The Centers for Medicare & Medicaid Services (CMS) Innovation Center recently announced that it will begin the first performance year of the Direct Contracting model for the Professional and Global options on April 1, 2021. The new start date reflects a three-month delay to account for coronavirus (COVID-19). The Direct Contracting model is a new voluntary value-based payment model that encourages participating entities to take higher levels of risk, in return for greater potential reward, for their traditional Medicare patients. The model requires participation in some level of capitation and affords participating entities additional regulatory flexibility. This model also includes an opportunity for organizations that have few, or no, Medicare fee-for-service (FFS) patients to participate and provides them additional time to align FFS beneficiaries through what CMS is calling an implementation period (IP). The IP gives participants additional tools and flexibilities to align FFS patients to their Direct Contracting Entity.

In response to the COVID-19 pandemic, CMS made several other changes to the Direct Contracting timeline that should facilitate greater participation in this
Entities that applied by February 25, 2020, may participate in the IP that will begin October 1, 2020.

The Innovation Center is accepting applications for the first performance year from June 4, 2020 through July 6, 2020. The application portal is available [here](#).

The Innovation Center announced a second cohort of Direct Contracting participation that will begin January 1, 2022. We expect CMS will start accepting applications for this cohort in spring 2021.

The adjusted timeline affords stakeholders additional time to assess the Direct Contracting model and to make participation decisions, as well as to share feedback with CMS and the Innovation Center about the model design. By moving ahead with the model in 2021, the Administration retains momentum for the movement to value-based care and capitation. The COVID-19 pandemic has exposed the flaws and economic risks inherent in the FFS system for many provider organizations as volume fell and provider organizations faced serious financial shortfalls. Models like Direct Contracting, which include capitated payment of some amount of funding, may become more attractive as organizations evaluate the lessons learned from COVID-19 and prepare for the future of healthcare delivery and reimbursement.

Below, we outline key considerations for entities considering participation in this model.

1. Direct Contracting Entity (DCE) organizational structure and capitated payment mechanisms.

   **Model Design:** Under the model, two capitated payment mechanisms are available for participants: primary care capitation and total care capitation. DC Participant Providers will submit claims to CMS for services provided to aligned beneficiaries. CMS will reduce the claims payment amounts to $0 for certain services and instead make the capitated payment for those services to the DCE.

   **Issue:** The significance of the cash flow mechanisms in the DC model will vary depending on the DCE’s organizational structure. For some organizations, for example, those with salaried physicians, the cash flow mechanism may be easier to adopt than for others, such as independent practice associations. However, the specifics of this analysis depend on the nature of the provider relationships and structure of the DCE. In addition, some DCE applicants may need to consider creating new legal structures in order to comply with the model’s requirements, including those related to governance structure of the DCE.

2. Financial exposure for DCEs far outpaces financial exposure in predecessor Innovation Center models, but new financial model may have advantages for certain participants.

   **Model Design:** The Direct Contracting model includes numerous discounts and withholds generally applied against the performance year benchmark: a 2-5% discount for global model participants; a 2% withhold for early contract termination;
the total care capitation withhold (to account for leakage); and a quality withhold. CMS also places a ceiling and floor on the effect of regional expenditures on the benchmark and includes risk corridors. The total impact of these discounts and withholds represents significant risk exposure for DCEs. However, other features of the financial model may weigh in favor of participation in this model, depending on the DCE’s specific characteristics.

**Issue:** Participants should evaluate the level of risk and opportunity for their population in Direct Contracting and compare it against other CMS advanced alternative payment models. Note that there will be no new cohort of Medicare Shared Savings Program accountable care organizations in 2021, so organizations looking to get into an alternative payment model for 2021 may want to take a closer look at Direct Contracting.

3. Critical payment details are still missing.

**Model Design:** CMS indicates that it will use an adjusted Medicare Advantage ratebook to calculate payment in this model and will also apply a risk adjustment methodology that differs from the methodology used in previous demonstrations – however, neither of these components have been specified at this time.

**Issue:** These payment elements are expected to have a significant effect on payment rates in the model. CMS anticipates releasing these elements this summer.

4. State regulation of risk bearing entities.

**Model Design:** The Direct Contracting model requires that a DCE demonstrate compliance with all applicable state licensure requirements regarding risk-bearing entities, unless the DCE provides CMS with an attestation that the DCE is exempt from such state laws.

**Issue:** Most states have not opined on the need for licensure for Innovation Center models. Because this is the first time that CMS will be providing capitated payments in traditional Medicare, states could view this model differently than prior Innovation Center models. The licensure requirements are unique to each state and are potentially burdensome for DCEs.

5. New approach to voluntary alignment may have promise.

**Model Design:** Similar to certain Medicare ACO models, Direct Contracting continues testing voluntary alignment in traditional Medicare, encouraging beneficiaries to take a more active role in choosing their provider relationships. CMS is giving DCEs additional tools, called patient engagement incentives, to engage beneficiaries. These tools, such as dental vouchers, wellness memberships, and phone apps, largely align to supplemental benefits currently available in Medicare Advantage.

**Issue:** Voluntary alignment has proven difficult in previous models, but the new tools may give some organizations additional levers to pull to encourage beneficiary engagement. An important missing piece that we expect in the Participation Agreement will be the parameters around how aggressively a DCE can market to a
patient and what, if any, limits are placed on supplemental benefit offerings.

**Conclusion**

Direct Contracting may offer an opportunity for entities to participate in a risk model that better aligns with their other payer value-based care arrangements, especially if they are currently taking capitation or two-sided risk from a Medicare Advantage plan. However, many details of the model remain undefined and could have significant financial implications. CMS is expected to release additional model details in the coming months.

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