COPE HEALTH SOLUTIONS

Webinar Q&A

Medicare Direct Contracting: What Payers and Providers Need to Succeed

March 25, 2021

1. **Do you have any insight into how CMS will handle 2020 for the benchmark year for potential 2022 starters? Will CMS include it and normalize it through a trend factor or use 2017-2019 trended forward? In the FAQ, CMS said they are "reviewing it."**

   The benchmarking method for Standard Direct Contracting Entities uses a fixed period when establishing historical expenditures that will be held static across all model performance years (this means that for PY2 performance, the same baseline period is used, but for the updated aligned participant list). These base years are 2017, 2018 and 2019 (with increasing weight for more recent years). There hasn't been anything that suggests this would be different for 2022 starters, thus the impact of COVID-19 on claims expenditures would not be reflected in the benchmark calculation. The only time this fixed period changes is for New Entrant and High Needs DCEs in later performance years (starting in PY5 and PY6), once their population has adequate claims history. In this instance, baseline years will be adjusted for 2021, 2022 and 2023 also avoiding 2020.

   Regional expenditures determined from the DC/KCC rate book and risk adjustment models are also critical components of benchmarking for all DCE types and unfortunately, the effect of COVID-19 on these elements is less clear. CMS has stated they may avoid using 2020 in the development of future rate books for program use. As for risk modeling, standard and new entrant DCEs under the HCC prospective risk adjustment model may see some impact as 2020 data is used prospectively. High needs DCEs may be less concerned as the concurrent risk model uses demographic indicators and diagnoses from the PY to predict expenditures in the same year. We expect CMS to continue to provide updates on the matter.

2. **Will Direct Contracting Entities start again under the new administration?**

   Some DCEs have already been selected and of those some have implemented at the time of this Q&A release effective April 1, 2021. A sub-set of the DCEs already accepted were allowed to delay implementation until 2022 and will still be allowed to do so.

   As of this Q&A release CMS has paused any new applications to become a Direct Contracting Entity for 2022 and it is not clear whether that decision may be reconsidered or whether there may new opportunities in future years.

   The Geographic Model has been placed under review and delayed indefinitely.

3. **How will the new Direct Contracting Entities factor into MDC models?**

   DCEs are the legal body and convener that will receive the capitated payments from CMS and administer payments to a curated network of providers. Similar to ACOs, DCEs are the umbrella to which beneficiaries are attributed for calculation of benchmarks, payments, quality performance and shared savings.

4. **What are the endpoints or metrics of improved patient care coordination and outcomes? What will be compensation pay for improving patient outcomes?**

   The program applies a 5% withhold on the calculated performance year benchmark, which can be earned back based on quality performance. Performance will be measured based on "Continuous

Improvement/Sustained Exceptional Performance Criteria" (CI/SEP). These criteria have not yet been released and will be provided prior to PY2.

Additional funds will be made available to DCEs through a High Performers Pool; to qualify, the DCE must have met the CI/SEP criteria and either demonstrate high quality performance or achievement of quality improvement criteria.

Domain	ACO Measure	Measure Title	Method of Data Submission
Patient/ Caregiver Experience	ACO-1	CAHPS®: Getting Timely Care, Appointments, and Information	Survey
Patient/ Caregiver Experience	ACO-2	CAHPS®: How Well Your Doctors Communicate	Survey
Patient/ Caregiver Experience	ACO-3	CAHPS®: Patients' Rating of Doctor	Survey
Patient/ Caregiver Experience	ACO-5	CAHPS®: Health Promotion and Education	Survey
Patient/ Caregiver Experience	ACO-6	CAHPS®: Shared Decision Making	Survey
Patient/ Caregiver Experience	ACO-7	CAHPS®: Health Status/Functional Status	Survey
Patient/ Caregiver Experience	ACO-34	CAHPS®: Stewardship of Patient Resources	Survey
Patient/ Caregiver Experience	ACO-45	CAHPS®: Courteous and Helpful Office staff	Survey
Patient/ Caregiver Experience	ACO-46	CAHPS®: Care Coordination	Survey
Patient Reported Outcome (optional)*	NQF-2483	Gains in Patient Activation Measure at 12 months	Survey
Care Coordination/ Patient Safety	ACO-8	Risk-Standardized, All Condition Readmission**	Claims
Care Coordination/ Patient Safety	ACO-38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions**	Claims
Care Coordination/ Patient Safety	NQF-326	Advanced care plan	Claims
Care Coordination/ Patient Safety	TBD	Days at home (proposed – to be developed) DCEs with overall HCC risk score of 2+	Claims

* Gains in patient activation measure at 12 months is an optional measure. DCEs that opt to implement and report on this measure will not receive any quality credit.

These metrics can be found on page 78 of the RFA.

**To mitigate the impact of COVID-19, quality performance benchmarks will be developed using 2021 claims data. The quality performance benchmarks for the Risk-Standardized All Condition Readmission and the Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions measure will be made available in April – May 2022. The benchmarks will apply for both performance years 1 and 2. To earn back 1% of the quality withhold in PY1 and PY2, the DCE must meet the quality performance benchmarks on one of the two utilization measures listed above.

5. Is this a pilot program and is this program funded for years to come?

Medicare Direct Contracting is a CMS demonstration program. While some adjustments may be made during the demonstration, the program is built off of previously tested principles of ACO models and Medicare Advantage. CMS may entertain additional application rounds for future years for all payment model options. The performance year schedule below was included in the CMS financial methodology Webinar Slides from September 17, 2020.

Calendar Year	PY	Global Discount	New Entrant / High Needs Beneficiary Minimums	New Entrant / High Needs Benchmark	Quality Withhold Basis
2021 (9 mo.)	1	2%	1000 / 250	Regional Rate	1% Performance, 4% Reporting
2022	2				
2023	3	3%	2000 / 500		5% Performance
2024	4	4%	3000 / 750		5% Performance
2025	5	5%	5000 / 1200	Blend of Regional Rate & Baseline	5% Performance
2026	6	5%	5000 / 1400		5% Performance

6. For the Home Bound Waiver, CMS states the patient has to have a "recent acute care episode" how many days does this acute care episode have to have taken place for the home bound waiver to be used for home health?

As indicated in the current RFA on page 60:

> Under the proposed Home Health Homebound Requirement Benefit Enhancement, CMS would waive the requirement under Sections 1814(a)(2) and 1835(a)(2) of the Act, and 42 C.F.R. § 409.42(a) that a beneficiary must be confined to the home to receive Medicare reimbursement for qualified home health services for eligible beneficiaries. Specifically, To qualify for home health services under this waiver, beneficiaries must (1) otherwise qualify for home health services under 42 C.F.R. § 409.42 except that the beneficiary is not required to be confined to the home; and (2) have a combination of clinical risks, which will be determined by CMS at a later date.

No new requirements are imposed outside of that which is already standard to qualify for home health services.

7. For Heritage Provider Network, do your non-staff clinicians underperform compared to your staff clinicians or is performance the same?

Heritage Provider Network (HPN) achieves similar results with the Staff Model Clinics and IPAs. 75% of HPN enrollment is in the IPAs. HPN uses the same operating system to manage the members whether they are in the clinic or in the IPAs. Strong population health management, which includes leadership, management and transparent incentives and communications, ultimately drives success under either model.

8. **How does one make this successful since members get attributed to you but have the freedom to go anywhere (out of network)? CMS is expecting a discount and providers are expected to offer incentives (ex. lower out of pocket cost) to get member loyalty and keep them in network.**

   CMS only takes a discount under the total care capitation model for Global DCEs. As indicated through the quality measures, DCEs and their providers will need to deliver quality care with a patient-as-consumer orientation.

   Key to success will be:
   1. Provider network selection and engagement, including selection of the right financial agreement model between the DCE and preferred providers.
   2. A top of license, evidence-based care model with clearly defined centralized and de-centralized components.
   3. Up to date data dashboards to share with providers and inform opportunities.
   4. A transparent funds flow model that incentivizes providers to engage with members, practice evidence-based medicine and make good referrals.

9. **Explain how plans get patients aligned to their program.**

   There are two methods of aligning beneficiaries to your DCE. The first is claims based alignment. This alignment is based on the participant providers in the DCE. In developing a network contracting strategy, plans establishing a DCE should consider Medicare FFS panel size when selecting the final network. The second mechanism is through voluntary alignment. Direct beneficiary engagement strategies can be developed to educate beneficiaries about the benefits of the practice they are using and the DCE and there will be a standard form that beneficiaries can sign to designate their alignment to the DCE. In all cases, voluntary alignment will always override claims-based alignment.

10. **I heard there have been some recent changes to the standard participation agreement for Direct Contracting, including reserve requirements. Can you speak to any such changes?**

    The latest publicly available information on reserve requirements outlines financial guarantee requirements of 2.5% to 4.0%, depending on the risk model.
    See question 14 for more details.

11. **What is the PMPM rate that you propose to pay PCPs with direct contracting model of care? What percentage of premium are being shared with PCPS for quality and hospital utilization?**

    This decision depends on a large variety of factors that must be carefully evaluated on a case-by-case basis. At one end of the spectrum, DCEs may elect to pay FFS and distribute shared savings. On the other end of the spectrum, DCEs may elect to capitate providers and even delegate care management for those with mature programs in place.

    To determine the strategy best suited for your DCE, we recommend a pro forma and network performance and capabilities analysis to inform the best suited funds flow and contracting strategy.

12. What is the application deadline for January 1, 2022 participation?

As of this Q&A release CMS has announced that there will not be any new application opportunities for January 1, 2022, however any previously accepted DCEs that delayed implementation will be allowed to launch in 2022.

13. What entities are eligible for DCE participation (e.g., IPA, ACO, other)?

The DCE is a newly established legal entity. The DCE must be a legal entity that contracts with DC Participant Providers and may contract with Preferred Providers. Participant Providers may include, but are not limited to:

- Physicians or other practitioners in group practice arrangements
- Networks of individual practices of physicians or other practitioners – *this would include IPAs, ACOs and CINs*
- Hospitals employing physicians or other practitioners
- Federally Qualified Health Centers
- Rural Health Clinics
- Critical Access Hospitals

14. What are the reserve requirements and how is it funded (perhaps with surety bonds)?

DCEs will be required to meet the reserve requirement in compliance with state regulations where the DCE is operated, with the exception of states deferring to CMS. Aside from state mandated requirements, DCEs are required to have a financial guarantee to ensure CMS is able to recoup shared losses. Options for securing the financial guarantee include funds placed in escrow, a line of credit or a surety bond. DCEs also have the option of proposing an alternative mechanism to CMS. The amount required for the financial guarantee depends on the risk arrangement selected (table below). Any funds left over will rollover to the following performance year. Should funds be used, DCEs have 60 days to replenish the guarantee or CMS shall begin withholding capitation payments.

Risk Arrangement	Primary Care Capitation Payment	Primary Care Capitation + Advanced Payment	Total Care Capitation Payment
Professional	2.5%	2.5%	N/A
Global	3.0%	3.0%	4.0%

https://innovation.cms.gov/media/document/dc-model-financial-reconcil-guidance

15. Are there any state specific regulations or participation required in addition to the national contract with CMS?

DCEs will be required to sign a participation agreement with CMS prior to the first performance year. However, CMS is requiring that DCEs meet all state requirements and regulations. Some states have waived the state oversight and are deferring to CMS and others are requiring licensing and risk-based capital, similar to what is required for other risk arrangements.

16. With regard to RAF impact in the risk assumption, is the pool determined by historical utilization costs or premium?

The RAF is calculated through claims-based alignment, using Parts A and B expenditures for those beneficiaries during the baseline period. The full calculation also considers baseline expenditures for

voluntarily aligned beneficiaries and regional expenditures. The baseline period is CY 2017, CY 2018 and CY 2019. For those selecting the High Needs Population Model, there is a Concurrent Risk Adjustment model that is applied, which also uses expenditures for aligned beneficiaries.

17. With relation to benchmark, how do I know if I will be successful under this model?

Succeeding under this model depends on a multitude of drivers including care management maturity, population health infrastructure investments, scale, market dynamics, past performance, regional performance, risk scores and other nuanced factors. To truly understand potential financial performance under this model, a pro forma should be developed to model out various scenarios, conduct sensitivity analyses and get clarity on the key levers for managing your DCE. This financial analysis is intrinsically related to the network contracting decisions and development of a funds flow model.

A network analysis will be required to support decisions around participant and preferred provider selection. Having the right analytical tools that allow you to see practice and individual physician performance at TIN and NPI levels, in conjunction with panel size and risk. This can empower DCEs to strategically select providers to maximize potential for performance, growth stringent alignment thresholds. The availability of claims data, such as past Medicare Shared Savings ACO data, allows for a robust and customized analysis.

More information on this topic is available here.