Medicare Direct: A Path to Competitive Medicare Membership and Revenue Growth

Monday, December 9, 2019

Today's Objectives

By the end of this webinar, you will:

1. Have an understanding of the minimum requirements to apply to be selected as a Direct Contracting Entity (DCE)

2. Understand how Medicare Direct Contracting fits within your broader Value-Based Payment (VBP) strategy and roadmap

3. Know how to "play to win" in direct contracting and position your organization for financial success and market growth

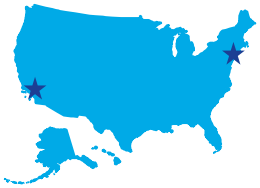
Today's Presenters

Allen Miller is the Principal and CEO of COPE Health Solutions. With over 25 years of experience providing health system and payor value-based payment strategy and transformation consulting services, Mr. Miller has led the planning and implementation of IDNs, IPAs and ACOs throughout the U.S. More recently, Mr. Miller has been focused on facilitating and implementing long-term payor/provider partnerships that go beyond the typical capitation and global risk models. These innovative collaborations are focused on reducing total cost of care and improving the total premium and other revenue needed to fund profitability and ongoing infrastructure investment. Under Mr. Miller's leadership, COPE Health Solutions and its subsidiary Analytics for Risk Contracting (ARC) LLC have become the preeminent go-to solutions companies for health systems and health plans committed to leadership roles in population health management for all lines of business.

Dr. Andrew Snyder is Principal and Chief Medical Officer with COPE Health Solutions with deep expertise in population health management, clinical integration and alternative payment models. In 2015, Dr. Snyder joined the Mount Sinai Health System as EVP and Chief Clinical Integration Officer, where he worked to develop the clinical strategy for population health across the system, ensuring the physicians and the system exceled under health reform within alternative payment models. Dr. Snyder also previously served as President of Mount Sinai Health Partners IPA, with approximately 3,500 physicians across the network, both employed and voluntary. He also has served as Senior Vice President and Chief Medical Officer of Brown & Toland Physicians IPA, where he oversaw all clinical programs including care management, quality improvement and utilization management across all products and ACOs from the initial Pioneer ACO through taking full risk on populations under restricted Knox Keene licensure.

About COPE Health Solutions

We are the partner of choice for providers and payors across the United States who are committed to success in the new value-based payment environment. We also develop the diverse talent needed to fill future health care roles



We have corporate offices in downtown Los Angeles and mid-town Manhattan with teams across the country in major markets including Texas, the Northwest, Florida and the Northeast

Our firm currently has over 100 employees partnering with health systems and health plans across several states and enrolls over 4,000 students annually in our programs, with a growing national and global presence

We have a proven track record in all aspects of strategy, population health management, Medicare/Medicaid transformation and workforce training across the continuum

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Let’s Talk Trends

VBP Policy Sets the Stage for Success

Current Administration

- Value-Based Purchasing (VBP) Programs accelerate competition for the fixed premium dollar
- Data-driven, patient care strategy drives demand for greater transparency and strategies that address interpretation of cost, quality and outcome data on its impact of business
- “Patients Over Paperwork” and the shift from “middle man entity” in managed care drives the need to engage and build consumer-directed health care and accountability models
- Focus on pharmaceutical management, transparency and pricing and the opioid epidemic in target populations

Impact of the End of the Sustainable Growth Rate, MACRA 2015

- Quality Payment Program’s (QPP) consolidation of pay-for-performance models with MIPS
- Increased impact to Medicare reimbursement with penalties and bonuses, levels of provider participation and four categories of reporting requirements that require interoperability
- MIPS requires a strategy to assess and identify measures, engage and motivate providers to improve metrics, map data sources in EHR, train staff and develop workflows to sustain success
- Future VBP initiatives are intended to streamline quality measures and APMs to reduce administrative burden

Risk-Based Contracting

- New CMS and direct to employer opportunities, coupled with state drivers toward VBP contracting, make for exciting opportunities and higher stakes with relation to the decision for providers and provider-owned risk-bearing entities to take more risk
- Payors, from CMS and employers to health plans, are looking for competent providers who can take risk and delegation – it is a key aspect of the JP Morgan, Buffet, Amazon collaboration

Medicaid Redesign and Expansion

- Cost containment, consumer accountability and work requirements, administrative simplification and more state control – providers are being positioned to take risk and manage population health
- Integrating care remains key and now includes models for maternal and child health populations
- Some states driving toward value-based payment and coordination of benefits for dual eligible in alignment with CMS

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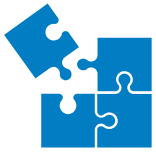
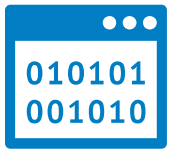
The Market Reality Reflects VBP Pressures

Issue	Implication
 **Managed Care Transition**	• Managed Medicare and Medicaid continue to be main growth areas, with direct-to-employer catching on, even in markets in which ASO relationships have been blockers • Less fee-for-service and more risk/capitation – ACOs and Advanced BPCI are just gateways to managed care/capitation • Providers, particularly hospitals, still have “one foot in each canoe,” with respect to revenue and EBITDA, between fee-for-service and value-based payments
 **Care Delivery Integration**	• Increasingly rapid migration of care from traditional locations to home and community care, sparked by financial incentives and penalties • Home and community monitoring, direct-to-member communication and management and telehealth all growing rapidly • Continued provider and payor consolidations with more integrative relationships
 **Role of Data**	• Today: Increasing demand for data-driven decisions and metrics to measure value and drive revenue; providers learning to use claims as well as encounter and clinical data • Tomorrow: Advanced AI and machine learning able to combine greater and more disparate data sets in search of correlations and drivers such as linking DNA data to market advanced trends

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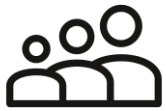
Medicare Direct Contracting – What Do I Need to Know?

Before Diving In: A Call to Action

CMS reopened the Letter of Intent (LOI) submission period and they are due by ***December 10, 2019*** (tomorrow)

- The LOI is non-binding
- Submitting a LOI ensures you are eligible to apply for participation in performance year one (2021). Applications for performance year one will be available in Spring 2020 to **only** those organizations which submitted a LOI
- If your organization is considering applying for the Medicare Direct Contracting model, and you did not formerly submit intent, it is critical that you submit a LOI no later than December 10, 2019 using this link: https://app1.innovation.cms.gov/dc
- Completing the LOI enables you to access non-public information such as the application, helping you to plan for potential future engagement even if you don't plan on applying in the next year

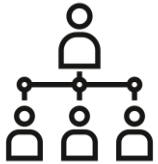
Why is Direct Contracting Important?



Unique ability to ***grow Medicare membership***, market share and access to more of the total premium

Reduced administrative burden and consolidation of quality metrics

Enhanced ***cash flow***



Ability to ***market to beneficiaries*** (different than Medicare Advantage)

Coordinated benefits for dual-eligible members

Allows for ability to add ***supplemental benefits*** outside of the medical loss ratio (MLR)

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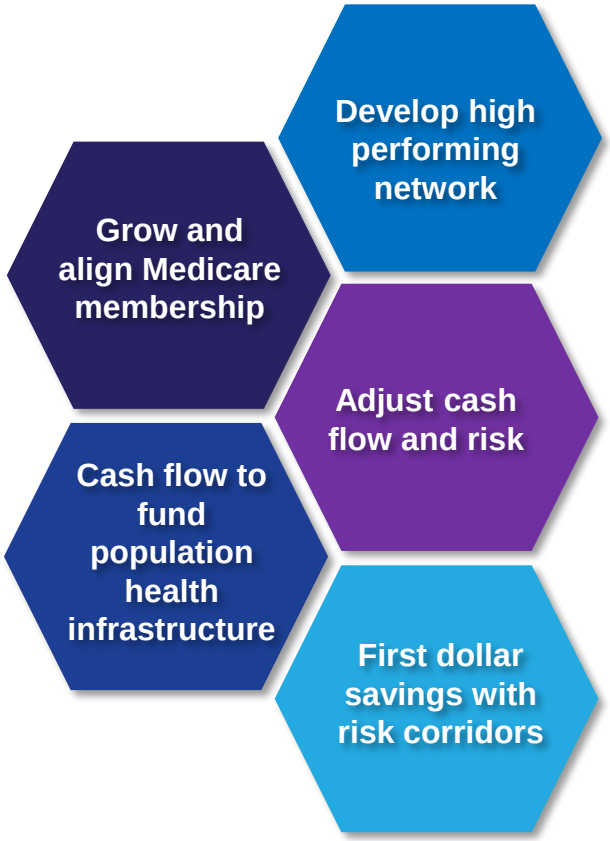
An Innovative Opportunity for VBP Participation

Introduction of Quality and Cost Control with Preservation of Beneficiary Choice

Medicare Direct Contracting is a unique opportunity for…

- Existing Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs)
- NextGen ACOs, particularly those not yet taking global capitation
- Organizations that have experience serving Medicare fee for service (FFS) patients
- Organizations with limited Medicare FFS experience that wish to grow their market share, particularly those who can drive a positive member experience



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What is Medicare Direct Contracting?

Medicare Direct Contracting is a ***voluntary***, ***risk-based*** initiative to ***transform*** the Medicare program's ***reimbursement*** of primary care services from a fee-for-service payment system to a ***value-based system*** that ***rewards physicians*** who keep patients healthy and reduce total cost of care *(absent Medicare Part D drug costs)*

- Creates a variety of pathways for taking on financial risk supported by enhanced flexibility
  - Reduces administrative burden (including consolidation of quality metrics)
  - Supports a focus on complex, chronically ill patients
  - Encourages participation by organizations that have not typically participated in Medicare fee-for-service (FFS) and/or other Medicare innovation models
- Large physician groups, hospitals with organized physician networks, ACOs, IPAs, Medicaid MCOs and others can apply to be a Direct Contracting Entity (DCE)
- A DCE can choose to participate in one of three risk sharing options
  - Standard
  - High Needs Population
  - New Entrant

Preparing to become a Direct Contracting Entity (DCE) – Three Risk Sharing Options

Standard	High Needs Population	New Entrant
Participants…		
• Have substantial experience serving Medicare FFS beneficiaries • May have participated in section 1115A and/or Shared Savings Program • Minimum 5,000 attributed at beginning of IP or PY1	• Focus on beneficiaries with complex, high needs • Focus on dually eligible individuals • Much lower attribution requirements, from 250 in year one to 1,400 by year five	• Have limited historical experience delivering care to Medicare FFS beneficiaries. • Beneficiaries aligned via claims in any baseline year must not exceed 3,000 • Incremental growth to 5,000 attributed over four years

These represent high-level requirements and are not comprehensive

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What are the Requirements to Participate?

- A DCE must demonstrate compliance with all applicable ***state licensure*** requirements regarding risk-bearing entities
- A DCE must be a ***legal entity*** identified by a federal taxpayer identification number (TIN) that contracts with Direct Contracting (DC) Participant Providers
- Applicants will not be expected to have formed their legal entity or to have verified state licensure until after participant selection but will be required to have satisfied these requirements before executing the ***Direct Contracting Model Participation Agreement*** with CMS
- A DCE will not be required to be a Medicare-enrolled provider or supplier in order to participate in Direct Contracting, *however*, all Participant Providers must be a ***Medicare-enrolled provider or supplier*** by no later than **June 30, 2020**, in order to be eligible to participate in the model during PY1 (2021)
- Additional competencies needed:
  - Adequate capital and reserves
  - Complete contracted provider network
  - Capabilities to manage risk (patient engagement, population health analytics, care management, provider relations, capitation management etc.)

Risk Sharing Options for Different Risk Appetites

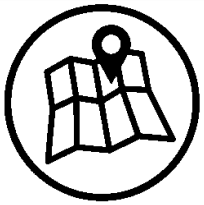
Professional

- Lower-risk option
- First dollar savings/loss
- Consisting of **50%** shared savings/shared losses and primary care capitation equal to **7%** of the total cost of care benchmark for enhanced primary care services
- Must participate in Primary Care Capitation payment mechanism

Global

- Full risk option
- First dollar savings/loss
- Consisting of **100%** shared savings and shared losses in either primary care capitation or total care capitation, which encompasses all Medicare Part A and B services
- May participate in either a Primary Care or Total Care Capitation payment mechanism

Geographic*



- Assume responsibility for the total cost of care for all Medicare FFS beneficiaries in a defined target region
- Health plans can be the applicant entity
- CMS still considering comments, no LOI or RFA released

** CMS is still considering the Geographic option; the RFA has been released for Professional and Global and the comment period for Geographic ended in May 2019*

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Strengthening Your VBP Roadmap

- Invest in clinical integration infrastructure, resources, management
- Orient operating culture around population health
- Focus on managed care competencies and improve ability to take risk
- Promote care delivery across the continuum of care
- Ensure ability to deliver access to accurate, consistently high quality of care & excellent patient experience
- Prioritize your necessity in the market: must-have provider network
- Create a high-performing network driven toward goals of VBP

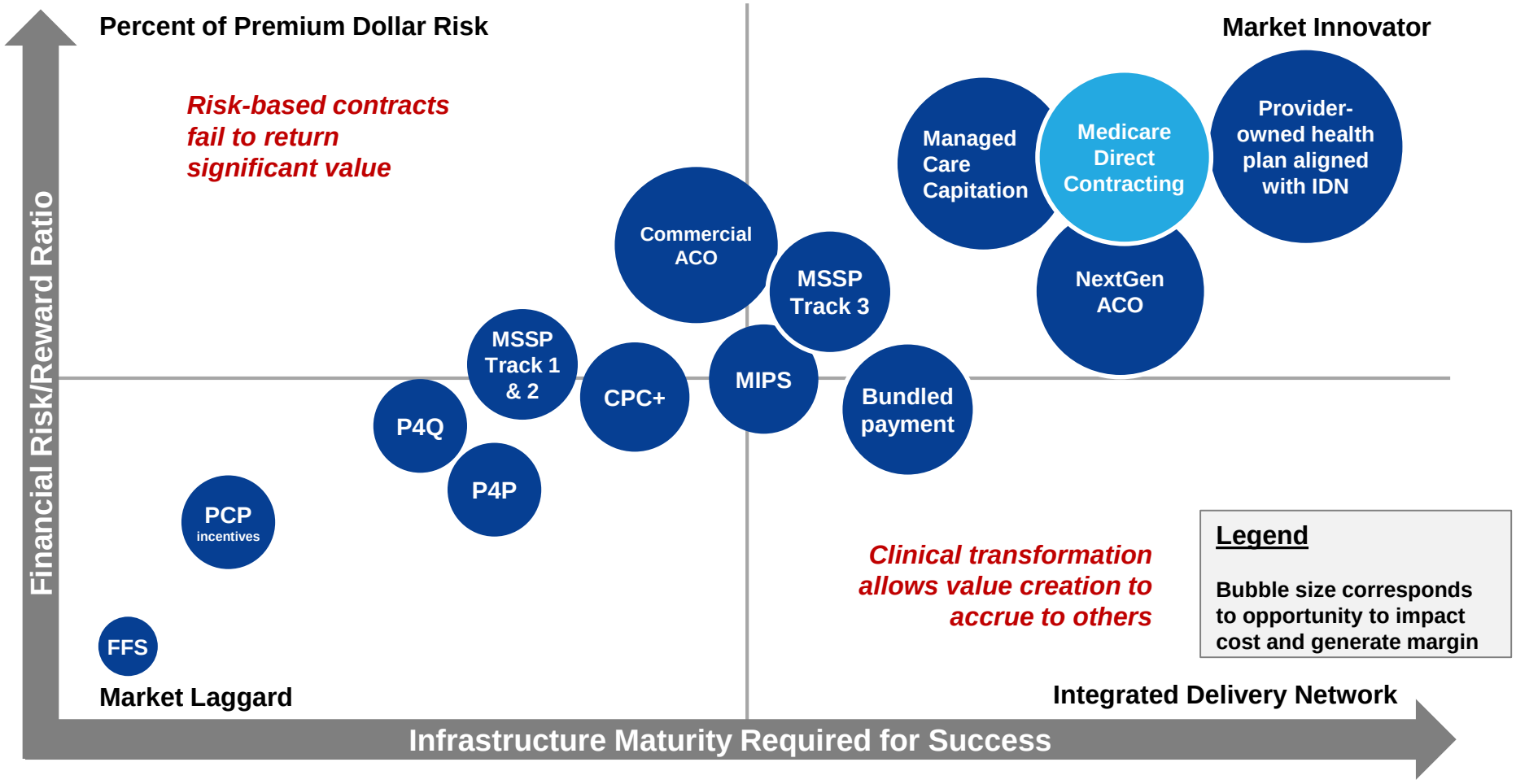
The Medicare Direct Contracting program should build upon, not drive, your value-based payment roadmap

Direct Contracting vs NextGen ACO vs MSSP

	Medicare Direct Contracting	NextGen ACO	MSSP ACO
Overview	• Based on capitation, professional or global option • Welcomes new entrants with less Medicare experience, as well as those serving high needs populations. • Streamlined quality focused on patient experience and total cost of care	• Initially 3 years, extended to 2 more years (2019 and 2020) • Capitation (AIPBP) is an option, many similarities to Medicare Direct Contracting	• Three tracks (and 1+) with varying levels of upside and downside risk • Requirement for those in upside at least two years to move to downside
Timeline	• LOI due tomorrow for 2021 • 2020 application for IP due February 25, 2020 • 4 year performance period application due Spring 2020	• For current participants, runs through 2020	• 4/20/20 – 5/8/20 notice of intent and 5/14/20 – 6/11/20 application for 2021 • 3 year performance period
Participant Limitations / Exceptions	• MCOs eligible to be DCE • Providers or DCEs without history or significant Medicare program engagement can join and attract patients through voluntary alignment	• No longer accepting applications (41 active participants)	• No longer accepting applications for 1+ (55 participants in pilot)
Risk Sharing Rate	• Professional: 50% • Global: 100% • (Geographic TBD)	• Arrangement A: 85% (years 4 & 5) • Arrangement B: up to 100%	• Track 1 and 1+: up to 50%; • Track 2: up to 60%; • Track 3: up to 75%
Shared Savings or Loss	First dollar savings or loss with risk corridors	First dollar savings or loss for spending below or above benchmark (includes a discount withhold)	First dollar once minimum savings rate (MSR) is met or exceeded
Minimum Beneficiary Size	250-5000 (varies by risk sharing option and grows incrementally after baseline)	10,000 (7,500 in rural area)	5,000
Quality Measures	14 quality measures proposed – P4R (count toward MIPS APMs)	34 quality measures – P4R→P4P (mirrors MSSP except ACO measure 11)	34 quality measures – P4R→P4P
Alignment	Prospective claims best and voluntary	Prospective with voluntary option	For tracks 1 and 2, preliminary prospective and final retrospective For tracks 1+, 3, prospective only
Capitation	Yes, required, either professional or global	Yes, AIPBP option	No

Direct Contracting vs. Other VBP Options

Value-Based Reimbursement Continuum



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Keys to Success in Risk-Based Environments

Quality Management

Approaches to effectively manage overall total cost of care through improving outcomes

Examples:

- STAR ratings
- HEDIS gap closure
- Member engagement
- Provider & staff engagement
- Ease of use of quality identification & action tools

Revenue Optimization

Strategies to increase total revenue and increase the risk sharing the provider can manage

Examples:

- Appropriate product category
- Appropriate risk coding
- Contracting strategy
- Financial reconciliation for claims & eligibility
- Capitation management

Utilization Management

Alignment of provider operational strategies with risk strategies to maximize care delivery value

Examples:

- Appropriate site, level of care, proactive UR, aligned incentives
- Ease of access & leakage reduction
- Identify & address SDH, CBO integration
- Rx dispensing channel
- High-volume/high-risk member management

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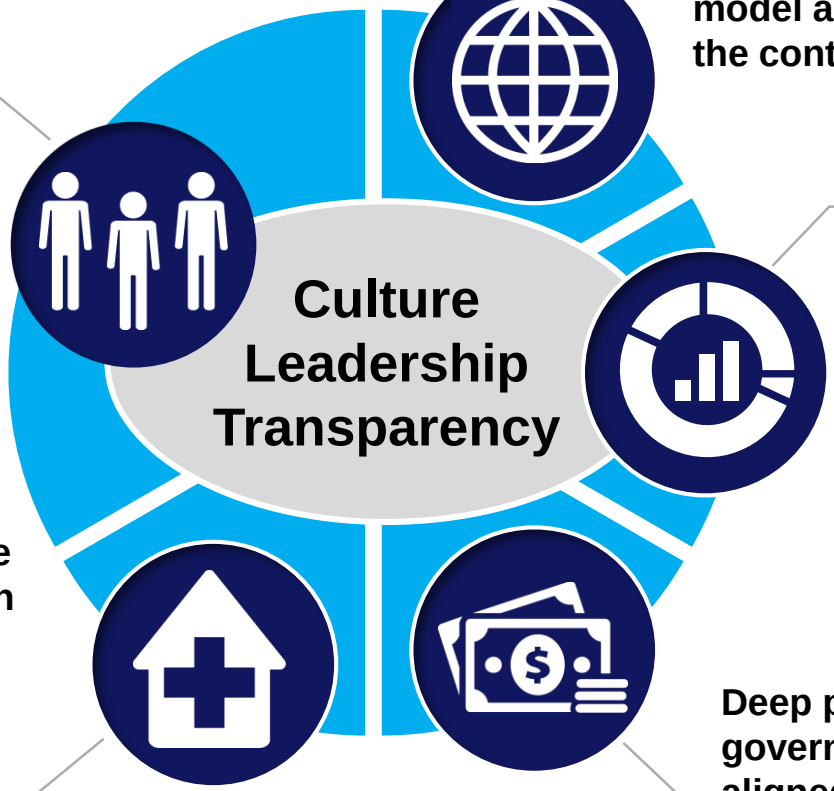
Positioning for Success and Creating Competitive Advantage

Six Key Questions

1. Do you have a network and alignment vehicle that can effectively impact provider behavior and patient utilization?
2. Do you have the position, experience, data and resources to negotiate favorable provider contracts?
3. Do you have a functional and effective care management solution? (not just a check box)
4. Do you have the capacity to get NCQA certified delegation for Utilization Management (UM) and Care Management (CM)?
5. Are you able to financially model your value-based payment arrangements and projected performance?
6. Are you able to transform claims data and manage, analyze and make the right data available to providers and care management in order to drive performance both internally and externally?

VBP Critical Success Factors

Fundamental design principles for Downside or Global Risk:



Unified, data-driven care model and care team across the continuum

Culture of accountability for managing health and total cost of care with members

Population and outcome margin metrics vs. volume and visit margin

Easily accessible primary care network with behavioral health integration, urgent care capabilities, high-value specialty co-management and care coordination

Deep physician engagement in governance and funds flow with aligned incentives

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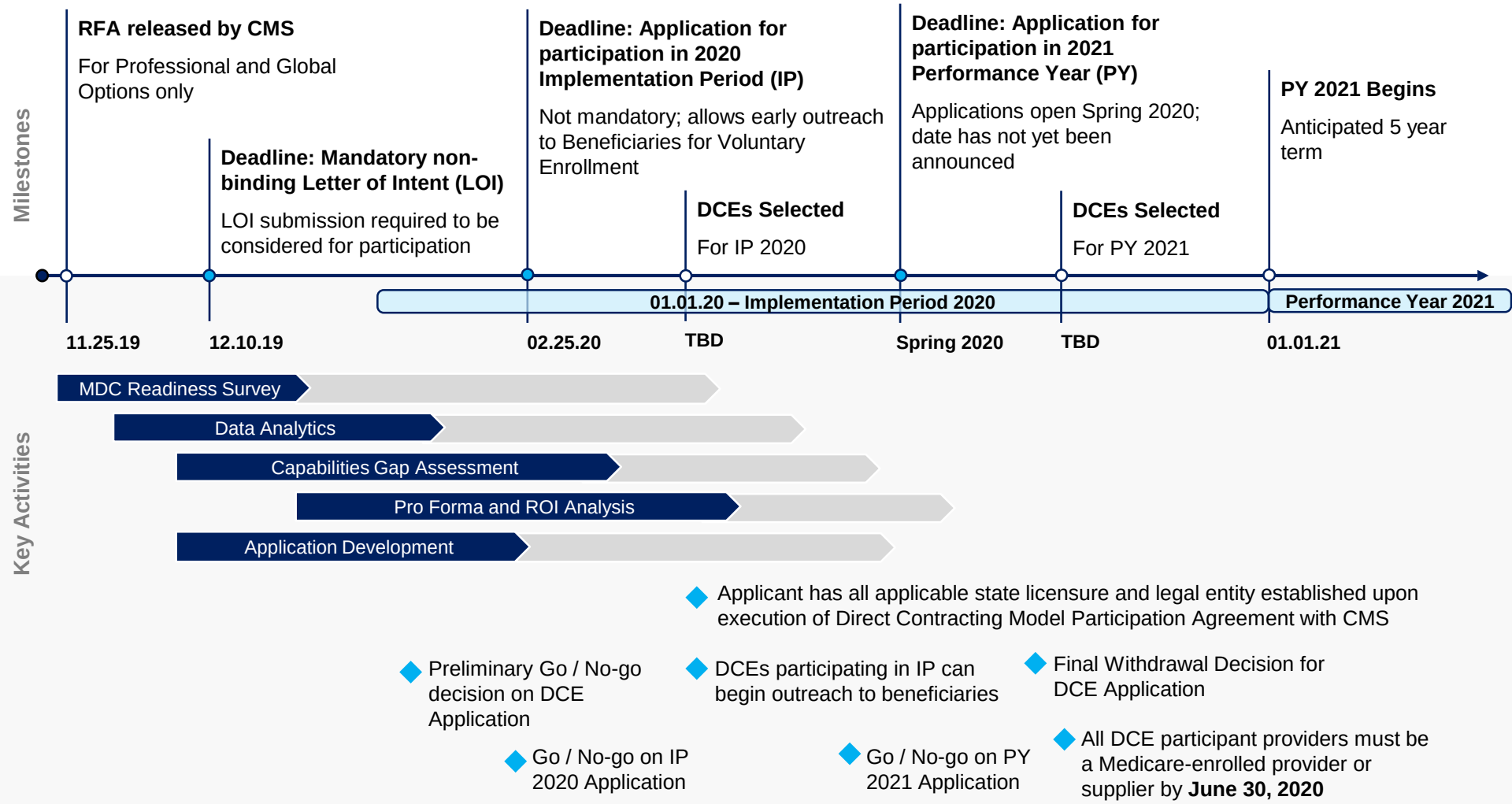
Key Considerations

- Succeeding in downside risk is heavily reliant on reducing acute hospital utilization
- It will be important for providers to review current performance data on specific measures compared to national averages to understand the adjustments CMS might make
- It is unclear how administration burden in this model will be reduced beyond the number of quality measures
- It will be important for DC participants to understand how quickly CMS will be able to share necessary data with participating providers in order to build this into operational workflows
- Markets with multiple DC participants will need to understand how to create adequate networks, refer beneficiaries and reduce administrative burden without participation of a health plan

Medicare Direct Contracting

Timeline and Milestones



Questions

Take the Next Step

See if Medicare Direct Contracting is Right For You

Considering Direct Contracting?
Take our quick online assessment to see if your organization is a good fit for this program.

TAKE OUR ONLINE ASSESSMENT

https://www.surveymonkey.com/r/cmsdcquiz

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Appendix

Acronyms

ACO	Accountable Care Organization
APM	Advanced Payment Model
CBO	Community Based Organization
CM	Care Management
CPC+	Comprehensive Primary Care Plus
DCE	Direct Contracting Entity
IDN	Integrated Delivery Network
IP	Implementation Period
MIPS	Merit-based Incentive Payment System
P4P	Pay-for-Performance
P4Q	Partnership for Quality Program
PY	Performance Year
QPP	Quality Payment Program's
SDH	Social Determinants of Health
UM	Utilization Management
VBP	Value-Based Payment