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Medicare Accountable Care Organizations: Beneficiary Assignment Update

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Purpose

This brief updates Brief No. 2014-3 and explains changes in the Centers for Medicare & Medicaid Services (CMS) Accountable Care Organization (ACO) regulations issued in June 2015 pertaining to beneficiary assignment for Medicare Shared Savings Program ACOs. Overall, the regulatory changes are intended to (1) encourage ACOs to participate in two-sided risk contracts, (2) increase the likelihood that beneficiaries are assigned to the physician (and ACO) from whom they receive most of their primary care services, and (3) make it easier for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to participate in ACOs. Understanding ACO beneficiary assignment policies is critical for ACO in managing their panel of ACO providers and beneficiaries.

Introduction

ACO beneficiary assignment starts with the ACO's choice of risk tracks from the three provided by CMS. Track 1 (one-sided risk model) includes no downside financial risk for ACOs. ACOs choosing Track 1 for the first three years may retain that method for three more years or switch to Track 2 or 3.[1] Tracks 2 and 3 (two-sided risk model) include downside financial risk, but provide an opportunity to gain a larger percent of any shared savings than can be gained under Track 1. Track 3 includes mandatory two-sided risk. For Tracks 1 and 2, beneficiaries are assigned retrospectively based on the services received over the past 12 months. For Track 3, beneficiaries are assigned prospectively on the same basis. Hence, only ACOs in Track 3 know the patient population that drives calculated savings in advance of that calculation.

Eligibility for Medicare Beneficiary Assignment to an ACO

Certain prerequisites are necessary for a Medicare beneficiary to be eligible for assignment to an ACO:

- Beneficiaries must be enrolled for at least one month in Medicare Part A and Part B;
- Beneficiaries may not have any months of Part A only or Part B only enrollment;
- Beneficiaries may not have any months of Medicare group (private) health plan enrollment;
- Beneficiaries are not assigned to any other Medicare shared savings initiative; and
- Beneficiaries must reside within the United States or United States territories.[2]

If the above conditions are not met, the beneficiary is *not* assigned to an ACO. If the above conditions are met, the beneficiary is eligible to be assigned to an ACO, as described below.

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Assignment Methodology

Beneficiaries are eligible for assignment to an ACO if they receive at least one primary care service (based on certain HCPCS* codes; see Table 1) from a primary care physician or from a physician in one of 19 designated specialties (see Table 2) affiliated with that ACO. As under the previous regulations, beneficiaries are assigned to the provider from whom they receive the greatest number of primary care services (see Figure 1) in the assignment methodology described below.[3]

- **Primary Care Based Assignment:** A beneficiary is assigned to an ACO if the allowed charges for primary care services furnished by primary care physicians, nurse practitioners, physician assistants, and clinical nurse specialists affiliated with that ACO are greater than those furnished by primary care physicians, nurse practitioners, physician assistants, and clinical nurse specialists affiliated with other ACOs, and greater than those furnished by primary care physicians, nurse practitioners, physician assistants, and clinical nurse specialists who are unaffiliated with any ACO and who are identified by a Medicare-enrolled billing tax ID number.

- **Special rules for ACOs that include FQHCs/RHCs:** For FQHCs/RHCs that are ACO participants, CMS considers a reported service to be primary care if the associated HCPCS or revenue center code (see Table 1) meets the definition of a primary care service, and if a primary care physician attested to by the ACO as a member provider is the attending provider as reported on the claim. Primary care services provided by non-physician ACO professionals are attributed to the ACO if the attending provider is an ACO professional. If a beneficiary is identified as "assignable," CMS will use claims for primary care services furnished by all ACO professionals submitted by an FQHC or RHC to determine whether the beneficiary received most of his or her primary care services from the ACO, as described above. For FQHCs/RHCs that are not ACO participants, CMS considers all primary care services (identified by HCPCS or revenue center codes) as having been provided by a primary care physician.[4]

- **Designated Specialty Physician-Based Assignment:** If the beneficiary has received *no* primary care services from a primary care physician, nurse practitioner, physician assistant, or clinical nurse specialist (regardless of ACO affiliation), the beneficiary will then be assigned to an ACO if he or she has received at least one allowed primary care service from a physician affiliated with that ACO who is in one of the 19 designated specialties, *and* if the allowed charges for primary care services furnished by the designated specialist physicians in that ACO are greater than the allowed charges for primary care services furnished by designated specialists affiliated with another ACO, or who are unaffiliated with any ACO.[5]

Conclusion

In June 2015, CMS released new regulations for ACO assignment. Changes to the shared savings methodology include prospective assignment of beneficiaries to ACOs, a change intended to improve ACOs' ability to assess and manage financial risk. Changes made to the beneficiary assignment methodology recognize that due to specific health challenges some beneficiaries receive primary care services from specialty physicians. In addition, services provided by FQHC and RHC professionals are included in the assignment determination. The changes are intended to increase the likelihood that beneficiaries are assigned to the physician, and ACO, from whom they receive most of their primary care services, including patients served by FQHCs and RHCs. Understanding the assignment process enables providers to focus improved care management on patient experiences (including expenditures) used in the shared savings calculations.

* Healthcare Common Procedure Coding System

Figure 1: ACO Beneficiary Assignment

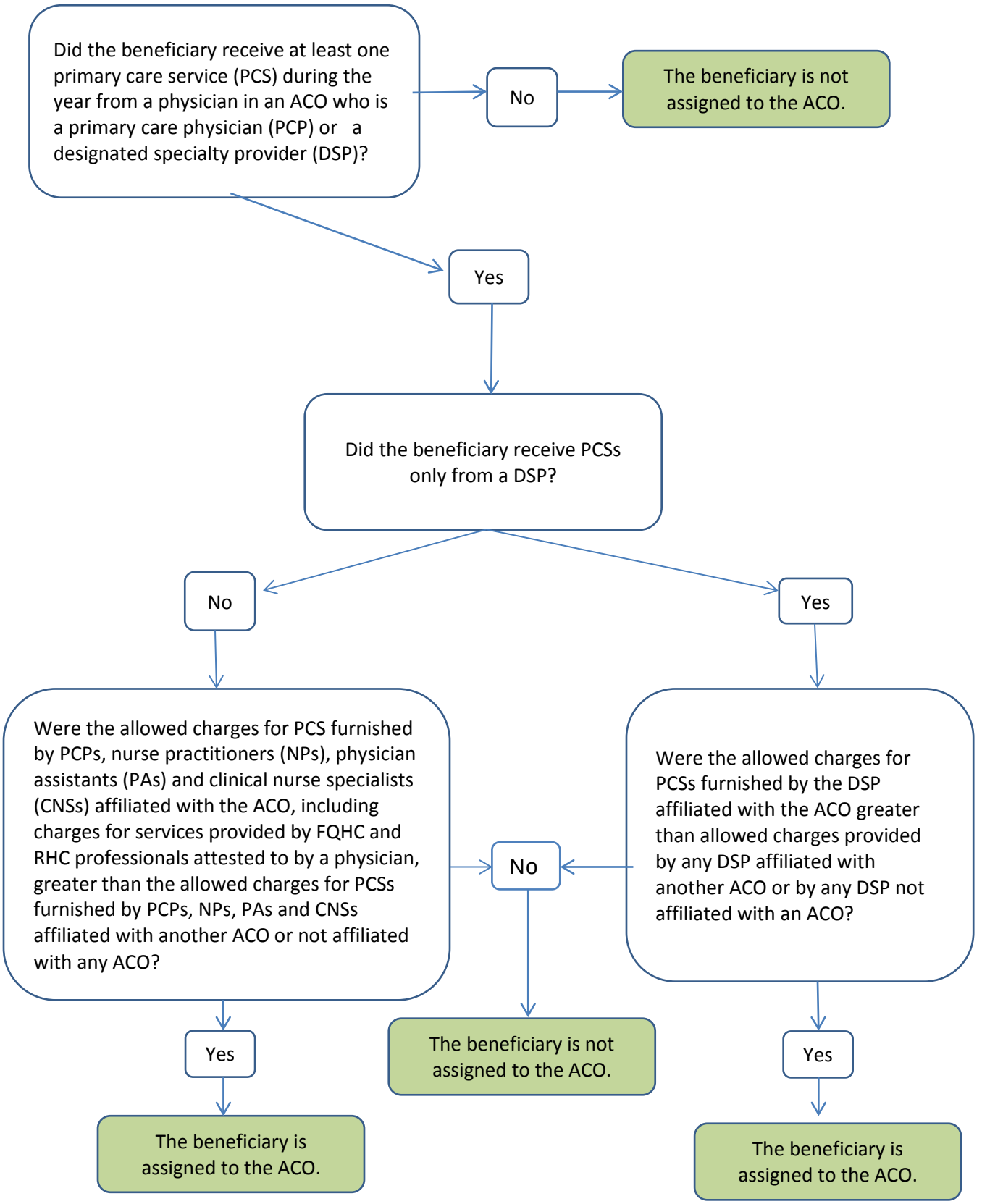

Table 1: Primary care services include services identified by the following HCPCS/CPT© * codes:[6]

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
99305 New or Established Patient, moderate
99306 New or Established Patient, comprehensive

Subsequent Nursing Facility Care
99307 New or Established Patient, brief
99308 New or Established Patient, limited
99309 New or Established Patient, comprehensive
99310 New or Established Patient, extensive

Nursing Facility Discharge Services
99315 New or Established Patient, brief
99316 New or Established Patient, comprehensive

Other Nursing Facility Services
99318 New or Established Patient

Domiciliary, Rest Home, or Custodial Care Services
99324 New Patient, brief
99325 New Patient, limited
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 RHC/FQHC
0522 Home visit by RHC/FQHC practitioner
0524 Visit by RHC/FQHC practitioner to a member, in a covered Part A stay at the SNF
0525 Visit by RHC/FQHC practitioner to a member in an SNF (not in a covered Part A stay) or NF 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 RHC/FQHC
0522 Home visit by RHC/FQHC practitioner
0524 Visit by RHC/FQHC practitioner to a member, in a covered Part A stay at the SNF
0525 Visit by RHC/FQHC practitioner to a member in an SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility

Table 2: Use of provider specialty codes in assignment

Specialty Code	Description	Primary Care *(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
39	Nephrology	No	**Yes**
46	Endocrinology (eff. 5/1992)	No	**Yes**
50	Nurse practitioner	**Yes**	**No**
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**
89	Clinical nurse specialist	**Yes**	**No**
90	Medical oncology (eff. 5/1992)	No	**Yes**
97	Physician assistant	**Yes**	**No**
98	Gynecologist/oncologist (eff. 10/1994)	No	**Yes**

NOTE: All specialties listed in this table are used to create the finder file. In Assignment Step 1 for ACOs with one or more FQHC/RHCs, we include any M.D. /D.O. that appears on the attestation list, including those with specialties not listed in the above table.

Footnotes

1. Federal Register, Vol. 80, No. 110 / Tuesday June 9, 2015 / Rules and Regulations, pp. 32833-32841. Available at (https://www.federalregister.gov/articles/2015/06/09/2015-14005/medicare-program-medicare-shared-savings-program-accountable-care-organizations). Accessed July 21, 2015.
2. Federal Register, Vol. 80, No. 110 / Tuesday June 9, 2015 / Rules and Regulations, pp. 32833-32841
3. Federal Register, Vol. 80, No. 110 / Tuesday June 9, 2015 / Rules and Regulations, pp. 32833-32841
4. Federal Register, Vol. 80, No. 110 / Tuesday June 9, 2015 / Rules and Regulations, pp. 32833-32841
5. Federal Register, Vol. 80, No. 110 / Tuesday June 9, 2015 / Rules and Regulations, pp. 32833-32841
6. Medicare Shared Savings Program Shared Savings and Losses and Assignment Methodology Specifications Applicable Beginning Performance Year 2016, Version 4. Available at (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-v2.pdf). Accessed January 5, 2016.