TWO-STEP ATTRIBUTION FOR CLAIMS-BASED QUALITY OUTCOME MEASURES AND PER CAPITA COST MEASURES INCLUDED IN THE VALUE MODIFIER

Overview

The Value-Based Payment Modifier (Value Modifier) Program evaluates the performance of solo practitioners and groups, as identified by their Medicare Taxpayer Identification Number (TIN), on the quality and cost of care provided to their Medicare Fee-for-Service (FFS) beneficiaries. The Centers for Medicare & Medicaid Services (CMS) makes this information available to TINs in confidential Quality and Resource Use Reports (QRURs). For TINs that qualify to have their Value Modifier calculated using CMS' quality-tiering methodology, CMS also uses these quality and cost measures to determine whether they will receive an upward or neutral payment adjustment to their Medicare Physician Fee Schedule (PFS) payments. The 2018 Value Modifier applies to Medicare PFS payments to physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs).

In assessing performance on several of the quality and cost measures included in the QRUR and Value Modifier, CMS uses a two-step attribution process to associate beneficiaries with TINs during the performance year. The attribution methodology determines which beneficiaries are included in the calculation of each TIN's quality and cost performance and payment adjustment under the Value Modifier.

For which measures is the two-step attribution methodology used?

Two-step attribution is implemented for the following claims-based measures included in the QRUR and Value Modifier: hospital admissions for Acute and Chronic Ambulatory Care-Sensitive Condition (ACSC) Composites, 30-day All-Cause Hospital Readmission, Per Capita Costs for All Attributed Beneficiaries, and four Per Capita Costs for Beneficiaries with Specific Conditions measures.[1,2]

[1] Refer to the Measure Information Forms for the hospital admissions for Acute and Chronic Ambulatory Care-Sensitive Condition (ACSC) Composites, 30-day All-Cause Hospital Readmission, Per Capita Costs for All Attributed Beneficiaries, and Per Capita Costs for Beneficiaries with Specific Conditions measures for more information on the attribution methodology used for these measures, including measure-specific exclusions: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html.

[2] A different attribution methodology is used for the Physician Quality Reporting System (PQRS) and Medicare Spending per Beneficiary (MSPB) measures included in the Value Modifier.

How does two-step attribution work for the 2016 performance period and 2018 Value Modifier?

The two-step attribution process. Beneficiaries are attributed to a single TIN[3] through a two-step process that takes into account the level of primary care services received (as measured by Medicare-allowed charges from final action claims during the performance period) and the provider specialties that performed these services. Only beneficiaries who received a primary care service during the performance period are considered in attribution. The following two steps are used to attribute beneficiaries to a TIN:

Step 1: A beneficiary is attributed to a TIN in the first step if the beneficiary received more primary care services from primary care physicians (PCPs), NPs, PAs, and CNSs in that TIN than in any other TIN.[4] These eligible professionals are referred to later in this document as "Step 1 Professionals." Primary care services include evaluation and management services provided in office and other non-inpatient and non–emergency-room settings, as well as initial Medicare visits and annual wellness visits.[5] If two TINs tie for the largest share of a beneficiary's primary care services, then the beneficiary is assigned to the TIN that provided primary care services most recently.

Step 2: If a beneficiary did not receive a primary care service from any PCP, NP, PA, or CNS during the performance period, then the beneficiary is attributed to a TIN in the second step if the beneficiary received more primary care services from specialist physicians (referred to later in this document as "Step 2 Professionals") within the TIN than in any other TIN.[6]

Beneficiaries excluded from attribution. Attribution for the measures listed above excludes beneficiaries who:

- were enrolled in Medicare Part A only or Medicare Part B only for any month during the performance period[7]

[3] CMS also attributes beneficiaries to Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Critical Access Hospitals (CAHs), and Electing Teaching Amendment (ETA) hospitals that are not subject to the Value Modifier.

[4] Please refer to Table 3 for a list specialty codes for providers (PCP, NP, PA or CNS) considered in the first step of the attribution process.

[5] Table 4 lists the Healthcare Common Procedure Coding System (HCPCS) codes that identify primary care services.

[6] Table 5 lists the eligible professional specialties considered in the second step of the attribution process. Table 6 lists the specialties of practitioners and therapists not included in the attribution process.

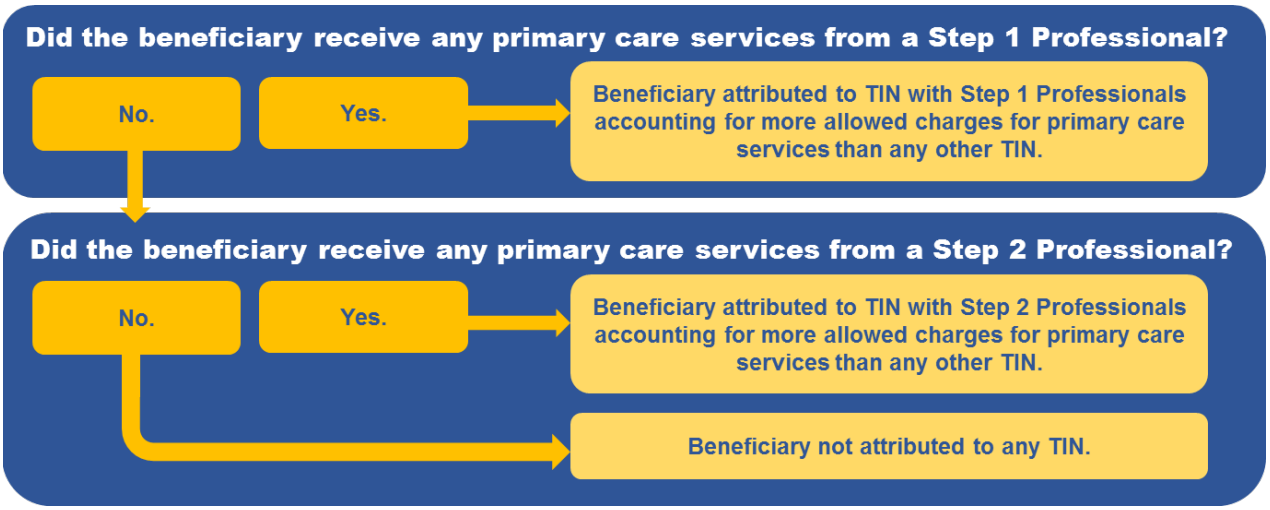
[7] For the per capita cost measures, there is an additional enrollment-related exclusion where beneficiaries are excluded if they were not enrolled in both Medicare Part A and Part B for every month during the performance period, unless that part year enrollment was the result of new enrollment or death. Additional information on the per capita cost measures is available in the Measure Information Forms for the Per Capita Costs for all Attributed Beneficiaries measure and the Per Capita Costs for Beneficiaries with Specific Conditions measures: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html.

- were enrolled in a private Medicare health plan (for example, a Medicare Advantage HMO/PPO, or a Medicare private FFS plan) for any month during the performance period
- resided outside of the United States, its territories, and its possessions during the performance period.

Beneficiaries excluded from this attribution process are not considered for inclusion in the calculation of the claims-based quality outcome and per capita cost measures.

Figure 1 summarizes the two-step attribution process.

Figure 1. Two-step attribution methodology



Case Study: Attribution to a Single Specialty, Non-Primary Care Practice

While two-step attribution is based on charges for primary care services, it is not always the case that a beneficiary will be attributed to a TIN that primarily provides primary care services. In fact, it is possible for a beneficiary to be attributed to a TIN composed entirely of non-PCP specialists (listed in Table 5), such as a specialty group consisting entirely of dermatologists. This is because beneficiaries who did not receive any primary care services from a Step 1 Professional are attributed to the TIN whose physician specialists accounted for more Medicare allowed charges for primary care services than any other TIN, even if that TIN has no PCPs or other Step 1 Professionals.

Table 1 below shows how this result might be achieved by displaying all the charges billed for services provided to a fictional Medicare beneficiary, Sarah Foster, during the course of calendar year 2016, the performance period for the 2016 Annual QRUR and 2018 Value Modifier.

In this example, Sarah was furnished services in 2016 by providers in three different TINs. TIN A is a primary care practice composed of one general internist and two NPs. All of these providers are Step 1 Professionals (see Table 3) but none of these eligible professionals provided any primary care services (see Table 4) to Sarah in 2016. TIN B is a single-specialty radiology

TIN with two diagnostic radiologists. The diagnostic radiologists are specialist physicians considered in Step 2 of attribution (see Table 5). The sum of allowed charges for primary care services at TIN B is $1,000. TIN C is a single-specialty dermatology practice composed of three dermatologists (a physician specialty considered in Step 2 of attribution). The sum of allowed charges for primary care services at TIN C is $2,300.

Table 1. Sarah Foster's fictional allowed charges during 2016

	Provider name specialty (CMS specialty code)	Allowed charges for primary care services	Allowed charges for non-primary care services	Total number of Step 1 Professionals	Total allowed charges for primary care services provided by Step 1 Professionals	Total number of Step 2 Professionals	Total allowed charges for primary care services provided by Step 2 Professionals
TIN A	Kevin Smith Internal Medicine (11)	$0	$4,500	3	$0	0	$0
	Joe Aiken Nurse Practitioner (50)	$0	$750				
	Amanda Klein Nurse Practitioner (50)	$0	$150				
TIN B	Jacob Buttery Diagnostic Radiology (30)	$1,000	$275	0	$0	2	$1,000
	Dan Darkow Diagnostic Radiology (30)	$0	$25				
TIN C	Brett Whelan Dermatology (07)	$800	$0	0	$0	3	$2,300
	Emily Vollbrecht Dermatology (07)	$750	$2,000				
	John Simms Dermatology (07)	$750	$0				

Because Sarah did not receive any primary care services from a Step 1 Professional, she is not attributed in the first step of attribution. In the second step of attribution she would be attributed to TIN C, the TIN with the specialist physicians that collectively provided a larger sum of allowed charges for primary care services than the specialist physicians of any other TIN.

Please note that Sarah is attributed to a *TIN* (TIN C) and not to an individual provider (in other words, she is not attributed to Brett Whelan).

Table 2A in the QRUR provides information about the eligible professionals involved in the attribution process. This table provides information on the beneficiaries attributed to your TIN via two-step attribution and the care your TIN and others provided to each attributed beneficiary. An example of this table, as it would appear for TIN C, is shown below in Table 2 for the fictional case of Sarah Foster. While beneficiaries' names are not shown in these tables, you can use a beneficiary's HIC number to track the beneficiary across tables to learn more about her or his outcomes and the care your TIN provided over the course of the year. Sarah's fictional HIC is 111111111A in this example.

The example Table 2A from TIN C's QRUR (located in Table 2 below) shows that Sarah was attributed to TIN C during Step 2 of the attribution process (under "Basis for Attribution") and TIN C provided the majority (69.7%) of primary care services to this beneficiary. Note that a TIN need not bill the *majority* of a beneficiary's primary care services to be attributed that beneficiary in either step of the process. If, for example, Joe Aiken had billed five dollars of allowed charges for primary care services, then Sarah Foster would have been attributed to TIN A under Step 1 of the attribution process. In this case, TIN A would have provided only 0.15% of Sarah's primary care services.

Table 2A in the QRUR also provides information about the care Sarah Foster received from TINs other than TIN C. The continuation of the example Table 2A identifies Jacob Buttery as the eligible professional who provided the most primary care services to Sarah outside of TIN C.

Table 2. Illustration of Beneficiary Attribution Information from Table 2A of the 2016 Annual QRUR

Table 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) and Claims-Based Quality Outcome Measures, and the Care that Your TIN and Other TINs Provided

Beneficiaries Attributed to Your TIN							Your TIN's Medicare FFS Claims			Elligible Professional in Your TIN Who Billed Most Primary Care Services †				Eligible Professional in Your TIN Who Billed Most Non-Primary Care Services †			
HIC	Gender	DOB	Index †	HCC Percentile Ranking †	Died in 2016	Basis for Attribution (Step 1 or Step 2) †	Date of Service on Last Claim	Number of Primary Care Services †	Percent of Total Primary Care Charges †	National Provider Identifier (NPI)	Name	Specialty	Date of Service on Last Claim	NPI	Name	Specialty	Date of Service on Last Claim
111111111A	F	04/29/1944	119605874	44	-	Step 2	12/04/2016	1	69.70%	6217019207	Brett Whelan	Dermatology	12/04/2016	-	Emily Vollbrecht	Dermatology	10/31/2016
450718530A	M	04/21/1946	122832317	76	-	Step 2	07/22/2016	4	51.69%	6217019207	SFQN RFQQTZR	General Surgery	07/22/2016	-	STSJ	-	-

† Crosses indicate terms to be defined through the hover-over function.

Table continued from above:

Hospital Admission	Chronic Condition Subgroup †				Eligible Professional Outside Your TIN Who Billed Most Primary Care Services †				Eligible Professional Outside Your TIN Who Billed Most Non-Primary Care Services †			
Date of Last Hospital Admission	Diabetes	Coronary Artery Disease	Chronic Obstructive Pulmonary Disease	Heart Failure	NPI	Name	Specialty	Date of Service on Last Claim	NPI	Name	Specialty	Date of Service on Last Claim
	No	No	No	No	6739946876	Jacob Buttery	Diagnostic Radiology	02/04/2016	6941101271	Kevin Smith	Internal Medicine	08/31/2016
05/14/2016	Yes	Yes	No	No		QFQNQ PQNGFSTKK	Optometrist	09/24/2016	6207936196	RNHMJQJ QFSHJQQTYYN	Chiropractor, Licensed	10/21/2016

Supplementary Tables

Table 3. CMS specialty codes for PCPs and nonphysician practitioners included in Step 1 of Attribution for the 2016 QRURs and 2018 Value Modifier

Specialty Description (CMS Specialty Code)
Primary Care Physicians
General Practice (01)
Family Practice (08)
Internal Medicine (11)
Geriatric Medicine (38)
Nonphysician Practitioners
Clinical Nurse Specialist (89)
Nurse Practitioner (50)
Physician Assistant (97)

Note: For claims for either FQHC or RHC services: All primary care services are considered in Step 1 of attribution unless the FQHC or RHC participates in an ACO but the attending physician does not. If the FQHC or RHC participates in an ACO but the attending physician does not, then the service is considered in Step 1 only if the attending physician is a PCP as defined in the table (Medicare Shared Savings Program 2014).

Table 4. Healthcare Common Procedure Coding System (HCPCS) primary care service codes

HCPCS codes	Brief description
99201–99205	New patient, office, or other outpatient visit
99211–99215	Established patient, office, or other outpatient visit
99304–99306	New patient, nursing facility care
99307–99310	Established patient, nursing facility care
99315–99316	Established patient, discharge day management service
99318	New or established patient, other nursing facility service
99324–99328	New patient, domiciliary or rest home visit
99334–99337	Established patient, domiciliary or rest home visit
99339–99340	Established patient, physician supervision of patient (patient not present) in home, domiciliary, or rest home
99341–99345	New patient, home visit
99347–99350	Established patient, home visit
G0402	Initial Medicare visit
G0438	Annual wellness visit, initial
G0439	Annual wellness visit, subsequent
G0463	Hospital outpatient clinic visit (Electing Teaching Amendment hospitals only)

Note: Labels are approximate. For more details, see the American Medical Association's Current Procedural Terminology ® and the CMS website (http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html).

Table 5. Medical specialists, surgeons, and other physicians included in Step 2 of attribution for the 2016 QRURs and 2018 Value Modifier

Specialty Description (CMS Specialty Code)	
Medical Specialists	**Other Physicians**
Addiction Medicine (79)	Anesthesiology (05)
Allergy/Immunology (03)	Chiropractic (35)
Cardiac Electrophysiology (21)	Diagnostic Radiology (30)
Cardiology (06)	Emergency Medicine (93)
Critical Care (Intensivists) (81)	Interventional Radiology (94)
Dermatology (07)	Nuclear Medicine (36)
Dentist (C5)	Optometry (41)
Endocrinology (46)	Pain Management (72)
Gastroenterology (10)	Pathology (22)
Geriatric Psychiatry (27)	Pediatric Medicine (37)
Hematology (82)	Podiatry (48)
Hematology/Oncology (83)	Radiation Oncology (92)
Hospice and Palliative Care (17)	Single or Multispecialty Clinic or Group Practice (70)
Infectious Disease (44)	Sports Medicine (23)
Interventional Cardiology (C3)	Unknown Physician Specialty (99)
Interventional Pain Management (09)	
Medical Oncology (90)	
Nephrology (39)	
Neurology (13)	
Neuropsychiatry (86)	
Osteopathic Manipulative Medicine (12)	
Physical Medicine and Rehabilitation (25)	
Preventive Medicine (84)	
Psychiatry (26)	
Pulmonary Disease (29)	
Rheumatology (66)	
Sleep Medicine (C0)	
Surgeons	
Cardiac Surgery (78)	
Colorectal Surgery (28)	
General Surgery (02)	
Gynecological/Oncology (98)	
Hand Surgery (40)	
Maxillofacial Surgery (85)	
Neurosurgery (14)	
Obstetrics/Gynecology (16)	
Ophthalmology (18)	
Oral Surgery (Dentists Only) (19)	
Orthopedic Surgery (20)	
Otolaryngology (04)	
Peripheral Vascular Disease (76)	
Plastic and Reconstructive Surgery (24)	
Surgical Oncology (91)	
Thoracic Surgery (33)	
Urology (34)	
Vascular Surgery (77)	

Table 6. Practitioners and therapists not included in Step 1 or Step 2 of attribution

Specialty Description (CMS Specialty Code)
Practitioners
Anesthesiologist Assistant (32)
Audiologist (Billing Independently) (64)
Certified Nurse Midwife (42)
Certified Registered Nurse Anesthetist (43)
Clinical Psychologist (68)
Clinical Psychologist (Billing Independently) (62)
Licensed Clinical Social Worker (80)
Registered Dietician/Nutrition Professional (71)
Therapists
Occupational Therapist in Private Practice (67)
Physical Therapist in Private Practice (65)
Speech Language Pathologists (15)

References

Medicare Shared Savings Program. "Shared Savings and Losses and Assignment Methodology Specifications," Version 3, December 2014. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Financial-and-Assignment-Specifications.html. Accessed December 14, 2015.