CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE AND MEDICAID INNOVATION

Findings at a Glance

Global and Professional Direct Contracting (GPDC) Model

Evaluation of the Second Performance Year (2022)

MODEL OVERVIEW

The Global and Professional Direct Contracting (GPDC) Model was a voluntary, Accountable Care Organization (ACO) model designed to put patients at the center of their care. Building upon lessons learned from initiatives involving Medicare ACOs, such as the Medicare Shared Savings Program and the Next Generation ACO Model, this model provided greater individualized attention to a beneficiary's specific health care needs within fee-for-service (FFS) Medicare and changed financial incentives to reward high quality care. Participants were Direct Contracting Entities (DCEs), a model-specific term for ACOs. The GPDC Model began in April 2021. New participants and continuing participants in the GPDC Model respectively started and joined the ACO Realizing Equity, Access, and Community Health (ACO REACH) Model in January 2023.

PARTICIPANTS

49,009 Total Participant Providers in 99 DCEs in the GPDC Model in PY2022

1.9 million Number of beneficiaries aligned to GPDC providers, almost all (96%) in Standard DCEs

Financial Elections:

73% of participants elected Global risk-sharing arrangements (100% savings/losses) and primary care capitation.

Types of Organizations:

44% of participants were networks of individual practices; 33% were medical group practices; 22% were integrated delivery system/hospital systems.

Standard DCEs (n=78)

Providers have **substantial Medicare FFS / Innovation Center model experience**

5,000+ aligned beneficiaries/DCE

Beneficiaries:

- 19% racial/ethnic minority
- 14% dually eligible
- 5.9 average chronic conditions

Strategies to engage providers:

- 75% embedded staff within practices, such as care managers and health educators

New Entrant DCEs (n=13)

Providers generally have **limited Medicare FFS / Innovation Center model experience**

2,000-5,000 aligned beneficiaries/DCE

Beneficiaries:

- 25% racial/ethnic minority
- 17% dually eligible
- 6.4 average chronic conditions

Strategies to engage providers:

- 92% focused on primary care touchpoints such as the annual wellness visit

High Needs DCEs (n=8)

Providers have **experience serving Medicare FFS beneficiaries with complex needs**

250-1,250 aligned beneficiaries/DCE

Beneficiaries:

- 33% racial/ethnic minority
- 68% dually eligible
- 12.3 average chronic conditions

Strategies to engage providers:

- 86% offered extended or weekend hours for practices or urgent / extended care

This document summarizes the evaluation report prepared by an independent evaluation contractor. To learn more about the GPDC model and to download the Second Annual Evaluation Report, visit https://innovation.cms.gov/innovation-models/gpdc-model.

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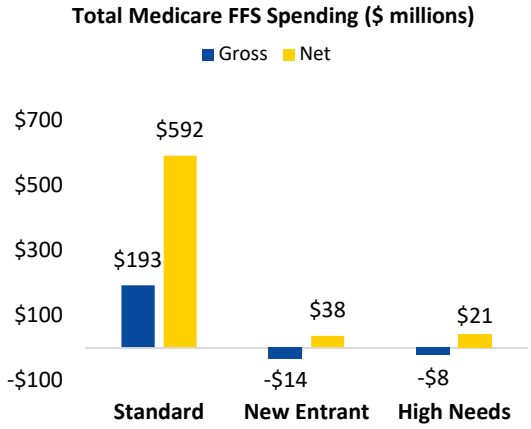
KEY TAKEAWAYS

In the second year of GPDC, the model showed mixed results in gross spending but consistent, significant increases in net spending relative to a comparison group of similar fee-for-service Medicare beneficiaries in their markets. Standard DCEs improved multiple quality measures but increased gross spending, particularly from acute care hospitalizations. New Entrants and High Needs DCEs reduced gross spending through improvements in utilization and minor improvements in quality. CMS is reviewing the impact of these increases in net spending on the ACO REACH Model. Future reports will provide results for new and continuing participants that transitioned to ACO REACH, with an emphasis on health equity outcomes and the model's impacts on underserved communities.

FINDINGS

- **Standard DCEs** improved on multiple quality measures, such as ambulatory care-sensitive conditions (ACSC), but increased professional, specialty, and acute care spending. Standard DCEs increased gross Medicare FFS spending by $193 million (0.8%).
- **New Entrant DCEs** reduced specialty care and emergency department (ED) visits with non-significant reductions in gross spending by $14 million (-1.4%) and improvement in one quality measure.
- **High Need DCEs** reduced utilization in high-cost care settings, had marginal improvements in quality, and reductions in total gross spending ($8 million [3.8%]).



After accounting for shared savings payouts to participants, all DCE types increased net spending.

	Standard DCEs (PY2021–PY2022)	New Entrant DCEs (PY2021–PY2022)	High Needs DCEs (PY2022 only)
Spending	▲ Professional services, specialty care, acute care	▼ Specialty care	▼ Specialty care*, acute care, outpatient, skilled nursing
Utilization	▲ Acute care hospitalizations and lengths of stay	▼ ED visits	▼ ED visits, acute care hospitalizations & lengths of stay
Quality	▼ Unplanned admissions for beneficiaries with MCC ▼ Hospitalizations for ACSC ▲ Use of recommended diabetes care	▲ Use of recommended diabetes care	▼ All-cause readmissions* ▼ Hospitalizations for ACSC*

NOTES: MCC=multiple chronic conditions. Findings are significant at $p<0.05$, except those marked * are significant at $p<0.10$. Triangles indicate an increase (▲) or decrease (▼) in measure. Green shaded boxes indicate the results were an improvement. Red shaded boxes indicate the results were unfavorable.

EVALUATION METHODOLOGY: These results were obtained using statistically rigorous evaluation methods. GPDC Model participants were assessed relative to a comparison group comprising beneficiaries with characteristics similar to GPDC beneficiaries. These beneficiaries resided within the same health care markets as the GPDC beneficiaries during the same time period but were mainly seen by providers not participating in the model. These providers included those participating in the Medicare Shared Savings Program and other Innovation Center models as well as providers without such experience. Evaluation results differ from the model's financial results, which use a benchmark that blends historical spending and regional expenditures and reflect incentive payments to participants.