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IS IT FEE-FOR-SERVICE OR MANAGED CARE? CMS LAUNCHES DIRECT CONTRACTING MODELS

In keeping with the trends of the commercial market, on April 22, 2019, the Centers for Medicare & Medicaid Services ("CMS") announced opportunities to participate in new direct contracting models under Medicare's Part A and Part B fee-for-service program. CMS intends to focus these models particularly on primary care coordination for medically complex and seriously ill patients, as well as individuals who are dually eligible for Medicare and Medicaid. CMS anticipates selecting approximately 75 Direct Contracting Entities ("DCEs") nationwide for this voluntary program. The initial roll out begins on January 1, 2020, and **important deadlines are listed below**.

BACKGROUND

As the name suggests, direct contracting means that CMS would directly contract with Medicare providers and suppliers, such as physician group practices, who would agree to be accountable for the cost and quality of care of a defined beneficiary population. Direct contracting resembles the Medicare Advantage managed care model, except that there is no health plan in the middle.

Physicians and other providers may be related to a DCE as a core member or "Participant," which is how primary care providers are likely to be designated; as a contracted collaborator or "Preferred Provider," which is how specialty providers are likely to be designated; or not at all as a "Non-Associated Provider." Providers can be classified as Participants at the Tax Identification Number or National Provider Identifier level.

CMS expects that DCEs generally will need at least 5,000 aligned Medicare fee-for-service beneficiaries to participate, though CMS plans to make exceptions for entities that are new to Medicare Parts A and B. Beneficiaries will be "aligned" with a DCE based on voluntary enrollment or historical claims information. For the first two models described below, CMS envisions that a group of health care providers will be operating under a common governance structure to be a DCE, possibly (but not necessarily) as an Accountable Care Organization. In fact, CMS is hoping that this model will expand participation opportunities to providers who have not been part of other alternative payment models to date. Further, existing Medicaid managed care organizations might align with, or become, DCEs to serve dual-eligible populations.

PARTICIPATION OPTIONS

CMS is proposing three Population-Based Payment ("PBP") models at this time:

- "Professional" PBP – DCEs will bear 50 percent of upside and downside risk for shared savings or losses based on the total cost of care for their aligned beneficiaries. DCEs will receive Primary Care Capitation monthly payments, calculated as 7 percent of the attributed members' total cost of care. The purpose of these payments is to support enhanced primary care services with a predictable flow of revenue for the DCE.
- "Global" PBP – DCEs will bear 100 percent upside and downside risk based on the total cost of care for their beneficiaries. DCEs may choose between Primary Care Capitation (described in the prior bullet) or Total Care Capitation, which will support all services managed by the DCE.
- "Geographic" PBP – Larger health systems or health plans, as DCEs, will bear 100 percent upside and downside risk for the total cost of care in a designated region with at least 75,000 Medicare beneficiaries. Under this model, the DCE will commit to providing CMS with a certain discount (projected to be 3 to 5 percent) off total cost of care for the assigned region. At this time, CMS anticipates selecting 4 geographic areas to pilot this model, ideally with at least 2 DCEs selected for each region. However, the details of this program are still being developed and are the focus of a Request for Information with a comment deadline of May 23, 2019. Therefore, this model will roll out on a later schedule and is outside the main scope of this alert.

Although CMS is hoping to reduce administrative burden on DCEs, including through the use of fewer and more focused quality measures, at this time providers and suppliers would still need to submit claims on a fee-for-service basis to Medicare when they participate in these models.

KEY DEADLINES

Professional and Global PBPs are scheduled to roll out as follows:

- **August 2, 2019** – Deadline for potential DCEs to submit a non-binding Letter of Intent ("LOI") to participate in the program. The form will be available on the CMS website link below. A provider must submit an LOI in order to be eligible to submit an application at the next step in the process.
- **Fall 2019** – Request for applications issued and DCEs selected.
- **January 1, 2020** – Performance Year 0 begins (baseline measurement year).
- **January 1, 2021** – Performance Year 1 begins (first payments distributed).
- A five-year term is anticipated.

CMS'S SECOND REQUEST FOR INFORMATION

Almost concurrently with the announcement of the direct contracting model options and the Request for Information regarding Geographic PHPs, the Center for Medicare and Medicaid Innovation issued a second, separate Request for Information seeking detailed feedback about future models for direct contracting. Comments are due on or before May 25, 2019. These concurrent initiatives suggest that CMS is just beginning its efforts to implement private sector models under Medicare Parts A and B.

NEXT STEPS

Providers and suppliers interested in participating in the direct contracting model should review CMS's published materials and free webinar announcements available here. Entities with any interest in this program should submit a non-binding LOI prior to August 2, 2019, in order to be eligible to submit an actual application later in the year if desired.

Hall Render will continue to monitor the direct contracting model closely as it develops. If you have any questions or would like additional information on this topic, please contact:

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