list XSD and sample XML.

6.5.4 File Layout

Each ACO-provided file has a header, record details, and trailer as described in Section 6.5.4.2.

6.5.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see Section 6.5.4.2.

6.5.4.2 Field/Element Definitions

All tables briefly describe a file transaction from the ACO to the ACO-OS. The description column describes basic file elements.

Table 16: Participant List File Header

Data Field	Description	Length	Format	Valid Values
Header Code	Code to show that the line entry is header information for the participant list	10	CHAR	HDR_PRVDR
Participant List File Creation Date	Date the file is created	8	CHAR	CCYYMMDD
ACO Program Code	Code indicating the program type	2	CHAR	07 = Pioneer

Table 17: ACO to ACO-OS Participant List Record Detail

Data Field	Description	Length	Format	Valid Values
ACO Identifier	Unique identifier for a Pioneer Organization	5	CHAR	P<nnn>
ACO Participant TIN*	The Tax Identification Number (TIN) for the ACO Participant	9	CHAR	
Old ACO Participant TIN	The old TIN for the ACO Participant, if the ACO Participant TIN is being changed; otherwise, this field is left blank	9	CHAR	Blanks
ACO Organization Participant NPI	The National Provider Identifier (NPI) for the ACO Organization Participant	20	CHAR	
ACO Individual Participant NPI	The NPI for the ACO Individual Participant	20	CHAR	
ACO Participant CCN	The CMS Certification Number (CCN) for the ACO Participant	15	CHAR	
ACO Participant Shared Savings Program Effective Date	The actual date the Participant became associated with the ACO	8	CHAR	CCYYMMDD
ACO Participant Shared Savings Program Termination Date	The actual date the Participant terminated their association with the ACO	8	CHAR	CCYYMMDD

Data Field	Description	Length	Format	Valid Values
ACO Participant Legal Business Name (TIN Name)	Must be the legal business name associated with the TIN	70	CHAR	

NOTE 1: All fields marked with an asterisk (*) are required.

NOTE 2:

- *The ACO Participant TIN is always required for each record in the Participant List File.*
- *TIN Legal Name must always be populated for records with TIN changes.*
- *The ACO Participant Shared Savings Program Termination Date should be 99991231 for the current alignment year. For prior years, the year of termination date should match the year specified in the effective date.*

Table 18: ACO-OS Participant List to ACO Response Record Detail

Data Field	Description	Length	Format	Valid Values
ACO Identifier	Unique identifier for an Pioneer Organization	5	CHAR	As received on Inbound Files
ACO Participant TIN	The TIN for the ACO Participant	9	CHAR	As received on Inbound Files
Old ACO Participant TIN	The TIN for the ACO Participant	9	CHAR	As received on Inbound Files
ACO Organization Participant NPI	The NPI for the ACO Organization Participant	20	CHAR	As received on Inbound Files
ACO Individual Participant NPI	The NPI for the ACO Individual Participant	20	CHAR	As received on Inbound Files
ACO Participant CCN	The CCN for the ACO Participant	15	CHAR	As received on Inbound Files
ACO Participant Shared Savings Program Effective Date	Effective date of the ACO Participant's association with a Program for the performance period (logical)	8	CHAR	As received on Inbound Files

Data Field	Description	Length	Format	Valid Values
ACO Participant Shared Savings Program Termination Date	Termination date of the ACO Participant's association with a Program for the performance period (logical)	8	CHAR	As received on Inbound Files
ACO Participant Legal Business Name (TIN Name)	Must be the legal business name associated with the TIN	70	CHAR	As received on Inbound Files
Response Code	Response code indicating if the record was processed successfully or not	2	CHAR	Valid values are documented and explained in Appendix B:

Table 19: Participant List File Trailer

Data Field	Description	Length	Format	Valid Values
Trailer Code	Code to that the line entry is trailer information	10	CHAR	TRL_PRVDR
Participant List File Creation Date	Date the file is created	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent to ACO-OS	10	NUMERIC	

6.5.4.3 Filenames

The file naming convention for the Participant List file sent by an ACO to the ACO-OS is **P#EFT.ON.ACO.P***.PRVDR.Dyymmdd.Thhmmsst**. For example, an incoming file for January 15, 2012, at 10:00 AM from RTI would be **P#EFT.ON.ACO.P***.PRVDR.D120115.T1000000**.

The file naming convention for the Participant List response file sent by the ACO-OS to an ACO will be **P.P***. PRVDR.RSP.Dyymmdd.Thhmmsst**. For example, an outbound file from the ACO-OS corresponding to the above file from a Pioneer ACO with ID "P123" would be **P.P123.PRVDR .RSP.D120115.T1000000**.

The local file created by the EFT process for the RACS would follow the naming convention PRVDR.P***.Dyymmdd.Thhmmsst.

6.5.5 Communication Methods

This section describes communication methods the interface uses, as well as error recovery.

6.5.5.1 Interface Initiation

Pioneer ACOs send Participant List files to the ACO-OS as needed.

6.5.5.2 Flow Control

Pioneer ACO data files are transferred to ACO-OS using EFT. If a transmission failure should occur at any point in the process within CMS, the CMS CITIC contractor works with the system maintainer to address matters. Any delays in schedule are communicated to the CMS GTL. The CMS GTL communicates status to the CMMI team and impacted partner(s) per operational procedures established external to this ICD.

6.5.6 Security Requirements

For information on security requirements, see Section 5.5, Security and Integrity.

6.6 Quarterly Participant Status File

This section describes the file that is sent by the ACO-OS to ACOs with Pioneer ACO participant status information.

6.6.1 General Processing

The ACO-OS sends the current Pioneer ACO participant status information to ACOs on a quarterly basis.

6.6.2 Interface Processing Time Requirements

Data files are generated as soon as the APCSS Job trigger is received by the ACO-OS application.

6.6.3 Message Format (or Record Layout) & Required Protocols

Each file is coded in XML. Please refer to Appendix A: XML Schema Definitions and Samples for the Quarterly Participant status XSD and sample XML.

6.6.4 File Layout

Each file has a header, record details, and a trailer as described in Section 6.6.4.2.

6.6.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see Section 6.6.4.2.

6.6.4.2 Field/Element Definitions

All tables briefly describe a file transaction to ACOs from the ACO-OS. The description column describes basic file elements.

Table 20: Quarterly Participant Status File Header

Data Field	Description	Length	Format	Valid Values
Header Code	Code to show that the line entry is header information	10	CHAR	HDR_PRVDR
ACO Program Code	Code indicating the program type	2	CHAR	07 = Pioneer
Participant List File Creation Date	Date the file is created	8	CHAR	CCYYMMDD

Table 21: ACO-OS Quarterly Participant Status File to ACOs Record Detail

Data Field	Description	Length	Format	Valid Values
ACO Identifier	Unique identifier for an Pioneer Organization	5	CHAR	P<nnn>
ACO Participant TIN	The TIN for the ACO Participant	9	CHAR	
ACO Organization Participant NPI	The NPI for the ACO Organization Participant	20	CHAR	
ACO Individual Participant NPI	The NPI for the ACO Individual Participant	20	CHAR	
ACO Participant CCN	The CCN for the ACO Participant	15	CHAR	
ACO Participant Shared Savings Program Effective Date	Effective date of the ACO Participant's association with a Program for the performance period (logical)	8	CHAR	CCYYMMDD
ACO Participant Shared Savings Program Termination Date	Termination date of the ACO Participant's association with a Program for the performance period (logical)	8	CHAR	CCYYMMDD
ACO Participant Effective Date	The actual date the Participant became associated with the ACO; not necessarily the Program Effective date.	8	CHAR	CCYYMMDD

Data Field	Description	Length	Format	Valid Values
ACO Participant Termination Date	The actual date the Participant terminated their association with the ACO; not necessarily the Program Termination date.	8	CHAR	CCYYMMDD
ACO Participant Legal Business Name	Must be the legal business name associated with the TIN	70	CHAR	
CCN Legal Name	Legal name associated with the CMS Certification Number	70	CHAR	
CCN Identification Code	CCN identification code indicating the assignment	1	CHAR	F = FQHC R = RHC C = CAH Method II X = Other
Organization NPI Legal Name	NPI organization legal name	70	CHAR	
First Name	NPI first name	30	CHAR	
Last Name	NPI last name	40	CHAR	

Table 22: Quarterly Participant Status File Trailer

Data Field	Description	Length	Format	Valid Values
Trailer Code	Code to that the line entry is trailer information	10	CHAR	TRL_PRVDR
Participant List File Creation Date	Date the file is created	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent to ACO-OS	10	NUMERIC	

6.6.4.3 Filenames

The file naming convention for the quarterly participant status file will be **P.P***.PRVDR.LIST.Dyymmdd.Thhmmsst**. For example, an outbound file for December 15, 2011, at 10:00 AM for a Pioneer ACO with ID “P123” would be **P.P123.PRVDR.LIST.D111215.T1000000**.

6.6.5 Communication Methods

This section describes communication methods the interface uses, as well as error recovery.

6.6.5.1 Interface Initiation

The ACO-OS sends the Quarterly Participant Status files to Pioneer ACOs on a quarterly basis.

6.6.5.2 Flow Control

The Quarterly Participant Status files are transferred from the ACO-OS to the Pioneer ACOs using EFT process.

6.6.6 Security Requirements

For information on security requirements, see Section 5.5, Security and Integrity.

7 Qualification Methods

Developers perform initial data processing, cross-check testing, and system integration testing.

Appendix A: XML Schema Definitions and Samples

I. Pioneer Attestation List XSD (through PY3)

```
<?xml version="1.0" encoding="UTF-8"?>
<xsd:schema xmlns:xsd="http://www.w3.org/2001/XMLSchema"
        elementFormDefault="qualified" attributeFormDefault="qualified">

        <xsd:element name="Header" type="HeaderType"/>
        <xsd:element name="Beneficiarys" type="BeneficiarysType"/>
        <xsd:element name="BatchErrorDetails" type="BatchErrorDetailsType"/>
        <xsd:element name="Trailer" type="TrailerType"/>
        <xsd:element name="Beneficiary" type="BeneficiaryType"/>

        <xsd:element name="PFDCACOBeneData">
        <xsd:complexType>
                <xsd:sequence>
                        <xsd:element ref="Header"/>
                        <xsd:choice>
                                <xsd:element ref="Beneficiarys" minOccurs="0"/>
                                <xsd:element ref="BatchErrorDetails" minOccurs="0"/>
                        </xsd:choice>
                        <xsd:element ref="Trailer"/>
                </xsd:sequence>
        </xsd:complexType>
        </xsd:element>
        <xsd:complexType name="BeneficiarysType">
                <xsd:sequence>
                        <xsd:element ref="Beneficiary" maxOccurs="unbounded"/>
                </xsd:sequence>
        </xsd:complexType>

        <xsd:complexType name="BeneficiaryType">
                <xsd:sequence>
                  <xsd:element name="HICAN" type="xsd:string" ></xsd:element>
```

```
                    <xsd:element name="FirstName" type="xsd:string" ></xsd:element>
                    <xsd:element name="MiddleName" type="xsd:string" ></xsd:element>
                    <xsd:element name="LastName" type="xsd:string" ></xsd:element>
                <xsd:element name="DOB"  nillable="true" type="DateType"></xsd:element>
                    <xsd:element name="Gender" type="xsd:string" ></xsd:element>
                <xsd:element name="Org_Id" type="xsd:string" ></xsd:element>
                    <xsd:element name="Bene_Atte_Sub_Dt" nillable="true"
type="DateType"></xsd:element>
                    <xsd:element name="Atsttn_Sw" type="xsd:string" ></xsd:element>
            </xsd:sequence>
        </xsd:complexType>

        <xsd:complexType name="BatchErrorDetailsType">
            <xsd:annotation>
                <xsd:documentation>
                    There may be one or more batch level errors reported
                </xsd:documentation>
            </xsd:annotation>
            <xsd:sequence>
                <xsd:element name="BatchFileName">
                    <xsd:annotation>
                        <xsd:documentation>
The name of the file that was processed with errors. The name of the file corresponds to the
information stored on the header record. If the entire file is unable to be read due to XSD
validation error, the filename will correspond to the local filename.
                        </xsd:documentation>
                    </xsd:annotation>
                    <xsd:simpleType>
                        <xsd:restriction base="xsd:string">
                            <xsd:minLength value="1"/>
                            <xsd:maxLength value="44"/>
                        </xsd:restriction>
                    </xsd:simpleType>
                </xsd:element>
                <xsd:element name="FileControlNumber">
                    <xsd:annotation>
                        <xsd:documentation>
```

The file control number is a CMS internally generated file control number for the file that was processed with errors. The file control number corresponds to the information contained on the header record. If the entire file is unable to be read due to XSD validation error, the file control number will be set to 0.

```
                    </xsd:documentation>
                </xsd:annotation>
                <xsd:simpleType>
                    <xsd:restriction base="xsd:string">
                        <xsd:minLength value="1"/>
                        <xsd:maxLength value="10"/>
                    </xsd:restriction>
                </xsd:simpleType>
            </xsd:element>
            <xsd:element name="BatchLevelErrors" type="BatchLevelErrorType"
                minOccurs="1" maxOccurs="unbounded">
            </xsd:element>
        </xsd:sequence>
    </xsd:complexType>

    <xsd:complexType name="BatchLevelErrorType">
        <xsd:sequence>
            <xsd:element name="BatchLevelErrorCode">
                <xsd:annotation>
                    <xsd:documentation>
This is the error code corresponding to the file validation process
                    </xsd:documentation>
                </xsd:annotation>
                <xsd:simpleType>
                    <xsd:restriction base="xsd:string">
                        <xsd:minLength value="2"/>
                        <xsd:maxLength value="10"/>
                    </xsd:restriction>
                </xsd:simpleType>
            </xsd:element>
            <xsd:element name="BatchLevelErrorDesc">
                <xsd:annotation>
                    <xsd:documentation>
```

```
This is the error description corresponding to the file validation error
                                        </xsd:documentation>
                                    </xsd:annotation>
                                    <xsd:simpleType>
                                        <xsd:restriction base="xsd:string">
                                            <xsd:minLength value="1"/>
                                            <xsd:maxLength value="120"/>
                                        </xsd:restriction>
                                    </xsd:simpleType>
                                </xsd:element>
                                <xsd:element name="BatchLevelErrorMsg" minOccurs="0">
                                    <xsd:annotation>
                                        <xsd:documentation>
                                            This is a verbose explanation for the error
encountered
                                        </xsd:documentation>
                                    </xsd:annotation>
                                    <xsd:simpleType>
                                        <xsd:restriction base="xsd:string">
                                            <xsd:minLength value="1"/>
                                            <xsd:maxLength value="500"/>
                                        </xsd:restriction>
                                    </xsd:simpleType>
                                </xsd:element>
                            </xsd:sequence>
                        </xsd:complexType>

                        <xsd:complexType name="HeaderType">
                            <xsd:sequence>
                                <xsd:element name="HeaderCode" type="HeaderCodeENUM" />
                                <xsd:element name="HeaderDescription"
type="InterfaceDescriptionENUM"/>
                                <xsd:element name="FileCreationDate">
                                    <xsd:simpleType>
                                        <xsd:restriction base="xsd:string"/>
                                    </xsd:simpleType>
```

```
                    </xsd:element>
                    <xsd:element name="ACOProgramType" type="xsd:string" />
                </xsd:sequence>
            </xsd:complexType>

            <xsd:complexType name="TrailerType">
                <xsd:sequence>
                    <xsd:element name="TrailerCode" type="TrailerCodeENUM"/>
                    <xsd:element name="TrailerDescription"
type="InterfaceDescriptionENUM"/>
                    <xsd:element name="FileCreationDate">
                        <xsd:simpleType>
                            <xsd:restriction base="xsd:string"/>
                        </xsd:simpleType>
                    </xsd:element>
                    <xsd:element name="RecordCount">
                        <xsd:simpleType>
                            <xsd:restriction base="xsd:integer">
                                <xsd:minInclusive value="0"/>
                                <xsd:maxInclusive value="9999999"/>
                            </xsd:restriction>
                        </xsd:simpleType>
                    </xsd:element>
                </xsd:sequence>
            </xsd:complexType>

            <xsd:simpleType name="InterfaceDescriptionENUM">
                <xsd:restriction base="xsd:string">
                    <xsd:minLength value="10"/>
                    <xsd:maxLength value="55"/>
                </xsd:restriction>
            </xsd:simpleType>

            <xsd:simpleType name="HeaderCodeENUM">
                <xsd:restriction base="xsd:string">
```

```
                    <xsd:minLength value="8"/>
                    <xsd:maxLength value="15"/>
                </xsd:restriction>
            </xsd:simpleType>

            <xsd:simpleType name="TrailerCodeENUM">
                <xsd:restriction base="xsd:string">
                    <xsd:minLength value="8"/>
                    <xsd:maxLength value="15"/>
                </xsd:restriction>
            </xsd:simpleType>

            <xsd:simpleType name="DateType">
                <xsd:restriction base="xsd:string">
                    <xsd:pattern value="\d{8}" />
                </xsd:restriction>
            </xsd:simpleType>
    </xsd:schema>
```

A. Sample Pioneer Attestation List XML (through PY3)

```
<?xml version="1.0" encoding="UTF-8" ?>
<PFDCACOBeneData xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
<Header>
<HeaderCode>HDR_ATTEST</HeaderCode>
<HeaderDescription>Beneficiary attestation file for the month of 12,2011
</HeaderDescription>
<FileCreationDate>20111225</FileCreationDate>
<ACOProgramType>07</ACOProgramType>
</Header>
<Beneficiarys>
<Beneficiary>
<HICAN>12345678901</HICAN>
                    <FirstName>John</FirstName>
<MiddleName>Adam</MiddleName>
```

```
<LastName>Doe</LastName>
                        <DOB>19741122</DOB>
                        <Gender>M</Gender>
<Org_Id>P999</Org_Id>
<Bene_Atte_Sub_Dt>20111225</Bene_Atte_Sub_Dt>
< Atsttn_Sw >Y</ Atsttn_Sw >
        </Beneficiary>
</Beneficiarys>
<Trailer>
                <TrailerCode>TRL_ ATTEST </TrailerCode>
 <TrailerDescription> Beneficiary attestation file for the month of 12,2011
</TrailerDescription>
<FileCreationDate>20111225</FileCreationDate>
<RecordCount>1</RecordCount>
  </Trailer>
  </PFDCACOBeneData>
```

II. Beneficiary Alcohol and Substance Abuse Data Sharing Preferences XSD

```
<?xml version="1.0" encoding="UTF-8"?>
<xsd:schema xmlns:xsd="http://www.w3.org/2001/XMLSchema"
        elementFormDefault="qualified" attributeFormDefault="qualified">

        <xsd:element name="Header" type="HeaderType"/>
        <xsd:element name="Beneficiarys" type="BeneficiarysType"/>
        <xsd:element name="BatchErrorDetails" type="BatchErrorDetailsType"/>
        <xsd:element name="Trailer" type="TrailerType"/>
        <xsd:element name="Beneficiary" type="BeneficiaryType"/>

        <xsd:element name="PFDCACOBeneData">
        <xsd:complexType>
                        <xsd:sequence>
                                <xsd:element ref="Header"/>
                                <xsd:choice>
                                        <xsd:element ref="Beneficiarys" minOccurs="0"/>
```

```
                                        <xsd:element ref="BatchErrorDetails" minOccurs="0"/>
                                    </xsd:choice>
                                    <xsd:element ref="Trailer"/>
                                </xsd:sequence>
                        </xsd:complexType>
                </xsd:element>

                <xsd:complexType name="BeneficiarysType">
                        <xsd:sequence>
                                <xsd:element ref="Beneficiary" maxOccurs="unbounded"/>
                        </xsd:sequence>
                </xsd:complexType>

                <xsd:complexType name="BeneficiaryType">
                        <xsd:sequence>
                          <xsd:element name="HICAN" type="xsd:string" ></xsd:element>
                          <xsd:element name="FirstName" type="xsd:string" ></xsd:element>
                          <xsd:element name="MiddleName" type="xsd:string" ></xsd:element>
                          <xsd:element name="LastName" type="xsd:string" ></xsd:element>
                     <xsd:element name="DOB"   nillable="true" type="DateType" ></xsd:element>
                          <xsd:element name="Gender" type="xsd:string" ></xsd:element>
                     <xsd:element name="Org_Id" type="xsd:string" ></xsd:element>
                          <xsd:element name="Bene_Enc_Dt" nillable="true"  type="DateType"
></xsd:element>
                          <xsd:element name="Bene_Sub_Abuse_Data_Shar_Pref_Cd"
type="PrefCodeType">
</xsd:element>

                          <xsd:element name="Bene_AlcoholSub_Data_Shar_Deci_Mech_Cd"
type="MechCodeType">
</xsd:element>
                    </xsd:sequence>
                </xsd:complexType>

                <xsd:complexType name="BatchErrorDetailsType">
                        <xsd:annotation>
                                <xsd:documentation>
```

```
                    There may be one or more batch level errors reported
                </xsd:documentation>
            </xsd:annotation>
            <xsd:sequence>
                <xsd:element name="BatchFileName">
                    <xsd:annotation>
                        <xsd:documentation>
```

The name of the file that was processed with errors. The name of the file corresponds to the information stored on the header record. If the entire file is unable to be read due to XSD validation error, the filename will correspond to the local filename.

```
                        </xsd:documentation>
                    </xsd:annotation>
                    <xsd:simpleType>
                        <xsd:restriction base="xsd:string">
                            <xsd:minLength value="1"/>
                            <xsd:maxLength value="44"/>
                        </xsd:restriction>
                    </xsd:simpleType>
                </xsd:element>
                <xsd:element name="FileControlNumber">
                    <xsd:annotation>
                        <xsd:documentation>
```

The file control number is a CMS internally generated file control number for the file that was processed with errors. The file control number corresponds to the information contained on the header record. If the entire file is unable to be read due to XSD validation error, the file control number will be set to 0.

```
                        </xsd:documentation>
                    </xsd:annotation>
                    <xsd:simpleType>
                        <xsd:restriction base="xsd:string">
                            <xsd:minLength value="1"/>
                            <xsd:maxLength value="10"/>
                        </xsd:restriction>
                    </xsd:simpleType>
                </xsd:element>
                <xsd:element name="BatchLevelErrors" type="BatchLevelErrorType"
                    minOccurs="1" maxOccurs="unbounded">
```

```
                </xsd:element>
            </xsd:sequence>
        </xsd:complexType>

        <xsd:complexType name="BatchLevelErrorType">
            <xsd:sequence>
                <xsd:element name="BatchLevelErrorCode">
                    <xsd:annotation>
                        <xsd:documentation>
This is the error code corresponding to the file validation process
                        </xsd:documentation>
                    </xsd:annotation>
                    <xsd:simpleType>
                        <xsd:restriction base="xsd:string">
                            <xsd:minLength value="2"/>
                            <xsd:maxLength value="10"/>
                        </xsd:restriction>
                    </xsd:simpleType>
                </xsd:element>
                <xsd:element name="BatchLevelErrorDesc">
                    <xsd:annotation>
                        <xsd:documentation>
This is the error description corresponding to the file validation error
                        </xsd:documentation>
                    </xsd:annotation>
                    <xsd:simpleType>
                        <xsd:restriction base="xsd:string">
                            <xsd:minLength value="1"/>
                            <xsd:maxLength value="120"/>
                        </xsd:restriction>
                    </xsd:simpleType>
                </xsd:element>
                <xsd:element name="BatchLevelErrorMsg" minOccurs="0">
                    <xsd:annotation>
                        <xsd:documentation>
```

```
                                        This is a verbose explanation for the error
encountered
                                    </xsd:documentation>
                                </xsd:annotation>
                                <xsd:simpleType>
                                    <xsd:restriction base="xsd:string">
                                        <xsd:minLength value="1"/>
                                        <xsd:maxLength value="500"/>
                                    </xsd:restriction>
                                </xsd:simpleType>
                            </xsd:element>
                        </xsd:sequence>
                    </xsd:complexType>

                    <xsd:complexType name="HeaderType">
                        <xsd:sequence>
                            <xsd:element name="HeaderCode" type="HeaderCodeENUM" />
                            <xsd:element name="HeaderDescription"
type="InterfaceDescriptionENUM"/>
                            <xsd:element name="FileCreationDate">
                                <xsd:simpleType>
                                    <xsd:restriction base="xsd:string"/>
                                </xsd:simpleType>
                            </xsd:element>
                            <xsd:element name="ACOProgramType" type="xsd:string" />
                        </xsd:sequence>
                    </xsd:complexType>

                    <xsd:complexType name="TrailerType">
                        <xsd:sequence>
                            <xsd:element name="TrailerCode" type="TrailerCodeENUM"/>
                            <xsd:element name="TrailerDescription"
type="InterfaceDescriptionENUM"/>
                            <xsd:element name="FileCreationDate">
                                <xsd:simpleType>
                                    <xsd:restriction base="xsd:string"/>
                                </xsd:simpleType>
```

```
                </xsd:element>
                <xsd:element name="RecordCount">
                        <xsd:simpleType>
                                <xsd:restriction base="xsd:integer">
                                        <xsd:minInclusive value="0"/>
                                        <xsd:maxInclusive value="9999999"/>
                                </xsd:restriction>
                        </xsd:simpleType>
                </xsd:element>
        </xsd:sequence>
</xsd:complexType>

<xsd:simpleType name="InterfaceDescriptionENUM">
        <xsd:restriction base="xsd:string">
                <xsd:minLength value="10"/>
                <xsd:maxLength value="55"/>
        </xsd:restriction>
</xsd:simpleType>

<xsd:simpleType name="HeaderCodeENUM">
        <xsd:restriction base="xsd:string">
                <xsd:minLength value="8"/>
                <xsd:maxLength value="15"/>
        </xsd:restriction>
</xsd:simpleType>

<xsd:simpleType name="TrailerCodeENUM">
        <xsd:restriction base="xsd:string">
                <xsd:minLength value="8"/>
                <xsd:maxLength value="15"/>
        </xsd:restriction>
</xsd:simpleType>

<xsd:simpleType name="DateType">
        <xsd:restriction base="xsd:string">
                <xsd:pattern value="\d{8}" />
```

```
            </xsd:restriction>
        </xsd:simpleType>

        <xsd:simpleType name="PrefCodeType">
            <xsd:restriction base="xsd:string">
                <xsd:pattern value="Y|N"/>
            </xsd:restriction>
        </xsd:simpleType>

        <xsd:simpleType name="MechCodeType">
            <xsd:restriction base="xsd:string">
                <xsd:pattern value="E|W"/>
            </xsd:restriction>
        </xsd:simpleType>

</xsd:schema>
```

A. Sample Beneficiary Alcohol and Substance Abuse Data Sharing Preferences XML

```
<?xml version="1.0" encoding="UTF-8" ?>
<PFDCACOBeneData xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
<Header>
<HeaderCode>HDR_DATAPRF</HeaderCode>
            <HeaderDescription>DATAPRF file for 12, 2011</HeaderDescription>
<FileCreationDate>20111225</FileCreationDate>
<ACOProgramType>07</ACOProgramType>
</Header>
<Beneficiarys>
<Beneficiary>
                    <HICAN>123456789A</HICAN>
                    <FirstName>John</FirstName>
                    <MiddleName>Adam</MiddleName>
                    <LastName>Doe</LastName>
                    <DOB>19741122</DOB>
                    <Gender>M</Gender>
```

```
                    <Org_Id>P999</Org_Id>
                    <Bene_Enc_Dt>20150101</Bene_Enc_Dt>

<Bene_Sub_Abuse_Data_Shar_Pref_Cd>Y</Bene_Sub_Abuse_Data_Shar_Pref_Cd>

<Bene_AlcoholSub_Data_Shar_Deci_Mech_Cd>W
</Bene_AlcoholSub_Data_Shar_Deci_Mech_Cd>
            </Beneficiary>
</Beneficiarys>
<Trailer>
            <TrailerCode>TRL_DATAPRF</TrailerCode>
            <TrailerDescription>DATAPRF file for 12, 2011</TrailerDescription>
            <FileCreationDate>20111225</FileCreationDate>
            <RecordCount>1</RecordCount>
      </Trailer>
 </PFDCACOBeneData>
```

III. Monthly Beneficiary Data Sharing Status XSD

```
<?xml version="1.0" encoding="UTF-8"?>
<xsd:schema xmlns:xsd="http://www.w3.org/2001/XMLSchema"
      elementFormDefault="qualified" attributeFormDefault="qualified">

      <xsd:element name="Header" type="HeaderType"/>
      <xsd:element name="Beneficiarys" type="BeneficiarysType"/>
      <xsd:element name="Trailer" type="TrailerType"/>
      <xsd:element name="Beneficiary" type="BeneficiaryType"/>

      <xsd:element name="PFDCACOBeneData">
      <xsd:complexType>
            <xsd:sequence>
                  <xsd:element ref="Header"/>
                  <xsd:choice>
                        <xsd:element ref="Beneficiarys" minOccurs="0"/>
                  </xsd:choice>
                  <xsd:element ref="Trailer"/>
```

```
                    </xsd:sequence>
                </xsd:complexType>
            </xsd:element>
            <xsd:complexType name="BeneficiarysType">
                <xsd:sequence>
                    <xsd:element ref="Beneficiary" maxOccurs="unbounded"/>
                </xsd:sequence>
            </xsd:complexType>

            <xsd:complexType name="BeneficiaryType">
                <xsd:sequence>
                  <xsd:element name="HICN" type="xsd:string" ></xsd:element>
                  <xsd:element name="FirstName" type="xsd:string" ></xsd:element>
                  <xsd:element name="MiddleName" type="xsd:string" ></xsd:element>
                  <xsd:element name="LastName" type="xsd:string" ></xsd:element>
              <xsd:element name="DOB"  nillable="true" type="DateType"></xsd:element>
                  <xsd:element name="Gender" type="xsd:string" ></xsd:element>
              <xsd:element name="Org_Id" type="xsd:string" ></xsd:element>
                  <xsd:element name="Bene_Enc_Dt" nillable="true"  type="DateType"
></xsd:element>
                  <xsd:element name="Bene_Term_Dt" nillable="true"  type="DateType"
></xsd:element>

<xsd:element name="Bene_Data_Shar_Src_Cd" nillable="true" type="xsd:string"
></xsd:element>
                  <xsd:element name="Bene_Sub_Abuse_Eff_Dt" nillable="true"
type="DateType">
</xsd:element>
          <xsd:element name="Bene_Data_Shar_Deci_Mech_Cd" nillable="true"
type="xsd:string" ></xsd:element>
                  <xsd:element name="Bene_AlcoholSub_Data_Shar_Deci_Mech_Cd"
nillable="true" type="xsd:string">
</xsd:element>
                  <xsd:element name="Bene_Data_Shar_Pre_Cd" nillable="true"
type="xsd:string" ></xsd:element>
                  <xsd:element name="Bene_Sub_Abuse_Data_Shar_Pref_Cd" nillable="true"
type="xsd:string">
</xsd:element>
```

```
                    <xsd:element name="Bene_Supp_Res_Cd" nillable="true" type="xsd:string">
</xsd:element>            </xsd:sequence>
        </xsd:complexType>
        <xsd:complexType name="HeaderType">
                <xsd:sequence>
                        <xsd:element name="HeaderCode" type="HeaderCodeENUM" />
                        <xsd:element name="FileCreationDate">
                                <xsd:simpleType>
                                        <xsd:restriction base="xsd:string"/>
                                </xsd:simpleType>
                        </xsd:element>
                </xsd:sequence>
        </xsd:complexType>

        <xsd:complexType name="TrailerType">
                <xsd:sequence>
                        <xsd:element name="TrailerCode" type="TrailerCodeENUM"/>
                        <xsd:element name="FileCreationDate">
                                <xsd:simpleType>
                                        <xsd:restriction base="xsd:string"/>
                                </xsd:simpleType>
                        </xsd:element>
                        <xsd:element name="RecordCount">
                                <xsd:simpleType>
                                        <xsd:restriction base="xsd:integer">
                                                <xsd:minInclusive value="0"/>
                                                <xsd:maxInclusive value="9999999"/>
                                        </xsd:restriction>
                                </xsd:simpleType>
                        </xsd:element>
                </xsd:sequence>
        </xsd:complexType>

        <xsd:simpleType name="HeaderCodeENUM">
                <xsd:restriction base="xsd:string">
```

```
                    <xsd:minLength value="8"/>
                    <xsd:maxLength value="15"/>
                </xsd:restriction>
            </xsd:simpleType>

            <xsd:simpleType name="TrailerCodeENUM">
                <xsd:restriction base="xsd:string">
                    <xsd:minLength value="8"/>
                    <xsd:maxLength value="15"/>
                </xsd:restriction>
            </xsd:simpleType>

            <xsd:simpleType name="DateType">
                <xsd:restriction base="xsd:string">
                    <xsd:pattern value="\d{8}" />
                </xsd:restriction>
            </xsd:simpleType>


    </xsd:schema>
```

A. Sample Monthly Beneficiary Data Sharing Status XML

```
<?xml version="1.0" encoding="UTF-8" standalone="no" ?>
<PFDCACOBeneData xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
<Header>
<HeaderCode>HDR_DPREF</HeaderCode>
<FileCreationDate>20111225</FileCreationDate>
</Header>
<Beneficiarys>
<Beneficiary>
                    <HICN>12345678901</HICN>
                    <FirstName>John</FirstName>
                    <MiddleName>Adam</MiddleName>
                    <LastName>Doe</LastName>
                    <DOB>19741122</DOB>
```

```
                    <Gender>M</Gender>
                    <Org_Id>P999</Org_Id>
                    <Bene_Enc_Dt>20111222</Bene_Enc_Dt>
                    <Bene_Term_Dt>20111201</Bene_Term_Dt>
        <Bene_Data_Shar_Src_Cd>ACO</Bene_Data_Shar_Src_Cd>
                    <Bene_Sub_Abuse_Eff_Dt>20111220</Bene_Sub_Abuse_Eff_Dt>
        <Bene_Data_Shar_Deci_Mech_Cd>E</Bene_Data_Shar_Deci_Mech_Cd>
<Bene_AlcoholSub_Data_Shar_Deci_Mech_Cd>W
</Bene_AlcoholSub_Data_Shar_Deci_Mech_Cd>
                    <Bene_Data_Shar_Pre_Cd>Y</Bene_Data_Shar_Pre_Cd>
        <Bene_Sub_Abuse_Data_Shar_Pref_Cd>N</Bene_Sub_Abuse_Data_Shar_Pref_Cd>
< Bene_Supp_Res_Cd>S</ Bene_Supp_Res_Cd>
            </Beneficiary>
        </Beneficiarys>
<Trailer>
            <TrailerCode>TRL_DPREF</TrailerCode>
            <FileCreationDate>20151225</FileCreationDate>
            <RecordCount>1</RecordCount>
        </Trailer>
 </PFDCACOBeneData>
```

B. Sample Monthly Beneficiary Data Sharing Status XML (when the Beneficiary Claims Sharing Code is neither 'R' nor 'S').

```
<?xml version="1.0" encoding="UTF-8" standalone="no" ?>
<PFDCACOBeneData xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
<Header>
<HeaderCode>HDR_DPREF</HeaderCode>
<FileCreationDate>20111225</FileCreationDate>
</Header>
<Beneficiarys>
<Beneficiary>
                    <HICN>12345678901</HICN>
                    <FirstName>John</FirstName>
                    <MiddleName>Adam</MiddleName>
                    <LastName>Doe</LastName>
                    <DOB>19741122</DOB>
```

```
                    <Gender>M</Gender>
                    <Org_Id>P999</Org_Id>
                    <Bene_Enc_Dt>20111222</Bene_Enc_Dt>
                    <Bene_Term_Dt>20111201</Bene_Term_Dt>
        <Bene_Data_Shar_Src_Cd>ACO</Bene_Data_Shar_Src_Cd>
                    <Bene_Sub_Abuse_Eff_Dt>20111220</Bene_Sub_Abuse_Eff_Dt>
        <Bene_Data_Shar_Deci_Mech_Cd>E</Bene_Data_Shar_Deci_Mech_Cd>
<Bene_AlcoholSub_Data_Shar_Deci_Mech_Cd>W
</Bene_AlcoholSub_Data_Shar_Deci_Mech_Cd>
                    <Bene_Data_Shar_Pre_Cd>Y</Bene_Data_Shar_Pre_Cd>
        <Bene_Sub_Abuse_Data_Shar_Pref_Cd>N</Bene_Sub_Abuse_Data_Shar_Pref_Cd>
<Bene_Supp_Res_Cd xsi:nil="true"/>
                </Beneficiary>
        </Beneficiarys>
<Trailer>
                <TrailerCode>TRL_DPREF</TrailerCode>
                <FileCreationDate>20151225</FileCreationDate>
                <RecordCount>1</RecordCount>
        </Trailer>
 </PFDCACOBeneData>
```

IV. Sample Error File XML

```
<?xml version="1.0" encoding="UTF-8" ?>
<ErrorFile xmlns="http://cms.gov/aco/BatchProcess/errors/1.0">
<Header>
 <HeaderCode>HDR_DATAPRF</HeaderCode>
 <HeaderDescription>HDR_DATAPRF</HeaderDescription>
 <FileName>T#EFT.ON.Pnnn.DATAPRF.RSP.Dyymmdd.Thhmmsst</FileName>
 <FileCreationDate>yyyy-mm-ddThh:mi:ss</FileCreationDate>
<FileControlNumber><number></FileControlNumber>
 </Header>
- <Details>
- <BatchInfo>
 <BatchFileName>DATAPRF.Pnnn.Dyymmdd.Thhmmsst</BatchFileName>
 <BatchRecordsProcessedCount>0</BatchRecordsProcessedCount>
```

```
  </BatchInfo>
- <BatchErrorDetails>
- <BatchLevelErrors>
  <BatchLevelErrorCode>CM09</BatchLevelErrorCode>
  <BatchLevelErrorDesc>Number of records does not match trailer record
count</BatchLevelErrorDesc>
  <BatchLevelErrorMsg>XML document has incorrect number of records, <number> found,
<number> required </BatchLevelErrorMsg>
  </BatchLevelErrors>
  </BatchErrorDetails>
  </Details>
<Trailer>
  <TrailerCode>TRL_DATAPRF</TrailerCode>
  <TrailerDescription>Beneficiary data sharing preference file for 01-2012</TrailerDescription>
  <FileName>T#EFT.ON.Pnnn.DATAPRF.RSP.Dyymmdd.Thhmmsst</FileName>
  <FileCreationDate>yyyy-mm-ddThh:mi:ss</FileCreationDate>
  <FileControlNumber>nnnn</FileControlNumber>
  <RecordCount>1</RecordCount>
  <FileTransmissionDate>yyyy-mm-ddThh:mi:ss</FileTransmissionDate>
  </Trailer>
  </ErrorFile>
```

V. Participant List XSD

```
<?xml version="1.0" encoding="UTF-8"?>
<xsd:schema xmlns:xsd="http://www.w3.org/2001/XMLSchema"
elementFormDefault="qualified" attributeFormDefault="qualified">
   <xsd:element name="Header" type="HeaderType"/>
        <xsd:element name="Participants" type="ParticipantsType"/>
        <xsd:element name="Participant" type="ParticipantType"/>
        <xsd:element name="Trailer" type="TrailerType"/>

        <xsd:element name="ACOParticipantData">
      <xsd:complexType>
                        <xsd:sequence>
           <xsd:element ref="Header"/>
                              <xsd:element ref="Participants" minOccurs="0"
maxOccurs="1"/>
```

```
                    <xsd:element ref="Trailer"/>
                </xsd:sequence>
            </xsd:complexType>
        </xsd:element>

        <xsd:complexType name="HeaderType">
            <xsd:sequence>
                <xsd:element name="HeaderCode" type="HeaderCodeENUM"/>
                <xsd:element name="FileCreationDate">
          <xsd:simpleType>
                            <xsd:restriction base="xsd:string"/>
                    </xsd:simpleType>
                </xsd:element>
                <xsd:element name="ACOProgCode" type="ACOProgCodeType"/>

            </xsd:sequence>
        </xsd:complexType>

        <xsd:complexType name="ParticipantsType">
            <xsd:sequence>
                <xsd:element ref="Participant" maxOccurs="unbounded"/>
            </xsd:sequence>
        </xsd:complexType>

        <xsd:complexType name="ParticipantType">
    <xsd:sequence>
        <xsd:element name="ACO_ID" type="OrgType"/>
        <xsd:element name="TIN" type="xsd:string"/>
        <xsd:element name="Old_TIN" nillable="true" type="xsd:string"/>
        <xsd:element name="Org_NPI" nillable="true" type="xsd:string"/>
        <xsd:element name="Ind_NPI" nillable="true" type="xsd:string"/>
        <xsd:element name="CCN" nillable="true" type="xsd:string"/>
        <xsd:element name="PRG_Eff_Dt" type="DateType"/>
        <xsd:element name="PRG_Term_Dt" nillable="true" type="xsd:string"/>
        <xsd:element name="Legal_Bus_Name" nillable="true" type="xsd:string"/>
    </xsd:sequence>
```

```
    </xsd:complexType>

    <xsd:complexType name="TrailerType">
<xsd:sequence>
                <xsd:element name="TrailerCode" type="TrailerCodeENUM"/>
                <xsd:element name="FileCreationDate">
                        <xsd:simpleType>
                                <xsd:restriction base="xsd:string"/>
                        </xsd:simpleType>
                </xsd:element>
                <xsd:element name="RecordCount">
                        <xsd:simpleType>
                                <xsd:restriction base="xsd:integer">
                                        <xsd:minInclusive value="0"/>
                                        <xsd:maxInclusive value="9999999"/>
                                </xsd:restriction>
                        </xsd:simpleType>
                </xsd:element>
        </xsd:sequence>
    </xsd:complexType>

    <xsd:simpleType name="HeaderCodeENUM">
            <xsd:restriction base="xsd:string">
              <xsd:pattern value="HDR_PRVDR"/>
            </xsd:restriction>
    </xsd:simpleType>

    <xsd:simpleType name="ACOProgCodeType">
            <xsd:restriction base="xsd:string">
              <xsd:pattern value="07"/>
            </xsd:restriction>
    </xsd:simpleType>

    <xsd:simpleType name="TrailerCodeENUM">
            <xsd:restriction base="xsd:string">
                    <xsd:pattern value="TRL_PRVDR"/>
```

```
            </xsd:restriction>
        </xsd:simpleType>

        <xsd:simpleType name="DateType">
            <xsd:restriction base="xsd:string">
                <xsd:pattern value="\d{8}"/>
            </xsd:restriction>
        </xsd:simpleType>

        <xsd:simpleType name="OrgType">
            <xsd:restriction base="xsd:string">
                <xsd:pattern value="P\d{3}"/>
            </xsd:restriction>
        </xsd:simpleType>

</xsd:schema>
```

A. Sample Participant List XML

```
<?xml version="1.0" encoding="UTF-8" standalone="no" ?>
- <ACOParticipantData xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
- <Header>
  <HeaderCode>HDR_PRVDR</HeaderCode>
 <FileCreationDate>20120801</FileCreationDate>
<ACOProgCode>07</ACOProgCode>
   </Header>
- <Participants>
- <Participant>
  <ACO_ID>P999</ACO_ID>
  <TIN>1234567891</TIN>
  <Old_TIN>2134567896</Old_TIN>
  <Org_NPI>3434343</Org_NPI>
  <Ind_NPI>23232323</Ind_NPI>
  <CCN>232323</CCN>
  <PRG_Eff_Dt>20120401</PRG_Eff_Dt>
```

```
<PRG_Term_Dt>20131231</PRG_Term_Dt>
<Legal_Bus_Name>Legal Business Name</Legal_Bus_Name>
</Participant>
</Participants>
- <Trailer>
<TrailerCode>TRL_PRVDR</TrailerCode>
<FileCreationDate>20120801</FileCreationDate>
<RecordCount>1</RecordCount>
</Trailer>
</ACOParticipantData>
```

VI. Quarterly Participant Status XSD

```
<?xml version="1.0" encoding="UTF-8"?>
<xsd:schema xmlns:xsd="http://www.w3.org/2001/XMLSchema"
        elementFormDefault="qualified" attributeFormDefault="qualified">

        <xsd:element name="Header" type="HeaderType"/>
        <xsd:element name="Participants" type="ParticipantsType"/>
        <xsd:element name="Trailer" type="TrailerType"/>
        <xsd:element name="Participant" type="ParticipantType"/>

        <xsd:element name="ACOParticipantData">
        <xsd:complexType>
                <xsd:sequence>
                        <xsd:element ref="Header"/>
                        <xsd:choice>
                                <xsd:element ref="Participants" minOccurs="0"/>
                        </xsd:choice>
                        <xsd:element ref="Trailer"/>
                </xsd:sequence>
        </xsd:complexType>
        </xsd:element>
        <xsd:complexType name="ParticipantsType">
                <xsd:sequence>
                        <xsd:element ref="Participant" maxOccurs="unbounded"/>
```

```
            </xsd:sequence>
        </xsd:complexType>

        <xsd:complexType name="ParticipantType">
            <xsd:sequence>
      <xsd:element name="ACO_ID" type="xsd:OrgType"></xsd:element>
            <xsd:element name="TIN"  type="xsd:string" ></xsd:element>
            <xsd:element name="Org_NPI" type="xsd:string" ></xsd:element>
            <xsd:element name="Ind_NPI"  type="xsd:string" ></xsd:element>
            <xsd:element name="CCN" type="xsd:string" ></xsd:element>
            <xsd:element name="PRG_Eff_Dt" nillable="true" type="xsd:DateType"
></xsd:element>
            <xsd:element name="PRG_Term_Dt" nillable="true" type="xsd:DateType"
></xsd:element>
            <xsd:element name="Actual_Eff_Dt" nillable="true" type="xsd:DateType"
></xsd:element>
            <xsd:element name="Actual_Term_Dt" nillable="true" type="xsd:DateType"
></xsd:element>
            <xsd:element name="Legal_Bus_Name" type="xsd:string" ></xsd:element>
            <xsd:element name="CCN_Legal_Name" type="xsd:string" ></xsd:element>
            <xsd:element name="CCN_Code" nillable="true" type="xsd:CCNIDType"
></xsd:element>
            <xsd:element name="Org_NPI_Legal_Name" type="xsd:string"
></xsd:element>
            <xsd:element name="NPI_First_Name" type="xsd:string" ></xsd:element>
            <xsd:element name="NPI_Last_Name" type="xsd:string" ></xsd:element>


          </xsd:sequence>
        </xsd:complexType>
        <xsd:complexType name="HeaderType">
            <xsd:sequence>
                <xsd:element name="HeaderCode" type="HeaderCodeENUM" />
                <xsd:element name="ACOProgCode" type="ACOProgCodeType" />

                <xsd:element name="FileCreationDate">
                    <xsd:simpleType>
                        <xsd:restriction base="xsd:string"/>
```

```
                    </xsd:simpleType>
                </xsd:element>
            </xsd:sequence>
        </xsd:complexType>

        <xsd:complexType name="TrailerType">
            <xsd:sequence>
                <xsd:element name="TrailerCode" type="TrailerCodeENUM"/>
                <xsd:element name="FileCreationDate">
                    <xsd:simpleType>
                        <xsd:restriction base="xsd:string"/>
                    </xsd:simpleType>
                </xsd:element>
                <xsd:element name="RecordCount">
                    <xsd:simpleType>
                        <xsd:restriction base="xsd:integer">
                            <xsd:minInclusive value="0"/>
                            <xsd:maxInclusive value="9999999"/>
                        </xsd:restriction>
                    </xsd:simpleType>
                </xsd:element>
            </xsd:sequence>
        </xsd:complexType>

        <xsd:simpleType name="HeaderCodeENUM">
            <xsd:restriction base="xsd:string">
              <xsd:pattern value="^HDR_PRVDR$" />
            </xsd:restriction>
        </xsd:simpleType>
        <xsd:simpleType name="ACOProgCodeType">
            <xsd:restriction base="xsd:string">
              <xsd:pattern value="^07$" />
            </xsd:restriction>
        </xsd:simpleType>

        <xsd:simpleType name="TrailerCodeENUM">
```

```
            <xsd:restriction base="xsd:string">
                <xsd:pattern value="^TRL_PRVDR$" />
            </xsd:restriction>
        </xsd:simpleType>

        <xsd:simpleType name="DateType">
            <xsd:restriction base="xsd:string">
                <xsd:pattern value="\d{8}" />
            </xsd:restriction>
        </xsd:simpleType>
        <xsd:simpleType name="OrgType">
            <xsd:restriction base="xsd:string">
                <xsd:pattern value="^(P[0-9]{3})$" />
            </xsd:restriction>
        </xsd:simpleType>
        <xsd:simpleType name="CCNIDType">
            <xsd:restriction base="xsd:string">
                <xsd:pattern value="^[F|R|C|X]+$" />
            </xsd:restriction>
        </xsd:simpleType>

</xsd:schema>
```

A. Sample Quarterly Participant Status XML

```
<?xml version="1.0" encoding="UTF-8" standalone="no" ?>
- <ACOParticipantData xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
- <Header>
  <HeaderCode>HDR_PRVDR</HeaderCode>
  <ACOProgCode>07</ACOProgCode>
  <FileCreationDate>20120801</FileCreationDate>
  </Header>
- <Participants>
- <Participant>
  <ACO_ID>P999</ACO_ID>
```

<TIN>**1234567891**</TIN>
<Org_NPI>**3434343**</Org_NPI>
<Ind_NPI>**23232323**</Ind_NPI>
<CCN>**232323**</CCN>
<PRG_Eff_Dt>**20120401**</PRG_Eff_Dt>
<PRG_Term_Dt>**20131231**</PRG_Term_Dt>
<Actual_Eff_Dt>**20120204**</Actual_Eff_Dt>
<Actual_Term_Dt />
<Legal_Bus_Name>**Legal Busniess Name**</Legal_Bus_Name>
<CCN_Legal_Name>**CCN Legal Name**</CCN_Legal_Name>
<CCN_Code>**CCN Id**</CCN_Code>
<Org_NPI_Legal_Name>**Org NPI Legal Name**</Org_NPI_Legal_Name>
<NPI_First_Name>**NPI First Name**</NPI_First_Name>
<NPI_Last_Name>**NPI Last Name**</NPI_Last_Name>
</Participant>
</Participants>
- <Trailer>
<TrailerCode>**TRL_PRVDR**</TrailerCode>
<FileCreationDate>**20120801**</FileCreationDate>
<RecordCount>**1**</RecordCount>
</Trailer>
</ACOParticipantData>

Appendix B: Response Codes and Explanations

Table 23: Explanation of Response Codes

Code	Description	Explanation
00	Success	The record was processed successfully.
05	System Exception	This response code is used to indicate that an unexpected exception was encountered during the processing of this record. This could be due to database or file system issues. The sender of the file should resend this record at a later time so that the system can attempt the transaction again.
10	Record level ICD validation failed	The data in the file does not conform to the file layout specified for the file transfer. The data format of the field or the data in the field does not conform to the list of valid values specified in ICD.
11	Record count does not match trailer	The Detail Record Count in the Trailer does not equal the number of records sent to ACO-OS.
12	Header record missing/invalid	The Header record is missing or invalid.
13	Trailer record missing/invalid	The Trailer record is missing or invalid.
20	Unable to identify beneficiary	The beneficiary HICN, Date of Birth and Gender code is used to look up and identify the beneficiary in the CME database against current and historical data. If the beneficiary is uniquely identified, then the ACO-OS application stores the data received in the files to the ACO-OS database. If the beneficiary cannot be identified in the CME database the system will not store the corresponding beneficiary data in the database and will generate a response code of 20.
21	Beneficiary Birth Date Invalid	The data does not correspond to a valid date, for example, 02/30/2012.
22	Beneficiary Data Sharing Preferences or Abuse Sharing Preferences switch should be a “Y” or “N” and cannot be blank	At least one sharing preference indicator must have a valid value. The Beneficiary Data Sharing Preferences switch must be “Y” or “N.” This is the check done to ensure Shared Savings Program ACOs send a “Y” or “N” for Data Sharing Preferences or Abuse Sharing Preferences. Anything else (such as a blank) is an error.
23	Beneficiary Attestation Submission or Encounter Date Invalid	The data does not correspond to a valid date, for example, 02/30/2012 (Through PY3).
27	Beneficiary Opt-out code received by 1-800-Medicare	This code provided when 1-800 indicates that a beneficiary has opted-in to substance abuse data sharing. Beneficiary can only opt-out (choose “N”) for Substance and Alcohol Abuse Preferences received by 1-800-Medicare.

Code	Description	Explanation
30	Provider TIN not found	The Provider TIN is not present on the record.
31	Provider NPI not found	The Provider NPI is not present on the record.
32	Duplicates within ACO	The Participant cannot be duplicated within the same ACO.
33	Cannot have both an Organization and Person NPI	The Organization Name and Person NPI cannot be present on the same record.
34	Provider Name not found	There is an Organization Provider without an ACO Participant Legal Business Name, a Person Provider without a Last Name, an ACO Participant CCN without a CCN Legal Name, or a ACO Organization Participant NPI without an Organization NPI Legal Name
35	Duplicates across ACO	The Participant cannot be duplicated across ACOs.
36	Invalid CCN and NPI Combination	If the CCN ID Code is F, R, or C, then an Organization NPI is required. If the CCN ID is "X," then Individual NPI must be blank and Organization NPI must be present.
37	Cannot have a CCN Type Code and no CCN	CCN must be present when there is a CCN Type Code.
38	Invalid Termination Date for a Prior Year	Termination Dates for previous years must be no greater than the last day of that year.
39	ACO-Provider Combo not found	An ACO-Provider combination was not found for the given effective date
40	Organization ID not found	The ACO ID provided on the record is not found in the database.
44	Organization Name not found	ACO ID does not have an Organization Name in the system
50	Provider CCO cross-check	The Provider CCO cross-check will identify a Participant already associated with another program/demo by using the TIN or TIN/NPI or TIN/NPI/CCN combination (as applicable).
51	Record already exists in the system for the same or future date	The Encounter Date provided in this file is superseded by a date provided by another ACO file submission or by 1-800 Medicare. The Attestation Submission Date provided in this file is superseded by a date provided by another ACO file submission through PY3. The date provided in this file was either equal to or earlier than the date already on file.
53	Sharing Preferences not sent by ACO for bene this month	The ACO did not send data sharing Preferences for this beneficiary during this month.

Code	Description	Explanation
54	Beneficiary has data sharing preference with higher priority	Beneficiary has a current data sharing preference record with a higher priority.
55	Beneficiary has abuse sharing preference with higher priority	Beneficiary has a current alcohol and abuse sharing preference record with a higher priority.
56	Invalid data sharing preference/decision mechanism code combination	Invalid beneficiary data sharing preference/decision mechanism code combination.
57	Invalid substance abuse sharing preference/decision mechanism code combination	Invalid beneficiary substance abuse sharing preference/decision mechanism code combination.
75	MDM System Error	An internal error in the MDM system has occurred.

Appendix C: Pass-Through Files

The following list of files is prepared by ACO-OS and other applications within CMS (Partners). These pass-through files are provided to the RACS utilizing EFT, and then moved from RACS via EFT to ACOs. Please refer to Figure 1 for a graphical representation of the data transfers.

Table 24: List of Pass-Through Files

Description	Frequency	Filename	File Format	Logical Record Length	Size Estimate	Scheduled Date	File Layout
Beneficiary Monthly Claims Line Feed (Summary Statistics)	Monthly	P.P***. ACO.MCCLF0. Dyymmdd.Thhmmsst	Extract (Text)	73	N/A	Middle of each month	Appendix P:
Beneficiary Monthly Claims & Claims-Line Feeds (PTA Headers)	Monthly	P.P***. ACO.MCCLF1. Dyymmdd.Thhmmsst	Extract (Text)	177	91 MB	Middle of each month	Appendix P:
Beneficiary Monthly Claims & Claims-Line Feeds (PTA RC Detail)	Monthly	P.P***. ACO.MCCLF2. Dyymmdd.Thhmmsst	Extract (Text)	163	19 MB	Middle of each month	Appendix P:
Beneficiary Monthly Claims & Claims-Line Feeds (PTA PROC)	Monthly	P.P***. ACO.MCCLF3. Dyymmdd.Thhmmsst	Extract (Text)	83	73 MB	Middle of each month	Appendix P:
Beneficiary Monthly Claims & Claims-Line Feeds (PTA Diag Codes)	Monthly	P.P***. ACO.MCCLF4. Dyymmdd.Thhmmsst	Extract (Text)	81	8 MB	Middle of each month	Appendix P:
Beneficiary Monthly Claims & Claims-Line Feeds (PTB Physicians)	Monthly	P.P***. ACO.MCCLF5. Dyymmdd.Thhmmsst	Extract (Text)	321	21 MB	Middle of each month	Appendix P:

Description	Frequency	Filename	File Format	Logical Record Length	Size Estimate	Scheduled Date	File Layout
Beneficiary Monthly Claims & Claims-Line Feeds (DME)	Monthly	P.P***. ACO.MCCLF6. Dyymmdd.Thhmmsst	Extract (Text)	216	121 MB	Middle of each month	Appendix P:
Beneficiary Monthly Claims & Claims-Line Feeds (PTD Data)	Monthly	P.P***. ACO.MCCLF7. Dyymmdd.Thhmmsst	Extract (Text)	182	14 MB	Middle of each month	Appendix P:
Beneficiary Monthly Claims & Claims-Line Feeds (Bene Demographics)	Monthly	P.P***. ACO.MCCLF8. Dyymmdd.Thhmmsst	Extract (Text)	157	0.5 MB	Middle of each month	Appendix P:
Beneficiary Monthly Claims & Claims-Line Feeds (Bene XREF)	Monthly	P.P***. ACO.MCCLF9. Dyymmdd.Thhmmsst	Extract (Text)	54	0.5 MB	Middle of each month	Appendix P:
Monthly Expenditure Report	Monthly	P#P***.ACOB.MPEXP.Dyymmdd.Thhmmsst	Excel	N/A	1 MB	TBD	Appendix I:
Monthly Claims Lag Report	Monthly	P.P***.ACOB.MCLAG. Dyymmdd.Thhmmsst	Excel	N/A	1 MB	TBD	Appendix J:
Monthly Reference Population Expenditure Report	Monthly	P.P***.ACOB.MRPEXP. Dyymmdd.Thhmmsst	Excel	N/A	1 MB	TBD	Appendix M:
Monthly Financial Reports	Monthly	P.P***.ACO.MONFIN. Dyymmdd.Thhmmsst	TBD	N/A	N/A	TBD	N/A
PAT Tool	Monthly	P.A****.ACO.PAT.Dyymmdd. Thhmmsst	Binary	N/A	N/A	TBD	N/A
PAT Tool - ACO Update	Monthly	P.A****.PATU.Dyymmdd.Thhmmsst	Binary	N/A	N/A	TBD	N/A
Quarterly List of Excluded Beneficiaries	Quarterly	P.ACOB.QBEXC. Dyymmdd.Thhmmsst	Excel	N/A	1 MB	TBD	Appendix D:

Description	Frequency	Filename	File Format	Logical Record Length	Size Estimate	Scheduled Date	File Layout
Quarterly Expenditure Utilization Trend Report	Quarterly	P.ACOB.QEXPU. Dyymmdd.Thhmmsst	Excel	N/A	1 MB	TBD	Appendix Q:
Benchmark Report†	Annually	P.ACOB.BNMRK. Dyymmdd.Thhmmsst	Excel	N/A	91 MB	April of each year	N/A
Alignment List	Annually	P.ACO.ALIGN. Dyymmdd.Thhmmsst	Extract (Text)	N/A	91 MB	December of each year	Appendix M:
Historical Claims Line Feed (Summary Statistics)	Annually	P.P***. ACO.CCLF0. Dyymmdd.Thhmmsst	Extract (Text)	N/A	N/A	TBD	Appendix P:
Historical Claims and Claim-Line Feeds – Identifiable (PTA Headers)	Annually	P.P***. ACO.CCLF1. Dyymmdd.Thhmmsst	Extract (Text)	177	91 MB	Middle of each month	Appendix P:
Historical Claims and Claim-Line Feeds – Identifiable (PTA RC Detail)	Annually	P.P***. ACO.CCLF2. Dyymmdd.Thhmmsst	Extract (Text)	163	19 MB	Middle of each month	Appendix P:
Historical Claims and Claim-Line Feeds – Identifiable (PTA PROC)	Annually	P.P***. ACO.CCLF3. Dyymmdd.Thhmmsst	Extract (Text)	83	73 MB	Middle of each month	Appendix P:
Historical Claims and Claim-Line Feeds – Identifiable (PTA Diag Codes)	Annually	P.P***. ACO.CCLF4. Dyymmdd.Thhmmsst	Extract (Text)	81	8 MB	Middle of each month	Appendix P:

† Files not produced by ACO-OS but supplied separately by CMS

Description	Frequency	Filename	File Format	Logical Record Length	Size Estimate	Scheduled Date	File Layout
Historical Claims and Claim-Line Feeds – Identifiable (PTB Physicians)	Annually	P.P***. ACO.CCLF5. Dyymmdd.Thhmmsst	Extract (Text)	321	21 MB	Middle of each month	Appendix P:
Historical Claims and Claim-Line Feeds – Identifiable (DME)	Annually	P.P***. ACO.CCLF6. Dyymmdd.Thhmmsst	Extract (Text)	216	121 MB	Middle of each month	Appendix P:
Historical Claims and Claim-Line Feeds – Identifiable (PTD Data)	Annually	P.P***. ACO.CCLF7. Dyymmdd.Thhmmsst	Extract (Text)	182	14 MB	Middle of each month	Appendix P:
Historical Claims and Claim-Line Feeds – Identifiable (Bene Demographics)	Annually	P.P***. ACO.CCLF8. Dyymmdd.Thhmmsst	Extract (Text)	157	0.5 MB	Middle of each month	Appendix P:
Historical Claims and Claim-Line Feeds – Identifiable (Bene XREF)	Annually	P.P***.ACO.CCLF9. Dyymmdd.Thhmmsst	Extract (Text)	54	0.5 MB	Middle of each month	Appendix P:
Mean Proportion Allowed Charges Summary	Annually	P.P***.ACOB.MPACS. Dyymmdd.Thhmmsst	Excel	N/A	1 MB	TBD	Appendix E:
Mean Number Primary Care Visits Summary	Annually	P.P***.ACOB.PCVST. Dyymmdd.Thhmmsst	Excel	N/A	1 MB	TBD	Appendix F:
Demographic and Eligibility Summary	Annually	P.P***.ACOB.DMELG. Dyymmdd.Thhmmsst	Excel	N/A	1 MB	TBD	Appendix G:
Settlement Sheet (incl. in 'Annual Performance Report') †	Annually	P.P***.ACOB.STLMT. Dyymmdd.Thhmmsst	Excel	N/A	N/A	TBD	N/A

† Files not produced by ACO-OS but supplied separately by CMS

Description	Frequency	Filename	File Format	Logical Record Length	Size Estimate	Scheduled Date	File Layout
Distribution of Aligned Beneficiaries by Beneficiary Address Counties Report	Annually	P.P***.ACOB.DSACS.Dyymmdd.Thhmmsst	Excel	N/A	1 MB	TBD	Appendix H:
Pioneer TINHICN Report †	Annually	P.P***.ACOB.TINHICN.Dyymmdd.Thhmmsst	Excel	N/A	1 MB	TBD	N/A

Note: *P*** corresponds to a valid Pioneer ACO ID.*

Appendix D: Pioneer ACO Quarterly Report on Excluded Beneficiaries

The following is the format of the Pioneer ACO Model Report on Excluded Beneficiaries Pioneer ACO ID (P*** number)] – [Pioneer ACO Name]
Prospectively Aligned Beneficiaries
[Performance Year #]: [mmm, d, yyyy to mmm, d, yyyy]
Cumulative report through [mmm, d, yyyy].

Table 1-2
Pioneer ACO Model
Quarterly Report on Beneficiaries Excluded from Aligned Population
P*** - Performance Year YYYY
Cumulative Report Through Exclusion Run MMM DD, YYYY

HICNO	First Name	Last Name	Address					State	Zip Code	Gender	Birth Date	Date of Exclusion (1)	Reason for Exclusion
xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxx	Male	xxxxx	1/31/2014	Date of Death prior to start of Performance Year
xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxx	Male	xxxxx	1/31/2014	Transition to Medicare Advantage including during the Open Enrollment Period (OEP)
xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxx	Female	xxxxx	1/30/2014	Transition to Medicare Advantage including during the Open Enrollment Period (OEP)
xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxx	Female	xxxxx	1/30/2014	Transition to Medicare Advantage including during the Open Enrollment Period (OEP)
xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxx	Female	xxxxx	1/31/2014	Date of Death prior to start of Performance Year

Notes:
(1) Date of Exclusion is the date the beneficiary was excluded from the alignment list, not the date the beneficiary became ineligible for alignment.

Figure 2: Format of Report 1-2

Appendix E: File Format – Mean Proportion of Allowed Charges for Primary Care Services Report

The following is the format of the Pioneer ACO Model Mean Proportion of Allowed Charges for Primary Care Services Visits Provided to Aligned Beneficiaries by P***, Performance Year YYYY.

Table 2-2
Pioneer ACO Model
Mean Proportion of Allowed Charges for Primary Care Services Visits Provided to Aligned Beneficiaries by P* , Performance Year YYYY**

Aligned Beneficiaries (1): XX,XXX

	2010		2011		2012	
Mean Proportion (2)	X.XX		X.XX		X.XX	
Proportion Ranges	**Beneficiaries**	**Percent**	**Beneficiaries**	**Percent**	**Beneficiaries**	**Percent**
Total	XX,XXX	XXX.XX %	XX,XXX	XXX.XX %	XX,XXX	XXX.XX %
0.8 to 1.0		XXX.XX %		XXX.XX %		XXX.XX %
0.6 to 0.79		XXX.XX %		XXX.XX %		XXX.XX %
0.4 to 0.59		XXX.XX %		XXX.XX %		XXX.XX %
0.2 to 0.39		XXX.XX %		XXX.XX %		XXX.XX %
0 to 0.19	XX,XXX	XXX.XX %	XX,XXX	XXX.XX %	XX,XXX	XXX.XX %

Notes:
(1) Alignment period is from July 1st, 2009 to June 30th, 2012.
(2) Proportion of all Office Primary Care Service visit allowed charges provided to the beneficiary that were provided by any of the ACO's physicians (MD, DO) or NPs or PAs. Primary care services are identified by the following HCPCS and/or revenue center codes: 99201-99205, 99211-99215; 99304-99306; 99307-99310; 99315-99316; 99318; 99324-99328, 99334-99337; 99339-99340; 99341-99345, 99347-99350; G0402, G0438, G0439.
Primary Care Services are based on the codes recorded on claims regardless of physician specialty.

Created on 1/18/2013 12:27:33 PM

Figure 3: Format of Report 2-2

Appendix F: File Format – Mean Number of Primary Care Services Visits for Aligned Beneficiaries Report

The following is the format of the Pioneer ACO Model Mean Number of Primary Care Services Visits for Aligned Beneficiaries P***, Performance Year YYYY.

Table 2-3
Pioneer ACO Model
Mean Number of Primary Care Services Visits for Aligned Beneficiaries
P* , Performance Year YYYY**

	2010		2011		2012	
Mean Visits:	X.XX		X.XX		X.XX	
Count of Visits (1)	**Beneficiaries**	**Percent**	**Beneficiaries**	**Percent**	**Beneficiaries**	**Percent**
Total (2)	X,XXX	XXX.XX %	X,XXX	XXX.XX %	X,XXX	XXX.XX %
7+						
6						
5						
4						
3						
2						
1						

Notes:
(1) Primary care services are identified by the following HCPCS and/or revenue center codes:
99201-99205, 99211-99215; 99304-99306; 99307-99310; 99315-99316;
99318; 99324-99328, 99334-99337; 99339-99340; 99341-99345, 99347-99350;
G0402, G0438, G0439.
Primary Care Services are based on the codes recorded on claims regardless of physician specialty.
(2) The total is defined as the beneficiaries with at least one primary care service visit during the reporting year.

Alignment period is from July 1st, 2009 to June 30th, 2012.

Created on 1/18/2013 12:28:59 PM

Figure 4: Format of Report 2-3

Appendix G: File Format – Demographic and Eligibility Characteristics of Aligned Beneficiaries Report

The following is the format of the Pioneer ACO Model Demographic and Eligibility Characteristics of Aligned Beneficiaries P***, Performance Year YYYY.

The following figure displays a full view of the first portion of the Table 2-7 report.

Table 2-7
Pioneer ACO Model
Demographic and Eligibility Characteristics of Aligned Beneficiaries
P* , Performance Year YYYY**

Aligned Beneficiaries (1):	XX,XXX	
	Beneficiary	**Percentage**
Beneficiaries Classification (2)		
Total	XXX	XXX.XX %
ESRD Dual Eligible		
ESRD Non-Dual Eligible		
Disabled Dual Eligible		
Disabled Non-Dual Eligible		
Aged Dual Eligible		
Aged Non-Dual Eligible		
Unknown Eligible (3)		
Hospice Status (4)		
Total		XXX.XX %
Hospice	XXX	
Non-Hospice	(XXX)	

Figure 5: Format of Report 2-7

The following figure displays a full view of the second portion of the Table 2-7 report.

Sex	
Total	XXX.XX%
Male	
Female	
Unknown (3)	
Age	
Total	XXX.XX%
Age<65	
Age 65-74	
Age 75-84	
Age 85+	
Unknown (3)	

Note:
(1) Alignment period is from July 1st, 2009 to June 30th, 2012.
(2) Classification derived from Medicare and Medicaid status codes. Dual-eligible refers to beneficiaries that are eligible for both Medicare and Medicaid. Demographic breakdown is based on data as of report run date. Thus not all prospectively aligned beneficiaries may be included in the report, for example as a result of becoming ineligible for the ACO program after the end of the alignment period.
(3) Known Medicare status was not available based on date as of the report run.
(4) Hospice includes any beneficiary that had at least one hospice claim during the reporting period.

Created on 1/18/2013 12:30:32 PM

Figure 6: Format of Report 2-7, Second Portion

Appendix H: File Format – Distribution of Aligned Beneficiaries by Beneficiary Address Counties Report

The following is the format of the Pioneer ACO Model Distribution of Aligned Beneficiaries by Beneficiary Address Counties P***, Performance Year YYYY.

Table 2-8
Pioneer ACO Model
Distribution of Aligned Beneficiaries by Beneficiary Address Counties
P* , Performance Year YYYY**

SSA County (State)	State # (1)	County # (1)	Beneficiaries	Percentage
County Names (State Name)	XX	XXX	X,XXX	XX.XX%
Total Remaining U.S Counties (2)			X,XXX	XX.XX%
Total			XX,XXX	XXX.XX%

Notes:
(1) State and county codes used by the Social Security Administration (SSA). County is defined as counties with at least 1% of aligned beneficiaries. Beneficiary address county is based on data as of report run time.
(2) Total Remaining U.S Counties is the sum of all counties that individually contain less than 1% of the aligned population for an ACO.

Alignment period is from July 1st, 2009 to June 30th, 2012.

Created on 1/18/2013 12:32:33 PM

Figure 7: Format of Report 2-8

Appendix I: File Format – Pioneer ACO Model Monthly Expenditure Report

The following are the report formats for each tab of the Pioneer ACO Model Monthly Expenditure Report:

Claims incurred in specified month that have been paid through Mar 2017 (Paid Claim for Any Provider - Summary)													
	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	CY2016
Pioneer ACO experience													
Aligned beneficiaries (months)	51,910	51,633	51,401	51,164	50,940	50,732	50,513	50,311	50,079	49,866	49,637	49,414	607,600
Aged/non-dual	34,577	34,404	34,275	34,140	34,018	33,910	33,791	33,688	33,555	33,440	33,309	33,183	406,290
Aged/dual	11,927	11,844	11,762	11,681	11,600	11,520	11,440	11,361	11,282	11,204	11,126	11,049	137,796
Disabled	4,914	4,902	4,890	4,878	4,866	4,854	4,842	4,830	4,818	4,806	4,794	4,782	58,176
ESRD	492	483	474	465	456	448	440	432	424	416	408	400	5,338
Paid claim amount													
Total paid claims	$66,505,133.08	$61,170,554.89	$67,238,285.81	$63,016,192.58	$66,296,412.02	$61,310,069.03	$63,982,928.13	$64,217,639.34	$59,475,534.07	$65,933,600.33	$61,027,612.29	$59,420,964.75	$759,594,926.33
Aged/non-dual	$38,849,640.08	$35,935,985.09	$39,051,195.14	$36,916,656.87	$39,089,668.30	$35,755,881.59	$37,625,884.09	$37,759,518.21	$35,116,762.09	$39,063,667.43	$36,190,858.58	$35,246,991.21	$446,602,708.68
Aged/dual	$18,063,248.08	$16,875,846.49	$18,138,184.10	$17,104,634.68	$17,807,601.54	$16,497,471.29	$17,215,685.52	$17,262,294.59	$15,993,776.09	$17,488,640.59	$16,161,314.72	$16,029,961.63	$204,638,659.32
Disabled	$6,281,247.04	$5,422,315.43	$6,661,676.85	$5,769,389.13	$6,236,786.05	$6,065,404.55	$6,152,465.33	$6,283,935.66	$5,531,682.32	$6,461,206.25	$5,895,487.87	$5,508,573.86	$72,270,170.33
ESRD	$3,310,997.88	$2,936,407.88	$3,387,229.72	$3,225,511.90	$3,162,356.14	$2,991,311.60	$2,988,893.19	$2,911,890.87	$2,833,313.57	$2,920,086.06	$2,779,951.13	$2,635,438.05	$36,083,387.99
Part A claims													
Inpatient claim payments	$27,631,567.33	$25,176,057.54	$25,873,485.34	$22,782,854.93	$24,102,536.45	$22,710,751.00	$24,961,752.27	$24,930,178.44	$20,843,746.07	$24,287,152.92	$23,798,226.87	$22,098,979.12	$289,197,288.28
SNF claim payments	$6,047,490.09	$5,865,943.12	$6,944,133.67	$5,502,152.05	$5,841,462.77	$5,189,225.14	$5,488,919.34	$6,065,232.77	$5,256,221.87	$5,377,703.82	$5,701,381.48	$5,469,116.79	$68,748,982.91
HHA claim payments	$4,203,269.28	$3,979,084.27	$4,406,390.72	$4,231,664.24	$4,603,291.33	$4,143,023.23	$4,263,073.62	$4,303,840.61	$4,007,275.23	$4,498,185.29	$3,927,509.42	$4,721,133.54	$51,287,740.78
Hospice claim payments	$1,974,655.46	$1,878,762.84	$1,909,048.79	$1,804,731.28	$1,818,248.59	$1,789,451.25	$1,734,550.46	$1,671,998.63	$1,692,274.99	$1,847,869.91	$1,871,297.50	$1,775,545.16	$21,768,434.86
Total Part A claims	$39,856,982.16	$36,899,847.76	$39,133,058.52	$34,321,402.50	$36,365,539.14	$33,832,450.63	$36,448,295.69	$36,971,250.46	$31,799,518.15	$36,010,911.94	$35,298,415.27	$34,064,774.62	$431,002,446.84
Part B claims													
Physician claim payments	$12,742,927.96	$12,322,615.25	$13,975,191.33	$14,797,783.57	$15,358,652.58	$14,209,004.83	$14,188,180.05	$14,017,525.40	$14,441,245.68	$15,668,839.32	$13,441,055.04	$13,345,497.56	$168,508,518.58
Outpatient claim payments	$12,715,408.03	$10,798,784.42	$12,829,602.25	$12,653,013.36	$13,219,203.68	$12,008,052.27	$12,145,915.04	$12,099,293.82	$12,017,430.55	$13,175,743.61	$11,412,032.03	$11,022,238.27	$146,096,717.33
DME claim payments	$1,189,814.92	$1,149,307.46	$1,300,433.71	$1,243,993.15	$1,353,016.62	$1,260,561.31	$1,200,537.34	$1,129,569.66	$1,217,339.69	$1,078,105.47	$876,109.94	$988,454.31	$13,987,243.58
Total Part B claims	$26,648,150.92	$24,270,707.13	$28,105,227.29	$28,694,790.08	$29,930,872.88	$27,477,618.41	$27,534,632.44	$27,246,388.88	$27,676,015.92	$29,922,688.39	$25,729,197.02	$25,356,190.14	$328,592,479.49
Supplemental data													
Adjustments to paid claim amount													
Sequestration	$0.00	$0.00	$0.00	$1,281,571.27	$1,350,790.80	$1,249,247.30	$1,305,516.84	$1,310,270.74	$1,212,989.89	$1,344,123.31	$1,243,794.87	$1,203,887.05	$11,502,192.05
Operating DSH	$1,685,885.27	$1,603,662.30	$1,652,564.22	$1,605,908.07	$1,522,078.24	$1,482,927.89	$1,686,503.16	$1,612,588.75	$1,499,343.51	$411,581.34	$429,575.87	$413,560.85	$15,606,179.48
Uncompensated Care Payments	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,657,186.21	$2,406,596.17	$1,620,306.48	$5,684,088.85
PBP reduction	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Claims incurred by opt-outs	$6,768,469.60	$5,663,283.73	$6,382,083.48	$5,797,618.35	$6,235,106.68	$6,386,685.42	$6,589,311.15	$5,510,204.17	$4,520,254.19	$4,921,607.68	$5,110,447.37	$6,138,264.76	$70,023,336.59
Claims with suppresed SA data	$2,746,793.71	$1,237,435.70	$2,049,168.02	$3,215,330.88	$3,337,779.15	$3,102,297.69	$1,305,588.79	$1,300,361.50	$2,440,587.91	$1,346,964.76	$1,253,973.81	$2,401,837.11	$25,738,119.02
Paid claim amount PBPM													
Total paid claims	$1,281.16	$1,184.72	$1,308.11	$1,231.65	$1,301.46	$1,208.51	$1,266.66	$1,276.41	$1,187.63	$1,322.22	$1,229.48	$1,202.51	$1,250.16
Aged/non-dual	$1,123.57	$1,044.53	$1,139.35	$1,081.33	$1,149.09	$1,054.43	$1,113.49	$1,120.86	$1,046.54	$1,168.17	$1,086.52	$1,062.20	$1,099.22
Aged/dual	$1,514.48	$1,424.84	$1,542.10	$1,464.31	$1,535.14	$1,432.07	$1,504.87	$1,519.43	$1,417.64	$1,560.93	$1,452.57	$1,450.81	$1,485.08
Disabled	$1,278.24	$1,106.14	$1,362.31	$1,182.74	$1,281.71	$1,249.57	$1,270.65	$1,301.02	$1,148.13	$1,344.40	$1,229.76	$1,151.94	$1,242.27
ESRD	$6,729.67	$6,079.52	$7,146.05	$6,936.58	$6,934.99	$6,677.03	$6,792.94	$6,740.49	$6,682.34	$7,019.44	$6,813.61	$6,588.60	$6,759.72
Part A claims													
Inpatient claim payments	$532.30	$487.60	$503.37	$445.29	$473.16	$447.66	$494.16	$495.52	$416.22	$487.05	$479.45	$447.22	$475.97
SNF claim payments	$116.50	$113.61	$135.10	$107.54	$114.67	$102.29	$108.66	$120.55	$104.96	$107.84	$114.86	$110.68	$113.15
HHA claim payments	$80.97	$77.06	$85.73	$82.71	$90.37	$81.66	$84.40	$85.54	$80.02	$90.21	$79.12	$95.54	$84.41
Hospice claim payments	$38.04	$36.39	$37.14	$35.27	$35.69	$35.27	$34.34	$33.23	$33.79	$37.06	$37.70	$35.93	$35.83
Total Part A claims	$767.81	$714.66	$761.33	$670.81	$713.89	$666.89	$721.56	$734.85	$634.99	$722.15	$711.13	$689.37	$709.35
Part B claims													
Physician claim payments	$245.48	$238.66	$271.89	$289.22	$301.50	$280.08	$280.88	$278.62	$288.37	$314.22	$270.79	$270.08	$277.33
Outpatient claim payments	$244.95	$209.15	$249.60	$247.30	$259.51	$236.70	$240.45	$240.49	$239.97	$264.22	$229.91	$223.06	$240.45
DME claim payments	$22.92	$22.26	$25.30	$24.31	$26.56	$24.85	$23.77	$22.45	$24.31	$21.62	$17.65	$20.00	$23.02
Total Part B claims	$513.35	$470.06	$546.78	$560.84	$587.57	$541.62	$545.10	$541.56	$552.65	$600.06	$518.35	$513.14	$540.80

Figure 8: Provider Summary Tab

	Claims incurred in specified month that have been paid through Mar 2017 (Paid Claim for Any Provider - Aged_non dual)												
	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	CY2016
Pioneer ACO experience													
Aligned beneficiaries (months)	34,577	34,404	34,275	34,140	34,018	33,910	33,791	33,688	33,555	33,440	33,309	33,183	406,290
Paid claim amount													
Total paid claims	$38,849,640.08	$35,935,985.09	$39,051,195.14	$36,916,656.87	$39,089,668.30	$35,755,881.59	$37,625,884.09	$37,759,518.21	$35,116,762.09	$39,063,667.43	$36,190,858.58	$35,246,991.21	$446,602,708.68
Part A claims													
Inpatient claim payments	$16,345,234.32	$14,999,692.33	$15,317,029.10	$13,618,818.31	$14,535,425.31	$13,398,461.03	$14,898,317.91	$14,828,149.48	$12,712,798.51	$14,657,251.21	$14,425,837.22	$13,420,715.12	$173,157,729.85
SNF claim payments	$3,633,752.42	$3,513,311.27	$4,094,088.83	$3,337,400.85	$3,511,281.74	$3,144,121.80	$3,281,131.67	$3,642,456.45	$3,185,739.19	$3,197,103.39	$3,399,524.83	$3,270,781.56	$41,210,694.00
HHA claim payments	$2,567,922.76	$2,381,575.95	$2,619,065.52	$2,550,576.10	$2,785,314.19	$2,452,716.23	$2,570,777.56	$2,573,304.22	$2,468,256.91	$2,727,087.27	$2,401,387.79	$2,898,317.68	$30,996,302.18
Hospice claim payments	$1,167,765.52	$1,120,442.62	$1,147,550.21	$1,072,995.68	$1,100,648.76	$1,071,652.59	$1,044,264.29	$1,014,316.07	$1,039,862.04	$1,117,642.77	$1,120,140.93	$1,087,437.04	$13,104,718.52
Total Part A claims	$23,714,675.02	$22,015,022.17	$23,177,733.66	$20,579,790.94	$21,932,670.00	$20,066,951.65	$21,794,491.43	$22,058,226.22	$19,406,656.65	$21,699,084.64	$21,346,890.77	$20,677,251.40	$258,469,444.55
Part B claims													
Physician claim payments	$7,397,855.76	$7,211,540.02	$8,105,436.45	$8,614,188.81	$8,947,113.74	$8,143,371.89	$8,273,291.80	$8,178,751.73	$8,271,758.63	$9,150,994.34	$7,954,336.90	$7,675,851.11	$97,924,491.18
Outpatient claim payments	$7,055,092.47	$6,038,323.50	$7,014,374.06	$7,005,073.41	$7,421,998.46	$6,813,238.33	$6,859,005.98	$6,870,119.17	$6,726,746.05	$7,588,250.05	$6,371,313.17	$6,317,092.40	$82,080,627.05
DME claim payments	$682,016.83	$671,099.40	$753,650.97	$717,603.71	$787,886.10	$732,319.72	$699,094.88	$652,421.09	$711,600.76	$625,338.40	$518,317.74	$576,796.30	$8,128,145.90
Total Part B claims	$15,134,965.06	$13,920,962.92	$15,873,461.48	$16,336,865.93	$17,156,998.30	$15,688,929.94	$15,831,392.66	$15,701,291.99	$15,710,105.44	$17,364,582.79	$14,843,967.81	$14,569,739.81	$188,133,264.13
Supplemental data													
Adjustments to paid claim amount													
Sequestration	$0.00	$0.00	$0.00	$748,927.68	$795,551.13	$727,733.27	$767,617.98	$770,309.08	$715,872.09	$795,757.33	$736,922.35	$710,540.65	$6,769,231.56
Operating DSH	$995,291.47	$946,841.46	$968,660.39	$946,191.64	$930,682.87	$870,807.98	$1,005,367.00	$950,826.32	$909,251.49	$250,183.51	$262,982.48	$252,996.32	$9,290,082.93
Uncompensated Care Payments	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$991,769.56	$1,466,506.09	$971,333.07	$3,429,608.72
PBP reduction	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Claims incurred by opt-outs	$4,273,460.41	$3,593,598.51	$3,905,119.51	$3,691,665.69	$3,908,966.83	$3,933,146.97	$4,138,847.25	$3,398,356.64	$2,809,340.97	$3,125,093.39	$3,257,177.27	$3,877,169.03	$43,911,942.48
Claims with suppressed SA data	$1,553,985.60	$718,719.70	$1,171,535.85	$1,845,832.84	$1,954,483.42	$1,787,794.08	$752,517.68	$755,190.36	$1,404,670.48	$781,273.35	$723,817.17	$1,409,879.65	$14,859,700.20
Paid claim amount PBPM													
Total paid claims	$1,123.57	$1,044.53	$1,139.35	$1,081.33	$1,149.09	$1,054.43	$1,113.49	$1,120.86	$1,046.54	$1,168.17	$1,086.52	$1,062.20	$1,099.22
Part A claims													
Inpatient claim payments	$472.72	$435.99	$446.89	$398.91	$427.29	$395.12	$440.90	$440.16	$378.86	$438.31	$433.09	$404.45	$426.19
SNF claim payments	$105.09	$102.12	$119.45	$97.76	$103.22	$92.72	$97.10	$108.12	$94.94	$95.61	$102.06	$98.57	$101.43
HHA claim payments	$74.27	$69.22	$76.41	$74.71	$81.88	$72.33	$76.08	$76.39	$73.56	$81.55	$72.09	$87.34	$76.29
Hospice claim payments	$33.77	$32.57	$33.48	$31.43	$32.35	$31.60	$30.90	$30.11	$30.99	$33.42	$33.63	$32.77	$32.25
Total Part A claims	$685.85	$639.90	$676.23	$602.81	$644.74	$591.77	$644.98	$654.78	$578.35	$648.90	$640.87	$623.13	$636.17
Part B claims													
Physician claim payments	$213.95	$209.61	$236.48	$252.32	$263.01	$240.15	$244.84	$242.78	$246.51	$273.65	$238.80	$231.32	$241.02
Outpatient claim payments	$204.04	$175.51	$204.65	$205.19	$218.18	$200.92	$202.98	$203.93	$200.47	$226.92	$191.28	$190.37	$202.02
DME claim payments	$19.72	$19.51	$21.99	$21.02	$23.16	$21.60	$20.69	$19.37	$21.21	$18.70	$15.56	$17.38	$20.01
Total Part B claims	$437.72	$404.63	$463.12	$478.53	$504.35	$462.66	$468.51	$466.08	$468.19	$519.28	$445.64	$439.07	$463.05

Figure 9: Aged Non-Dual Detail Tab

	Claims incurred in specified month that have been paid through Mar 2017 (Paid Claim for Any Provider - Aged_dual)												
	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	CY2016
Pioneer ACO experience													
Aligned beneficiaries (months)	11,927	11,844	11,762	11,681	11,600	11,520	11,440	11,361	11,282	11,204	11,126	11,049	137,796
Paid claim amount													
Total paid claims	$18,063,248.08	$16,875,846.49	$18,138,184.10	$17,104,634.68	$17,807,601.54	$16,497,471.29	$17,215,685.52	$17,262,294.59	$15,993,776.09	$17,488,640.59	$16,161,314.72	$16,029,961.63	$204,638,659.32
Part A claims													$0.00
Inpatient claim payments	$7,498,712.47	$7,229,359.91	$7,095,974.03	$6,337,162.47	$6,443,477.38	$6,326,950.07	$6,960,513.88	$6,850,919.33	$5,642,141.16	$6,433,253.40	$6,360,517.03	$6,211,518.52	$79,390,499.65
SNF claim payments	$1,729,730.05	$1,632,825.81	$1,938,831.47	$1,530,134.75	$1,664,292.63	$1,441,975.29	$1,499,624.09	$1,670,608.20	$1,424,592.69	$1,488,943.82	$1,544,310.37	$1,470,254.90	$19,036,124.06
HHA claim payments	$1,160,371.79	$1,106,847.18	$1,195,368.25	$1,195,570.97	$1,272,706.33	$1,141,543.75	$1,183,663.86	$1,214,955.86	$1,078,853.73	$1,196,953.18	$1,058,799.41	$1,254,575.10	$14,060,209.40
Hospice claim payments	$555,876.92	$509,158.52	$527,691.63	$488,276.84	$487,911.79	$502,409.44	$459,598.67	$444,690.64	$458,010.96	$494,292.22	$512,590.67	$481,574.06	$5,922,082.36
Total Part A claims	$10,944,691.22	$10,478,191.42	$10,757,865.38	$9,551,145.02	$9,868,388.13	$9,412,878.56	$10,103,400.50	$10,181,174.03	$8,603,598.53	$9,613,442.63	$9,476,217.47	$9,417,922.59	$118,408,915.48
Part B claims													$0.00
Physician claim payments	$3,495,991.24	$3,277,112.94	$3,671,588.90	$3,890,494.67	$4,179,773.40	$3,734,760.24	$3,697,236.68	$3,723,592.31	$3,893,630.55	$4,261,769.12	$3,480,588.96	$3,578,177.70	$44,884,716.71
Outpatient claim payments	$3,309,676.36	$2,806,335.59	$3,369,928.37	$3,331,532.07	$3,391,367.63	$3,008,996.08	$3,088,430.29	$3,058,296.12	$3,166,371.88	$3,330,579.16	$2,979,438.66	$2,776,505.17	$37,617,457.39
DME claim payments	$312,889.25	$314,206.54	$338,801.46	$331,462.92	$368,072.37	$340,836.41	$326,618.05	$299,232.14	$330,175.12	$282,849.68	$225,069.62	$257,356.17	$3,727,569.74
Total Part B claims	$7,118,556.85	$6,397,655.07	$7,380,318.72	$7,553,489.66	$7,939,213.40	$7,084,592.73	$7,112,285.03	$7,081,120.56	$7,390,177.55	$7,875,197.97	$6,685,097.25	$6,612,039.04	$86,229,743.84
Supplemental data													
Adjustments to paid claim amount													$0.00
Sequestration	$0.00	$0.00	$0.00	$349,074.18	$363,420.44	$336,683.09	$351,340.52	$352,291.73	$326,403.59	$356,911.03	$329,822.75	$327,142.07	$3,093,089.40
Operating DSH	$461,176.54	$470,036.94	$466,704.90	$453,494.21	$391,938.47	$411,208.32	$479,102.97	$448,087.95	$415,646.41	$106,514.45	$110,154.39	$115,923.51	$4,329,989.05
Uncompensated Care Payments	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$448,359.24	$640,133.36	$472,040.87	$1,560,533.47
PBP reduction	0	0	0	0	0	0	0	0	0	0	0	0	$0.00
Claims incurred by opt-outs	$1,609,435.40	$1,383,819.41	$1,596,160.20	$1,368,370.77	$1,549,261.33	$1,596,955.22	$1,609,666.60	$1,382,709.80	$1,113,166.82	$1,147,254.82	$1,192,705.03	$1,463,535.50	$17,013,040.90
Claims with suppresed SA data	$787,557.62	$344,267.27	$555,028.43	$880,888.69	$899,283.88	$849,619.77	$368,415.67	$352,150.81	$684,533.62	$363,763.72	$349,084.40	$647,610.45	$7,082,204.32
Paid claim amount PBPM													
Total paid claims	$1,514.48	$1,424.84	$1,542.10	$1,464.31	$1,535.14	$1,432.07	$1,504.87	$1,519.43	$1,417.64	$1,560.93	$1,452.57	$1,450.81	$1,485.08
Part A claims													
Inpatient claim payments	$628.72	$610.38	$603.30	$542.52	$555.47	$549.21	$608.44	$603.02	$500.10	$574.19	$571.68	$562.18	$576.15
SNF claim payments	$145.03	$137.86	$164.84	$130.99	$143.47	$125.17	$131.09	$147.05	$126.27	$132.89	$138.80	$133.07	$138.15
HHA claim payments	$97.29	$93.45	$101.63	$102.35	$109.72	$99.09	$103.47	$106.94	$95.63	$106.83	$95.16	$113.55	$102.04
Hospice claim payments	$46.61	$42.99	$44.86	$41.80	$42.06	$43.61	$40.17	$39.14	$40.60	$44.12	$46.07	$43.59	$42.98
Total Part A claims	$917.64	$884.68	$914.63	$817.67	$850.72	$817.09	$883.16	$896.15	$762.60	$858.04	$851.72	$852.38	$859.31
Part B claims													
Physician claim payments	$293.12	$276.69	$312.16	$333.06	$360.33	$324.20	$323.19	$327.75	$345.12	$380.38	$312.83	$323.85	$325.73
Outpatient claim payments	$277.49	$236.94	$286.51	$285.21	$292.36	$261.20	$269.97	$269.19	$280.66	$297.27	$267.79	$251.29	$272.99
DME claim payments	$26.23	$26.53	$28.80	$28.38	$31.73	$29.59	$28.55	$26.34	$29.27	$25.25	$20.23	$23.29	$27.05
Total Part B claims	$596.84	$540.16	$627.47	$646.65	$684.41	$614.98	$621.70	$623.28	$655.04	$702.89	$600.85	$598.43	$625.78

Figure 10: Aged Dual Detail Tab

	Claims incurred in specified month that have been paid through Mar 2017 (Paid Claim for Any Provider - Aged_dual)												
	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	CY2016
Pioneer ACO experience													
Aligned beneficiaries (months)	11,927	11,844	11,762	11,681	11,600	11,520	11,440	11,361	11,282	11,204	11,126	11,049	137,796
Paid claim amount													
Total paid claims	$18,063,248.08	$16,875,846.49	$18,138,184.10	$17,104,634.68	$17,807,601.54	$16,497,471.29	$17,215,685.52	$17,262,294.59	$15,993,776.09	$17,488,640.59	$16,161,314.72	$16,029,961.63	$204,638,659.32
Part A claims													$0.00
Inpatient claim payments	$7,498,712.47	$7,229,359.91	$7,095,974.03	$6,337,162.47	$6,443,477.38	$6,326,950.07	$6,960,513.88	$6,850,919.33	$5,642,141.16	$6,433,253.40	$6,360,517.03	$6,211,518.52	$79,390,499.65
SNF claim payments	$1,729,730.05	$1,632,825.81	$1,938,831.47	$1,530,134.75	$1,664,292.63	$1,441,975.29	$1,499,624.09	$1,670,608.20	$1,424,592.69	$1,488,943.82	$1,544,310.37	$1,470,254.90	$19,036,124.06
HHA claim payments	$1,160,371.79	$1,106,847.18	$1,195,368.25	$1,195,570.97	$1,272,706.33	$1,141,543.75	$1,183,663.86	$1,214,955.86	$1,078,853.73	$1,196,953.18	$1,058,799.41	$1,254,575.10	$14,060,209.40
Hospice claim payments	$555,876.92	$509,158.52	$527,691.63	$488,276.84	$487,911.79	$502,409.44	$459,598.67	$444,690.64	$458,010.96	$494,292.22	$512,590.67	$481,574.06	$5,922,082.36
Total Part A claims	$10,944,691.22	$10,478,191.42	$10,757,865.38	$9,551,145.02	$9,868,388.13	$9,412,878.56	$10,103,400.50	$10,181,174.03	$8,603,598.53	$9,613,442.63	$9,476,217.47	$9,417,922.59	$118,408,915.48
Part B claims													$0.00
Physician claim payments	$3,495,991.24	$3,277,112.94	$3,671,588.90	$3,890,494.67	$4,179,773.40	$3,734,760.24	$3,697,236.68	$3,723,592.31	$3,893,630.55	$4,261,769.12	$3,480,588.96	$3,578,177.70	$44,884,716.71
Outpatient claim payments	$3,309,676.36	$2,806,335.59	$3,369,928.37	$3,331,532.07	$3,391,367.63	$3,008,996.08	$3,088,430.29	$3,058,296.12	$3,166,371.88	$3,330,579.16	$2,979,438.66	$2,776,505.17	$37,617,457.39
DME claim payments	$312,889.25	$314,206.54	$338,801.46	$331,462.92	$368,072.37	$340,836.41	$326,618.05	$299,232.14	$330,175.12	$282,849.68	$225,069.62	$257,356.17	$3,727,569.74
Total Part B claims	$7,118,556.85	$6,397,655.07	$7,380,318.72	$7,553,489.66	$7,939,213.40	$7,084,592.73	$7,112,285.03	$7,081,120.56	$7,390,177.55	$7,875,197.97	$6,685,097.25	$6,612,039.04	$86,229,743.84
Supplemental data													
Adjustments to paid claim amount													$0.00
Sequestration	$0.00	$0.00	$0.00	$349,074.18	$363,420.44	$336,683.09	$351,340.52	$352,291.73	$326,403.59	$356,911.03	$329,822.75	$327,142.07	$3,093,089.40
Operating DSH	$461,176.54	$470,036.94	$466,704.90	$453,494.21	$391,938.47	$411,208.32	$479,102.97	$448,087.95	$415,646.41	$106,514.45	$110,154.39	$115,923.51	$4,329,989.05
Uncompensated Care Payments	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$448,359.24	$640,133.36	$472,040.87	$1,560,533.47
PBP reduction	0	0	0	0	0	0	0	0	0	0	0	0	$0.00
Claims incurred by opt-outs	$1,609,435.40	$1,383,819.41	$1,596,160.20	$1,368,370.77	$1,549,261.33	$1,596,955.22	$1,609,666.60	$1,382,709.80	$1,113,166.82	$1,147,254.82	$1,192,705.03	$1,463,535.50	$17,013,040.90
Claims with suppresed SA data	$787,557.62	$344,267.27	$555,028.43	$880,888.69	$899,283.88	$849,619.77	$368,415.67	$352,150.81	$684,533.62	$363,763.72	$349,084.40	$647,610.45	$7,082,204.32
Paid claim amount PBPM													
Total paid claims	$1,514.48	$1,424.84	$1,542.10	$1,464.31	$1,535.14	$1,432.07	$1,504.87	$1,519.43	$1,417.64	$1,560.93	$1,452.57	$1,450.81	$1,485.08
Part A claims													
Inpatient claim payments	$628.72	$610.38	$603.30	$542.52	$555.47	$549.21	$608.44	$603.02	$500.10	$574.19	$571.68	$562.18	$576.15
SNF claim payments	$145.03	$137.86	$164.84	$130.99	$143.47	$125.17	$131.09	$147.05	$126.27	$132.89	$138.80	$133.07	$138.15
HHA claim payments	$97.29	$93.45	$101.63	$102.35	$109.72	$99.09	$103.47	$106.94	$95.63	$106.83	$95.16	$113.55	$102.04
Hospice claim payments	$46.61	$42.99	$44.86	$41.80	$42.06	$43.61	$40.17	$39.14	$40.60	$44.12	$46.07	$43.59	$42.98
Total Part A claims	$917.64	$884.68	$914.63	$817.67	$850.72	$817.09	$883.16	$896.15	$762.60	$858.04	$851.72	$852.38	$859.31
Part B claims													
Physician claim payments	$293.12	$276.69	$312.16	$333.06	$360.33	$324.20	$323.19	$327.75	$345.12	$380.38	$312.83	$323.85	$325.73
Outpatient claim payments	$277.49	$236.94	$286.51	$285.21	$292.36	$261.20	$269.97	$269.19	$280.66	$297.27	$267.79	$251.29	$272.99
DME claim payments	$26.23	$26.53	$28.80	$28.38	$31.73	$29.59	$28.55	$26.34	$29.27	$25.25	$20.23	$23.29	$27.05
Total Part B claims	$596.84	$540.16	$627.47	$646.65	$684.41	$614.98	$621.70	$623.28	$655.04	$702.89	$600.85	$598.43	$625.78

Figure 11: Disabled Detail Tab

	Claims incurred in specified month that have been paid through Mar 2017 (Paid Claim for Any Provider - Aged_dual)												
	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	CY2016
Pioneer ACO experience													
Aligned beneficiaries (months)	11,927	11,844	11,762	11,681	11,600	11,520	11,440	11,361	11,282	11,204	11,126	11,049	137,796
Paid claim amount													
Total paid claims	$18,063,248.08	$16,875,846.49	$18,138,184.10	$17,104,634.68	$17,807,601.54	$16,497,471.29	$17,215,685.52	$17,262,294.59	$15,993,776.09	$17,488,640.59	$16,161,314.72	$16,029,961.63	$204,638,659.32
Part A claims													$0.00
Inpatient claim payments	$7,498,712.47	$7,229,359.91	$7,095,974.03	$6,337,162.47	$6,443,477.38	$6,326,950.07	$6,960,513.88	$6,850,919.33	$5,642,141.16	$6,433,253.40	$6,360,517.03	$6,211,518.52	$79,390,499.65
SNF claim payments	$1,729,730.05	$1,632,825.81	$1,938,831.47	$1,530,134.75	$1,664,292.63	$1,441,975.29	$1,499,624.09	$1,670,608.20	$1,424,592.69	$1,488,943.82	$1,544,310.37	$1,470,254.90	$19,036,124.06
HHA claim payments	$1,160,371.79	$1,106,847.18	$1,195,368.25	$1,195,570.97	$1,272,706.33	$1,141,543.75	$1,183,663.86	$1,214,955.86	$1,078,853.73	$1,196,953.18	$1,058,799.41	$1,254,575.10	$14,060,209.40
Hospice claim payments	$555,876.92	$509,158.52	$527,691.63	$488,276.84	$487,911.79	$502,409.44	$459,598.67	$444,690.64	$458,010.96	$494,292.22	$512,590.67	$481,574.06	$5,922,082.36
Total Part A claims	$10,944,691.22	$10,478,191.42	$10,757,865.38	$9,551,145.02	$9,868,388.13	$9,412,878.56	$10,103,400.50	$10,181,174.03	$8,603,598.53	$9,613,442.63	$9,476,217.47	$9,417,922.59	$118,408,915.48
Part B claims													$0.00
Physician claim payments	$3,495,991.24	$3,277,112.94	$3,671,588.90	$3,890,494.67	$4,179,773.40	$3,734,760.24	$3,697,236.68	$3,723,592.31	$3,893,630.55	$4,261,769.12	$3,480,588.96	$3,578,177.70	$44,884,716.71
Outpatient claim payments	$3,309,676.36	$2,806,335.59	$3,369,928.37	$3,331,532.07	$3,391,367.63	$3,008,996.08	$3,088,430.29	$3,058,296.12	$3,166,371.88	$3,330,579.16	$2,979,438.66	$2,776,505.17	$37,617,457.39
DME claim payments	$312,889.25	$314,206.54	$338,801.46	$331,462.92	$368,072.37	$340,836.41	$326,618.05	$299,232.14	$330,175.12	$282,849.68	$225,069.62	$257,356.17	$3,727,569.74
Total Part B claims	$7,118,556.85	$6,397,655.07	$7,380,318.72	$7,553,489.66	$7,939,213.40	$7,084,592.73	$7,112,285.03	$7,081,120.56	$7,390,177.55	$7,875,197.97	$6,685,097.25	$6,612,039.04	$86,229,743.84
Supplemental data													
Adjustments to paid claim amount													$0.00
Sequestration	$0.00	$0.00	$0.00	$349,074.18	$363,420.44	$336,683.09	$351,340.52	$352,291.73	$326,403.59	$356,911.03	$329,822.75	$327,142.07	$3,093,089.40
Operating DSH	$461,176.54	$470,036.94	$466,704.90	$453,494.21	$391,938.47	$411,208.32	$479,102.97	$448,087.95	$415,646.41	$106,514.45	$110,154.39	$115,923.51	$4,329,989.05
Uncompensated Care Payments	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$448,359.24	$640,133.36	$472,040.87	$1,560,533.47
PBP reduction	0	0	0	0	0	0	0	0	0	0	0	0	$0.00
Claims incurred by opt-outs	$1,609,435.40	$1,383,819.41	$1,596,160.20	$1,368,370.77	$1,549,261.33	$1,596,955.22	$1,609,666.60	$1,382,709.80	$1,113,166.82	$1,147,254.82	$1,192,705.03	$1,463,535.50	$17,013,040.90
Claims with suppresed SA data	$787,557.62	$344,267.27	$555,028.43	$880,888.69	$899,283.88	$849,619.77	$368,415.67	$352,150.81	$684,533.62	$363,763.72	$349,084.40	$647,610.45	$7,082,204.32
Paid claim amount PBPM													
Total paid claims	$1,514.48	$1,424.84	$1,542.10	$1,464.31	$1,535.14	$1,432.07	$1,504.87	$1,519.43	$1,417.64	$1,560.93	$1,452.57	$1,450.81	$1,485.08
Part A claims													
Inpatient claim payments	$628.72	$610.38	$603.30	$542.52	$555.47	$549.21	$608.44	$603.02	$500.10	$574.19	$571.68	$562.18	$576.15
SNF claim payments	$145.03	$137.86	$164.84	$130.99	$143.47	$125.17	$131.09	$147.05	$126.27	$132.89	$138.80	$133.07	$138.15
HHA claim payments	$97.29	$93.45	$101.63	$102.35	$109.72	$99.09	$103.47	$106.94	$95.63	$106.83	$95.16	$113.55	$102.04
Hospice claim payments	$46.61	$42.99	$44.86	$41.80	$42.06	$43.61	$40.17	$39.14	$40.60	$44.12	$46.07	$43.59	$42.98
Total Part A claims	$917.64	$884.68	$914.63	$817.67	$850.72	$817.09	$883.16	$896.15	$762.60	$858.04	$851.72	$852.38	$859.31
Part B claims													
Physician claim payments	$293.12	$276.69	$312.16	$333.06	$360.33	$324.20	$323.19	$327.75	$345.12	$380.38	$312.83	$323.85	$325.73
Outpatient claim payments	$277.49	$236.94	$286.51	$285.21	$292.36	$261.20	$269.97	$269.19	$280.66	$297.27	$267.79	$251.29	$272.99
DME claim payments	$26.23	$26.53	$28.80	$28.38	$31.73	$29.59	$28.55	$26.34	$29.27	$25.25	$20.23	$23.29	$27.05
Total Part B claims	$596.84	$540.16	$627.47	$646.65	$684.41	$614.98	$621.70	$623.28	$655.04	$702.89	$600.85	$598.43	$625.78

Figure 12: ESRD Detail Tab

Appendix J: File format – Pioneer ACO Model Monthly Claims Lag Report (1) (2) (3)

The following is the format of the Pioneer ACO Model Monthly Claims Lag Report (1) (2) (3) P***, Performance Year YYYY.

Table 6-2
Pioneer ACO Model
Monthly Claims Lag Report (1) (2) (3)
P* , Performance Year YYYY**

Month of Payment	Metrics / Month of Service	Total Expenditure			
		Jan-2012	Feb-2012	Mar-2012	Apr-2012
Jan-2012		$X,XXX,XXX.XX			
Feb-2012		$X,XXX,XXX.XX			
Mar-2012		$X,XXX,XXX.XX			
Apr-2012		$X,XXX,XXX.XX			
May-2012		$X,XXX,XXX.XX			
Jun-2012		$X,XXX,XXX.XX	$X,XXX,XXX.XX		
Jul-2012		$X,XXX,XXX.XX	$X,XXX,XXX.XX	$X,XXX,XXX.XX	
Aug-2012		$X,XXX,XXX.XX	$X,XXX,XXX.XX	$X,XXX,XXX.XX	$X,XXX,XXX.XX
Sep-2012		$X,XXX,XXX.XX	$X,XXX,XXX.XX	$X,XXX,XXX.XX	$X,XXX,XXX.XX
Oct-2012		$X,XXX,XXX.XX	$X,XXX,XXX.XX	$X,XXX,XXX.XX	$X,XXX,XXX.XX
Nov-2012		$X,XXX,XXX.XX	$X,XXX,XXX.XX	$X,XXX,XXX.XX	$X,XXX,XXX.XX

Notes:
(1) Expenditures reported are Total expenditures.
(2) Expenditures are uncapped.
(3) Data is included for aligned beneficiaries based on the current alignment data at the time the report is run.

It is possible for certain types of claims to have a through date that is later than the date on which the payment is effective. These typically involve claims for DME. These claims amounts should be attributed to the month in which the payment occurs even though the payment covers services provided through the later period.

Created on 1/18/2013 12:36:41 PM

Figure 13: Format of Report 6-2

Appendix K: File Format – Pioneer ACO Model Provider Specific Payment Reduction Report

Inpatient expenditure from participating facilities

				May 2014 experience (1)				
Organization NPI	CCN	TIN	Participating Provider Name	Beneficiaries with claims (3)	Total incurred claims (4)	Claims incurred by opt-outs (5)	Full FFS payment amount (6)	FFS fee reduction amount (7)
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 1	0	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX
Total					$XXX,XXX.XX			$XXX,XXX.XX

Notes

(1) Experience during the specified calendar month
(2) Cumulative experience during the current performance year through the current month.
(3) Number of beneficiaries with claims of the specified type (inpatient, snf, etc.) during the reporting period
(4) Total amount paid for claims incurred during the specified reporting period. The amount paid reflects the amount of any FFS fee reduction agreed to by the
(5) Total amount paid for claims incurred by beneficiaries opting out of the data sharing.
(6) Total amount that would have been paid in the absence of fee reductions.
(7) Total amount of the fee reduction will not be exactly equal to the difference between total incurred claims and full FFS payment amount due to sequestration.

Figure 14: Report 6-3 Inpatient PSP Reduction Report

SNF expenditure from participating providers

				May 2014 experience (1)				
Organization NPI	CCN	TIN	Participating Provider Name	Beneficiaries with claims (3)	Total incurred claims (4)	Claims incurred by opt-outs (5)	Full FFS payment amount (6)	FFS fee reduction amount (7)
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 1	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 2	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 3	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 4	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 5	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 6	2	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
Total					$X,XXX.XX			$X,XXX.XX

Notes

(1) Experience during the specified calendar month
(2) Cumulative experience during the current performance year through the current month.
(3) Number of beneficiaries with claims of the specified type (inpatient, snf, etc.) during the reporting period
(4) Total amount paid for claims incurred during the specified reporting period. The amount paid reflects the amount of any FFS fee reduction agreed to by the
(5) Total amount paid for claims incurred by beneficiaries opting out of the data sharing.
(6) Total amount that would have been paid in the absence of fee reductions.
(7) Total amount of the fee reduction will not be exactly equal to the difference between total incurred claims and full FFS payment amount due to sequestration.

Figure 15: Report 6-3 SNF PSP Reduction Report

HHA expenditure from participating providers

				May 2014 experience (1)				
Organization NPI	CCN	TIN	Participating Provider Name	Beneficiaries with claims (3)	Total incurred claims (4)	Claims incurred by opt-outs (5)	Full FFS payment amount (6)	FFS fee reduction amount (7)
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 1	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 2	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 3	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 4	6	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 5	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 6	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
Total					$X,XXX.XX			$X,XXX.XX

Notes

(1) Experience during the specified calendar month
(2) Cumulative experience during the current performance year through the current month.
(3) Number of beneficiaries with claims of the specified type (inpatient, snf, etc.) during the reporting period
(4) Total amount paid for claims incurred during the specified reporting period. The amount paid reflects the amount of any FFS fee reduction agreed to by the
(5) Total amount paid for claims incurred by beneficiaries opting out of the data sharing.
(6) Total amount that would have been paid in the absence of fee reductions.
(7) Total amount of the fee reduction will not be exactly equal to the difference between total incurred claims and full FFS payment amount due to sequestration.

Figure 16: Report 6-3 HHA PSP Reduction Report

Hospice expenditure from participating providers

				May 2014 experience (1)				
Organization NPI	CCN	TIN	Participating Provider Name	Beneficiaries with claims (3)	Total incurred claims (4)	Claims incurred by opt-outs (5)	Full FFS payment amount (6)	FFS fee reduction amount (7)
XXXXXXXX	XXXXX	XXXXXXXX	General Provider 1	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXX	XXXXXXXX	General Provider 2	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXX	XXXXXXXX	General Provider 3	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXX	XXXXXXXX	General Provider 4	6	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXX	XXXXXXXX	General Provider 5	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXX	XXXXXXXX	General Provider 6	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXX	XXXXXXXX	General Provider 7	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXX	XXXXXXXX	General Provider 8	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXX	XXXXXXXX	General Provider 9	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXX	XXXXXXXX	General Provider 10	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXX	XXXXXXXX	General Provider 11	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXX	XXXXXXXX	General Provider 12	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXX	XXXXXXXX	General Provider 13	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXX	XXXXXXXX	General Provider 14	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
Total					$X,XXX.XX			$X,XXX.XX

Notes

(1) Experience during the specified calendar month
(2) Cumulative experience during the current performance year through the current month.
(3) Number of beneficiaries with claims of the specified type (inpatient, snf, etc.) during the reporting period
(4) Total amount paid for claims incurred during the specified reporting period. The amount paid reflects the amount of any FFS fee reduction agreed to by the
(5) Total amount paid for claims incurred by beneficiaries opting out of the data sharing.
(6) Total amount that would have been paid in the absence of fee reductions.

Figure 17: Report 6-3 Hospice PSP Reduction Report

Institutional outpatient expenditure from participating providers

				May 2014 experience (1)				
Organization NPI	CCN	TIN	Participating Provider Name	Beneficiaries with claims (3)	Total incurred claims (4)	Claims incurred by opt-outs (5)	Full FFS payment amount (6)	FFS fee reduction amount (7)
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 1	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 2	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 3	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 4	6	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 5	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 6	0	$XXX.XXX	$XXX.XX	$XXX.XXX	$XXX.XXX
Total					$X,XXX.XX			$X,XXX.XX

Notes

(1) Experience during the specified calendar month
(2) Cumulative experience during the current performance year through the current month.
(3) Number of beneficiaries with claims of the specified type (inpatient, snf, etc.) during the reporting period
(4) Total amount paid for claims incurred during the specified reporting period. The amount paid reflects the amount of any FFS fee reduction agreed to by the
(5) Total amount paid for claims incurred by beneficiaries opting out of the data sharing.
(6) Total amount that would have been paid in the absence of fee reductions.
(7) Total amount of the fee reduction will not be exactly equal to the difference between total incurred claims and full FFS payment amount due to sequestration.

Figure 18: Report 6-3 Outpatient PSP Reduction Report

Physician expenditure from participating providers

				May 2014 experience (1)				
Individual NPI	Billing TIN	First Name	Last Name	Beneficiaries with claims (3)	Total incurred claims (4)	Claims incurred by opt-outs (5)	Full FFS payment amount (6)	FFS fee reduction amount (7)
XXXXXXXXXXX	XXXXXXX	John	Doe	0	$0.00	$0.00	$0.00	$0.00
Total					$0.00			$0.00

Notes

(1) Experience during the specified calendar month
(2) Cumulative experience during the current performance year through the current month.
(3) Number of beneficiaries with claims of the specified type (inpatient, snf, etc.) during the reporting period
(4) Total amount paid for claims incurred during the specified reporting period. The amount paid reflects the amount of any FFS fee reduction agreed to by the
(5) Total amount paid for claims incurred by beneficiaries opting out of the data sharing.
(6) Total amount that would have been paid in the absence of fee reductions.
(7) Total amount of the fee reduction will not be equal to the difference between total incurred claims and full FFS payment amount due to sequestration.

Figure 19: Report 6-3 Physician PSP Reduction Report

DMEPOS supplier expenditure from participating providers

			May 2014 experience (1)				
Organization NPI	Billing TIN	Supplier Name	Beneficiaries with claims (3)	Total incurred claims (4)	Claims incurred by opt-outs (5)	Full FFS payment amount (6)	FFS fee reduction amount (7)
XXXXXXXXX	XXXXXXXX	Medical Supply, Inc 1	0	$0.00	$0.00	$0.00	$0.00
XXXXXXXXX	XXXXXXXX	Medical Supply, Inc 2	0	$0.00	$0.00	$0.00	$0.00
Total				$0.00			$0.00

Notes

(1) Experience during the specified calendar month
(2) Cumulative experience during the current performance year through the current month.
(3) Number of beneficiaries with claims of the specified type (inpatient, snf, etc.) during the reporting period
(4) Total amount paid for claims incurred during the specified reporting period. The amount paid reflects the amount of any FFS fee reduction agreed to by the
(5) Total amount paid for claims incurred by beneficiaries opting out of the data sharing.
(6) Total amount that would have been paid in the absence of fee reductions.
(7) Total amount of the fee reduction will not be exactly equal to the difference between total incurred claims and full FFS payment amount due to sequestration.

Figure 20: Report 6-3 DME PSP Reduction Report

Inpatient expenditure from participating facilities

				May 2014 experience (1)				
Organization NPI	CCN	TIN	Participating Provider Name	Beneficiaries with claims (3)	Total incurred claims (4)	Claims incurred by opt-outs (5)	Full FFS payment amount (6)	FFS fee reduction amount (7)
XXXXXXXX	XXXXXX	XXXXXXXX	General Provider 1	0	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX
Total					$XXX,XXX.XX			$XXX,XXX.XX

Notes

(1) Experience during the specified calendar month
(2) Cumulative experience during the current performance year through the current month.
(3) Number of beneficiaries with claims of the specified type (inpatient, snf, etc.) during the reporting period
(4) Total amount paid for claims incurred during the specified reporting period. The amount paid reflects the amount of any FFS fee reduction agreed to by the
(5) Total amount paid for claims incurred by beneficiaries opting out of the data sharing.
(6) Total amount that would have been paid in the absence of fee reductions.
(7) Total amount of the fee reduction will not be exactly equal to the difference between total incurred claims and full FFS payment amount due to sequestration.

Figure 21: Inpatient PSP Reduction Report

Appendix L: File Format – Pioneer ACO Model Monthly Beneficiary Entitlement Category Report

The Monthly Beneficiary Entitlement Category Report (Report 6-4) shall display the following data fields:

- Current Medicare Health Insurance Claim Number (HICN)
- First Name
- Last Name
- Gender
- Date of Birth (MMDDCCYY)
- Calendar Month
- Date of Death (MMDDCCYY)
- Entitlement Category

Current HICN	First Name	Last Name	Gender	Date of Birth	Calendar Month	Date of Death	Entitlement Category
AXXXXXXXX1	John	Doe	M	01/01/1945	201501		ESRD
AXXXXXXXX1	John	Doe	M	01/01/1945	201502		ESRD

Figure 22: Format of Report 6-4

Appendix M: Pioneer ACO Program Monthly Reference Population Expenditure Report

The following are the report formats for each tab of the Pioneer ACO Program Monthly Reference Population Expenditure Report.

	Claims incurred in specified month that have been paid through Mar 2017 (Paid Claim for ACO Providers - Summary)												
	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	CY2016
Pioneer ACO experience													
Aligned beneficiaries (months)	51,910	51,633	51,401	51,164	50,940	50,732	50,513	50,311	50,079	49,866	49,637	49,414	607,600
Aged/non-dual	34,577	34,404	34,275	34,140	34,018	33,910	33,791	33,688	33,555	33,440	33,309	33,183	406,290
Aged/dual	11,927	11,844	11,762	11,681	11,600	11,520	11,440	11,361	11,282	11,204	11,126	11,049	137,796
Disabled	4,914	4,902	4,890	4,878	4,866	4,854	4,842	4,830	4,818	4,806	4,794	4,782	58,176
ESRD	492	483	474	465	456	448	440	432	424	416	408	400	5,338
Paid claim amount													
Total paid claims	$66,505,133.08	$61,170,554.89	$67,238,285.81	$63,016,192.58	$66,296,412.02	$61,310,069.03	$63,982,928.13	$64,217,639.34	$59,475,534.07	$65,933,600.33	$61,027,612.29	$59,420,964.75	$759,594,926.33
Aged/non-dual	$38,849,640.08	$35,935,985.09	$39,051,195.14	$36,916,656.87	$39,089,668.30	$35,755,881.59	$37,625,884.09	$37,759,518.21	$35,116,762.09	$39,063,667.43	$36,190,858.58	$35,246,991.21	$446,602,708.68
Aged/dual	$18,063,248.08	$16,875,846.49	$18,138,184.10	$17,104,634.68	$17,807,601.54	$16,497,471.29	$17,215,685.52	$17,262,294.59	$15,993,776.09	$17,488,640.59	$16,161,314.72	$16,029,961.63	$204,638,659.32
Disabled	$6,281,247.04	$5,422,315.43	$6,661,676.85	$5,769,389.13	$6,236,786.05	$6,065,404.55	$6,152,465.33	$6,283,935.66	$5,531,682.32	$6,461,206.25	$5,895,487.87	$5,508,573.86	$72,270,170.33
ESRD	$3,310,997.88	$2,936,407.88	$3,387,229.72	$3,225,511.90	$3,162,356.14	$2,991,311.60	$2,988,893.19	$2,911,890.87	$2,833,313.57	$2,920,086.06	$2,779,951.13	$2,635,438.05	$36,083,387.99
Part A claims													
Inpatient claim payments	$27,631,567.33	$25,176,057.54	$25,873,485.34	$22,782,854.93	$24,102,536.45	$22,710,751.00	$24,961,752.27	$24,930,178.44	$20,843,746.07	$24,287,152.92	$23,798,226.87	$22,098,979.12	$289,197,288.28
SNF claim payments	$6,047,490.09	$5,865,943.12	$6,944,133.67	$5,502,152.05	$5,841,462.77	$5,189,225.14	$5,488,919.34	$6,065,232.77	$5,256,221.87	$5,377,703.82	$5,701,381.48	$5,469,116.79	$68,748,982.91
HHA claim payments	$4,203,269.28	$3,979,084.27	$4,406,390.72	$4,231,664.24	$4,603,291.33	$4,143,023.23	$4,263,073.62	$4,303,840.61	$4,007,275.23	$4,498,185.29	$3,927,509.42	$4,721,133.54	$51,287,740.78
Hospice claim payments	$1,974,655.46	$1,878,762.84	$1,909,048.79	$1,804,731.28	$1,818,248.59	$1,789,451.25	$1,734,550.46	$1,671,998.63	$1,692,274.99	$1,847,869.91	$1,871,297.50	$1,775,545.16	$21,768,434.86
Total Part A claims	$39,856,982.16	$36,899,847.76	$39,133,058.52	$34,321,402.50	$36,365,539.14	$33,832,450.63	$36,448,295.69	$36,971,250.46	$31,799,518.15	$36,010,911.94	$35,298,415.27	$34,064,774.62	$431,002,446.84
Part B claims													
Physician claim payments	$12,742,927.96	$12,322,615.25	$13,975,191.33	$14,797,783.57	$15,358,652.58	$14,209,004.83	$14,188,180.05	$14,017,525.40	$14,441,245.68	$15,668,839.32	$13,441,055.04	$13,345,497.56	$168,508,518.58
Outpatient claim payments	$12,715,408.03	$10,798,784.42	$12,829,602.25	$12,653,013.36	$13,219,203.68	$12,008,052.27	$12,145,915.04	$12,099,293.82	$12,017,430.55	$13,175,743.61	$11,412,032.03	$11,022,238.27	$146,096,717.33
DME claim payments	$1,189,814.92	$1,149,307.46	$1,300,433.71	$1,243,993.15	$1,353,016.62	$1,260,561.31	$1,200,537.34	$1,129,569.66	$1,217,339.69	$1,078,105.47	$876,109.94	$988,454.31	$13,987,243.58
Total Part B claims	$26,648,150.92	$24,270,707.13	$28,105,227.29	$28,694,790.08	$29,930,872.88	$27,477,618.41	$27,534,632.44	$27,246,388.88	$27,676,015.92	$29,922,688.39	$25,729,197.02	$25,356,190.14	$328,592,479.49
Supplemental data													
Adjustments to paid claim amount													
Sequestration	$0.00	$0.00	$0.00	$1,281,571.27	$1,350,790.80	$1,249,247.30	$1,305,516.84	$1,310,270.74	$1,212,989.89	$1,344,123.31	$1,243,794.87	$1,203,887.05	$11,502,192.05
Operating DSH	$1,685,885.27	$1,603,662.30	$1,652,564.22	$1,605,908.07	$1,522,078.24	$1,482,927.89	$1,686,503.16	$1,612,588.75	$1,499,343.51	$411,581.34	$429,575.87	$413,560.85	$15,606,179.48
Uncompensated Care Payments	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,657,186.21	$2,406,596.17	$1,620,306.48	$5,684,088.85
PBP reduction	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Claims incurred by opt-outs	$6,768,469.60	$5,663,283.73	$6,382,083.48	$5,797,618.35	$6,235,106.68	$6,386,685.42	$6,589,311.15	$5,510,204.17	$4,520,254.19	$4,921,607.68	$5,110,447.37	$6,138,264.76	$70,023,336.59
Claims with suppresed SA data	$2,746,793.71	$1,237,435.70	$2,049,168.02	$3,215,330.88	$3,337,779.15	$3,102,297.69	$1,305,588.79	$1,300,361.50	$2,440,587.91	$1,346,964.76	$1,253,973.81	$2,401,837.11	$25,738,119.02

Figure 23: Report 6-5 Summary Report

	Claims incurred in specified month that have been paid through Mar 2017 (Paid Claim for ACO Providers - Aged_non dual)												
	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	CY2016
Pioneer ACO experience													
Aligned beneficiaries (months)	34,577	34,404	34,275	34,140	34,018	33,910	33,791	33,688	33,555	33,440	33,309	33,183	406,290
Paid claim amount													
Total paid claims	$38,849,640.08	$35,935,985.09	$39,051,195.14	$36,916,656.87	$39,089,668.30	$35,755,881.59	$37,625,884.09	$37,759,518.21	$35,116,762.09	$39,063,667.43	$36,190,858.58	$35,246,991.21	$446,602,708.68
Part A claims													
Inpatient claim payments	$16,345,234.32	$14,999,692.33	$15,317,029.10	$13,618,818.31	$14,535,425.31	$13,398,461.03	$14,898,317.91	$14,828,149.48	$12,712,798.51	$14,657,251.21	$14,425,837.22	$13,420,715.12	$173,157,729.85
SNF claim payments	$3,633,752.42	$3,513,311.27	$4,094,088.83	$3,337,400.85	$3,511,281.74	$3,144,121.80	$3,281,131.67	$3,642,456.45	$3,185,739.19	$3,197,103.39	$3,399,524.83	$3,270,781.56	$41,210,694.00
HHA claim payments	$2,567,922.76	$2,381,575.95	$2,619,065.52	$2,550,576.10	$2,785,314.19	$2,452,716.23	$2,570,777.56	$2,573,304.22	$2,468,256.91	$2,727,087.27	$2,401,387.79	$2,898,317.68	$30,996,302.18
Hospice claim payments	$1,167,765.52	$1,120,442.62	$1,147,550.21	$1,072,995.68	$1,100,648.76	$1,071,652.59	$1,044,264.29	$1,014,316.07	$1,039,862.04	$1,117,642.77	$1,120,140.93	$1,087,437.04	$13,104,718.52
Total Part A claims	$23,714,675.02	$22,015,022.17	$23,177,733.66	$20,579,790.94	$21,932,670.00	$20,066,951.65	$21,794,491.43	$22,058,226.22	$19,406,656.65	$21,699,084.64	$21,346,890.77	$20,677,251.40	$258,469,444.55
Part B claims													
Physician claim payments	$7,397,855.76	$7,211,540.02	$8,105,436.45	$8,614,188.81	$8,947,113.74	$8,143,371.89	$8,273,291.80	$8,178,751.73	$8,271,758.63	$9,150,994.34	$7,954,336.90	$7,675,851.11	$97,924,491.18
Outpatient claim payments	$7,055,092.47	$6,038,323.50	$7,014,374.06	$7,005,073.41	$7,421,998.46	$6,813,238.33	$6,859,005.98	$6,870,119.17	$6,726,746.05	$7,588,250.05	$6,371,313.17	$6,317,092.40	$82,080,627.05
DME claim payments	$682,016.83	$671,099.40	$753,650.97	$717,603.71	$787,886.10	$732,319.72	$699,094.88	$652,421.09	$711,600.76	$625,338.40	$518,317.74	$576,796.30	$8,128,145.90
Total Part B claims	$15,134,965.06	$13,920,962.92	$15,873,461.48	$16,336,865.93	$17,156,998.30	$15,688,929.94	$15,831,392.66	$15,701,291.99	$15,710,105.44	$17,364,582.79	$14,843,967.81	$14,569,739.81	$188,133,264.13
Supplemental data													
Adjustments to paid claim amount													
Sequestration	$0.00	$0.00	$0.00	$748,927.68	$795,551.13	$727,733.27	$767,617.98	$770,309.08	$715,872.09	$795,757.33	$736,922.35	$710,540.65	$6,769,231.56
Operating DSH	$995,291.47	$946,841.46	$968,660.39	$946,191.64	$930,682.87	$870,807.98	$1,005,367.00	$950,826.32	$909,251.49	$250,183.51	$262,982.48	$252,996.32	$9,290,082.93
Uncompensated Care Payments	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$991,769.56	$1,466,506.09	$971,333.07	$3,429,608.72
PBP reduction	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Claims incurred by opt-outs	$4,273,460.41	$3,593,598.51	$3,905,119.51	$3,691,665.69	$3,908,966.83	$3,933,146.97	$4,138,847.25	$3,398,356.64	$2,809,340.97	$3,125,093.39	$3,257,177.27	$3,877,169.03	$43,911,942.48
Claims with suppressed SA data	$1,553,985.60	$718,719.70	$1,171,535.85	$1,845,832.84	$1,954,483.42	$1,787,794.08	$752,517.68	$755,190.36	$1,404,670.48	$781,273.35	$723,817.17	$1,409,879.65	$14,859,700.20

Figure 24: Report 6-5 Aged Non-Dual Report

	Claims incurred in specified month that have been paid through Mar 2017 (Paid Claim for ACO Providers - Aged_dual)												
	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	CY2016
Pioneer ACO experience													
Aligned beneficiaries (months)	11,927	11,844	11,762	11,681	11,600	11,520	11,440	11,361	11,282	11,204	11,126	11,049	137,796
Paid claim amount													
Total paid claims	$18,063,248.08	$16,875,846.49	$18,138,184.10	$17,104,634.68	$17,807,601.54	$16,497,471.29	$17,215,685.52	$17,262,294.59	$15,993,776.09	$17,488,640.59	$16,161,314.72	$16,029,961.63	$204,638,659.32
Part A claims													$0.00
Inpatient claim payments	$7,498,712.47	$7,229,359.91	$7,095,974.03	$6,337,162.47	$6,443,477.38	$6,326,950.07	$6,960,513.88	$6,850,919.33	$5,642,141.16	$6,433,253.40	$6,360,517.03	$6,211,518.52	$79,390,499.65
SNF claim payments	$1,729,730.05	$1,632,825.81	$1,938,831.47	$1,530,134.75	$1,664,292.63	$1,441,975.29	$1,499,624.09	$1,670,608.20	$1,424,592.69	$1,488,943.82	$1,544,310.37	$1,470,254.90	$19,036,124.06
HHA claim payments	$1,160,371.79	$1,106,847.18	$1,195,368.25	$1,195,570.97	$1,272,706.33	$1,141,543.75	$1,183,663.86	$1,214,955.86	$1,078,853.73	$1,196,953.18	$1,058,799.41	$1,254,575.10	$14,060,209.40
Hospice claim payments	$555,876.92	$509,158.52	$527,691.63	$488,276.84	$487,911.79	$502,409.44	$459,598.67	$444,690.64	$458,010.96	$494,292.22	$512,590.67	$481,574.06	$5,922,082.36
Total Part A claims	$10,944,691.22	$10,478,191.42	$10,757,865.38	$9,551,145.02	$9,868,388.13	$9,412,878.56	$10,103,400.50	$10,181,174.03	$8,603,598.53	$9,613,442.63	$9,476,217.47	$9,417,922.59	$118,408,915.48
Part B claims													$0.00
Physician claim payments	$3,495,991.24	$3,277,112.94	$3,671,588.90	$3,890,494.67	$4,179,773.40	$3,734,760.24	$3,697,236.68	$3,723,592.31	$3,893,630.55	$4,261,769.12	$3,480,588.96	$3,578,177.70	$44,884,716.71
Outpatient claim payments	$3,309,676.36	$2,806,335.59	$3,369,928.37	$3,331,532.07	$3,391,367.63	$3,008,996.08	$3,088,430.29	$3,058,296.12	$3,166,371.88	$3,330,579.16	$2,979,438.66	$2,776,505.17	$37,617,457.39
DME claim payments	$312,889.25	$314,206.54	$338,801.46	$331,462.92	$368,072.37	$340,836.41	$326,618.05	$299,232.14	$330,175.12	$282,849.68	$225,069.62	$257,356.17	$3,727,569.74
Total Part B claims	$7,118,556.85	$6,397,655.07	$7,380,318.72	$7,553,489.66	$7,939,213.40	$7,084,592.73	$7,112,285.03	$7,081,120.56	$7,390,177.55	$7,875,197.97	$6,685,097.25	$6,612,039.04	$86,229,743.84
Supplemental data													
Adjustments to paid claim amount													$0.00
Sequestration	$0.00	$0.00	$0.00	$349,074.18	$363,420.44	$336,683.09	$351,340.52	$352,291.73	$326,403.59	$356,911.03	$329,822.75	$327,142.07	$3,093,089.40
Operating DSH	$461,176.54	$470,036.94	$466,704.90	$453,494.21	$391,938.47	$411,208.32	$479,102.97	$448,087.95	$415,646.41	$106,514.45	$110,154.39	$115,923.51	$4,329,989.05
Uncompensated Care Payments	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$448,359.24	$640,133.36	$472,040.87	$1,560,533.47
PBP reduction	0	0	0	0	0	0	0	0	0	0	0	0	$0.00
Claims incurred by opt-outs	$1,609,435.40	$1,383,819.41	$1,596,160.20	$1,368,370.77	$1,549,261.33	$1,596,955.22	$1,609,666.60	$1,382,709.80	$1,113,166.82	$1,147,254.82	$1,192,705.03	$1,463,535.50	$17,013,040.90
Claims with suppresed SA data	$787,557.62	$344,267.27	$555,028.43	$880,888.69	$899,283.88	$849,619.77	$368,415.67	$352,150.81	$684,533.62	$363,763.72	$349,084.40	$647,610.45	$7,082,204.32

Figure 25: Report 6-5 Aged Dual Report

	Claims incurred in specified month that have been paid through Mar 2017 (Paid Claim for ACO Providers - Disabled)												
	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	CY2016
Pioneer ACO experience													
Aligned beneficiaries (months)	4,914	4,902	4,890	4,878	4,866	4,854	4,842	4,830	4,818	4,806	4,794	4,782	58,176
Paid claim amount													
Total paid claims	$6,281,247.04	$5,422,315.43	$6,661,676.85	$5,769,389.13	$6,236,786.05	$6,065,404.55	$6,152,465.33	$6,283,935.66	$5,531,682.32	$6,461,206.25	$5,895,487.87	$5,508,573.86	$72,270,170.33
Part A claims													$0.00
Inpatient claim payments	$2,787,534.42	$2,073,091.42	$2,600,476.27	$2,062,640.64	$2,328,676.15	$2,263,126.90	$2,305,604.09	$2,444,875.22	$1,825,369.19	$2,443,588.19	$2,283,863.52	$1,818,014.89	$27,236,860.89
SNF claim payments	$464,778.13	$515,606.31	$671,717.24	$448,244.02	$477,147.45	$436,559.13	$535,984.52	$558,791.83	$484,870.36	$523,816.33	$582,239.43	$560,909.02	$6,260,663.79
HHA claim payments	$328,452.30	$352,908.52	$440,919.97	$346,210.45	$394,432.52	$414,286.99	$368,373.38	$376,325.12	$326,052.66	$435,050.34	$349,076.09	$421,853.14	$4,553,941.47
Hospice claim payments	$184,215.63	$181,994.74	$166,994.92	$180,908.20	$168,459.63	$154,934.23	$175,073.34	$157,061.22	$141,843.32	$179,903.05	$182,174.48	$153,576.27	$2,027,139.05
Total Part A claims	$3,764,980.48	$3,123,600.98	$3,880,108.40	$3,038,003.31	$3,368,715.75	$3,268,907.25	$3,385,035.34	$3,537,053.38	$2,778,135.52	$3,582,357.91	$3,397,353.53	$2,954,353.33	$40,078,605.20
Part B claims													$0.00
Physician claim payments	$1,209,070.27	$1,202,204.22	$1,352,987.12	$1,366,204.29	$1,484,582.29	$1,515,373.20	$1,458,166.76	$1,477,506.75	$1,484,627.22	$1,565,066.32	$1,282,207.87	$1,382,708.01	$16,780,704.32
Outpatient claim payments	$1,183,130.25	$989,415.22	$1,290,951.80	$1,241,116.80	$1,252,755.14	$1,160,573.17	$1,199,070.60	$1,152,449.85	$1,149,374.47	$1,199,642.43	$1,127,899.75	$1,065,116.26	$14,011,495.73
DME claim payments	$124,066.04	$107,095.01	$137,629.53	$124,064.73	$130,732.86	$120,550.93	$110,192.63	$116,925.68	$119,545.11	$114,139.59	$88,026.72	$106,396.26	$1,399,365.08
Total Part B claims	$2,516,266.56	$2,298,714.45	$2,781,568.45	$2,731,385.82	$2,868,070.29	$2,796,497.29	$2,767,429.99	$2,746,882.27	$2,753,546.80	$2,878,848.34	$2,498,134.34	$2,554,220.54	$32,191,565.14
Supplemental data													
Adjustments to paid claim amount													$0.00
Sequestration	$0.00	$0.00	$0.00	$117,742.64	$127,281.35	$123,783.77	$125,560.52	$128,243.58	$112,891.48	$131,861.35	$120,316.08	$112,419.87	$1,100,100.63
Operating DSH	$169,738.11	$132,170.56	$162,811.51	$150,470.91	$150,592.88	$154,442.10	$150,918.98	$159,908.34	$127,943.92	$42,543.61	$43,300.14	$32,900.86	$1,477,741.91
Uncompensated Care Payments	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$168,650.03	$225,208.47	$127,632.62	$521,491.13
PBP reduction	0	0	0	0	0	0	0	0	0	0	0	0	$0.00
Claims incurred by opt-outs	$594,205.97	$439,207.55	$592,889.24	$473,089.91	$523,890.03	$560,443.38	$548,184.66	$508,998.79	$398,281.13	$460,037.89	$440,392.94	$545,348.81	$6,084,970.29
Claims with suppresed SA data	$268,837.37	$112,784.16	$211,841.32	$314,431.71	$324,312.87	$309,335.63	$124,279.80	$130,705.86	$230,117.98	$138,269.81	$123,805.25	$235,766.96	$2,524,488.74

Figure 26: Report 6-5 Disabled Report

	Claims incurred in specified month that have been paid through Mar 2017 (Paid Claim for ACO Providers - ESRD)												
	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	CY2016
Pioneer ACO experience													
Aligned beneficiaries (months)	492	483	474	465	456	448	440	432	424	416	408	400	5,338
Paid claim amount													
Total paid claims	$3,310,997.88	$2,936,407.88	$3,387,229.72	$3,225,511.90	$3,162,356.14	$2,991,311.60	$2,988,893.19	$2,911,890.87	$2,833,313.57	$2,920,086.06	$2,779,951.13	$2,635,438.05	$36,083,387.99
Part A claims													$0.00
Inpatient claim payments	$1,000,086.12	$873,913.88	$860,005.94	$764,233.51	$794,957.61	$722,213.01	$797,316.39	$806,234.41	$663,437.21	$753,060.11	$728,009.11	$648,730.59	$9,412,197.89
SNF claim payments	$219,229.49	$204,199.73	$239,496.13	$186,372.43	$188,740.94	$166,568.92	$172,179.06	$193,376.29	$161,019.63	$167,840.28	$175,306.85	$167,171.31	$2,241,501.06
HHA claim payments	$146,522.43	$137,752.61	$151,036.98	$139,306.73	$150,838.30	$134,476.26	$140,258.81	$139,255.42	$134,111.94	$139,094.50	$118,246.13	$146,387.62	$1,677,287.73
Hospice claim payments	$66,797.39	$67,166.96	$66,812.03	$62,550.56	$61,228.40	$60,454.98	$55,614.16	$55,930.70	$52,558.67	$56,031.87	$56,391.42	$52,957.79	$714,494.93
Total Part A claims	$1,432,635.44	$1,283,033.19	$1,317,351.08	$1,152,463.23	$1,195,765.25	$1,083,713.17	$1,165,368.42	$1,194,796.82	$1,011,127.44	$1,116,026.76	$1,077,953.50	$1,015,247.30	$14,045,481.61
Part B claims													$0.00
Physician claim payments	$640,010.70	$631,758.07	$845,178.87	$926,895.80	$747,183.15	$815,499.50	$759,484.81	$637,674.61	$791,229.27	$691,009.53	$723,921.31	$708,760.74	$8,918,606.37
Outpatient claim payments	$1,167,508.95	$964,710.11	$1,154,348.02	$1,075,291.08	$1,153,082.45	$1,025,244.69	$999,408.18	$1,018,428.68	$974,938.15	$1,057,271.97	$933,380.45	$863,524.43	$12,387,137.16
DME claim payments	$70,842.80	$56,906.51	$70,351.75	$70,861.79	$66,325.29	$66,854.25	$64,631.78	$60,990.76	$56,018.70	$55,777.79	$44,695.86	$47,905.57	$732,162.86
Total Part B claims	$1,878,362.45	$1,653,374.70	$2,069,878.64	$2,073,048.67	$1,966,590.89	$1,907,598.44	$1,823,524.77	$1,717,094.05	$1,822,186.12	$1,804,059.29	$1,701,997.63	$1,620,190.75	$22,037,906.38
Supplemental data													
Adjustments to paid claim amount													$0.00
Sequestration	$0.00	$0.00	$0.00	$65,826.77	$64,537.88	$61,047.18	$60,997.82	$59,426.34	$57,822.73	$59,593.59	$56,733.70	$53,784.45	$539,770.46
Operating DSH	$59,679.15	$54,613.34	$54,387.42	$55,751.31	$48,864.02	$46,469.50	$51,114.21	$53,766.15	$46,501.69	$12,339.77	$13,138.86	$11,740.16	$508,365.58
Uncompensated Care Payments	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$48,407.37	$74,748.25	$49,299.92	$172,455.54
PBP reduction	0	0	0	0	0	0	0	0	0	0	0	0	$0.00
Claims incurred by opt-outs	$291,367.81	$246,658.26	$287,914.53	$264,491.98	$252,988.49	$296,139.85	$292,612.64	$220,138.95	$199,465.28	$189,221.58	$220,172.13	$252,211.42	$3,013,382.91
Claims with suppresed SA data	$136,413.11	$61,664.57	$110,762.41	$174,177.64	$159,698.99	$155,548.20	$60,375.64	$62,314.46	$121,265.82	$63,657.88	$57,266.99	$108,580.05	$1,271,725.77

Figure 27: Report 6-5 ESRD Report

Appendix N: File Format – Initial Alignment Report

The following is the list of data elements present on the Alignment Report produced by CMS supporting system.
The Alignment Report is in pipe "|" delimited format.

Table 25: Alignment Report Data Elements

Element #	Element Name	Data Description	Data Length	Format	Comments
1	ACO_NAME	ACO Name	100	VARCHAR(100)	Pioneer ACO's name; this must contain a value.
2	BENE_HIC_NUM	Current HIC NUM	12	VARCHAR(12)	Beneficiary's current HIC NUM; this must contain a value. It can start with an {, a letter, or a number.
3	BENE_1ST_NAME	First Name	30	VARCHAR(30)	Beneficiary's first name; this must contain a value.
4	BENE_LAST_NAME	Last Name	40	VARCHAR(40)	Beneficiary's last name; this must contain a value.
5	BENE_LINE_1_ADR	Address Line 1	45	VARCHAR(45)	First line of the beneficiary's address; this must contain a value.
6	BENE_LINE_2_ADR	Address Line 2	45	VARCHAR(45)	Second line of the beneficiary's address; this value can be blank.
7	BENE_LINE_3_ADR	Address Line 3	40	VARCHAR(40)	Third line of the beneficiary's address; this value can be blank.
8	BENE_LINE_4_ADR	Address Line 4	40	VARCHAR(40)	Fourth line of the beneficiary's address; this value can be blank.
9	BENE_LINE_5_ADR	Address Line 5	40	VARCHAR(40)	Fifth line of the beneficiary's address; this value can be blank.
10	BENE_LINE_6_ADR	Address Line 6	40	VARCHAR(40)	Sixth line of the beneficiary's address; this value can be blank.
11	GEO_ZIP_PLC_NAME	City	100	VARCHAR(100)	City's name for a beneficiary; this value can be blank if outside the United States.

Element #	Element Name	Data Description	Data Length	Format	Comments
12	GEO_USPS_STATE_CD	USPS State Code	2	CHAR(2)	State abbreviation code for a beneficiary; this can be blank if outside the United States.
13	GEO_ZIP5_CD	5 digit zip code	5	CHAR(5)	Beneficiary's 5 digit Zip code; the value can contain blank or a tilde (~), primarily for addresses outside the United States.
14	GEO_ZIP4_CD	4 digit zip code	4	CHAR(4)	Beneficiary's +4 digit Zip code; the value can contain blank or a tilde (~), primarily for addresses outside the United States.
15	BENE_SEX_CD_DESC	Gender	100	VARCHAR(100)	Beneficiary's gender; there may be instances where the data value contains "UNKNOWN."
16	BENE_BRTH_DT	Birth Date	10	YYYY-MM-DD	Beneficiary's birth date.
17	BENE_AGE	Calculated Age	3	INTEGER	Beneficiary's calculated age at the time of alignment or time of death. BENE AGE is calculated based on current system date or death date as follows: (CASE WHEN BENE_DEATH_DT is not null THEN CAST((BENE_DEATH_DT - BENE_BRTH_DT)/365 as Integer) ELSE CAST ((DATE - BENE_BRTH_DT)/365 as integer) END) BENE_AGE
18	BENE_ELGBL_ALGNMNT_YR_1_IND	Beneficiary Eligibility Alignment Year 1	1	CHAR(1)	Identifies if a beneficiary was alignment-eligible based on the AY1 with either a "Y" (Yes) or "N" (No).

Element #	Element Name	Data Description	Data Length	Format	Comments
19	BENE_ELGBL_ALGNMNT_YR_2_IND	Beneficiary Eligibility Alignment Year 2	1	CHAR(1)	Identifies if a beneficiary was alignment-eligible based on the AY2 with either a “Y” (Yes) or “N” (No).
20	BENE_ELGBL_ALGNMNT_YR_3_IND	Beneficiary Eligibility Alignment Year 3	1	CHAR(1)	Identifies if a beneficiary was alignment-eligible based on the AY3 with either a “Y” (Yes) or “N” (No).
21	BENE_PTD_CVRG_ALGNMNT_YR_1_IND	Beneficiary Part D Coverage Alignment Year 1	1	CHAR(1)	Identifies if a beneficiary had Pharmacy Coverage for Part D during alignment year with either a “Y” (Yes) or “N” (No).
22	BENE_PTD_CVRG_ALGNMNT_YR_2_IND	Beneficiary Part D Coverage Alignment Year 2	1	CHAR(1)	Identifies if a beneficiary had Pharmacy Coverage for Part D during alignment year with either a “Y” (Yes) or “N” (No).
23	BENE_PTD_CVRG_ALGNMNT_YR_3_IND	Beneficiary Part D Coverage Alignment Year 3	1	CHAR(1)	Identifies if a beneficiary had Pharmacy Coverage for Part D during alignment year with either a “Y” (Yes) or “N” (No).
24	BENE_ALGNMNT_YR_1_HCC_SCRE_NUM	Final Community Hierarchical Condition Categories Year 1 Indicator	7	DECIMAL(6,4)	The beneficiary’s Part C HCC Score for the calendar year at the start of the AY.
25	BENE_ALGNMNT_YR_2_HCC_SCRE_NUM	Final Community Hierarchical Condition Categories Year 2 Indicator	7	DECIMAL(6,4)	The beneficiary’s Part C HCC Score for the calendar year at the start of the AY.

Element #	Element Name	Data Description	Data Length	Format	Comments
26	BENE_ALGNMNT_YR_3_HCC_SCRE_NUM	Final Community Hierarchical Condition Categories Year 3 Indicator	7	DECIMAL(6,4)	The beneficiary's Part C HCC Score for the calendar year at the start of the AY.
27	PRVDR_ACO_NEW_ALGN_BENE_SW	Newly Aligned Beneficiary Flag	1	CHAR(1)	Identifies if a beneficiary is newly aligned with a "Y" (Yes) or if aligned to the same ACO as the last performance year an "N" (No).

Appendix O: Instructional Aide – Opening Text Files in Excel

(Currently addresses Initial Alignment Report provide in Appendix N:)

1. Copy or save your file to your computer or a secure network drive as a text file.
2. Open Excel.
3. Select **File**, then **Open.**
4. Select the location of the file you saved or copied in Step 1.
5. The first Import Wizard pop-up will display, as shown in Figure 28: Text Import Wizard Step 1.
6. Choose the **Delimited** radio button under **Original data type**.
7. Select the **Next** button at the bottom of the pop-up window.

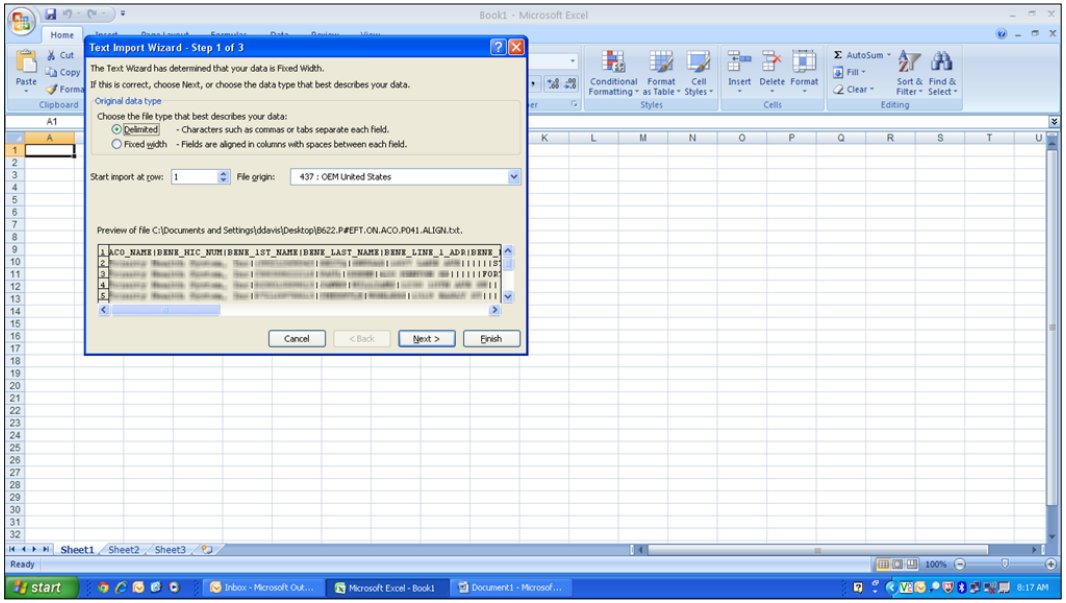


Figure 28: Text Import Wizard Step 1

8. The second Import Wizard pop-up will display, as shown in Figure 29: Text Import Wizard Step 2.

9. Select the **Other** checkbox.
   Note: If the **Tab** checkbox is already selected, you must de-select it.
10. Enter the pipe symbol in the text box next to **Other**.
    Note: To enter the pipe symbol, press the **Shift** key on your keyboard and select the backward slash **(\)** key at the same time.
11. Select the **Next** button at the bottom of the pop-up window.

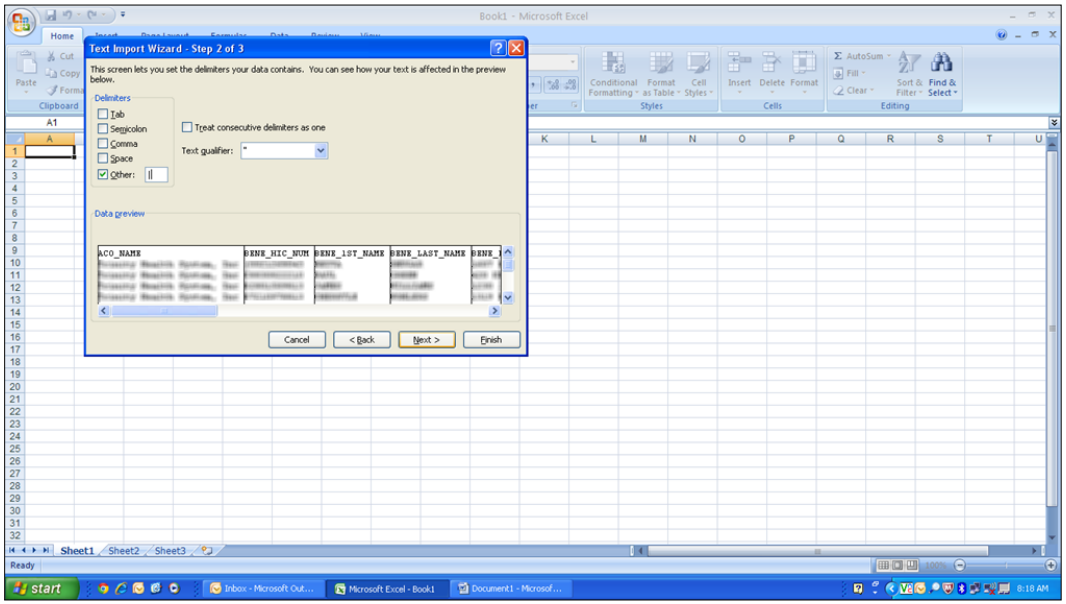


Figure 29: Text Import Wizard Step 2

12. The third Import Wizard pop-up will display, as shown in Figure 30: Text Import Wizard Step 3.
13. Change the data format from **General** to **Text** for the following columns:
    - ACO_NAME
    - BENE_HIC_NUM
    - BENE_1ST_NAME
    - BENE_LAST_NAME
    - BENE_LINE_1_ADR
    - BENE_LINE_2_ADR
    - BENE_LINE_3_ADR

- BENE_LINE_4_ADR
- BENE_LINE_5_ADR
- BENE_LINE_6_ADR
- GEO_ZIP_PLC_NAME
- GEO_USPS_STATE_CD
- GEO_ZIP5_CD
- GEO_ZIP4_CD
- BENE_SEX_CD_DESC
- BENE_BRTH_DT
- BENE_AGE
- BENE_ELGBL_ALGNMNT_YR_1_IND
- BENE_ELGBL_ALGNMNT_YR_2_IND
- BENE_ELGBL_ALGNMNT_YR_3_IND,
- BENE_PTD_CVRG_ALGNMNT_YR_1_IND
- BENE_PTD_CVRG_ALGNMNT_YR_2_IND
- BENE_PTD_CVRG_ALGNMNT_YR_3_IND
- BENE_ALGNMNT_YR_1_HCC_SCRE_NUM
- BENE_ALGNMNT_YR_2_HCC_SCRE_NUM
- BENE_ALGNMNT_YR 3_HCC_SCRE_NUM
- PRVDR_ACO_NEW_ALGN_BENE_SW

Note: This ensures that the data is correctly identified by Excel and displays properly in your worksheet file.

14. Select the **Finish** button at the bottom of the pop-up window.

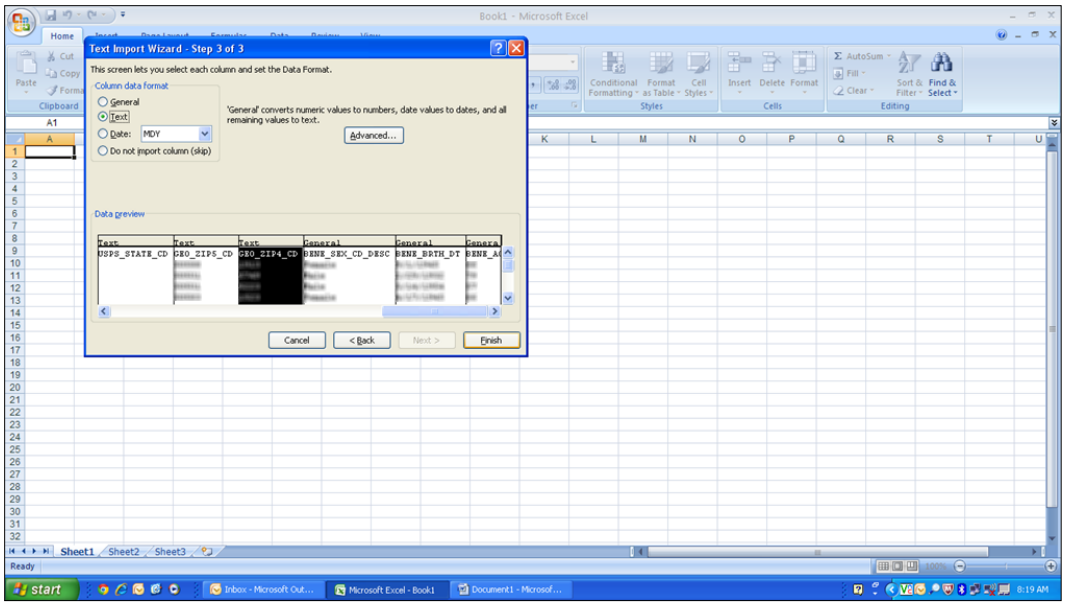


Figure 30: Text Import Wizard Step 3

15. Your open spreadsheet will display with data for your ACO.
16. Resize the columns in the spreadsheet as needed.

Appendix P: BI/ETL ACO Pioneer/Claim Line Feed Data Mapping

The following is the list of data elements present on the CCLF Reports and the Monthly CCLF Reports. The only difference between the Historical CCLF report files and the Monthly CCLF report files is the time period for which the claims line feed report file extract is executed. The records in the text file are fixed width. The Filename Convention is listed prior to each table.

The Filename Convention for *Table 26: Part A Claim Header File* is P#EFT.ON.ACOT.P***.MCCLF1. Dyymmdd.Thhmmsst.

Table 26: Part A Claim Header File (CCLF 1)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2	PRVDR_OSCAR_NUM	Provider Online Survey, Certification, and Reporting (OSCAR) Number	14	19	6	X(06)	OSCAR is a facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare-certified for a particular type of services.
3	BENE_HIC_NUM	Beneficiary HIC Number	20	30	11	X(11)	HICN is a beneficiary identifier. The HICN that appears in this field is the beneficiary's *current* HICN, not necessarily the HICN that was used to process the claim.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
4	CLM_TYPE_CD	Claim Type Code	31	32	2	9(02)	This code signifies the type of claim being submitted through the Medicare or Medicaid programs Claim type codes are: 10=Home Health Agency (HHA) claim 20=Non swing bed Skilled Nursing Facility (SNF) claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient “Full-Encounter” claim
5	CLM_FROM_DT	Claim From Date	33	42	10	YYYY-MM-DD	This date is the first day on the billing statement that covers services rendered to the beneficiary. This date is also known as “Statement Covers From Date.”
6	CLM_THRU_DT	Claim Thru Date	43	52	10	YYYY-MM-DD	This date is the last day on the billing statement that covers services rendered to the beneficiary. This date is also known as the “Statement Covers Through Date.”

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	CLM_BILL_FAC_TYPE_CD	Claim Bill Facility Type Code	53	53	1	X(01)	This code is the first digit of the type of bill (TOB1), and is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1=Hospital 2= SNF 3= HHA 4=Religious non-medical (hospital) 5=Religious non-medical (extended care) 6=Intermediate care 7=Clinic or hospital-based renal dialysis facility 8=Specialty facility or Ambulatory Surgical Center (ASC) surgery 9=Reserved

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
8	CLM_BILL_CLSFCTN_CD	Claim Bill Classification Code	54	54	1	X(01)	This code is the second digit of the type of bill (TOB2), and it is used to indicate with greater specificity where the service was provided (e.g., a department within a hospital). Claim Service Classification Codes are available at: http://www.resdac.org/cms-data/variables/Claim-Service-classification-Type-Code
9	PRNCPL_DGNS_CD	Principal Diagnosis Code	55	61	7	X(07)	The International Classification of Diseases (ICD)-9/10 diagnosis code identifying the beneficiary's principal illness or disability.
10	ADMTG_DGNS_CD	Admitting Diagnosis Code	62	68	7	X(07)	The ICD-9/10 diagnosis code identifying the illness or disability for which the beneficiary was admitted.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
11	CLM_MDCR_NPMT_RSN_CD	Claim Medicare Non-Payment Reason Code	69	70	2	X(02)	If payment on an institutional claim is denied by Medicare, this code indicates the reason. Medicare Non-Payment Reason Codes can be found here: http://www.resdac.org/cms-data/variables/claim-medicare-non-payment-reason-code
12	CLM_PMT_AMT	Claim Payment Amount	71	87	17	-9(13).99	The amount that Medicare paid on the claim.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
13	CLM_NCH_PRMRY_PYR_CD	Claim National Claims History (NCH) Primary Payer Code	88	88	1	X(01)	If a payer other than Medicare has primary responsibility for payment of the beneficiary's health insurance bills, this code indicates the responsible primary payer. If this field is blank, Medicare is the primary payer for the beneficiary. NCH Primary Payer Codes are available at: http://www.resdac.org/cms-data/variables/NCH-Primary-Payer-Code
14	PRVDR_FAC_FIPS_ST_CD	Federal Information Processing Standards (FIPS) State Code	89	90	2	X(02)	The FIPS code identifies the state where the facility providing services is located.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
15	BENE_PTNT_STUS_CD	Beneficiary Patient Status Code	91	92	2	X(02)	This code indicates the patient's discharge status as of the Claim Through Date. For example, it may indicate where a patient was discharged to (e.g., home or another facility) or the circumstances of a discharge (e.g., against medical advice or patient death). Patient Discharge Status Codes are available at: http://www.resdac.org/cms-data/variables/patient-discharge-status-code
16	DGNS_DRG_CD	Diagnosis Related Group Code	93	96	4	X(04)	This code indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
17	CLM_OP_SRVC_TYPE_CD	Claim Outpatient Service Type Code	97	97	1	X(01)	This code indicates the type and priority of outpatient service. Claim Outpatient Service Type Codes are: 0=Blank 1=Emergency 2=Urgent 3=Elective 5-8=Reserved 9=unknown
18	FAC_PRVDR_NPI_NUM	Facility Provider NPI Number	98	107	10	X(10)	This number identifies the facility associated with the claim. Each facility is assigned its own unique NPI.
19	OPRTG_PRVDR_NPI_NUM	Operating Provider NPI Number	108	117	10	X(10)	This is a number that identifies the operating provider associated with the claim. Each provider is assigned its own unique NPI.
20	ATNDG_PRVDR_NPI_NUM	Attending Provider NPI Number	118	127	10	X(10)	This is a number that identifies the attending provider associated with the claim. Each provider is assigned its own unique NPI.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
21	OTHR_PRVDR_NPI_NUM	Other Provider NPI Number	128	137	10	X(10)	This is a number that identifies the other providers associated with the claim. Each provider is assigned its own unique NPI.
22	CLM_ADJSMT_TYPE_CD	Claim Adjustment Type Code	138	139	2	X(02)	This code indicates whether the claim is an original, cancellation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Cancellation Claim 2=Adjustment claim
23	CLM_EFCTV_DT	Claim Effective Date	140	149	10	X(10)	This is the date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date.
24	CLM_IDR_LD_DT	Claim IDR Load Date	150	159	10	X(10)	This date is when the claim was loaded into the Integrated Data Repository (IDR).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
25	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	160	170	11	X(11)	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.
26	CLM_ADMSN_TYPE_CD	Claim Admission Type Code	171	172	2	X(2)	This code indicates the type and priority of inpatient services. Claim Admission Type Codes are: 0=Blank 1=Emergency 2=Urgent 3=Elective 4=Newborn 5=Trauma Center 6-8=Reserved 9=unknown

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
27	CLM_ADMSN_SRC_CD	Claim Admission Source Code	173	174	2	X(2)	This code indicates the source of the beneficiary's referral for admission or visit (e.g., a physician or another facility). Admission Source Codes are available at: http://www.resdac.org/cms-data/variables/Claim-Source-Inpatient-Admission-Code
28	CLM_BILL_FREQ_CD	Claim Bill Frequency Code	175	175	1	X(1)	This is the third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Claim Frequency Codes are available at: http://www.resdac.org/cms-data/variables/Claim-Frequency-Code.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
29	CLM_QUERY_CD	Claim Query Code	176	176	1	X(1)	Code indicating the type of claim record being processed with respect to payment (e.g., debit/credit indicator or interim/final indicator). Claim Query Codes are: 0=Credit adjustment 1=Interim bill 2=HHA benefits exhausted 3=Final bill 4=Discharge notice 5=Debit adjustment
30	DGNS_PRCDR_ICD_IND	ICD Version Indicator	177	177	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than “9” or “0” in the source data.

The Filename Convention for *Table 27: Part A Claims Revenue Center Detail File* is P#EFT.ON.ACOT.P***.MCCLF2. Dyymmdd.Thhmmsst.

Table 27: Part A Claims Revenue Center Detail File (CCLF 2)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	This a unique identification number assigned to the claim.
2	CLM_LINE_NUM	Claim Line Number	14	23	10	9(10)	This number is a sequential number that identifies a specific claim line.
3	BENE_HIC_NUM	Beneficiary HIC Number	24	34	11	X(11)	The HICN is a beneficiary identifier. The HICN that appears in this field is the beneficiary's *current* HICN, not necessarily the HICN that was used to process the claim.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
4	CLM_TYPE_CD	Claim Type Code	35	36	2	9(02)	This code signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient “Full-Encounter” claim
5	CLM_LINE_FROM_DT	Claim Line From Date	37	46	10	YYYY-MM-DD	This is the date the service associated with the line item began.
6	CLM_LINE_THRU_DT	Claim Line Thru Date	47	56	10	YYYY-MM-DD	This is the date the service associated with the line item ended.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	CLM_LINE_PROD_REV_CTR_CD	Product Revenue Center Code	57	60	4	X(04)	This is the number a provider assigns to the cost center to which a particular charge is billed (e.g., accommodations or supplies). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). Revenue Center Codes are available at: http://www.resdac.org/sites/resdac.org/files/Revenue%20Center%20Table.txt Revenue center code 0001 represents the total of all revenue centers included on the claim.
8	CLM_LINE_INSTNL_REV_CTR_DT	Claim Line Institutional Revenue Center Date	61	70	10	YYYY-MM-DD	This is the date that applies to the service associated with the Revenue Center code.
9	CLM_LINE_HCPCS_CD	Healthcare Common Procedure Coding System (HCPCS) Code	71	75	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
10	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	76	86	11	X(11)	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.
11	PRVDR_OSCAR_NUM	Provider OSCAR Number	87	92	6	X(6)	The OSCAR is a facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare-certified for a particular type of services

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
12	CLM_FROM_DT	Claim From Date	93	102	10	YYYY-MM-DD	This date is the first day on the billing statement that covers services rendered to the beneficiary. This date is also known as the “Statement Covers From Date.”
13	CLM_THRU_DT	Claim Thru Date	103	112	10	YYYY-MM-DD	This date is the last day on the billing statement that covers services rendered to the beneficiary This date is also known as the “Statement Covers Through Date.”
14	CLM_LINE_SRVC_UNIT_QTY	Claim Line Service Unit Quantity	113	136	24	-9(18).9999	The number of dosage units of medication that were dispensed in this fill.
15	CLM_LINE_CVRD_PD_AMT	Claim Line Covered Paid Amount	137	153	17	-9(13).99	The amount Medicare reimbursed the provider for covered services associated with the claim-line.
16	HCPCS_1_MDFR_CD	HCPCS First Modifier Code	154	155	2	X(2)	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
17	HCPCS_2_MDFR_CD	HCPCS Second Modifier Code	156	157	2	X(2)	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
18	HCPCS_3_MDFR_CD	HCPCS Third Modifier Code	158	159	2	X(2)	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
19	HCPCS_4_MDFR_CD	HCPCS Fourth Modifier Code	160	161	2	X(2)	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
20	HCPCS_5_MDFR_CD	HCPCS Fifth Modifier Code	162	163	2	X(2)	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.

The Filename Convention for *Table 28: Part A Procedure Code File* is P#EFT.ON.ACOT.P***.MCCLF3. Dyymmdd.Thhmmsst.

Table 28: Part A Procedure Code File (CCLF 3)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	This is a unique identification number assigned to the claim.
2	BENE_HIC_NUM	Beneficiary HIC Number	14	24	11	X(11)	The HICN is a beneficiary identifier. The HICN that appears in this field is the beneficiary's *current* HICN, not necessarily the HICN that was used to process the claim.
3	CLM_TYPE_CD	Claim Type Code	25	26	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient "Full-Encounter" claim
4	CLM_VAL_SQNC_NUM	Claim Value Sequence Number	27	28	2	9(2)	An arbitrary sequential number that uniquely identifies a procedure code record within the claim.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
5	CLM_PRCDR_CD	Procedure Code	29	35	7	X(07)	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
6	CLM_PRCDR_PRFRM_DT	Procedure Performed Date	36	45	10	YYYY-MM-DD	The date the indicated procedure was performed.
7	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	46	56	11	X(11)	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary’s spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.
8	PRVDR_OSCAR_NUM	Provider OSCAR Number	57	62	6	X(6)	The OSCAR is a facility’s Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
9	CLM_FROM_DT	Claim From Date	63	72	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as “Statement Covers From Date.”
10	CLM_THRU_DT	Claim Thru Date	73	82	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the “Statement Covers Through Date.”
11	DGNS_PRCDR_ICD_IND	ICD Version Indicator	83	83	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than “9” or “0” in the source data.

The Filename Convention for *Table 29: Part A Diagnosis Code File* is P#EFT.ON.ACOT.P***.MCCLF4. Dyymmdd.Thhmmsst.

Table 29: Part A Diagnosis Code File (CCLF 4)

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2	BENE_HIC_NUM	Beneficiary HIC Number	14	24	11	X(11)	The HICN is a beneficiary identifier. The HICN that appears in this field is the beneficiary's *current* HICN, and not necessarily the HICN that was used to process the claim.
3	CLM_TYPE_CD	Claim Type Code	25	26	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient "Full-Encounter" claim
4	CLM_PROD_TYPE_CD	Claim Product Type Code	27	27	1	X(01)	Codes classifying the diagnosis category: E=Accident diagnosis code 1=First diagnosis E code D=Other diagnosis codes

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
5	CLM_VAL_SQNC_NUM	Claim Value Sequence Number	28	29	2	9(2)	An arbitrary sequential number that uniquely identifies a procedure code record within the claim
6	CLM_DGNS_CD	Diagnosis Code	30	36	7	X(07)	The ICD-9/10 diagnosis code identifying the beneficiary's illness or disability
7	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	37	47	11	X(11)	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.
8	PRVDR_OSCAR_NUM	Provider OSCAR Number	48	53	6	X(6)	The OSCAR is a facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services.

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
9	CLM_FROM_DT	Claim From Date	54	63	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers From Date."
10	CLM_THRU_DT	Claim Thru Date	64	73	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers Through Date."
11	CLM_POA_IND	Claim Present-on-Admission Indicator	74	80	7	X(7)	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility. Find Present-on-admission values here: http://www.resdac.org/cms-data/variables/claim-diagnosis-code-i-diagnosis-present-admission-indicator-code
12	DGNS_PRCDR_ICD_IND	ICD Version Indicator	81	81	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than "9" or "0" in the source data.

The Filename Convention for *Table 30: Part B Physicians File* is P#EFT.ON.ACOT.P***.MCCLF5. Dyymmdd.Thhmmsst.

Table 30: Part B Physicians File (CCLF 5)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2	CLM_LINE_NUM	Claim Line Number	14	23	10	9(10)	A sequential number that identifies a specific claim line within a given claim.
3	BENE_HIC_NUM	Beneficiary HIC Number	24	34	11	X(11)	The HICN is a beneficiary identifier. The HICN that appears in this field is the beneficiary's *current* HICN, not necessarily the HICN that was used to process the claim
4	CLM_TYPE_CD	Claim Type Code	35	36	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 71=RIC O local carrier non-DMEPOS claim 72=RIC O local carrier DMEPOS claim

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
5	CLM_FROM_DT	Claim From Date	37	46	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers From Date."
6	CLM_THRU_DT	Claim Thru Date	47	56	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers Through Date."

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	PRVDR_TYPE_CD	Provider Type Code	57	59	3	X(03)	Indicates the type of provider who provided the service associated with this line item on the claim. Provider Type Codes are: 0=Clinics, groups, associations, partnerships, or other entities 1=Physicians or suppliers reporting as solo practitioners 2=Suppliers (other than sole proprietorship) 3=Institutional provider 4=Independent laboratories 5=Clinics (multiple specialties) 6=Groups (single specialty) 7=Other entities
8	RNDRG_PRVDR_FIPS_ST_CD	Rendering Provider FIPS State Code	60	61	2	X(02)	Identifies the state that the provider providing the service is located in.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
9	CLM_PRVDR_SPCLTY_CD	Claim-Line Provider Specialty Code	62	63	2	X(02)	Indicates the CMS specialty code associated with the provider of services. CMS used this number to price the service on the line-item. Find Provider Specialty Codes here: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/JSMTDL-08515MedicarProviderTypetoHCPTaxonomy.pdf
10	CLM_FED_TYPE_SRVC_CD	Claim Federal Type Service Code	64	64	1	X(01)	Indicates the type of service (e.g., consultation, surgery) provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual. Find Types of Service Codes here: http://www.resdac.org/sites/resdac.org/files/CMS%20Type%20of%20Service%20Table.txt

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
11	CLM_POS_CD	Claim Place of Service Code	65	66	2	X(02)	Indicates the place where the indicated service was provided (e.g., ambulance, school). Places of service are defined in the Medicare Carrier Manual. Place of Service Codes are available here: http://www.resdac.org/sites/resdac.org/files/Place%20of%20Service%20Table.txt
12	CLM_LINE_FROM_DT	Claim Line From Date	67	76	10	YYYY-MM-DD	The date the service associated with the line item began.
13	CLM_LINE_THRU_DT	Claim Line Thru Date	77	86	10	YYYY-MM-DD	The date the service associated with the line item ended.
14	CLM_LINE_HCPCS_CD	HCPCS Code	87	91	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
15	CLM_LINE_CVRD_PD_AMT	Claim Line Covered Paid Amount	92	106	15	-9(11).99	This is the amount of payment made by Medicare on behalf of the beneficiary for the indicated service *after* deductible and coinsurance amounts have been paid.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
16	CLM_PRMRY_PYR_CD	Claim Primary Payer Code	107	107	1	X(01)	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer. This field is also known as the Line Beneficiary Primary Payer Code. If this field is blank, Medicare is the primary payer for the beneficiary. Find Primary Payer Codes here: http://www.resdac.org/cms-data/variables/Line-Beneficiary-Primary-Payer-Code
17	CLM_LINE_DGNS_CD	Diagnosis Code	108	114	7	X(07)	The ICD-9/10 diagnosis code identifying the beneficiary's principal illness or disability.
18	CLM_RNDRG_PRVDR_TAX_NUM	Claim Line Provider Tax Number	115	124	10	X(10)	The SSN or Employee Identification Number (EIN) of the provider of the indicated service. This number identifies who receives payment for the indicated service.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
19	RNDRG_PRVDR_NPI_NUM	Rendering Provider NPI Number	125	134	10	X(10)	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI.
20	CLM_CARR_PMT_DNL_CD	Claim Carrier Payment Denial Code	135	136	2	X(02)	Indicates to whom payment was made (e.g., physician, beneficiary), or if the claim was denied. Find Carrier Payment Denial Codes here: http://www.resdac.org/sites/resdac.org/files/Carrier%20Claim%20Payment%20Denial%20Table.txt
21	CLM_PRCSG_IND_CD	Claim-Line Processing Indicator Code	137	138	2	X(02)	Indicates whether the service indicated on the claim line was allowed or the reason it was denied. Find Processing Indicator Codes here: http://www.resdac.org/sites/resdac.org/files/Line%20Processing%20Indicator%20Table.txt

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
22	CLM_ADJSMT_TYPE_CD	Claim Adjustment Type Code	139	140	2	X(02)	Indicates whether the claim an original, cancellation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Cancellation Claim 2=Adjustment claim
23	CLM_EFCTV_DT	Claim Effective Date	141	150	10	YYYY-MM-DD	The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date.
24	CLM_IDR_LD_DT	Claim IDR Load Date	151	160	10	YYYY-MM-DD	When the claim was loaded into the IDR.
25	CLM_CNTL_NUM	Claim Control Number	161	200	40	X(40)	A unique number assigned to a claim by the Medicare carrier. This number allows CMS to associate each line item with its respective claim.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
26	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	201	211	11	X(11)	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.
27	CLM_LINE_ALOWD_CHRG_AMT	Claim Line Allowed Charges Amount	212	228	17	-9(13).99	The amount Medicare approved for payment to the provider.
28	CLM_LINE_SRVC_UNIT_QTY	Claim Line Service Unit Quantity	229	252	24	-9(18).9999	The number of dosage units of medication that were dispensed in this fill.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
29	HCPCS_1_MDFR_CD	HCPCS First Modifier Code	253	254	2	X(2)	This is the first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
30	HCPCS_2_MDFR_CD	HCPCS Second Modifier Code	255	256	2	X(2)	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
31	HCPCS_3_MDFR_CD	HCPCS Third Modifier Code	257	258	2	X(2)	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
32	HCPCS_4_MDFR_CD	HCPCS Fourth Modifier Code	259	260	2	X(2)	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
33	HCPCS_5_MDFR_CD	HCPCS Fifth Modifier Code	261	262	2	X(2)	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
34	CLM_DISP_CD	Claim Disposition Code	263	264	2	X(2)	Information regarding payment actions on the claim. Claim Disposition Codes are: 01=Debit accepted 02=Debit accepted (automatic adjustment) 03=Cancel accepted
35	CLM_DGNS_1_CD	Claim Diagnosis First Code	265	271	7	X(7)	The first of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
36	CLM_DGNS_2_CD	Claim Diagnosis Second Code	272	278	7	X(7)	The second of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
37	CLM_DGNS_3_CD	Claim Diagnosis Third Code	279	285	7	X(7)	The third of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
38	CLM_DGNS_4_CD	Claim Diagnosis Fourth Code	286	292	7	X(7)	The fourth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
39	CLM_DGNS_5_CD	Claim Diagnosis Fifth Code	293	299	7	X(7)	The fifth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
40	CLM_DGNS_6_CD	Claim Diagnosis Sixth Code	300	306	7	X(7)	The sixth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
41	CLM_DGNS_7_CD	Claim Diagnosis Seventh Code	307	313	7	X(7)	The seventh of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
42	CLM_DGNS_8_CD	Claim Diagnosis Eighth Code	314	320	7	X(7)	The eighth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
43	DGNS_PRCDR_ICD_IND	ICD Version Indicator	321	321	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than "9" or "0" in the source data.

The Filename Convention for *Table 31: Part B DME* File is P#EFT.ON.ACOT.P***.MCCLF6. Dyymmdd.Thhmmsst.

Table 31: Part B DME File (CCLF 6)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2	CLM_LINE_NUM	Claim Line Number	14	23	10	9(10)	A sequential number that identifies a specific claim line.
3	BENE_HIC_NUM	Beneficiary HIC Number	24	34	11	X(11)	The HICN is a beneficiary identifier. The HICN that appears in this field is the beneficiary's *current* HICN, not necessarily the HICN that was used to process the claim.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
4	CLM_TYPE_CD	Claim Type Code	35	36	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 81=RIC M DMERC non-DMEPOS claim 82=RIC M DMERC DMEPOS claim
5	CLM_FROM_DT	Claim From Date	37	46	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers From Date."
6	CLM_THRU_DT	Claim Thru Date	47	56	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers Through Date."

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	CLM_FED_TYPE_SRVC_CD	Claim Federal Type Service Code	57	57	1	X(01)	Indicates the type of service (e.g. consultation, surgery), provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual. Find Types of Service Codes here: http://www.resdac.org/sites/resdac.org/files/CMS%20Type%20of%20Service%20Table.txt
8	CLM_POS_CD	Claim Place of Service Code	58	59	2	X(02)	Indicates place where the indicated service was provided (e.g., ambulance, school). Places of service are defined in the Medicare Carrier Manual. Place of Service Codes are available here: http://www.resdac.org/sites/resdac.org/files/Place%20of%20Service%20Table.txt
9	CLM_LINE_FROM_DT	Claim Line From Date	60	69	10	YYYY-MM-DD	The date the service associated with the line item began.
10	CLM_LINE_THRU_DT	Claim Line Thru Date	70	79	10	YYYY-MM-DD	The date the service associated with the line item ended.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
11	CLM_LINE_HCPCS_CD	HCPCS Code	80	84	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
12	CLM_LINE_CVRD_PD_AMT	Claim Line Covered Paid Amount	85	99	15	-9(11).99	The amount of payment made by Medicare on behalf of the beneficiary for the indicated service *after* deductible and coinsurance amounts have been paid.
13	CLM_PRMRY_PYR_CD	Claim Primary Payer Code	100	100	1	X(01)	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer. This field is also known as the Line Beneficiary Primary Payer Code. If this field is blank, Medicare is the primary payer for the beneficiary. Primary Payer Codes are available at: http://www.resdac.org/cms-data/variables/Line-Beneficiary-Primary-Payer-Code

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
14	PAYTO_PRVDR_NPI_NUM	Pay-to Provider NPI Number	101	110	10	X(10)	A number that identifies the provider billing for the indicated service on the claim line. Each provider is assigned its own unique NPI.
15	ORDRG_PRVDR_NPI_NUM	Ordering Provider NPI Number	111	120	10	X(10)	A number that identifies the provider ordering the indicated service on the claim line. Each provider is assigned its own unique NPI.
16	CLM_CARR_PMT_DNL_CD	Claim Carrier Payment Denial Code	121	122	2	X(02)	Indicates to whom payment was made (e.g. physician, beneficiary) or if the claim was denied Find Carrier Payment Denial Codes here: http://www.resdac.org/sites/resdac.org/files/Carrier%20Claim%20Payment%20Denial%20Table.txt
17	CLM_PRCSG_IND_CD	Claim Processing Indicator Code	123	124	2	X(02)	Indicates whether the service indicated on the claim line was allowed or the reason it was denied. Find Processing Indicator Codes here: http://www.resdac.org/sites/resdac.org/files/Line%20Processing%20Indicator%20Table.txt

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
18	CLM_ADJSMT_TYPE_CD	Claim Adjustment Type Code	125	126	2	X(02)	Indicates whether the claim an original, cancellation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Cancellation Claim 2=Adjustment claim
19	CLM_EFCTV_DT	Claim Effective Date	127	136	10	YYYY-MM-DD	The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date.
20	CLM_IDR_LD_DT	Claim IDR Load Date	137	146	10	YYYY-MM-DD	When the claim was loaded into the IDR.
21	CLM_CNTL_NUM	Claim Control Number	147	186	40	X(40)	A unique number assigned to a claim by the Medicare carrier. This number allows CMS to associate each line item with its respective claim.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
22	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	187	197	11	X(11)	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.
23	CLM_LINE_ALOWD_CHRG_AMT	Claim Line Allowed Charges Amount	198	214	17	-9(13).99	The amount Medicare approved for payment to the provider.
24	CLM_DISP_CD	Claim Disposition Code	215	216	2	X(2)	This code contains information regarding payment actions on the claim. Claim Disposition Codes are: 01=Debit accepted 02=Debit accepted (automatic adjustment) 03=Cancel accepted

The Filename Convention for *Table 32: Part D File* is P#EFT.ON.ACOT.P***.MCCLF7. Dyymmdd.Thhmmsst.

Table 32: Part D File (CCLF 7)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2	BENE_HIC_NUM	Beneficiary HIC Number	14	24	11	X(11)	The HICN is a beneficiary identifier. The HICN that appears in this field is the beneficiary's *current* HICN, not necessarily the HICN that was used to process the claim.
3	CLM_LINE_NDC_CD	National Drug Code (NDC) Code	25	35	11	X(11)	The NDC is a universal unique product identifier for human drugs.
4	CLM_TYPE_CD	Claim Type Code	36	37	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 01=Part D - Original without resubmitted Prescription Drug Event (PDE) 02=Part D - Adjusted PDE 04=Part D - Resubmitted PDE

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
5	CLM_LINE_FROM_DT	Claim Line From Date	38	47	10	YYYY-MM-DD	The date the service associated with the line item began (i.e., the date upon which the prescription was filled).
6	PRVDR_SRVC_ID_QLFYR_CD	Provider Service Identifier Qualifier Code	48	49	2	X(02)	Indicates the type of number used to identify the pharmacy providing the services: 01= NPI Number 06=Unique Physician Identification Number (UPIN) 07=National Council for Prescription Drug Programs (NCPDP) Number 08=State License Number 11=TIN 99=Other mandatory for Standard Data Format
7	CLM_SRVC_PRVDR_GNRC_ID_NUM	Claim Service Provider Generic ID Number	50	69	20	X(20)	The number associated with the indicated code in the Provider Service Identification Qualifier Code field.
8	CLM_DSPNSNG_STUS_CD	Claim Dispensing Status Code	70	70	1	X(01)	Indicates the status of prescription fulfillment. Dispensing Codes are: P=Partially filled C=Completely filled

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
9	CLM_DAW_PROD_SLCTN_CD	Claim Dispense as Written (DAW) Product Selection Code	71	71	1	X(01)	Indicates the prescriber's instructions regarding generic substitution or how those instructions were followed. DAW Product Selection Codes are: 0=No product selection indicated 1=Substitution not allowed by prescriber 2=Substitution allowed – Patient requested that brand be dispensed 3=Substitution allowed – Pharmacist selected product dispensed 4=Substitution allowed – Generic not in stock 5=Substitution allowed – Brand drug dispensed as generic 6=Override 7=Substitution not allowed – Brand drug mandated by law 8=Substitution allowed – Generic drug not available in marketplace 9=Other

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
10	CLM_LINE_SRVC_UNIT_QTY	Claim Line Service Unit Quantity	72	95	24	-9(18).9999	The number of dosage units of medication that were dispensed in this fill.
11	CLM_LINE_DAYS_SUPLY_QTY	Claim Line Days' Supply Quantity	96	104	9	9(09)	The number of days the supply of medication dispensed by the pharmacy will cover.
12	PRVDR_PRSBNG_ID_QLFYR_CD	Provider Prescribing ID Qualifier Code	105	106	2	X(02)	Indicates the type of number used to identify the prescribing provider: 01= NPI Number 06= UPIN 07= NCPDP Number 08=State License Number 11= TIN 99=Other mandatory for Standard Data Format
13	CLM_PRSBNG_PRVDR_GNRC_ID_NUM	Claim Prescribing Provider Generic ID Number	107	126	20	X(20)	The number associated with the indicated code in the Provider Prescribing Service Identification Qualifier Code field.
14	CLM_LINE_BENE_PMT_AMT	Claim Line Beneficiary Payment Amount	127	139	13	-9(9).99	The dollar amount paid by the beneficiary that is not reimbursed by a third party (e.g., copayments, coinsurance, deductible or other patient pay amounts).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
15	CLM_ADJSMT_TYPE_CD	Claim Adjustment Type Code	140	141	2	X(02)	Indicates whether the claim an original, cancellation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Cancellation Claim 2=Adjustment claim
16	CLM_EFCTV_DT	Claim Effective Date	142	151	10	YYYY-MM-DD	The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date.
17	CLM_IDR_LD_DT	Claim IDR Load Date	152	161	10	YYYY-MM-DD	When the claim was loaded into the IDR.
18	CLM_LINE_RX_SRVC_RFRNC_NUM	Claim Line Prescription Service Reference Number	162	173	12	X(012)	Identifies a prescription dispensed by a particular service provider on a particular service date.
19	CLM_LINE_RX_FILL_NUM	Claim Line Prescription Fill Number	174	182	9	X(09)	The number assigned to the current dispensed supply by the pharmacy. It designates the sequential order of the original fill or subsequent refills of a prescription.

* Note: The source of this column will be changed to V1_CLM.CLM_SCHLD_PMT_DT

The Filename Convention for *Table 33: Beneficiary Demographics File* is P#EFT.ON.ACOT.P***.MCCLF8. Dyymmdd.Thhmmsst.

Table 33: Beneficiary Demographics File (CCLF 8)

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
1	BENE_HIC_NUM	Beneficiary HIC Number	1	11	11	X(11)	The HICN is a beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, and not necessarily the HICN that was used to process the claim.
2	BENE_FIPS_STATE_CD	Beneficiary FIPS State Code	12	13	2	9(02)	Identifies the state where the beneficiary receiving services resides.
3	BENE_FIPS_CNTY_CD	Beneficiary FIPS County Code	14	16	3	9(03)	Identifies the county where the beneficiary receiving services resides.
4	BENE_ZIP_CD	Beneficiary ZIP Code	17	21	5	X(05)	The beneficiary's ZIP code as indicated in their Medicare enrollment record.
5	BENE_DOB	Beneficiary Date of Birth	22	31	10	YYYY-MM-DD	The month, day, and year of the beneficiary's birth.
6	BENE_SEX_CD	Beneficiary Sex Code	32	32	1	X(01)	The beneficiary's sex: 1=Male 2=Female 0=Unknown

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
7	BENE_RACE_CD	Beneficiary Race Code	33	33	1	X(01)	The beneficiary's race: 0=Unknown 1=White 2=Black 3=Other 4=Asian 5=Hispanic 6=North American Native
8	BENE_AGE	Beneficiary Age	34	36	3	9(03)	The beneficiary's current age, as calculated by subtracting the beneficiary's date of birth from the current date.
9	BENE_MDCR_STUS_CD	Beneficiary Medicare Status Code	37	38	2	X(02)	Indicates the reason for a beneficiary's entitlement to Medicare benefits as of a particular date, broken down by the following categories: OASI, Disabled, and ESRD, and by appropriate combinations of these categories: 10=Aged without ESRD 11=Aged with ESRD 20=Disabled without ESRD 21=Disabled with ESRD 31=ESRD only
10	BENE_DUAL_STUS_CD	Beneficiary Dual Status Code	39	40	2	X(02)	Identifies the most recent entitlement status of beneficiaries eligible for a program(s) in addition to Medicare (e.g., Medicaid). Find Dual Status Codes here: http://www.resdac.org/cms-data/variables/Dual-Status-Code-occurs-12-times

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
11	BENE_DEATH_DT	Beneficiary Death Date	41	50	10	YYYY-MM-DD	The month, day, and year of a beneficiary's death.
12	BENE_RNG_BGN_DT	Date beneficiary enrolled in Hospice	51	60	10	YYYY-MM-DD	The date the beneficiary enrolled in Hospice.
13	BENE_RNG_END_DT	Date beneficiary ended Hospice	61	70	10	YYYY-MM-DD	The date the beneficiary ended enrollment in hospice.
14	BENE_1ST_NAME	Beneficiary First Name	71	100	30	X(30)	The first name of the beneficiary.
15	BENE_MIDL_NAME	Beneficiary Middle Name	101	115	15	X(15)	The middle name of the beneficiary.
16	BENE_LAST_NAME	Beneficiary Last Name	116	155	40	X(40)	The last name of the beneficiary.
17	BENE_ORGNL_ENTLMT_RSN_CD	Beneficiary Original Entitlement Reason Code	156	156	1	X(01)	The reason for the beneficiary's original entitlement to Medicare benefits. 0 - Old Age and Survivors Insurance (OASI) 1 - Disability Insurance Benefits (DIB) 2 - ESRD 3 - Both DIB and ESRD 4 - Unknown

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
18	BENE_ENTLMT_BUYIN_IND	Beneficiary Entitlement Buy-in Indicator	157	157	1	X(01)	Indicates for each month of the denominator reference year, the entitlement of the beneficiary to Medicare Part A, Medicare Part B, or Medicare Parts A and B both, as well as whether or not the beneficiary's state of residence was liable and paid for the beneficiary's Medicare Part B monthly premiums. 0 Not Entitled 1 Part A Only 2 Part B Only 3 Part A and Part B A Part A, State Buy-In B Part B, State Buy-In C Parts A and B, State Buy-In

The Filename Convention for *Table 34: Beneficiary XREF File* is P#EFT.ON.ACOT.P***.MCCLF9. Dyymmdd.Thhmmsst.

Table 34: Beneficiary XREF File (CCLF 9)

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
1	CRNT_HIC_NUM	Current HIC Number	1	11	11	X(11)	The HICN is a beneficiary identifier. The HICN that appears in this field is the beneficiary's *current* HICN, not necessarily the HICN that was used to process the claim
2	PRVS_HIC_NUM	Previous HIC Number	12	22	11	X(11)	The HICN that appears in this field is the beneficiary's *previous* HICN.
3	PRVS_HICN_EFCTV_DT	Previous HICN Effective Date	23	32	10	YYYY-MM-DD	The date the previous HICN became active.
4	PRVS_HICN_OBSLT_DT	Previous HICN Obsolete Date	33	42	10	YYYY-MM-DD	The date the previous HICN ceased to be active.
5	BENE_RRB_NUM	Beneficiary Railroad Board (RRB) Number	43	54	12	X(12)	The external (to Medicare) HICN for beneficiaries that are RRB members.

The Filename Convention for Table 35: Summary Statistics Header Record and Table 36: Summary Statistics Detail Records is P#EFT.ON.ACOT.P***.MCCLF0. Dyymmdd.Thhmmsst.

Table 35: Summary Statistics Header Record (CCLF 0)

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
1	Column Title 1	Title	1	11	11	X(11)	Field will contain “File Number.”
2	Filler	Filler	12	15	4	X(4)	N/A
3	Column Title 2	Title	16	31	16	X(16)	Field will contain “File Description.”
4	Filler	Filler	32	36	5	X(5)	N/A
5	Column Title 3	Title	37	54	18	X(18)	Field will contain “Total Records Count.”
6	Filler	Filler	55	56	2	X(2)	N/A
7	Column Title 4	Title	57	69	13	X(13)	Field will contain “Record Length.”
8	Filler	Filler	70	73	4	X(14)	N/A

Table 36: Summary Statistics Detail Records

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
1	File Type	Title	1	11	11	X(11)	Field will contain either “CCLF1”, “CCLF2”, “CCLF3”, “CCLF4”, “CCLF5”, “CCLF6”, “CCLF7”, “CCLF8”, or “CCLF9.”
2	Filler	Filler	12	14	3	X(3)	N/A

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
3	Filename	Title	15	54	40	X(40)	For file CCLF 1, this field will contain "Part A Claims Header File." For file CCLF 2, this field will contain "Part A Claims Revenue Center Detail File." For file CCLF 3, this field will contain "Part A Procedure Code File." For file CCLF 4, this field will contain "Part A Diagnosis Code File." For file CCLF 5, this field will contain "Part B Physicians File." For file CCLF 6, this field will contain "Part B DME File." For file CCLF 7, this field will contain "Part D File." For file CCLF 8, this field will contain "Beneficiary Demographics File." For file CCLF 9, this field will contain "BENE XREF File."
4	Filler	Filler	55	58	4	X(4)	N/A
5	Number of records	Contains the number of records in the file	59	67	9	X(9)	N/A
6	Filler	Filler	68	72	5	X(5)	N/A
7	Length of record	Contains the length of the record in the file.	73	75	3	X(3)	N/A
8	Filler	Filler	76	79	4	X(4)	N/A

Appendix Q: Pioneer ACO Quarterly/Annual Expenditure Utilization Report

The following is the format of the Quarterly/Annually ACO-Level Expenditure/Utilization Trend Report, Pioneer 2013, First Quarter.

Quarterly/Annual ACO-Level Utilization Trend Report
Pxxx Pioneer 2013, First Quarter

	Overall Aligned Population(1)		All ACO Count/Percent	
	Annual(2)	Quarter	Annual	Quarter
Transition of Care/Care Coordination Utilization(3)				
30-Day All-Cause Readmissions Per 1,000 Discharges	xxxx	xxxx	xxxx	xxxx
30-Day Post-Discharge Provider Visits Per 1,000 Discharges	xxxx	xxxx	xxxx	xxxx
Ambulatory Care Sensitive Conditions Admission Rates Per 1000 Benes:				
Diabetes, Short-Term Complications	xxxx	xxxx	xxxx	xxxx
Uncontrolled Diabetes	xxxx	xxxx	xxxx	xxxx
Chronic Obstructive Pulmonary Disease	xxxx	xxxx	xxxx	xxxx
Congestive Heart Failure	xxxx	xxxx	xxxx	xxxx
Bacterial Pneumonia	xxxx	xxxx	xxxx	xxxx
Additional Utilization Rates(4)				
Hospitalizations	xxxx	xxxx	xxxx	xxxx
Emergency Department Visits	xxxx	xxxx	xxxx	xxxx
Emergency Department Visits That Lead To Hopsitalizations	xxxx	xxxx	xxxx	xxxx
Computed Tomography (CT) Events	xxxx	xxxx	xxxx	xxxx
Magenetic Resonance Imaging (MRI) Events	xxxx	xxxx	xxxx	xxxx
Primary Care Visits, (Total)(5)	xxxx	xxxx	xxxx	xxxx
With a Primary Care Physician(6)	xxxx	xxxx	xxxx	xxxx
With a Specialist Physician(7)	xxxx	xxxx	xxxx	xxxx
With a Nurse Practitioner/Physician's Assistant/Clinical Nurse Specialist(8)	xxxx	xxxx	xxxx	xxxx
Ambulance Events	xxxx	xxxx	xxxx	xxxx

Notes:
1. Includes aligned beneficiaries for the performance period.
2. Annual data are annualized, capped, and divided by 12 to convert to a PBPM basis. The average is weighted by the number of each beneficiary's eligible months during the year.
3. Quarterly expenditures are annualized based on eligible months, capped, and divided by 12 to convert to a PBPM basis. The average is weighted by the number of each beneficiary's eligible months during the quarter.
4. These transition of care/care coordination measures are part of the claims-based quality measure set.
5. These additional utilization rates are expressed per 1,000 person years or person quarters.
6. Primary care services are identified by the following HCPCS and/or revenue center codes, regardless of physician specialty: 99201-99205, 99211-99215; 99304-99306; 99307-99310; 99315-99316; 99318; 99324-99328, 99334-99337; 99339-99340; 99341-99345, 99347-99350; G0402, G0438, G0439.
7. Defined as a qualifying E&M visit with a primary care physician, defined with a CMS specialty code of 1 (general practice), 8 (family practice),11 (internal medicine), 38 (geriatric medicine).
8. Defined by primary care visit with a physician with a CMS specialty code of 02, 03, 04, 05, 06, 07, 09, 10, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26, 28, 29, 30, 33, 34, 36, 37, 39, 40, 44, 46, 66, 70, 72, 76, 77, 78, 79, 81, 82, 83, 84, 86, 90, 91, 92, 93, 94, 98, 99.
9. Defined by primary care visits with CMS specialty code 50 (nurse practitioner), 89 (clinical nurse specialist), or 97 (physician's assistant).

Created on 1/24/2013 5:33:26 PM

Figure 31: Format of Quarterly /Annually ACO-Level Expenditure/Utilization Trend Report

Appendix R: Data Sharing Preference Usage Scenarios

Each Beneficiary Data Sharing Preference file received from an ACO includes codes used to identify the mechanism which the ACO used to record their data sharing preference decision. The Usage Scenarios outlined in this section are for the ACO data sharing decision mechanism codes.

Medical Data Sharing
The following data sharing preference scenarios in Table 37 are initially processed and always take precedence over all other data sharing preference scenarios in the logical workflow.

Note: The Medical Claims Usage Scenarios for Pioneer are effective until Final Rule is implemented.

Table 37: Medical Claims Usage Scenarios for Pioneer and Shared Savings Program

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer), O (Shared Savings Program), T (Pioneer), T (1-800)	Y or N	N (Shared Savings Program)	N	X	X	X	56	Error	An "N" Decision Mech Code with an "N" Preference Switch is always error code 56

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
N (Shared Savings Program)	Y	N (Shared Savings Program)	Y	X			51	Error	
N (Shared Savings Program)	Y	N (Shared Savings Program)	Y		X		51	Error	
N (Shared Savings Program)	Y	N (Shared Savings Program)	Y			X	54	Error	
N (Shared Savings Program)	Y	N (Shared Savings Program)	N	X	X	X	56	Error	
N (Shared Savings Program)	Y	R (Shared Savings Program), W (Pioneer), T (Pioneer, 1-800), O, E (Pioneer, Shared Savings Program)	Y or N	X	X	X	00	Valid	ACO_0040
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y or N	N (Shared Savings Program)	Y	X			51	Error	

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y or N	N (Shared Savings Program)	Y	-	X	X	54	Error	
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y or N	N (Shared Savings Program)	N	X	X	X	56	Error	An “N” Decision Mech Code with an “N“ Preference Switch is always error code 56
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y	R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y	X			51	Error	
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y	R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y		X		51	Error	

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y	R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y			X	00	Valid	ACO_0040
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y	R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	N	X			51	Error	
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y	R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	N		X		00	Valid	ACO_0040
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y	R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	N			X	00	Valid	ACO_0040

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	N	R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y	X			51	Error	
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	N	R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y		X		51	Error	
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	N	R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y			X	00	Valid	ACO_0040
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	N	R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	N	X			51	Error	

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	N	R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	N		X		51	Error	ACO_0040
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	N	R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	N			X	00	Valid	ACO_0040
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y	O (Shared Savings Program), T (Pioneer, 1-800)	Y or N	X			51	Error	
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y	O (Shared Savings Program), T (Pioneer, 1-800)	Y or N		X		00	Valid	ACO_0040

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y	O (Shared Savings Program), T (Pioneer, 1-800)	Y or N			X	00	Valid	
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	N	O (Shared Savings Program), T (Pioneer, 1-800)	Y or N	X			51	Error	
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	N	O (Shared Savings Program), T (Pioneer, 1-800)	Y or N		X		00	Valid	ACO_0040
R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	N	O (Shared Savings Program), T (Pioneer, 1-800)	Y or N			X	00	Valid	

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
O (Shared Savings Program), T (Pioneer)	Y or N	N (Shared Savings Program)	Y	X			51	Error	
O (Shared Savings Program), T (Pioneer)	Y or N	N (Shared Savings Program)	Y		X	X	54	Error	
O (Shared Savings Program), T (Pioneer)	Y or N	N (Shared Savings Program)	N	X	X	X	56	Error	An “N” Decision Mech Code with an “N” Preference Switch is always error code 56
O (Shared Savings Program), T (Pioneer)	Y or N	R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y or N	X			51	Error	
O (Shared Savings Program), T (Pioneer)	Y or N	R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y or N		X		54	Error	ACO_0040

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
O (Shared Savings Program), T (Pioneer)	Y or N	R (Shared Savings Program), E (Pioneer, Shared Savings Program), W (Pioneer)	Y or N			X	00	Valid	ACO_0040
O (Shared Savings Program), T (Pioneer)	Y or N	O (Shared Savings Program), T (Pioneer)	Y	X			51	Error	
O (Shared Savings Program), T (Pioneer)	Y or N	O (Shared Savings Program), T (Pioneer)	Y		X		51	Error	
O (Shared Savings Program), T (Pioneer)	Y or N	O (Shared Savings Program), T (Pioneer)	Y			X	00	Valid	ACO_0040
O (Shared Savings Program), T (Pioneer)	Y	O (Shared Savings Program), T (Pioneer)	N	X			51	Error	
O (Shared Savings Program), T (Pioneer)	Y	O (Shared Savings Program), T (Pioneer)	N		X		00	Valid	ACO_0040
O (Shared Savings Program), T (Pioneer)	Y	O (Shared Savings Program), T (Pioneer)	N			X	00	Valid	ACO_0040

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
O (Shared Savings Program), T (Pioneer)	N	O (Shared Savings Program), T (Pioneer)	N	X			51	Error	
O (Shared Savings Program), T (Pioneer)	N	O (Shared Savings Program), T (Pioneer)	N		X		51	Error	ACO_0040
O (Shared Savings Program), T (Pioneer)	N	O (Shared Savings Program), T (Pioneer)	N			X	00	Valid	ACO_0040
O (Shared Savings Program), T (Pioneer)	Y or N	T (1-800)	Y or N	X			51	Error	
O (Shared Savings Program), T (Pioneer)	Y or N	T (1-800)	Y or N		X		00	Valid	ACO_0040
O (Shared Savings Program), T (Pioneer)	Y or N	T (1-800)	Y or N			X	00	Valid	ACO_0040
T (1-800)	Y or N	N (Shared Savings Program)	Y	X			51	Error	
T (1-800)	Y or N	N (Shared Savings Program)	Y		X	X	54	Error	

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
T (1-800)	Y or N	N (Shared Savings Program)	N	X	X	X	56	Error	An “N” Decision Mech Code with an “N” Preference Switch is always error code 56
T (1-800)	Y or N	R (Shared Savings Program), W (Pioneer), T (Pioneer), O (Shared Savings Program), E (Pioneer, Shared Savings Program)	Y or N	X			51	Error	
T (1-800)	Y or N	R (Shared Savings Program), W (Pioneer), T (Pioneer), O (Shared Savings Program), E (Pioneer, Shared Savings Program)	Y or N		X		54	Error	

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
T (1-800)	Y or N	R (Shared Savings Program), W (Pioneer), T (Pioneer), O (Shared Savings Program), E (Pioneer, Shared Savings Program)	Y or N			X	00	Valid	ACO_0040
T (1-800)	Y or N	T (1-800)	Y	X			51	Error	
T (1-800)	Y or N	T (1-800)	Y		X		51	Error	ACO_0040
T (1-800)	Y or N	T (1-800)	Y			X	00	Valid	ACO_0040
T (1-800)	Y	T (1-800)	N	X			51	Error	
T (1-800)	Y	T (1-800)	N		X		00	Valid	ACO_0040
T (1-800)	Y	T (1-800)	N			X	00	Valid	ACO_0040
T (1-800)	N	T (1-800)	N	X			51	Error	
T (1-800)	N	T (1-800)	N		X		51	Error	ACO_0040
T (1-800)	N	T (1-800)	N			X	00	Valid	ACO_0040
Note: Same encounter date 1-800 trumps ACO Record									

Alcohol and Substance Abuse Data Sharing

The following alcohol and substance abuse data sharing scenarios in Table 38 provide information on processing of the incoming data, the validation of the preference is done at the ACO ID level.

Note: The Alcohol and Substance Abuse Claims Usage Scenarios for Pioneer are effective until Final Rule is implemented.

Table 38: Pioneer Alcohol and Substance Abuse User Scenarios

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
T (1-800)	N	T (1-800)	Y	X	X	X	27	Error	An incoming value of T(1-800) with a "Y" Preference is always error code 27
N (Shared Savings Program)	Y	n/a							This situation will never exist
E (Pioneer) & W (Pioneer)	Y	E (Pioneer) & W (Pioneer)	Y	X			51	Error	
E (Pioneer) & W (Pioneer)	Y	E (Pioneer) & W (Pioneer)	Y		X		51	Error	
E (Pioneer) & W (Pioneer)	Y	E (Pioneer) & W (Pioneer)	Y			X	00	Valid	ACO_0040
E (Pioneer) & W (Pioneer)	Y	E (Pioneer) & W (Pioneer)	N	X			51	Error	

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
E (Pioneer) & W (Pioneer)	Y	E (Pioneer) & W (Pioneer)	N		X		00	Valid	ACO_0040
E (Pioneer) & W (Pioneer)	Y	E (Pioneer) & W (Pioneer)	N			X	00	Valid	ACO_0040
E (Pioneer) & W (Pioneer)	N	E (Pioneer) & W (Pioneer)	Y	X			51	Error	
E (Pioneer) & W (Pioneer)	N	E (Pioneer) & W (Pioneer)	Y		X		51	Error	ACO_0040
E (Pioneer) & W (Pioneer)	N	E (Pioneer) & W (Pioneer)	Y			X	00	Valid	
E (Pioneer) & W (Pioneer)	N	E (Pioneer) & W (Pioneer)	N	X			51	Error	
E (Pioneer) & W (Pioneer)	N	E (Pioneer) & W (Pioneer)	N		X		51	Error	
E (Pioneer) & W (Pioneer)	N	E (Pioneer) & W (Pioneer)	N			X	00	Valid	
E (Pioneer) & W (Pioneer)	Y	T (1-800)	N	X			51	Error	
E (Pioneer) & W (Pioneer)	Y	T (1-800)	N		X		00	Valid	ACO_0040
E (Pioneer) & W (Pioneer)	Y	T (1-800)	N			X	00	Valid	ACO_0040

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
E (Pioneer) & W (Pioneer)	N	T (1-800)	N	X			51	Error	
E (Pioneer) & W (Pioneer)	N	T (1-800)	N		X		00	Valid	ACO_0040
E (Pioneer) & W (Pioneer)	N	T (1-800)	N			X	00	Valid	ACO_0040
T (1-800)	N	W (Pioneer), E (Pioneer)	Y or N	X			51	Error	
T (1-800)	N	W (Pioneer, E (Pioneer)	Y or N		X		55	Error	
T (1-800)	N	W (Pioneer), E (Pioneer)	Y or N			X	00	Valid	ACO_0040
T (1-800)	Y	T (1-800)	Y	X	X	X			This situation should never exist
T (1-800)	N	T (1-800)	N		X		51	Error	ACO_0040
T (1-800)	N	T (1-800)	N			X	00	Valid	ACO_0040 ACO_0154
Blank (Default)	N	W (Pioneer), E (Pioneer)	Y or N	X			51	Error	RT# INC000003162978
Blank (Default)	N	W (Pioneer), E (Pioneer)	Y or N			X	00	Valid	RT# INC000003162978

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
Blank (Default)	N	W (Pioneer), E (Pioneer)	Y or N		X		51	Error	RT# INC000003162978
Note: Decision Mechanism Code and Sharing Source Code fields are stored as blank in a default record in the system.									

Appendix S: Medical Data Sharing Preferences User Scenarios – Effective FINAL RULE Go-Live Date

Medical Data Sharing

The following data sharing preference scenarios below are applicable to medical preferences submitted to the ACO-OS by 1-800 after the FINAL RULE Go-Live Date.

Table 39: Pioneer Medical Claim User Scenarios

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New Record Encounter Date[2] Earlier than Existing Record	New Record Encounter Date[2] Equal to Existing Record	New Record Encounter Date[2] Later than Existing Record	Response Code	Response	Comments
E (Pioneer, W (Pioneer)	Y	T (1-800)	Y or N	X			51	Error	ACO_0200
E (Pioneer, W (Pioneer)	Y	T (1-800)	Y or N		X		00	Valid	ACO_0040 ACO_0200
E (Pioneer, W (Pioneer)	Y	T (1-800)	Y or N			X	00	Valid	ACO_0200
E (Pioneer, W (Pioneer)	N	T (1-800)	Y or N	X			51	Error	ACO_0200
E (Pioneer, W (Pioneer)	N	T (1-800)	Y or N		X		00	Valid	ACO_0200

[2] Refer to Glossary for definition of Encounter Date

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New Record Encounter Date[2] Earlier than Existing Record	New Record Encounter Date[2] Equal to Existing Record	New Record Encounter Date[2] Later than Existing Record	Response Code	Response	Comments
E (Pioneer, W (Pioneer)	N	T (1-800)	Y or N			X	00	Valid	ACO_0200
T (Pioneer)	Y or N	T (1-800)	Y or N	X			51	Error	ACO_0200
T (Pioneer)	Y or N	T (1-800)	Y or N		X		00	Valid	ACO_0040 ACO_0200
T (Pioneer)	Y or N	T (1-800)	Y or N			X	00	Valid	ACO_0040 ACO_0200
T (1-800)	Y or N	T (1-800)	Y	X			51	Error	ACO_0200
T (1-800)	Y or N	T (1-800)	Y		X		51	Error	ACO_0040 ACO_0200
T (1-800)	Y or N	T (1-800)	Y			X	00	Valid	ACO_0040 ACO_0200
T (1-800)	Y	T (1-800)	N	X			51	Error	ACO_0200
T (1-800)	Y	T (1-800)	N		X		00	Valid	ACO_0040 ACO_0200
T (1-800)	Y	T (1-800)	N			X	00	Valid	ACO_0040 ACO_0200
T (1-800)	N	T (1-800)	N	X			51	Error	ACO_0200
T (1-800)	N	T (1-800)	N		X		51	Error	ACO_0040 ACO_0200
T (1-800)	N	T (1-800)	N			X	00	Valid	ACO_0040 ACO_0200

Table 40: Pioneer Alcohol and Substance Abuse User Scenarios

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
T (1-800)	N	T (1-800)	Y	X	X	X	27	Error	An incoming value of T(1-800) with a "Y" Preference is always error code 27
E (Pioneer) & W (Pioneer)	Y	E (Pioneer) & W (Pioneer)	Y	X			51	Error	
E (Pioneer) & W (Pioneer)	Y	E (Pioneer) & W (Pioneer)	Y		X		51	Error	
E (Pioneer) & W (Pioneer)	Y	E (Pioneer) & W (Pioneer)	Y			X	00	Valid	ACO_0040
E (Pioneer) & W (Pioneer)	Y	E (Pioneer) & W (Pioneer)	N	X			51	Error	
E (Pioneer) & W (Pioneer)	Y	E (Pioneer) & W (Pioneer)	N		X		00	Valid	ACO_0040
E (Pioneer) & W (Pioneer)	Y	E (Pioneer) & W (Pioneer)	N			X	00	Valid	ACO_0040
E (Pioneer) & W (Pioneer)	N	E (Pioneer) & W (Pioneer)	Y	X			51	Error	

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
E (Pioneer) & W (Pioneer)	N	E (Pioneer) & W (Pioneer)	Y		X		51	Error	ACO_0040
E (Pioneer) & W (Pioneer)	N	E (Pioneer) & W (Pioneer)	Y			X	00	Valid	
E (Pioneer) & W (Pioneer)	N	E (Pioneer) & W (Pioneer)	N	X			51	Error	
E (Pioneer) & W (Pioneer)	N	E (Pioneer) & W (Pioneer)	N		X		51	Error	
E (Pioneer) & W (Pioneer)	N	E (Pioneer) & W (Pioneer)	N			X	00	Valid	
E (Pioneer) & W (Pioneer)	Y	T (1-800)	N	X			51	Error	
E (Pioneer) & W (Pioneer)	Y	T (1-800)	N		X		00	Valid	ACO_0040
E (Pioneer) & W (Pioneer)	Y	T (1-800)	N			X	00	Valid	ACO_0040
E (Pioneer) & W (Pioneer)	N	T (1-800)	N	X			51	Error	
E (Pioneer) & W (Pioneer)	N	T (1-800)	N		X		00	Valid	ACO_0040

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
E (Pioneer) & W (Pioneer)	N	T (1-800)	N			X	00	Valid	ACO_0040
T (1-800)	N	W (Pioneer), E (Pioneer)	Y or N	X			51	Error	
T (1-800)	N	W (Pioneer, E (Pioneer)	Y or N		X		55	Error	
T (1-800)	N	W (Pioneer), E (Pioneer)	Y or N			X	00	Valid	ACO_0040
T (1-800)	Y	T (1-800)	Y	X	X	X			This situation should never exist
T (1-800)	N	T (1-800)	N		X		51	Error	ACO_0040
T (1-800)	N	T (1-800)	N			X	00	Valid	ACO_0040 ACO_0154
Blank (Default)	N	W (Pioneer), E (Pioneer)	Y or N	X			51	Error	RT# INC000003162978
Blank (Default)	N	W (Pioneer), E (Pioneer)	Y or N			X	00	Valid	RT# INC000003162978
Blank (Default)	N	W (Pioneer), E (Pioneer)	Y or N		X		51	Error	RT# INC000003162978

Existing Record Mechanism Code	Preference Values	New Record Mechanism Code	Preference Values	New record encounter date earlier than existing record	New record encounter date equal to existing record	New record encounter date later than existing record	Response Code	Response	Comments
Note: Decision Mechanism Code and Sharing Source Code fields are stored as blank in a default record in the system.									

Glossary

Term	Definition
Attestation list	List of beneficiaries who attested into an ACO for the subsequent program performance period (Through PY3).
Prospectively aligned	A beneficiary is prospectively aligned based on the following rules: • Based on the Attestation list from ACOs, CMS compiles a list of beneficiaries who are aligned with an ACO for the next alignment period. • The CMS assignment/alignment process aligns beneficiaries to ACOs based on plurality of service.
Non-prospectively aligned	Beneficiaries who had previously been aligned with an ACO, but who are not aligned with an ACO for the subsequent alignment period

Acronyms

Term	Definition
ACO	Accountable Care Organization
ACO-OS	Accountable Care Organization Operational System
APCSS	Automated Production Control & Scheduling System
ASC	Ambulatory Surgical Center
CCN	CMS Certification Number
CHAR	Character
CME	Common Medicare Environment
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
ConOps	Concept of Operations
DAW	Dispense As Written
DMEPOS	Durable Medical Equipment, Prosthetics/Orthotics & Supplies
DMERC	Durable Medical Equipment Regional Carrier
DOB	Date of Birth
EFT	Electronic File Transfer
EIN	Employer Identification Number
FIPS	Federal Information Processing Standard
GTL	Government Team Lead
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HICN	Health Insurance Claim Number
ICD	Interface Control Document
ICD	International Classification of Diseases
ID	Identifier
IDR	Integrated Data Repository
MBD	Medicare Beneficiary Database
NCH	National Claims History
NCPDP	National Council for Prescription Drug Providers
NDC	National Drug Code
NGC	Northrop Grumman Corporation
NGD	Next Generation Desktop (1-800-Medicare)
NPI	National Provider Identifier
OASI	Old Age and Survivors Insurance
OMM	Operations and Maintenance Manual

Term	Definition
OSCAR	Online Survey, Certification, and Reporting
PDE	Prescription Drug Event
POC	Point of contact
RACS	Receipt and Control System
RRB	Railroad Board
RTI	Research Triangle Institute
SDD	System Design Document
SNF	Skilled Nursing Facility
SSN	Social Security Number
TBD	To be determined
TIN	Taxpayer Identification Number
TOB	Type of Bill
TWS	Tivoli Workload Scheduler
UPIN	Unique Physician Identification Number
XML	Extensible Markup Language
XSD	XML Schema Definition