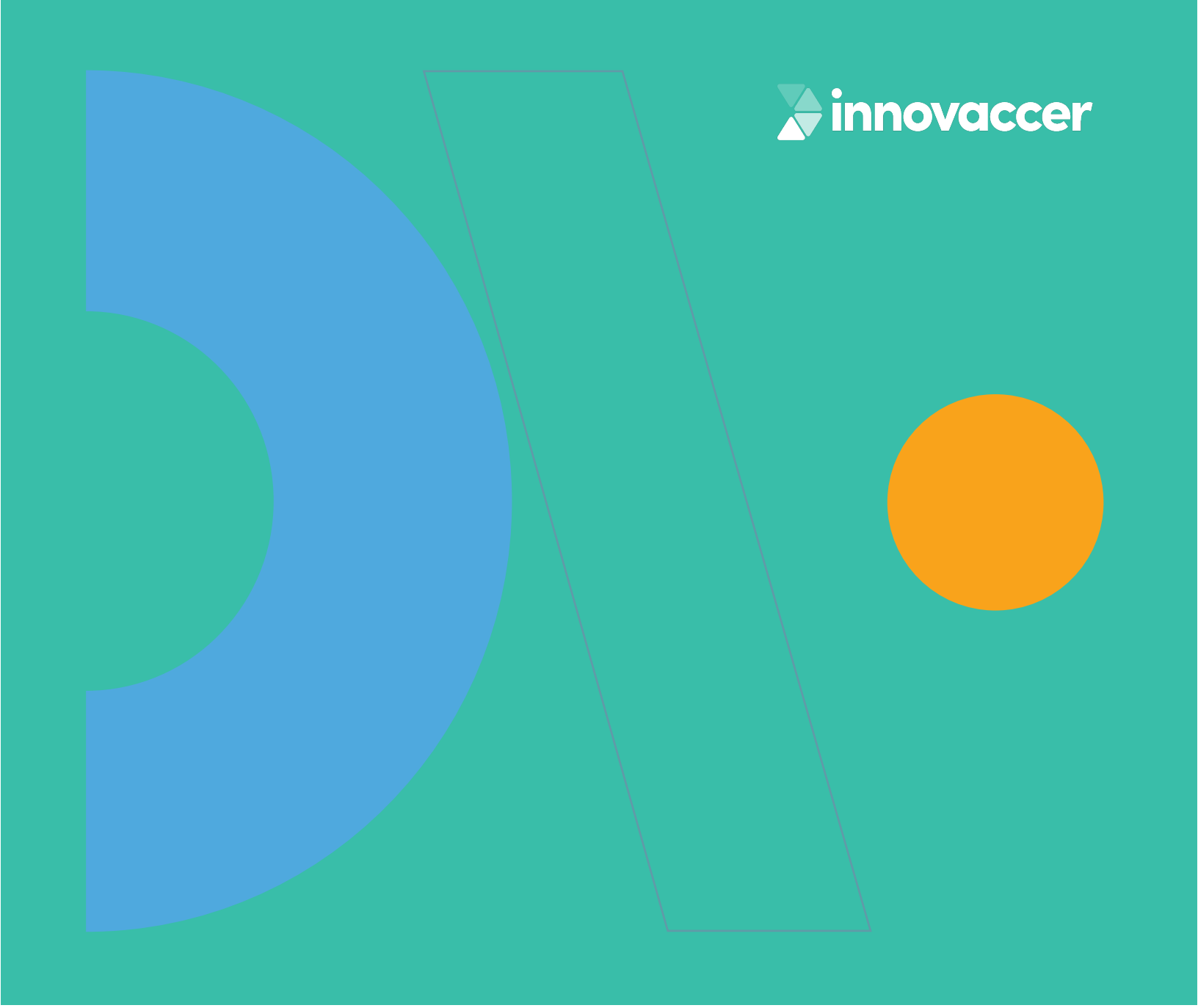

Greater Risks and Better Incentives: Achieve Success in Direct Contracting

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Executive Summary

The healthcare sector is undergoing a paradigm shift as value-based care becomes more common than the traditional fee-for-service (FFS) model. With the introduction of new value-based care models, CMS is potentially signaling a new era in which providers are required to transition from lower to higher risk-based care. Healthcare providers being the primary stakeholders in value-based care are responsible for making pivotal changes in care delivery to enable value-based contracting.

To assess the next evolution of risk-sharing arrangements for producing high-quality health care, the Centers for Medicare & Medicaid Services (CMS) and Center for Medicare and Medicaid Innovation (Innovation Center) launched the **Direct Contracting Model**. This voluntary payment model is designed to:

- transform healthcare by paying providers for outcomes rather than services
- encourage providers to shift from volume-based payments to value-based payments reducing healthcare costs for Medicare beneficiaries in several regions across the United States.

In April 2019, Direct Contracting was initially announced, and on November 25, 2019, CMS released the Request for Applications (RFA). The RFA showcases details about the model's policies and operations. Direct Contracting is a five-year payment model, with its first performance year (PY) starting January 1, 2021. The RFA focused on two program options: Professional and Global. These program options can be implemented by different types of Direct Contracting Entities (DCEs), including Standard, New Entrant, and High Needs Population.

This paper discusses how the Direct Contracting Model is creating the next generation of risk-sharing arrangements by lowering costs, ensuring high-quality care, and improving population health outcomes.

Why did CMS develop new payment model options for Direct Contracting?

Healthcare organizations showed interest in a model that could implement private sector approaches to risk-sharing arrangements and payments while minimizing administrative burden and downside risk. The payment model options available under Direct Contracting can be appealing to provider organizations since the model is expected to reduce burden, focus on beneficiaries with complex chronic conditions, and boost participation from organizations that have not yet engaged in Medicare FFS or CMS Innovation Center models. There was a need to develop payment model options that included higher-quality measures prioritizing outcomes and patient experience over processes.

Half of Medicare patients have Medicare Advantage (MA) plans (i.e., value-based care), and the other half have Medicare fee-for-service (FFS) plans. CMS is trying to shift Medicare FFS beneficiaries to value-based care through Direct Contracting.

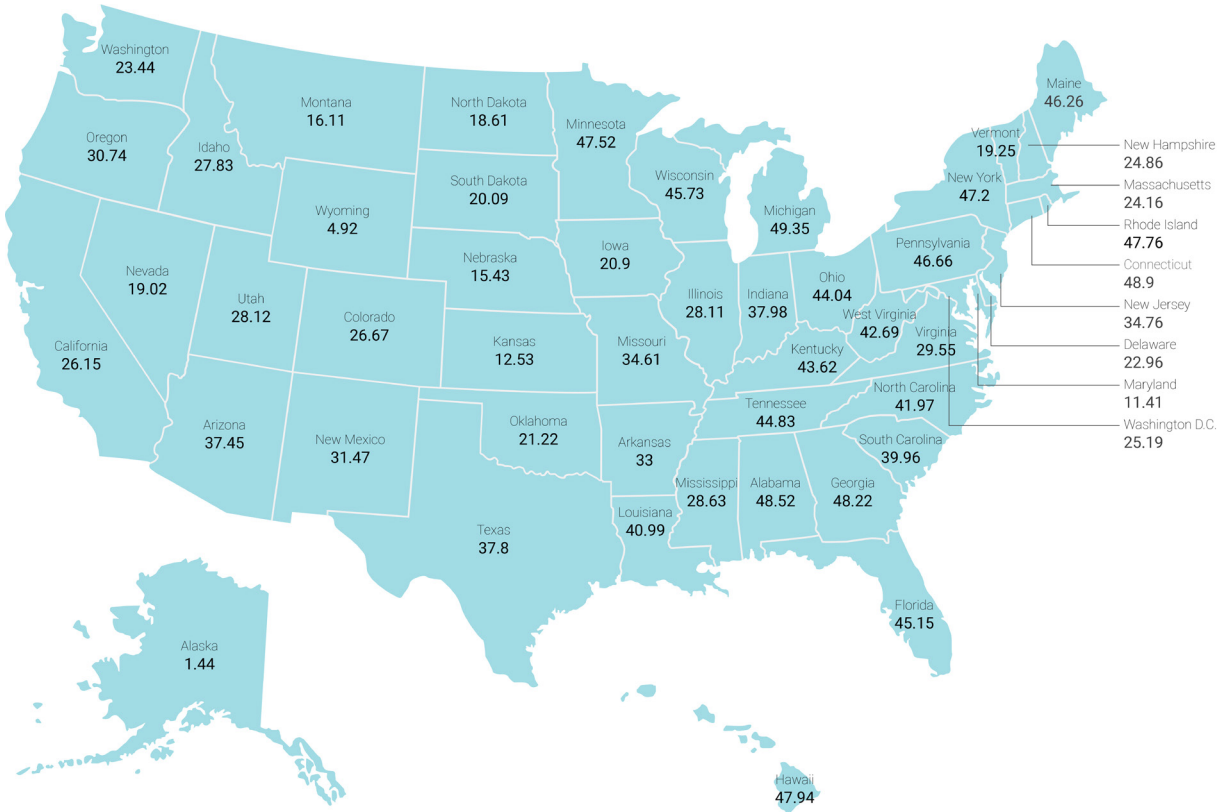


Fig 1: State Level Penetration of MA plans (CMS report 2021/06)

How is it different from the other CMS models?

The Direct Contracting Model will have a significant impact on the Medicare fee-for-service model in reducing expenditures and preserving quality of care for beneficiaries. All the other models, including the Next Generation ACOs, the Medicare Shared Savings Program ACOs, and the Medicare bundled payment program still rely on fee-for-service payments.

- In Direct Contracting, more organization types can participate than just ACOs, after approval by CMS via an application
- The model offers partially or fully capitated payments for relevant Medicare Part A and Part B services
- It incentivizes providers to participate for the loyalty of beneficiaries, particularly new beneficiaries.
- It induces greater complexity compared to other models like, benchmarking methodologies, numerous participation options and performance parameters

The model allows the CMS Innovation Center to evaluate financial risk-sharing arrangements in order to control Medicare costs while enhancing patient experience. Direct Contracting uses findings from other Medicare Accountable Care Organization (ACO) initiatives, such as the Medicare Shared Savings Program and the Next Generation ACO (NGACO) Model, as well as innovative approaches from Medicare Advantage and private sector risk-sharing arrangements.

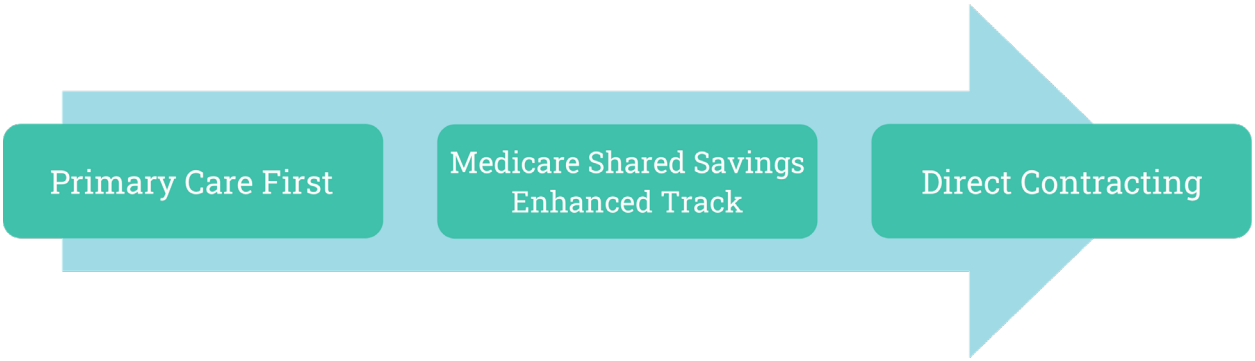


Fig 2: The CMS strategy to redesign primary care to improve health and reduce costs

The Direct Contracting Model supports organizations and suppliers that carry financial risk with reinforced flexibilities. It's part of a CMS Innovation Center strategy to revolutionize healthcare by paying providers for outcomes rather than services and redesign primary care as a platform to power broader healthcare delivery reform.

What is the Opportunity in Direct Contracting?

The Direct Contracting payment model options help align financial incentives and focus on care delivery while streamlining access to care for beneficiaries, which includes patients with complex chronic conditions and seriously ill populations.

CMS links a significant percentage of performance benchmarks to care quality and monitoring to ensure that access to care and patient involvement is not adversely affected by the Direct Contracting Model. The payment model options also aim to increase participation in CMS Innovation Center models by accepting organizations that are new to Medicare FFS, like provider-managed organizations that exclusively function in the MA program and Medicaid MCOs that offer Medicaid benefits for dually eligible beneficiaries.

Model options under Direct Contracting

CMS has released three voluntary risk-sharing payment model options:

- The **Professional** option is a lower-risk payment model option with 50% shared savings and losses with CMS. If features:
    1. Primary Care Capitation for enhanced primary care services (equal to 7% of the total cost of care for enhanced primary care services)
    2. ACO structure with Participating and Preferred Providers defined at the Tax Identification Number ("TIN") and National Provider Identifier ("NPI") level
- The **Global** option offers the highest risk-sharing arrangement, with 100% shared savings and losses with CMS. It features:
    1. Primary Care Capitation
    2. Total Care Capitation (equal to 100% of the total cost of care provided by Participant and Preferred Providers)
    3. ACO structure with Participating and Preferred Providers defined at the TIN/NPI level
- The **Geographic** Model is currently under review by CMS and will no longer begin on January 1, 2022. The model was open to organizations, including health plans, providers and supplier organizations interested in taking on financial responsibility for all FFS patients in an entire geographic region.
    1. Open to any HIPAA covered entity interested in taking on regional risk
    2. Choice between Total Capitation or Partial Capitation
    3. New flexibilities (e.g. program integrity)
    4. 100% shared savings/ losses (regional basis)

Latest updates on Direct Contracting

CMS has announced that it will not be soliciting any more applications for the Global and Professional Direct Contracting Models slated to launch on January 1, 2022. Organizations that had already applied to the model—either for the Implementation Period or Performance Year (PY) 2021—and had deferred their start date to January 1, 2022, will still be able to participate as expected at the start of next year.

CMS also announced that it has selected 53 organizations to take part in PY 2021 for the two directing contracting options. Of the organizations, 39 are participating in the global risk sharing option and 14 have selected the professional risk shared options.

What type of organizations are best suited for Direct Contracting?

The Medicare Direct Contracting program is a significant opportunity for existing NextGen ACOs, Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs), organizations with experience serving Medicare fee-for-service beneficiaries, and organizations with less experience with Medicare FFS aiming to increase their market share.

By providing a potentially stable revenue stream for provider organizations and prioritizing beneficiary choice, the payment model options work to:

- **Transform** risk-sharing arrangements in Medicare FFS by offering both capitated and partially capitated population-based payments that divert from traditional FFS through predictable, prospective spending targets and cost that acknowledges the challenges of caring for patients with complex chronic conditions
- **Empower** beneficiary engagement in care delivery through benefit enhancements, voluntary alignment, and member engagement incentives
- **Reduce** provider burden to meet healthcare needs effectively through a set of core quality measures and opportunities for organizations new to Medicare FFS to participate

The provider organizations can select the type of Direct Contracting Entity (DCE) they wish to join based on their experience in managing Medicare FFS populations, existing Medicare FFS beneficiary population, and the level of risk they are willing to assume.

The Direct Contracting Entity—an organization similar to an ACO—consists of healthcare providers and suppliers. DCEs are expected to increase beneficiaries' access to cutting-edge, affordable care, beneficiary engagement initiatives while maintaining all the Medicare benefits.

A DCE is a legal entity that participates in Direct Contracting under a participation agreement with CMS. Therefore, DCEs should ensure that they meet all state licensure and insurance requirements necessary to make downstream payments to their providers since they will be receiving capitated payments from CMS.

There are three types of DCEs with different characteristics and operational parameters:

1. **Standard DCEs:** These organizations generally have experience serving Medicare FFS beneficiaries, including Medicare-only and dually eligible beneficiaries, who are aligned to a DCE through voluntary alignment or claims-based alignment. Such organizations may have previously participated in section 1115A models involving shared savings or the Shared Savings Program. New organizations, comprised of existing Medicare FFS providers and suppliers, may also be created to operate as this DCE type.
2. **New entrant DCEs:** These organizations have not previously provided services to a Medicare FFS population. They depend on voluntary alignment, at least in the first few performance years of the model. No more than half of participating providers may have prior experience in CMS shared savings models
3. **High needs population DCEs:** These DCEs are tailored to Medicare FFS beneficiaries with complex needs, including dually eligible beneficiaries aligned to the DCE through voluntary alignment or claims-based alignment. These DCEs are expected to use a care model similar to the one employed by the Program of All-Inclusive Care for the Elderly (PACE) to coordinate care for aligned beneficiaries.

How does CMS align beneficiaries to Direct Contracting Entities?

1. **Voluntary alignment:** Medicare beneficiaries are aligned to a DCE by electing a participating provider affiliated with the DCE as a primary clinician. Here, DCEs are permitted to proactively reach out to beneficiaries.
2. **Claims-based alignment:** Building upon NextGen, CMS aligns beneficiaries based on where they receive the majority of their primary care services according to claims utilization data. CMS will use a two-year "alignment period" that includes two consecutive 12-month periods, with the second period ending six months prior to the start of the relevant performance year.

Benefit enhancements and member engagement incentives

CMS emphasizes high-value services and believes in the potential of DCEs to manage the care of beneficiaries through benefit enhancements and member engagement incentives. The payment model options offer a suite of tools to enhance member engagement and affordability and improve the quality of care, including:

Post-discharge home visits rule

Care management home visits

Telehealth expansion

Three-Day Skilled Nursing Facility (SNF) rule waiver

Cost-sharing support for Medicare Part B services

Chronic disease management reward program

CMS also proposes to implement three new benefit enhancements to improve care coordination and service delivery:

Home health services certified by nurse practitioners

This option will enable nurse practitioners to certify beneficiaries for home health services, improving care coordination and transitions of care.

Home health homebound requirement

This rule would permit reimbursement of Medicare services to receive care at home (for beneficiaries with certain clinical risk factors who are not homebound). This rule is anticipated to reduce hospital readmissions, improve patient outcomes, and reduce costs for the beneficiaries. It would allow DCEs to createalternative payment options with healthcare organizations.

Concurrent care for beneficiaries that elect the Medicare hospice benefit

According to CMS, under this rule, services would be associated with a hospice enrollee's terminal and associated conditions that are well-positioned with the patient's wishes and are appropriate to provide on a transitional basis. This will simplify the transition of care, providing a tool for DCEs to improve care quality.

How will the provider organizations be paid under the payment model options?

For participants in the Professional Population-Based Payment (PBP) option, CMS will offer 50% shared savings/shared losses with CMS, as well as with primary care capitation equal to 7% of the total cost of care for enhanced primary care services.

For participants in the Global PBP option, CMS will offer the choice of Primary Care Capitation or Total Care Capitation, along with 100% shared savings and losses.

How to succeed in Medicare Direct Contracting?

Direct Contracting is a voluntary payment model and beneficiaries have the power to receive care from any Medicare provider at any time. The Direct Contracting Entities will be required to ensure care quality, control costs, and increase patient engagement to keep care within the network.

To succeed in Direct Contracting, DCEs must,

- Understand their population and their needs. Since the model is voluntary and requires claims-based alignment, beneficiary engagement should be a top priority.
- Know the strength of their network and find out the areas for improvement. The claims and voluntary alignment will be decided on the basis of how well your provider network engages and delivers quality care.
- Leverage data and analytics to enable monitoring and adjustment of the program as required. Establishing key metrics, communicating them to providers, and sharing ongoing results are crucial to succeed in Direct Contracting.
- Perform a routine identification of care gaps. Ensure beneficiaries understand their options and focus on quality, convenience, and prevention.
- Optimize provider alignment. Contract with other provider networks, including high-risk population provider groups or groups with limited Medicare fee-for-service experience and build relationships to meet the needs of their provider network and population. Direct Contracting offers new opportunities for provider compensation reform an incentive alignment.

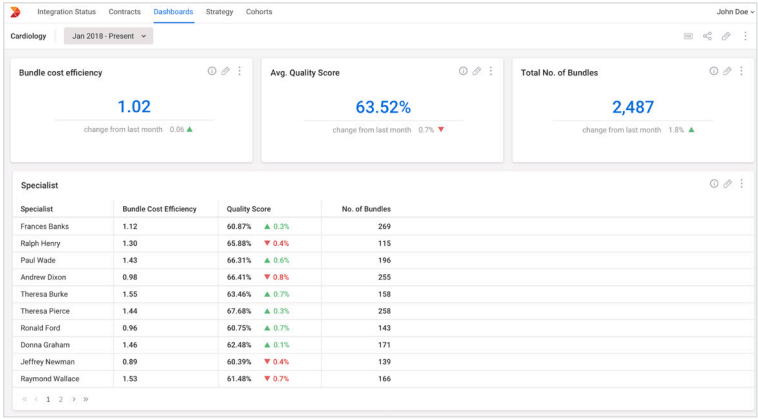
Innovaccer's approach to helping health organizations succeed with Direct Contracting Models

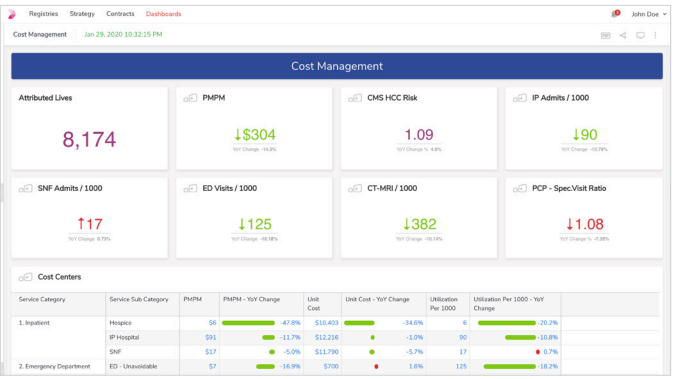
Innovaccer's suite of solutions can help participating organizations effectively manage their patients within the Direct Contracting Model by:

- Deploying technology to easily engage patients and drive voluntary alignment
- Automating care plans to ensure timely interventions that support patients' health, especially people with chronic conditions
- Providing real-time information through ADT data that will give participants advanced insights for successful prioritization and care coordination
- Creating cost-saving opportunities and measuring care program success
- Assessing if Direct Contracting is a suitable model for organizations by engaging with a consulting partner company
- Helping assess risk-readiness, choosing the correct DCE organization type, and identifying the pace of model adoption

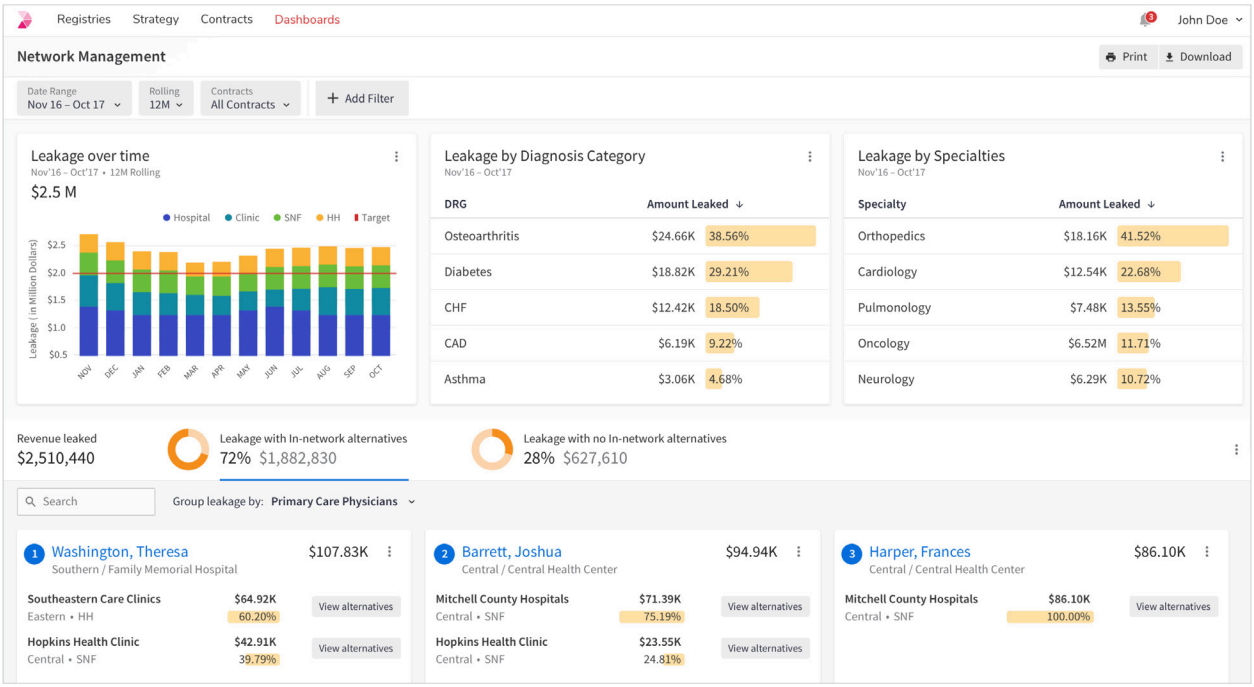
Innovaccer's platform offerings

1 **Data integration:** Powered by Innovaccer Health Cloud, Innovaccer's high-quality data integration platform creates a longitudinal patient record with information derived from various data sources including EMRs, claims, pharmacy, labs, billing, HIE, patient SDOH surveys, and more to create a unified data model.

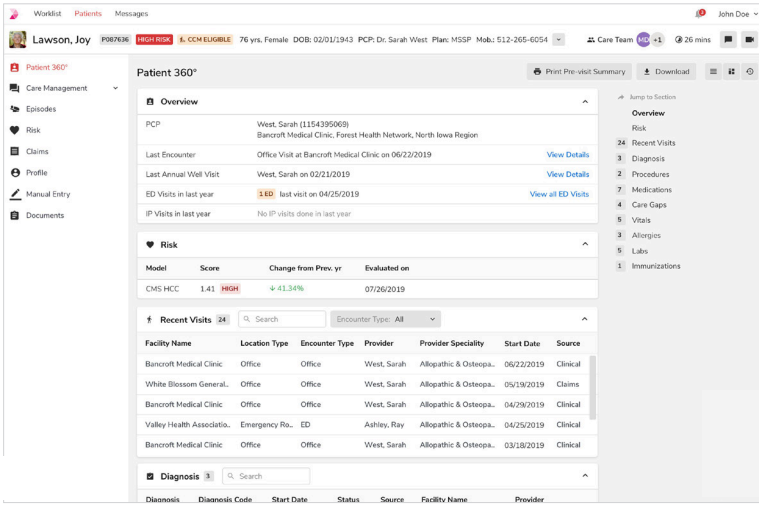


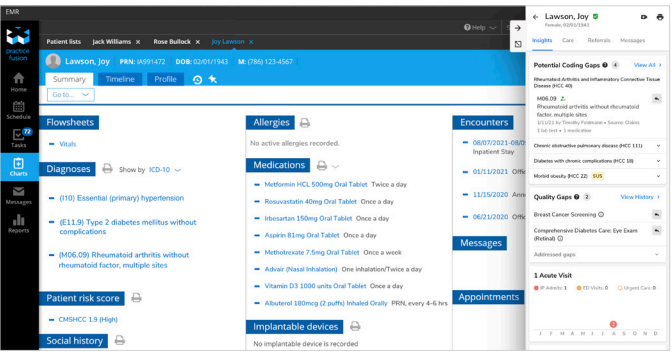


2 **Analytics:** Innovaccer's healthcare analytics solution provides healthcare organizations with a full suite of capabilities needed to transform their data into real-world intelligence and enables enhanced trend analysis and reporting. The advanced analytics support evidence-based care programs to help achieve practice goals, easily report required metrics, and highlight cost-saving opportunities.



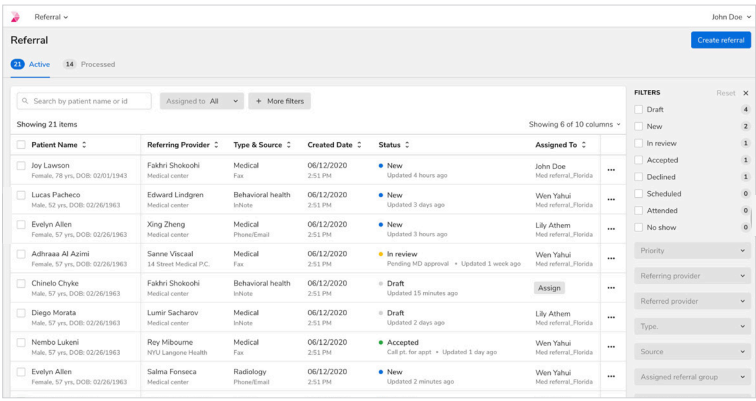
3 **Care Management:** Innovaccer's care management solution offers a 360-degree patient view, prebuilt care plans, and accurate risk stratification to ensure patient-centered care coordination. It supports better care quality for patients, reduces costs, and encourages analytics-driven care coordination to manage patient health. The solution also empowers healthcare providers to effectively manage SDOH impacting the population they serve with built-in surveys, bulk outreach management, and real-time notifications.

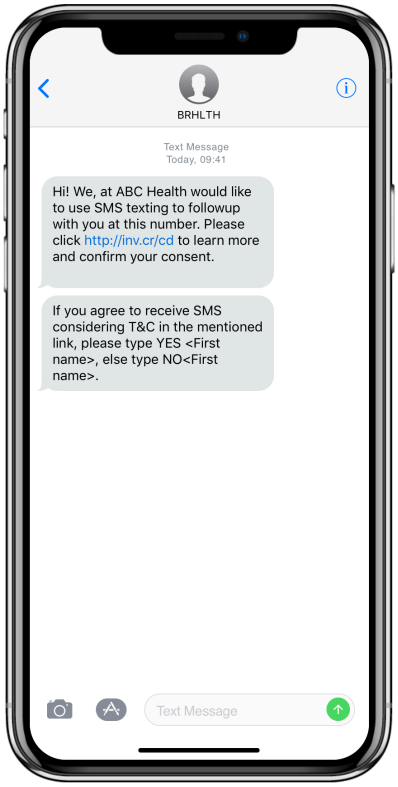




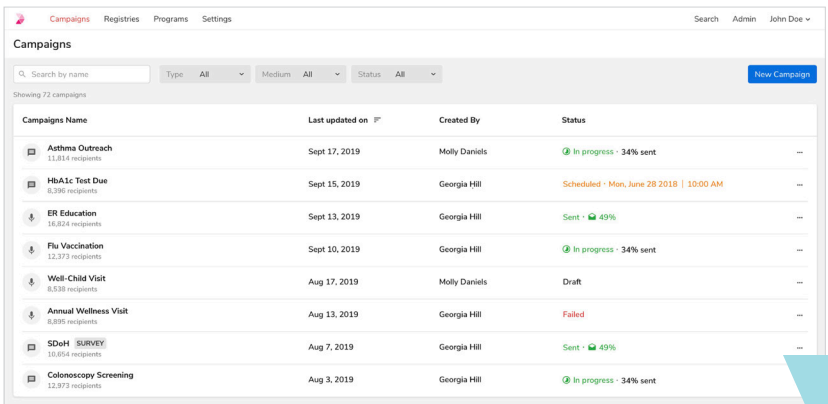
4 **Physician engagement:** Innovaccer's physician engagement solution aims to streamline data acquisition and help physicians leverage data at the point of care. It extracts relevant information from EHRs, data reports, and analytics platforms and delivers it in an actionable format to physicians—all within their EHR. It also increases revenue opportunities by accurately identifying coding gaps and care gaps.

5 **Referral Management:** The referral management solution facilitates hassle-free patient referrals and reduced network leakage with a centralized referral management team, which is crucial for success in the new Direct Contracting Model. The solution retrieves point-of-care insights about the patient and generates preferred provider lists to encourage optimal referrals.





6 **Member engagement:** Innovaccer's patient engagement solution features automated outreach and two-way communication, enabling providers to streamline their care delivery while helping patients make more informed decisions. The solution also offers targeted campaigns using psychographic information to drive voluntary alignment and patient retention.



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Daniel Roberts is a healthcare executive with more than a decade of demonstrated history fostering adoption, understanding, and success in value-based healthcare contract negotiations and operations. His experience spans filing and launching Medicare Advantage plans, leading a clinically integrated network serving as its Chief Operating Officer, and serving in advisory capacities for multiple healthcare start-up ventures. Through these opportunities, he has gained the unique vantage point of serving as the executive representation for ACOs, vendors, and payors during contract negotiations and operations. This is the lens he brings to Innovaccer as the National Director of Value Engineering. He and his team partner with Innovaccer's diverse customer base to ensure each tool is leveraged to each customer's unique strategy. Daniel has served on America's Physician Group's Risk Evolution Task Force and Contracting Committees, as a steering committee member of the Next Generation ACO Coalition, and a subject matter expert for the Accountable Care Learning Collaborative Committee for Data Aggregation.

Innovaccer Inc. is a leading San Francisco-based healthcare technology company committed to helping healthcare care as one. The Innovaccer Health Cloud unifies patient data across systems and settings and empowers healthcare organizations to rapidly develop scalable, modern applications that improve clinical, operational and financial outcomes. Innovaccer's solutions have been deployed across more than 1,000 care settings in the U.S., enabling more than 37,000 providers to transform care delivery and work collaboratively with payers and life sciences companies. Innovaccer has helped organizations integrate medical records for more than 24 million people and generate more than $600 million in savings. Innovaccer is recognized as a Best in KLAS vendor for 2021 in population health management and a No. 1 customer-rated vendor by Black Book.

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