April 30 Interim Final Rule on COVID-19 PHE

Introduction and Summary of Key Points

On April 30, CMS released a second interim final rule with comment making additional policy changes for the Medicare Shared Savings Program (MSSP) in light of the COVID-19 public health emergency (PHE). This follows a March 30 interim final rule which activated the MSSP extreme and uncontrollable circumstances policy for the COVID-19 pandemic. As a result of NAACOS advocacy, CMS makes several important updates to the extreme and uncontrollable circumstances policy to provide additional support and relief to ACOs. Key updates include:

- Adjustments to MSSP calculations to mitigate the impact of COVID-19 on ACOs by removing payment amounts for episodes of care (as identified by inpatient care for treatment of COVID-19) from MSSP performance year expenditures, while making updates to the historical benchmarks and revenue calculations for determining loss sharing limits for certain ACOs,
- Canceling the application cycle for new ACOs to enter the MSSP in 2021,
- Allowing ACOs whose current agreement periods expire on December 31, 2020, the option to extend their existing agreement periods by one year (ACOs extending their agreements for an additional year would remain under their existing historical benchmarks for that year),
- Allowing ACOs in the Basic Track's glide path the option to elect to maintain their current level of participation for performance year (PY) 2021, therefore not assuming higher levels of risk,
- Altering the extreme and uncontrollable circumstances policy to specify that the PHE began in January 2020,
- Including services provided virtually through telehealth, virtual check-ins, e-visits or telephone in the definition of primary care services used in the MSSP assignment methodology, effective January 1, 2020, and for any subsequent performance year that starts during the PHE,
- Increasing reimbursement for newly introduced audio-only telehealth services,
- Waiving the video requirement for certain evaluation and management services delivered via telehealth, and
- Easing regulatory requirements for COVID-19 testing, while increasing the availability to get reimbursed for COVID-19 testing.

The rule also expands coverage for certain telehealth services and expands payment rule waivers available to healthcare providers during the PHE. NAACOS will submit a comment letter to CMS, and we encourage ACOs to also send comments in response to this interim final rule by the June 30, 2020 deadline. Comments may be submitted via regulations.gov and must be submitted no later than 5:00 p.m. EDT. The CMS press release reviewing these changes is available here. NAACOS also developed a summary of the March 30 interim final rule that reviews the MSSP extreme and uncontrollable circumstances policy and is available here.

Application Cycle for January 1, 2021 Start Date, Extension of Agreement Periods Expiring on December 31, 2020, and Allowing Basic Track ACOs to Elect to Maintain Their Participation Level for One Year

The interim final rule notes CMS is canceling the application cycle for a January 1, 2021 start date. In light of this change, the agency also will allow ACOs that entered a first or second agreement period with a start date of January 1, 2018, to elect to extend their agreement period for an optional fourth performance year. The fourth performance year would be a 12-month performance year (January 1, 2021, to December 21, 2021). ACOs electing this option will remain under their existing historical benchmark for one additional year to increase stability and predictability given the potential impact of the PHE on Medicare Fee for Services (FFS) beneficiary expenditures. Additionally, CMS notes for those ACOs who elect this option that 2020 will not serve as a benchmark year three for the cohort of ACOs that would otherwise be January 1, 2021 starters.

CMS also will allow ACOs participating in the Basic Track glide path to elect to maintain their current level under the Basic Track for PY 2021. If making this election, the ACO will automatically be advanced to the level of the Basic Track's glide path in which it would have participated during PY 2022 if it had advanced automatically to the next level for PY 2021 (unless the ACO elects to advance more quickly before the start of PY 2022). Those ACOs who do not make this election will be automatically advanced to the next level of the glide path for 2021, unless they elect to advance to a higher level of risk more quickly than is required.

ACOs will make these voluntary elections during the Change Request (CR) cycle taking place in 2020. In the May 1 (Issue 9) ACO Spotlight Newsletter, CMS notes beginning on June 18, 2020, ACOs may take the following actions during this change request cycle:

- Voluntary election to extend agreement period for an optional fourth performance year for ACOs whose MSSP participation agreements are scheduled to end December 31, 2020
- Voluntary election to maintain current level under the Basic Track for PY 2021 or to transition to a higher level within the Basic Track's glide path
- Application for a Skilled Nursing Facility (SNF) 3-Day Rule Waiver and/or to operate a Beneficiary Incentive Program (BIP)
- Change their selection of beneficiary assignment methodology

CMS notes the anticipated final deadline to make these elections will be September 22, 2020. Please note these dates are subject to change and changes will be announced in the ACO Spotlight Newsletter. Finally, ACOs electing to extend their participation agreements must require ACO participants and ACO providers/suppliers to comply with the program's requirements through December 31, 2021. This would require an ACO to extend the duration of its agreements with these ACO participants and ACO providers/suppliers.

Applicability of Extreme and Uncontrollable Circumstances Policies to the COVID-19 Pandemic

In this rule, CMS makes a clarification regarding the extreme and uncontrollable circumstances policy for MSSP. Under the current policy, CMS will mitigate the amount of shared losses an ACO must pay back to CMS by an amount determined by multiplying: (1) the percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance and (2) the percentage of the ACO's assigned beneficiaries who reside in an area affected by an extreme and uncontrollable circumstance. In the March 30 interim final rule, CMS established that 100 percent of assigned beneficiaries for all MSSP ACOs will be determined to reside in an affected area and the number of affected months will begin with March and continue through the end of the current PHE. In this interim final rule, CMS notes the PHE

began in January 2020 and has been extended until July. Therefore, if the PHE is declared to remain in place for the remainder of 2020, all ACOs would be forgiven of all losses for 2020. The Secretary of Health and Human Services is responsible for determining the length of the PHE. More information is available here.

Adjustments to Shared Savings Program Calculations to Address the COVID-19 Pandemic

CMS establishes the agency will make adjustments to MSSP calculations to mitigate the impact of COVID-19 on ACOs by removing payment amounts for episodes of care, as identified by inpatient care for treatment of COVID-19, from MSSP performance year expenditures, while making updates to the historical benchmarks and revenue calculations for determining loss sharing limits for certain ACOs.

Removing Payment Amounts for Episodes of Care for Treatment of COVID-19 from MSSP Expenditure and Revenue Calculations

The Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 established that for discharges occurring during the PHE for individuals diagnosed with COVID-19 an increased weighting factor would be applied to the diagnosis-related group (DRG) by 20 percent and established diagnosis codes and condition codes will be used to identify these discharges.

Specifically, CMS will exclude from MSSP calculations all Parts A and B FFS payment amounts of an episode of care for treatment of COVID-19, triggered by an inpatient service and as specified on Parts A and B claims, when the date of admission occurs within the COVID-19 PHE. In addition to having a date of admission during the PHE, CMS will identify an episode of care 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 Inpatient Prospective Payment System (IPPS), such as Critical Access Hospitals (CAHs).

CMS will identify, for example, discharges of an individual diagnosed with COVID-19 using the following ICD-10 codes: B97.29 (other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after January 27, 2020; U07.1 (COVID-19) for discharges occurring on or after April 1, 2020 through the duration of the COVID-19 PHE period.

Episodes of care for treatment of COVID-19 may be triggered by an inpatient admission for acute care either at an acute care hospital or other healthcare facility, which may include temporary expansion sites, Ambulatory Surgical Centers (ASCs) providing hospital services to help address the urgent need to increase capacity, CAHs, and potentially other types of providers, according to CMS. The episode of care will be defined as starting in the month in which the inpatient stay begins as identified by admission date, all months during the inpatient stay, and through the month following the end of the inpatient stay as identified by the discharge date.

Additionally, CMS will exclude the affected months from total person years used in per capita expenditure calculations. As an example, if a beneficiary had a two-month COVID-19 episode and was enrolled as aged/non-dual eligible for PY 2020, CMS will exclude the Part A and B expenditures for two months and compute the fraction of the year enrolled in the aged/non-dual eligible population as 10/12.

CMS will adjust the following MSSP calculations to exclude all Parts A and B FFS payment amounts for a beneficiary's episode of care for treatment of COVID-19:

- Calculation of Medicare Parts A and B FFS expenditures for an ACO's assigned beneficiaries for all purposes, including the following: establishing, adjusting, updating, and resetting the ACO's historical benchmark and determining performance year expenditures
- Calculation of FFS expenditures for assignable beneficiaries as used in determining county-level FFS expenditures and national Medicare FFS expenditures*
- Calculation of Medicare Parts A and B FFS revenue of ACO participants for purposes of calculating the ACO's loss recoupment limit under the Basic Track
- Calculation of total Medicare Parts A and B FFS revenue of ACO participants and total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries 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
- Calculation or recalculation of the amount of the ACO's repayment mechanism arrangement

CMS also clarifies that payments related to COVID-19 that fall outside of the Medicare FFS Parts A and B claims would not be utilized under MSSP expenditure calculations, such as accelerated or advance payments and lump sum payments made to hospitals and other healthcare providers through the CARES Act Provider Relief Fund.

Finally, CMS notes that some trends and longer lasting effects of the COVID-19 pandemic may be challenging to anticipate at this time and will require further evaluation. CMS notes additional rulemaking may be necessary to further adjust MSSP policies in light of these unforeseen effects.

**Detailed Explanation of County-Level FFS Expenditures and National MFFS Expenditures Calculations to Adjust For COVID-19*

Calculation of FFS expenditures for assignable beneficiaries as used in determining county-level FFS expenditures and national Medicare FFS expenditures will be adjusted as follows to exclude all Parts A and B FFS payment amounts for a beneficiary's episode of care for treatment of COVID-19:

- Determining average county FFS expenditures based on expenditures for the assignable population of beneficiaries in each county in the ACO's regional service area for purposes of calculating the ACO's regional FFS expenditures
    - For ACOs in agreement periods beginning on July 1, 2019, and in subsequent years, CMS will use county FFS expenditures from which the agency will exclude all Parts A and B FFS payment amounts for a beneficiary's episode of care for treatment of COVID-19 in determining the regional component of the blended national and regional growth rates used to (1) trend forward benchmark year one and benchmark year two expenditures to benchmark year three, and (2) to update the benchmark
    - CMS will use county expenditures from which the agency will exclude all Parts A and B FFS payment amounts for a beneficiary's episode of care for treatment of COVID-19 to update the ACO's rebased historical benchmark for ACOs in a second agreement period beginning on or before January 1, 2019, based on regional growth rates in Medicare FFS expenditures
- Determining the 99th percentile of national Medicare FFS expenditures for assignable beneficiaries for purposes of the following: (1) truncating assigned beneficiary expenditures used in calculating benchmark expenditures and performance year expenditures; and (2) truncating expenditures for assignable beneficiaries in each county for purposes of determining county FFS expenditures

- Determining 5 percent of national per capita expenditures for Parts A and B services under the original Medicare FFS program for assignable beneficiaries for purposes of capping the regional adjustment to the ACO's historical benchmark
- Determining the flat dollar equivalent of the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare FFS program for assignable beneficiaries, for purposes of updating the ACO's historical benchmark
- Determining national growth rates that are used as part of the blended growth rates used to trend forward benchmark year one and benchmark year two expenditures to benchmark year three, and as part of the blended growth rates used to update the benchmark

Expansion of Codes used in Beneficiary Assignment

CMS uses more than 60 Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes for MSSP assignment and lists them in §425.400(c)(1)(iv). Of these, 51 appear on CMS's list of services eligible to be delivered through telehealth. NAACOS has heard from some ACOs whose physician practices are now conducting as many as 90 percent of their visits through telehealth. Unless CMS recognizes these telehealth visits for the purposes of patient assignment, these ACOs run the risk of either losing their assigned patient populations or not meeting the minimum 5,000 beneficiary threshold for MSSP.

As a result of NAACOS advocacy, CMS in this rule says it will count certain services delivered virtually, through telehealth, virtual check-ins, e-visits, or telephone, toward MSSP assignment effective for the 2020 performance year and any other performance year that starts during the COVID-19 public health emergency. This means some of the primary care services used to develop ACO assignment lists will be used in assignment if delivered through telehealth beginning March 1 and lasting through the public health emergency.

Several codes included on CMS's list of Covered Telehealth Services for the COVID-19 PHE are already included in the definition of primary care services used in MSSP assignment Those codes are: 99304-99306, 99315-99316, 99327-99328, 99334-99337, 99341-99345, and 99347-99350. In this rule, CMS clarifies that these CPT codes will continue to be included in the definition of primary care services used for assignment, including when they are furnished via telehealth starting March 1 and going forward during the public health emergency. However, there are many telehealth codes used in MSSP assignment that the agency doesn't mention in the May 8 rule. Those codes are: 96160-96161, 99201-99205, 99211-99215, 99307-99310, 99324-99326, 99354-99355, 99495-99498, G0438- G0439, G0442- G0444, and G0506. NAACOS has asked CMS to clarify if those codes will still be used in MSSP assignment even when delivered through telehealth.

Additionally, CMS will use remote evaluation of patient video/images (G2010), virtual check-ins (G2012), e-visits (99421-99423), and newly covered telephone E/M services (99441-99443) for ACO patient attribution for performance year 2020 and for any subsequent performance year that starts during the public health emergency. CMS states in the rule that it believes including these telehealth services in MSSP beneficiary assignment would result in a more accurate reflection of where patients receive a plurality of their primary care.

Applicability of Policies to Track 1+ Model ACOs

Because there are still 20 Track 1+ Model ACOs in 2020, CMS makes clear that policies in the IFR also apply to those ACOs. Changes include those to beneficiary assignment to count certain telehealth and

other virtual services, clarification that MSSP's extreme and uncontrollable circumstances policies to mitigate shared losses will begin with January 2020 and continue through the end of the COVID-19 PHE, and removing expenditures related to COVID-19 episodes of care. Track 1+ began as an Innovation Center Model in 2018 with 55 ACOs as a way to offer more limited downside risk to Tracks 2 or 3. Under Pathways to Success regulation changes, Track 1+ became Basic Level E.

Telehealth and Other Payment Rule Waivers

Audio-Only Telehealth for Certain Services
As a result of NAACOS advocacy, CMS said it would waive its video requirement for certain telehealth services, allowing them to be delivered through audio-only telephone calls. NAACOS heard from members that many Medicare beneficiaries do not have access to the interactive, audio-video technology Medicare typically requires for telehealth. In order to increase access to care for these beneficiaries, CMS granted a blanket waiver pursuant to authority granted to it under the CARES Act. On the downloadable file listing all of Medicare's telehealth-eligible services, CMS created a new column that states if a services can meet the new audio-only requirements. Eighty-nine of the 238 services listed are eligible for audio-only.

Payment for Audio-Only Telephone Evaluation and Management Services
In its March 30 internal final rule, CMS began reimbursing CPT codes 98966-98968 and 99441-99443, which cover prolonged, audio-only communication between the practitioner and the patient. These were previously uncovered and can be delivered to new or established patients. This would allow clinicians to communicate with patients through simple telephone calls if patients were unable to access video for visits. NAACOS and other stakeholders noted how low the reimbursement was for these services.

As a result of advocacy, CMS in the April 30 internal final rule said it would more than double the reimbursement for CPT codes 99441-99443. Specifically, CMS is cross-walking CPT codes 99212-99214, which are the most analogous office/outpatient Evaluation and Management (E/M) codes, to 99441-99443. The RVUs for the duration of the COVID-19 public health emergency will be 0.48 for CPT code 99441; 0.97 for CPT code 99442; and 1.50 for CPT code 99443. This would increase payments for these services from a range of about $14-$41 to about $46-$110. The payments are retroactive to March 1, 2020. CMS is not increasing payment rates for CPT codes 98966-98968 since these are furnished by practitioners who cannot independently bill for E/M services, and so these telephone services, by definition, are not furnished in lieu of an office/outpatient E/M service.

Changes to Hospital Payment
For the duration of the public health emergency, hospitals may bill the originating site facility fee for telehealth services when a patient is receiving a telehealth service in a temporary expansion location that is a provider-based department of the hospital and the patient is a registered outpatient of the hospital. Furthermore, hospitals may bill for telehealth services provided by hospital-based clinicians to registered outpatients, including when the patient is at home.

Eligible Practitioners
CMS is expanding the types of practitioners that may bill for telehealth services when furnished from the distant site. This allows health care professionals who were previously ineligible to provide and bill for Medicare telehealth services, including physical therapists, occupational therapists, and speech language pathologists.

Payment for Remote Physiologic Monitoring Services

Through CPT codes 99091, 99453, 99454, 99457, and 99458, CMS in recent years has moved to pay for remote patient monitoring, which allows clinicians to be reimbursed for the collection and reading of patients' physiologic data, such as weight, blood pressure, pulse oximetry, and respiratory flow rate, through digital technologies. But Medicare only pays for these services if data is collected for at least 16 days out of a 30-day period.

For the duration of the COVID-19 public health emergency, CMS will pay for remote patient monitoring for as short as two days, as long as all other requirements for billing the code are met. The agency states it is making this change because many COVID-19 patients don't need as many as 16 days of remote monitoring. CMS will not alter the payment for remote monitoring CPT codes 99454, 99453, 99091, 99457, and 99458. This change is limited to patients who have a suspected or confirmed diagnosis of COVID-19.

Updating the Medicare Telehealth List

CMS is changing the way it adds services to Medicare's list of those eligible to be delivered via telehealth. Normally, CMS adds services annually through the Physician Fee Schedule. But since the agency needs to be nimbler adding codes to its list, CMS will instead use sub-regulatory guidance during the COVID-19 public health emergency to add services to Medicare's list of those eligible to be delivered via telehealth. For example, the agency added about 80 services in the March 30 interim final rule. CMS isn't specifying a specific process it will use but notes changes will appear on its website that lists telehealth-eligible services. CMS points out that any services added during the pandemic would remain on the list only during the COVID-19 public health emergency.

NAACOS will continue to keep members updated of any further changes during the COVID-19 PHE via our website. If you have questions, please email us at advocacy@naacos.com.