Interim Final Rule in Response to the COVID-19 Public Health Emergency

On March 30, CMS released an interim final rule with comment period (IFC) that activates the extreme and uncontrollable circumstances policies for the Medicare Shared Savings Program (MSSP) for 2020, among other changes. Below is a summary of some key provisions of the IFC, which was published on April 6. While NAACOS is pleased that CMS formally invokes the MSSP extreme and uncontrollable circumstances policy for the COVID-19 pandemic, CMS does not go far enough given the momentous impact of the public health emergency. Under the CMS policy, an ACO that hypothetically owes $3 million in shared losses for Performance Year (PY) 2020 would still have to pay $2 million back to CMS (assuming a four-month long public health emergency). **ACOs should not shoulder the costs of a global pandemic. NAACOS will continue to express concerns to CMS and also ask Congress to hold ACOs harmless from any losses incurred in the 2020 performance year. We are also asking that CMS not require ACOs to advance to new risk levels in 2021.** We urge members to share this sentiment with your members of Congress to assist us in our advocacy efforts. Your voice matters! NAACOS will also submit a comment letter to CMS, and we encourage ACOs to also send comments in response to this rule by the June 1, 2020 deadline. Comments may be submitted via regulations.gov and must be submitted no later than 5:00 p.m. EDT.

Mitigating ACO Losses Due to COVID-19

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 rule, CMS notes 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 public health emergency.

ACO Quality Assessment and COVID-19

CMS makes changes to the regulation to allow for the extreme and uncontrollable circumstances policy to apply, even in cases when the quality reporting period has been extended. The agency notes it makes this change to allow for the option for CMS to apply the policy in 2019, however the agency does not actually invoke the extreme circumstances policy for 2019 at this time. CMS does discuss that it will consider making further changes to quality assessment in 2020 beyond what is provided through the extreme and uncontrollable circumstances policy. The extreme and uncontrollable circumstances policy will make the following changes in relation to quality assessments for ACOs in 2020: If an ACO is unable to report quality due to the extreme and uncontrollable circumstance, the ACO's quality score will be set to the mean quality performance score for all MSSP ACOs for the applicable performance year. However, if the ACO is able to completely and accurately report all quality measures, CMS will use the higher of the ACO's quality performance score or the mean quality performance score for all MSSP ACOs. NAACOS does not feel this policy goes far enough to mitigate the vast impact of the COVID-19 public health

emergency, and we are instead urging the agency to consider suspending all ACO quality assessments in 2020.

ACOs and the Merit-Based Incentive Payment System (MIPS)
The regulation clarifies that a recently announced extreme and uncontrollable circumstances policy for 2019 MIPS does not apply to ACOs, and MIPS eligible clinicians will continue to be scored under the existing alternative payment model (APM) scoring standard, unless all clinicians in the ACO fail to report Promoting Interoperability (PI) or quality data. CMS notes the agency may address this in future rulemaking. We have concerns with this policy, as many ACOs report their clinicians will have difficulties submitting PI data by the extended April 30 deadline. We request that, at a minimum, CMS instead adopt a policy that will exempt clinicians in ACOs that do not report PI data from the denominator in the calculation of the ACO entity average PI score. NAACOS does not believe it is fair to penalize clinicians and practices in APMs who are subject to MIPS by applying this different standard for the extreme and uncontrollable circumstances policy.

Comprehensive Care for Joint Replacement (CJR) Model
CMS also makes changes to the Comprehensive Care for Joint Replacement (CJR) Model to specify that for fracture or non-fracture episodes with a date of admission to the anchor hospitalization that is on or within 30 days before the public health emergency period begins, or that occurs through the termination of the emergency period, actual episode payments are capped at the target price. CMS also extends the CJR Model through March 31, 2021. We feel holding CJR participants harmless from spending above the target price is a fair and appropriate approach and will encourage CMS and Congress to take the same approach with ACOs by holding ACOs harmless from any losses in PY 2020.

Telehealth Provisions
CMS instituted several telehealth-related policies in response to ongoing feedback from providers during the COVID-19 pandemic and the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The agency added about 80 additional telehealth-eligible services, including emergency department visits, initial nursing facility and discharge visits, and home visits. CMS will reimburse CPT codes 98966-98968 and 99441-99443, which pay for prolonged, audio-only communication between the practitioner and the patient. Clinicians will be paid for telehealth services at a "non-facility rate," which yields a higher reimbursement for clinicians. CMS instructs clinicians who bill for Medicare telehealth services to report the point-of-service (POS) code that would have been reported had the service been furnished in-person. Additionally, CMS finalized on an interim basis the use of the CPT telehealth modifier, modifier 95, which should be applied to claim lines that describe services furnished via telehealth.

There were also a few notable changes related to remote patient monitoring. Clinicians will be allowed to deliver remote patient monitoring and virtual check-ins to new patients, as well as established patients. Clinicians can provide remote patient monitoring services for patients, no matter if it is for the COVID-19 disease or a chronic condition. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry.

NAACOS has developed this telehealth resource to help ACOs better understand telehealth and will continue to update it as additional changes in Medicare policy are made. We are working with CMS to address topics that needs need help with, including being able to document hierarchical condition category risk scores in non-face-to-face visits, understand how to deliver annual wellness visits through telehealth, and clarify how telehealth visits will impact beneficiary assignment for ACOs.