COPE HEALTH SOLUTIONS

# Medicare Direct Contracting: The First Five Things a Direct Contracting Entity Should Do


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The Center for Medicare and Medicaid Innovation (CMMI) has announced the 51 Direct Contracting Entities (DCEs) selected to participate in the initial 2021 Implementation Period (IP) for the Direct Contracting Model Global and Professional Options. The IP began on October 1, 2020, and will run through March 31, 2021. The first Performance Year (PY) begins on April 1, 2021, truncated by a quarter due to Covid-19 delays. Each subsequent period will follow the calendar year, through December 31, 2026. In addition to the 51 DCEs selected for the IP, DCEs selected to begin at the start of the April 2021 Performance Year will be announced closer to the start of that period. CMS also recently announced that letters of intent (LOI) are due for potential applicants for MDC Geographic in 15 communities across the country (that program will be covered in a future article).

As a participant in the IP, your clock is ticking to have the core population health management competencies in place to hit the ground running on April 1, 2021, and ensure that this program is aligned with your other value-based payment (VBP) arrangements, leveraging any planned scaling of population health management infrastructure. Although DCEs are not bearing any financial risk during the IP through the end of March 2021, the remaining period is a prime opportunity to assess and diagnose gaps for rapid closure to maximize return during the first PY and beyond. For those considering an application for the PY start in January 2022, now is also a good time to consider how to lay the groundwork for success in Medicare Direct Contracting (MDC), and how this opportunity complements and aligns with other VBP arrangements and population health management infrastructure requirements.


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## Successful DCE MDC Checklist

### Take inventory of value-based arrangements across lines of business

Medicare Direct Contracting is essentially an advanced VBP contract for Medicare Fee-for-Service (FFS) attributed beneficiaries. It affords the opportunity to bring another population into alignment with other payer value-based payment arrangements, including for some organizations your self-insured population through your employee health plan. Having misaligned payment models across populations spells trouble for designing, building and governing networks and care models that are population agnostic. Success requires a concrete strategy for bringing all value-based payment arrangements, contracted providers and attributed members into alignment and monitoring ongoing performance while maintaining alignment.

- ☐ Assess and explore opportunities to align network, financial incentives, quality metrics and population health management infrastructure across all risk-bearing organizations (RBOs), including owned plans, ACOs, CINs and other risk-bearing provider organizations
- ☐ Quantify opportunities across the board with relation to network leakage, total cost of care, quality bonus and any other factors
- ☐ Bring the opportunity analysis to bear through concrete deal points to drive ongoing negotiations both through RBOs and direct with payers

### Perform a network analysis and establish an ongoing network management strategy

Aligning contracts across lines of business creates an organization with clear financial imperatives. An essential pillar of success is a network that goes beyond adequacy and is designed to meet the needs of the population at the level required to achieve contracted quality, utilization and financial targets. This network of providers must be properly incentivized, adequately engaged and monitored for practice and physician level performance using population health data analytics. Through these mechanisms, physicians will have the financial freedom and information required to deliver on a value-based care model.

- ☐ Develop a way to measure network performance across key population health indicators, paying special attention to measures with associated risk and quality contract requirements
- ☐ Get to know your practices and understand penetration of VBP contract attributed membership in their practice and payer mix
- ☐ Take a comprehensive look at your network across all RBOs and payers to understand where there is overlap in contracted physicians as well as high concentration of members served

### Conduct a Population Health Capabilities Gap Assessment

The DCE may very well be appended to or drive the organization of a population health management hub that services the entire organization. Taking inventory of where these functions may currently sit across RBOs and various payer arrangements and identifying gaps can avoid building duplicate services or, worse, silos that undermine performance strategy. Truly building out the functional capacity to succeed in value -based arrangements requires a capital intensive investment, and an additional cost for ongoing operations. Centralizing this function as a set of shared services for the entire network and across lines of business enhances the return on investment and reduces the ongoing cost burden on a PMPM basis. It is not always possible to be fully centralize, but a thoughtful strategy should be developed to determine what is uniquely optimal for your organization in the immediate, near and long-term.

- ☐ Take stock of current data analytics capabilities and close gaps immediately to establish an accurate understanding of your business and lay the groundwork for ongoing population health management
- ☐ Assess for potential optimization/scaling or establish a care management function within the population health management hub, including a vision for a consistent vision and frame staffing and programs to supplement network care management capabilities
- ☐ Establish deliberate member engagement and incentive tools to maximize beneficiary alignment and retention in MDC, as well as increase member satisfaction across lines of business

**Develop a comprehensive financial pro forma**

The realized shared savings and performance bonuses are intrinsically linked to targeted investments and initiatives, and shifts in utilization. Furthermore, organizations must still contend with fee-for-service revenue streams that are strained during value-based transitions. This creates for a complex relationship between expenses and revenues. A dynamic pro forma will provide leadership with the line of sight into these interdependencies required to make important investment, contracting and timing decisions.

- ☐ Estimate shared savings/losses across lines of business with relation to anticipated changes in the care model to drive results
- ☐ Quantify needed investments and initiatives required to realize value and align the timing of implementation with the ability to see changes in network performance payments and utilization patterns
- ☐ Establish risk pools and funds for network contracting and risk/reward distribution across stakeholders

**Update your VBP Roadmap**

Operationalization of all these elements is a multistage process. Each effort must be prioritized and sequenced to ensure feasibility, financial solvency and regulatory compliance. For leadership to have what they need to stay organized and on track, manage network and stakeholder communications on changes and challenges, and have streamlined and effective governance, they need a well-planned roadmap.

- ☐ Synthesize all of the above to inform the budgeting process, target setting and resource allocation
- ☐ Schedule and phase capital investments based on anticipated revenue and begin any vendor procurement processes
- ☐ Develop contract renegotiation strategy to drive alignment across and between payer and network contracts to drive value

*For more information on Medicare Direct Contracting, value based contracting strategies, and mechanisms to deploy population health analytics, please contact Allen Miller at amiller@copehealthsolutions.com or (310) 386-5812 or Shanah Tirado at stirado@copehealthsolutions.com or (213) 369-7415.*

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