COPE HEALTH SOLUTIONS

Medicare Direct Contracting Pivot: Act Quickly to Capitalize on Alternatives

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If you were shut out of Medicare Direct Contracting (MDC) when the Centers for Medicare and Medicaid Services (CMS) recently announced it would not accept new 2022 applicants, all is not lost. The pause on new MDC applicants is part of a broader examination of CMS' various Medicare models to encourage value-based care and value-based payments. While the specific models that will survive or emerge is not yet clear, the trajectory remains toward value and risk; expanding risk experience and capabilities can only benefit providers and payers.

Even if CMS does not reopen 2022 MDC applications despite industry pressure to do so, there are alternatives that will enable you to advance your risk strategy for Medicare fee-for-service (FFS) along with other payers and lines of business. However, you will need to move quickly to take advantage of them in 2022.

Here are three options for an interim MDC substitute, starting with those facing near-term deadlines:

1. Primary Care Model

Best-fit Participants: Smaller medical practices. Of note, existing Medicare Shared Savings Program (MSSP) participants can simultaneously participate in Primary Care First (PCF).

Critical dates: Applications close May 21st. There is still time to apply because the application is straight-forward and can be completed if you act expeditiously.

Evolving out of the CPC+ model, the PCF program targets primary care practices and rewards complex care management and quality, while reimbursing services with an enhanced payment rate.

Key considerations:

- Minimum of 125 aligned FFS beneficiaries required for each practice applying
- Includes beneficiary engagement incentives and waivers
- Uses Professional Population-Based Payments, which are risk-adjusted, have a base rate for all patients in the practice and include a flat primary care visit payment
- Performance Based Payments are adjusted based on performance versus a national benchmark, with those in the top 50th percentile of the benchmark earning increases
- No shared savings or losses

The Primary Care First Program gives medical practices the opportunity to increase revenue by up to 50% of their total primary care payment based on key performance measures including acute hospital utilization.

2. Leverage data and analytics

Best-fit Participants: Large medical groups, IPAs, CINs; health plans are ineligible. No TIN can be in both MSSP and MDC.

Critical dates: June 1st to 7th for notice of intent and June 8th to 28th for phase I of application.

Medicare Shared Savings Program (MSSP) is geared more toward developing and maturing your ability to successfully manage risk versus MDC's glide-path to scaling attribution under higher levels of risk. MSSP also continues to rely on standard FFS

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funds flow, while MDC introduces capitation and allows the DCE to contract directly with Participant and Preferred providers.

Key considerations:

- A minimum of 5,000 voluntarily aligned Medicare FFS beneficiaries required, like the standard MDC model and past ACO programs
- Two tracks with differing levels of risk, Basic A through E and Enhanced, and applicants with more risk experience can only qualify for highest levels of risk
- Uses FFS payments, so no access to MDC's pre-payment and enhanced provider financial alignment models
- Uses quality gates for deriving shared savings and loss exposure
- Shared savings start at 30-50% in Basic and 75% in Enhanced models

Basic Track E is the closest to the MDC Professional model with 50% upside risk exposure but includes a 1% Medicare Loss Ratio/Medicare Savings Ratio and downside caps.

3. Join Existing Direct Contracting Entities and those Launching in 2022

Best-fit Participants: Any size providers, IPAs, CINs

Critical dates: Late summer 2021, when DCEs must submit provider lists to CMS for 2022

DCEs, both those that launched April 2021 and those accepted by CMS for a January 2022 start date, would potentially want to add providers in order to grow their attributed membership and therefore their potential for accessing more shared savings.

Key considerations:
For existing DCEs considering taking on new providers:

1. Would the additional providers fit the geographic, performance and attributed membership profile to support your strategy?
2. Will the new providers be committed to integrating into your network, following your care model and using/being supported by your tools and capabilities?
3. Will the new providers potentially add to a strategy that includes the option for DCE beneficiaries to enroll in a Medicare Advantage product you are aligned with?

For providers considering joining existing DCEs:

1. Will participating in the DCE accelerate and complement your overall value-based payment roadmap strategy?
2. Are you aligned with the risk model of the DCE and prepared to have your FFS claims reduced to meet the model?
3. Is the DCE limited to your geography(s) or does it include geographies in which you are not present?
4. Do you see value in the DCE's population health management capabilities?
5. Are there opportunities to collaborate with the DCE on value-based payment agreements with other payers and lines of business?
6. Do you and the DCE have a mutual alignment and strategy with relation to having a Medicare Advantage product, for which you can access adequate premium risk and delegation, for DCE attributed members who may want that option over time?

If you were approached by a DCE and previously decided against joining, it could be time to revisit that option, however the structure of the agreement and your opportunity to obtain access to the upside benefits from high performance is key.

We stand ready to assist you in pursuing any of these options and in developing, planning and implementing comprehensive population health management and risk strategies. Please contact us at info@copehealthsolutions.com.