MILLIMAN WHITE PAPER

Direct Contracting Duals Model

Medicaid MCOs managing Medicare FFS costs for dual-eligible beneficiaries

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In December 2020, the Centers for Medicare and Medicaid Services (CMS) introduced Medicaid managed care organizations (MCOs) as a new type of Direct Contracting entity (DCE) to begin participating in the model in January 2022.

This option was created to better serve the needs of individuals dually eligible for Medicaid and Medicare. In this white paper, we summarize this new Direct Contracting option.

Background

Direct Contracting (DC) models are voluntary payment models that allow participating entities to manage healthcare costs and accept risk for Medicare fee-for-service (FFS) beneficiaries. The DC models build off of, and are structurally similar to, predecessor risk-sharing programs including the Medicare Shared Savings Program (MSSP) and the Next Generation ACO (NGACO) models. DC, MSSP, and NGACO all feature financial benchmark methodologies, Medicare FFS beneficiaries aligned to participating organizations, and an annual shared savings or shared loss settlement based on the total cost of care for aligned beneficiaries compared to a benchmark. Whereas participation in predecessor programs was limited to provider organizations, a primary goal of the DC models is to "broaden participation in CMS Innovation Center models" for non-provider organizations such as MCOs.[1]

In December 2020, CMS introduced the newest DCE model option: The Direct Contracting Duals Model. This new DCE model, which will begin in January 2022, is the first DC model to be designed for Medicaid MCOs and is also the first model to specifically target beneficiaries that are dually eligible for both Medicare and Medicaid coverage.

Eligible organizations

Eligible organizations for the MCO-based DCE model must fulfill three qualifications:

1. **Medicaid MCO:** The DCE must be a Medicaid MCO or a legal entity that is affiliated with a Medicaid MCO under common ownership.
2. **Active Medicaid managed care contract covering dual-eligible beneficiaries:** The DCE must have an active Medicaid managed care contract to cover dual-eligible beneficiaries within the applicable state. The Medicaid managed care plan must cover long-term supports and services (LTSS) including nursing facility costs and/or Medicaid behavioral health (BH) services.
3. **Medicare-Medicaid integration experience:** The DCE or a related entity must have experience with integrated Medicare-Medicaid programs through a Medicare Advantage (MA) fully integrated, dual-eligible special needs plan (FIDE SNP) or Medicare-Medicaid Plan (MMP), though not necessarily within the applicable state.

Consistent with other Medicare-Medicaid integration program requirements, MCO-based DCE entities must receive approval from the applicable state Medicaid agency to participate.

An example of an eligible DCE is a health plan that offers a Medicaid managed long-term services and supports (MLTSS) plan and separately offers a FIDE SNP or MMP, potentially in a different state. As a participant in the MCO-based DC model, the MCO would be at risk for Medicare FFS costs for the full benefit dual-eligible beneficiaries in its MLTSS plan that are enrolled in Medicare FFS.

Beneficiary alignment

Full benefit dual-eligible beneficiaries enrolled in a Medicaid managed care plan covering LTSS and/or BH benefits and Medicare FFS are eligible for alignment to DCEs within the

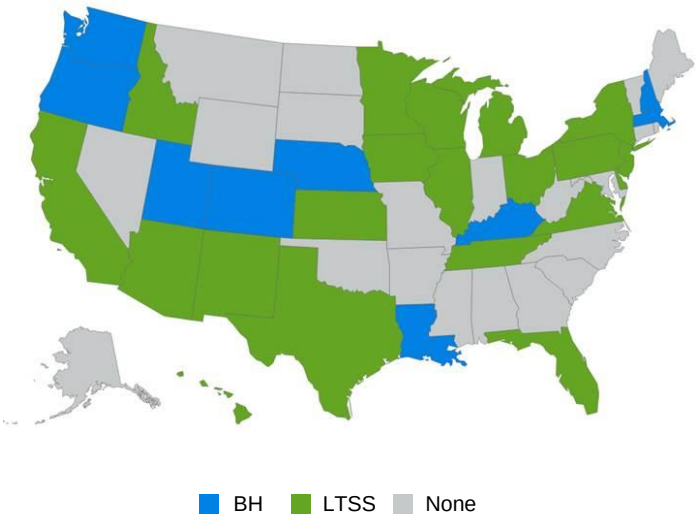
[1] CMS. Direct Contracting Model Options. Retrieved February 2, 2021, from https://innovation.cms.gov/innovation-models/direct-contracting-model-options.

MCO-based DC model. Full benefit dual-eligible beneficiaries currently comprise approximately 14% of Medicare enrollment and over 70% of full benefit dual-eligible beneficiaries were enrolled in Medicare FFS as of 2018.[2] This means there are approximately 6 million full benefit dual-eligible beneficiaries enrolled in FFS nationwide.

States with a Medicaid MLTSS program that is not fully integrated may be ideal candidates for MCO-based DCE participation because they will likely have MCOs that are eligible to participate and are not currently at risk for Medicare FFS expenditures. Medicaid MLTSS programs have become increasingly common, with approximately half of all states supporting a Medicaid MLTSS program.[3]

Because Medicaid programs vary significantly by state, eligible beneficiaries may currently only come from the states in blue or green in Figure 1. These states are states where full benefit dual-eligible members may mandatorily or voluntarily enroll in managed care programs covering LTSS (green) or BH services (blue). Programs covering both LTSS and BH are classified as LTSS and programs where Medicaid coverage is only included if the member is already part of an aligned Medicare Advantage plan (e.g., Medicare-Medicaid Plans participating in the Financial Alignment Initiative) are excluded. Additionally, we exclude states in the process of transitioning managed care programs, such as North Carolina.

FIGURE 1: STATES WITH MEDICAID MANAGED LTSS OR BH PROGRAMS



Benefits of participation

The introduction of MCO-based DCEs may have potential benefits for both participating DCEs and beneficiaries.

Potential benefits for MCO-based DCEs are similar to the potential benefits of participation in the Global or Professional options of DC for a standard DCE:

- DCEs that keep Medicare FFS expenditures for aligned beneficiaries below the benchmark are eligible to earn shared savings. Because MCO-based DCEs manage Medicaid LTSS and/or behavioral health services, they may be well-positioned to manage Medicare FFS costs for aligned dual-eligible beneficiaries.
- DCEs will have additional care management tools (outlined below) that may enable them to better manage both Medicare and Medicaid costs for aligned beneficiaries.
- MCO-based DCEs are not required to select a capitation option, unlike their standard DCE counterparts. MCO-based DCEs that choose a capitation option may elect either fully capitated or partially capitated payment models and must identify Participant and/or Preferred Providers. MCO-based DCEs may use capitation payments to facilitate value-based contracting with providers and/or investment in care management tools. This may be attractive for providers as a way to receive more predictable revenue streams than traditional FFS.

For beneficiaries, the advantages will include potential benefit enhancements and additional focus on quality. According to a fact sheet released by CMS, examples of actions MCO-based DCEs can take include:

- Establishing processes to connect aligned beneficiaries to a primary care provider, particularly high-value Medicare FFS healthcare providers
- Risk-stratifying and targeting care coordination resources toward aligned beneficiaries at risk of high Medicare spending
- Deploying care coordinators or in-home aides who provide Medicaid LTSS to also actively promote flu vaccines, preventive screenings, evidence-based falls prevention, and diabetes management activities
- Having care coordinators or in-home aides who provide Medicaid LTSS assist enrollees with managing Medicare-covered medical appointments to help reduce missed treatments

[2] CMS (March 2020). Fact Sheet: People Dually Eligible for Medicare and Medicaid. Retrieved February 2, 2021, from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.

[3] Medicaid and CHIP Payment and Access Commission. Medicare Advantage Dual Eligible Special Needs Plans Aligned With Medicaid Managed Long-Term Services and Supports. Retrieved February 2, 2021, from https://www.macpac.gov/subtopic/medicare-advantage-dual-eligible-special-needs-plans-aligned-with-medicaid-managed-long-term-services-and-supports/.

- Training in-home aides—who often cook meals for their clients—on meal preparation for individuals with nutrition-sensitive conditions, like diabetes
- Entering into value-based purchasing arrangements with nursing facilities that factor in these facilities' hospitalization rates

Dual-eligible beneficiaries will retain the ability to see the providers of their choosing, and will have full access to Medicare FFS benefits in addition to potential benefit enhancements offered by the DCE.

Unique features of MCO-based Direct Contracting

While CMS has not released full details about the financial benchmark and settlement methodology for MCO-based DCEs, the methodology is expected to be similar to that of standard DCEs. Milliman has recently published other articles discussing the mechanics of the DC benchmark methodology.[4,5]

Like standard DCEs participating in Global and Professional options, MCO-based DCEs are at risk for the total Medicare FFS cost of care for aligned beneficiaries. A benchmark will be calculated for each performance year based on a mix of historical experience for aligned beneficiaries and regional average expenditures. Performance year expenditures will be compared to the benchmark each year, and DCEs will share in 50% of savings/losses in the Professional option and 100% in the Global option. Both the Global and Professional options include risk corridors that scale down the percentage of shared savings/losses applied as total cost of care varies further from the benchmark.

While much of the methodology is expected to be similar between standard DCEs and MCO-based DCEs, there are a few key differences:

- Beneficiaries are aligned to standard DCEs based on voluntary alignment and claims-based alignment. In contrast, beneficiaries are aligned to MCO-based DCEs using MCO enrollment-based alignment only. Therefore, all aligned beneficiaries for MCO-based DCEs will already be enrolled in the MCO's Medicaid managed care plan. This is a potential risk for MCO-based DCEs if the characteristics of the MCO enrollees in the historical baseline period vary materially from the enrollees in the performance year. This is different from the risk experienced by standard DCEs because claims-based alignment is generally expected to result in a similar pool of aligned beneficiaries in the historical baseline period and performance year.
- MCO-based DCEs are not required to have arrangements with DC Participant Providers and Preferred Providers. As a result, the capitation options (required for standard DCEs) are not mandatory for MCO-based DCEs.
- MCO-based DCEs must have a minimum of 3,000 aligned beneficiaries for each performance year. Standard DCEs must have at least 5,000 aligned beneficiaries in each performance year.

Conclusion

The new MCO-based DC option is an opportunity for Medicaid MCOs to utilize new care management tools and leverage existing expertise in managing care for dual-eligible beneficiaries to improve outcomes and share in Medicare financial savings. The shared savings or losses can be significant given the high medical costs for dual-eligible beneficiaries, so it is critical that participating DCEs understand the financial mechanics to assess the opportunity, understand risks, and monitor results.

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[4] Kramer, M.J., Shellabarger, S., & Reijula, E. (December 2020). Medicare FFS Direct Contracting: Financial Benchmark Observations. Milliman White Paper. Retrieved January 15, 2021, from https://www.milliman.com/en/insight/Medicare-FFS-Direct-Contracting-Financial-benchmark-observations.

[5] Norris, C., Jensen, B., & Grzeskowiak, D. (March 2020). Direct Contracting: A Program Summary and Comparison With MSSP and NGACO. Milliman White Paper. Retrieved February 2, 2021, from https://us.milliman.com/-/media/milliman/pdfs/articles/direct_contracting_a_program_summary_and_comparison_with_mssp_and_ngaco.ashx.