IHA-PBGH Commercial ACO Measurement & Benchmarking Initiative

ACO Reporting Guidelines

December 2017
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Overview

This document is a set of guidelines for MY 2017 (Year 1) ACO Reporting, which is a new initiative undertaken by IHA. IHA will be soliciting feedback on the efficacy of these guidelines from participants throughout year 1 in order to revise and enhance these guidelines in future reporting years. The following overview and reporting guidelines are specific to IHA’s ACO measurement program. Health plans and physician organizations should refer to the MY 2017 Value Based Pay for Performance Manual for ACO measure specifications and General Guidelines. The reporting guidelines outlined here are for anything specific to reporting the ACO measures.

IHA/PBGH ACO Reporting Background

California is on the leading edge of provider payment innovations, such as accountable care organizations (ACOs), and performance measurement and benchmarking initiatives to foster better care, better health, and smarter spending. At the same time, performance measures have proliferated nationally, increasing demands on providers and potentially challenging efforts to advance high-value care.

To make performance measurement more meaningful and less burdensome, IHA and the Pacific Business Group on Health have partnered to develop a standardized performance measurement and benchmarking program for commercial ACOs in California. The goal of the IHA-PBGH partnership is to develop and implement a standard measure set for commercial ACOs that meets the needs of participating purchasers, health plans, and providers while advancing national efforts for coordinated, meaningful performance measurement that promotes high-quality, affordable, patient-centered care—or high-value care.

The following plans are currently participating in ACO reporting:

- Aetna
- Anthem Blue Cross
- Blue Shield of California
- Health Net

ACOs also have the option to voluntary self-report, similar to the PO-self reporting in the VBP4P reporting.

Key Organizations Involved in Data Collection, Aggregation and Reporting

**IHA** The Integrated Healthcare Association manages the VBP4P, Medicare and ACO reporting programs and convenes all relevant committees. IHA arranges for all necessary services, including measure development, data aggregation and publication of the results in a public report card.

**NCQA** The National Committee for Quality Assurance develops and maintains the clinical measures. The majority of clinical quality measures are adapted from the NCQA Healthcare Effectiveness Data and Information Set (HEDIS) measures, the most widely used set of performance measures in the managed care industry. Non-HEDIS measures are noted in the specifications. NCQA is a nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

**PBGH** The Pacific Business Group on Health has partnered with IHA to create a standard measure set for use in performance measurement of commercial ACOs.

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1HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
**TransUnion HealthCare** (formerly the Diversified Data Design Corporation, a subsidiary of TransUnion LLC), helps IHA collect clinical data from POs and health plans.

**Onpoint Health Data** helps collects and standardizes claims, encounter and eligibility data from health plans; aggregates data across health plans for each PO and calculates the ACO measures; and creates reports for all parties.

### ACO Data Collection and Reporting Timeline

The timeline includes major milestones in the ACO data collection and reporting processes, which leverages the VBP4P and Medicare reporting timelines. Refer to the complete VBP4P Data Collection and Reporting Timeline in the MY 2017 VBP4P Manual for all dates related to VBP4P and Medicare reporting.

#### General VBP4P, Medicare and ACO Program Dates

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>PO Deadline</th>
<th>Health Plan Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MY 2017 Measure Set and Summary of Changes</strong> posted to the IHA website.</td>
<td>December 15, 2016</td>
<td></td>
</tr>
<tr>
<td><strong>Calendar year 2017 Public Comment Period</strong> posted to the IHA website.</td>
<td></td>
<td>September 1–29, 2017</td>
</tr>
<tr>
<td>- Public Comment Overview document</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Draft MY 2017 Manual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- MY 2018 Proposed Measure Set</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Final MY 2017 VBP4P Manual</strong> posted to the IHA website.</td>
<td>December 1, 2017</td>
<td></td>
</tr>
<tr>
<td><strong>MY 2018 Measure Set and Summary of Changes</strong> posted to the IHA website.</td>
<td>December 14, 2017</td>
<td></td>
</tr>
<tr>
<td><strong>MY 2017 ACO Reporting Guidelines</strong> posted to the IHA website.</td>
<td>December 15, 2017</td>
<td></td>
</tr>
<tr>
<td><strong>MY 2017 Intentions Period:</strong> ACOs declare their intent to participate for MY 2017 and confirm their health plan contracts.</td>
<td>TBD – will be communicated separately</td>
<td>TBD – will be communicated separately</td>
</tr>
</tbody>
</table>

#### Data Submission Deadlines (ACO specific)

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>PO Deadline</th>
<th>Health Plan Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NDC Lists:</strong> MY 2017 NDC lists posted to NCQA website.</td>
<td>November 1, 2017</td>
<td></td>
</tr>
<tr>
<td><strong>Data Submission File Layout:</strong> MY 2017 data submission file layout posted to IHA website. E-mail notification will also be sent out to health plans and self-reporting ACOs notifying them of the most recent postings.</td>
<td>Preliminary File: January 12, 2018 Final File: February 2, 2018</td>
<td></td>
</tr>
<tr>
<td><strong>Q1-Q4 Encounter Data:</strong> Organizations that use TransUnion HealthCare as the encounter data intermediary must submit all remaining Q4 2017 encounter data to TransUnion HealthCare. POs that use a different data intermediary or supply encounters directly to health plans should confirm the final acceptance date of encounter data to be included in VBP4P reporting.</td>
<td>February 16, 2018</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Supplemental Data Collection Deadline:</strong> Organization completes and stops all nonstandard supplemental data collection and entry.</td>
<td>February 16, 2018</td>
<td>March 1, 2018</td>
</tr>
<tr>
<td><strong>Data Layout Test Files:</strong> Self-reporting ACOs submit data layout test files to TransUnion HealthCare.</td>
<td>March 21–May 2, 2018</td>
<td>NA</td>
</tr>
</tbody>
</table>
### Activity or Milestone

<table>
<thead>
<tr>
<th>Description</th>
<th>PO Deadline</th>
<th>Health Plan Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Reporting ACO review period:</strong> Self-reporting ACOs review all submissions before sending to auditors to ensure data validity and completeness.</td>
<td>April 18 – May 2, 2018</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Current Year Data Submission, MY 2017: Medical, Enrollment, Pharmacy:</strong> Health plans submit final files of MY 2017 claims, enrollment, and pharmacy data to Onpoint for each contracted ACO.</td>
<td>NA</td>
<td>May 4, 2018</td>
</tr>
<tr>
<td><strong>Final VBP4P Results:</strong> Self-reporting ACOs submit ACO results to TransUnion HealthCare. Note that ACO self-reporting is optional.</td>
<td>May 9, 2018</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Current Year TCC Data Submission, MY 2017:</strong> Cost Health plans submit final files of MY 2017 cost data to Onpoint for each contracted ACO.</td>
<td>NA</td>
<td>June 1, 2018</td>
</tr>
<tr>
<td><strong>Current Year Data Submission, MY 2017:</strong> Lab results Health plans submit final files of MY 2017 lab data to Onpoint for each contracted ACO.</td>
<td>NA</td>
<td>June 29, 2018</td>
</tr>
</tbody>
</table>

#### ACO Report Release Dates and Review Periods (TBD)

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>Time Frame or Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reports Release:</strong> IHA posts preliminary reports to ACOs and health plans</td>
<td>October 1, 2018</td>
</tr>
<tr>
<td><strong>Review Period:</strong> IHA and Onpoint work with ACOs and health plans to respond to any questions or issues related to the results.</td>
<td>October 1-22, 2018</td>
</tr>
</tbody>
</table>

#### Review Period for MY 2017 ACO Results

IHA is committed to providing ACOs and health plans an opportunity to review their ACO results and to submit questions to understand the reported rates.

The full timeline for reviewing ACO results is documented in the Data Collection and Reporting Timeline. IHA program staff encourage participants to seek corrections and additional information throughout the measurement cycle.

Throughout the measurement cycle, participants can request additional information or clarification on program processes and methodology.

#### What’s included in ACO MY 2017 Measurement

The following measures are included in ACO reporting for MY 2017. While most measures can be reported both via option PO self-reporting and the health plan claims submission calculated by the IHA data aggregator, five measures will only be reported via one data source, due to anticipated challenges with data availability. For MY 2017 ACO reporting, refer to measure specifications in the MY 2017 VBP4P Manual.

<table>
<thead>
<tr>
<th>Measure Set</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPC</td>
<td>Statin Therapy for Patients With Cardiovascular Disease</td>
</tr>
<tr>
<td>CBPH</td>
<td>Controlling Blood Pressure for People with Hypertension</td>
</tr>
<tr>
<td>CDC</td>
<td>Comprehensive Diabetes Care: HbA1c Testing</td>
</tr>
<tr>
<td>CDC</td>
<td>Comprehensive Diabetes Care: Blood Pressure Control &lt;140/90 mm Hg.</td>
</tr>
</tbody>
</table>
For MY 2017 ACO reporting, refer to measure specifications in the MY 2017 VBP4P Manual; the MY 2017 ACO measures are a subset of the measures included in VBP4P. NCQA and IHA update the technical specifications twice a year.


Specifications in the *MY 2017 Value Based P4P Manual* that are posted to the IHA website on December 1, 2017, are frozen. The National Drug Code (NDC) lists are published on the NCQA website in November. Health plans and POs are accountable for all changes included in the December manual and the November NDC lists. Auditors assess compliance based on these.

### If You Have Questions About the Specifications

**PCS System**

VBP4P Stakeholders who have questions regarding a measure specification should submit them through NCQA's Policy Clarification Support (PCS) system.

**Step 1**  Go to the PCS page using the following link: [http://my.ncqa.org](http://my.ncqa.org)

**Step 2**  Complete the Register section.
Step 3 Log in and click My Questions.

- To ask a new question click Ask a Question.
- Click PCS Policy/Program Clarification Support.
- For Product/Program Type, click P4P—IHA Pay for Performance in the drop-down box.
- For General Content Area, select the appropriate category for your question.
- For Specific Area, scroll down and click the appropriate measure for your question, or click Not Applicable if your question type is not listed.
- For Publication Year, click 2017 (for P4P MY 2017) from the drop-down box.
- For Subject, enter a short subject for your question.
- Type your question (3,000 characters or less).

Step 4 Click Submit Your Question.

FAQs

The FAQs clarify HEDIS and VBdP4P specifications, and are posted to the NCQA website (http://ncqa.force.com/faq) on the 15th of each month, and on the IHA website (www.iha.org), as needed.

Read the entire guidelines section and measure specifications before implementing the ACO MY 2017 measures.
General Guidelines for Data Collection and Reporting

For MY 2017 ACO Reporting
Health Plans and Self-Reporting POs
General Guidelines for Data Collection and Reporting

The reporting guidelines outlined below are specifically outlined for reporting ACO measures by health plans (through Onpoint) and self-reporting ACOs. Most of the General Guidelines from the Value Based Pay for Performance program apply, as referenced below; any guidelines that differ for ACO reporting are noted here. Please note that references to “self-reporting physician organization” or “PO” have been replaced throughout with reference to “self-reporting ACO” or “ACO.” For those guidelines that reference back to the VBP4P guidelines, guidelines referencing self-reporting POs or POs apply to self-reporting ACOs for ACO reporting.

1. Two Data Sources

   **Health plan claims submission** For all ACO measures, participating health plans submit to Onpoint member-level enrollment, claims and encounter files for all ACO contracts, including an ACO identifier along with the member eligibility file. Onpoint applies the ACO measure specifications and produces the ACO contract results.

   **Self-reporting ACO** A PO may self-report data for the ACO population, collecting and submitting administrative results directly to the TransUnion for any or all clinical measures.

   A self-reporting ACO submits ACO results for all commercial ACO members belonging to a participating health plan, based on the health plan member eligibility file.

   For MY 2017 ACO reporting, no audit is required. An audit may be required in future reporting years.

   ACOs that intend to self-report in the coming year should indicate this in the annual intentions survey in November. ACOs can download the ACO Reporting File Layout and from the IHA website in January (final files available in February), and submit unaudited data files to TransUnion according to the timeline specified in the Overview.

   **Electronic data only** Regardless of data source, IHA requires that only electronic data (automated claims and encounter data and auditor-approved supplemental administrative databases) be used to calculate the measures. Sampling and the HEDIS Hybrid Methodology may not be used to collect data for ACO reporting. For MY 2017, no audit review is required for ACO reporting.

2. Reporting Level


Encounter/Claims Submission

3. Submitting Data


ACO Reporting Policies

4. Not applicable for ACO Reporting
5. VBP4P Consent to Disclosure Agreement

ACOs need to sign the Consent to Disclosure Agreement to confirm their participation in ACO reporting.

6. ACO Definition and Attribution

For the purpose of IHA-PBGH Commercial ACO Measurement & Benchmarking Initiative, IHA is defining accountable care organizations broadly. In year 1 (MY 2017) IHA will include any arrangement a participating health plan identifies as an ACO. We’ll document these definitions and use them to inform subsequent discussions and decisions about standardizing ACO measurement.

All participating plans will use their own definitions of ACO, as well as their own attribution methodologies, with the understanding that the models differ. IHA will document ACO models during MY 2017 data intake and assess appropriate benchmarking.

There are three key distinguishing features of ACOs identified that are seen as relevant to the interpretation and benchmarking of results:

- ACO participants (e.g., 2-way, 3-way, or 4-way contract between health plans, POs, hospitals, pharmacy, and/or purchasers)
- Payment/incentive structure (e.g., financial risk arrangements)
- Product line (e.g., HMO, PPO, FFS)

The below table outlines the information that each participating plan will be asked to report to IHA:

<table>
<thead>
<tr>
<th>Required ACO Documentation</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO type</td>
<td>HMO 3-way agreement (plan, physician organization, hospital)</td>
</tr>
<tr>
<td></td>
<td>HMO global risk</td>
</tr>
<tr>
<td></td>
<td>HMO dual risk</td>
</tr>
<tr>
<td></td>
<td>PPO 3-way agreement (plan, PO, hospital)</td>
</tr>
<tr>
<td></td>
<td>PPO 2-way agreement (plan and physician organization)</td>
</tr>
<tr>
<td></td>
<td>HMO/PPO 4-way agreement (plan, PO, hospital, employer)</td>
</tr>
<tr>
<td>Member assignment</td>
<td>Attribution algorithm</td>
</tr>
<tr>
<td></td>
<td>Patient selection</td>
</tr>
<tr>
<td></td>
<td>Plan assignment</td>
</tr>
<tr>
<td></td>
<td>Employer assignment</td>
</tr>
<tr>
<td>Timing</td>
<td>Retrospective</td>
</tr>
<tr>
<td></td>
<td>Prospective</td>
</tr>
<tr>
<td>Attribution provider definition</td>
<td>PCPs including OB-GYNs</td>
</tr>
<tr>
<td></td>
<td>PCPs excluding OB-GYNs</td>
</tr>
<tr>
<td></td>
<td>PCPs and specialists (non-surgical)</td>
</tr>
<tr>
<td>Attribution coverage</td>
<td>All members are assigned (except HMO)</td>
</tr>
<tr>
<td></td>
<td>Some members left unassigned</td>
</tr>
<tr>
<td>Attribution provider exclusivity</td>
<td>Member assigned to only one provider</td>
</tr>
<tr>
<td>Attribution methodology</td>
<td>Plurality – provider with most visits</td>
</tr>
<tr>
<td></td>
<td>Temporal proximity – provider with most recent visit</td>
</tr>
<tr>
<td></td>
<td>Hybrid – mix of both</td>
</tr>
<tr>
<td>Attribution basis</td>
<td>E&amp;M visits</td>
</tr>
<tr>
<td></td>
<td>All visits</td>
</tr>
<tr>
<td>Attribution period</td>
<td>12 months</td>
</tr>
<tr>
<td></td>
<td>18 months</td>
</tr>
<tr>
<td></td>
<td>24 months</td>
</tr>
<tr>
<td>Attribution frequency</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Quarterly</td>
</tr>
</tbody>
</table>
In addition to the above information, IHA will also collect information on the target population of the ACO, in order to understand the potential impact on performance. For example, some ACOs may be formed to address specific populations or care models (e.g., high cost members, specialists managing chronic conditions). Documenting these methodologies and the rationale behind them will help inform any variation seen between ACOs for MY 2017 reporting. IHA will collect this information from both the plans and the ACOs.

7. Not Applicable for ACO Reporting

8. Risk Adjustment


9. Reliability Testing/Minimum Number of Observations

Refer to General Guideline 9: Reliability Testing/Minimum Number of Observations

10. Eligible Population

The eligible population for any measure is all members who satisfy all criteria specified in the measure, including age, continuous enrollment (including allowable gap), benefit, event or anchor-date requirement. The rate is calculated using the eligible population after exclusions.

For MY 2017 ACO reporting, participating plans will provide an ACO Identifier flag in the member eligibility file provided to the IHA data aggregator. The participating plans will also provide additional information on the effective enrollment segment for the ACO flag. See Guideline 21: Continuous Attribution Periods and Benefits for more information.

11. Optional Exclusions


12. Product Reporting

For MY 2017 ACO Reporting, members are reported for each individual commercial ACO contract, which may be in the HMO or PPO product line. If an ACO member is already included the VBP4P commercial HMO/POS population, also include that member in the applicable ACO population and report.

13. Members Who Switch Health Plans or POs

Refer to General Guideline 13: Members Who Switch Health Plans or POs in the MY 2017 VBP4P Manual.

14. Members Who Switch Health Plans or POs as the Result of a Merger or Acquisition

Refer to General Guideline 14: Members Who Switch Health Plans or POs as the Result of a Merger or Acquisition in the MY 2017 VBP4P Manual.
15. Not Applicable for ACO Reporting

16. Members With Dual Commercial/Medicaid Coverage
Refer to General Guideline 16: Members with Dual Commercial/Medicaid Coverage in the MY 2017 VBP4P Manual.

17. Members With Dual Commercial Coverage

18. Self-Insured Members

19. Members Who Switch Products/Product Lines

20. Members in Hospice

21. Members who refuse services
Refer to General Guideline 21: Members Who Refuse Services in the MY 2017 VBP4P Manual

Required Enrollment Periods and Benefits

22. Continuous Enrollment and Allowable Gaps

Continuous enrollment specifies the minimum amount of time a member must be enrolled in the organization before becoming eligible for a measure. The member must also be continuously enrolled in the benefit specified for each measure (e.g. pharmacy or mental health) accounting for any allowable gaps to be considered continuously enrolled. For ACO reporting, the same concept applies, using the participating plans’ attribution or assignment of members. For reporting purposes, the plan attribution or assignment, as described below, will be used in the same way as continuous enrollment when applying the measure specifications.

One of several criteria used to identify the eligible population, continuous enrollment ensures that the health plan or ACO had sufficient time to render services to its members to be accountable for providing those services. The continuous enrollment period and allowable gaps are specified in each measure.

For MY 2017 ACO reporting, participating plans will provide an ACO Identifier flag in the member eligibility file provided to Onpoint. The participating plans will also provide additional information on the effective member month or enrollment segment for the ACO flag. This information will be used to identify continuous enrollment to the ACO. The ACO attribution or assignment, as indicated by the member eligibility file and effective member month/enrollment segment, will be used to determine if a member met the continuous enrollment criteria for a specific measure. For example, a member that has an ACO Identifier flag with effective member months dates from January through December 2017 will be considered continuously enrolled in the ACO from January 1, 2017 – December 31, 2017, or the measurement year.
Participating plans will receive an eligibility layout file from Onpoint. The information provided by plans to Onpoint, along with the effective member month date for the ACO flag, will also be provided by the plans to any participating, contract physician organizations that will be self-reporting the ACO measures. The participating physician organizations must use this information to identify the eligible population for ACO reporting and to determine which members meet the continuous enrollment criteria. Using this method, the plans and self-reporting ACOs will have the same denominator for all ACO measures.

A gap is the time when a member is not covered by the organization (i.e., the time between disenrollment and re-enrollment). For example, if a member disenrolls on June 30 and re-enrolls on July 1, there is no gap because the member was covered on both June 30 and July 1. If the member disenrolls on June 30 and re-enrolls on July 2, there is a one-day gap because the member was not covered on July 1.

With the member month or other enrollment segment flags described above, the gaps will be translated from the enrollment segments provided by the plan. For example, if the plan identifies member month eligibility for January and February 2017, and April through December 2017, the month of March 2017, or 31 days, is considered a gap, because the member was continuously enrolled from 1/1/2017 – 2/28/17 and again from 4/1/2017 – 12/31/17.

An allowable gap (less than 45 days) can occur at any time during continuous enrollment. For example, the Diabetes Care measure requires continuous enrollment from January 1–December 31 and allows one gap of up to 45 days. A member who enrolls for the first time on February 1 of the measurement year is continuously enrolled if there are no other gaps throughout the remainder of the measurement year (the member had a 31-day gap, January 1–January 31).

Enrollment in Medicare or Medicaid (FFS or HMO) plan is considered a gap in Commercial enrollment.

23. Continuous Enrollment and Allowable Gaps Over Multiple Years

Unless otherwise specified, members are allowed one gap of up to 45 days during each year of continuous enrollment for measures spanning more than 1 year. A gap that extends over multiple years of a continuous enrollment period may exceed 45 days.

For example, in the Colorectal Cancer Screening measure (which requires 2 years of continuous enrollment), a member who disenrolls on November 30 of the year prior to the measurement year and re-enrolls on February 1 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment during either year. The member has one gap of 31 days (December 1–31) in the year prior to the measurement year and one gap of 31 days (January 1–31) in the measurement year.

24. Anchor Dates

If a measure requires a member to be enrolled and to have a specified benefit on a particular date, the allowable gap must not include that date (i.e., the member must also have the benefit on that date). For example, a 55-year-old with only one gap in enrollment from November 30 of the measurement year through the remainder of the year is not eligible for the Colorectal Cancer Screening measure. Although the member meets the continuous enrollment criterion, she does not meet the anchor date criterion, which requires her to be enrolled as of December 31 of the measurement year.

25. Continuous Enrollment for ACOs

For each measure, members are assessed for continuous enrollment (attribution or assignment) in the ACO contract.

As described in Guideline 21, health plans will provided a membership eligibility file to Onpoint, along with an ACO flag for enrollment segments, to identify continuous enrollment in the ACO. This information will also be shared with the POs that have ACO contracts with the participating plans, for use in identifying the eligible population in each ACO measure for ACO self-reporting.
Determine continuous enrollment using the following steps.

**Step 1** Determine if the member was continuously enrolled (attributed or assigned) to the ACO contract, including allowable gaps.

**Step 2** Determine if the member was enrolled (attributed or assigned) in the ACO on the anchor date.

### 26. Not Applicable for ACO Reporting

### 27. Required Benefits


### Data Collection

### 28. Administrative Method


### 29. What Services Count?


### 30. Supplemental Data


### 31. Measures That Require Results From the Most Recent Test

Refer to General Guideline 31: Measures that Require Results From the Most Recent Test in the MY 2017 VBP4P Manual.

### 32. Date Specificity

Refer to General Guideline 32: Date Specificity in the MY 2017 VBP4P Manual.

### 33. Collecting Data for Measures With Multiple Numerator Events

Refer to General Guideline 33: Collecting Data for Measures With Multiple Numerator Events in the MY 2017 VBP4P Manual.

### 34. Measures That Use Pharmacy Data

Refer to General Guideline 34: Measures that Use Pharmacy Data in the MY 2017 VBP4P Manual.

### 35. Identifying Events/Diagnoses Using Laboratory or Pharmacy Data

Refer to General Guideline 35: Identifying Events/Diagnoses Using Laboratory or Pharmacy Data in the MY 2017 VBP4P Manual.
36. Facility Data


37. Member-Collected Samples and Biometric Values

Refer to General Guidelines 37: Member-Collected Samples and Biometric Values in the MY 2017 VBP4P Manual.

38. Member-Reported Services

Refer to General Guideline 38: Member-Reported Services in the MY 2017 VBP4P Manual.

Coding Conventions

39. Coding Systems Included in VBP4P²


40. Presentation of Codes in VBP4P Value Sets

Refer to General Guideline 40: Presentation of Codes in MY 2017 VBP4P Manual.

41. Using Claims to Identify Events in Conjunction With Diagnoses


42. Principal vs. Secondary Diagnosis


43. CPT Code Modifiers


44. Uniform Bill Codes Specificity


45. Mapping Proprietary or Other Codes

Refer to General Guideline 45: Mapping Proprietary or Other Codes in the MY 2017 VBP4P Manual.

46. Retiring Codes


Current Procedural Terminology © 2017 American Medical Association. All rights reserved.
47. Table Format

Refer to General Guidene 47: Table Format in the MY 2017 VBP4P Manual.

ACO Data Submission

48. Reporting Small Numbers

Health plans and self-reporting ACOs must report all available denominators, numerators and rates to the data aggregator even if the denominators are small.

49. Reporting Date

The previous calendar year is the standard measurement year for the ACO clinical data. All health plan ACO-reported clinical data should be submitted to TransUnion HealthCare on or before the date specified in the Data Collection and Reporting Timeline.

Note

• POs that use TransUnion HealthCare as the encounter data intermediary must submit all Q1–Q4 2017 encounter data to TransUnion HealthCare by February 16, 2018. No new data will be accepted after this deadline. POs that use a different data intermediary or supply encounters directly to health plans should confirm the final acceptance date of encounter data to be included in ACO reporting.
• Self-reporting ACOs must submit ACO clinical results by May 9, 2018. Health plans must submit claims data for all clinical measures for each ACO contract to Onpoint by the date specified in the timeline.

50. Required Data Elements

ACOs should report data based on all services delivered through December 31 of the measurement year, not encounters submitted or claims paid through that date. Data elements that must be submitted for each measure are listed below.

• Record type (Header—HDR, Detail—DTL, Trailer—TRL).
• ACO ID (IHA will assign)
• ACO enrollment as of December 31 of the measurement year (must match plan-provided enrollment)
• Measure ID.
• Numerator.
• Denominator.
• Rate.

The ACO Audit Review

For MY 2017 ACO reporting, no audit is required. Audit guidelines for ACO reporting will be developed for future reporting years.