Direct Contracting Model: Professional and Global Options

- Last Updated January 2020 -

What is it? The Direct Contracting (DC) Model is a voluntary, five-year Medicare Accountable Care Organization (ACO) model aimed at larger organizations that is scheduled to start Jan. 1, 2021. It aims to reduce administrative burden through partially or fully capitated payments for relevant Medicare Part A and Part B services. In 2021, it will feature two distinct risk options. CMS plans to add a third risk option *(i.e. the "geographic option")* in the future.

Do I still submit claims? Yes, clinicians continue to submit claims as normal but payments are reduced based on the financial risk option selected.

Will this model cover Part D costs? No, though CMS will consider it in future years.

Will it qualify as an Advanced Alternative Payment Model (APM)? Yes, and as a MIPS APM.

Will it be available nationwide? The Professional and Global Options will be available nationwide. The Geographic Option is expected to be available in certain geographic regions.

Is it a multi-payer model? No, this model will not be formally aligned with other payers.

How do I apply? A Request for Applications (RFA) was issued in November 2019 for the Professional and Global Options. Applicants interested in an optional patient alignment year in 2020 must apply by **Feb. 25, 2020.** A second application period will be conducted in spring 2020. To be eligible to apply in either case, practices must have previously submitted a Letter of Intent. Applications are non-binding; however, participation agreements are binding.

What should I know for applying? Applicants are not expected to have formed their legal entity prior to application, but must do so before signing a participation agreement. Applicants must provide a list of "participant providers" and "preferred providers." Medicare Advantage Organizations and Medicaid Managed Care Organizations (MCOs) are encouraged to apply. All relevant clinicians and entities will be subject to a program integrity screening.

Where can I find more information? At the CMS DC Model webpage and in the RFA. CMS will release more details on the financial methodology, risk adjustment, and quality performance in the coming months, as well as more details concerning the Geographic Option. This fact sheet will be periodically updated to reflect new information.

Model Selection Criteria

- Organizational structure
- Leadership and management
- Clinical care
- Data capacity
- Financial plan and risk-sharing experience
- Patient centeredness/beneficiary engagement

Participation

Participation for the Professional and Global Options will be defined at an Accountable Care Organization (ACO)-level with "Participant Providers" and "Preferred Providers" defined at the Tax Identification Number (TIN)/National Provider Identifier (NPI) level.

- ***Direct Contracting Entities (DCEs)*** are legal entities with their own TIN. DCEs comprised of a single "participant provider" (such as a group practice) may use its same TIN. Those comprised of 2+ "participant providers" must be a separate legal entity from either.

  Three types of DCEs may participate in the model:
  - Standard DCEs: Have prior experience serving Medicare beneficiaries
  - New Entrant DCEs: Do not traditionally serve Medicare beneficiaries*
  - High Needs Population DCEs: Serve Medicare beneficiaries with complex needs

  The following types of organizations are eligible:
  - Individual group practices
  - Networks of individual practices
  - Hospitals
  - Federally Qualified Health Centers
  - Rural Health Clinics
  - Critical Access Hospitals

  * New Entrant DCEs must:

  - Identify any legacy TINs from the Next Generation ACO model;
  - Have less than half of "Participant Providers" with prior experience in an ACO (including Next Gen, Shared Savings Program, Comprehensive ESRD Care, or Pioneer).
  - Not have more than 3,000 "alignable" beneficiaries during the baseline period.
  - Have the capacity to assume risk for total cost of care for aligned beneficiaries.

- ***"Participating Providers"*** Core Medicare-enrolled clinicians and suppliers responsible for aligning patients (and notifying them at the start of each year) and reporting quality. Subject to mandatory capitated payments as explained in financial methodology section.

- ***"Preferred Providers"*** Participate in downstream arrangements with DCEs. Contribute to DCE's goals and are covered by waivers but do not contribute to patient alignment. May, but are not obligated to, participate in whichever capitation option their DCE has selected and may agree to have FFS claims paid by CMS to be reduced by any amount ranging from 1% to 100% for services furnished under the DCE depending on the terms of agreement.

Beneficiary Eligibility Criteria

- Enrolled in both Medicare Parts A and B
- Not enrolled in an MA, Medicare Cost, PACE, or other Medicare health plan
- Have Medicare as the primary payer
- Are United States residents
- Reside in a county included in the DC Entity's service area

To be aligned to a High Needs Population DCE, one of the following must apply:

- Has a condition that impairs mobility (see Appendix F on pp 95 of the RFA)
- Has complex, high needs, i.e. one of the following:
  - HCC risk score of 3.0 or greater; **OR**
  - HCC risk score greater than 2.0 **AND** 2+ unplanned hospital admissions in past year; **OR**
  - Signs of frailty (e.g. claims for hospital bed or transfer equipment for home use)

* Note: High needs patients may (but are not required to be) dual-eligible and under 55 in age.

Patient Alignment

Alignment features a combination of prospective, claims-based alignment and voluntary alignment. Voluntary alignment generally supersedes claims-based alignment.

- ***Claims-based assignment***: Patients are aligned prospectively based on majority of allowable charges for qualifying primary care (PC) services received from qualifying practitioners within a baseline period. CMS will prioritize services rendered by PC clinicians, but will base alignment on charges from certain non-primary specialists in cases where <10% of charges were billed by a PC clinician. A full list of PC and select specialties can be found in Appendix G on page 100 of the RFA.
- ***Voluntary alignment:*** Beneficiaries select a primary clinician on MyMedicare.gov or complete the paper-based form. DCEs may take steps, within certain parameters, to affirmatively ask beneficiaries to confirm their relationships with participating clinicians.

- DCEs chose whether voluntarily aligned beneficiaries count the following year (prospective alignment) or quarterly throughout the current year (prospective alignment plus).
- Beneficiaries who were eligible but later become ineligible (e.g. for enrolling in an MA plan) will contribute partial-year data up to the month prior to which he/she loses eligibility.
- The DC Model requires a minimum number of beneficiaries for each DCE type (see below).

Number of Required Beneficiaries by DCE Type:

	PY 1 (2021)	PY 2 (2022)	PY 3 (2023)	PY 4 (2024)	PY 5 (2025)
Standard	5,000	5,000	5,000	5,000	5,000
New Entrant	1,000	2,000	3,000	4,000	5,000
High Needs Population	250	500	750	1,200	1,400

Beneficiary Protections and Enhancements

- DC clinicians must make medically necessary covered services available to beneficiaries.
- Beneficiaries must maintain freedom to choose their clinicians and suppliers, even if they are not participating in the DCE.
- DCEs must inform beneficiaries that they have been aligned to the DCE, what that means, how to opt out of data sharing, and any available beneficiary enhancements.
- DCEs may provide gifts of nominal value to beneficiaries for the purpose of outreach regarding voluntary alignment, provided they do not violate the anti-kickback statute and other applicable laws. CMS can review any marketing materials and activities.
- Outside of what is set forth in the participation agreement, clinicians and entities may not provide gifts to induce beneficiaries to receive items/services from the DCE. However, DCEs may provide in-kind items/services provided there is a reasonable connection to the beneficiary's medical care, they advance a clinical goal or are preventative, and are not rendered on the same date as the in-kind offer. These would be funded by the DCE and not count toward its benchmark or expenditures.
- Subject to CMS approval, the DCE may choose to waive beneficiary cost sharing (in whole or in part) for certain beneficiaries and services (excluding Rx drugs and DME).
- Subject to CMS approval and out of its own funds, DCEs may give beneficiaries gift cards worth up to $75 annually for participating in a chronic disease management program.
- Below is a set of Benefit Enhancements and their various stages of approval.

Anticipated for PY 1	**Proposed for PY 1**	**Potential for Future PYs**
• SNF 3-day rule waiver • Asynchronous telehealth • Supervision requirements for home visits	• Home health services by NPs • Homebound requirement waiver for home health services • Allow concurrent curative care for hospice beneficiaries (Global Option only)	• Tired cost sharing reduction • Alternative sites of care • Cost-sharing for SNF services • Long-term care hospital 25-day stay and site restrictions

Monitoring and Oversight

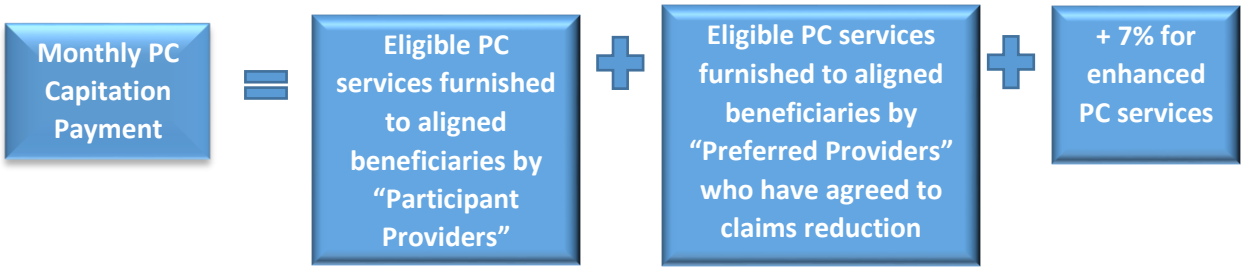
- DCEs must develop a compliance plan that includes, among other items, training that the DCE and its participating clinicians must complete periodically.
- To protect patient safety and against fraud, CMS may audit charts, medical records, implementation plans, and other data, perform site visits, conduct beneficiary interviews, and request supporting documentation.
- If a DCE violates the terms of its participation agreement, CMS may take several actions including requiring a corrective action plan, terminating waivers, terminating voluntary alignment, requiring the DCE to terminate agreements with specific "participant providers" or "preferred providers," and termination from the program.
- In PY 1, DCEs will be subject to an additional 2% withhold that will be returned to them at financial reconciliation provided they are still enrolled. Otherwise, it will be forfeited.

Financial Methodology

2021 Risk Options:

- **The Professional Option** 50% shared savings/losses ***and*** primary care capitation.
- **The Global Option** 100% shared savings/losses ***and*** primary care ***or*** total care capitation

Primary Care (PC) Capitation:



- Monthly payment based on applicable PC services during a lookback period.
- CMS pays the DCE the capitated payment for PC services. The DCE then enters into payment arrangements with "participant providers" and "preferred providers."
- "Participant providers" are subject to 100% claims reduction for PC services furnished to aligned beneficiaries.
- "Preferred providers" are subject to 1-100% claims reduction for aligned beneficiaries and CMS would pay the remaining amount. Both will continue to bill claims as normal and will be fully reimbursed under the FFS for non-PC claims.
- The difference between the enhanced up-front payments and actual payments will be recouped by CMS at the end of the performance year.
- DCEs may the elect optional advanced payment with prospective claims reduction, in which CMS would reduce non-PC claims between 1-100% and would make monthly advanced payments equivalent to this estimated value, which will be reconciled at year's end.
- Eligible PC services are described below.

New patient visit	99201-99205
Established patient visit	99211-99215
Prolonged care	99354-99355
Transitional Care Management	99495-99496
Home Care	99324-99328, 99334-99337, 99339-99345, 99347-99350
Advance Care Planning	99497-99498
Welcome to Medicare & Annual Wellness Visits	G0402, G0438, G0439
Chronic Care Management	99490
Virtual Check-Ins	G20212

Total Care Capitation:

* Total Care Capitation Withhold*:* Withhold from monthly TCC payments to offset anticipated payments to non-participating clinicians; calculated before each PY based on historic utilization.

"Participant Providers" must agree to prospective 100% claims reductions and "preferred providers" who have agreed to participate will be subject to prospective claims reductions ranging from 1-100% based on what they have negotiated with the DCE.

Benchmark: Prospective, target expenditure amount used to calculate monthly capitated payments *and* shared savings/losses. Calculated based on relevant claims during a baseline period. Benchmark composition depends on DCE type, performance year, and alignment-type as outlined below. Benchmarks are trended forward based on the US per capita growth trend, risk-adjusted for aged, disabled, and ESRD patients, and adjusted for quality performance.

- For DCEs participating in the Global Option *only*, an automatic discount will be taken into account (2% in PYs 1-2, 3% in PY 3, 4% in PY 4, and 5% in PY 5).
- For all DCEs, a 5% quality withhold will apply to the benchmark at the start of each PY, which DCEs will have an opportunity to "earn back" based on quality performance.
- The MA rate book will be used to derive regional expenditures. Adjustments due to regional expenditures will be capped at 5% upward and 2% downward.
- Beneficiaries who are aligned both voluntarily and via claims will be treated as claims-based for benchmarking purposes.
- CMS will test a new prospective benchmarking methodology for beneficiaries assigned solely through voluntary alignment.

Composition of Financial Benchmark

		Standard	**New Entrant**	**High Needs Population**
Voluntarily-aligned beneficiaries	**PYs 1-3**	Regional expenditures	Regional expenditures	Regional expenditures
	PYs 4-5	Blend of regional expenditures with recent historical expenditures of aligned beneficiaries	Blend of regional expenditures with recent historical expenditures of aligned beneficiaries	Blend of regional expenditures with recent historical expenditures of aligned beneficiaries
Claims-based aligned beneficiaries	**PYs 1-3**	Blend of regional expenditures with aligned beneficiary historical expenditures	Regional expenditures	Regional expenditures
	PYs 4-5		Blend of regional expenditures with recent historical expenditures of aligned beneficiaries	Blend of regional expenditures with recent historical expenditures of aligned beneficiaries

Baseline Years and Weights by Performance Year

PY 1-3	PY 4	PY 5
2017: 10% 2018:30% 2019: 60%	2021: 33.33% 2022: 66.66%	2021: 10% 2022: 30% 2023: 60%

Phase-In Schedule for Regional Expenditures in Financial Benchmark

	PYs 1-2	PY 3 (2023)	PY 4 (2024)	PY 5 (2025)
Historical	65%	60%	55%	50%
Regional	35%	40%	45%	50%

Minimum Savings/Losses: This model features "first dollar" savings and losses. There is no minimum threshold DCEs must reach.

Shared Savings/Losses Rates: The rate of shared savings/losses will progressively decrease as gross savings/losses increases according to the rates below.

Savings/Losses Rates under Professional Option

Gross Savings/Losses	< 5%	5–10%	10–15%	> 15%
Savings/Losses Rate	50%	35%	15%	5%

Savings/Losses Rates under Global Option

Gross Savings/Losses	< 25%	25–35%	35–50%	> 50%
Savings/Losses Rate	100%	50%	25%	10%

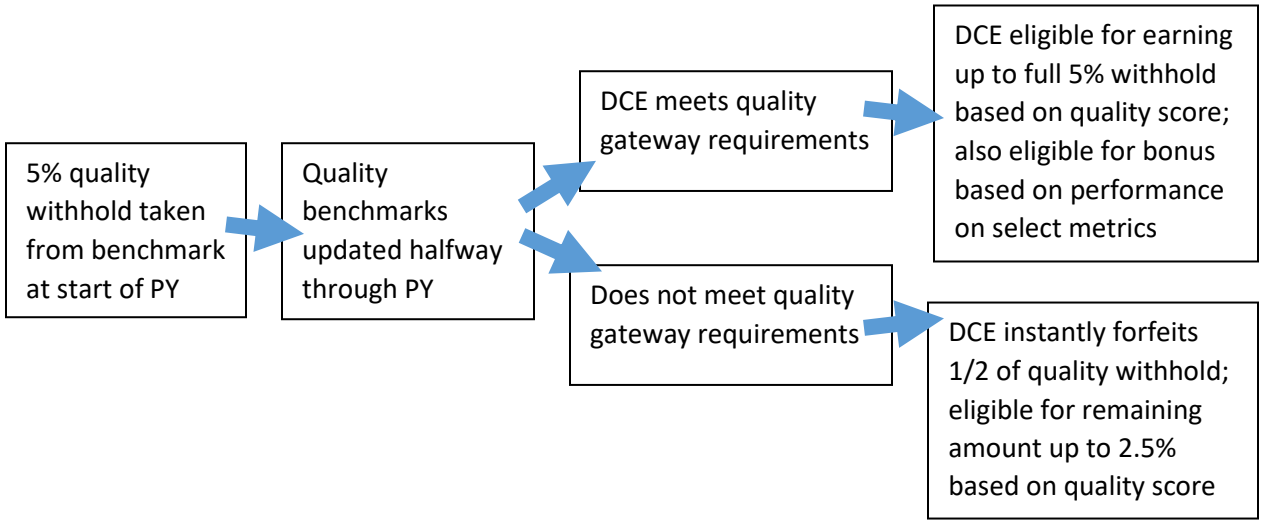
Stop-Loss: DCEs can elect an optional stop-loss point for total savings/losses before each performance year which would be "charged" on a per-beneficiary per-month basis. However, DCEs will still retain a degree of liability for expenditures above the stop-loss.

Financial Reconciliation: Shared savings/losses totals will be determined approximately six months after the close of each performance year and will include a three-month claims runout. When they apply, DCEs may elect an optional "provisional financial reconciliation," which would make preliminary shared/savings losses determinations in late January based on the first six half of the year and initial risk scores, but would be subject to a de minimums threshold and final reconciliation.

Quality Incentives

- 5% will be deducted from the benchmark for a given performance year as a quality withhold, which can be earned back in final reconciliation based on performance on quality metrics related to improvement and sustained exceptional performance.
- DCEs who fail to meet quality gateway requirements will automatically forfeit half of their quality withhold and have their remaining 2.5% adjusted based on performance.
- Those who meet quality gateway requirements and demonstrate a high level of performance on a pre-determined subset of quality measures set will qualify for an additional bonus that is funded from quality withholds not earned back by DCEs.
- The first performance year is pay for reporting. DCEs will receive 100% quality credit for fully satisfying data reporting requirements or 0% for failing to do so and there will be no quality bonus for exceptional performance. Newly developed measures will be pay-for reporting until they have been tested and found to be valid and reliable.
- Quality scores will be based on claims-based measures and CAHPS for ACOs surveys. DCEs may conduct an optional CMS-funded Patient Activation Measure (PAM) survey. DCEs would receive quality data but PAM scores would not count toward quality scores.
- CMS may conduct data validation audits of quality data.
- Quality measure benchmarks will be set using the methodologies below. **Final reconciliation will always be updated to include an adjusted quality withhold that reflects the actual quality score for the applicable performance year.**
- A complete list of proposed quality measures for PY 1 can be found on page 78 of the Request for Applications.

	PY 1	**PY 2**	**PY 3**
Qs 1-2	Pay for reporting-benchmarks based on 100%	Pay for performance scored out of 100%	Pay for performance based on PY 1 scores
Qs 3-4		Pay for performance based on PY 1 scores	Pay for performance based on PY 2 scores



Certified EHR Technology (CEHRT) Requirements and Data

- 75% of participating clinicians must use CEHRT and meet all applicable interoperability requirements, as consistent with the requirements to be considered an Advanced APM.
- During the initial alignment year and in each performance year, CMS will provide DCEs with detailed claims data that will include individually identifiable claim and claim line feed reports for services furnished to aligned beneficiaries.
- At the beginning of each performance year, CMS will provide historical CCLF files featuring a 36-month lookback of claim for newly aligned beneficiaries.
- CMS will provide operational reports on a regular basis which will include data including but not limited to quarterly and annual utilization, monthly expenditures, beneficiary data sharing preferences, monthly claims lag, and beneficiary alignment reports.
- During each performance year, CMS will provide quarterly baseline benchmark reports to enable DCEs to monitor their financial performance.
- CMS will provide quality performance feedback.

Model Overlap

DC Entities may not simultaneously participate in the following models during performance years (but may do so during the initial alignment year):

- Medicare Shared Savings Program
- Maryland Total Cost of Care Model
- Vermont All-Payer ACO Model
- Comprehensive Primary Care Plus
- Primary Care First

DC entities may otherwise simultaneously participate in models that do not entail shared savings.