National MLTSS Health Plan Association

Value Proposition of MLTSS Health Plan Participation in the Center for Medicare and Medicaid Innovation (CMMI) Direct Contracting (DC) Model

Overview of the CMMI Direct Contracting Model

On Monday, April 22, 2019, CMMI announced a new type of alternative payment model: **Direct Contracting (DC).** The DC model is focused on giving participants the ability to take increasing levels of risk for a patient population through flexible payments and benefit enhancements. There are two tracks based on the level of risk and flexibility that CMMI has released information on to date *(more information to come on a third track in late 2020 or early 2021)*:

- **Professional** – partial risk arrangement with 50% shared savings/losses and a Primary Care Capitation payment
- **Global** – full-risk arrangement with 100% shared savings/losses and option of either a Primary Care Capitation or Total Care Capitation payment

Value of Integrated Care

Integrated care products assume responsibility for the full spectrum of medical and non-medical benefits under a capitated payment rate tied to quality metrics. Integrated products (1) create a better and more seamless care experience for a beneficiary, (2) reinvest savings to the medical system generated by long-term services and supports (LTSS) back into non-medical supports to improve overall quality of life, and (3) help better manage state and federal expenditures.

Managed LTSS (MLTSS) plans currently take risk for managing and providing long-term care to their beneficiaries, which often include a large subpopulation of dual-eligible individuals. For these dual-eligibles, the non-medical interventions of the MLTSS plans result in reduced acute medical utilization, such as emergency department visits and/or hospitalizations.

However, this reduction in medical utilization and medical spending accrues to the Medicare program, rather than the MLTSS plan. Therefore, managed care entities pursue integrated delivery models such as aligned D-SNPs and MLTSS plans, FIDE-SNPs, and MMPs, in part, to be able to reinvest these medical savings. Integrated products serve as a useful tool to not only facilitate coordination between the medical and non-medical systems but also to capture savings accrued to either by the efforts of the other.

The Dual-Eligible Population

The dual-eligible population is particularly complex:

- 41% have at least one mental health diagnosis
- 49% receive LTSS
- 60% have multiple chronic conditions

Dual-eligibles typically receive their health care coverage through two separate and uncoordinated programs – one federal and the other state-run. Services and supports for those individuals are often fragmented, with separate systems for physical health, behavioral health, and LTSS that are unaligned and poorly coordinated. This often results in significant care gaps and avoidable and expensive medical and/or institutional care.

The Current State

Currently, only 9% of full-benefit dual eligible beneficiaries are enrolled in an integrated product. Therefore, there exists a substantial number of beneficiaries who could benefit from additional care coordination through an integrated product.

Over 80% of dual-eligibles live in the 24 states already offering MLTSS. For example, one member of the National MLTSS Health Plan Association reports that it currently serves approximately 180,000 MLTSS beneficiaries that receive care from fee-for-service (FFS) Medicare that could benefit from participation in the DC model.

Why Should MLTSS Plans Participate in the DC Model?

Through participation in the DC Model as a MLTSS Plan-Operated DC Entity (DCE):

- **MLTSS plans can increase the number of dual-eligibles benefiting from integrated care.** MLTSS plans can take responsibility and risk for their FFS dually-eligible members which are not part of an affiliated managed care product through Medicare.
- **MLTSS plans can leverage their extensive experience with managing care for beneficiaries with complex care needs.** There is significant overlap between the beneficiary eligibility criteria of the current High Needs

Population DCE type and the characteristics of the population of dual eligible beneficiaries enrolled in MLTSS plans (i.e., beneficiaries with several chronic conditions and high rates of hospitalization).

- **MLTSS plans can have access to a beneficiary's Medicare data and Medicare FFS primary care provider (PCP), allowing them to better respond to and coordinate their medical and non-medical needs.** While MLTSS plans and providers gain valuable insights into dual-eligible beneficiaries' health care needs and quality of life through LTSS interventions, fundamental system constraints limit their access to PCP and other medical utilization data. MLTSS plans generally lack access to these data and therefore are not necessarily aware of when a beneficiary is admitted or discharged from a hospital. These data will give plans a more holistic view of their members' care.
- **MLTSS plans can enhance its care management model to better serve members' needs.** New flexibility through this model would allow plans to address many of the drivers of avoidable Medicare-funded hospitalization and skilled nursing facility usage within the target population.

National MLTSS Health Plan Association's Proposed Changes to the DC Model

Current Model Parameter	Challenge(s) Posed to MLTSS and Integrated Plans	Recommendation
Beneficiary alignment and attribution methodologies based solely on voluntarily or claims-based alignment to a participant provider *(i.e., MLTSS Plan DCE would receive beneficiaries from providers not enrolled in its MCO, since provider panels likely include enrollees of multiple MCOs regardless of dual eligible status)*	MLTSS plan would not be able to benefit from their efforts through the Medicaid program in managing this heterogenous population since it would not have any financial or care delivery connection with those receiving LTSS through FFS or a different plan	Create a third beneficiary attribution method based on MCO MLTSS enrollment that is prioritized above voluntary and claims-based assignments in the attribution hierarchy with an opportunity for beneficiaries to opt out
Requirements to enlist participant and preferred providers before identifying aligned beneficiaries	MLTSS plans generally do not have existing relationships with Medicare FFS providers and they would subsequently need to form contractual agreements with a critical mass to ensure proper beneficiary care management and to meet the beneficiary threshold requirements for the DC model based on their DCE type	Allow MLTSS MCOs participating in the DC demonstration to first align beneficiaries to their DCE based on MLTSS enrollment and then contract with the Medicare providers of the beneficiary's choice to form a participant provider list
The magnitude of the quality withholds and a lack of a phase-in *(i.e., Global track includes a 2% payment "discount" for all DCEs, along with a 5% quality withhold based on quality measure performance)*	Working to assess and address needs that may not have been met under the traditional FFS system requires both adequate and readily available payment that would be difficult under a combination of the proposed withholds. Also, quality withholds are based on quality measures from CAHPS, which is largely provider-focused	Phase in the current 5% quality withhold over the current five performance years and add certain quality measures used for Medicare-Medicaid Plans (MMPs)
The structure of the governing body for a DCE *(i.e., requires at least one Medicare beneficiary, at least one consumer advocate, and that at least 25 percent control of the DCE's governing body would be held by the DC participant providers)*	The DC model's governing body deviates significantly from the structure and role of MLTSS and integrated plans' existing advisory committees and would create operational challenges for an MLTSS plan who wishes to operate a DCE. Additionally, the current structure's focus on medical providers could lead to an overmedicalization of DCE operations	Waive the requirement in part or in whole for MLTSS-based DCEs to form a governing body using participating physicians
Uncertainty around the financial methodology	CMS plans to release information on certain payment withholds prior of the start of the performance period and additional financial methodology (e.g. risk adjustment and benchmarking), which creates difficulty in being able to fully assess the full feasibility of the model	Maintain the general financial benchmarking methodology used for the High-Needs Population DCE type by first using adjusted regional expenditures followed by blended historical and regional expenditures