SCORECARD MEASURES THAT REQUIRE ANCHOR DATES FOR AGE

Core Measure Set	NQF #	Anchor dates for age
Annual Monitoring for Patients on Persistent Medications	2371	Patients age 18 and older as of the end of the measurement year (e.g., December 31)
Breast Cancer Screening	2372	52-74 years as of December 31 of the measurement year
Cervical Cancer Screening	0032	24-64 years of age as of the end of the measurement year
Chlamydia Screening in Women	0033	16-24 years as of December 31 of the measurement year
Human Papillomavirus Vaccine for Female Adolescents	1959	Female adolescents who turned 13 years of age during the measurement year.
Well-Child Visits in the First 15 Months of Life	1392	Children 15 months old during the measurement year.
Adolescent well-care visits	NCQA	12–21 years as of December 31 of the measurement year.
Behavioral Health Screening Ages 1 through 18	Medicaid	Members who had a claim with CPT code 96110 or 96127 by their birthday in their new age band i.e. Between 15th and 16th Birthday = 16
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	0057	18-75 years of age by the end of the measurement year
Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062	18-75 years of age by the end of the measurement year
Use of Imaging Studies for Low Back Pain	0052	18 years at the beginning of the measurement year to 50 years by the end of the measurement year
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	0058	18 years of age as of January 1 of the year prior to the measurement year to 64 years as of December 31 of the measurement year
Appropriate Treatment for Children With Upper Respiratory Infection	0069	age 3 months as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year
Metabolic Monitoring for Children and Adolescents on Antipsychotics	2800	age 1-17 as of December 31 of the measurement year

Reporting measure set	NQF #	Anchor dates related to age
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1516	Ages: Children 3-6 years old as of December 31 of the measurement year.

Core Measure Set	NQF #	Medical record specifications
Cervical Cancer Screening	0032	Numerator: pap smear results Denominator: hysterectomy with no residual cervix (optional exclusion)
Human Papillomavirus Vaccine for Female Adolescents	1959	Numerator: immunization evidence from note specifying specific antigen with date of service or a certificate of immunization from provider
Well-Child Visits in the First 15 Months of Life	1392	(Hybrid measure) Numerator: requires a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of medical history and exam from EMR.
Adolescent well-care visits	NCQA	(Hybrid measure) Numerator: at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year, as documented through either administrative data or medical record review.
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	0057	Numerator: documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. Denominator: (exclusion) must include a note indicating the patient did not have diagnosis diabetes and had a diagnosis of gestational steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.
Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062	Numerator: need a nephropathy screening or monitoring test during the measurement year or evidence of nephropathy during the measurement year as documented by medical record review.

Reporting measure set	NQF #	Medical record
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1516	(Hybrid measure)[1] Numerator: documentation from the medical record must include a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of Health history and physical exam.

[1] There are two types of measures-1) Measures with separate administrative and medical record specifications. 2) Measures with administrative and combined (hybrid) administrative and medical record specifications.

Medicare Shared Savings Program

SHARED SAVINGS AND LOSSES AND ASSIGNMENT METHODOLOGY

Specifications

April 2017
Version #5
Applicable Beginning Performance Year 2017

MEDICARE
SHARED SAVINGS
PROGRAM

3 BENEFICIARY ASSIGNMENT FOR MEDICARE SHARED SAVINGS PROGRAM

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

In addition to retrospective assignment for Tracks 1 and 2 ACOs, preliminary prospective assignment is performed for three types of occasions. One is during the pre-screening (or application) phase when applications submitted by potential ACOs and existing ACOs applying to renew their participation under the program are assessed by CMS. Prior to the start of each performance year, Track 1 and 2 ACOs receive preliminary prospective assignment lists based on the same offset assignment window as used to determine prospective assignment for the performance year for Track 3 ACOs. Quarterly reports are based on the most recent four quarters of claims and eligibility data and include lists of preliminary prospectively assigned beneficiaries.

During retrospective assignment to a Track 1 or Track 2 ACO for the benchmark and performance year financial reconciliation, the most recent claims are used with a three-month claims run out period. For preliminary prospective assignment, the claims are used with, at most, a seven-day claims run out period.

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

While a beneficiary who is prospectively assigned to a Track 3 ACO for a benchmark or performance year is not eligible for assignment to another ACO, prospectively assigned beneficiaries that meet exclusion criteria at the end of a performance or benchmark year will be excluded from the prospective assignment list prior to calculating the historical benchmark or financial reconciliation. In addition, CMS will also perform this exclusion

on a quarterly basis during each performance year, and incorporate these exclusions into quarterly reports provided to Track 3 ACOs. The remaining exclusion criteria applied to prospectively assigned beneficiaries match the assignment criteria B, C and E included in Section 3.1 below. Also note that in determining prospective assignment for the Track 3 ACO's benchmark and performance years, CMS will identify beneficiaries that, although assigned using the offset assignment window (October – September), have died following the end of the assignment window. CMS will exclude these deceased beneficiaries from use in determining financial reconciliation for the Track 3 ACO for the performance year and make a similar exclusion for deceased beneficiaries in determining benchmark year assignment for Track 3 ACOs. ACOs are accountable for the cost and quality of care for prospectively assigned beneficiaries that die during the performance year.

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

Under the participation agreement, the ACO is required to tell CMS of changes in the composition of its ACO participants and ACO providers/suppliers. The ACO must report to CMS within 30 days of removing ACO participants and adding or removing ACO providers/suppliers and must certify its ACO participant and ACO Provider/Supplier List at the beginning of each performance year and at other such times as CMS specifies. Annually, an ACO may add TINs vetted through CMS' screening process or delete participants, resulting in a certified ACO Participant List which is the basis for beneficiary assignment used in program operations for the ACO's next performance year. Specifically, the ACO's updated certified ACO Participant List is used to:

- Recalculate the ACO's historical benchmark based on the three years prior to the start of its agreement period (herein adjusted historical benchmark);
- Determine the ACO's quality sample;
- Determine performance year expenditures (shared savings/losses); and
- Produce quarterly and annual feedback reports.

As a result, an ACO may have up to three historical benchmarks for a three-year agreement period if it makes revisions to its ACO Participant List prior to the start of its second and third performance years. A Track 1 ACO that extends its first agreement period by one year before moving to a risk-based track may have up to four historical benchmarks for its first agreement period if it makes revisions to its ACO Participant List prior to the start of its second and third and fourth performance years.

The remainder of Section 3 describes the steps used for assigning beneficiaries to Shared Savings Program ACOs.

3.1 ASSIGNMENT CRITERIA

Using Medicare claims, CMS will assign beneficiaries to an ACO in a two-step process if they get at least one primary care service from a physician utilized in assignment within the ACO (see criterion F below). For each year, a beneficiary will be assigned to a participating ACO if the following criteria are met:

A. Beneficiary must have a record of enrollment.

Medicare must have information about the beneficiary's Medicare enrollment status and other information, which is needed to determine if the beneficiary meets other criteria below.[10]

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

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

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

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

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

Beneficiaries cannot be assigned to more than one Medicare shared savings initiative. For example, beneficiaries cannot be assigned to a Shared Savings Program ACO if they are associated with another Medicare shared savings initiative before the start of the Shared Savings Program ACO's performance year. Consequently, CMS will also

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[10] Medicare Secondary Payer (MSP) status does not exclude a beneficiary from assignment to an ACO.

exclude beneficiaries from each of the benchmark years if they are aligned to another Medicare shared savings initiative in the performance years.

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

CMS excludes beneficiaries whose permanent residence is outside of the United States or U.S. territories and possessions in the last available month of the benchmark or performance year assignment window. As these beneficiaries may have received care outside of the U.S., Medicare claims may not be available. If the beneficiary was a U.S. resident in the last available month of the benchmark or performance year assignment window, CMS considers the beneficiary to be a U.S. resident for the entire period. CMS uses the same method (residency in the last available month of the assignment window) for quarterly preliminary prospective assignments for Tracks 1 and 2 ACOs. Similarly, CMS looks at residency in the last available month of the quarter when performing quarterly exclusions for Track 3 ACOs. U.S. residence includes the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Marianas.

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

To be eligible for assignment to an ACO, a beneficiary must have had at least one primary care service furnished by a physician, included in the definition of an ACO professional, utilized in assignment.[11] Note that for beneficiaries receiving primary care services at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), the physician NPI must be included on an attestation as part of the ACO Participant List. These and other special cases are described below. Tables 2 through 5 below define key terms for the assignment process, such as “primary care service.”

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

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

- Assignment Policy Step (1): CMS will assign a beneficiary to a participating ACO when the beneficiary has at least one primary care service furnished by a primary care practitioner (primary care physician, nurse practitioner, physician assistant, clinical nurse specialist at the participating ACO or an ACO professional providing

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

services at a FQHC/RHC) within the ACO (see Tables 3, 4, and 5), and more primary care services (measured by Medicare allowed charges) furnished by primary care practitioners at the participating ACO than from the same types of providers at any other Shared Savings Program ACO or non-ACO individual or group taxpayer identification number (TIN).[12]

- Assignment Policy Step (2): This step applies only for beneficiaries that have not received any primary care services from a primary care practitioner. CMS will assign the beneficiary to the participating ACO in this step if the beneficiary got at least one primary care service from a specialist physician utilized in assignment (see § 425.402(c)) at the participating ACO, and more primary care services (measured by Medicare allowed charges) from specialist physicians utilized in assignment at a participating ACO than from any other ACO or non-ACO individual or group TIN.

  CMS will include TINs from the physician/supplier carrier claims file, and other identifiers discussed below for Method II Critical Access Hospitals (CAHs), FQHCs, RHCs, and Electing Teaching Amendment (ETA) hospitals in the assignment algorithm in both Assignment Policy Steps 1 and 2 using claims from the outpatient (institutional) file loaded in the IDR. Sections 3.3, 3.4, and 3.5 contain details on how these other organization types will be identified in the outpatient claims. These organizations may include either a participant in an ACO or a non-ACO organization.

[12] As assigned by the U.S. Internal Revenue Service. There are two types of TINs: Social Security numbers and Employer Identification Numbers.

3.2 PROGRAMMING STEPS IN ASSIGNING BENEFICIARIES TO ACOs

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

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

CMS identifies all Part B claims that have at least one line item with a primary care code furnished by an ACO, based on the ACO's TINs, (Employer Identification Numbers, or Social Security numbers). CMS will use a participating ACO's TIN to identify beneficiaries that had a Part B claim that includes at least one primary care service (identified by the Healthcare Common Procedure Coding System (HCPCS) and/or revenue center codes listed in Table 2) furnished by a physician at the ACO utilized in assignment (see Table 3) within the year—this includes RHC, FQHC, and method II CAH professional services claims, which are Part B claims billed on institutional forms. Note that RHCs, FQHCs, and method II CAHs will be identified on claims by their CMS Certification Number (CCN). For claims for services provided by an ACO's FQHC/RHC participants, beneficiaries are identified if they had at least one primary care service at the ACO from a physician NPI (Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO)) listed on an attestation as part of the ACO Participant List. As noted in Table 2, beginning in 2017 CMS will not consider certain HCPCS codes in physician claims with skilled nursing facilities (SNFs) as the place of service (POS = 31) to be primary care services for purposes of assignment.

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

CMS will create a "finder file" for each ACO of the beneficiaries identified in Programming Step 1. The finder file includes the beneficiary identifier for each beneficiary who was furnished at least one primary care service by the ACO's physicians utilized in assignment within the assignment window.

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

CMS will use the finder file from Step 2 to get enrollment information for each beneficiary that had a primary care service from physicians utilized in assignment at the ACO. Eligibility information includes Medicare Parts A and B enrollment, enrollment in a group health plan, and other enrollment information for these beneficiaries. CMS will ultimately drop beneficiaries that do not meet general eligibility requirements described in Section 3.1.

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

For beneficiaries identified in the finder file in Step 3, CMS will identify their primary care services from a primary care practitioner at the participating ACO during the assignment

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

For each ACO, CMS will sum allowed charges for primary care services by beneficiary identifier. CMS includes the primary care allowed charges for each beneficiary at each ACO participant (TINs and CCNs) identified as associated with the ACO's organizational ID.[13] Note that the CCN is used for FQHC, RHC, method II CAH and ETA hospital claims as indicated in Sections 3.3, 3.4, and 3.5 below. CMS will sum primary care allowed charges by the "Line HCPCS Code" on Part B, FQHC,[14] and method II CAH claims, and by revenue codes on claims from RHCs. See Table 2 for a list of the primary care HCPCS codes and revenue codes CMS includes in beneficiary assignment. CMS will use allowed charges for assignment because unlike expenditures, they include the Medicare deductible, the first dollars of Medicare Part B payments by a beneficiary within the year (for example, $147 in 2014). By using allowed charges rather than a simple service count, CMS also reduces the likelihood that there would be ties. To determine where a beneficiary got the plurality of his or her primary care services, CMS compares the allowed charges for each beneficiary for primary care services provided by the ACO (in total for all ACO participants) to the allowed charges for primary care services provided by other ACOs and non-ACO providers.

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

Programming Step 5: Apply Assignment Policy Step 2 to beneficiaries that were not assigned in Assignment Policy Step 1.

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

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

This step applies only to beneficiaries that have not received any primary care services from a primary care physician, nurse practitioner, physician assistant, clinical nurse specialist or ACO professional providing services at an FQHC/RHC at the participating ACO, or the same type of providers outside of the ACO. In other words, it applies to beneficiaries in the finder file from Step 2 who, after Step 4, remain unassigned to any ACO, or non-ACO individual or group TIN or FQHC, RHC, method II CAH or ETA hospitals. CMS will assign each of these beneficiaries to an ACO if:

- The allowed charges for primary care services given to the beneficiary by all other ACO physicians utilized in assignment (including physician specialists as indicated in Table 3) are greater than the allowed charges for primary care services furnished by all ACO physician specialists used in assignment in each other ACO, and
- The allowed charges are greater than the allowed charges for primary care services furnished by physician specialists used in assignment in each non-ACO individual or group TIN or method II CAH or ETA hospitals.

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

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

3.3 SPECIAL POLICY FOR PROCESSING METHOD II CAH CLAIMS FOR PROFESSIONAL SERVICES

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

- CMS will use the CCN as the unique identifier for an individual method II CAH.
- To obtain the rendering physician/practitioner for method II CAH claims, CMS will use the “rendering NPI” field. In the event the rendering NPI field is blank, CMS will use the “other provider” NPI field. If the other provider NPI field is also blank on a claim, CMS will use the attending NPI field.

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

3.4 SPECIAL RULES FOR PROCESSING FQHC AND RHC CLAIMS

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

- A primary care physician is any physician NPI included in an attestation by the FQHC or RHC as part of the ACO Participant List. CMS will use FQHC/RHC physician attestation information only for purposes of determining whether a beneficiary is eligible to be assigned to an ACO. If a beneficiary is identified as being eligible for assignment to the ACO, then CMS will use claims for primary care services furnished by all FQHC/RHC ACO professionals submitted by the FQHC or RHC to determine whether the beneficiary received a plurality of his or her primary care services from the ACO under Step 1.
- For FQHCs/RHCs that are participants in an ACO, CMS treats a FQHC or RHC service reported on an institutional claim as a primary care service if the claim includes a HCPCS or revenue center code that meets the definition of a primary care service.
- For FQHCs/RHCs that are NOT participants in an ACO, CMS treats a FQHC or RHC service reported on an institutional claim as a primary care service if the claim includes a HCPCS or revenue center code that meets the definition of a primary care service. That is, for these non-ACO FQHCs and RHCs, CMS assumes a primary care physician performed all their primary care services. This will help make sure CMS does not disrupt established relationships between beneficiaries and FQHCs/RHCs.
- CMS uses the CCN as the unique identifier for an individual FQHC/RHC.

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

3.5 SPECIAL RULES FOR PROCESSING ETA INSTITUTIONAL CLAIMS

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

ETA institutional claims are identified with claim type code equal to 40, bill type equal to 13, and require that the CCN on the claim is on a list of CMS-recognized ETA hospitals. The line item HCPCS codes on the ETA institutional claims are used to identify whether a primary care service was provided. The reason for this is that physician services provided at ETA hospitals do not otherwise appear in either outpatient or physician claims.[15] ETA hospitals, however, do bill CMS to recover facility costs incurred when ETA hospital physicians provide services. The HCPCS code, thus, will provide identification that a primary care service was rendered to a beneficiary. However, CMS will not scan revenue center codes. Table 2 lists the HCPCS codes that will be used to identify primary care services for ETA institutional claims, except for two: G0438 and G0439 are not included in the list of HCPCS codes for ETA hospitals in 2009 and 2010.

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

3.6 TABLES FOR SECTION 3

- Table 2 lists the primary care codes (HCPCS and Revenue Center Codes) included in beneficiary assignment criteria.
- Table 3 lists specialty codes used to identify physicians who are the basis for beneficiary assignment. Specialty is identified by the specialty code associated with each line item on a claim. The table includes the specialty codes used to define a primary care physician (used in Assignment Step 1 and specified under § 425.20), and specialists (used in Assignment Step 2 and specified under § 425.402(c)). Note that the definition of a physician for purposes of the Shared Savings Program includes only MD/DO physicians.
- Table 4 lists specialty codes for non-physician practitioners included in the definition of an ACO professional.
- Table 5 lists the bill types for selecting carrier (physician/supplier Part B), method II CAH, FQHC, RHC, and ETA institutional claims.

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

Table 2. Primary care codes included in beneficiary assignment criteria

PRIMARY CARE CODES AND SERVICES
For services billed under the physician fee schedule (including method II CAHs), and for FQHC services furnished after 1/1/2011, primary care services include services identified by the following HCPCS/CPT©[16] codes:
Office or Other Outpatient Services
99201 New Patient, brief
99202 New Patient, limited
99203 New Patient, moderate
99204 New Patient, comprehensive
99205 New Patient, extensive
99211 Established Patient, brief
99212 Established Patient, limited
99213 Established Patient, moderate
99214 Established Patient, comprehensive
99215 Established Patient, extensive
Initial Nursing Facility Care
99304 New or Established Patient, brief (use except when POS = 31)
99305 New or Established Patient, moderate (use except when POS = 31)
99306 New or Established Patient, comprehensive (use except when POS = 31)
Subsequent Nursing Facility Care
99307 New or Established Patient, brief (use except when POS = 31)
99308 New or Established Patient, limited (use except when POS = 31)
99309 New or Established Patient, comprehensive (use except when POS = 31)
99310 New or Established Patient, extensive (use except when POS = 31)
Nursing Facility Discharge Services
99315 New or Established Patient, brief (use except when POS = 31)
99316 New or Established Patient, comprehensive (use except when POS = 31)
Other Nursing Facility Services
99318 New or Established Patient (use except when POS = 31)
Domiciliary, Rest Home, or Custodial Care Services
99324 New Patient, brief
99325 New Patient, limited

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PRIMARY CARE CODES AND SERVICES
99326 New Patient, moderate
99327 New Patient, comprehensive
99328 New Patient, extensive
99334 Established Patient, brief
99335 Established Patient, moderate
99336 Established Patient, comprehensive
99337 Established Patient, extensive
Domiciliary, Rest Home, or Home Care Plan Oversight Services
99339, brief
99340, comprehensive
Home Services
99341 New Patient, brief
99342 New Patient, limited
99343 New Patient, moderate
99344 New Patient, comprehensive
99345 New Patient, extensive
99347 Established Patient, brief
99348 Established Patient, moderate
99349 Established Patient, comprehensive
99350 Established Patient, extensive
99490 Chronic Care Management Service, 20 minutes
99495 Transitional Care Management Services within 14 days of discharge
99496 Transitional Care Management Services within 7 days of discharge
Wellness Visits
G0402 Welcome to Medicare visit
G0438 Annual Wellness Visit
G0439 Annual Wellness Visit
New G Code for Outpatient Hospital Claims
G0463 Hospital Outpatient Clinic Visit (see note below)
For FQHC services furnished prior to 1/1/2011, primary care services include services identified by HCPCS code G0402 (effective 1/1/2009) or the following revenue center codes:
0521 Clinic Visit by Member to FQHC/RHC

PRIMARY CARE CODES AND SERVICES
0522 Home Visit by FQHC/RHC Practitioner
0524 Visit by FQHC/RHC Practitioner to a Member, in a Covered Part A Stay at the SNF
0525 Visit by FQHC/RHC Practitioner to a Member in an SNF (not in a Covered Part A Stay) or Nursing Facility or ICF MR or other Residential Facility
For RHC services, primary care services include services identified by HCPCS code G0402 (effective 1/1/2009) or G0438 (effective 1/1/2011), G0439 (effective 1/1/2011) or the following revenue center codes:
0521 Clinic Visit by Member to FQHC/RHC
0522 Home Visit by FQHC/RHC Practitioner
0524 Visit by FQHC/RHC Practitioner to a Member, in a Covered Part A Stay at the SNF
0525 Visit by FQHC/RHC Practitioner to a Member in an SNF (not in a Covered Part A Stay) or Nursing Facility or ICF MR or other Residential Facility

NOTE: 42 CFR part 425 defines primary care services as the set of services identified by the following HCPCS codes: 99201 through 99215; 99304 through 99340; 99341 through 99350; G0402; G0438; G0439; and G0463. Revenue center codes 0521, 0522, 0524, and 0525. Table 2 contains all codes in that range that are currently in use. When comment indicates "use except when POS = 31", this refers to physician claims only (Claim Type = 71 or 72). While G0463 is used by hospital outpatient departments covered by Outpatient Prospective Payment System (OPPS) (bill type 13x) since January 1, 2014, for assignment purposes it is used only for ETA hospitals. The Shared Savings Program assignment algorithm ignores claims with bill type 13x except for ETA hospitals. That is, only CCNs belonging to ETA hospitals can use G0463 during the assignment process.

Table 3. Use of physician specialty codes in assignment

SPECIALTY CODE	DESCRIPTION	PRIMARY CARE PHYSICIAN (STEP 1)	SPECIALIST (STEP 2)
01	General practice	Yes	No
06	Cardiology	No	Yes
08	Family practice	Yes	No
11	Internal medicine	Yes	No
12	Osteopathic manipulative medicine	No	Yes
13	Neurology	No	Yes
16	Obstetrics/gynecology	No	Yes
23	Sports medicine	No	Yes
25	Physical medicine and rehabilitation	No	Yes
26	Psychiatry	No	Yes
27	Geriatric psychiatry	No	Yes
29	Pulmonary disease	No	Yes
37	Pediatric medicine	Yes	No
38	Geriatric medicine	Yes	No

SPECIALTY CODE	DESCRIPTION	PRIMARY CARE PHYSICIAN (STEP 1)	SPECIALIST (STEP 2)
39	Nephrology	No	Yes
46	Endocrinology (eff. 5/1992)	No	Yes
70	Multispecialty clinic or group practice	No	Yes
79	Addiction medicine (eff. 5/1992)	No	Yes
82	Hematology (eff. 5/1992)	No	Yes
83	Hematology/oncology (eff. 5/1992)	No	Yes
84	Preventive medicine (eff. 5/1992)	No	Yes
86	Neuropsychiatry (eff. 5/1992)	No	Yes
90	Medical oncology (eff. 5/1992)	No	Yes
98	Gynecologist/oncologist (eff. 10/1994)	No	Yes

NOTE: All specialties listed in this table are used to create the finder file based on non-FQHC/RHC claims. For FQHC/RHCs participating in an ACO, CMS will use any MD/DO. included on the FQHC/RHC attestation list, including those with specialties not listed in the table above, when creating the finder file. In Assignment Step 1 CMS includes any MD/DO at an FQHC/RHC, including those with specialties not listed in the above table.

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

SPECIALTY CODE	DESCRIPTION
50	Nurse practitioner
89	Clinical nurse specialist
97	Physician assistant

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

SPECIALTY CODE	SPECIALTY CODE NAME
Method II CAH Claims	Type of bill 85X with the presence of one or more of the following revenue center codes: 096x, 097x, and/or 098x
RHC Claims	71x bill types
FQHC Claims	73x (for dates of service prior to 4/1/2010) and 77x (for dates of service on or after 4/1/2010)
ETA Claims	13x bill types (from ETA hospitals)

What Can Go Wrong with PCP Attribution and How It Can Be Prevented

September 24th, 2014 / By L. Gordon Moore, MD

Attributing a person to a primary care physician (PCP) is an essential feature of population health management because it enables an accurate and fair assessment of the quality of care a provider delivers. Attribution is based on the concept that a PCP is responsible to a person across time and the entire continuum of care. It establishes this responsibility, creating a relationship between a person and his or her PCP. When members have a designated PCP, plans are able to consider the overall health of a PCP's unique panel of patients, enabling them to measure and reward provider performance on an apples-to-apples basis.

Outside of health plans that require up-front PCP choice, Treo Solutions, part of 3M Health Information Systems, has a PCP attribution process designed to help determine and assign the relationship between a health plan member and the particular PCP who is primarily responsible for the individual's overall health care.

When health plan data does not specify an existing PCP-member relationship, we identify the connection through the preponderance of claims data in a multi-step PCP attribution process.

1. Define the PCP: We start by defining a PCP as a physician with a specialty of Family Medicine, Internal Medicine, Pediatrics or General Practice. Some clients choose to include OB/GYNs and/or Nurse Practitioners (NPs) and Physician Assistants (PAs) as PCPs.
2. Identify the physician group: Once the definition of a PCP has been established, we identify the physician group that provided the patient the majority of evaluation & management (E&M) services (99201-99499) from typical PCP place-of-service codes (office, walk-in retail health clinic, independent clinic, federally qualified health center, public health clinic and rural health clinic). In case of a tie, we choose the group with the most non-E&M services for that individual. We use "most dates of services" and "most recent service" for further tie-breaking.
3. Identify the PCP: Using the same process in step 2, we identify the PCP within the group who has the majority of E&M services (99201-99499), with the same tie-breaking process.

Issues that can arise in claims-based attribution
Despite a fine-tuned attribution process, the task of determining the PCP for each health plan member can still encounter issues. There are several that can arise at the early stages and

they're often related to data integrity. Below are a few of the most common and what can be done to solve them.

- A member has not had a recent PCP visit. Individuals with no PCP visits in the 12-month reporting period will be unassigned. At Treo, we counter this issue by extending the look-back period to 24 months to capture more visits.
- A PCP's information (name, specialty, physician group) is wrong. An inaccurate PCP listing or inaccurate link between a PCP and physician group leads to inaccurate attribution. Health plans and provider systems must review the accuracy of PCP listings as well as the links between PCPs and groups. As the accuracy of these files improves, so will the attribution process.
- A Nurse Practitioner or Physician Assistant is inaccurately assigned. If an NP or PA is assigned to primary care versus specialty care, it can skew the attribution process at Step 1 by misrepresenting which providers qualify as a PCP. Health plans and provider systems must review the list of NPs and PAs to improve the accuracy of their listing as PCP. The more accurate the listing, the more accurate the attribution process will be. Achieving a high member attribution rate starts with quality data and calls for a fine-tuned PCP attribution process. It is a collaborative effort among payers, provider systems and the analytics vendor that leads to better coordinated patient care and effective pay-for-performance models.

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https://www.3mhisinsideangle.com/blog-post/what-can-go-wrong-with-pcp-attribution-and-how-it-can-be-prevented/