COPE HEALTH SOLUTIONS

Webinar Q&A

Updates to Medicare Direct and Medicare Shared Savings Programs and How They Fit in Your Overall Value-based Payment Strategy

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1. **Will the current healthcare problem require greater organization capitalization in the future in order to participate in value-based payment (VBP)?**

   Potentially. Participation in VBP in the future will require the capitalization of new technologies, such as telehealth, network builds, care model development, analytics and other key capabilities. Depending on where organizations are on their VBP roadmap, some may have already invested and built out infrastructure that can be scaled or leveraged.

   There are current opportunities to support providers considering such investments through some of the Covid-19 financial relief programs as well as through programs like Medicare Direct Contracting (MDC). MDC in particular has several features that enhance cash flow and provide early access to capital to support providers in investing in their population health infrastructure.

2. **It would be helpful to review the specific requirements for enrolling to see if our medical group could qualify.**

   The Centers for Medicare & Medicaid Services (CMS) has expressly stated interest in attracting a diverse set of providers, including health plans, to operate under a common legal structure that centers primary care and embraces risk and advanced payment models. This includes providers with experience in Next Generation Accountable Care Organization (NGACO) and Medicare Shared Savings Program as well as those just entering this space with Medicare Fee for Services (FFS).

   The program has features that expand the set of eligible providers such as voluntary alignment and options for organizations with fewer than 5,000 aligned Medicare FFS beneficiaries to participate.

   A Direct Contracting Entity (DCE), whether newly formed or leveraging an existing body, must be a legal entity that contracts with a network of Participant Providers and Preferred Providers – defined in the Request for Applications (RFA). The DCE Participants are required to be a Medicare-enrolled provider or supplier as defined at 42 C.F.R. § 400.202.

   More information can be found in the released RFA from CMS: https://innovation.cms.gov/files/x/dc-rfa.pdf.

3. **How have you seen organizations, poised to apply for Medicare Shared Savings Program starting in 2021 and impacted by the announcement that no new applicants would be taken, think creatively about how to partner with existing Shared Savings Program ACOs in order to participate next year?**

   Yes. Partnership strategies are valuable tools in advancing risk-based contracting efforts, inclusive of aspiring Shared Savings Program participants.

   There are some important considerations to keep in mind for partnering opportunities:

   - Patient population overlap
   - Mutual goals and definitions of value proposition
   - Complimentary vs. competitive networks
   - Contract and incentive alignment

- Past performance and how the partnership would impact membership growth and savings opportunities

4. **I think that the answer is yes, but can you comment on an entity participating in Direct Contracting as well as in Medicare Advantage (MA) and Shared Savings Program?**

   There are two parts to this question:

   - Providers are allowed to participate in both Medicare Advantage and Direct Contracting. CMS has also encouraged plan participation, particularly those with special needs plans, to consider forming a DCE and deepen their provider partnerships
   - Providers participating in the Shared Savings Program must discontinue participation and transition to MDC. There is fine print to explore in disaggregating networks at the TIN and NPI levels for larger organizations, but this is case by case, complicated and ultimately boils down to needing completely separate entities with separate networks and patients. Even if technically possible, it may not be optimal operationally depending on your structure.

5. **Do you see opportunities for a free standing Rural Health Clinic to integrate with a nearby (30-50 miles) Urban Integrated Network that is into Shared Savings Program at risk shared relationship?**

   Yes. Integrated networks will be looking for partners to join their network to meet the needs of patients in their current or target service areas. That said, whether a partnership is a good match requires examination to understand potential synergies and compatible performance and goals. It would be important for example to understand what the Shared Savings Program would expect and what the defined value proposition would be for your clinic.

6. **Can MA Plans get involved in this program or is this program for physicians/medical groups to directly contract with Medicare?**

   Yes, Medicare Advantage plans can become involved in Medicare Direct Contracting, along with an array of provider types as long as they meet the requirements outlined in the RFA.