

Direct Contracting and the impact of COVID-19 on physicians

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The COVID-19 pandemic has had a radical impact on physicians as well as other healthcare entities and led to severe declines in fee-for-service (FFS) revenue. The pandemic also caused the Center for Medicare and Medicaid Innovation (CMMI) to make adjustments to its Direct Contracting program (DC).¹ DC adjustments include adding a second cohort that begins January 2022, providing a capitation payment glide path, and increasing physician capitation choices.

These major changes have created an opportunity for organizations considering becoming Direct Contracting Entities (DCEs) to attract physicians who might not have been interested in the program previously. The application window for the second cohort of DCEs opens in March 2021.

COVID-19 increases interest in capitated revenue among physicians

COVID-19 has had a financially debilitating effect on many medical practices, and some are not expected to survive.² Virtually all elective procedures and the majority of in-person outpatient visits were canceled in many parts of the country between March and May of 2020.³ Primary care practices are particularly vulnerable, as a significant portion of primary care revenue is derived from in-person evaluation and management visits. A 2020 analysis published in Health Affairs predicts large, meaningful reductions in revenue for primary care practices as a result of COVID-19. These reductions may threaten their viability if practices cannot secure adequate funding through either additional FFS

revenue or alternative payment mechanisms such as capitation.⁴ With the current resurgence of COVID-19, this situation is likely to continue into 2021.

Physicians are likely to be aware of risks associated with capitation, such as the need to carefully define covered services and ensure rate adequacy. A recent American Medical Association (AMA) survey showed that an average of 70% of practice revenue is still coming from a FFS payment method (including Medicare as well as other lines of business).⁵ Although capitation is relatively more common among physicians located in the western region of the United States, there are many areas of the country where capitation is rare.⁶ Physicians located in these regions are even more exposed to financial hardship than their colleagues who have benefited from capitated payments throughout the COVID-19 pandemic. For physicians who primarily rely on Medicare FFS payments, COVID-19 exposed the risk associated with this dependency. Through DCEs, physicians can access a capitated revenue stream for their DC-attributed Medicare FFS patients, diversifying their revenue sources.

¹ CMS (September 2020). Direct Contracting Model Financial Methodology. Retrieved January 6, 2021, from <https://innovation.cms.gov/media/document/dc-model-options-fnclmeth-slides>.

² Rubin, R. (June 18, 2020). COVID-19's crushing effects on medical practices, some of which might not survive. JAMA. Retrieved January 6, 2021, from <https://jamanetwork.com/journals/jama/fullarticle/2767633>.

³ Cutler, D.M. et al. (May 1, 2020). The business of medicine in the era of COVID-19. JAMA. Retrieved January 6, 2021, from <https://jamanetwork.com/journals/jama/article-abstract/2765668>.

⁴ Basu, S. et al. (June 25, 2020). Primary Care Practice Finances in the United States Amid the COVID-19 Pandemic. Health Affairs. Retrieved January 6, 2021, from <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00794>.

⁵ AMA. 2018 Physician Practice Benchmark Survey. Retrieved January 6, 2021, from <https://www.ama-assn.org/about/research/physician-practice-benchmark-survey>.

⁶ Zuvekas, S.H. & Cohen, J.W. (March 2016). Fee-For-Service, While Much Maligned, Remains the Dominant Payment Method for Physician Visits. Health Affairs. Retrieved January 6, 2021, from <https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1291>.

Enhancements to the Direct Contracting program

The DC program was originally intended to have only one cohort that would begin in January 2021. In order to address the COVID-19 public health emergency, CMMI has made adjustments to certain models, including DC. Some of these changes make DC more attractive to physicians looking to add a prospectively determined revenue stream or transition from other alternative payment models such as Comprehensive Primary Care Plus (CPC+). Enhancements under the DC program that may be appealing to potential applicants include:

- **A new application cycle for a second cohort.** CMMI is creating a new application cycle during 2021 for a second cohort to launch January 1, 2022.⁷ This cohort's request for application (RFA) will be available in January 2021, with the application window opening in March 2021. Participants in this second cohort will not be required to have submitted a letter of intent (as was required for the first cohort) in order to participate.
- **Improved capitation glide path.** Rather than being required to accept 100% capitation from the start of the program, individual participating primary care physicians can now choose their own capitation percentages starting with minimal floors — ranging from 5% of revenue in 2022, to 20% in 2024 — before being required to transition to full capitation in 2025 and 2026, the final two years of the program. This enables physicians to start small and assume more capitation risk over time as illustrated in Figure 1.

FIGURE 1: DCE PRIMARY CARE CAPITATION (PCC) REQUIREMENTS⁸

PY	DC Participant Providers
PY1=2021	Optional; 1%-100%
PY2=2022	Mandatory; 5%-100%
PY3=2023	Mandatory; 10%-100%
PY4=2024	Mandatory; 20%-100%
PY5=2025	Mandatory; 100%
PY6=2026	Mandatory; 100%

- **Increased payment flexibility.** CMMI is offering more flexibility around the amount of enhanced PCC payments. For example, DCEs can now choose to receive at least 2% of the benchmark in enhanced payments regardless of their base PCC percentages. These up-front payments can be critical for some physicians by providing a source of cash

flow for infrastructure investment to support value-based care (VBC) that does not need to be paid back until year-end. These investments can also help physicians transition toward more VBC arrangements for their commercial and Medicare Advantage patients.

Leveraging a window of opportunity for DCEs

Given the DC model adjustments, addition of the second DC cohort, and increased physician interest in capitated revenue, the opportunities for DC program success have expanded. For organizations considering applying, it is critical to begin analyzing key issues such as:

- **Regional costs.** What are the DCE's cost levels relative to regional averages? This relationship will affect the benchmarks for both claims-aligned and voluntarily aligned beneficiaries.
- **Leakage control.** How likely is it that beneficiaries will use the DCE's providers, or visit physicians and hospitals outside of the DCE? Unlike the majority of Medicare Advantage patients, Medicare FFS beneficiaries have the freedom to seek care wherever they want.
- **Voluntary alignment.** How well-positioned is the DCE to attract and retain voluntary alignment? Medicare FFS beneficiaries can choose to voluntarily align with a specific DCE. Two program elements that can help DCEs gain voluntary alignment are patient engagement incentives and benefit enhancements, which can be critical to preventing leakage, more effectively managing care, and ensuring that capitation payments sufficiently cover patient costs.
- **Provider selection.** How should the DCE select providers to maximize its likelihood of program success? DCEs select Participant and Preferred providers and can evaluate providers along a broad spectrum of criteria including a provider's quality of care and historical cost-effectiveness.
- **Quality performance and reporting.** How well positioned is the DCE to report and improve on DC quality measures to earn back the 5% quality withhold? Having good reporting in place early will improve a DCE's chances of meeting the quality measures in later years.
- **Ongoing monitoring and management.** What other reporting tools can the DCE use or implement to help monitor and manage a DC-attributed population? Generating accurate reports and modifying performance on a timely basis are also key to being a successful DCE.

⁷ CMS (June 3, 2020). CMS Innovation Center Models COVID-19 Related Adjustments. Retrieved January 6, 2021, from <https://www.cms.gov/files/document/covid-innovation-model-flexibilities.pdf>.

⁸ Direct Contracting Model Financial Methodology, op cit.

Conclusion

COVID-19 has exposed the risk inherent to physicians in depending on the Medicare FFS payment model and the potential value of receiving some portion of payment on a capitated basis. The market trend toward VBC as well as enhancements to CMMI's DC program make it an opportune time for many physicians and medical groups still dependent on Medicare FFS to consider joining or creating a DCE.

Caveats and Limitations

The analysis provided in this brief is based on the information made available by the Centers for Medicare and Medicaid Services (CMS) and other entities. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.



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