TWO-STEP ATTRIBUTION FOR MEASURES INCLUDED IN THE VALUE MODIFIER

Overview

The Value-Based Payment Modifier Program evaluates the performance of solo practitioners and groups, as identified by their Taxpayer Identification Number (TIN), on the quality and cost of care they provide to their Fee-for-Service Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) disseminates this information to TINs in confidential Quality and Resource Use Reports (QRURs). For each TIN subject to the Value Modifier, CMS also uses these data to calculate a Value Modifier that adjusts the TIN's physicians' Medicare Physician Fee Schedule payments upward, downward, or not at all, based on the TIN's performance.

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 year performance is assessed. This process assigns a beneficiary to the TIN providing more primary care services to that beneficiary than any other TIN. 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: Acute and Chronic Ambulatory Care-Sensitive Condition (ACSC) Composite, 30-day All-Cause Hospital Readmissions, Per Capita Costs for All Attributed Beneficiaries, and four Per Capita Costs for Beneficiaries with Specific Conditions measures.[1,2]

How does two-step attribution work for the 2014 performance period and 2016 Value modifier?

The two-step attribution process. Beneficiaries who do not receive any primary care service from a physician during the performance period are not attributed to any TIN. CMS

[1] Refer to the Measure Information Forms for the Acute and Chronic ACSC Composite, 30-day All-Cause Hospital Readmissions, 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: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

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

attributes beneficiaries who did receive a primary care service from a physician during the performance period to TINs[3] according to the following two-step process:

Step 1: A beneficiary is attributed to a TIN if the TIN's primary care physicians (PCPs)—defined as family practice, internal medicine, geriatric medicine, or general practice physicians—accounted for a larger share of allowed charges for primary care services for the beneficiary than PCPs of any other TIN. 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.[4] 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: Beneficiaries who are not assigned to a TIN after the first step (because they did not receive any eligible primary care services from a PCP) may be assigned to the TIN whose Step 2 Professionals [i.e., physician specialists, nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs)] accounted for more Medicare allowed charges for primary care services than any other TIN.[5] However, in order to be attributed to a TIN in the second step, a physician at the TIN (regardless of specialty) must have provided a primary care service to the beneficiary. If the beneficiary did not receive a primary care service from a physician at the TIN whose Step 2 Professionals provided more primary care services to the beneficiary than any other TIN, then the beneficiary will not be attributed to any 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 year
- were enrolled in Medicare managed care (for example, a Medicare Advantage plan) for any month during the year
- resided outside of the United States, its territories, and its possessions for any month during the year

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

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

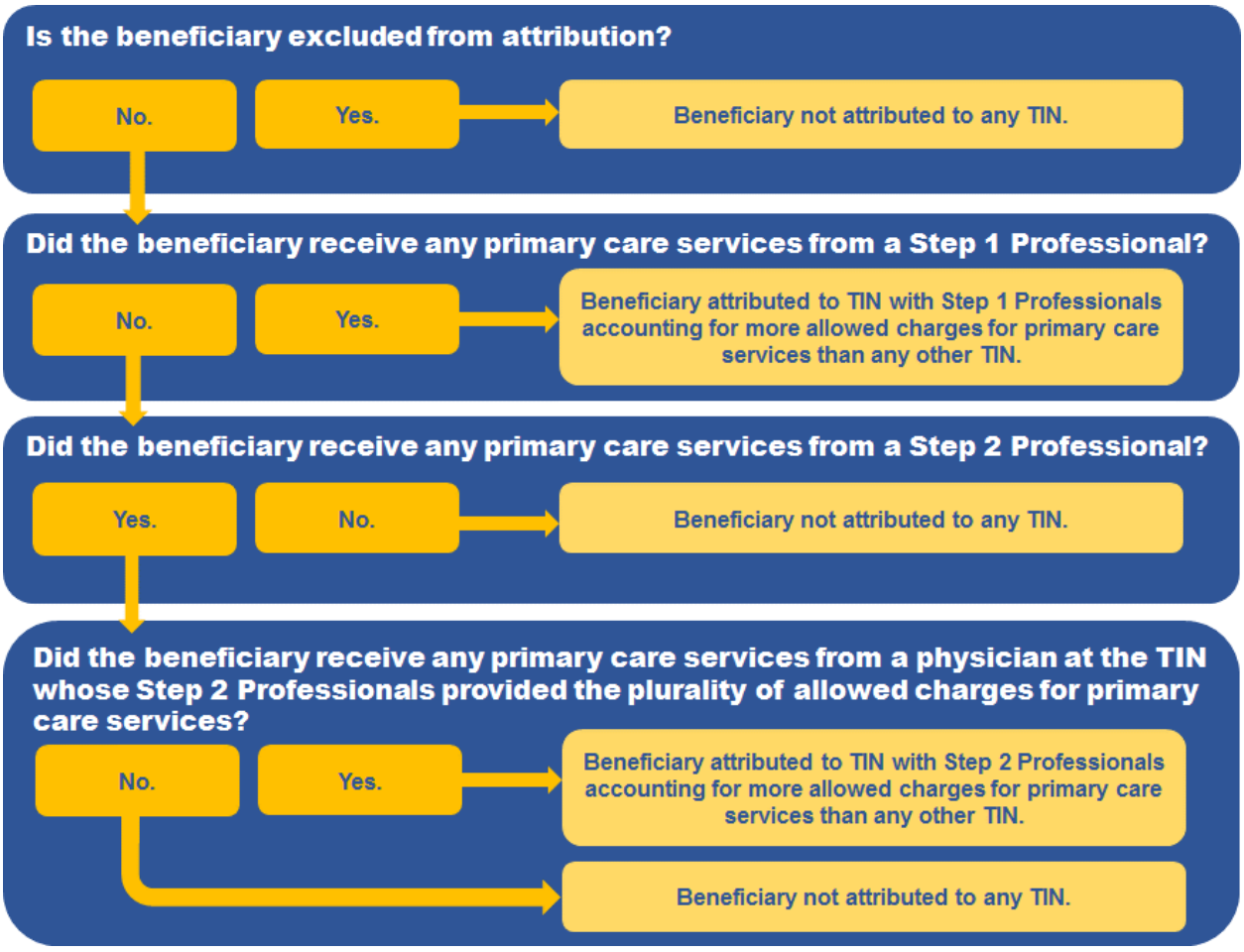
[4] Please refer to Table 1 for a list of PCPs considered in the first step of the attribution process. Table 2 lists the Healthcare Common Procedure Coding System (HCPCS) codes that identify primary care services.

[5] Table 3 lists the eligible professional specialties considered in the second step of the attribution process. Table 4 lists the specialties of practitioners and therapists not included in the attribution process.

[6] Refer to the Measure Information Forms for the Acute and Chronic ACSC Composite, 30-day All-Cause Hospital Readmissions, 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: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

Figure 1 summarizes the two-step attribution process.

Figure 1. Two-step attribution methodology



How will the two-step attribution methodology change for the 2015 performance period and 2017 Value Modifier?

The two-step attribution process described above is used for the 2013 and 2014 performance periods and the 2015 and 2016 Value Modifiers. In the 2015 Medicare Physician Fee Schedule Final Rule, CMS finalized a change to the two-step attribution methodology for the 2015 QRURs and the 2017 Value Modifier (79 FR 67790). In particular, CMS will include NPs, PAs, and CNSs in the first step of attribution. CMS also will no longer require that a beneficiary receive primary care services from a physician in order to be attributed to a TIN. As a result, in the first step of attribution, a beneficiary would be attributed to a TIN if the TIN's PCPs, NPs, PAs, and CNSs account for a larger share of allowed charges for primary care services for the beneficiary than those specialties at any other TIN. This change was recommended by the National Quality Forum, in recognition of the contribution of non-physician practitioners in the provision of primary care services.

Supplementary Tables

Table 1. CMS specialty codes for primary care physicians included in Step 1 of Attribution for 2014 QRURs and 2016 Value Modifier

Specialty Description (Specialty Code)
Primary Care Physicians
General Practice (01)
Family Practice (08)
Internal Medicine (11)
Geriatric Medicine (38)

Note: For claims for either Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) services: A PCP is any physician National Provider Identifier (NPI) included in an attestation by the FQHC or RHC. The specialty code is not reviewed for these claims because all attested physicians are considered to be PCPs (Medicare Shared Savings Program 2013).

Table 2. 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	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 (ETA hospitals only)

Note: Labels are approximate. See the American Medical Association's Current Procedural Terminology and the CMS website (http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html) for detailed definitions.

*Services billed under this code are considered to be primary care services for the 2014 Annual QRUR and 2016 Value Modifier, but not for the 2014 Mid-Year QRUR.

Table 3. Medical specialists, surgeons, other physicians, and practitioners included in Step 2 of attribution for 2014 QRURs and 2016 Value Modifier

Specialty Description (Specialty Code)

Medical Specialists

- Addiction Medicine (79)
- Allergy/Immunology (03)
- Cardiac Electrophysiology (21)
- Cardiology (06)
- Critical Care (Intensivists) (81)
- Dermatology (07)
- Endocrinology (46)
- Gastroenterology (10)
- Geriatric Psychiatry (27)
- Hematology (82)
- Hematology/Oncology (83)
- Hospice and Palliative Care (17)
- Infectious Disease (44)
- Interventional Pain Management (09)
- Medical Oncology (90)
- Nephrology (39)
- Neurology (13)
- Neuropsychiatry (86)
- Osteopathic Manipulative Therapy (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)
- Gynecologist/Oncologist (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)

Other Physicians

- Anesthesiology (05)
- Chiropractor, Licensed (35)
- Diagnostic Radiology (30)
- Emergency Medicine (93)
- Interventional Radiology (94)
- Nuclear Medicine (36)
- Optometrist (41)
- Pain Management (72)
- Pathology (22)
- Pediatric Medicine (37)
- Podiatry (48)
- Radiation Oncology (92)
- Single or Multispecialty Clinic or Group Practice (70)
- Sports Medicine (23)
- Unknown Physician (99)

Practitioners Considered in Step 2 of Attribution

- Certified Clinical Nurse Specialist (89)
- Nurse Practitioner (50)
- Physician Assistant (97)

Table 4. Practitioners and therapists not included in Step 1 or Step 2 of attribution

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

References

Centers for Medicare and Medicaid Services. "2015 Physician Fee Schedule Final Rule." November 13, 2014. Available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html. Accessed March 14, 2015.

Medicare Shared Savings Program. "Shared Savings and Losses and Assignment Methodology Specifications," Version 2, April 2013. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Financial-and-Assignment-Specifications.html. Accessed March 14, 2015.