Direct Contracting: Global and Professional Options

Payment Part Two Webinar

January 22, 2020

Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services (CMS)
Webinar Agenda

Payment Part 1 Webinar Agenda (January 15th)

- Payment Mechanisms
- Risk Mitigation
- Reconciliation

Payment Part 2 Webinar Agenda (TODAY)

- Direct Contracting Overview
- Benchmarking
  - Standard DCEs
  - New Entrant & High Needs Population DCEs
- Reconciliation Example

The financial methodology described in this webinar is still in development and is subject to change. CMS will release additional information as it becomes available.
Direct Contracting Overview
Model Goals

Transform risk-sharing arrangements in Medicare Fee-For-Service (FFS)
Empower beneficiaries to personally engage in their own care delivery
Reduce provider burden to meet health care needs effectively
The Direct Contracting Model builds on the Next Generation ACO Model, introducing several new model design elements including:

- **New performance year benchmark methodologies** focused on increasing benchmark stability, simplicity, and prospectivity;

- **Capitation and other advanced payment alternatives** for model participants; and

- Financial model that **supports broader participation** by entities new to Medicare FFS and/or focused on delivering care for high needs populations.
Provider Relationships

Direct Contracting Entity (DCE)

- Must have arrangements with Medicare-enrolled providers or suppliers, who agree to participate in the Model and contribute to the DCE's goals pursuant to a written agreement with the DCE.
- DCEs form relationships with two types of provider or supplier:

DC Participant Providers

- Used to align beneficiaries to the DCE
- Required to accept payment from the DCE through their negotiated payment arrangement with the DCE, continue to submit claims to Medicare, and accept claims reduction
- Report quality
- Eligible to receive shared savings
- Have option to participate in benefit enhancements and beneficiary engagement incentives

Preferred Providers

- Not used to align beneficiaries to the DCE
- Can elect to accept payment from the DCE through a negotiated payment arrangement with the DCE, continue to submit claims to Medicare, and accept claims reduction
- Eligible to receive shared savings
- Have option to participate in benefit enhancements and beneficiary engagement incentives
## Risk Options

### Professional

50% shared savings / shared losses risk arrangement

- Must select the Primary Care Capitation (PCC)
- No discount for the Performance Year Benchmark

### Global

100% shared savings / shared losses risk arrangement

- Must choose either the Total Care Capitation (TCC) or Primary Care Capitation (PCC)
- Performance Year Benchmark includes a discount that begins at 2% in PY1 and increases to 5% by PY5
## Summary of DCE Types

<table>
<thead>
<tr>
<th>DCE Types</th>
<th>Risk Arrangement Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard</strong></td>
<td>Professional and Global are available for each DCE type</td>
</tr>
<tr>
<td>DCEs with substantial historical claims-based experience serving Medicare FFS</td>
<td></td>
</tr>
<tr>
<td><strong>New Entrant</strong></td>
<td>Professional and Global are available for each DCE type</td>
</tr>
<tr>
<td>DCEs with limited experience delivering care to Medicare FFS beneficiaries</td>
<td></td>
</tr>
<tr>
<td><strong>High Needs</strong></td>
<td>Professional and Global are available for each DCE type</td>
</tr>
<tr>
<td>DCEs that focus on beneficiaries with complex, high needs, including individuals dually eligible for Medicare and Medicaid</td>
<td></td>
</tr>
</tbody>
</table>
Performance Year Benchmark
What is the Benchmark?

- The benchmark is a **Per Beneficiary Per Month (PBPM) dollar amount** against which a DCE is held accountable for performance year (PY) Medicare FFS expenditures for its aligned beneficiaries.
- The benchmark is inclusive of the **total cost of care** for Medicare Parts A & B services (Part D is not included).
- Separate benchmarks will be set for the Aged & Disabled (A&D) and ESRD beneficiary entitlement categories.
- CMS compares expenditures incurred in the performance year for beneficiaries aligned to a DCE against the benchmark to **determine shared savings or shared losses** during reconciliation.

The method for calculating the benchmark varies depending on the type of DCE and how beneficiaries are aligned to the DCE (claims-based or voluntary alignment).
### Benchmarking Approaches

<table>
<thead>
<tr>
<th>DCE Type</th>
<th>Standard</th>
<th>New Entrant</th>
<th>High Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alignment Option</strong></td>
<td><strong>Option 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Claims-Based Alignment</td>
<td>Voluntary Alignment</td>
<td>Both Options</td>
</tr>
<tr>
<td><strong>PY1</strong></td>
<td>Standard Benchmarking Approach using historical expenditures for beneficiaries that would have aligned to the DCE in the base years (CY17 – CY19)</td>
<td>Voluntary Alignment</td>
<td>Both Options</td>
</tr>
<tr>
<td><strong>PY2</strong></td>
<td><strong>Regional Benchmarking Approach</strong> that does not use historical expenditures, instead composed entirely of the adjusted MA Rate Book for the PY (this approach uses only the final three steps in the following slide)</td>
<td>Both Options</td>
<td>Both Options</td>
</tr>
<tr>
<td><strong>PY3</strong></td>
<td>Modified Standard Benchmarking Approach using recent historical expenditures (from PY1 – PY3, as applicable) for beneficiaries aligned to the DCE</td>
<td>Both Options</td>
<td>Both Options</td>
</tr>
<tr>
<td><strong>PY4</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PY5</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Beneficiaries who could be aligned to the same DCE via both voluntary and claims-based alignment will be treated as having claims-based alignment for benchmarking
How is the Benchmark Calculated?

The benchmarking methodology generally includes the following steps, but will be applied differently depending on the type of DCE and how beneficiaries are aligned to the DCE:

1. **Calculate Historical Expenditures**
   - Calculate historical expenditures based on beneficiaries aligned to the DCE through Participant Providers.

2. **Trend Baseline with USPCC**
   - Apply a trend based on projected US Per Capita Cost (USPCC) to account for changes in health care spending by year.

3. **Apply Risk- and Geographic-Standardization**
   - Standardize historical expenditures for variations in beneficiary health risk and Geographic Adjustment Factors (GAFs).

4. **Incorporate Regional Expenditures (MA Rate Book)**
   - Blend historical expenditures with performance year regional expenditures using adjusted Medicare Advantage (MA) rate book.

5. **Adjust for Risk and Geography for Performance Year**
   - Adjust for the health risk and Geographic Adjustment Factors (GAFs) of aligned beneficiaries in performance year.

6. **Apply Discount / Quality Withhold**
   - Apply discount (Global only) as well as quality withhold and amount of the quality withhold earned back.
Standard DCE Benchmarking Approach
Calculate Historical Expenditures: Claims-Based Alignment¹

- The historical baseline expenditure is calculated using a weighted average of historical Medicare expenditures for beneficiaries that would have been aligned to the DCE (via its current Participant Providers) in the base years (CYs 2017, 2018, and 2019)
- The base years will remain 2017-2019 for the entire 5-year model
- However, the historical baseline expenditure will be updated each PY as CMS will use a DCE’s most recent list of DC Participant Providers to identify the beneficiaries that would have been aligned to the DCE for each base year and determine their associated expenditures

1. Beneficiaries who could be aligned to the same DCE via both voluntary and claims-based alignment will be treated as having claims-based alignment for benchmarking.
Standard DCE

Calculate Historical Expenditures: Voluntary Alignment¹

- For PY1 – PY3, the benchmark will not incorporate any of the voluntarily aligned beneficiaries’ historical expenditures.
- Beginning in PY4, the benchmark will incorporate recent historical expenditures for aligned beneficiaries to establish the historical baseline expenditure.
- The historical baseline expenditure will be a weighted average of the recent beneficiary Medicare expenditures, with rolling base years.

### Historical Base Year Weighting for the Baseline Period

#### Rolling Baseline Years

<table>
<thead>
<tr>
<th>Baseline Year</th>
<th>PY4 (2024)</th>
<th>PY5 (2025)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Contribution to Historical Baseline</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td>Baseline Year</td>
<td>2021</td>
<td>2022</td>
</tr>
</tbody>
</table>

¹ Beneficiaries who could be aligned to the same DCE via both voluntary and claims-based alignment will be treated as having claims-based alignment for benchmarking.
The historical baseline expenditures will be prospectively trended forward each performance year using the projected US Per Capita Cost (USPCC) growth (developed annually by the CMS Office of the Actuary (OACT)).

Trending the baseline expenditures accounts for the differences in healthcare costs between the base years and the performance year.

As the trend is prospective, DCEs will know the trend rate prior to the start of the performance year.

1. Under limited circumstances, CMS reserves the right to make changes to the trend retrospectively if the trend is inaccurate to prevent DCEs from being unfairly penalized or rewarded for major payment changes beyond their control.
Apply Risk and Geographic Standardization

• CMS will risk standardize the historical baseline expenditures to account for differences in risk for the beneficiaries included in the historical baseline expenditures calculation.

• CMS will apply a modified risk adjustment methodology for the Direct Contracting Model to achieve two primary goals:
  1. Improve the accuracy of risk adjustment for complex, high-risk beneficiaries with serious illness.
  2. Mitigate the influence of coding intensity on risk adjustment.

• CMS will also standardize the historical baseline expenditures to account for the regional Geographic Adjustment Factors (GAFs)\(^1\) applied to payments in the base years.

1. GAFs are applied to Medicare FFS payments to account for county pricing differences (e.g., the Medicare area wage index, and the geographic practice cost index)
Incorporate Regional Expenditures

The Direct Contracting Model incorporates regional dynamics by using an adjusted version of the Calendar Year’s (CY) MA Rate Book that CMS’ Office of the Actuary (OACT) updates annually.

Adjust the MA Rate Book

- Adjust the MA Rate Book to make it appropriate for the Direct Contracting context
- The adjusted MA Rate Book will be established by county prior to each PY
- Additional details on the adjustments to the MA Rate Book for the Direct Contracting Model are forthcoming

Blend Baseline with Rate Book

- Determine the weighted average adjusted MA Rate Book expenditures ("Regional Expenditures") for each DCE based on the geographic distribution of its beneficiaries
- Blend the Regional Expenditures with the DCE’s trended Historical Baseline Expenditure
- The weight assigned to the Regional Expenditure component of the blend will increase each PY

Cap Impact of the Rate Book

- The impact of incorporating the Regional Expenditures on the trended Historical Baseline Expenditures will be constrained
- Maximum upward adjustment is limited to 5% of the FFS USPCC for the PY
- Maximum downward adjustment is limited to 2% of the FFS USPCC for the PY

Each PY, CMS will apply the corresponding CY’s Adjusted MA Rate Book (i.e., in PY1 the 2021 Adjusted MA Rate Book will be used, in PY2 the 2022 Adjusted MA Rate Book will be used, etc.)
Incorporate Regional Expenditures (cont.)

- The Historical Baseline Expenditures will be blended with the Regional Expenditures from the Adjusted MA Rate Book.
- The weighting of the Regional Expenditures component in the PY benchmark will increase over the model performance period.

### Blending the Historical Baseline Expenditures with the Regional Expenditures

<table>
<thead>
<tr>
<th>Period</th>
<th>DCE’s Historical Baseline Expenditures</th>
<th>Regional Expenditures (Adj. MA Rate Book)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PY 1 (2021)</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td>PY 2 (2022)</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td>PY 3 (2023)</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>PY 4 (2024)</td>
<td>55%</td>
<td>45%</td>
</tr>
<tr>
<td>PY 5 (2025)</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
After incorporating Regional Expenditures, CMS will risk adjust the benchmark to account for the risk profiles of the beneficiaries aligned to the DCE for the performance year.

As with risk standardization, CMS will apply the modified risk adjustment methodology to achieve two primary goals:

1. Improve the accuracy of risk adjustment for complex, high-risk beneficiaries with serious illness.
2. Mitigate the influence of coding intensity on risk adjustment.

CMS will also apply an adjustment to the benchmark to account for the regional Geographic Adjustment Factors (GAFs) applied to payments in the performance year.

---

1. GAFs are applied to Medicare FFS payments to account for county pricing differences (e.g., the Medicare area wage index, and the geographic practice cost index.)
Discount and Quality Withhold

**Step 1: Apply Discount**

*Global Only*

- Reduction to the benchmark, that increases each PY

**Step 2: Assess Quality**

*Global & Professional*

- Reduction to the benchmark applied prior to the PY
- Quality Withhold
- Quality Performance Earn Back
- DCEs can earn back some or all of the Quality Withhold at the end of the PY, based on their performance on quality measures

**Step 3: Apply High Performers’ Pool (HPP)**

*Global & Professional*

- The amount of the Quality Withhold that DCEs fail to earn back contributes to the High Performers’ Pool; high performing DCEs have the opportunity to earn a portion of this pool

---

1. Note, the quality strategy was updated in December 2019.
   - Advanced Care Planning quality measure removed. A new Care coordination/planning measure is currently under development.
   - A pre-defined performance benchmark will serve as the continuous improvement / sustained exceptional performance (CI/SEP) criteria for PY2
## Discount and Quality Withhold (cont.)

### Discount and Quality Withhold Impact on PY Benchmark

<table>
<thead>
<tr>
<th>Step 1: Apply Discount Global Only</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount Global Only</td>
<td>Discount</td>
<td>-2%</td>
<td>-2%</td>
<td>-3%</td>
<td>-4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 2: Assess Quality Global &amp; Professional</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Withhold Global &amp; Professional</td>
<td>Quality Withhold</td>
<td>-5%</td>
<td>-5%</td>
<td>-5%</td>
<td>-5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 3: Apply HPP Global &amp; Professional</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>High Performers’ Pool (HPP)</td>
<td>High Performers’ Pool (HPP)</td>
<td>N/A</td>
<td>Up to +TBD%</td>
<td>Up to +TBD%</td>
<td>Up to +TBD%</td>
</tr>
</tbody>
</table>

### Quality Measures

- **Patient / Caregiver Experience Survey**[^3]
- **Risk Standardized All Condition Readmission**[^3]
- **Risk Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions**[^3]
- **Care Coordination / Planning Under Development**
- **Days Spent at Home Under Development**
  (for High Needs DCE type only)

---

1. For PY1, CMS anticipates using pay-for-reporting for the quality measure set that will be used to determine the DCE’s quality performance.
2. The High Performers’ Pool will not be applicable in PY1; the detailed methodology for HPP will be made available prior to PY2.

[^3]: Standard DCE Regional Expenditures Risk / GAF Adjust Discount / Quality

---

### Notes

- Historical Expenditures
- Trend Baseline
- Risk / GAF Stand.
- Regional Expenditures
- Risk / GAF Adjust

---

**CMS**

[22]
Discount and Quality Withhold (cont.)

- Payment for quality will be tied to demonstrable continuous improvement / sustained exceptional performance (CI/SEP) in PY 3 - PY 5.
- Specifically, half of the quality withhold will be tied to a set of CI/SEP criteria (PY 3 - PY 5) requiring either improvement relative to criteria or, for high performing DCEs, maintenance of performance.
- In PY2, a pre-defined performance benchmark¹ will serve as the CI/SEP criteria.

1. This is new relative to the RFA and the pre-defined performance benchmark criteria is under development.

Calculation of Quality Performance Earn Back

<table>
<thead>
<tr>
<th>If DCE meets CI/SEP criteria</th>
<th>If DCE fails to meet CI/SEP criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Score Up to 100%</td>
<td>Quality Withhold 5%</td>
</tr>
<tr>
<td>Quality Score Up to 100%</td>
<td>Half of Quality Withhold 2.5%</td>
</tr>
</tbody>
</table>

¹. This is new relative to the RFA and the pre-defined performance benchmark criteria is under development.
New Entrant & High Needs Population
DCE Benchmark
## Overview of New Entrant DCE & High Needs DCE Benchmark Methodology

<table>
<thead>
<tr>
<th>PY1 – PY3</th>
<th>PY4 &amp; PY5</th>
</tr>
</thead>
<tbody>
<tr>
<td>PY1</td>
<td>PY2</td>
</tr>
</tbody>
</table>

- Aligned beneficiaries’ historical expenditures are not incorporated into the PY benchmark.
- Only the regional expenditures, as measured by the Adjusted MA Rate described earlier, are used to establish the PY Benchmark.

- Beginning in PY4, the benchmark will incorporate aligned beneficiaries’ recent experience to establish the Historical Baseline Expenditures. The Historical Baseline Expenditures will be a weighted average of the recent years’ aligned beneficiary Medicare FFS claims:
  - PY4 (2024): 2021 (33%) and 2022 (67%)
  - PY5 (2025): 2021 (10%), 2022 (30%), and 2023 (60%)
- The Historical Baseline will then be blended with the Regional Expenditures (i.e. adj. MA Rate Book) to establish the benchmark, using a weighted average:
  - PY4 (2024): Historical Baseline (55%), Regional Expenditure (45%)
  - PY5 (2025): Historical Baseline (50%), Regional Expenditure (50%)

The benchmark methodology for New Entrant and High Needs DCEs is consistent with the approach for voluntary aligned beneficiaries in a Standard DCE.

Other benchmarking steps (e.g., Risk and GAF Adjustment) will continue to apply.
Reconciliation Against the Benchmark
Example of Final Reconciliation

After the Performance Year is completed, CMS compares all Medicare FFS expenditures for services delivered to aligned beneficiaries against the DCE’s performance year benchmark to determine shared savings or shared losses.

<table>
<thead>
<tr>
<th>Final PY Benchmark</th>
<th>Total PY Expenditures</th>
<th>Gross Savings</th>
<th>Application of Risk Corridors</th>
<th>Shared Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1000 PBPM</td>
<td>$940 PBPM</td>
<td>$60 PBPM (6% of benchmark)</td>
<td>$28.5 PBPM</td>
<td></td>
</tr>
</tbody>
</table>

- **Performance Year Benchmark:** $1000 PBPM
- **Total PY Expenditures:** $940 PBPM
- **Gross Savings:** $60 PBPM (6% of benchmark)
- **Application of Risk Corridors:**
  - Professional Corridor
    - 0-5%: $50 x 50% = $25 PBPM
    - 5-10%: $10 x 35% = $3.5 PBPM
- **Shared Savings:** $28.5 PBPM

1. The Capitation Payment Mechanisms under the Direct Contracting Model include TCC, PCC, and Advanced Payments, and recoupment / reconciliation will be applied before calculation of total expenditures.
Open Q&A
Direct Contracting Open Q&A

Please submit questions via the Q&A pod to the right of your screen. Specific questions about your organization can be submitted to DPC@cms.hhs.gov
Model Timeline
# Model Timeline

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Implementation Period (IP) DCE Applicants</th>
<th>Performance Period (PY1) DCE Applicants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Application Period</strong></td>
<td>November 25, 2019 – February 25, 2020</td>
<td>March 2020 – May 2020</td>
</tr>
<tr>
<td></td>
<td>(Application tool opened December 20, 2019)</td>
<td></td>
</tr>
<tr>
<td><strong>DCE Selection</strong></td>
<td>May 2020</td>
<td>September 2020</td>
</tr>
<tr>
<td><strong>Deadline for applicants to sign and return</strong></td>
<td>June 2020 (IP PA)</td>
<td>December 2020</td>
</tr>
<tr>
<td>Participant Agreement (PA)</td>
<td>December 2020 (Performance Period PA)</td>
<td></td>
</tr>
<tr>
<td><strong>Initial Voluntary Alignment Outreach and</strong></td>
<td>June 2020</td>
<td>January 2021</td>
</tr>
<tr>
<td>start of IP or PY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*This timeline may be subject to change. Please check the Directing Contracting webpage for webinar and office hour dates and times.*
Upcoming Webinars and Office Hours
# Upcoming Webinars and Office Hours

<table>
<thead>
<tr>
<th>Webinar</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Hour Session for Payment: Part 1</td>
<td>February 4, 2020</td>
</tr>
<tr>
<td></td>
<td>(register here)</td>
</tr>
<tr>
<td>Office Hour Session for Payment: Part 2</td>
<td>February 11, 2020</td>
</tr>
<tr>
<td></td>
<td>(register here)</td>
</tr>
</tbody>
</table>

*This timeline may be subject to change. Please check the Direct Contracting webpage for webinar and office hour dates and times.*
Audience Poll

How likely are you to apply to participate in the Direct Contracting model?

a) Very likely
b) Likely
c) Unlikely
d) Very unlikely
e) Unsure
Contact Information

Direct Contracting Webpage
(includes link to application):
https://innovation.cms.gov/initiatives/direct-contracting-model-options/

Email:
DPC@cms.hhs.gov

Salesforce Support:
CMMIForceSupport@cms.hhs.gov