Medicare Direct Contracting and the Impact of COVID-19 on Value-Based Payment Strategy

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The Chinese saying, "Crisis equals opportunity," may seem callous with relation to the COVID-19 pandemic; however, it is definitely apt. By most indications, the next several quarters, if not years, will be daunting for senior leaders, boards, and the health systems and hospitals they run, while at the same time creating new opportunities for those nimble enough to move quickly. There will be unique opportunities amid the challenges for boards to assess and provide counsel to management but also to take on longer-term strategic planning work.

There has been much written recently on the havoc COVID-19 treatment and prevention efforts have inflicted on physicians and hospitals. Both are rethinking their partners and payment models in order to minimize the financial impact of the massive reductions in office visits and elective services. Amidst this increasingly complex and strategic reimbursement environment, the reimbursement landscape post-COVID-19 will continue the trend toward health systems and physicians assuming greater financial risk.

Therefore, one of the most pivotal strategic decisions is the assessment of opportunities to adopt and implement a value-based payment (VBP) (or premium risk-based) reimbursement strategy as a core design element. An increasing number of providers, particularly physician groups, have embraced VBP with downside risk and its focus on accountability for cost and quality. VBP models can incentivize hospitals and healthcare providers to work in a more coordinated manner, focusing on delivering high-quality care while avoiding unnecessary utilization and costs. There are opportunities to partner closely with payers to develop benefit plans and VBP agreements that can grow market share, access to premium dollars, and accountability for actively managing an attributed or assigned population.

This issue is not on the top of executive leadership or board members' minds as they respond to the crisis; however, advancing value-based care has been a priority for Congress, multiple administrations, and large self-insured employers for some time. Given crushing fiscal constraints, it is likely that the pressure to engage will only increase.

One VBP model that became available for participation during 2020 is the Centers for Medicare and Medicaid Services (CMS) Medicare Direct Contracting Model ("Direct Contracting"), which encourages health providers to assume increased financial risk for greater reimbursement returns.[1]

Medicare Direct Contracting envisions allowing providers and risk-bearing entities such as independent physician associations to "directly contract" with CMS and receive monthly capitated payments for the care of their patients. It 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.

Regrettably, CMS maintained the close date of May 1, 2020, for applying to participate in Direct Contracting for the 2021 performance year. This was an unfortunate decision that compelled potential applicants to design a risk-based direct contracting program in the middle of a crisis. Failure to have submitted an application during the allowed timeframe resulted in many organizations now ineligible to complete an application and plan. As well, to further muddy the strategic waters, it is unclear whether there will be additional application windows for future performance years through 2025 when the program is currently slated to end.

Despite this uncertainty, CMS is the "lead dog" in fostering reimbursement and contracting relationships, whether with health plans or providers. Collectively, Medicare patients offer the largest opportunity to reduce healthcare spending for the federal government. It is unquestionable that the devastating financial landscape post-COVID will create far greater pressures to flatten healthcare costs and therefore a continued focus on VBP.

Key Board Takeaways

- Post-COVID providers are seeing the unique opportunities to achieve consistent financial sustainability through value-based payment arrangements; Medicare Direct Contracting, if not a good fit or if your organization missed the letter of intent, provides an excellent roadmap in its application for what is required for success in value-based contracting.
- Additional value-based payment options include the MSSP ACO model through CMS, Medicaid managed care, commercial health plans, and direct-to-employer relationships.
- It is imperative that physicians, hospitals, and health systems build competencies to succeed with value-based contracting, foster alliances between providers, and engage with patients as affiliated "members" in order to create more stable sources of revenue.
- New rules, regulations, funding, and waivers that have resulted from COVID-19 will allow hospitals and health systems to jump-start the development or expansion of high-performing physician and other provider networks that will be foundational for success in VBP contracts.

1 For more information, see CMS, "Direct Contracting Model Options" (available at https://innovation.cms.gov/innovation-models/direct-contracting-model-options).

Direct Contracting does not replace the Medicare Shared Savings Program (MSSP), which is also a VBP opportunity for Medicare beneficiaries who have not selected to participate in Medicare Advantage. For those who may have missed the Direct Contracting application window, the notice of intent to apply for the Medicare Shared Savings Program (MSSP) was due May 8 and the final application for 2021 opened on May 14 and closes on June 11. Once again, failure to submit a letter of intent during the allowed timeframe will result in the organization being ineligible to apply during the application period.

It is important to keep in mind that, in addition to the VBP opportunities for Medicare represented by Direct Contracting and MSSP, enrollment in Medicare Advantage is steadily increasing across the country. Thus, any VBP strategy needs to include engagement with Medicare Advantage health plans to develop VBP agreements for their populations.

Many systems that have not had experience with Medicare Advantage VBP agreements now have an opportunity, even if not participating, to learn from and leverage the Medicare Direct Contracting application and contracting model as a starting point for understanding how these agreements with health plans should be structured. Planning for the launch of a Medicare Advantage plan network and contracts must begin now for 2022.

In addition to VBP opportunities with Medicare, many hospitals and health systems are developing VBP models through direct-to-employer relationships and with Medicaid managed care and commercial health plans.

Key Questions for the Board around Risk-Based Reimbursement

The following questions help frame longer-term strategic planning around risk-based reimbursement such as CMS Direct Contracting participation. These questions can guide board members in striking a respectful balance between the next unknown months and the future.

Has the board and management team established key indicators for continuously monitoring operational and financial impacts, as well as the effectiveness of efforts to mitigate risk?

The first order of business must be to monitor business stability. This includes evaluation of potentially devastating short-term financial impacts from many areas, including reduction or elimination of elective services and non-COVID admissions. It is essential to future planning to have a sense of where the bottom is. The board must receive information that identifies the sources of disruptions caused by COVID-19 that are most likely to affect the short- and longer-term finances and operations. There are second- and third-order effects in the broader community that could influence these areas, as well.

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Pulling back from crisis, what has been our organization's larger strategy?

Over the last few years, the ongoing trend all hospitals and health systems were identifying was the flattening or marked decline of hospital admissions. As healthcare has shifted from inpatient to ambulatory and home health sites of care, reductions in per capita admissions now affect entire market areas. While there is a small offset by an aging population in some areas, the trend for admissions per 1,000 overall continues to push downward.

Longer term, the market and financial realities portend grim additional trials. Healthcare boards must plan on continued lower overall inpatient and even ambulatory volume as patients

are wary of hospitals and other potentially unsafe environments.

Further, particularly in states that failed to expand Medicaid under the Affordable Care Act (ACA) in good financial times, providers will be caring for many patients who have lost coverage through unemployment or can no longer afford their premiums. Entire communities surrounding hospitals, particularly in safety net communities, will have raw socioeconomic needs that will foster population health risks in the community.

Additionally, prior to COVID-19, the telehealth market had not just struggled to penetrate; it had struggled to exist because of privacy and security restrictions, broadband capabilities, and arcane reimbursement rules and rates. A 2019 study found that 66 percent of patients had never used a virtual platform for health services and 63 percent of patients did not understand their telemedicine insurance coverage.[2] As of 2017, only 30 percent of physicians reported telemedicine usage.

Health systems must develop robust capabilities in delivering services through telehealth and engage physician networks to ensure they have the tools and training necessary. Telehealth may over time reduce in-office and outpatient visits but can also expand the reach of the physical plant of the hospital and its ambulatory network. Remote consultations can improve access to timely care and patient compliance, while helping to reduce costs and thereby improve performance on value-based payment contracts.

In response to COVID-19, in March 2020, CMS issued a sweeping array of new rules and waivers of federal requirements to expand care capacity as hospitals and health systems act as coordinators of healthcare delivery in their areas.[3] CMS expanded access to telehealth services for people with Medicare through changes in what devices may be used, remote monitoring, and increased reimbursement. After crisis conditions ease, most experts believe that CMS cannot retreat on this relaxation of some privacy restrictions in the name of greater access, as well as its increased reimbursement for telehealth visits.

What are the questions to ask of management to assess and weigh in on new opportunities in a value-based payment strategy?

Obviously, the short-term daily crises weigh heavily on management and all staff members, and the board must respect the need not to divert important resources to producing informational presentations. However, it continues to be essential for board members to monitor the following issues:

- Where do we stand with regard to projected declining inpatient and, at least temporarily, ambulatory volumes and revenue?
- What is our plan to differentiate ourselves relative to our competitors in the eyes of payers and patients?
- Where are we on the transition continuum from fee-for-service to VBP models?
- What is the anticipated pace of change?
- What strategies do we have to protect and increase patient volume and revenues as the shift occurs?

How should we assess and prepare for success in risk-based or value-based reimbursement strategies? What is the "COVID impact," including regulatory relief, on related options and strategies?

Pre-existing and now further COVID-19 impacted squeezes on reimbursement require a forward-thinking strategy. This strategy must acknowledge that the organization is already "taking risk" when it serves patients that come in the door uninsured, underinsured, or with a highly constrained payment, such as Medicaid or even Medicare. With high revenue-generating hospitalizations trending down now for years and with the COVID-19 pandemic creating unparalleled shifts in ambulatory care, telemedicine, remote care, and monitoring at home, as well as historic rates of attrition of commercially insured patients, hospitals and health systems will need to adapt.

Optum-owned medical groups, entrepreneurial medical groups, telehealth medical groups, ambulatory surgery centers, and home care models have already been a game-changer for hospitals and health systems pre-COVID-19. For better or worse, they will be coming out of this crisis firing on all cylinders.

2 Lisa Hedges, "Should You Offer Telemedicine Services? Patients Weigh In," Software Advice, August 5, 2019 (available at www.softwareadvice.com/resources/should-you-offer-telemedicine-services).

3 CMS, Center for Consumer Information and Insurance Oversight, "FAQs on Availability and Usage of Telehealth Services through Private Health Insurance Coverage in Response to Coronavirus Disease 2019 (COVID-19)," March 24, 2020 (available at www.cms.gov/files/document/faqs-telehealth-Covid-19.pdf).

Every board must make critical decisions as to the role its hospital or hospitals will play in their communities. Is it a "must have" provider, virtually guaranteeing network inclusion and some flexibility to command premium rates? That is increasingly wishful thinking as lucrative commercial markets rapidly compress in the face of record unemployment.

The status of most hospitals, particularly those without large and well-aligned physician networks, will be less lofty. They will fall into a category of "important" in their communities as medical safety nets, employers, and potentially centers of population health, but not irreplaceable network "assets" for contracting payers. It is imperative that physicians, hospitals, and health systems build competencies in risk-based contracts, foster alliances between providers, and engage with patients as affiliated "members" in order to create more stable sources of revenue. This means that board members must be proactive in raising the value that the hospital or system can bring to the bargaining table. In turn, proactive and aggressive engagement with community physicians and other key providers will be required.

The ability to develop a high-performing network and to assume financial risk for discrete populations can be a game-changer. COVID-19 has not only produced a significant impact on hospitalizations and other health system utilization; it has also presented unique opportunities for hospitals and health systems to jump-start the development or expansion of high-performing physician and other provider networks that will be foundational for success in VBP contracts. Regulatory relief, including blanket waivers of Stark and antitrust rules, actually encourage the type of physician, hospital, federally qualified health center, and other provider engagement and investment required to develop a high-performing clinically integrated network. This is also an opportunity to access funding and build high-value, integrated telehealth and remote home-based monitoring and care management models.

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Is it likely that CMS will continue its push to move financial risk to providers?

CMS has given clear indications that it expects healthcare providers to assume greater financial risk in the delivery of its services. CMS in the Trump administration continued the emphasis of the prior administration in introducing risk to providers through the various Medicare VBP programs mentioned above. There is notable uncertainty on how the pandemic will affect these programs, such as changes to acuity or risk scores and diminished opportunities to meet quality requirements related to preventive care, and which patients the ACO will be accountable for this year.

What is the background of CMS Medicare Direct Contracting?

Direct Contracting evolves elements of legacy shared-savings programs and inherits some best practices from industry payers. The Direct Contracting's capitation options clearly build on experience in markets with long histories of capitation and global risk such as California, Massachusetts, downstate New York, and Florida. It also builds on lessons learned from the NextGen ACO program, which is currently the highest risk-sharing (upside/downside) program available from CMS. These two programs potentially coordinate well with the fact that better attention to care integration for seniors, and particularly for those eligible for both Medicare and Medicaid, can generate significant savings.

Who can participate?

Participants are called Direct Contracting Entities (DCEs). A DCE can differentiate based on length of experience in serving Medicare fee-for-service members, a focus on high-needs beneficiaries, and/or experience in taking financial risk.

A DCE must have a legal entity that contracts with Direct Contracting Medicare-enrolled Participant Providers. State rules will vary; the entity must demonstrate compliance with all applicable state licensure requirements regarding risk-bearing entities. The role of a board member is to validate that applicable state and federal laws are met in the process.

How might Medicare Direct Contracting fit in with our larger strategy towards taking on financial risk with payers?

Consideration of the move to take risk, perhaps contracting for Medicare patients, is in many ways a "lesser of

two evils" analysis of which strategies offer the best chance of longer-term financial survival. There is increasing likelihood federal and state policymakers will look to providers to assume greater financial risk to reduce healthcare costs; it is further likely that other payers will follow suit. The decision to delay building infrastructure capacity to assume financial risk will increase the likelihood that health systems will need to cobble together component system pieces under extreme pressures downstream. If successful, Direct Contracting can help health systems build competencies in risk-based contracting, generate stronger alliances between providers, build affiliation with patients, and create a new source of revenues.

What are critical success factors?

Medicare Direct Contracting requires adequate capital and reserves, a thorough contracted provider network, and capabilities to manage risk (patient engagement, population health analytics, care management, provider relations, capitation management, etc.). An assessment of the organization's ability to take on and manage risk requires an understanding of the strength of the provider network, the gaps in the capabilities of the network, and the financial modeling of likely costs and revenue projections. The financial model is essential; it will reveal operational and financial strengths and weaknesses of the proposed new contracting model. The complexity and the high stakes of this program make it that much more important for precise information to drive decision making. Further, health systems looking to take on financial risk must ensure that they meet all licensing and reporting requirements imposed by the state or states in which the activities will be conducted.

How should the board monitor progress in Direct Contracting and measure successes?

In the post-COVID-19 environment, characterized by unprecedented challenges, risks, and uncertainty, hospitals and health system CEOs face daily fire drills, new challenges, and more complex responsibilities. However, continuous feedback is critical to effective board and CEO alignment related to strategy, performance, results, and the need for continuous improvement.

Boards must add goals related to population health and value-based care to their strategic and financial plans. It is important to keep in mind that different payers will have different metrics and methodologies for determining shared savings and quality bonus earnings thresholds. Boards must partner with their executive team to reconcile these varying metrics—to define a set of VBP metrics that are consistently applicable across numerous payers and VBP arrangements. Increasingly, the focus will be on total cost of care (utilization and pricing), patient satisfaction, and clinical outcomes. The selected strategic VBP metrics should be reported on regularly that "tell the story" as to the key critical aspects of successful Direct Contracting or other VBP program participation.

The reality is that board discussions about population health and value-based care can be difficult not only because of the need for background knowledge, but also because of a central concern: profit. As the industry erodes fee-for-service reimbursement, it means that hospitals beginning the shift to value-based care today will see a further and frightening dip in revenue. Boards need to understand this, because if the board does not appreciate the goals and mileposts, and inevitable financial hits, they are not going to be able to support the strategy long-term.

Conclusion

Amid all of the pressures of the current crisis, board members must not lose sight of their longer-term strategic oversight responsibilities. Boards, together with senior leadership, must traverse the delicate balancing act of thinking both long term and short term. Returning to the original premise that "Crisis can equal opportunity," crises can offer rare opportunities for innovation to not only defend the core business, but also to plan for a vibrant future post-COVID-19. Among the options are strategies to assume financial risk for discrete populations, such as Medicare members. Participation in the Medicare Direct Contracting program should be evaluated within a larger construct of moving to risk- or value-based reimbursement.

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