Medicare Shared Savings Program

SHARED SAVINGS AND LOSSES AND ASSIGNMENT METHODOLOGY

Specifications of Policies to Address the Public Health Emergency for COVID-19

December 2020

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
MEDICARE SHARED SAVINGS PROGRAM

Contents

EXECUTIVE SUMMARY

This document describes specifications for the following changes and clarifications to Medicare Shared Savings Program (Shared Savings Program) policies, addressing the impact of the Coronavirus Disease 2019 (COVID-19) pandemic and the resulting public health emergency (PHE) as defined in 42 CFR § 400.200:

- Benchmarking methodology applied in adjusting and updating the historical benchmark for Performance Year (PY) 2021 for Accountable Care Organizations (ACOs) that elect a 1-year extension and whose agreement period expires December 31, 2020 (Section 2).
- Applicability of the Shared Savings Program extreme and uncontrollable circumstances policy to mitigate shared losses for the period of the PHE for COVID-19 starting in January 2020 (Section 3).
- Adjustment to certain Shared Savings Program calculations, for a beneficiary's episode of care for treatment of COVID-19 (Section 4).
- Expanded definition of primary care services, including telehealth codes for virtual check-ins, e-visits, and telephonic communication, used in determining beneficiary assignment when the assignment window (as defined at § 425.20) for a benchmark or performance year includes any months during the PHE for COVID-19 defined in § 400.200 (Section 5).

1 REGULATORY BACKGROUND

The Shared Savings Program regulations are codified at 42 CFR part 425. For details on changes to the regulations, please refer to the Federal Register publications listed on the Shared Savings Program's Program Statutes & Regulations website.

This document provides specifications for Shared Savings Program policies established by the Centers for Medicare & Medicaid Services (CMS) through rulemaking in 2020. Refer to the following:

- The "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency" interim final rule with comment period (IFC) appeared in the April 6, 2020 Federal Register (85 FR 19230, 19267 and 19268) with an effective date of March 31, 2020 (hereafter referred to as the "March 31st COVID-19 IFC").
- The "Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program" IFC appeared in the May 8, 2020 Federal Register (85 FR 27550, 27573 through 27587) with an effective date of May 8, 2020 (hereafter referred to as the "May 8th COVID-19 IFC").
- The final rule entitled "Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services

Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID-19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID-19" was released by CMS on December 1, 2020, and is available at the Federal Register website (hereafter referred to as the "CY 2021 PFS final rule").

The definition for public health emergency (PHE) at 42 CFR § 400.200 identifies the PHE determined to exist nationwide as of January 27, 2020, by the Secretary of Health and Human Services (the Secretary) pursuant to Section 319 of the Public Health Service Act on January 31, 2020, as a result of confirmed cases of COVID-19, including any subsequent renewals. CMS referenced this definition of PHE in several policies in connection with the Shared Savings Program specified in the March 31st COVID-19 IFC and the May 8th COVID-19 IFC.

In the March 31st COVID-19 IFC, CMS removed 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, to offer relief under the Shared Savings Program to all ACOs that may be unable to completely and accurately report quality data for 2019 due to the PHE for the COVID-19 pandemic (85 FR 19267 and 19268).

In the May 8th COVID-19 IFC (85 FR 27573 through 27587), CMS modified Shared Savings Program policies to: (1) allow ACOs whose current agreement periods expire on December 31, 2020, the option to extend their existing agreement period by 1 year; (2) allow ACOs in the BASIC track's glide path the option to elect to maintain their current level of participation for PY 2021; (3) adjust certain program calculations to remove payment amounts for episodes of care for treatment of COVID-19; and (4) expand the definition of primary care services for purposes of determining beneficiary assignment to include telehealth codes for virtual check-ins, e-visits, and telephonic communication. CMS clarified the applicability of the program's extreme and uncontrollable circumstances policy to mitigate shared losses for the period of the PHE for COVID-19 starting in January 2020. Further, CMS addressed the applicability of the policies to ACOs participating in the Medicare ACO Track 1+ Model (Track 1+ Model).

In the calendar year (CY) 2021 PFS final rule, CMS summarized and responded to public comments received on modifications to and clarifications of Shared Savings Program policies included in the March 31st COVID-19 IFC (refer to section III.I.3 of the final rule) and May 8th COVID-19 IFC (refer to section III.G.5. of the final rule), and discussed final policies.

Additionally, the resource "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service (FFS) Billing" (which is updated periodically) includes questions and answers with information on policy modifications to the Shared Savings Program established in the March 31st COVID-19 IFC and May 8th COVID-19 IFC, among other content.

2 BENCHMARK METHODOLOGY APPLIED TO OPTIONAL FOURTH PERFORMANCE YEAR FOR ACOS THAT ELECT 1-YEAR EXTENSION OF AGREEMENT PERIOD EXPIRING DECEMBER 31, 2020

In the May 8th COVID-19 IFC (85 FR 27574), CMS announced it was forgoing the application cycle for a January 1, 2021 start date. CMS revised § 425.200(b)(3)(ii) to 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, spanning 12 months from January 1, 2021, to December 31, 2021. This election to extend the agreement period is voluntary, and an ACO could choose not to make this election, and therefore conclude its participation in the program with the expiration of its current agreement period on December 31, 2020. Refer to 85 FR 27574 and 27575, and the CY 2021 PFS final rule (section III.G.5.a).

ACOs that choose to extend their existing agreement period for 1 year will continue to be subject to the applicable benchmarking methodology under § 425.602 or § 425.603. These ACOs' historical benchmarks will continue to be based on the 3 years prior to their existing agreement period. Refer to the Shared Savings and Losses and Assignment Methodology Specifications, Version 7 sections 4.1 and 4.3. These ACOs will be financially reconciled for PY 2021 according to the methodology for calculating shared savings or shared losses applicable to the ACO under the terms of the participation agreement that is in effect for PY 2021. Refer to the Shared Savings and Losses and Assignment Methodology Specifications, Version 7 sections 4.4, 4.5, and 4.6.

3 EXTREME AND UNCONTROLLABLE CIRCUMSTANCES POLICY MITIGATING SHARED LOSSES DURING THE PHE FOR COVID-19

Under the Shared Savings Program's Extreme and Uncontrollable Circumstances Policy for mitigating shared losses, CMS reduces the amount of the ACO's shared losses by an amount determined by multiplying the shared losses by the percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance, and the percentage of the ACO's assigned beneficiaries who reside in an area affected by an extreme and uncontrollable circumstance.[1]

The Secretary's declaration of the PHE for COVID-19 in January 2020 triggered the Shared Savings Program's Extreme and Uncontrollable Circumstances Policy for mitigating shared losses.[2] The extreme and uncontrollable circumstance of the PHE for COVID-19 began in January 2020, and will apply nationwide for the duration of the COVID-19 PHE, as defined in

[1] Refer to §§ 425.605(f), 425.606(i), and 425.610(i).
[2] Refer to discussions in the March 31st COVID-19 IFC (85 FR 19268), May 8th COVID-19 IFC (85 FR 27576 and 27577), and CY 2021 PFS final rule (section III.G.5.c.).

§ 400.200, which includes any subsequent renewals. The PHE for COVID-19 applies to all counties in the country; therefore, 100 percent of assigned beneficiaries for all Shared Savings Program ACOs reside in an affected area.

The following examples illustrate mitigation of shared losses for all ACOs participating in a performance-based risk track, including Track 2, the ENHANCED track, Levels C, D, and E of the BASIC track, and the Track 1+ Model:

1. For PY 2020, the PHE for COVID-19 covers the full year (January through December 2020), and any shared losses an ACO incurs for PY 2020 will be reduced completely, and the ACO will not owe any shared losses.
2. If the PHE for COVID-19 covers additional months in PY 2021, for example 1 month in January,[3] any shared losses an ACO incurs for the performance year would be reduced by at least one-twelfth. This scenario is used to illustrate the calculations for mitigating shared losses, as shown in the example below.

Further, in the portion of the performance year following the PHE for COVID-19, the reduction of shared losses will be larger for ACOs with assigned beneficiaries residing in areas affected by other events deemed by CMS to be extreme and uncontrollable circumstances.

Example: How the extreme and uncontrollable circumstances policy will affect shared losses when the PHE for COVID-19 covers 1 month (January):

Shared losses before adjustment: $1 million

Percentage of year affected by extreme and uncontrollable circumstances: 8.33% (1 ÷ 12)

Percentage of assigned beneficiaries in affected counties: 100.0%

$$Shared\ losses \times Percentage\ of\ year\ affected\ by\ extreme\ and\ uncontrollable\ circumstances \times Percentage\ of\ assigned\ beneficiaries\ in\ affected\ counties$$

$$\$\mathbf{1,000,000} \times \mathbf{8.33}\% \times \mathbf{100.0}\% = \$\mathbf{83,333.33}$$

In this example, shared losses of $1 million would be reduced by $83,333.33 to adjust for extreme and uncontrollable circumstances. In this example, the ACO would owe CMS shared losses in the amount of $916,666.67.

[3] As explained in the CY 2021 PFS final rule, at the time of the final rule in December 2020, the PHE for COVID-19 had been renewed for another 90 days, with an effective date of October 23, 2020. Unless the PHE for COVID-19 is terminated early, CMS would continue to mitigate shared losses until at least January 2021.

4 ADJUSTMENTS TO SHARED SAVINGS PROGRAM CALCULATIONS FOR EPISODES OF CARE FOR TREATMENT OF COVID-19

CMS adjusts certain Shared Savings Program calculations to address the impact of the COVID-19 pandemic. As specified in § 425.611, CMS excludes from certain Shared Savings Program calculations all Parts A and B FFS payment amounts for a beneficiary's episode of care for treatment of COVID-19, triggered by an inpatient service, and as specified on Parts A and B claims with dates of service during the episode.

4.1 DEFINITION OF AN EPISODE OF CARE FOR TREATMENT OF COVID-19

According to § 425.611(b), CMS identifies an episode of care for treatment of COVID-19 based on either of the following:

- Discharges for inpatient services eligible for the 20 percent adjustment under Section 1886(d)(4)(C) of the Social Security Act.
- 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), when the date of discharge occurs within the PHE as defined in § 400.200.

As discussed in the CY 2021 PFS final rule (section III.G.5.d.), CMS will identify inpatient claims that trigger an episode of care for treatment of COVID-19 using all of the following criteria, regardless of whether the claim is submitted by an IPPS or non-IPPS provider. Claims that do not meet these criteria will not trigger an episode of care for treatment of COVID-19.

1. Inpatient claims identified by claim type 60.
2. Facility type as identified by the character in the third position of the CMS Certification Number (CCN) equal to "T" (Rehabilitation Unit) or "R" (CAH Rehabilitation Unit), or by the last four digits of the CCN in any of the following ranges:
    - 0001–0879, Short-term (General or Specialty) Hospital
    - 0880–0899, Hospital that participated in an Office of Research and Development demonstration project
    - 1300–1399, CAH
    - 2000–2299, Long-term Care Hospital
    - 3025–3099, Inpatient Rehabilitation Facility
    - 3300–3399, Children's Hospital
3. Admission date and discharge date both populated.

4. Discharge date between January 27, 2020, and March 31, 2020 (inclusive), and diagnosis code equal to B97.29, or discharge date between April 1, 2020, and expiration date of the PHE for COVID-19 specified in § 400.200 (if known, inclusive) and diagnosis code equal to U07.1. (The applicable diagnosis code may be present in any diagnosis code field based on established coding guidelines.)

The aforementioned criteria were used in identifying episodes of care for treatment of COVID-19 in Q2 and Q3 2020 program reports provided to ACOs. Prior to preparing the Q4 2020 program reports, CMS plans to incorporate an additional criterion that will ensure that expenditures related to treatment of COVID-19 are not excluded from program calculations when the IPPS provider is not eligible to receive the 20 percent diagnosis-related group (DRG) adjustment, for example, because the provider has specified a billing note NTE02 “No Pos Test” on the electronic claim 837I, or a remark “No Pos Test” on a paper claim. This note or remark on the claim indicates that the beneficiary did not have a positive laboratory test result for COVID-19 documented in the beneficiary’s medical record. This is for consistency with the CMS requirement that there must be a positive laboratory test result for COVID-19 documented in the beneficiary’s medical record in order for an IPPS provider to receive the 20 percent DRG adjustment. This requirement was developed to address potential Medicare program integrity risks, and became effective with admissions occurring on or after September 1, 2020.[4]

CMS will next identify episode months associated with each triggering inpatient claim. Episode months will include:

- Calendar month of admission;
- Calendar month of discharge;
- Any calendar months between calendar month of admission and calendar month of discharge; and
- Calendar month following calendar month of discharge.

Each episode will start at the beginning of the admission month and end at the end of the month following the discharge month.

Throughout the remainder of this document, use of the term “episode of care for treatment of COVID-19” refers to an episode of care as defined in this section.

[4] For more information, see CMS, MLN Matters, “New Waivers for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act” (revised September 11, 2020), available at https://www.cms.gov/files/document/se20015.pdf.

Example: Episode of Care for Treatment of COVID-19

Assume that a beneficiary had an inpatient claim (claim type 60) meeting the following criteria:

- Admission date equal to January 30, 2020
- Discharge date equal to February 26, 2020
- Third character of CCN equal to "T" (Rehabilitation Unit)
- A diagnosis code equal to B97.29 present on a diagnosis code field based on coding guidelines

This claim would identify the beneficiary as having an episode of care for treatment of COVID-19. The episode of care would include the months of January, February, and March 2020.

4.2 PROGRAM CALCULATIONS ADJUSTED TO EXCLUDE PAYMENT AMOUNTS FOR EPISODES OF CARE FOR TREATMENT OF COVID-19

In accordance with § 425.611, CMS adjusts the following Shared Savings Program calculations to exclude all Parts A and B FFS payment amounts for a beneficiary's episode of care for treatment of COVID-19 as described in Section 4.1:

1. 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.
2. Calculation of FFS expenditures for assignable beneficiaries as used in determining county-level FFS expenditures and national Medicare FFS expenditures, including the following calculations:
    a. Determining average county FFS expenditures based on expenditures for the assignable population of beneficiaries in each county in the ACO's regional service area according to §§ 425.601(c) and 425.603(e) for purposes of calculating the ACO's regional FFS expenditures.
    b. Determining the 99th percentile of national Medicare FFS expenditures for assignable beneficiaries for purposes of the following:
        i Truncating assigned beneficiary expenditures used in calculating benchmark expenditures under §§ 425.601(a)(4), 425.602(a)(4), and 425.603(c)(4), and performance year expenditures under §§ 425.604(a)(4), 425.605(a)(3), 425.606(a)(4), and 425.610(a)(4).
        ii Truncating expenditures for assignable beneficiaries in each county for purposes of determining county FFS expenditures according to §§ 425.601(c)(3) and 425.603(e)(3).
    c. 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 according to § 425.601(a)(8)(ii)(C).
    d. 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 according to § 425.602(b)(2).

e. Determining national growth rates that are used as part of the blended growth rates used to trend forward Benchmark Year (BY) 1 and BY2 expenditures to BY3 according to § 425.601(a)(5)(ii) and as part of the blended growth rates used to trend the benchmark and update the benchmark according to § 425.601(b)(2).

3. 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 as specified in § 425.605(d). Note that a similar policy applies to Track 1+ Model ACOs, for adjusting revenue calculations used in determining the revenue-based loss sharing limit (if applicable), to remove expenditures for episodes of care for treatment of COVID-19 (85 FR 27586 and 27587).[5]

4. 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, as defined under § 425.20, and determining an ACO's eligibility for participation options according to § 425.600(d).

5. Calculation or recalculation of the amount of the ACO's repayment mechanism arrangement according to § 425.204(f)(4).

Note that as part of excluding all Parts A and B FFS payment amounts in all of the above calculations, CMS will exclude non-claims based individually beneficiary identifiable final payments made under a demonstration, pilot, or limited time program (herein referred to as non-claims based payments). For example, CMS will exclude non-claims based payments occurring within an episode of care from calculations of ACO benchmark and performance year expenditures,[6] and calculations of county expenditures for factors based on regional expenditures used in establishing, adjusting, and updating an ACO's historical benchmark.[7]

4.3 PROGRAM CALCULATIONS ADJUSTED TO EXCLUDE MONTHS ASSOCIATED WITH EPISODES OF CARE FOR THE TREATMENT OF COVID-19

For consistency within program calculations, CMS will exclude months associated with episodes of care for the treatment of COVID-19, described in Section 4.1, from program calculations that incorporate monthly data. As discussed in the CY 2021 PFS final rule (section III.G.5.d.), these include the following:

[5] See also the Medicare ACO Track 1+ Model, Second Amended and Restated Participation Agreement (Updated 2020), available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/track-1plus-model-par-agreement.pdf (herein Track 1+ Model Participation Agreement).

[6] Refer to §§ 425.601(a)(1)(ii), 425.602(a)(1)(ii), 425.603(c)(1)(ii), 425.604(a)(6)(ii), 425.605(a)(5)(ii), 425.606(a)(6)(ii), and 425.610(a)(6)(ii).

[7] Refer to §§ 425.601(c)(2)(ii) and 425.603(e)(2)(ii).

1. Calculation of ACO, county, or national level weighted mean CMS-Hierarchical Condition Categories (HCC) prospective risk scores or demographic risk scores used in program risk adjustment calculations described in §§ 425.601, 425.602, 425.603, 425.604, 425.605, 425.606, and 425.610. CMS will exclude monthly prospective beneficiary CMS-HCC risk scores (based on diagnoses from the prior calendar year) from months associated with episodes of care for treatment of COVID-19. CMS will also exclude these months when computing person year values that are used to calculate weighted means of CMS-HCC and/or demographic risk scores across beneficiaries. Note, however, that CMS will continue to use diagnoses that meet risk adjustment criteria from claims submitted by FFS providers for items and services furnished during the months associated with episodes of care for treatment of COVID-19, when calculating final CMS-HCC risk scores for future years. For example, final CMS-HCC risk scores for 2021 will include risk adjustment eligible diagnoses from all eligible claims in 2020, including claims from months associated with episodes of care for treatment of COVID-19. CMS calculates risk scores for all Medicare beneficiaries, and these risk scores are used in a variety of calculations across the Medicare Program; CMS does not calculate separate CMS-HCC risk scores for use in Shared Savings Program calculations.
2. Calculation of assigned beneficiary person years used in determining the proportion of the ACO's assigned beneficiaries in each county by Medicare enrollment type (end-stage renal disease [ESRD], disabled, aged/dual eligible, aged/non-dual eligible) used to weight risk-adjusted county FFS expenditures as described in §§ 425.601(d) and 425.603(f).
3. Calculation of the weights applied to national and regional components of the blended growth rates used to trend forward benchmark year (BY) 1 and BY2 expenditures to BY3 according to § 425.601(a)(5) and to update the benchmark according to § 425.601(b).
4. Calculation of assigned beneficiary enrollment proportions used to calculate the weighted average across the four Medicare enrollment types, in order to obtain a single per capita updated benchmark and a single performance year per capita expenditure value.[8]
5. Calculation of total person years used to calculate total benchmark expenditures and total performance year expenditures used in financial reconciliation calculations.[9]

[8] For example, refer to the description of the calculation in Sections 4.1.4 and 4.3.1 of the Shared Savings and Losses and Assignment Methodology Specifications, Version 8, available at https://www.cms.gov/files/document/shared-savings-losses-assignment-spec-v8.pdf-0.
[9] For example, refer to the description of the calculation in Sections 4.3.1 of the Shared Savings and Losses and Assignment Methodology Specifications, Version 8, available at https://www.cms.gov/files/document/shared-savings-losses-assignment-spec-v8.pdf-0.

Example: Calculation of person years used to calculate expenditures by Medicare enrollment type

The following is based on a hypothetical beneficiary.

- Months of CY 2020 enrolled in Medicare as aged/non-dual eligible: 12 months
- Months of episode of care for treatment of COVID-19 while beneficiary is enrolled as aged/non-dual eligible: 2 months
- Total beneficiary expenditures for 12 months as aged/non-dual eligible (including expenditures for episode of care for treatment of COVID-19): $50,000
- Total beneficiary expenditures for 2 months for the episode of care for treatment of COVID-19 while enrolled as aged/non-dual eligible: $40,000

Calculate the fraction of the year during which each assigned beneficiary is enrolled in each Medicare enrollment type (referred to as person years) excluding months of episode(s) of care for treatment of COVID-19 while beneficiary is enrolled in the Medicare enrollment type:

$$\frac{(Months\ enrolled\ as\ aged/non\text{–}dual\ eligible)\ -\ (Months\ of\ episodes\ of\ care\ for\ treatment\ of\ COVID\text{–}19\ while\ enrolled\ as\ aged/non\text{–}dual\ eligible\ )}{12\ months\ (number\ of\ months\ in\ CY)}$$

$$\frac{\mathbf{12-2}}{\mathbf{12}}=\frac{\mathbf{10}}{\mathbf{12}}=\mathbf{0.83}$$

Note that if a beneficiary's episode of care spans months when the beneficiary is in different Medicare enrollment types (such as aged/non-dual eligible and aged/dual eligible), CMS excludes the relevant month(s) of the episode of care from the calculation of total months for each enrollment type.

Calculate total beneficiary expenditures excluding total beneficiary expenditures for months of episodes of care for treatment of COVID-19, by Medicare enrollment type:

$$(Total\ beneficiary\ expenditures\ for\ aged/non\text{–}dual\ eligible\ status)\ -\ (Total\ beneficiary\ expenditures\ for\ the\ episodes\ of\ care\ for\ treatment\ of\ COVID\text{–}19\ for\ aged/non-dual\ eligible\ status\ )$$

$$\mathbf{\$50,000-\$40,000=\$10,000}$$

Calculate annualized expenditures excluding total beneficiary expenditures for months of episodes of care for treatment of COVID-19, by Medicare enrollment type:

$$\frac{Total\ beneficiary\ expenditures\ excluding\ episodes\ of\ care\ for\ treatment\ of\ COVID\text{–}19\ for\ aged/non\text{–}dual\ eligible\ status}{Fraction\ of\ the\ year\ beneficiary\ enrolled\ in\ aged/non\text{–}dual\ eligible\ status\ excluding\ months\ of\ episodes\ of care\ for\ treatment\ of\ COVID\text{–}19}$$

$$\frac{\mathbf{\$10,000}}{\mathbf{0.83}}=\mathbf{\$12,048.19}$$

Thus, the beneficiary's annualized aged/non-dual eligible expenditures, excluding episodes of care for COVID-19, are $12,048.19. This annualized value would then be compared with the established truncation threshold for the aged/non-dual eligible enrollment type and then multiplied by the applicable completion factor.

Note that this example shows beneficiary-level calculations. Expenditures and person years are aggregated by enrollment type across the ACO's assigned population.

4.4 EPISODES OF CARE AND BENEFICIARY ASSIGNMENT

Although payment amounts and months associated with episodes of care for treatment of COVID-19 will be excluded from certain Shared Savings Program calculations as described in Section 4.2 and Section 4.3, these adjustments are not applied in determining beneficiary assignment. In determining beneficiary assignment for each performance year and benchmark year, CMS identifies allowed charges for services billed under the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT)[10] codes included in the applicable definition of primary care services under § 425.400(c), and according to the methodology specified in subpart E of the Shared Savings Program's regulations, during all months of the 12-month period of the assignment window. Any primary care services included in the Shared Savings Program assignment methodology, described in 42 CFR part 425, subpart E, provided during an episode of care for treatment of COVID-19 (identified according to § 425.611), will be used for purposes of beneficiary assignment to the Shared Savings Program. Part B services provided during an inpatient stay that do not meet the definition of primary care services will not be used to assign beneficiaries to ACOs.

It may be the case that an assigned beneficiary has only eligible months[11] that are months associated with an episode of care for treatment of COVID-19. Should there be any beneficiaries whose only months of eligibility are COVID-19 episode months, those beneficiaries will still be included in total assignment counts. Assignment counts are used for a number of Shared Savings Program operations, including to determine an ACO's variable minimum savings rate and, if applicable, minimum loss rate based on the ACO's number of assigned beneficiaries and as part of calculating the adjustment to shared losses for extreme and uncontrollable circumstances. However, as described in Section 4.3, excluded months would not count toward person year calculations.

5 EXPANSION OF CODES USED IN BENEFICIARY ASSIGNMENT

Section 425.400(c)(2)(i) specifies that the following additional primary care service codes are used in determining beneficiary assignment when the assignment window (as defined at § 425.20) for a benchmark or performance year includes any months during the COVID-19 PHE defined in § 400.200: (1) CPT codes 99421, 99422, and 99423 (online digital evaluation and management services (e-visit)); (2) CPT codes 99441, 99442, and 99443 (telephone evaluation and management services); and (3) HCPCS code G2010 (remote evaluation of patient video/images) and HCPCS code G2012 (virtual check-in). Refer to the CY 2021 PFS final rule (section III.G.5.e.). Under this provision, the CPT codes and HCPCS codes included in the applicable definition of primary care services at § 425.400(c)(1) will continue to apply for purposes of determining beneficiary assignment under § 425.402.

[10] CPT is copyright 2011 American Medical Association. All rights reserved.

[11] As described in Section 3.1 of the Shared Savings and Losses and Assignment Methodology Specifications, Version 8, beneficiaries are only assigned a monthly enrollment status by Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible) for months in which they are alive on 1st of the month, enrolled in both Parts A and B, and not enrolled in a Medicare Group Health Plan for the month (referred to as Shared Savings Program-eligible months).

According to § 425.400(c)(2)(ii) (as discussed in the CY 2021 PFS final rule), the additional primary care service codes are applicable to all months of the assignment window (as defined in § 425.20), when the assignment window includes any month(s) during the COVID-19 PHE as defined in § 400.200. Therefore, the expanded definition of primary care services specified in § 425.400(c)(2) does not apply for purposes of determining prospective assignment for PY 2020 or under prospective assignment for 2020 when it serves as a benchmark year, because the months in the assignment window (October 1, 2018, through September 30, 2019) did not occur during the PHE for COVID-19. For ACOs under prospective assignment, beneficiary assignment for PY 2021 will be based on the October 1, 2019, through September 30, 2020, assignment window, which includes months before the start of and during the PHE for COVID-19. Accordingly, CMS will consider any services billed under the additional primary care service codes specified in § 425.400(c)(2) during this assignment window when conducting beneficiary assignment for PY 2021. Further, CMS will use this same approach in determining prospective assignment for 2021 when it serves as a benchmark year.

CMS will apply the expanded definition of primary care services to determine beneficiary assignment for ACOs under prospective assignment according to § 425.400(a)(3), and for ACOs under preliminary prospective assignment with retrospective reconciliation according to § 425.400(a)(2). The expanded definition of primary care services is also applicable for purposes of determining beneficiary assignment for Track 1+ Model ACOs in the same way in which it applies to Shared Savings Program ACOs under prospective assignment according to § 425.400(a)(3).[12] CMS will apply the expanded definition of primary care services consistently when performing beneficiary assignment in program operations, which includes (for example), determining the ACO's performance year assigned population, determining the assigned population for purposes of producing quarterly assignment list reports and quarterly aggregate reports for ACOs, and determining assignment for benchmark years.

[12] Refer to the terms of the Track 1+ Model Participation Agreement, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/track-1plus-model-par-agreement.pdf.