Direct Contracting Model: Professional and Global Options

Model Overview Webinar

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Speakers

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Agenda

1. Model Design and Goals
2. Participation and Eligibility
3. Direct Contracting Entity (DCE) Types
4. Beneficiary Alignment
5. Payment and Quality
6. Benefit Enhancements and Patient Engagement Incentives
7. Model Timeline
8. Upcoming Webinars and Questions

Model Design and Goals

CMS Innovation Center Statute

"The purpose of the [CMS Innovation Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles."

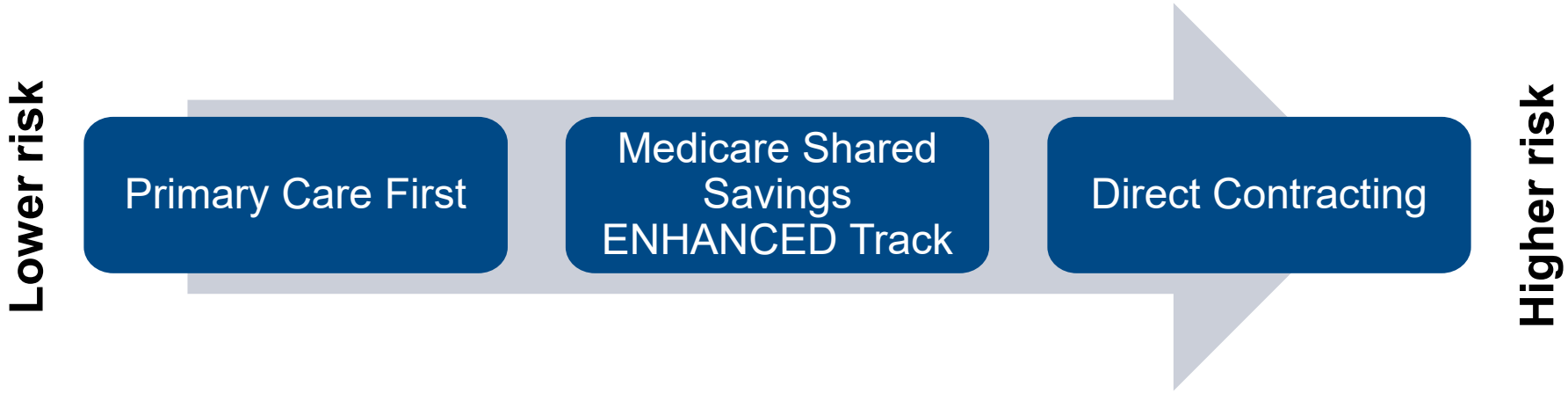
Three scenarios under which the duration and scope of an initial model test may be expanded:

1. Quality improves; cost neutral
2. Quality neutral; cost reduced
3. Quality improves; cost reduced (best case)

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking.

Background

- Direct Contracting Model (Direct Contracting), together with the Primary Care First Model and the updated Medicare Shared Savings Program ENHANCED Track, are part of the CMS strategy to use the redesign of primary care to drive broader delivery system reform to improve health and reduce costs.
- The model builds off the Next Generation Accountable Care Organization (ACO) Model and innovations from Medicare Advantage and private sector risk sharing arrangements.



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.

Approach

Goal	How CMS expects that Direct Contracting will achieve these goals
Transform risk-sharing arrangements	• Flexible cash flows • Predictable, prospective spending targets • Payment that recognizes the challenges of caring for complex chronically ill populations
Empower and engage beneficiaries	• Enhanced voluntary alignment • Various benefit enhancements and patient engagement incentives
Reduce provider burden	• Small set of core quality measures • Waivers to facilitate care delivery • Opportunities for organizations new to Medicare FFS to participate

Risk Options

Professional	Global	Geographic (proposed)
• ACO structure with Participants and Preferred Providers defined at the TIN/NPI level • 50% shared savings/shared losses with CMS • **Primary Care Capitation (PCC)** equal to 7% of total cost of care for enhanced primary care services	• ACO structure with Participants and Preferred Providers defined at the TIN/NPI level • 100% risk • Choice between **Total Care Capitation (TCC)** equal to 100% of total cost of care provided by Participant and Preferred Providers, and PCC	• Would be open to entities interested in taking on regional risk and entering into arrangements with clinicians in the region • 100% risk • Would offer a choice between **Full Financial Risk with FFS claims reconciliation** and TCC

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Model Timeframe

- Implementation Period (IP) in 2020 (optional)
  - IP provides time to engage in beneficiary alignment activities and plan care coordination and management strategies prior to the first performance year (PY1).
  - Model participants can also participate in other shared savings initiatives models such as the Medicare Shared Savings Program and Next Generation ACO Model, and other Innovation Center models.
- Five Performance Years (PYs) from 2021 through 2025
  - Model Payments begin in PY1 (2021).
  - Direct Contracting will be an **Advanced Alternative Payment Model (APM)**.
  - Model participants cannot participate in the Medicare Shared Savings Program or other shared savings initiatives.

Participation and Eligibility

Model Participants

A Direct Contracting Entity (DCE) is an ACO-like organization, comprised of health care providers and suppliers, operating under a common legal structure, which enters into an arrangement with CMS and accepts financial accountability for the overall quality and cost of medical care furnished to Medicare FFS beneficiaries aligned to the entity.

Standard DCEs	DCEs that have experience serving Medicare FFS beneficiaries.
New Entrant DCEs	DCEs that have not traditionally provided services to a Medicare FFS population. Beneficiaries are aligned primarily based on voluntary alignment.
High Needs Population DCEs	DCEs that serve Medicare FFS beneficiaries with complex needs employing care delivery strategies, such as those used by Program of All-Inclusive Care for the Elderly (PACE) organizations.

What is a Direct Contracting Entity?

- Legal entity identified by tax identification number (TIN) that contracts with CMS for the Direct Contracting Model
- Minimum of at least 5,000 Medicare FFS beneficiaries, with glide path for New Entrant DCEs; lower beneficiary threshold for High Needs DCEs
- Responsible for receiving shared savings and paying shared losses to CMS
- **Must be capable of administering payments to DC Participant Providers, and if applicable, Preferred Providers**

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 the option to participate in benefit enhancements or patient engagement incentives

Preferred Providers

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

Eligible Providers and Suppliers

- DC Participant and Preferred Providers **must be Medicare-enrolled providers or suppliers and identified on the DCE's Participant Provider list or Preferred Provider list by name**, National Physician Identifier (NPI), TIN, CMS Certification Number (CCN), and Legacy TIN or CCN (if applicable).
- DC Participant and Preferred Providers may include but are not limited to:
  - Physicians or other Practitioners in group practice arrangements
  - Network of individual practices of physicians or other practitioners
  - Federally Qualified Health Centers (FQHCs)
  - Rural Health Clinics (RHCs)
  - Critical Access Hospitals (CAHs)

Prohibited Participants

- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers
- Ambulance suppliers
- Drug or device manufacturers
- Providers and suppliers excluded or otherwise prohibited from participation in Medicare or Medicaid

DCE Service Area

- The DCE Service Area, used for beneficiary alignment, consists of a Core Service Area and an Extended Service Area. DCEs can operate in multiple, non-contiguous service areas including in the same state or in multiple states.
  - **Core Service Area** includes all counties in which DC Participant Providers have office locations.
  - **Extended Service Area** includes all counties contiguous to the Core Service Area.
- Service area is distinct from a DCE's region, which is used to determine the DCE's Performance Year benchmark; a DCE's region includes all counties where DCE-aligned beneficiaries reside.

Beneficiary Eligibility

Beneficiaries will be eligible for alignment to a DCE if they meet the following criteria:

- Are enrolled in both Medicare Parts A and B;
- Are not enrolled in an Medicare Advantage plan, Medicare Cost Plan under section 1876, PACE organization, or other Medicare health plan;
- Have Medicare as their primary payer;
- Are a resident of the United States; and
- Reside in a county included in the DCE's service area.

Beneficiary Eligibility (Continued)

For High Needs Population DCEs, beneficiaries also must meet at least one of the following criteria:

- Have conditions that impair their mobility and/or
- Meet one of the complex high needs special conditions for eligibility:
  - Significant chronic or other serious illness (Risk Score using CMS Hierarchical Condition Category (CMS-HCC) > 3.0);
  - Risk score greater than 2.0 and less than 3.0 with two or more unplanned hospital admissions in the previous 12 months; or
  - Signs of frailty, evidenced by claim for a hospital bed or transfer equipment for use in the home.

Direct Contracting Entity (DCE) Types

Standard DCEs

- DCEs with substantial historical experience serving Medicare FFS beneficiaries.
- Use both voluntary and claims-based beneficiary alignment.
- Minimum of 5,000 aligned beneficiaries is required prior to the start of each performance year.
- Performance Year Benchmark is a blend of regional expenditures (Adjusted MA Rate Book) with aligned beneficiary historical expenditures.

New Entrant DCEs

- DCEs with limited historical experience delivering care to Medicare FFS beneficiaries.
  - Not more than 50% of the DC Participant Providers may have prior experience in the Medicare Shared Shavings Program, Next Generation ACO, the Comprehensive ESRD Care Model or the Pioneer ACO Model
- Voluntary alignment used primarily; claims-based alignment also conducted.
  - For PY1-3, beneficiaries aligned via claims must not exceed 3,000.
  - For PY4-5, DCEs will be expected to align 3,000 or more beneficiaries via claims.
- Performance Year Benchmark is based on regional expenditures (not historical expenditures) for first three performance years.

New Entrant DCEs (Continued)

Glide path for minimum number of aligned beneficiaries required:

Performance Year	Number of Beneficiaries
PY1	1,000
PY2	2,000
PY3	3,000
PY4	5,000
PY5	5,000

High Needs Population DCEs

- DCEs that focus on beneficiaries with conditions that impair mobility AND/OR complex/high needs who have:
  - Significant chronic illness (Risk score >3.0); OR
  - Risk score greater than 2.0 and less than 3 AND two unplanned hospital admissions in previous 12 months; OR
  - Signs of frailty (e.g., Durable Medical Equipment (DME) claim for hospital bed or transfer equipment).
- DCEs caring for one or more specific sub-populations must clearly specify the clinical criteria used to define these populations as well as still meet the above eligibility criteria.
- Expected to employ care delivery strategies such as those used by PACE organizations.
- Use both voluntary and claims-based beneficiary alignment.
- Performance Year Benchmark is based on regional expenditures (not historical expenditures) in first three performance years.

High Needs Population DCEs (Continued)

Glide path for minimum number of aligned beneficiaries required:

Performance Year	Number of Beneficiaries
PY1	250
PY2	500
PY3	750
PY4	1,200
PY5	1,400

Beneficiary Alignment

Beneficiary Alignment

CMS will align beneficiaries to a DCE in two ways:

1. **Voluntary alignment:** Beneficiaries choose to align to a DCE by designating a DC Participant Provider affiliated with the DCE as their primary clinician or main source of care
2. **Claims-based alignment:** CMS aligns a beneficiary based on where the beneficiary receives the plurality of their primary care services, as evidenced in claims utilization data.

Voluntary alignment takes precedence over claims-based alignment.

Voluntary Alignment

A beneficiary can voluntarily align to a DCE by one of two means:

1. **Electronic voluntary alignment:** Beneficiary selects a “primary clinician” on MyMedicare.gov.
2. **Paper-based voluntary alignment:** Beneficiary identifies a primary clinician by completing a paper-based form using the “Voluntary Alignment Form” template developed by CMS.

If a beneficiary seeks voluntary alignment through both electronic and paper-based means, the electronic choice will take precedence.

Frequency of Voluntary Alignment

- **Prospective Alignment**
  - Annual alignment process with all voluntary alignment and claims-based alignment completed prior to each performance year.
- **Prospective Plus Alignment *(optional)***
  - Quarterly alignment process in which voluntarily aligned beneficiaries are added to the DCE's aligned beneficiary population throughout the performance year.
  - Prospective Plus alignment will be used for two purposes: (1) calculating the Performance Year Benchmark, and (2) determining aligned beneficiaries for the purpose of making monthly capitated payments.

Schedule for Prospective Plus

Alignment Date	Months DCE Alignment Recognized*
January 1	12 months (January through December)
April 1	9 months (April through December)
July 1	6 months (July through December)
October 1	3 months (October through December)

*Assumes continuous alignment to the DCE through the end of the performance year. Beneficiaries may contribute fewer months due to loss of alignment eligibility or due to mortality.

Claims-based Alignment

- **Claims-based Alignment will occur prior to the start of each performance year (PY).**
- Beneficiaries will be aligned based on historical claims for certain primary care services furnished by DC Participant Providers, identified by TIN/NPI combination.
- A two-year look back period, the “Alignment Period,” will be used to identify Primary Care Qualified Evaluation and Management (PQEM) claims furnished by a DC Participant Provider (either a primary care practitioner or select non-primary care specialists).
  - Consists of two consecutive 12-month periods, with the second period ending six months prior to the start of the relevant performance year.
- CMS will align a beneficiary to a DCE if the beneficiary has historically received the plurality of their PQEM services from the DCE’s DC Participant Providers.

Claims-based Alignment Algorithm

Alignment of a beneficiary for a performance year and each base year is determined by comparing:

1. Weighted allowable charge for all PQEM services received from DC Participant Providers in the DCE; and
2. Weighted allowable charge for all PQEM services received from each physician practice (including institutional practices) not participating in the DCE.

Allowable Charges Billed by Primary Care Specialties	Basis for Alignment
Greater than or Equal to 10%	• Allowable charges for PQEM services provided by primary care specialists
Less than 10%	• Allowable charges for PQEM services provided by physicians and practitioners with certain non-primary specialties

Legacy TINs or CCNs

A Legacy TIN or CCN is a TIN or CCN that was used by a proposed DC Participant Provider when billing for primary care services during the Alignment Period but will not be used during the performance year.

- Submission of Legacy TINs and CCNs can help ensure that services furnished during the Alignment Period are accurately reflected during beneficiary alignment.
- Legacy TINs or CCNs are only submitted once a year, prior to the start of the performance year, on the Proposed DC Participant Provider List.
- Submission of Legacy TINs or CCNs are required for New Entrant DCEs, optional for Standard DCEs, and High Needs DCEs are prohibited from submitting them.

Alignment for the IP

CMS will conduct Alignment for the IP:

- Allows DCEs to establish a relationship with beneficiaries for the benefit of beneficiary engagement,
- Includes both voluntary alignment and claims-based alignment that will be conducted at the beginning of the IP for certain primary care services furnished by DC Participant Providers as identified by TIN/NPI combination, and
- Does not include verification of Medicare program overlaps.

Payment and Quality

Financial Goals and Opportunities

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.

Payment Mechanisms

The Thesis

Having control of the flow of funds with their downstream providers and suppliers will enable DCEs to improve care coordination and delivery, and to better manage the health needs of their aligned population, resulting in reduced costs and better outcomes.

The Direct Contracting Model offers DCEs several mechanisms to receive stable monthly payments.

Capitation Payment Mechanisms

DCEs receive a capitation payment covering total cost of care or cost of primary care services.

MANDATORY

Payment amount is **NOT RECONCILED** against actual claims expenditures.

Advanced Payment

DCEs that select Primary Care Capitation may receive an advanced payment of their FFS non-primary care claims.

VOLUNTARY

Payment amount is **RECONCILED** against actual claims expenditures

Capitation Payments

DCEs must select one of the two Capitation Payment Mechanisms. The Capitation Payment Mechanisms available vary based on the Risk Option selected.

1	**Primary Care Capitation (PCC)**	Monthly capitation payments for primary care services furnished to aligned beneficiaries.	*Available for Global and Professional*
2	**Total Care Capitation (TCC)**	Monthly capitation payments for all services furnished to aligned beneficiaries.	*Available for Global Only*

Reconciliation

- **Shared Savings or Shared Losses** will be determined by CMS after comparing actual Medicare expenditures against a Final Performance Year Benchmark.
  - Medicare expenditures include capitated payments, Advanced Payments, and FFS claim amounts paid by CMS directly.
  - Discount is applied to the Performance Year Benchmark for Global as primary mechanism for CMS to obtain savings.
  - 5% quality withhold is applied to Performance Year Benchmark to incentivize quality performance.
- **Final Financial Reconciliation:** Conducted for all DCEs after the end of the performance year and sufficient time has passed for claims processing.
- **Provisional Financial Reconciliation *(optional)*:**Conducted shortly after the end of the performance year based on six months of expenditures.

Key Features of the Direct Contracting Performance Year Benchmark

Direct Contracting will introduce several innovative methodologies to benchmark construction, including:

MA Rate Book	The DCE's Performance Year Benchmark will incorporate an adjusted version of the Medicare Advantage Rate Book.
US Per Capita Cost (USPCC)	The DCE's Performance Year Benchmark will use the USPCC, developed annually by the Office of the Actuary (OACT), to establish the trend rate.
Risk Adjustment	The DCE's Performance Year Benchmark will be adjusted to account for the risk of the population. CMS is exploring the possible application of a risk adjustment methodology that better addresses the costs experienced by complex and chronically ill populations.

Quality Performance

- Quality Strategy is designed to:
  - Reduce reporting burden;
  - Focus on relevant, actionable measures; and
  - Provide incentives for continuous improvement and sustained exceptional performance.
- Measure tools include:
  - Claims-based utilization and process measures; and
  - Patient experience measures
- DCEs may choose to implement a Patient Activation Measure (PAM) survey.

Proposed Quality Measure Set

Claims-based Measures

- Risk-Standardized, All Condition Readmission
- All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
- Advanced care plan
- Days at home *(proposed – to be developed)*

Patient Experience Survey

- CAHPS®* for ACOs survey

*CAHPS®, stands for Consumer Assessment of Healthcare Providers and Systems, is a registered trademark of the Agency for Healthcare Research and Quality

Benefit Enhancements and Patient Engagement Incentives

Benefit Enhancements and Patient Engagement Incentives

CMS is seeking to emphasize high-value services and support the ability of DCEs to manage the care of beneficiaries through benefit enhancements and patient engagement incentives.

- We propose to use the authority under Section 1115A of the Social Security Act (Section 3021 of the Affordable Care Act) to conditionally waive certain requirements.
- DCEs may choose which, if any, of these benefit enhancements and patient engagement incentives to implement.
- Applicants must provide information regarding the proposed implementation of selected benefit enhancements and patient engagement incentives in their applications.

Building on the Next Generation ACO Model

Direct Contracting is proposing the same benefit enhancements and patient engagement incentives available in the Next Generation ACO Model:

- 3-Day SNF Rule Waiver Benefit Enhancement
- Telehealth Expansion Benefit Enhancement
- Post-Discharge Home Visits Rule Benefit Enhancement
- Care Management Home Visits Benefit Enhancement
- Chronic Disease Management Reward Program
- Cost Sharing Support for Part B Services

New Proposed Benefit Enhancements

CMS also proposes to implement three new benefit enhancements to improve care coordination and service delivery:

1	**Home Health Services Certified by Nurse Practitioners**	Allows nurse practitioners (per state scope of practice) to certify beneficiaries for home health services, improving care coordination and transitions.
2	**Home Health Homebound Requirement**	Provides access to home health services for beneficiaries with specified conditions that are not homebound.
3	**Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit**	Waives requirement that beneficiaries electing the Medicare Hospice Benefit give up their right to receive curative care.

Model Timeline

Model Timeline

Timeline	Implementation Period (IP) DCE Applicants	Performance Period (PY1) DCE Applicants
Application Period	November 25, 2019 – February 25, 2020 (Application tool available December 20, 2019 [tentative])	March 2020 – May 2020
DCE Selection	April 2020	September 2020
Deadline for applicants to sign and return Participant Agreement (PA)	Late April 2020 (Implementation Period PA) December 2020 (Performance Period PA)	December 2020
Initial Voluntary Alignment Outreach and start of IP or PY	May 2020	January 2021

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

Upcoming Webinars and Questions

Upcoming Webinars

Webinar	Date
Office Hour Session for Questions and Answers – 1	December 17, 2019
Benefit Enhancements and Patient Engagement Incentives	December 18, 2019
Application Overview	January 7, 2020
Office Hour Session for Questions and Answers – 2	January 8, 2020
Payment – Part 1 (Risk Sharing, Risk Mitigation, Cash Flow)	January 15, 2020
Payment – Part 2 (Risk Adjustment, Benchmarking, Quality)	January 22, 2020
Office Hour Session for Questions and Answers – 3	January 28, 2020
Office Hour Session for Questions and Answers – 4	February 11, 2020

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

Questions

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