WHITE PAPER

Direct Contracting Geographic Model – Questions and Considerations

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On January 15, 2021, the Center for Medicare and Medicaid Innovations released the Request for Application (RFA) for the Direct Contracting Geographic Model (DC Geo). Wakely previously released a brief on DC Geo here that provided an overview of the program and considerations. This White Paper provides an update on the latest information and expands on some of the consideration topics included in the brief.

The most important update since the publication of our brief is that it appears CMS will delay the application deadline from the original April 2, 2021 date. On March 2, CMS posted on the DC Geo website[1] that the model is "currently under review." We believe this very likely means the relevant deadline for submission of application will be delayed; however, we do not have any insights as to whether the performance period start date will be delayed beyond the January 1, 2022 date identified in the RFA.

At Wakely, we believe that the movement toward value-based payment arrangements and increased financial accountability will continue to be a priority for both CMS and the private sector. The DC Geo model offers exciting opportunities for all stakeholders in the Medicare arena. At the same time, the breadth and complexity of the DC Geo model along with multiple value-based arrangements available within Medicare (e.g. Medicare Shared Savings, Direct Contracting Global, and Next Generation ACO program) have created questions and concerns that have not yet been addressed by CMMI. We continue to study information released so far with regards to this model, assemble the questions we have heard in discussions with industry leaders, and offer some of our considerations in this report to provoke thinking among our readers.

The following sections identify areas of consideration and uncertainty within the Direct Contracting Geographic model. Some of the questions are technical and should be answered by the CMMI; some other questions bring forth challenges that DCEs may face under the current RFA and are worth considering by the CMMI for clarification / re-designing of the model; and still others encourage strategic

[1] https://innovation.cms.gov/innovation-models/geographic-direct-contracting-model

considerations by potential applicants. Any answers provided here are based on our interpretation of the information released thus far.

Benchmark Methodology

Will the Geo DCE's strong performance bring down its own benchmark in future years, making it more difficult to achieve savings? The RFA states that CMS will utilize a fixed three-year baseline period (CY2017, CY2018 and CY2019) to derive the regional expenditures. The Geo Fact Sheet states that "for Performance Years Two and Three, CMS will utilize a national matched prospective trend, therefore not causing prospective trends to decrease due to prior Performance Year performance." Since the benchmarks will be determined at the county level and based on a fixed historical three-year period, we do not believe the DCE's own performance will influence its benchmarks during the first performance period.

It is unclear whether benchmarks for a potential second three-year iteration of the DC Geo program will be reduced if improved performance does result from DC Geo participants. This will be an important question for DCEs to monitor as they consider participating again.

Financial Guarantee

Will the Geo DCE know their market share prior to signing the participation agreement? The hierarchy of member alignment in the RFA provides potential DCEs with some ability to predict market share, particularly if they are in a Medicaid Managed Care Organization or currently operate as an ACO. Given the RFA requires a substantial financial guarantee of 10% of the total performance year benchmark, it is important for the DCE to be able to predict its membership. While the alignment hierarchy allows DCEs some insight into potential membership levels, there are other aspects that make such predictions challenging, including the fact that there is voluntary alignment, the number of winning DCEs in a region is not known in advance, and that membership alignment is re-determined every quarter.

What if some other DCE withdraws in the region? The RFA states that "Upon a Geo DCE withdrawing from the model, whether voluntarily or as a result of the Geo DCE's termination from the model by CMS, all of the Geo DCE's aligned beneficiaries will be randomly aligned to the remaining Geo DCEs in that region following the share distribution outlined in the Bidding Process." The RFA does not explicitly specify how the required financial guarantees will be impacted in the event of DCE withdrawals. It may be challenging for a DCE to secure significant additional funds to meet the 10% guarantee.

Financial Methodology

How does the specified admin load of 5% get included in the DCE's savings calculation? The examples provided in the RFA and Geo Fact Sheet make it clear that the DCE's gross savings percentage will be reduced by an admin load of 5% (as well as the proposed discount) to determine the risk corridor band into which it falls. However, it is not clear whether the shared savings will also be reduced by this admin load or not.

In our modeling, we believe it makes the most sense that the gross savings amount does not include the 5% admin reduction. We believe the shared savings will be calculated as the gross benchmark minus the proposed discount, compared to the DCE's actual expenditures. It will be critical for CMMI to provide a definition of the gross savings amount so DCEs can accurately assess the proposed discount they wish to bid.

Program Overlap

What's the order of operations between the DC Geo and other VBP programs? If a DCE partners with a Medicare Shared Savings Program (MSSP) ACO, how do providers under the MSSP ACO get reimbursed? The DC Geo program allows the participating providers to reduce their Medicare payments by a fixed percentage and then negotiate a separate fee with the DCE for the balance of the allowed charges. Under MSSP, a participating provider is paid on the Medicare fee schedule. This creates a conflicting situation that we believe needs to be addressed by CMMI. It is currently unclear if there will be a defined hierarchy of payment under the different programs, or if the DCE and providers are free to structure an arrangement.

With respect to financial reconciliation, the RFA provides examples in the Model Overlap Payment section on page 26 that imply the DC Geo would be last in the hierarchy in financial reconciliation, with the savings or losses from other VBP programs deducted or credited to the DC Geo savings or losses calculation. While these examples provide clarity on the reconciliation, there is no explicit language addressing the payment mechanism as services are rendered by providers participating in both MSSP and DC Geo.

How will coordination of benefits work if an aligned beneficiary has Medicare Supplement coverage? Similar to the MSSP/DC Geo overlap question, we are not aware of any guidance identifying which carrier bears primary liability if a DCE offers enhanced benefits and beneficiary engagement incentives that overlap with the beneficiary's Medicare Supplement coverage.

Provider Incentives

What are the benefits of being a Geo Preferred Provider? Do those benefits remain if the Provider is Participating in a different Value-Based Program? Individual situations vary, but in general, we think the DC Geo model could offer alternative and/or advanced payment arrangements to providers, as well as increased patient volume through the DCE's beneficiary incentives that are not available under other programs. In addition, the Geo Fact Sheet cites the "Quality Payment Program Bonus" for providers; although, we need more details from CMMI on how this will work for Geo Preferred Providers.

Beneficiary Engagement and Education

Will the DCE Geo Program create Beneficiary Confusion? Because the DC Geo program seeks to align all eligible beneficiaries in a region, any changes to the delivery of care will need to be communicated clearly in order to avoid confusion. The DC Geo program preserves the ability for beneficiaries to use

any provider they choose, as is the case under traditional Medicare, and imposes communication requirements on the DCEs. Despite these features of the program, there are questions that need to be addressed by CMMI such as:

- What does it mean for a beneficiary to be aligned to a DCE?
- How will their provider-patient relationships be affected if the patient's existing doctor is not a Geo Preferred Provider?
- Will there be any provider disruption if a beneficiary is realigned to another DCE?
- What provisions are in place to ensure randomly aligned beneficiaries do not experience frequent changes in alignment?

We will continue to monitor any evolvement in the DC Geo program and provide you with timely information as they become available. In the meantime, we will keep thinking and are open to discussing any of these concepts with you.

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