MEDICARE SHARED SAVINGS PROGRAM

ACCOUNTABLE CARE ORGANIZATION
SPOTLIGHT
NEWSLETTER

AT A GLANCE

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  December 15th | 1:30–3:00 P.M. ET

December 9, 2020 | ISSUE 25

PROGRAM HIGHLIGHTS

Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021

On December 1, 2020, CMS issued a final rule that included updates on policy changes for Medicare payments under the Physician Fee Schedule (PFS) and other Medicare Part B issues. Final policies to amend Shared Savings Program are discussed, primarily in sections III.G and III.I of the Final Rule, and include the following:

ACO Quality Measure Redesign

For Performance Year (PY) 2020, CMS finalized a proposal to waive the requirement for ACOs to field a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. ACOs will receive automatic full credit for the patient experience of care measures.

For PY 2021 and subsequent performance years, CMS finalized a redesign of the Shared Savings Program quality measure set and quality performance standard. These final policies include the following:

Shared Savings Program ACOs will be required to report quality data for purposes of the Shared Savings Program via the Alternative Payment Model (APM) Performance Pathway (APP). ACOs must meet the requirements described below:

- For PY 2021, ACOs will be required to report quality data via the APP and can choose to actively report either the 10 measures under the CMS Web Interface or the three Electronic Clinical Quality Measures (eCQM)/Merit-based Incentive Payment System (MIPS) Clinical Quality Measures (CQM) measures. In addition, ACOs will be required to field the CAHPS® for MIPS survey, and CMS will calculate two measures using administrative claims data.
- For PY 2022 and subsequent performance years, ACOs will be required to actively report quality data on the three eCQM/MIPS CQM measures via the APP and to field the CAHPS® for MIPS survey, and CMS will calculate two measures using administrative claims data.

CMS also finalized a gradual phase-in of the increase in the level of quality performance that would be required for all ACOs to meet the Shared Savings Program quality performance standard in order to share in the maximum amount of savings based on their track, potentially avoid maximum shared losses under certain payment

tracks, and avoid quality-related compliance actions for that performance year. An ACO would meet the Shared Savings Program quality performance standard under the following conditions:

- For PY 2021 and PY 2022, the ACO achieves a quality performance score that is equivalent to or higher than the 30th percentile across all MIPS Quality performance category scores; and
- For PY 2023 and subsequent performance years, the ACO achieves a quality performance score that is equivalent to or higher than the 40th percentile across all MIPS Quality performance category scores.

CMS also finalized policies strengthening the Shared Savings Program requirements regarding compliance with the quality performance standard by broadening the conditions under which CMS may terminate an ACO's participation agreement when an ACO demonstrates a pattern of failure to meet the quality performance standard.

Primary Care Service Assignment Code Updates

In response to new telehealth code policies finalized in this rule and to update the definition of primary care services used for beneficiary assignment to reflect the codes for assessment and care planning services for patients with cognitive impairment and chronic care management services, CMS is finalizing the inclusion of new evaluation and management and care management Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes in the methodology used to assign beneficiaries to ACOs. In addition, CMS is finalizing proposals to exclude certain services furnished in skilled nursing facilities from the assignment methodology when provided by clinicians billing through Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) and to modify the definition of primary care services to exclude advance care planning CPT® code 99497 and the add-on code 99498 when billed for services furnished in an inpatient care setting. Furthermore, CMS is codifying the policy of adjusting an ACO's historical benchmark to reflect any regulatory changes to the beneficiary assignment methodology in the regulations governing the benchmarking methodology.

Repayment Mechanism Updates

CMS also finalized several policies that will further reduce the burden associated with repayment mechanisms. Beginning with the application cycle for an agreement period starting on January 1, 2022, and annually thereafter, renewing ACOs and re-entering ACOs that are the same legal entities as ACOs that previously participated in the program, and that wish to continue the use of their existing repayment mechanism in a new agreement period, may decrease their repayment mechanism amount if a higher amount is not needed for their new agreement period. The final rule also offers a one-time opportunity for eligible ACOs that renewed their agreement periods beginning on July 1, 2019, or January 1, 2020, to elect to decrease the amount of their repayment mechanisms if the ACO's recalculated repayment mechanism amount for PY 2021 is less than their existing repayment mechanism amount.

IFC Final Policy Modifications

The interim final rule with comment period (IFC) issued by CMS on March 31, 2020, and the IFC issued by CMS on May 8, 2020, included provisions modifying or clarifying Shared Savings Program policies to address the impact of the public health emergency (PHE) for coronavirus disease 2019 (COVID-19) on ACOs. In response to public comments received in these IFCs, CMS finalized the Shared Savings Program provisions in the Calendar Year (CY) 2021 PFS final rule with several modifications:

- CMS finalized the adjustment to program calculations to remove payment amounts for episodes of care for treatment of COVID-19, with a revision to ensure consistency in the policies used to identify inpatient services provided by Inpatient Prospective Payment System (IPPS) and non-IPPS providers that trigger an episode of care for treatment of COVID-19.
- CMS finalized the regulation specifying the expanded definition of primary care services for purposes of determining beneficiary assignment, which includes telehealth codes for virtual check-ins, e-visits, and telephonic communication, and which will apply when the assignment window for a benchmark or performance year includes any months during the PHE for COVID-19 as defined in 42 CFR § 400.200.
- CMS finalized the revisions made to the regulation at 42 CFR § 425.502(f) in the IFC issued on March 31, 2020, to remove the restriction which prevented the application of the Shared Savings Program extreme and uncontrollable circumstances policy for disasters that occur during the quality reporting period if the reporting period is extended.

For additional information, refer to the following:

- Press Release: *Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients*
- PFS Fact Sheet: *Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021*
- Quality Payment Program (QPP) Informational Zip File: 2021 QPP Final Rule Resources
- Final Rule: *Medicare Program: CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; etc.*

HHS Finalizes Stark Law and Anti-Kickback Statute Reforms to Support Value-Based and Coordinated Care

On November 20, 2020, the Department of Health and Human Services (HHS) announced two rules that finalized changes to modernize and clarify the regulations that interpret the Physician Self-Referral Law (the "Stark Law") and the Federal Anti-Kickback Statute. The final rules provide greater flexibility for healthcare providers participating in value-based arrangements and providing coordinated care for patients. The final rules ease the compliance burden for healthcare providers across the industry while maintaining strong safeguards to protect patients and programs from fraud and abuse. Also finalized is the codification of the statutory exception to the definition of "remuneration" related to the ACO Beneficiary Incentive Program for the Shared Savings Program. It is important to note that the final rules do not change or eliminate the existing fraud and abuse waivers that have been issued for the Shared Savings Program and other CMS Innovation Center models. The complete press release and related materials can be found on the HHS.gov News webpage. Readers should consult the final rules for the regulations and further explanation of the regulations being finalized. Both rules set forth an effective date of January 19, 2021, with the exception of one provision in the Physician Self-Referral Law (which is effective January 1, 2022).

Availability of Data Following the Discontinuation of the Enhanced Reports

As previously announced, CMS will retire the SSP ACO Portal and will decommission the enhanced reports after December 31, 2020. This includes the *Assignment Summary Report (ASR), Trends for Tables 2-4 and 2-5*, and *Expenditure/Utilization (EXPU) Reports, Trends, Graphs, and Drill Down for Table 1*.

In lieu of the ASR enhanced reports, ACOs may use data provided in their ASR and Assignment List Reports (ALRs) to produce similar analyses. ACOs may compare the demographic characteristics in ASR Table 2-4 between different report runs to observe how their assigned beneficiary populations change over time.

To replicate the data provided in the ASR Table 2-5 enhanced report, which includes counties with less than one percent of assigned beneficiaries, ACOs may use the data provided in ALR Table 1-1, which includes all beneficiaries assigned to the ACO, to determine the total number of beneficiaries by county and the person years by enrollment type at the county-level. ACOs should use the "STATE_COUNTY_CD" variable in ALR Table 1-1 to determine a beneficiary's county and the monthly eligibility flags ("EnrollFlag1" through "EnrollFlag12") to calculate the person years by enrollment type for each assigned beneficiary. Person years are calculated by taking the sum of months with a particular eligibility flag and dividing by 12 (e.g., 6 months of End-stage Renal Disease (ESRD) eligibility corresponds to 0.5 ESRD person years). ACOs can then aggregate the person years and beneficiaries by county to produce data similar to the enhanced report for ASR Table 2-5.

CMS is exploring options to replace the data currently provided through the EXPU drill down enhanced report, which provides beneficiary-level expenditure and utilization data, with a CSV file in the upcoming Informational Report packages beginning in PY 2020 Quarter 4 (Q4) reports. More information will be provided in an upcoming *ACO Spotlight Newsletter*.

Letter of Interest for Geographic Direct Contracting Model: Now Open

The CMS Innovation Center is excited to announce the Geographic Direct Contracting Model (also known as the "Model" or "Geo"). The Model will test a geographic-based approach expected to improve health and reduce costs in set regions across the

country. Geo will enable Direct Contracting Entities (DCEs) to build more integrated relationships with health care providers and community organizations in a region to better coordinate care for Medicare beneficiaries.

In an effort to gauge interest in participation in Geo, CMS is now seeking non-binding Letters of Interest (LOI) from sophisticated entities, such as ACOs, health systems, health care provider groups, and health plans in certain target regions. The LOI for Geo is open until **December 21, 2020**. Interested stakeholders can submit an LOI on CMS.gov. Entities that choose not to submit an LOI will still be able to apply to participate in Geo.

For more information, please refer to the recently released model fact sheet on the Geographic Direct Contracting Model webpage. Stakeholders can also email the Geo model team with questions and comments at DCGEO@cms.hhs.gov.

Seeking Volunteers to Participate in Interview with BCDA Researchers

The Beneficiary Claims Data Application Programming Interface (API) (BCDA) enables ACOs participating in the Shared Savings Program to retrieve Medicare Part A, Part B, and Part D claims data for their assigned or assignable beneficiaries.

The BCDA Team is seeking organizations interested in participating in an interview with BCDA researchers. The BCDA Team is interested in learning how ACOs and their associated vendors receive ACO and CMS-related information so BCDA can best communicate with current and prospective API users. If you are interested in participating, please email Jimmy@adhocteam.us. This research opportunity is available until December 31, 2020.

Please visit the BCDA website and BCDA Google Group if you have any questions about the API. The BCDA Team appreciates ACOs' continued feedback and support as CMS continues to refine and improve the API.

RESOURCES NOW AVAILABLE

County-Level Expenditures for PY 2020 Q3 Year-to-Date Report Period: Now Available

CMS has made a data file available containing county-level per capita expenditure and person year values by Medicare enrollment type for PY 2020 Q3 year-to-date report period. Data is based on the prospective national assignable fee-for-service (FFS) population and is adjusted to exclude months associated with an episode of care for the treatment of COVID-19. Data may be accessed through the Program Resources section of the Knowledge Library tab in the ACO Management System (ACO-MS) by searching for "County-Level Expenditures for PY 2020 Q3 Year-to-Date Report Period."

ACOs under prospective assignment may find it useful to compare their own year-to-date expenditures reported in Table 1A of the *PY 2020 Q3 Aggregate Expenditure/Utilization (EXPU) Report* with the values provided in this file for the counties in which the ACO's beneficiaries reside.

ACOs may also approximate year-to-date expenditures for their regional service area by combining the county-level expenditure data with the data on assigned beneficiary person years by county of residence (adjusted to remove months associated with COVID-19 episodes) in Table 2-5A of the PY 2020 Q3 ASR. To perform this approximation for a given enrollment type, an ACO should follow these steps:

1. Multiply assigned beneficiary person years for the enrollment type for each county where at least one percent of the ACO's assigned beneficiaries reside (from ASR Table 2-5A) by the per capita expenditure value for that county for that enrollment type from the county-level expenditure file.
2. Sum the products from Step 1 across the counties where at least one percent of the ACO's assigned beneficiaries reside.
3. Divide the sum of the products from Step 2 by the sum of assigned beneficiary person years for that enrollment type across the counties where at least one percent of the ACO's assigned beneficiaries reside.

Note that actual program financial calculations consider all counties where at least one of an ACO's assigned beneficiaries reside, not only those that meet the one percent threshold. For this reason, the approximation described above may be less accurate for ACOs with a large share of beneficiaries residing in counties where fewer than one percent of assigned beneficiaries reside.

Refreshed Drill Down Data for 2020 Q3 Expenditure Utilization Report: Now Available

ACOs now have access to an additional period of the Aggregate EXPU beneficiary drill down data. This release adds drill down data associated with the Q3 EXPU report for PY 2020. This data can be accessed through the Enhanced Reports section of the SSP ACO Portal through the *Expenditure/Utilization Report, Trends, Graphs, and Drill Down for Table 1*. This report allows drill down to beneficiary level person years, total expenditures, and health service utilization aggregate measures seen on the EXPU report.

Please note, this December release will be the final enhanced report update for the SSP ACO Portal. At the end of December, the SSP ACO Portal will be decommissioned, and ACOs will no longer have access to the enhanced reports within the SSP ACO Portal. Please retrieve any of the reports or data that your ACO would like to retain prior to December 31st.

Stayer, Leaver, Joiner Resources: Now Available

CMS has developed an updated version (V2) of the Stayer, Leaver, Joiner templates to assist ACOs in comparing assigned beneficiaries between two time periods. An ACO may be interested in using these resources to learn how changes in their assigned beneficiary population may relate to changes in expenditures and utilization between two time periods. For example, an ACO could compare its assigned beneficiary population between a benchmark year and a performance year, between two different performance years, or between two quarterly reports. ACO Participant List changes, changes in providers and suppliers associated with the participants, competition in the market, and regulatory changes can all affect which beneficiaries are assigned to a given ACO in a specific time period.

For the analysis performed by these templates, “Stayers” are beneficiaries who were assigned to the ACO in both time periods. “Leavers” are beneficiaries who were assigned to the ACO in the former time period but not in the latter time period. “Joiners” are beneficiaries who were assigned in the later time period, but not in the former time period. The templates allow ACOs to use information from their ALRs to categorize the ACO’s assigned beneficiaries into these three categories. The templates also calculate the person years and average risk scores for each of these categories and for each of the four Medicare enrollment types: ESRD, disabled, aged/dual, and aged/non-dual.

These updated template versions account for changes to the formatting of the ALRs and can be used with ALRs from Q1 2019 and onward.

Access the Stayer, Leaver, Joiner resources in the Program Resources section of the Knowledge Library tab in ACO-MS by searching for “Stayer, Leaver, Joiner Resources.”

PY 2021 ALR and ASR Packages: Available December 9, 2020

CMS delivered your ACO’s PY 2021 ALR and ASR Package on December 9, 2020. The report package was sent as a zip file and included the cover notice, ALR (zip file), and ASR. For additional information about the PY 2021 Report Package, please reference the accompanying cover notice and the report user guides, *Assignment List Report and Assignment Summary Report User’s Guide (Version 12),* located in the Program Resources section of the Knowledge Library tab in ACO-MS.

The zip file containing the program reports delivered to your ACO is accessible through the ACO-MS Data Hub, your ACO’s Managed File Transfer (MFT) mailbox, and the SSP ACO Portal. The zip file is named per the following convention: “P.Axxxx.ACO.HASSGN.” Please note that the zip name includes a date stamp beginning with “D21,” where the year indicates the applicable performance year, PY 2021. If accessing the file through your MFT mailbox, save the file and append “.zip” to the end of the file name to open the zip file and its contents. The zip file will be available in the MFT mailbox and the SSP ACO Portal until December 31, 2020. This file will be available in the ACO-MS Data Hub indefinitely. ACOs may access this file by navigating to the ACO-MS Data Hub, selecting your ACO, and selecting “2021” from the program year drop-down menu. ACOs should then navigate to the “Reports” folder within this program year in the ACO-MS Data Hub, and the zip file will appear under the name “Annual Assignment List Report.”

In order to provide more clarity and consistency for ACOs, ASR Tables 2-1A (“Voluntarily Aligned Beneficiaries and Exclusions”) and 2-1B (“Claims-Based Beneficiary Assignment Exclusions”) will be presented consistently throughout the performance year,

starting in PY 2021 and beginning with your ACO's *Prospective/Preliminary Prospective ASR*. Please see the relevant footnote in the report for information on this measure and on when Part I and Part II of this table are populated throughout the performance year.

CMS is also introducing the Long-Term Institutionalized Status measure in ASR Table 2-4 ("Demographic and Eligibility Characteristics of Total Assigned Beneficiaries"). Please see the relevant footnote in the report for information on when this measure is populated throughout the performance year. This measure will not be populated in this *Prospective/Preliminary Prospective ASR*. However, the variable is shown to create consistency between ASR reports as mentioned above.

CMS has added an "All MSSP ACOs Percentage" column to ASR Table 2-7 ("Prevalence of COVID-19 Among Total Assigned Beneficiaries") to be consistent with other tables in the ASR. Please refer to the cover notice included in your report package for more information on assignment changes applicable for PY 2021.

2020 Q3 Opioid Utilization Report: Available December 11, 2020

CMS expects to release the informational-only 2020 Q3 Opioid Utilization Report package on December 11, 2020. The report package will be sent as a zip file and will include the cover notice and opioid report. The report will be accessible through the ACO-MS Data Hub, your ACO's MFT mailbox, and the SSP ACO Portal. The download will be entitled *Quarterly Claims-Based Quality Measure Report.*

The zip file will be named per the following convention: "P.Axxxx.ACO.QQR." If accessing the file through your MFT mailbox, save the file and append ".zip" to the end of the file name to open the zip file and its contents. The zip file will be available in your MFT mailbox and the SSP ACO Portal until December 31, 2020. This file will be available in the ACO-MS Data Hub indefinitely.

For additional assistance, the informational Opioid Utilization Report Overview video can help review the contents of the quarterly *Opioid Utilization Report* and details of the four opioid utilization measures.

December CCLF Files: Available December 14, 2020

December Claim and Claim Line Feed (CCLF) files will be available to ACOs on December 14th for PY 2020 assignable or prospectively assigned beneficiaries. These files will be available in the ACO-MS Data Hub and the MFT mailbox. The files will continue to be available in the MFT mailbox until the mailbox is retired on December 31, 2020.

The December delivery timeline for the CCLF, Exclusion, and Medicare Beneficiary Identifier (MBI) cross-reference (XREF) files are as follows:

FILE	DELIVERY	NAMING CONVENTION
Monthly Exclusion Files	December 10th	P.A****.BNEX.Y**.Dyymmdd.Thhmmsst
MBI XREF Files	December 10th	P.A****.ACO.MBIY**.Dyymmdd.Thhmmsst
CCLF Files	December 14th	P.A****.ACO.ZCY**.Dyymmdd.Thhmmsst

ACOs should refer to the *Claim and Claim Line Feed Information Packet,* V30 and the *ACO and ACO-OS Data Exchange User Guide,* V11 for additional information on the CCLF and Exclusion files.

The CCLF Information Packet (IP) and the Data Exchange User Exchange (DEUG) are available in the Program Resources section of the Knowledge Library tab in ACO-MS.

For technical assistance, contact the ACO Information Center at SharedSavingsProgram@cms.hhs.gov, or call 1-888-734-6433 (Option 1) or 1-888-734-6563 (TTY/TDD).

EVENT ANNOUNCEMENTS

CCLF User Group Webinar: Using the Data Hub in ACO-MS to Access CCLFs and Reports

TUESDAY, DECEMBER 15, 2020, 1:30 P.M.–3:00 P.M. EASTERN TIME

- Register here
- **Audience:** All ACOs
- **Description:** CMS will provide information on how to access the CCLF files and the static quality and financial reports in the ACO-MS Data Hub. The delivery of CCLFs and program reports in the Data Hub will replace the delivery via the MFT mailbox and SSP ACO Portal.

CONTACT INFORMATION FOR ACOS

To help ACOs navigate questions regarding the Shared Savings Program.

ACO Information Center

SharedSavingsProgram@cms.hhs.gov

- Include your ACO ID (Axxxx) in the Subject line or text of the email
- Program operations and policy inquiries; technical inquiries related to MFT, CCLFs, the SSP ACO Portal, and ACO-MS; and assistance with user access to CMS systems, including password resets
- 1-888-734-6433 (select Option 1) or 1-888-734-6563 (TTY/TDD)

Quality Payment Program Service Center

QPP@cms.hhs.gov

- Inquiries related to MIPS, APMs, MACRA, CAHPS® for ACOs survey, quality measures, quality reporting for 2017 and future years, and CMS Web Interface
- 1-866-288-8292