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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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.

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

DCE Types

Standard	New Entrant	High Needs
DCEs with substantial historical claims-based experience serving Medicare FFS	DCEs with limited experience delivering care to Medicare FFS beneficiaries	DCEs that focus on beneficiaries with complex, high needs, including individuals dually eligible for Medicare and Medicaid

Risk Arrangement Options

Professional and Global are available for each DCE type

Performance Year Benchmark

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

DCE Type	Standard		New Entrant	High Needs
Alignment Option[1]	Claims-Based Alignment	Voluntary Alignment	Both Options	Both Options
PY1	***Standard Benchmarking Approach*** *using historical expenditures for beneficiaries that would have aligned to the DCE in the base years (CY17 – CY19)*	***Regional Benchmarking Approach*** *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)*		
PY2				
PY3				
PY4		***Modified Standard Benchmarking Approach*** *using recent historical expenditures (from PY1 – PY3, as applicable) for beneficiaries aligned to the DCE*		
PY5				

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

Calculate Historical Expenditures	*Trend Baseline with USPCC*	*Apply Risk- and Geographic-Standardization*	*Incorporate Regional Expenditures (MA Rate Book)*	*Adjust for Risk and Geography for Performance Year*	*Apply Discount / Quality Withhold*
Calculate historical expenditures based on beneficiaries aligned to the DCE through Participant Providers	Apply a trend based on projected US Per Capita Cost (USPCC) to account for changes in health care spending by year	Standardize historical expenditures for variations in beneficiary health risk and Geographic Adjustment Factors (GAFs)	Blend historical expenditures with performance year regional expenditures using adjusted Medicare Advantage (MA) rate book	Adjust for the health risk and Geographic Adjustment Factors (GAFs) of aligned beneficiaries in performance year	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 Alignment[1]

- 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

Historical Base Year Weighting for the Baseline Period

Fixed Baseline Years

Baseline Year	2017	2018	2019
% Contribution to Historical Baseline	10%	30%	60%

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.

Calculate Historical Expenditures: Voluntary Alignment[1]

- 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

	PY4 (2024)		PY5 (2025)		
Baseline Year	2021	2022	2021	2022	2023
% Contribution to Historical Baseline	33%	67%	10%	30%	60%

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

Trend Baseline with USPCC

- 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 year1

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

	PY 1 (2021)	PY2 (2022)	PY3 (2023)	PY4 (2024)	PY5 (2025)
DCE's Historical Baseline Expenditures	65%	65%	60%	55%	50%
Regional Expenditures (Adj. MA Rate Book)	35%	35%	40%	45%	50%

Risk and GAF Adjust for Performance Year

- 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)[1] 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*	*Quality Withhold*	Reduction to the benchmark applied prior to the PY
	Quality Performance Earn Back[1]	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

Top performing DCEs may exceed 100% of their pre-discounted benchmark after quality and HPP adjustments

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.)

		Impact on PY Benchmark				
		PY1[1] (2021)	PY2 (2022)	PY3 (2023)	PY4 (2024)	PY5 (2025)
Step 1: Apply Discount *Global Only*	*Discount*	-2%	-2%	-3%	-4%	-5%
Step 2: Assess Quality *Global & Professional*	*Quality Withhold*	-5%	-5%	-5%	-5%	-5%
	Quality Performance Earn Back	Up to +5%	Up to +5%	Up to +5%	Up to +5%	Up to +5%
Step 3: Apply HPP[2] *Global & Professional*	*High Performers' Pool (HPP)*	N/A	Up to +TBD%	Up to +TBD%	Up to +TBD%	Up to +TBD%

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. Pay for performance in PY2

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 benchmark[1] will serve as the CI/SEP criteria.

Calculation of Quality Performance Earn Back

If DCE meets CI/SEP criteria

Quality Score (*Up to 100%*) × Quality Withhold (*5%*) = ***Up to 5% Earn Back***

If DCE fails to meet CI/SEP criteria

Quality Score (*Up to 100%*) × Half of Quality Withhold (*2.5%*) = ***Up to 2.5% Earn Back***

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

PY1 – PY3

PY1

- 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

PY2

PY3

PY4 & PY5

PY4

- 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%)

PY5

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

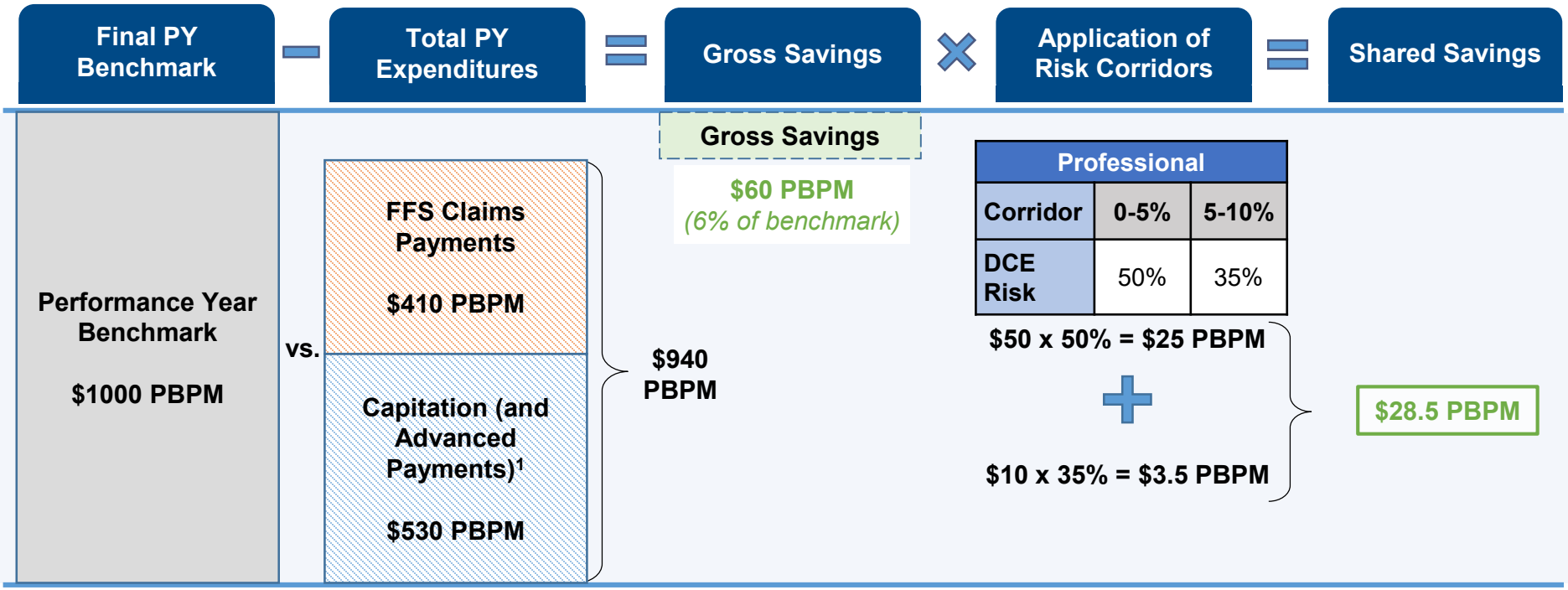
Other benchmarking steps (e.g., Risk and GAF Adjustment) will continue to apply

Reconciliation Against the Benchmark

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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



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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Direct Contracting Open Q&A

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Model Timeline

Timeline	Implementation Period (IP) DCE Applicants	Performance Period (PY1) DCE Applicants
Application Period	November 25, 2019 – February 25, 2020 *(Application tool opened December 20, 2019)*	March 2020 – May 2020
DCE Selection	May 2020	September 2020
Deadline for applicants to sign and return Participant Agreement (PA)	June 2020 *(IP PA)* December 2020 *(Performance Period PA)*	December 2020
Initial Voluntary Alignment Outreach and start of IP or PY	June 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 Office Hours

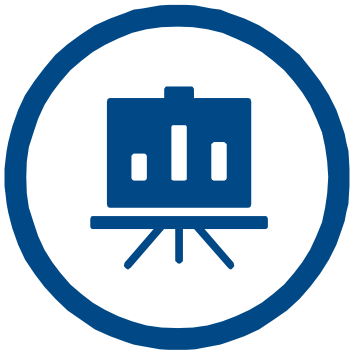
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Upcoming Webinars and Office Hours

Webinar	Date
Office Hour Session for Payment: Part 1	February 4, 2020 (register here)
Office Hour Session for Payment: Part 2	February 11, 2020 (register here)

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