

Direct Contracting may offer ACOs a unique opportunity

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The Center for Medicare and Medicaid Innovation (CMMI) introduced a new accountable care organization (ACO) model—Direct Contracting. This model includes a unique feature allowing ACOs the ability to contract with providers. This feature gives ACOs an additional tool they can use to incentivize providers to achieve ACO objectives.

CMMI published a request for applications (RFA) on November 25, 2019, for the Global and Professional tracks of the new Direct Contracting (DC) ACO Model. This RFA further solidified the framework for the DC model that was originally outlined in the proposed rule from April 2019.

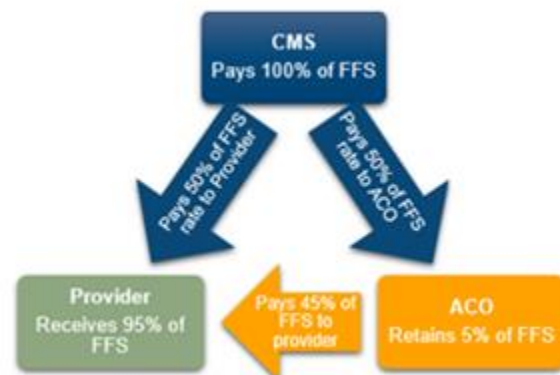
A key aspect of the Direct Contracting model, carried over from the Next Generation ACO Model, is Advanced Payments (referred to in the Next Generation model as “population-based payments”). The Advanced Payments mechanism allows an ACO to specify DC Participant Providers and Preferred Providers who agree to receive reduced percentages of fee-for-service (FFS) payments for non-primary-care services provided to beneficiaries attributed to the ACO. These reductions are anywhere from 1% to 100%. Throughout the program year, the Centers for Medicare and Medicaid Services (CMS) will pay the specified providers the agreed-upon percentage of FFS for non-primary-care services while paying out the remainder of the FFS amount directly to the ACO¹ (such that CMS still pays 100% of Medicare FFS for these services). In this way, a Direct Contracting entity (DCE) can begin to negotiate internal payment mechanisms designed to drive savings, akin to Medicare Advantage plans. The ACO can negotiate discounts from FFS with providers in exchange for steerage or tying reimbursement to whether or not the provider is able to meet ACO-defined incentives.

How Advanced Payments work

ACOs participating in Primary Care Capitation (available under both the Professional and Global DC options) can choose to take part in Advanced Payments for specific providers’ non-primary-care services. Under this program, anywhere between 1% and 100% of non-primary-care FFS claims payments for specific providers is paid by CMS to the ACO instead of directly to the participating provider. The ACO is then responsible for paying participating providers the remainder of the claims payments owed, according to their contractual agreements. Any providers within the ACO that do not wish to participate in this agreement will continue to receive non-primary-care FFS payments directly from CMS.

An example of an Advanced Payments arrangement is shown in Figure 1. In this example, the provider has agreed to receive 50% of its traditional FFS payment for non-primary-care services directly from CMS. The ACO has negotiated with this provider to pay only 45% of FFS for the remaining 50%. As such, the provider will be paid 95% of traditional FFS for non-primary-care services while the ACO will retain 5%. It is important to note that these contractual arrangements do not impact the calculation of savings compared to the DC benchmark, as CMS is still paying out 100% of the FFS rate for each claim.

FIGURE 1: EXAMPLE OF AN ADVANCED PAYMENT ARRANGEMENT



¹ Operationally, CMS provides the ACO with the estimated total claims amount each month, and this amount is later reconciled based on actual utilization. Only non-primary-care claims are eligible.

Advanced Payments allow specific providers (as indicated by the ACO) to receive reduced FFS payments from CMS (anywhere from a 1% to a 100% reduction). The percentage received can vary by provider. CMS will pay the ACO the remaining portion of the FFS payment in estimated monthly installments, with a reconciliation at the end of the year. The ACO is then responsible for paying participating providers according to their contractual arrangements with the ACO, which may include metrics beyond service volume (e.g., quality measures).

Generating additional ACO revenue

The Advanced Payments mechanism allows the ACO to receive FFS payments from CMS and then pay providers for all or part of non-primary-care services rendered, based on contractual arrangements between the ACO and the participating providers. This gives the ACO the flexibility to enter into contracts with providers to pay less than FFS payment rates and retain any differences. These arrangements would also allow ACOs to enter into capitation or other payment arrangements that are dependent on quality or cost metrics, which may result in additional revenue for the ACOs—either in shared savings through met incentives or withheld payments. Additionally, these arrangements allow ACOs to reimburse providers for services that are not traditionally reimbursable under Medicare FFS but may contribute to the ACO's overall care management plan. The ACO may only be able to successfully negotiate these types of arrangements with a subset of its provider roster.

ACOs can leverage their relationships with primary care providers and other referring physicians to secure favorable payment arrangements with downstream providers as well as improve the efficiency of care.

For example, a cardiologist might agree to accept 90% of Medicare FFS rates for all of the ACO's members if the ACO's primary care physicians (PCPs) agree to refer their cardiology cases to that specific cardiologist, when appropriate. This arrangement may provide the cardiologist with additional patients while allowing the ACO to retain 10% of the cardiologist's payments as revenue.

Experience with Medicare Advantage (MA) has shown that providers are sometimes willing to accept a reimbursement rate lower than 100% of traditional Medicare FFS. A study performed in 2017 reviewed claims data from 2007 through 2012 and found

that the average MA reimbursement for common physician services varied between 91.3% and 100.2% of traditional Medicare FFS payments.² It is important to note that, because beneficiaries are not restricted to only utilizing in-network providers in an ACO, the contracted savings realized by the ACO may not reach the levels found in MA.

Prospective ACOs should approach providers within their current or prospective ACO networks to discuss renegotiating the payment arrangement for DC beneficiaries. Providers that have high amounts of regional competition and available capacity would be ideal partners for this type of arrangement, e.g., skilled nursing facilities (SNFs), radiology centers, labs, ambulatory surgical centers, etc. Additionally, an ACO's providers may accept lower overall reimbursement rates in exchange for more shared savings. ACOs should also consider other factors when entering contractual arrangements, such as quality of care, coding patterns, and other medical management considerations. For Medicare Shared Savings Program (MSSP) ACOs struggling to achieve satisfactory returns from shared savings, these types of arrangements could provide valuable operational revenue

Conclusion

Advanced Payments provide an additional avenue through which DC participants can generate revenue potentially equal to or greater than their shared savings.

The inclusion of this managed care tool in the DC model is an indication that CMS is interested in providing ACOs with more "advanced" mechanisms to manage care delivery in order to improve their overall value and effectiveness. Current and prospective ACOs would be wise to consider how they might leverage such advanced mechanisms as they could be introduced to the MSSP or other Medicare risk-sharing programs in the future.

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² Trish, E., Ginsburg, P., & Gascue, L. (September 2017). Physician reimbursement in Medicare Advantage compared with traditional Medicare and commercial health insurance. *JAMA Internal Medicine*. Retrieved March 27, 2020, from <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2643349>.