Law360
Should Health Orgs Join CMS' Direct Contracting Program?

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February 4, 2020 - The Centers for Medicare & Medicaid Services recently issued a request for applications, or RFA, for the direct contracting program.[1]

Direct contracting is the next stage in the progression of value-based care. It introduces true population-based payment structures, and incorporates private sector and Medicare Advantage approaches to risk-sharing. It also focuses uniquely on primary care providers, as the heart of the clinical and — through the program — economic system.

Many organizations are in the midst now of applications for the first implementation period, due in February. Many others are considering whether to apply directly for the first performance year — those applications are not due until the spring.

First, we will summarize how the direct contracting model works. Then, we will summarize some of the key requirements for applicants. Finally, we discuss factors that potential applicants might consider when determining whether the model is right for them.

How It Works

Overall

Take one part Medicare Shared Savings Program, one part Medicare Advantage Program and a dash of the Bundled Payments for Care Initiative. Shake with ice. Serve. The resulting concoction is direct contracting.

In brief, the direct contracting model invites participants to form a direct contracting entity, or DCE, with which CMS contracts on a risk basis. In turn, the DCE contracts with an array of provider organizations, with primary care providers playing a leading role. For some, the model will involve capitation payments. For others, the model may involve modified fee-for-service payments. For all, in exchange for their assumption of financial risk, the model will involve increased financial flexibility from CMS for care delivery to Medicare fee-for-service beneficiaries. The program is expected to take place over an implementation period during 2020, followed by five performance years.

Payment Mechanisms

The direct contracting model uses a series of payment mechanisms through which CMS pays DCEs on a per-beneficiary per-month basis for the Medicare fee-for-service beneficiaries aligned to the DCE. Each DCE must select one of the following payment mechanisms:

Total Care Capitation

CMS provides a capitated payment for all services provided by the DCE's participant and preferred providers (essentially, the care network). The capitation payment reflects the estimated total cost of care for the DCE's beneficiaries. This is available only to DCEs that select the so-called global option, which imposes on the DCE full financial responsibility for cost overruns, and pays to the DCE the full amount of cost savings.

Primary Care Capitation

CMS provides a capitated payment for certain primary care services provided by the DCE and its direct contracting participant and preferred providers. That subcapitated payment amounts to 7% of the

estimated total cost of care for the DCE's beneficiaries.[2] Subject to a caveat noted below, CMS continues to pay at fee-for-service rates for other services. This mechanism is available for DCEs in the so-called professional option in which the DCE shares with CMS in 50% of any excess costs above the benchmark, and receives 50% of any amount by which costs fall below the benchmark. and the global option.

Under the primary care capitation mechanism, direct contracting participant providers providing primary care services will look exclusively to the DCE for payment for those services (although they do need to submit claims to their CMS contractor — but the contractor will not pay those claims). Preferred providers, on the other hand, may choose whether to participate in the mechanism and negotiate with their respective DCEs the percentage reduction of the participant provider's primary care fee-for-service claims payments.

For example, a so-called preferred provider (again, more below on the categories of network partners) might agree to an 80% reduction in fee-for-service reimbursement. In that case, it would receive 20% of usual fee-for-service reimbursement from its CMS contractor through submission of claims in the ordinary course, and would receive the balance of its reimbursement through whatever model it negotiates with the DCE.

DCEs that opt in to the primary care capitation mechanism have an additional choice — this is the caveat noted above. They can elect to receive advanced payments for some nonprimary care services. These essentially expand the subcapitation rate to include additional services, for which the DCEs can then contract with their network partners on an alternative payment basis. In a nutshell, a DCE and its network partners would agree to a percentage reduction in the nonprimary care claims payment amount in exchange for a monthly advanced payment from CMS.

This monthly payment would be equivalent to the estimated value of the reduced fee-for-service claims for non-primary care provided to aligned beneficiaries. The DCE receives these monthly payments and pays its network partners.

Risk Mitigation

To mitigate risk, the direct contracting model incorporates risk corridors and stop-loss arrangements.

Risk Corridors

Cap the shared savings/losses based on risk bands, meaning that greater deviance from the performance year benchmark will result in a lower percentage of shared savings/losses. For example, a DCE in the professional option would experience 50% of savings and losses within 5% of the benchmark, but would be exposed to only 35% of losses more than 5% above the benchmark.

Stop-Loss Arrangements

Reduce risk associated with outlier expenditures by limiting DCEs' financial liability for beneficiary expenditures above a prospectively determined attachment point. This limits but does not eliminate risk. DCEs retain responsibility for a percentage of expenditures above the attachment point, as incentive to continue managing costs.

Optional Benefit Enhancements

As part of the direct contracting model, CMS has waived certain Medicare payment restrictions, to give DCEs the option to implement benefit enhancements designed to reduce costs. Examples include:

Post-Discharge Home Visits

The direct supervision requirement may be waived for qualified DCEs to provide home visits furnished by

auxiliary personnel under general supervision.

Certification of Home Health Services by Nurse Practitioners

DCEs may allow nurse practitioners (in lieu of a physician) to certify that a beneficiary is eligible for home health benefits.

Concurrent Care for Beneficiaries who Elect the Medicare Hospice Benefit

Traditionally, a beneficiary who elects the Medicare hospice benefit forgoes the right to receive curative care. Under this conditional waiver for DCEs in the global option, a DCE and its participant and preferred providers may provide curative care to beneficiaries who have elected hospice care.

These benefit enhancements will be available for the first performance year. CMS is considering others for later years.

Beneficiary Engagement

While organizations operating within the direct contracting model will remain subject to the Civil Monetary Penalties Law's prohibition on gifts or remuneration to beneficiaries as inducement to receive items or services, the direct contracting model also allows DCEs and their network partners to offer benefit enhancements to engage beneficiaries in care delivery.

Beneficiary Engagement

DCEs can encourage beneficiary engagement by providing certain in-kind items or services to their beneficiaries. Examples of patient engagement incentives include vouchers for over-the-counter medication recommended by a health care provider, wellness program memberships and meal programs.

Cost-Sharing Support for Part B Services

DCEs also can enter into cost-sharing arrangements with their participant and preferred providers. Those arrangements can provide for a DCE to pay all or part of the amount of beneficiary cost-sharing for certain categories of beneficiaries and Part B services that would ordinarily be collected by its participant and preferred providers. DCEs planning on providing cost-sharing support must submit an implementation plan to CMS.

Quality Reporting

Annually, CMS will evaluate whether quality care is being delivered to beneficiaries by assessing DCEs' claims-based quality measures and information from the Consumer Assessment of Healthcare Providers and Systems for accountable care organization surveys.

The quality performance scores will inform CMS's application of a quality withhold to the DCEs' performance year benchmark calculation. DCEs that meet or exceed predefined performance criteria can earn back all or a portion of their quality withhold based on their scores, while those falling short of the criteria can earn back up to half of the quality withhold.

Key Requirements for Applicants

Through the RFA, CMS invites organizations — with a core of primary care providers — to apply to participate. The RFA offers an implementation period, which begins first, and for which applications are due on Feb. 25. The RFA also invites organizations that wish to skip the implementation period to apply directly for participation in the first performance year. Those applications will be due in the spring of 2020.

Application Scoring and Selection

Through the evaluation criteria in the RFA, CMS has articulated its views of what characteristics organizations should possess in order to succeed in the program — i.e., in order to manage population health, patient care and provider coordination effectively. As such, CMS will review applications and score them based on the following elements:

- Organizational structure;
- Leadership and management;
- Financial plan and risk-sharing experience;
- Patient-centeredness and beneficiary engagement; and
- Clinical care.

Applicants must also provide a list of providers and suppliers who have committed to participate with them in the program. A panel of experts from CMS and other organizations will select the participants based upon the scoring, program integrity considerations and market effects. CMS may also interview applicants as part of the evaluation process.

Legal Entity and State Licensure

DCEs must be legal entities and separate from any participant provider or preferred provider. DCEs' compliance obligations include state risk-bearing organization licensure requirements (e.g., insurers, third-party administrators). A DCE need not be a Medicare-enrolled provider or supplier.

Governing Body

CMS requires that each DCE must have a governing body separate and unique to the DCE (e.g., not the same governing body of an entity participating in the DCE), and that the governing body must be responsible for overseeing and directing the DCE.

Members of this governing body must have a fiduciary duty to the DCE and be subject to a conflict of interest policy. As with the requirements for accountable care organizations, DCE boards must include at least one Medicare beneficiary served by the DCE and one consumer advocate (who may be the same person as the Medicare beneficiary).

Contracting with Providers

DCEs must contract with a network of other health care providers, called participant providers and preferred providers. Participant providers are the core of the networks. They must participate in the DCE's chosen payment mechanism (which may involve capitation, rather than fee-for-service payments, for services furnished to fee-for-service Medicare beneficiaries). They also must agree to report quality data through the DCE, and to comply with care improvement objectives and model quality performance standards.

Preferred providers play more of a supporting role, and are not tied to the DCE's payment methodology (although they can opt in if they and the DCE wish).

Screening

DCEs and their providers must undergo a program integrity review as part of the screening process, which includes confirmation of Medicare enrollment, review of performance in other CMS models and review of billing history and any activities conducted regarding potential program fraud and abuse. Applicants and their senior leadership will also be required to disclose a five-year history of investigations and sanctions.

Program Overlap

The direct contracting model prohibits DCEs and their participant providers from participating in other shared savings programs during the first five performance years. In contrast, the limitations on program overlap generally do not apply to preferred providers — they may participate in direct contracting with one or more DCEs, as well as accountable care organizations and other Medicare initiatives that involve shared savings.

Monitoring

Both the DCE and CMS must monitor compliance with the terms of the direct contracting model, as well as any requirements specified in the participation agreement. DCEs must develop a compliance plan and designate an experienced compliance officer, among other elements. CMS will monitor DCEs through audits, interviews of DCE members and beneficiaries and site visits.

Remedial Actions

If any DCE fails to comply with the terms of its participation agreement, remedial actions may ensue, such as education, implementation of a corrective action plan, termination of payments, and suspension or termination from the model.

Factors that Potential Applicants Might Consider

The direct contracting model essentially puts fee-for-service beneficiaries into a quasi-Medicare Advantage environment, in which the DCE has financial responsibility for performance, and flexibility to develop arrangements with providers and, to a degree, with beneficiaries, in order to improve performance. As such, potential applicants might ask two questions initially.

First, if the DCE is in a local market with significant Medicare Advantage saturation, does the fee-for-service population have characteristics that would challenge success under the direct contracting model?

Second, does the prospective applicant have access (whether through its own work as a plan sponsor, in other Medicare or in Medicaid value-based programs, or through a partner) to care management systems necessary to be able to manage population health and patient care sufficiently?

For example, has the prospective applicant (or its constituent providers) assumed risk from a Medicare Advantage plan or other payor such that it has developed its own health and care management expertise? Or does it need help to do the work necessary to succeed?

As noted above, the direct contracting model has parentage in both Medicare Advantage and in the Medicare Shared Savings Program. But it presents points of exclusivity. A DCE and its participant providers cannot simultaneously participate in the direct contracting model and in the Medicare Shared Savings Program.

If a prospective applicant already is in the Shared Savings Program, it will need to consider what more the direct contracting model has to offer, as the choice is one or the other — not both.

And of course, even if the prospective applicant sees opportunity in the Medicare fee-for-service population that it serves, and sees that it has the internal tools to manage that opportunity, are there care partners in the community with whom it can partner effectively? And, if the market may be competitive, what risk sharing — both upside and downside — terms and protection might it have to offer?

Conclusion

The direct contracting model presents a fun hybrid to consider. It has a strong flavor of managed care, but

without the managed care plan, and for beneficiaries who have not elected managed care. It has a strong flavor of the Shared Savings Program, but is much more than an accountable care organizations.

"Fun" of course is an interesting term, as, while there is opportunity for creative design, that opportunity comes with, and, in a way, as a byproduct of, real financial risk that a DCE would assume. That financial risk, however, is a doorway to an array of self-designed network relationships that many organizations may find augment their care networks. And those opportunities, in competitive markets in particular, might tip the balance for many in deciding to apply.

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[1] Centers for Medicare & Medicaid Services, direct contracting Model: Global and Professional Options (Nov. 25, 2019), https://innovation.cms.gov/Files/x/dc-rfa.pdf.

[2] CMS proposes the following primary care services and their associated CPT codes to be included under this mechanism: new patient visit (99201 – 99205); established patient visit (99211 – 99215); prolonged care for outpatient visit (99354 – 99355); transitional care management (99495 – 99496); home care evaluation and management (99324 – 99328, 99334 – 99337, 99339 – 99345, 99347 – 99350); advance care planning (99497 – 99498); Welcome to Medicare and annual wellness visits (G402, G0438, G0439); chronic care management (99490); and virtual check-ins (G20212).