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CLIENT ALERT

CMS's Direct Contracting Model: What's New from Next Gen?

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The Centers for Medicare & Medicaid Services ("CMS") recently introduced three new population-based payment ("PBP") risk-sharing Direct Contracting ("DC") model options that intend to decrease expenditures and increase quality for beneficiaries in Medicare fee-for-service ("FFS"): Professional PBP, Global PBP, and Geographic PBP. As the Geographic PBP is still being designed, this Client Alert focuses only on the Professional PBP and Global PBP Models.

The model options are voluntary, and they build upon initiatives involving Medicare Shared Savings Program ("MSSP") accountable care organizations ("ACOs"), such as the Next Generation ACO ("NGACO") Model.

These new payment models with preliminary beneficiary alignment will begin in January 2020, with performance periods beginning in January 2021 that will last five years. Entities that are interested in participating in DC (known as "DC Entities") must submit a non-binding letter of intent ("LOI") by August 2, 2019.

Both the Professional and Global PBP Models require DC Entities to assume financial risk for the cost of delivering care for a defined patient population through a combination of capitation and shared savings/losses. The main difference between these two models is that Global PBP entities have the opportunity to earn a higher return by accepting more risk than Professional PBP entities.

A summary of the Professional PBP and Global PBP Models appears below:

	Professional PBP	Global PBP
DC Entity	ACO-like structure with "Participants" (for beneficiary attribution alignment) and "Preferred Providers" defined at Tax Identification Number ("TIN") and National Provider Identifier ("NPI") level	ACO-like structure with "Participants" (for beneficiary attribution alignment) and "Preferred Providers" defined at TIN/NPI level

	Professional PBP	Global PBP
Payment Model	Primary care capitation (7% of total cost of care for enhanced primary care services) ("Primary Care Capitation") plus *50%* shared savings and losses with CMS (Medicare Parts A and B services)	*Either:* Primary Care Capitation plus *100%* shared savings and losses with CMS (Medicare Parts A and B services) *or* Full (total care) capitation for all services by Participants and, optionally, Preferred Providers ("Total Care Capitation")
Risk Mitigation Mechanisms Offered	• Risk corridors • Stop loss	• Risk corridors • Stop loss

Entities that are currently familiar with the NGACO Model are well positioned to apply for participation in DC. As mentioned, the DC model options build upon the NGACO Model and bear a resemblance to it. Among other similarities, the NGACO and DC model options all (1) require the contracting entity to assume upside and downside financial risk, (2) allow entities to offer benefit enhancements that are designed to promote accessible and affordable care, and (3) allow dual-eligible patient populations to align with the contracting entity.

However, lack of prior experience with the NGACO Model or other Alternative Payment Models offered through CMS is not a barrier to participation in DC. In two May 2019 webinars, CMS expressed that it hopes to encourage DC participation among entities that have not traditionally been involved in Medicare FFS or CMS's Innovation Center models, but rather have exclusively contracted with Medicare Advantage ("MA") plans. CMS further stated in these webinars that the agency aims to increase DC opportunities for organizations that provide care for complex, chronically ill patient populations.

In this vein, CMS has released two new beneficiary alignment features. First, if a DC Entity so chooses, beneficiaries may align with that DC Entity not only annually but also quarterly throughout the performance year. Permitting alignment at the quarterly level may provide important risk-adjustment opportunities for DC Entities, especially if such entities serve populations with chronic conditions. The DC Model also offers new alignment opportunities for Medicaid managed care organizations ("MCOs") by allowing dual-eligible beneficiaries to align to a DC Entity based on enrollment in the affiliated Medicaid MCO.

Another difference between the two models is the minimum required number of enrollees. CMS requires that NGACO Models serve at least 10,000 beneficiaries (or 7,500 if the

NGACO is located in a rural area). However, DC Entities may have as few as 5,000 beneficiaries in order to participate.

Further, while NGACOs have had the option to accept a capitation-based payment mechanism, DC Entities are required to do so, either through Primary Care Capitation or Total Care Capitation (as explained above).

The following chart sets out other key features of the NGACO Model and the DC Model.

Alternative Payment Model Features	NGACO Model	DC Model
Is the model only available to MSSP ACOs and NGACOs?	Yes	No; NGACOs and MSSP ACOs may apply, but CMS also seeks to attract organizations that are new to risk-based contracting, such as health care providers and organizations currently participating in traditional Medicare or receiving FFS payments from MA plans, as well as Medicaid MCOs for dual-eligible members; no specific type of legal structure is required
Does the model require the contracting entity to assume both upside and downside risk?	Yes	Yes
Is there a risk sharing arrangement?	CMS offers NGACOs two options: Arrangement A: Shared savings/losses up to 80% of actual savings/losses realized in Years 1-3, then up to 85% in Years 4 & 5 Arrangement B: Shared savings/losses of up to 100% of actual savings/losses realized	Professional PBP = 50% savings/losses of actual savings/losses realized Global PBP = 100% savings/losses of actual savings/losses realized
Does the model contemplate a capitation-based payment mechanism?	Yes, capitation-based payment is *optional*; NGACOs have had the option to participate in a capitation-like payment mechanism called “All-Inclusive Population-Based Payments”	Yes; DC Entities *must* participate in a capitation arrangement, either Total Care Capitation or Primary Care Capitation; a Professional PBP may only participant in the Primary Care Capitation option, and a Global PBP may participate in either option

Alternative Payment Model Features	NGACO Model	DC Model
Does the model feature a voluntary patient-alignment process?	Yes, annually; NGACOs have the option to offer voluntary alignment to their beneficiaries, and confirmation of the care relationship through voluntary alignment also supersedes claims-based alignment	Yes, annually or quarterly: A new alignment feature (Prospective Plus) will allow beneficiaries to align to a DC Entity on a quarterly basis throughout the performance year, if the DC Entity so chooses at the outset of the performance year
Does the model allow for alignment of dual-eligible (Medicare and Medicaid) beneficiaries?	Yes	Yes; in fact, the DC Model provides new alignment opportunities for Medicaid MCOs by allowing dual-eligible beneficiaries to align to a DC Entity on the basis of enrollment in the affiliated Medicaid MCO
Does the model allow for a prospective claims-based alignment process, if beneficiaries are not voluntarily aligned?	Yes, by default	Yes; however, the DC Model aims to emphasize voluntary alignment
What is the minimum number of beneficiaries required for an entity to participate in the model?	10,000 (or 7,500 if NGACO is in a rural area)	5,000
Is experience with risk sharing generally required to participate?	Yes	No
Is the model currently open for additional applicants?	No	Yes, if a non-binding LOI is submitted by August 2, 2019
What is the frequency of reconciliation?	CMS will perform reconciliation when full claims run out and data is available for the complete performance year ("Final Reconciliation")	In addition to Final Reconciliation, DC Entities will have the option to select "Provisional Reconciliation," which is performed immediately following the performance year, reflecting the cost experience through the first six months for what CMS believes will be a "more timely distribution" of shared savings/losses

Alternative Payment Model Features	NGACO Model	DC Model
Can the contracting entity elect to participate in benefit enhancements?	Yes; NGACOs may elect to participate in the following: (1) waivers of the three-day skilled nursing facility rule; (2) coverage for telehealth services furnished in non-Health Professional Shortage Areas and at the beneficiary's place of residence; (3) "incident to" post-discharge home visit services performed by auxiliary personnel (e.g., licensed clinicians) under the general supervision of a Next Generation Participant or Preferred Provider two times in a 30-day period; (4) the Cost Sharing Support for Medicare Part B Services Benefit Enhancement; (5) the Chronic Disease Management Reward Program; and (6) the Care Management Home Visits Benefit Enhancement	Yes; DC Entities may offer benefit enhancements and certain additional services

CMS is rolling out more specific information on benchmarking, alignment, and additional features of these DC PBP models this summer. We will update this Client Alert at such time.

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This Client Alert was authored by **Gregory R. Mitchell, Jackie Selby,** *and* **Sidra S. Zaidi.** *For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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