# COVID-19 and Medicare Alternate Payment Programs

Neil M. Sullivan
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Insurance payments for healthcare services and supplies are frequently based on projections of future costs, often measured against a baseline calculated on past costs. However, COVID-19 and its attendant changes to the healthcare delivery system seriously disrupted those expectations, and traditional Medicare is no exception.

The Centers for Medicare and Medicaid Services (CMS), through its Center for Medicare and Medicaid Innovation (CMMI), have implemented a series of changes to the Medicare Value-Based and Shared Savings Programs to reflect these altered circumstances. Over the past several months, changes have been made, and additional options offered, which touch on most value-based models. These changes include adjustments to the payment methodologies, mitigating risk during the emergency, and/or modifying cost targets and benchmarks to adjust for the response to COVID-19.

**Medicare Shared Savings Programs – Accountable Care Organizations**

Changes made to Medicare Shared Savings Programs include excluding episodes of care for treatment of COVID-19 for all Accountable Care Organizations (ACOs), reducing 2020 downside risk by reducing shared losses by the proportion of months during which the Public Health Emergency (PHE) is effective, and removing 2020 financial guarantee requirements for Next Generation ACOs.

For example, any shared losses an ACO incurs for performance year 2020 will be reduced by at least one-third. If the period of health emergency covers the full year (January through December 2020), any shared losses an ACO incurs for performance year 2020 would be reduced completely and the ACO would not owe any shared losses.

Attorneys
Neil M. Sullivan

All Part A and B payment amounts for episodes of care for treatment of COVID-19 will be removed from the determination of benchmark year and performance year expenditures (e.g., trend and update factors based on national and regional FFS expenditures, truncation factors, and revenue-based loss recoupment limits). Corresponding changes for purposes of identifying whether an ACO is a high revenue ACO or low revenue ACO, determining an ACO's eligibility for participation options, and calculation or recalculation of repayment mechanism amounts are also being made.

An episode of care for treatment of COVID-19 is triggered by an inpatient service for treatment of COVID-19. The episode of care starts 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.

CMS **published a response** to COVID-19 for the Medicare Shared Savings Program.

**Value-Based Programs**

Other changes to Value-Based Programs include the following:

- *Bundled Payments for Care Improvement Advanced Model* - Option for participants to eliminate upside and downside risk by excluding clinical episodes from reconciliation for Model Year 3 (2020); BPCI-Advanced participants that choose to remain in two-sided risk can exclude certain clinical episodes from reconciliation with a COVID-19 diagnosis during the episode.
- *Comprehensive ESRD Care Model* - Reduce 2020 downside risk by reducing shared losses by proportion of months during the PHE; cap gross savings upside potential at 5% of gross savings; remove COVID-19 inpatient episodes; remove 2020 financial guarantee requirement.
- *Comprehensive Care for Joint Replacement Model* - Remove downside risk by capping actual episode payments at the target price for episodes with a date of admission to the anchor hospitalization between January 31, 2020 through the termination of the emergency period; extend the appeals timeline for Performance Year (PY) 3 and PY 4 from 45 days to 120 days
- *Oncology Care Model* - Option for OCM practices to elect to forgo upside and downside risk for performance periods affected by the PHE; for OCM practices that remain in one- or two-sided risk for the performance periods affected by the PHE, remove COVID-19 episodes from reconciliation for those performance periods.

Lesser changes, including changes to quality reporting and timelines, apply to these other models:

- Direct Contracting Model
- Emergency Triage, Treat and Transport Model
- Home Health Value-Based Purchasing Model
- Independence at Home

- Integrated Care for Kids Model
- Kidney Care Choices
- Maternal Opioid Misuse Model
- Medicare Choices Model
- Medicare Diabetes Prevention Program Expanded Model
- Primary Care First Model

A full version of the table outlining CMMI changes and options for Value-Based Programs is available here: **CMS Innovation Center Models COVID-19 Related Adjustments**

The changes to Medicare Shared Savings Programs and other Value-Based Programs include multiple revisions to model implementation dates and reporting requirement dates for some new models, and adjusted deadlines for some of the existing models. Clients with or interested in these programs should check in regularly at the **CMS website** for updates, including in application and reporting date requirements.

Please contact the author of this Alert, **Neil M. Sullivan** nsullivan@greenbaumlaw.com | 973.577.1804 if you require assistance or have questions concerning the changes outlined in this Alert. Mr. Sullivan is Counsel in the firm's **Healthcare Department**.