Medicare Shared Savings Program: CMS Flexibilities to Fight COVID-19

Since the beginning of the COVID-19 Public Health Emergency, the Trump Administration has issued an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. These temporary changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration. The goals of these actions are 1) expand the healthcare system workforce by removing barriers for physicians, nurses, and other clinicians to be readily hired from the community or from other states; 2) ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients through temporary expansion sites (also known as CMS Hospital Without Walls); 3) increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home; 4) expand in-place testing to allow for more testing at home or in community based settings; and 5) put Patients Over Paperwork to give temporary relief from many paperwork, reporting and audit requirements so providers, health care facilities, Medicare Advantage and Part D plans, and States can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

As of January 1, 2020, there are 517 Medicare Shared Savings Program (Shared Savings Program) ACOs serving approximately 11.2 million Medicare fee-for-service (FFS) beneficiaries across the country. Thirty-seven percent of ACOs are participating under two-sided shared savings and shared losses models.

- *Calculation of Shared Losses*: The Secretary's declaration of the COVID-19 pandemic public health emergency in January 2020 triggered the Medicare Shared Savings Program's Extreme and Uncontrollable Circumstances Policy. The extreme and uncontrollable circumstance of the COVID-19 pandemic began in January 2020, and will apply for the duration of the Public Health Emergency (PHE). Shared losses will be mitigated for all ACOs participating in a performance-based risk track, including: Track 2, the ENHANCED track, the BASIC track, levels C through E, and the Track 1+ Model, based on the length of the Public Health Emergency. As an example, at this time, the PHE has already covered 4 months (January through April 2020) meaning any shared losses an ACO incurs for performance year 2020 will be reduced by at least one-third. If the PHE covers the full year (January through December 2020) any shared losses an ACO incurs for performance year 2020 would be reduced completely, and the ACO would not owe any shared losses.

- *Quality Reporting*: In an interim final rule issued on March 31, 2020, CMS modified the Shared Savings Program Extreme and Uncontrollable Circumstances Policy as it relates to disasters that occur during the quality reporting period to indicate that it applies when the quality reporting period is extended. The 2019 quality reporting period for ACOs was extended for an additional 30 days until April 30, 2020. Since all ACOs and

their beneficiaries are impacted by the PHE, under the Shared Savings Program Extreme and Uncontrollable Circumstances Policy, ACOs that do not complete quality reporting will receive the ACO quality performance mean and ACOs that do complete quality reporting will receive the higher of their own quality performance score or the ACO mean quality performance score. We continue to monitor the impact on performance year 2020 quality reporting.

- *Participation in the Shared Savings Program*: As a result of the PHE, CMS is making the following modifications to the Shared Savings Program policies:
  - We will forgo an application cycle in 2020 for an agreement start date of January 1, 2021 and offer a voluntary 1-year agreement extension for ACOs with agreement periods ending on December 31, 2020, including Track 1+ Model ACOs.

  - We will offer BASIC track ACOs participating in the glide path the option to forgo the first automatic advancement along the glide path's increasing levels of risk and potential reward. BASIC track ACOs electing this option will be automatically advanced for performance year 2022 to the level at which they would have otherwise participated under automatic advancement if they hadn't elected the option.

  - Eligible ACOs may make voluntary elections to either extend their agreements, and/or maintain (or "freeze") their current BASIC Track level for performance year 2021 starting June 18, 2020, and the anticipated final date to make these elections is September 22, 2020. We will provide additional guidance regarding the form and manner, and the timeframe (including any changes to the above dates), for making the election on the Medicare Shared Savings Program web page.

ACO ACTION	ACO RESPONSE PERIOD
Voluntary election & Initial Change Request Submission	6/18 – 7/20/20 at 12:00 p.m. (noon) Eastern Time (ET)
Request for information 1	8/11 – 8/24/20 at 12:00 p.m. (noon) ET
Request for information 2	9/16 – 9/22/20 at 12:00 p.m. (noon) ET
Final Disposition	10/20/20
Annual Certification	10/27 – 11/9/20 at 12:00 p.m. (noon) ET

As applicable, ACOs may voluntarily elect to extend their agreement, and/or freeze BASIC Level, apply for a SNF 3-Day Rule Waiver or to operate a Beneficiary Incentive Program, change beneficiary assignment methodology if eligible, and make ACO Participant and/or SNF Affiliate changes up until September 22, 2020. Dates are subject to change.

  - *Financial Methodology*: To avoid rewarding or penalizing ACOs for having higher/lower COVID-19 spread in their assigned beneficiary populations, we will remove all Parts A and B payment amounts for episodes of care for treatment of

COVID-19 from the determination of benchmark year and performance year expenditures. For example, we are excluding these payment amounts from the

calculation of trend and update factors based on national and regional FFS expenditures, truncation factors, and revenue-based loss recoupment limits. We are also making corresponding changes for purposes of identifying whether an ACO is a high revenue ACO or low revenue ACO and determining an ACO's eligibility for participation options, and calculation or recalculation of repayment mechanism amounts. We will identify an episode of care for treatment of COVID-19 as triggered by an inpatient service for treatment of COVID-19, based on either: (1) discharges for inpatient services eligible for the 20 percent DRG adjustment under section 1886(d)(4)(C) of the Act; or (2) discharges for acute care inpatient services for treatment of COVID-19 from facilities that are not paid under the IPPS, such as CAHs, when the date of admission occurs within the COVID-19 PHE. We define an episode of care for treatment of COVID-19 as starting in the month in which the inpatient stay begins as identified by the admission date, all months during the inpatient stay, and the month following the end of the inpatient stay as indicated by the discharge date. This approach, coupled with the retrospective application of historical benchmark update factors that reflect actual expenditure and utilization changes nationally and regionally, other than expenditures for episodes of care for treatment of COVID-19, will help mitigate the potential for windfall shared savings and mitigate the potential for shared losses due to COVID-19.

- *Telehealth and Beneficiary Assignment*: ACOs and their participating health care providers are using telehealth visits to continue to coordinate and deliver high quality care to their assigned beneficiaries. Consequently, for performance year 2020 and any subsequent performance year that starts during the PHE, we are including additional codes within the definition of primary care services used in determining beneficiary assignment under the Shared Savings Program so we can appropriately assign beneficiaries to ACOs based on remotely provided primary care services. Specifically, when performing claims-based assignment, we will include services billed by an ACO professional consistent with our current definition of primary care services in §425.400, but will also include remote evaluation of patient video/images HCPCS code G2010 and virtual check-in HCPCS code G2012, online digital evaluation and management services (e-visit) CPT codes 99421, 99422 and 99423, and telephone evaluation and management service CPT codes 99441, 99442, and 99443.

Additional Guidance

- The Interim Final Rules and waivers can be found at https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers.