The Impact of CMMI’s Direct Contracting Program
INTRODUCTION

The CMMI Direct Contracting (DC) program is a set of three voluntary payment models, which builds on the Next Generation ACO, and is part of CMS' ongoing efforts to reduce Medicare expenditures and enhance quality for beneficiaries. Direct Contracting Entities (DCEs) will initially select between two payment options:

- **Professional** with shared saving/loss of 50% and capitated payments for enhanced primary care services, or
- **Global** with 100% risk and the choice of capitated payments for either enhanced primary care services or the total cost of care.

The third DC option, **Geographic**, is still in development and would provide 100% risk for entities interested in taking on total cost of care risk for beneficiaries in a specific region / geography.

A summary of the three DC payment models is presented in Exhibit 1.

<table>
<thead>
<tr>
<th></th>
<th>Professional</th>
<th>Global</th>
<th>Geographic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structure</strong></td>
<td>ACO structure with providers defined at the TIN/NPI level</td>
<td>ACO structure with providers defined at the TIN/NPI level</td>
<td>Open to entities interested in taking on 'regional risk'</td>
</tr>
<tr>
<td><strong>Risk Share</strong></td>
<td>50% shared saving / loss</td>
<td>100% risk</td>
<td>100% risk</td>
</tr>
<tr>
<td><strong>Payment Models</strong></td>
<td>Primary care capitation (7% of estimated total medical expense)</td>
<td>Choice of: • Primary care capitation • Total care capitation (100% of total medical expense)</td>
<td>Choice of: • Full Financial Risk with FFS claims reconciliation • Total care capitation (100% of total medical expense)</td>
</tr>
</tbody>
</table>

DCEs are legal entities that contract with CMS and are responsible for shared savings and losses to CMS. They must meet beneficiary thresholds defined by CMS for participation in the DC program. There are three classes of DCEs including Standard DCEs, New Entrant DCEs and High Needs Population DCEs.

- Standard DCEs have experience in serving Medicare FFS beneficiaries.
- New Entrant DCEs have not historically serviced Medicare FFS beneficiaries and are aligned primarily based on voluntary enrollment.
- High Needs Population DCEs serve Medicare FFS beneficiaries with complex needs and employ specific care delivery strategies.

A summary of the three DC payment models is presented in Exhibit 2.

Source: CMS Innovation Website and Webinar Presentations
Exhibit 2. High Level Overview of Types of DCEs

<table>
<thead>
<tr>
<th></th>
<th>Standard</th>
<th>New Entrant</th>
<th>High Needs Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview</strong></td>
<td>Providers with substantial historical experience serving Medicare FFS</td>
<td>Providers with limited experience participating in Medicare FFS programs (e.g. MSSP, Next Gen ACO, etc.)</td>
<td>Providers serving a clearly defined “complex needs” Medicare FFS population using specific care models²</td>
</tr>
<tr>
<td><strong>Alignment Method</strong></td>
<td>Voluntary and claims-based alignment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Minimum Beneficiary Threshold Prior to Performance Year (PY)** | PY1-PY5: 5,000                                                          | PY1: 1,000  
PY2: 2,000  
PY3: 3,000  
PY4: 5,000  
PY5: 5,000³ | PY1: 250  
PY2: 500  
PY3: 750  
PY4: 1,200  
PY5: 1,400 |
| **PY Benchmarks**       | Blend of regional expenditures (Adjusted MA Rate Book) with aligned beneficiary historical expenditures | Regional expenditures (not historical expenditures) for first three performance years | Regional expenditures (not historical expenditures) for first three performance years |

Source: CMS Innovation Website and Webinar Presentations

1. High Needs Population DCEs focus on beneficiaries with impaired mobility and / or clearly specified clinical criteria (e.g. risk score >3.0).
2. High Needs Population DCEs are expected to employ care delivery strategies such as those used by Program of All-Inclusive Care for the Elderly (PACE) organizations.
3. For New Entrant DCEs, there are also expectations related to how many beneficiaries are aligned through claims. In PY1-PY3, no more than 3,000 beneficiaries can be aligned via claims. In PY4-PY5, at least 3,000 beneficiaries should be aligned via claims.

More than 1,400 organizations have submitted non-binding letters of intent expressing interest in the DC program and now face the decision of whether to move forward with the DC program and which DC option to pursue. The deadline for binding applications for the implementation period is February 25th and for performance year 1 is May 2020. The purpose of this bulletin is to:

- Provide an overview of important new design elements of the Direct Contracting program
- Summarize high level differences between the MSSP Pathways to Risk, CMMI’s Direct Contracting and a typical Medicare Advantage risk contract to inform senior leadership decision making, and
- Present competitive implications for future planning for providers, including health systems and physician groups.
EXECUTIVE SUMMARY

CMMI’s DC Program, which seeks to improve upon the Next Generation ACO and integrate useful elements of the Medicare Advantage program, continues CMS’ efforts to improve quality and bend the Medicare cost curve. The goal of the program is to provide a new alternative payment model with higher levels of risk and reward than with traditional ACO programs. The program is designed to provide financial flexibility through capitated payments, increase Medicare beneficiary engagement and attract new risk sharing players to the Medicare fee-for-service market.

The impact of this new program on a participant’s business will vary based on an organization’s position in the healthcare value chain and posture toward total cost of care efforts. For physician organizations focused on serving the Medicare Advantage population through total cost of care contracts, the new program may be game changing. For most large health systems, the impacts will likely be more modest.

Six Key Impacts of the Direct Contracting Program

1. **Negotiating dynamics will shift as direct contracting entities can create value-based contracts with preferred providers:** DCEs will now have the opportunity to negotiate value-based deals with Preferred Providers including rates, sub-capitation or other desired contract terms. High quality, efficient specialists, hospitals and post-acute providers will try to take advantage of this by securing greater Medicare market share in exchange for volume discounts or favorable sub-capitated rates.

2. **The DC Program will attract Medicare Advantage providers to enter the Medicare FFS game:** CMS is trying to entice physician groups that have traditionally focused on the Medicare Advantage population to expand their care models and clinical capabilities to serve the Medicare FFS populations. For physician groups with strong total cost of care management capabilities for the Medicare Advantage population, the new DC program will be a very attractive opportunity and potentially transformative as it expands access to a greater pool of patients paid via total cost of care models.

3. **Providers will need to check state regulations to understand regulatory implications of increased downside risk:** The DC Global option provides significantly greater levels of downside risk to providers. Providers will want to check state regulations to understand if they would be classified as an insurance company or risk bearing entity that would need to obtain a limited insurance license and / or be subject to specific rules / regulations (e.g. potential need to maintain risk reserves in compliance with state formulas).
4. **Capitated payments will provide short term investment flexibility to physician groups:** Advanced capitated payments will provide physician groups the short-term capital to make important incremental investments in redesigning how care is delivered. These payments may make a big difference for physician groups that face significant capital constraints. Specifically, these payments could be used to help physician groups implement beneficial patient engagement technology or fund an innovative Patient Incentive Program.

5. **Increased program flexibility and reduced reporting requirements will increase physician group participation:** The DC program increases program flexibility in the delivery of care through an expanded set of Medicare Waivers, building upon the enhancements available to the Next Generation ACO. These benefit enhancements are designed to pave the way for greater financial success for physician group participants. The number of quality measures in the Direct Contracting program are also greatly reduced with only 14 measures compared to the MSSP Pathway program’s 23 measures, increasing the ease of reporting.

6. **Hospital providers will continue to face an uphill battle:** Consistent with other accountable care programs from CMS, the DC program provides a strong financial incentive for primary care physicians to control total medical expense. Primary care physicians are likely to first seek to reduce excess utilization in high-cost areas of the delivery system including hospital and post-acute services. From a fee for service perspective, most hospital providers do not stand to gain from this program. Aggregate reductions in Medicare utilization rates will intensify competition for Medicare market share. Focused Medicare Advantage players will be more accepting of Medicare FFS patients and are likely to shake up referral patterns. DCEs acting as downstream negotiating vehicles will seek advantageous terms for volume discounts and cut out other hospital providers.
DISCUSSION OF PHYSICIAN GROUP AND HEALTH SYSTEM PERSPECTIVES

The DC program will impact a variety of healthcare stakeholders including physician groups, health systems and Medicare beneficiaries.

Physician Group Perspective

Consistent with other accountable care programs from CMS, the DC program provides a strong financial incentive for primary care physicians to control total medical expense.

For physician groups interested in expanding emerging total cost of care operations, the new DC program provides greater flexibility to get more primary care physicians engaged and increases the likelihood of favorable financial performance. Specifically, a novel component of this program is to how it enable the DCEs to have greater control over the total cost of care for their patient population by negotiating with downstream providers.

For physician groups with existing strong total cost of care management capabilities for the Medicare Advantage population, the new DC program will be a very attractive option to also manage traditional Medicare FFS patients. Many organizations will find it financially attractive to pursue the global DC option in lieu of the standard MSSP pathway options because of the greater sharing of risk and reward. The DC program is a step closer to Medicare Advantage in terms of financial opportunity.

The programs include five important design elements which are structured to encourage greater participation by physician groups and to increase the likelihood of success in controlling total medical expense:

1. **Address cash flow challenges by providing capitated payments to attributed physicians.**

Physician groups will be able to use capitated payments to make short term investments needed to deliver care differently. Providers will have the upfront capital necessary to implement new patient navigation tools or care managers rather than have to wait until the end of a reconciliation period to be paid. The DC professional option provides a monthly primary care capitated payment equal to 7% of the estimated total cost of care for the aligned population and also provides the option to receive advanced payments of their non-primary care claims. The DC global option allows providers to choose either the primary care capitated payment equal to 7% of the estimated total cost of care or total capitated payments equal to 100% of estimated total cost of care. The advanced payments will provide physician groups the short-term capital to make important incremental investments in redesigning how care is delivered.
2. Provide greater flexibility in the delivery of care through an expanded set of Medicare Waivers.

The DC program builds on many of the benefit enhancements available to the Next Gen ACO. By employing a Medicare Waiver to eliminate specific Medicare payment requirements, DCEs can apply for a variety of optional benefit enhancement programs geared toward allowing for lower-cost care management initiatives and improved access to alternative sites of service. For Medicare beneficiaries, the DC program represents a strong net positive compared to traditional Medicare FFS. Beneficiaries will have opportunities to receive critical items and services by their DCEs to best take care of their on-going health issues. The benefit flexibility will also enable healthcare providers to more adequately address social determinants of health. DCEs may be able to provide vouchers for meal programs, transportation to care sites, services to support management of chronic diseases such as home improvement to prevent falls or reinjury and air-filtering systems for asthmatic patients.

**Benefit Enhancements Anticipated for Performance Year 1:**

- 3-day SNF Rule Waiver Benefit Enhancement
  - Covers SNF or swing-bed hospital stays for beneficiaries with an inpatient stay of fewer than three days

- Asynchronous Telehealth Expansion Benefit Enhancement
  - Covers telehealth services, specifically dermatology and ophthalmology services, provided by DC Participant or Preferred Providers

- Post-Discharge Home Visits Rule Benefit Enhancement
  - Covers home health visits for non-homebound beneficiaries following an acute inpatient stay by auxiliary personnel under general supervision rather than direct supervision

- Care Management Home Visits Benefit Enhancement
  - Covers home visits that are made to beneficiaries in advance of potential hospitalization as a preventive method

**Benefit Enhancements and Patient Engagement Programs Proposed for Performance Year 1:**

- Home Health Services Certified by Nurse Practitioners
  - Allows Nurse Practitioners (NP) to order home care for beneficiaries rather than only Physicians to improve beneficiary access if primary care received by NPs

- Home Health Homebound Requirement
  - Expands access of home health services to beneficiaries with certain conditions who are not homebound

- Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit
  - Allows beneficiaries within DC Global models who elect for Hospice benefit to receive concurrent curative care, making hospice care a more reasonable long term care option

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1. CMS Direct Contracting Request for Application, Global and Professional Options
Patient Engagement Incentives
- Allows DCEs to offer patients gift cards up to a specified amount based on completion of desired patient behaviors, or vouchers for medications, transportation, etc. to support patient engagement and disease management

Cost Sharing Support for Part B Services
- Allows DCEs to enter cost sharing support arrangements with its providers to cover out of pocket payments (whole or in part) for specific patient populations or service categories

Chronic Disease Management Rewards Program
- Allows DCEs to provide gift cards to eligible beneficiaries up to a specified amount to incentivize participation in chronic disease management programs

3. Offer DCEs the opportunity to negotiate rates and other terms with ‘downstream’ participating providers.

Due to the capitated payment mechanisms available to the Professional and Global DC options, primary care physicians are positioned to impact care patterns and negotiate value-based arrangements with downstream participating providers to enhance coordination of care. This allows providers the opportunity to steer volume to high quality, efficient providers and potentially receive a ‘volume discount’ from standard Medicare rates. DCEs selecting either Primary Care Capitation (PCC) or Total Care Capitation (TCC) arrangements can both employ these options because DCEs that select PCC can also elect Advanced Payment, receiving payment of non-primary care FFS claims in advance of claims submission. Taking advantage of this system would require DCEs to be able to operationalize a claims payment system for providers.

4. Streamline governance and quality reporting requirements to make it easier for physician groups to join.

The governance requirements for the MSSP are substantial and require time / resources to fulfill while DC makes important advances in streamlining this through limited requirements around the composition of the ACO and ACO governing body. For example, DCEs only require 25% of the governing body to be DC Participant Providers or designated representatives, while MSSP requires 75% of the board to be ACO participants. Additionally, the number of quality measures in the DC program number only 14 compared to the MSSP Pathway program’s 23 measures. In the DC program, the quality program is focused on continuous improvement, but gives the option to still receive benefit for sustained exception performance.

5. Provide opportunity to align through beneficiary choice (in addition to claims-based approaches). Voluntary beneficiary alignment offers physician providers the chance to have beneficiaries choose them as their provider. Beneficiaries choosing their provider may offer a solid foundation for establishing a greater level of connection to their physician group and the broader provider network used by the physician, helping to improve beneficiary engagement.
Health System Perspective

Health systems will need to consider the impact of the DC program on their current Medicare ACO performance payments and on their existing FFS business.

- The DC program provides another Medicare ACO option for health systems to consider. Moving from MSSP to DC will likely make sense for many current MSSP participants based on the additional flexibility offered by the program outlined above. Health systems who have had success in managing the Medicare Advantage population or health systems with provider sponsored plans with a Medicare Advantage book of business will be particularly interested in this program. The DC program will likely offer more favorable economics than MSSP for these providers and can play the same ‘gateway’ role to transition patients to the desired Medicare Advantage plans. Additional details and a comparison of program options are included in Exhibit A.

- The DC program may have more significant impacts on a health system’s existing FFS Medicare business. The impact of this will be driven by where existing Medicare volumes originate today and whether physicians will be switching into this model. The new DC program will also encourage providers with Medicare Advantage focused practices to also focus on the Medicare FFS population changing referral and care patterns. Successful DCEs will likely try to commoditize other elements of the delivery system and negotiate advantageous deals with high quality, efficient providers. Most hospital providers do not stand to gain from a FFS perspective from this program because of negative utilization impacts on hospitals and post-acute assets. The bright spot for some health systems will be that low cost providers may be able to gain Medicare volume from DCEs by negotiating favorable contracts. Overall, the impact on health system FFS business will be largely negative.

CONCLUSION

CMMI’s DC Program represents meaningful progress in CMS’ journey to improve quality and meaningfully bend the Medicare cost curve. Physician groups and health systems are now facing time sensitive and critical decisions of which Medicare ACO model to pursue. Beyond the ACO selection decision, which is right around the corner, it will be critical to start assessing and preparing for the impacts the new DC program may have on your organizations’ competitive landscape and referral patterns now.
BDC Advisors, LLC is a national health care strategy consulting firm that transforms and grows health care organizations. Established in 1990, its services include health enterprise strategy, payer/provider innovation, physician enterprise strategy, organization design and development, and population health management.

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The authors would like to thank Whitney Perlen, a Consultant with BDC Advisors, for her contributions to this article. The authors would like to encourage readers to share questions or commentary they may have on their perspectives on the Direct Contracting program.
Exhibit A: Highlights of Medicare ACO Programs

<table>
<thead>
<tr>
<th>Term</th>
<th>Track E</th>
<th>Enhanced</th>
<th>Professional</th>
<th>Global</th>
<th>Representative Full-Risk Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MedicareShared Savings Program (MSSP)</strong></td>
<td></td>
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<tr>
<td><strong>Attribution</strong></td>
<td>• Choice of Prospective or Retrospective • Voluntary and Claim-Based Alignment</td>
<td>• Prospective • Voluntary and Claim-Based Alignment</td>
<td></td>
<td><strong>Prospective</strong></td>
<td><strong>Claim-Based Alignment</strong></td>
</tr>
<tr>
<td><strong>Definition of ACO Providers</strong></td>
<td>Defined at TIN level</td>
<td>Defined at TIN / NPI level</td>
<td>Defined at NPI level</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Benchmark Foundation</strong></td>
<td>Blend of Historical Baseline Expenditures &amp; Regional Expenditures (Medicare FFS)</td>
<td>Blend of Historical Baseline Expenditures &amp; Regional Expenditures (Adjusted MA rate book)</td>
<td>MA Premium or Historical Total Medical Expense</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk Adjustment</strong></td>
<td>CMS Hierarchical Condition Category (HCC) prospective risk adjustment model</td>
<td>Modified risk adjustment methodology (<em>additional information forthcoming from CMM I</em>)</td>
<td>Payer-specific risk adjustment methodology</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Type of Risk</strong></td>
<td>Shared Risk</td>
<td>Shared Risk (with corridors)</td>
<td>Capitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk Share (%) (Savings / Losses)</strong></td>
<td>Up to 50%/30%</td>
<td>Up to 75%/40-75%</td>
<td>100%/100% Dependent on Risk Band</td>
<td>50% 50% Dependent on Risk Band</td>
<td>DCE shared saving / loss % decreases at higher risk bands.</td>
</tr>
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<td></td>
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<td></td>
<td><em>Note: CMS discounts benchmark starting with 2% in PY1 and increasing to 5% in PY5</em></td>
</tr>
<tr>
<td><strong>Min Savings Rate (MSR) / Min Loss Rate (MLR)</strong></td>
<td>Three Options Exist: • No MSR / MLR • Symmetric MSR / MLR in 0.5% increments (0.5%-2.0%) • Symmetric MSR / MLR 2.0-3.9% based on size of attributed population</td>
<td>No MSR / MLR</td>
<td>No MSR / MLR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Term</td>
<td>Track E</td>
<td>Enhanced</td>
<td>Professional</td>
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<tr>
<td>Capitated Payments</td>
<td>No</td>
<td>Primary care capitation (7% of estimated total medical expense)</td>
<td>Choice of: • Primary care capitation • Total care capitation (100% of total medical expense)</td>
<td>Total or partial capitation</td>
<td></td>
</tr>
<tr>
<td>Advanced APM Eligible (Y/N?)</td>
<td>Yes</td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Quality Incentive</td>
<td>23 measures Quality performance impacts total shared savings and losses. ACOs with higher quality scores will receive a larger portion of savings or will be liable for a smaller amount of losses compared to ACOs with lower quality scores.</td>
<td>14 Measures 5% Quality Withhold Subject to Quality Performance including ‘Continuous Improvement / Sustained Excellent Performance Gateway’</td>
<td>Variable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Flexibility</td>
<td>Medicare Waiver Enhancements • 3-Day SNF Rule Waiver • Telehealth Expansion Waiver</td>
<td>Medicare Waiver Enhancements • 3-Day SNF Rule Waiver • Telehealth Expansion • Post-Discharge Home Visits Rule • Care Management Home Visits Proposed Medicare Waiver Enhancements: • Home Health Services Certified by Nurse Practitioners • Home Health Homebound Requirement • Concurrent Care for Hospice Beneficiaries • Patient Incentive Programs • Chronic Disease Management Reward Program • Cost Sharing Support for Part B Services</td>
<td>Maximum benefit flexibility with ability to design your own program (if sponsor of the plan)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: BDC Analysis of CMS Resources on Medicare FFS ACO and Direct Contracting Models