MILLIMAN WHITE PAPER

Direct Contracting opportunity for MA plans

Noah Champagne, FSA, MAAA
Jonah Broulette, ASA, MAAA
Catherine Murphy-Barron, MBA, FSA, MAAA

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In 2020, the Center for Medicare and Medicaid Innovation (CMMI) introduced a new Medicare fee-for-service (FFS) risk program, Direct Contracting (DC), which is open to participation by Medicare Advantage (MA) plans. The DC model's professional and global tracks offer MA plans an opportunity to leverage their existing provider relationships and care management structures to take risk and potentially generate savings on the Medicare FFS population.

Since 2012, the Centers for Medicare and Medicaid Services (CMS) and CMMI have operated various population-based payment models allowing organizations to take financial risk for Medicare FFS patients. Over time, the number of Medicare lives covered under these models has steadily grown and the models have evolved—requiring more risk (with more reward) and permitting participants to utilize additional tools for managing their attributed populations. As of 2019, there were approximately 11.6 million beneficiaries—1.2 million in the Next Generation model[1] and 10.4 million in the Medicare Shared Savings Program (MSSP)[2]—attributed to a Medicare accountable care organization (ACO), representing nearly 30%[3] of the Medicare FFS population.

The origination of these value-based payment models came in 2012 when both the Pioneer ACO and MSSP were introduced. CMMI then went on to replace the Pioneer ACO option with the Next Generation ACO (NextGen) model in 2016, which offers entities more risk (and more reward) as well as introducing additional care management tools to assist ACOs in controlling costs. In 2020, CMMI introduced the Direct Contracting Professional/Global models, which expanded the participant scope to include health plans as well as focused on provider contracting as an avenue to generate savings.

CMMI has also recently detailed a separate Geographic Direct Contracting Model, which is significantly different (in structure and scope) from the Professional and Global models. In this brief we focus on the DC Professional/Global models. Subsequent briefs will address the Geographic Direct Contracting model specifically.

What is a DCE?

A Direct Contracting entity (DCE) is any entity (including providers, provider groups, health plans, and other non-provider organizations) that takes total cost of care risk for a selection of Medicare Part A and B FFS beneficiaries.

Beneficiaries are attributed to a DCE based on either:

- A plurality of primary care services delivered by participating providers or voluntary alignment (Standard DCE)
- Enrollment in a Medicaid Managed Care organization (Medicaid MCO DCE).

How does a DCE generate savings?

Within the DC Professional/Global models, there are three main avenues for DCEs to generate savings: care management, risk coding, and provider contracting.

Each DCE receives a claim cost benchmark based on a combination of the DCE's historical FFS expenditures and a risk-adjusted regional rate. They can generate shared savings by managing costs for their attributed lives below this benchmark.

[1] CMS. Medicare Next Generation Accountable Care Organization Model Performance Year 4 (2019) Results. Retrieved February 25, 2021, from https://innovation.cms.gov/media/document/nextgenaco-py4finqualresults (Excel download).

[2] CMS. Shared Savings Program Fast Facts – As of January 1, 2021. Retrieved February 25, 2021, from https://www.cms.gov/files/document/2021-shared-savings-program-fast-facts.pdf.

[3] Kaiser Family Foundation (2019). Total Number of Medicare Beneficiaries. Retrieved February 25, 2021, from https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Additionally, benchmarks for the DCE are adjusted for changes in the CMS Hierarchical Condition Category (CMS-HCC) risk score of the DCE-attributed population between benchmark year 3 (2019) and each performance year. If DCEs are able to more effectively capture diagnoses for their populations and increase risk scores (on a normalized basis) in the performance year versus 2019, they will realize that improvement as an increased benchmark and, in consequence, increased shared savings.

The third avenue for savings is through provider contracting. DCEs can negotiate with providers such that the providers receive a reduced percentage of fee-for-service (FFS) payments from CMS for services provided to attributed beneficiaries. Throughout the program year, CMS will pay the specified providers the agreed-upon reduced percentage of Medicare FFS reimbursement, while paying the balance directly to the DCE. These alternative provider payment arrangements use value- or quality-based components to incentivize better patient management and quality outcomes, thus generating savings for the DCE and increased patient panels for the providers. We have discussed provider contracting in greater depth in our April 2020 brief.

ACOs participating in MSSP have only the first two avenues available to generate savings. In the 2019 performance year, there were 97 ACOs in two-sided risk under MSSP; 76 of those ACOs were able to generate shared savings payments that averaged 3.3% of the benchmark.[4] Under the DC Professional/Global models the DCE will have the added lever of provider contracting.

Why should an MA plan become a DCE?

MA plans are uniquely positioned to be successful in the DC Professional and Global tracks.

- MA plans already have numerous existing provider relationships through their MA books of business. They can be leveraged to generate favorable contracting rates as well as additional provider/network engagement.
- MA plans also have existing health plan functions such as care management programs, risk score coding initiatives, and reporting/administrative infrastructure in place at many of their providers. These functions likely already impact the costs and risk scores for Medicare FFS patients seen by those providers even though the MA plan is not at risk for their care. By expanding to be a DCE, MA plans have the opportunity to potentially increase their operating profits across the board by spreading the cost of these programs across larger populations.

MA plans are uniquely positioned for success but as with all value-based arrangements there are potential downside risks that the plan will need to evaluate prior to entering the program.

What can a potential DCE do now?

MA plans seeking to become DCEs will apply for a model *start date of January 1, 2022*. The application and specific deadlines have yet to be released, but we expect an *application will be due to CMMI around the beginning of April 2021*.

In order to understand whether DC is a good fit, interested MA plans should perform financial feasibility analyses exploring the historical expenditures for likely attributed beneficiaries and how those expenditures compare to regional rates on a risk-adjusted basis (regional cost efficiency). In addition to understanding the volume and nature of the risk they will be taking on, it is essential that DCEs understand how the inclusion or exclusion of individual providers can impact model feasibility.

Conclusion

Historically, the population-based payment models that CMS and CMMI have operated for Medicare FFS patients have been targeted and designed for provider groups. However, with the introduction of Direct Contracting, MA plans are well positioned to leverage their existing provider relationships, care management, and risk score coding programs to become successful DCE participants.

CONTACT

Noah Champagne
Noah.Champagne@milliman.com

Jonah Broulette
Jonah.Broulette@milliman.com

Catherine Murphy-Barron
Cathy.Murphy-Barron@milliman.com

[4] CMS (October 5, 2020). Data set: 2019A Shared Savings Program (SSP) Accountable Care Organizations (ACO) PUF. Retrieved February 25, 2021, from https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/2019A-Shared-Savings-Program-SSP-Accountable-Care-/jzuc-h562.