

Taking on Risk Through CMS Direct Contracting

The Centers for Medicare and Medicaid Services (CMS) announced in April its new direct contracting model that will push the Medicare market closer to commercial and will resemble Medicare Advantage without a health plan as an intermediary. With a focus particularly on primary care coordination for medically complex and seriously ill patients, as well as Medicare and Medicaid dually eligible, CMS plans to select 75 Direct Contracting Entities (DCEs) for this voluntary program, with an anticipated launch date of January 1, 2020. This presents an opportunity for provider groups that have not participated in Medicare fee-for-service or CMS's Innovation Center models, as well as those who are already participating in other programs such as MSSP ACOs, to make the transition to value-based payments (VBP). For organizations with high dual eligible populations such as disproportionate share hospitals with affiliated medical groups, Federally Qualified Health Centers (FQHCs) and many district or other local government health systems not made the transition away from fee-for-service, this new model may offer an effective mechanism to take on risk and reduce administrative burden. For instance, there is a smaller set of core quality measures for providers to focus on.

One of the primary changes in this new model is how members are attributed to providers. Through Direct Contracting, CMS assigns the Medicare Fee-for-Service (FFS) members directly to a provider's panel. This new update may help health systems, medical groups, IPAs, ACOs and FQHCs gain attributed members and therefore market share. On the flipside, the provider groups that elect not to participate may no longer be able to see the Medicare FFS members that were previously part of their panel. CMS is setting up a potentially new competitive landscape.

The new model includes two direct contracting options - global and professional. Providers will receive a fixed monthly capitation payment ranging from the anticipated cost of primary care to the total cost of care. Providers in the global model will take full financial risk for the total cost of care, while providers in the professional model will receive primary care capitation and share 50/50 upside and downside (risk) directly with CMS. For FQHCs, this can be particularly attractive because it will likely not have an impact on the wrap-around rate. As with most VBP arrangements, the provider groups who manage the population well will be eligible to generate more margin, turning investments in care management and coordination, data analytics, physician alignment and overall network management critical.

Interested providers can submit a Letter of Intent (LOI) now through August 2, 2019. Request for Applications (RFA) is expected to be released in summer/fall 2019 and selected entities will be notified in fall/winter 2019.



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COPE Health Solutions is a national leader in helping health care organizations succeed amid complexity and uncertainty

For more information on how your organization can prepare for the CMS direct contracting model, please contact **Carla D'Angelo, Vice President, COPE Health Solutions at cdangelo@copehealthsolutions.com** or **Samuel Shutman, Senior Vice President, COPE Health Solutions at sshutman@copehealthsolutions.com.**