

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

At the beginning of the COVID-19 Public Health Emergency (PHE), CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID-19. CMS has developed a cross-cutting initiative to use a comprehensive, streamlined approach to reestablish certain health and safety standards and other financial and program requirements at the eventual end of the COVID-19 public health emergency.

This CMS cross-cutting initiative aims to evaluate CMS-issued PHE blanket waivers and flexibilities to prepare the health care system for operation after the PHE. This review is being done in three concurrent phases:

1. CMS is assessing the need for continuing certain blanket waivers based on the current phase of the PHE. Since the beginning of the PHE, CMS has both added and terminated flexibilities and waivers as needed. In doing so, CMS considered the impacts on communities — including underserved communities — and the potential barriers and opportunities that the flexibilities may address.
2. CMS is assessing which flexibilities would be most useful in a future PHE, such as natural and man-made disasters and other emergencies, to ensure a rapid response to future emergencies, both locally and nationally, or to address the unique needs of communities that may experience barriers to accessing health care.
3. CMS is continuing to collaborate with federal partners and the health care industry to ensure that the health care system is holistically prepared for addressing future emergencies.

As CMS identifies barriers and opportunities for improvement, the needs of each person and community served will be considered and assessed with a health equity lens to ensure our analysis, stakeholder engagement, and policy decisions account for health equity impacts on members of underserved communities and health care professionals disproportionately serving these communities.

As of January 1, 2022, there are 483 Medicare Shared Savings Program (Shared Savings Program) ACOs serving over 11 million Medicare fee-for-service (FFS) beneficiaries across the country. Fifty-nine 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: the ENHANCED track and the BASIC track, levels C through E, based on the length of the Public Health Emergency. As an example, at this time, the PHE has already covered 6 months of this year (January through June 2022) meaning any shared losses an ACO incurs for performance year 2022 will be reduced by at least one half. If the PHE covers the full year (January through December 2022) any shared losses an ACO incurs for performance year 2022 would be reduced completely, and the ACO would not owe any shared losses. **When the COVID-19 PHE ends, the Medicare Shared Savings Program's Extreme and Uncontrollable Circumstances Policy will continue to apply, consistent with existing regulatory authority.**

- *Quality Reporting:* Since all ACOs and their beneficiaries are impacted by the PHE, under the Shared Savings Program Extreme and Uncontrollable Circumstances Policy, ACOs that are able to report quality data via the Alternative Payment Model (APM) Performance Pathway (APP) and meet MIPS data completeness and case minimum requirements, will receive the higher of their ACO's MIPS quality performance category score or the 30th percentile MIPS quality performance category score. ACOs that are unable to report quality data via the APP, will have their ACO quality performance score set equal to the 30th percentile MIPS quality performance category score. **When the COVID-19 PHE ends, the Medicare Shared Savings Program's Extreme and Uncontrollable Circumstances Policy will continue to apply, consistent with existing regulatory authority.**

- *Participation in the Shared Savings Program:* As a result of the PHE, CMS made the following modifications to the Shared Savings Program policies:
 - Eligible ACOs had the opportunity to extend their participation agreements for performance year 2021. We also offered BASIC track ACOs participating in the glide path the option to forgo their first automatic advancement along the glide path's increasing levels of risk and potential reward in PY 2021 and PY 2022. For PY 2023, BASIC track ACOs who elected this option in PY 2022 will be automatically advanced to the level at which they would have otherwise participated under automatic advancement. **When the PHE ends, participation options consistent with existing regulatory authority will apply.**

- *Financial Methodology:* To avoid rewarding or penalizing ACOs for having higher/lower COVID-19 spread in their assigned beneficiary populations, we 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 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% 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, helps mitigate the potential for windfall shared savings and mitigate the potential for shared losses due to COVID-19. **When the COVID-19 PHE ends, the Medicare Shared Savings Program's financial methodology consistent with existing regulatory authority will apply.**
- *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, we have added 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, and online digital evaluation and management services (e-visit) CPT codes 99421, 99422 and 99423. For a benchmark or performance year that includes any month(s) during the COVID-19 Public Health Emergency, in addition to the codes specified above, we will also include the primary care and telephone evaluation and management service CPT

codes 99441, 99442, and 99443 for the purpose of determining beneficiary assignment, until these codes are no longer payable under Medicare fee-for-service payment policies. **When the COVID-19 PHE ends, the Medicare Shared Savings Program’s assignment methodology consistent with existing regulatory authority will apply.**

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>.