MEDICARE DIRECT CONTRACTING

Move to Value Summit 2021

June 22, 2021

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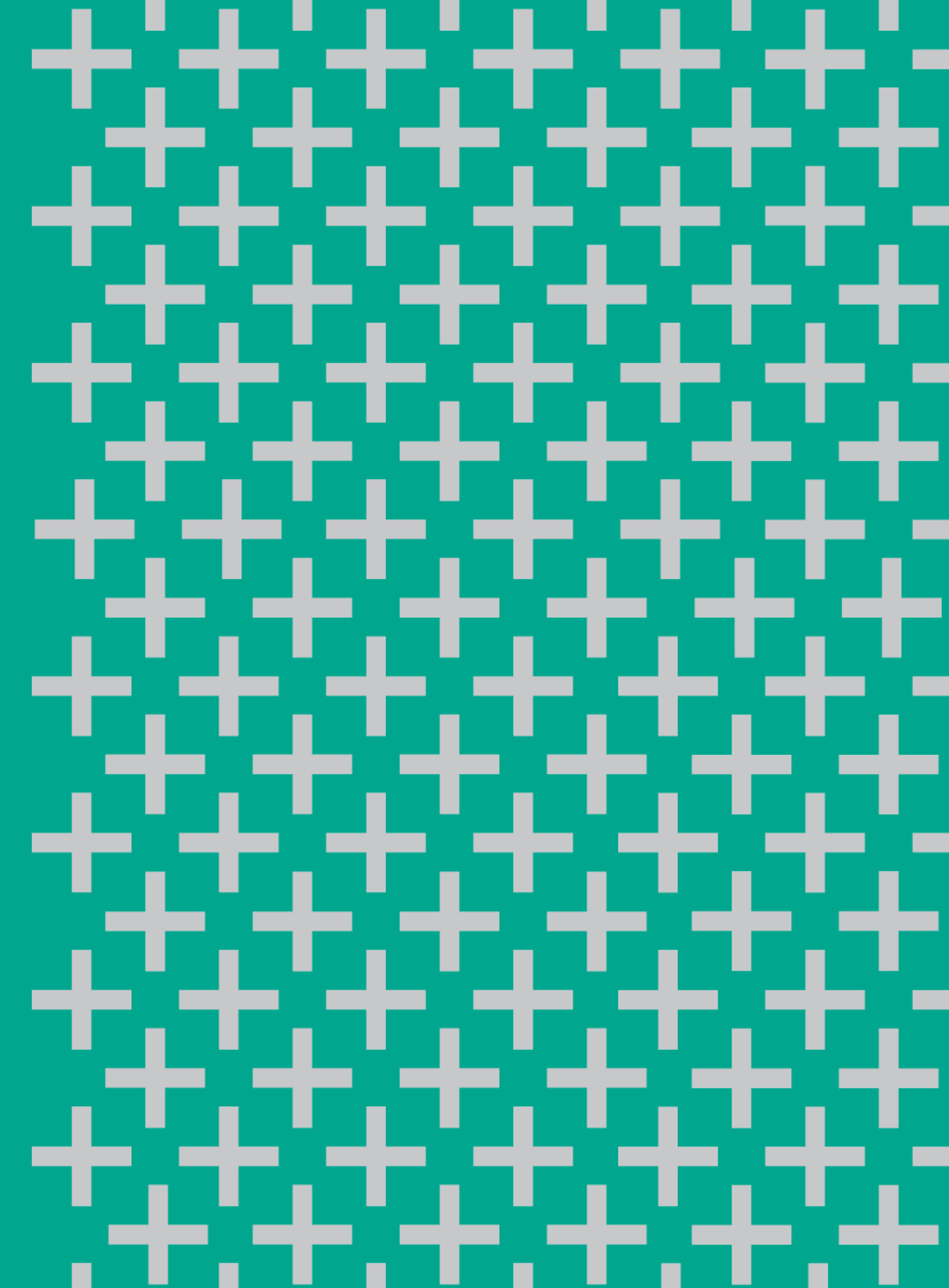
PRESENTATION ROADMAP

- Landscape for Medicare payment policy
- New Administration shifts focus
- Direct Contracting overview
- Next steps

LANDSCAPE FOR MEDICARE PAYMENT POLICY

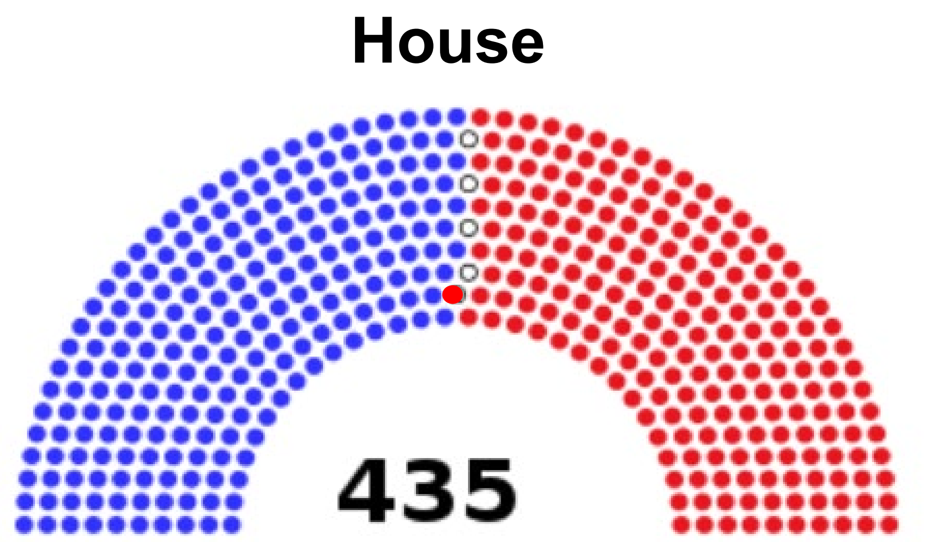


LEGISLATIVE PRIORITIES HAVE CENTERED ON COVID-19 RECOVERY, EQUITY

- American Rescue Plan Act – COVID-19 rescue package
- Infrastructure package
- Coverage expansion
  - Affordable Care Act (ACA) ruling removes some of the urgency around coverage conversation
  - A 7-2 majority finds no standing for plaintiffs to bring the case

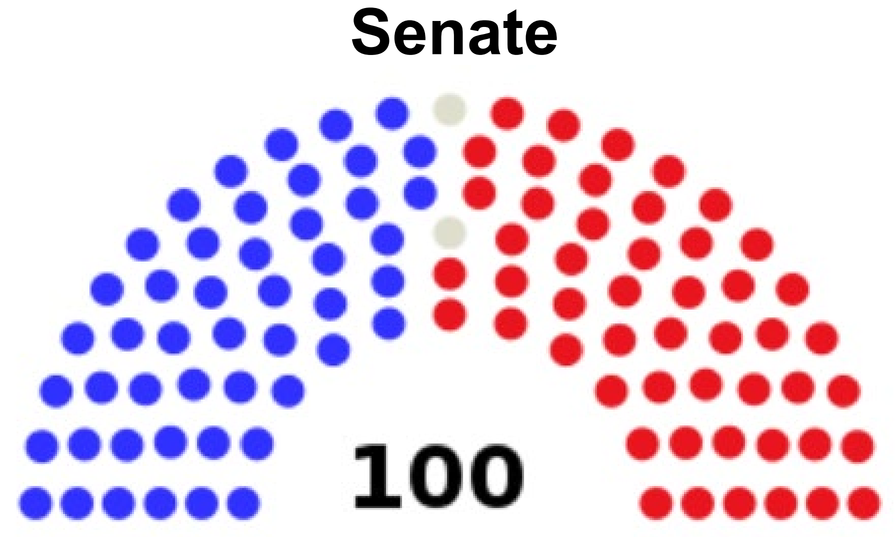
CLOSELY DIVIDED HOUSE AND SENATE

House



220 Democrats
211 Republicans
5 Vacancies

Senate

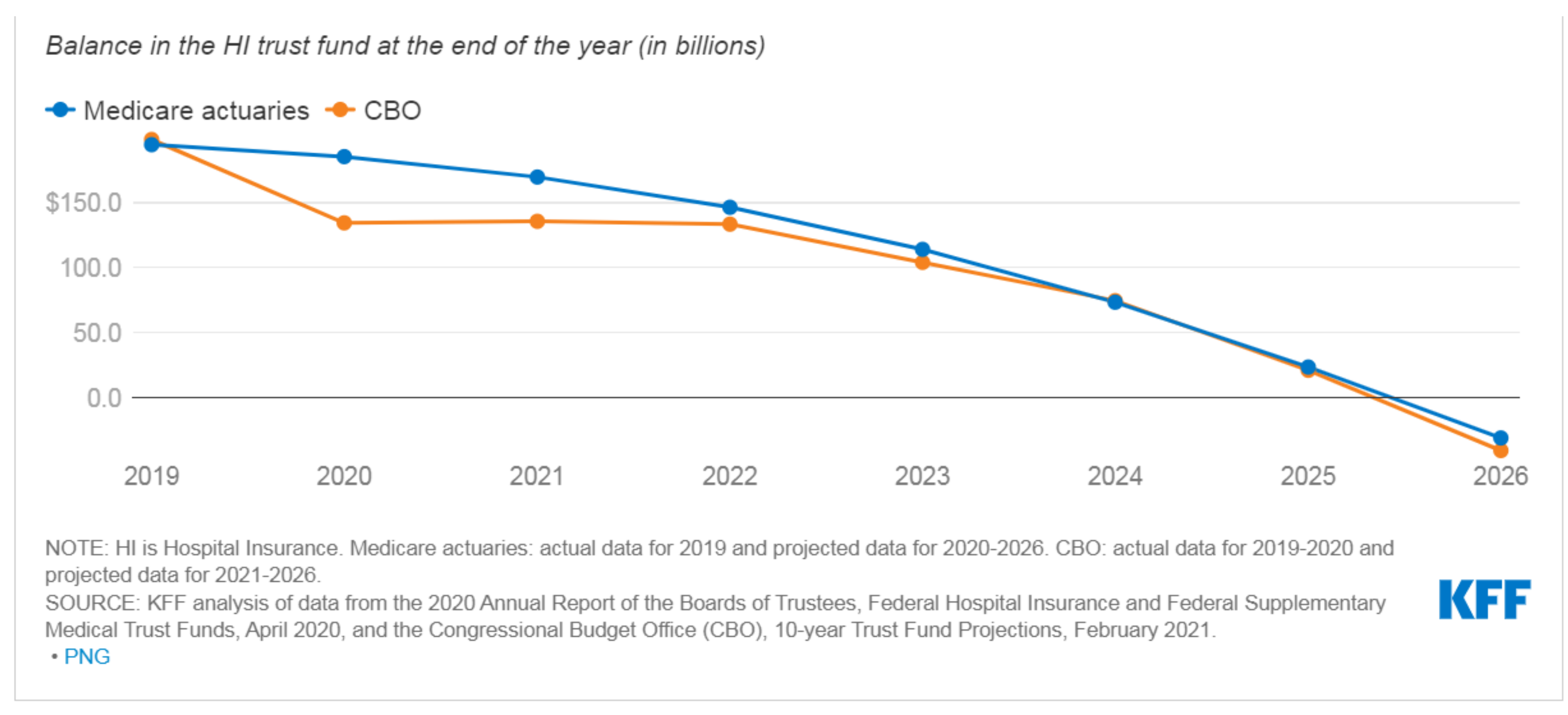


50 Democrats*
*Senators King and Sanders caucus with Democrats

50 Republicans

MEDICARE HOSPITAL INSURANCE TRUST FUND

- Potentially runs out as early as 2024 (conservative prediction is **2026**).
  - Funded almost 90% by payroll taxes
- Medicare Trustees Report remains delayed indefinitely, creating challenges for Congress.



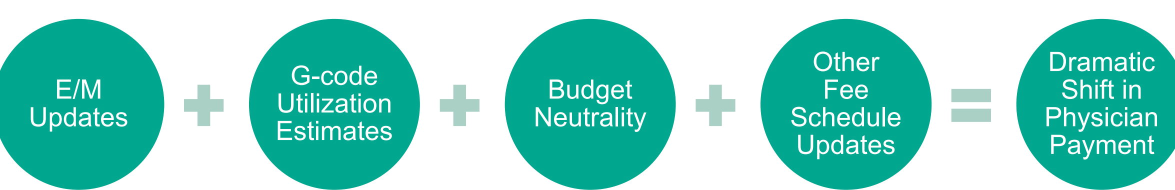
Impact of the Consolidated Appropriations Act of 2021 on the Medicare Physician Fee Schedule and Physician Conversion Factor

In the CY 2021 Medicare Physician Fee Schedule (PFS) final rule, the 2021 physician conversion factor (CF) was $32.4085, **a negative 10.2% adjustment** from the final 2020 conversion factor.

	2020 Final Rule CF	2021 Final Rule CF *(Pre-Legislative Update)*	2021 Final CF *(Post-Legislative Update)*
Conversion Factor	$36.0896	$32.4085	$34.8931
Percent Change	+0.14%	-10.2%	-3.3%

Select Contributing Factors:

1. **Increases in E/M Payment Rates:** CMS implemented previously established changes to evaluation and management (E/M) payment.
2. **G2211 Add-on Code:** CMS estimated utilization of a new code for time, intensity and practice expense related to caring for complex patients.



The CAA provided some adjustments for CY 2021: The Consolidated Appropriations Act of 2021 (H.R.133), made two significant changes to Medicare payments in 2021:

- **Requires CMS to increase PFS payments by 3.75%,** the agency implemented this provision through a 3.75% increase in the PFS CF.
- **Places a moratorium on G2211 through 2023** eliminating a significant amount of predicted utilization within the Medicare PFS; offsetting CF reductions.

These provisions reduce previously finalized CF cuts.

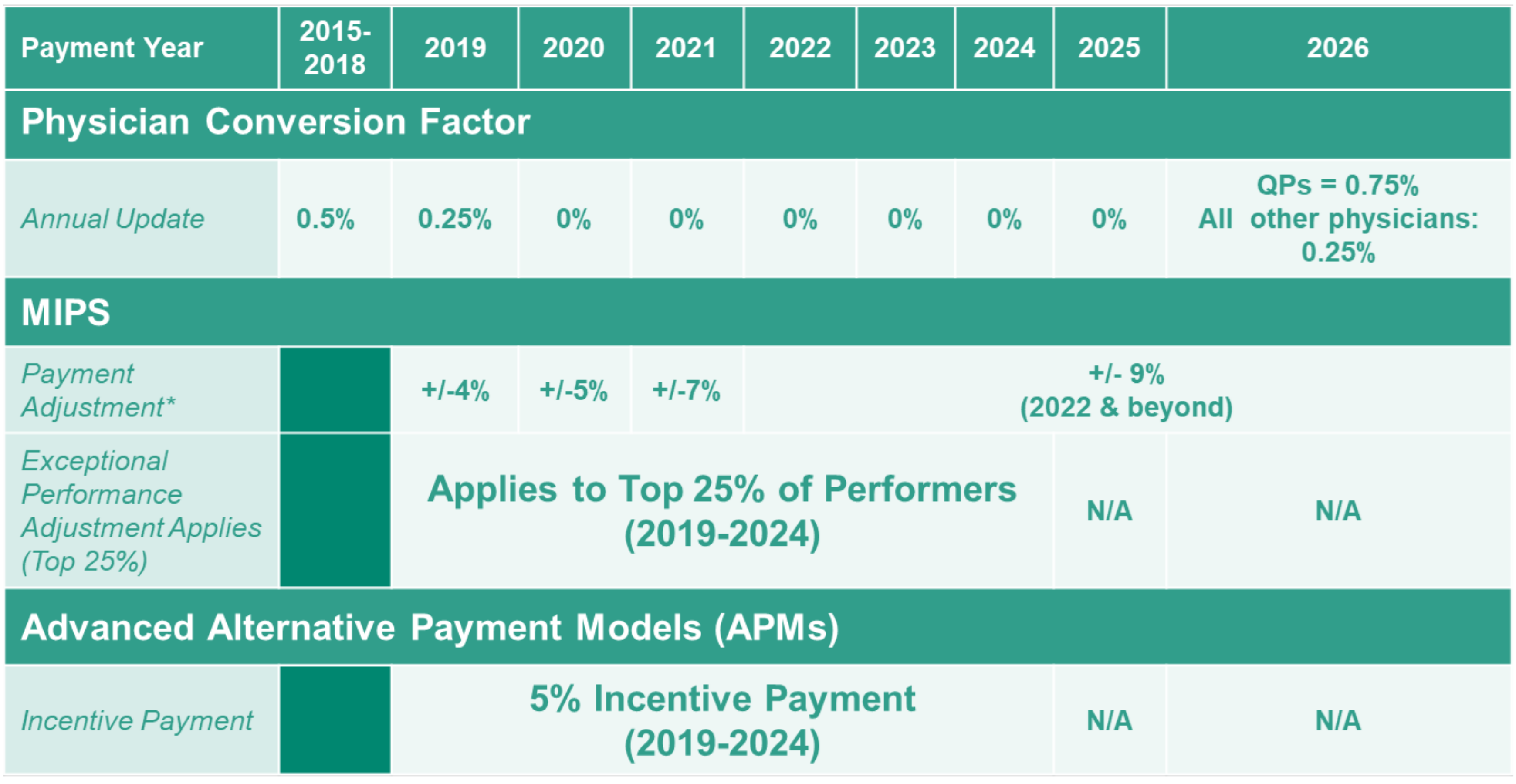
CAA improved payments for some specialties, reduced for others (compared to 2021 Final Rule):

Specialty	CY 2021 Final Rule Impact	Final Legislative Impact
Critical Care	-7%	0%
Family Medicine	+13%	12%
Neurosurgery	-6%	0%
Pediatrics	+6%	+7%

Source: "CY 2021 Combined Specialty Impact with New Medicare Physician Payment schedule & Anesthesia Conversion Factors, Updated RVUS and without G2211." American Medical Association. https://www.ama-assn.org/system/files/2021-01/2020-combined-impact-table.pdf

Physician payment beyond 2021: The 3.75% increase in the physician conversion factor only provides one year of payment relief to providers. In CY 2022 physicians will be impacted by Medicare payment rates returning to pre-2021 rates and by other potential coding and quality payment program updates.

MACRA - REFRESHER



Payment Year	2015-2018	2019	2020	2021	2022	2023	2024	2025	2026
Physician Conversion Factor									
Annual Update	0.5%	0.25%	0%	0%	0%	0%	0%	0%	QPs = 0.75% All other physicians: 0.25%
MIPS									
*Payment Adjustment**		+/-4%	+/-5%	+/-7%	+/- 9% (2022 & beyond)				
Exceptional Performance Adjustment Applies (Top 25%)		Applies to Top 25% of Performers (2019-2024)						N/A	N/A
Advanced Alternative Payment Models (APMs)									
Incentive Payment		5% Incentive Payment (2019-2024)						N/A	N/A

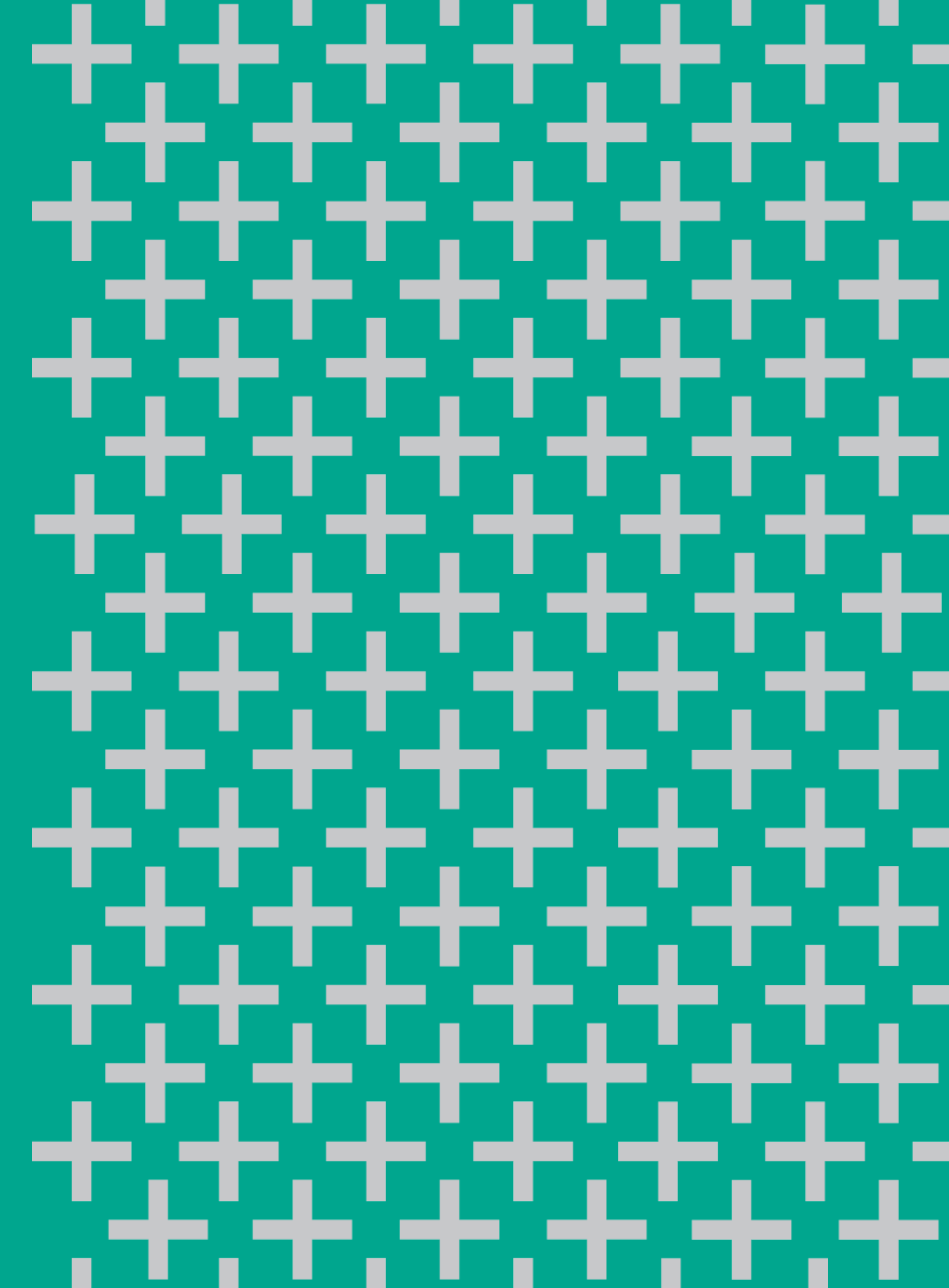
- ✓ 2019 CF update was reduced to 0.25 percent from the 0.50 authorized by MACRA as a result of a provision in the BBA of 2018
- ✓ Beginning in 2020 a period of zero percent updates begins, which could potentially result in negative updates due to the application of other scalers, such as the RVU budget neutrality adjustment

*Note that the MACRA statute included additional bonus potential due to application of a scaling factor, not reflected here.

LANDSCAPE RECAP

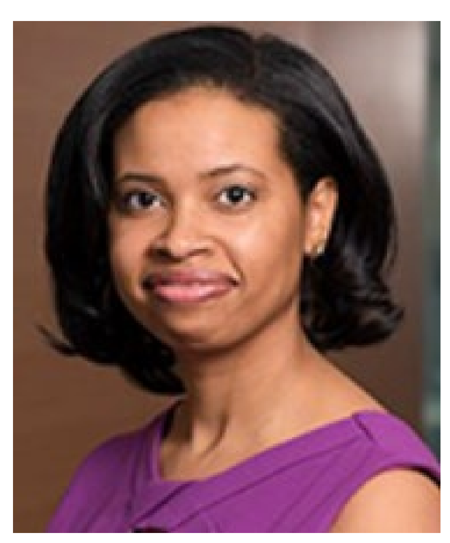
- Ambitious legislative objectives, may be scaled back due to balance of power in Washington
- Medicare spending remains a concern
- Key events on the horizon that could spark legislative action
- COVID-19 underscores need to move away from fee-for-service

NEW ADMINISTRATION SHIFTS FOCUS



KEY HHS APPOINTMENTS

Xavier Becerra
HHS Secretary



Chiquita Brooks-LaSure
CMS Administrator

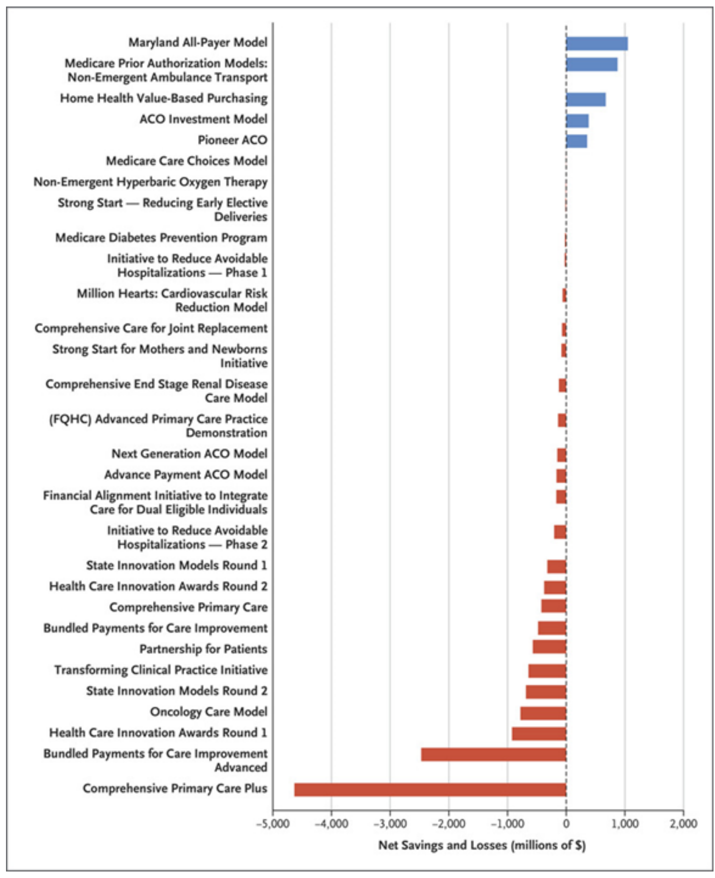
Liz Fowler
CMMI Director

NEW ADMINISTRATION BRINGS NEW PRIORITIES ACROSS HHS PORTFOLIO

- COVID-19 recovery, response and transition
- Border crisis
- Focus on health equity across all of government

INNOVATION CENTER LOOK BACK

- Previous Administration criticizes CMMI for lack of savings/results across models
- Out of 54 models, only five produced significant savings
- Announced a portfolio of models, including Direct Contracting intended to generate more cost savings



PRIORITIES FOR THE BIDEN ADMINISTRATION'S CMMI PORTFOLIO

- Advancing health equity
- Goal of having every beneficiary in an attributed care relationship
- Defining success – not only looking at cost, how do we determine if a model has "worked"

MEDPAC RECOMMENDATIONS

- The Medicare Payment Advisory Commission (MedPAC) recommends streamlining at CMS/CMMI

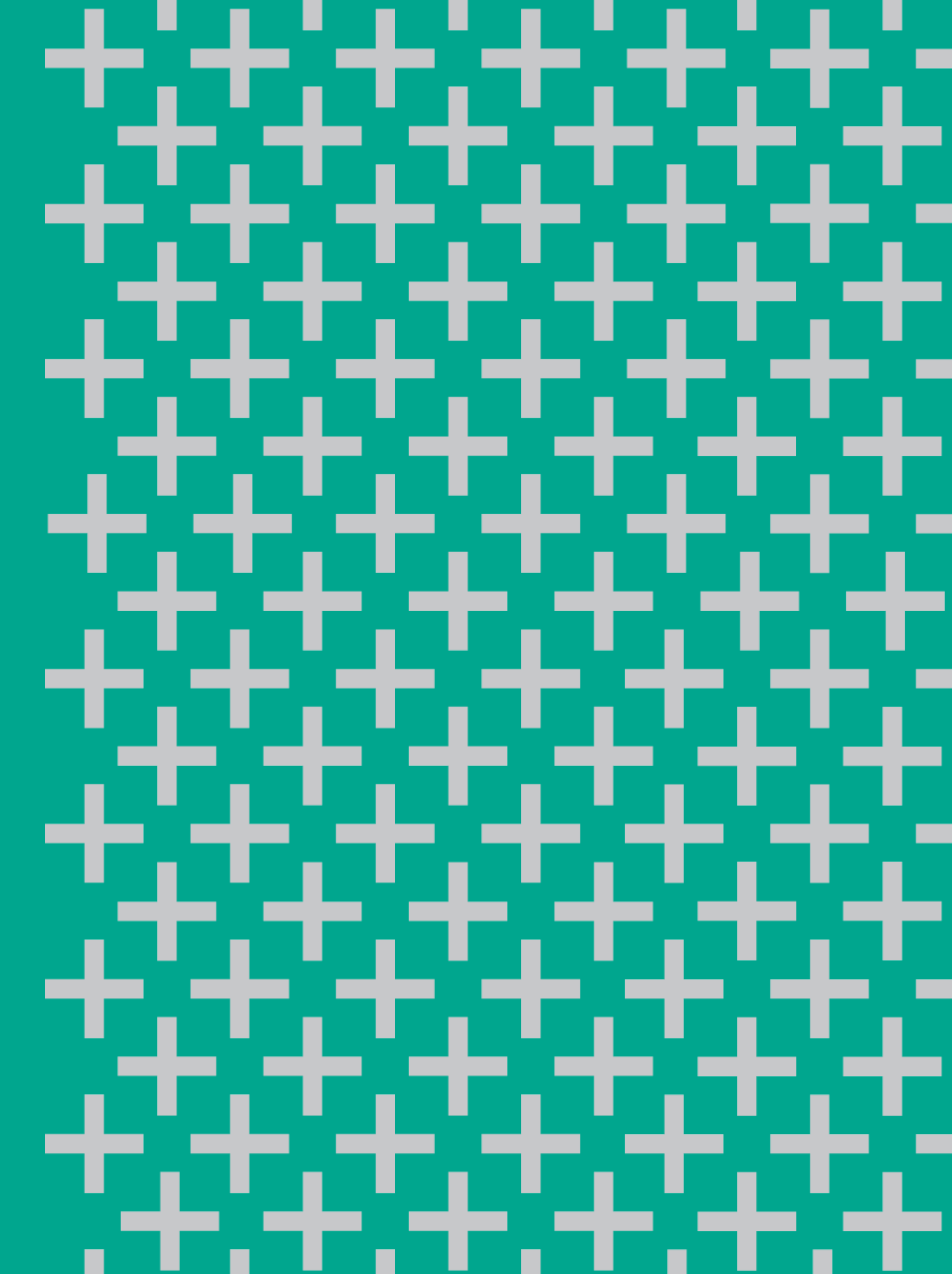
- Focusing on demonstrations that have worked and consolidating the model portfolio
  - "Population-based models have generated the most consistently favorable financial results among APMs"

MedPAC Chapter 2: http://www.medpac.gov/docs/default-source/reports/jun21_medpac_report_to_congress_sec.pdf

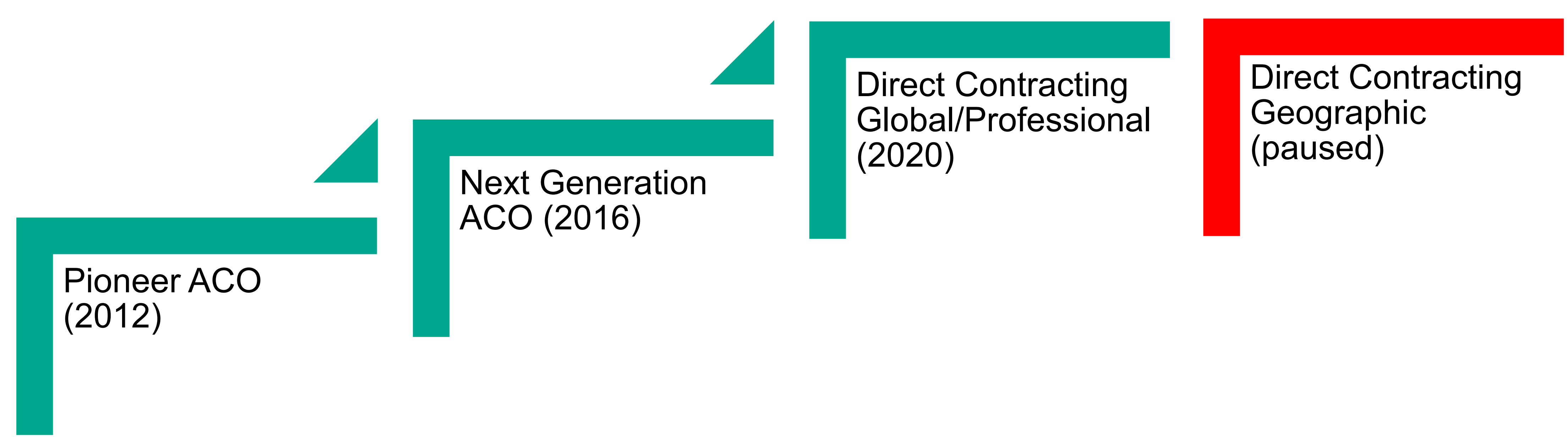
ADMINISTRATION RECAP

- Seemingly competing goals: expand participation in models while condensing the number of models available
- Equity lens on Innovation Center portfolio and HHS portfolio more broadly
- Leveraging enthusiasm for value based models

DIRECT CONTRACTING



CMS INNOVATION CENTER ACO EVOLUTION



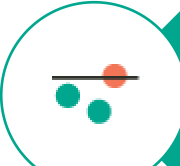
BUT FIRST, A BRIEF NOTE ABOUT NEXT GEN…

- Administration concludes that Next Gen did not generate sufficient savings to be extended or made permanent
  - Evaluation report has key limitations that prevent savings from being recognized
    - Does not include discount to CMS in savings calculation
    - Compares Next Gen population to MSSP and other demonstrations
- Next Gens have the option to enter Direct Contracting
- Stakeholders urge CMS to add a Next Gen-like track to MSSP

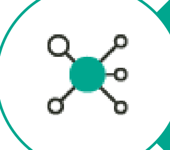
DIRECT CONTRACTING: GLOBAL & PROFESSIONAL

- DC Glo/Pro builds on Next Gen ACO model
  - CMS announced **53 participants** for the first Performance Year (April 1, 2021 - December 31, 2021)
  - An additional cohort in 2022 will include some Next Generation ACOs and applicants who have been accepted for 2021 but deferred their start date
- In 2021, Biden Administration announced it would not accept new applicants for 2022
- Possible new cohort for 2023

DIRECT CONTRACTING MODEL GOALS

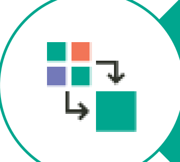


Shift from FFS to capitated payments for entities and clinicians in traditional Medicare



Broaden participation in models

Improve fee-for-service beneficiary engagement



Reduce provider burden by providing waivers

MODEL OPTIONS

Professional	Global	Geographic
50% shared savings/losses	100% savings/losses	100% savings/losses
Primary Care Capitation – per-beneficiary per-month (PBPM) capitated payment for primary care services. The amount is equal to seven percent of the estimated total cost of care for the DCE's aligned population	Primary Care Capitation or Total Care Capitation – PBPM capitated payment for all services. Reflects estimated total costs of care for the DCE's aligned population	Total Capitation or Partial capitation – providers agree to receive a reduction of FFS payments between 1% and 50% and Geo DCE receives monthly capitated payment equal to estimated portion of the payments

DIRECT CONTRACTING ENTITY TYPES

Standard DCEs	New Entrant DCEs	High Needs Population DCEs
Experience with FFS Medicare, including FFS models	Little or no experience with FFS patients	Serve Medicare beneficiaries with complex needs, including duals

KEY DIFFERENCES BETWEEN GLO/PRO DIRECT CONTRACTING AND PRIOR ACO EXPERIMENTS

Design Element	MSSP	Next Gen	Global & Professional Direct Contracting
Ability to move away from FFS payment (population based payment; capitation)	N	Y	Y
Voluntary alignment	Y	Y	Y
MA-like beneficiary incentives (comparable to supplemental benefits)	N	N	Y
Attribution threshold facilitates new entrant participation	N	N	Y
Health plan participation	Y	Y	Y

DIRECT CONTRACTING: GEOGRAPHIC

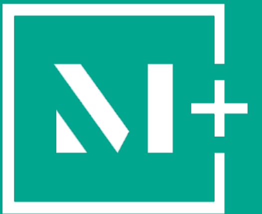
- In late 2020, Trump Administration announced Geographic Direct Contracting model as another Direct Contracting model in addition to Global and Professional
  - Geo Direct Contracting Entities (DCE) would take risk across an entire region
  - Random alignment is a core feature – beneficiaries would be randomly assigned to a Geo DCE
  - Additional tools for Geo DCEs, like utilization management

- In April 2021, Biden Administration paused Geo model; seems unlikely to be offered as described by previous Administration

- Key attribution/assignment issue still remains for Biden Administration:
  - In Medicare ACO models, beneficiaries are primarily attributed by utilization of primary care services (claims based attribution)
  - How does CMS/CMMI get to beneficiaries who are not utilizing primary care services?
  - Elevated importance of this issue with agency/Administration focus on equity

DIRECT CONTRACTING RECAP

- Direct Contracting Global/Professional offered for two cohorts, but CMMI is not accepting new applications except for Next Gens
- Direct Contracting Geographic risk is paused indefinitely, unlikely to return as previously formulated
- Awaiting new Innovation Center strategy

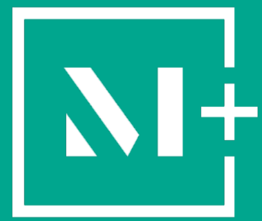


NEXT STEPS

PIVOTAL TIME FOR VALUE

- COVID-19 exposed the vulnerabilities of fee-for-service reimbursement

- Innovation Center has an opportunity to continue to drive value
  - Improve evaluations
  - Create off-ramps for model participants
  - Expand participation options for value based care



QUESTIONS

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