DCE 2021 video

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SPEAKERS

Wendy Rubas, Intro Music, Lucy Sola

I **Intro Music** 00:02
Welcome to Working Smarter, concise compliance conversations featuring Wendy Rubas. Sponsored by VillageMD primary care physicians practice medicine, the way you always wanted. Data, resources, and clinical decision support to care for your patients inside and outside the exam room.

W **Wendy Rubas** 00:23
Hi, welcome to Working Smarter. I'm Wendy Rubas. General Counsel of VillageMD and back by popular demand is one of my favorite people. Lucy Sola, who's the manager of ACO operations to give us an update on Direct Contract entities. Lucy How are you?

L **Lucy Sola** 00:39
Doing well, how are you Wendy?

W **Wendy Rubas** 00:41
Doing well? How is it like what the paparazzi and everything now that your star of the most popular working smarter episode has it changed your life?

L Lucy Sola 00:50

It's changed my life entirely. I can I can go anywhere without being stopped. Everyone just bows down asks for my autograph. It's insane. They stalk my dog, they need to know what he's up to report it out. So yeah, it's it's a full thing.

W Wendy Rubas 01:04

Well, I'm so glad to have you back. Because, you know, direct contract entities are complicated and confusing. And people are very curious about them. And I find it's very hard to get good information. It's either way too much or too high level. So. So just as a quick refresher, Lucy, let's just zoom out a minute and just say, how did we get here, in terms of what is the DCE program, and I think most people know that when a person becomes of age, to qualify for Medicare, they make an election, and they choose Medicare Advantage, or they choose fee for service. And fee for service is just how it sounds. Once a patient is in that pathway. They don't elect further, they don't elect whether they're in ACO or now a DCE. When they're in Medicare Advantage, a payment is different. It's a capitated payment, it's paid to a private health insurance company who manages the cost of care based on acuity diagnosis codes of the patients. And so if it goes well, there's a there's a benefit in terms of a savings that's that's kept by that private insurance company. And once a patient is in that, then they have another election to make PPO, HMO, or other. The bottom line is it's very confusing for patients many times they really don't know what they're in. But the payment is very different for the to adding to the confusion, though, is if we go and look at we've got a picture here of the difference. Although these two programs Medicare Advantage and DCE, come out of different payment like DCE he comes from fee for service. Medicare Advantage, you know, is a totally different program. They're starting to blend back because this is both. In both cases, there's a capitated payment, and a benefit for reduction in cost. And so some ways these two options are converging in a sense in different ways. Is that how you see it, Lucy?

L Lucy Sola 03:06

That is I think they really what they were trying to do. And I don't know, I wasn't the policymaker, but I assume that they saw the success that they were seeing in Medicare Advantage, and wanted to model it in a way that felt right for Medicare fee for service. So I think that they took a lot of the model, a lot of the regulations and operational methods from Medicare Advantage and modeled a lot of it in direct contracting. And then I think that the biggest difference for me between the two is I think that indirect contracting, it's going directly to a physician or physician group. And it's less, it's not guaranteed that it would be a private insurance company that is in the in between the care and the doctor in the same way it is a Medicare Advantage. And I think that's a big deal. I think it's a signal

that they think that the future is with primary care, and making sure that providers are involved in the care of their patients, and payment of health care costs. So yeah, I think that's how I've touched on it takes out the middleman.

W Wendy Rubas 04:11
All that causes an expense, but it also puts more risk potentially, and more reward on the doctor.

L Lucy Sola 04:18
Yep.

W Wendy Rubas 04:19
Now take a look at how Medicare Advantage is kind of like you go off on the fork in the road Medicare Advantage is on the left fee for services on the right. But in another sense, I think that there are some comparisons to Medicare Advantage and fee for service. That kind of help explain. So we've got this picture where the dotted lines show payment in Medicare Advantage. A private insurance company steps in and administers payment. And that insurance company deals with Medicare. So the payment goes from Medicare to through to the blue, the insurance company through to the physician, direct contracting is similar in some ways, because you're going to create a plan, you're going to create a lot of the synergies that were achieved in Medicare Advantage in a way that the ACA is really could not. But it takes that private carrier out of the middle. And so just for people listening, that's really why it's direct contracting. Hopefully that explains it. Although I understand we're going to talk about a name change. Yeah. And I think the key also is who has the risk. so in this situation in Medicare Advantage, it's going to automatically be a denture that keeps a lot of the risk, like should performance go in a strange way, but in direct, affecting, that they're really trying to get physicians into more risk based contracting. I mean, it just takes out a lot of the cost, and profit and so on of that middle piece. But it's a great point, you're making an exchange, the risk is more direct. Now, privilege, that's a good thing, because we want to be at risk. But it's an important distinction, for sure. So thank you. That's hopefully that's for our listeners, just reminding you what we're talking about, because there's so much jargon. And our goal always is to make our listeners smarter in meetings. So, Lucy, let's move on and get us updated. There's been so much news. So give us the headlines here as to what has evolved since since your last recording.

L Lucy Sola 06:35

Yeah. So we did start our performance here on April 1 of 2021. I think that was included in last recording. So not a huge news there. But it is a nine month performance here this year, and will and December 31 of 2021. And then we'll move into 12 month performance years moving forward. That was part of the COVID, just a COVID delay that needed to happen because of the pandemic. And then, in addition, as part of the COVID relief, we've learned that the direct contracting entities had an option to defer their start date from 2021 to 2022. And they also had the option to opt out of receiving of having to participate in capitation for the first year. So typically before COVID directs contracting entities had to choose capitation, immediately once I started the performance here, but that was delayed due to COVID. And providers not being able to take as much risk that I think you're gonna give us more detail about that in a minute, was any any other big headlines? I think the there's a couple things that ended surprisingly. So the next generation ACO model is officially ending after 2021. And they are allowing next generation ACOs to apply for direct contracting for 2022. And this is really important because no entities were able to apply for a new direct contracting entity starting in 2022. Because they closed that application window, so the only people who can start in 2022 are those that deferred and had already applied before the pandemic has started. And then any eligible next generation ACOs. In addition, I don't think we even covered that announcement of the geographic direct contracting model. But there was an announcement, close to the end of 2020, announcing geographic bases, and then they actually ended up putting that model on hold. And so that is so so complicated. But missing. I mean, that's like, in my mind, that's like true population health, like, here's your zip code, you know, so But yeah, I think that complexity with figuring that out is probably why they've put that on hold. Yes, it was a quick timeline, they wanted to start at 2022. But there isn't an announced timeline at all. So we're not sure how long it will take. But it is a complicated model. So I think it will take some time for them to get going.

W Wendy Rubas 09:12

Good. Okay, well, that gets us caught up, I think on the news. So loosely, I think the big thing that people definitely want to understand is how payment works. I know that those that are familiar with next gen acio payment may be familiar with some of this, but why don't you take us through some of the mechanics of how the payments work?

L Lucy Sola 09:33

Definitely, I think that this is definitely a hot topic. We were waiting for the financial methodology anxiously when we were waiting for it to be released. So basically, on this slide, you'll see the benchmarking process that is used and just like any other acio so the

Medicare Shared Savings Program or the next generation ACO model, they will set a benchmark of the expected expenditures for for your beneficiaries. And then they will measure your performance against that benchmark. So in order to do this, they calculate the historical baseline expenditures for the beneficiaries that are aligned to our direct contracting entity. And then they'll go ahead and trend the historical baseline expenditures forward. So that way, it's in terms of the current performance here. And then they will go ahead and blend that historical baseline expenditure with regional expenditures. And then once they blend in that regional rate, though, risk adjusted. So the one thing I want to call out here is that in the standard direct contracting entity model, and the new entrant direct contracting entity model, you are subject to a plus or minus 3% risk workup. So you cannot increase your risk score more or less than 3% from the base year. And then in addition, you are subject to a coding intensity factor. So that, and that is similar to Medicare Advantage plans. So if everyone in direct contracting increases their risk score, then you will have that will be subtracted, the whole increase for all DCEs will be subtracted from your increase or decrease. And that's what you will get netted out at the end. So this is really a way to make sure that the risk adjustment is in line with everyone else.

W Wendy Rubas 11:26

Just one comment on the regional because I think people see regional and they get used to thinking with Medicare regional often means it's a geographical cost of living adjustment. But here what it is, is it's basically saying if you're an outlier, you're going to be averaged against the way that it's going in that region. So it's kind of really a, it's kind of a truth serum, or it's like a adjustment for outliers to fall back in line is that kind of way of thinking of it. 100%.

L Lucy Sola 11:54

So yeah, basically, it was a regional adjustment, it will take into account not just how you have performed, but it will take into account how everyone else in your region is performing. So that way, if you're originally efficient, or if you're regionally inefficient, then you will get that from your benchmark, and it creates incentives to basically become more efficient. And then in addition, I one thing I wanted to call out on the first step is that the baseline period is fixed. So what they use, the years they use are 2017, 2018, and 2019. And they do not move forward as you move through the model. And this is a new feature. The Medicare Shared Savings Program always measures you against your previous performance here. So you're kind of always measured against yourself and also wet yourself in a model that is creating incentives for you to improve quality, decrease cost. So the nice thing about this is that you will be you'll have those references locked in for 2017

to 2019. So you won't be measured against yourself while you've already been participating in direct contracting. And then the final thing, the final step after they do their risk adjustment, is they apply the discount and quality withhold. So professional direct contracting entities do not have a discount taken off their benchmark global DCEs, or GPDCs do have a discount applied. And that is outlined on the slide. And then in addition, there is a quality withhold of 5% for all direct contracting entities, and you earn it back based on your quality performance.

W Wendy Rubas 13:34
Well, that's obviously very simple and easy to understand all of that, Lucy.

L Lucy Sola 13:39
Straightforward.

W Wendy Rubas 13:40
Yeah, so thanks for taking us through that. I mean, obviously, as we've said many times on the podcast payment or healthcare is complicated. So thanks for taking us through that one thing that you told us about before that I think we should just revisit is the different options professional and global, can you just give us a little bit of an overview of that?

L Lucy Sola 13:59
Yep. So in the professional model, you are taking risk on 50% of your shared savings and losses. So as I outlined on the previous slide, that is that is the calculation that they will use to get to your benchmark, and then your benchmark is what you're going to be measured against during your performance here. So, basically, in the professional option, you are if you generate savings compared to your benchmark, then you are splitting those savings 50%, both you will keep and then 50% will go to Medicare. And if you generate losses, so you spend above your benchmark on average, then you will have to pay back those losses to CMS. In the global in the global model, it is 100% shared savings and losses. So if you generate savings, then you get to keep it all and then if you generate losses, then you're responsible for paying all of that back to CMS. In addition, I think that this is something that we should think about. It is aligned with the model features. But I think that it's good to think about it almost separately, there are capitated payments. And that's a new feature as we moved from next generation ACOs to direct contracting. And in the professional model, you either have the opportunity to take primary care capitation. So that would be capitation. That's only paid on primary care claims. And then you are also

able to elect into advance payments, which is being able to advance all of your money if you wanted to, and then that will get reconciled at the end of the year. And if you were overpaid, then you will that will be recouped by CMS. And if you were underpaid, then CMS will pay additional and the global model it is you can take primary care capitation. Or you can take total care capitation. So if you're in primary care capitation, it's just like the professional model where you are just taking capitated payments on primary care services. But if you're in total care, capitation, then you are taking capitation across all services, regardless of visit type associated with any of the providers on your roster. And the reason why you would elect into primary care capitation maybe versus total care capitation or advanced payments, is really just dependent on what the direct contracting strategy is. And if they're only working with primary care physicians, maybe primary care capitation is the right option. But if they're working with specialists and have a large network that they're working with, then they can adjust payment arrangements. And by and in order to do so they would need to take capitation from CMS. In addition, there are three model types that you can participate in. So you can either do a standard, new entrant, or high needs. The standard model is a standard ACO model. So the ACO or the direct contracting participants have had experience in an ACO previously or other risk based contracts with Medicare and a new entrant model, it would be for folks who are new to the Medicare fee for service space and wanting to be also be new and ACOs. So they could elect into the new entrant model, because that would allow them some time to build up their alignment. So that way they can meet their alignment thresholds that the model requires. And then if you're behind me and start contracting entity, then that entity is really focused on the highest risk beneficiaries and being able to provide really comprehensive care to beneficiaries who have multiple chronic conditions and very high risk scores.

W Wendy Rubas 17:41

So another change Lucy that's come about is there's a refinement to the options for capitation. So whether you're global or or just professional, you can make an option at the beginning here. So whether you're global or professional, you can change the capitation payments that apply to primary care services. Is that the way of thinking about it?

L Lucy Sola 18:07

Yes. So if you are in the professional track, you can you are only eligible to take primary care capitation. And that would only be a capitated amounts on primary care designated services that CMS has decided our primary care services, you do have the ability to take above the primary care cap and advance payment. But the advanced payments do get recouped at the end of the year if you spend less on them, or they will be adjusted if you

spend more on them. The difference between that and total care capitation is that if you choose total care capitation it is not going to be readjusted based off of how your performance goes. You are at risk for all of the capitated amount, and then less than you keep it if you spend more than you lose it. And total care competition is only available for global.

W Wendy Rubas 19:04
Good. Okay, so moving on, then we just did a podcast that was very popular. Lucy, I hope you don't lose your throne thrown the most popular podcast guest ever. But you might.

L Lucy Sola 19:17
I really do need to prepare Steve and Mason for what they're going to end for because it is insane.

W Wendy Rubas 19:24
I don't think they're ready. Okay. But what we talked about was attribution, which we now know if you listened to our listeners listen to that. They understand that is the way that a patient is assigned to a provider in a population health world. And the good news here with those formerly known as DCEs is that it's voluntary alignment, meaning we said in the podcast, it's either you're signed based on your claims, or you make an election which we prefer because it's just a lot more clean and direct and easier. And so that's allowed here and so they can do it in my understanding is electronically or they could do it paper. There's different rules about that. But But voluntary alignment is possible. That means that there can be direct communication with the beneficiaries about filling out those alignment forms. But just take note and heed, there are still limitations on other types of communications and marketing. So just because you can communicate about voluntarily alignment does not mean that those other prohibited marketing activities are different. So there's still those same prohibitions.

L Lucy Sola 20:33
Yep, exactly.

W Wendy Rubas 20:35
Okay, Lucy, last thing. We did a podcast recently with Joanne and the quality payment. And of course, we have quality, as you explained, there's a quality payment hold back in

the DCE program, so percentage of your payments are held, and you get them back if you achieve quality standards. Tell us what these standards are. And more importantly, my understanding is we're done with that manual reporting process that was so complex in the ACO world.

L Lucy Sola 21:05

Yep, exactly. So there are really three buckets that are two buckets, I think. The first is claim space measures. So that is going to be measured based off of claims experience that CMS will be measuring will be calculating. For the first year there are two claims based measures. The first is all condition readmissions. And that is really just measuring how the DCE is doing on their readmissions. And then the second claims based metric is going to be risk standardized acute admission rates for patients with multiple chronic conditions. So they're trying to measure really, how are your patients that have chronic conditions getting admitted into the hospital. And then the other bucket is caps, which is the patient satisfaction survey that is administered by vendor. This was done in the Medicare Shared Savings Program and next generation ACO model. And it's really just to try to understand patients experience with their provider. And I think that what I've seen some folks be surprised by is the depth of questions that a patient will be asked about, were you able to call and get an appointment? Was it timely care? Was your patient was your doctor engaging in your care with you? And I think that it's really important for physicians to understand that they will be measured on very granular levels, and it's gonna affect their payment.

W Wendy Rubas 22:31

Right. So basically, this goes beyond bedside manner. And it's the experience of the patient and it's based on their opinion, and it affects you getting that that bonus back.

L Lucy Sola 22:43

Yep, exactly.

W Wendy Rubas 22:45

Okay, Lucy, this has been so helpful. And I'm so grateful that you came back to explain it. I want to ask our listeners. If you have questions about this, let us know if there's more information you need. And maybe if we're really lucky, we'll get Lucy back again to help us understand it.

L

Lucy Sola 23:03

I got you covered. I would love to come back. Thanks, Wendy.

W

Wendy Rubas 23:06

Thank you, Lucy.

I

Intro Music 23:09

Thank you to our sponsor, VillageMD. We hope you will join us for future concise compliance conversations.