



## Direct Contracting Model

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On April 22, 2019 the Centers for Medicare & Medicaid (CMS) [announced](#) its Primary Cares Initiative, which encompasses two new Alternative Payment Models (APMs) with five total tracks. This fact sheet overviews the Direct Contracting (DC) Model, for more information on the Primary Care First (PCF) Model, view our [separate fact sheet](#). ACP will update this fact sheet as information evolves. Stay tuned to ACP's [Advocate Newsletter Archive](#), [Advocate Blog](#), and [APMs practice resources webpage](#), and [Quality Payment Program advocacy webpage](#) for more ACP guidance and perspective.

- **What is it?** A voluntary, five-year Accountable Care Organization (ACO) model aimed at larger organizations (5,000+ FFS beneficiaries) based loosely on the Next Generation ACO Program.
- **When will it start?** Payments start in January 2021. Optional patient alignment begins in 2020.
- **Will it qualify as an Advanced Alternative Payment Model (APM)?** Yes.
- **What is the basic structure?** The model will feature up to three tracks: 1) the Professional Option; 2) the Global Option; and 3) the Geographic Option, which is not yet finalized.
- **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?** CMS anticipates other payers may align with the model requirements but this model will not be formally aligned with other payers. CMS expects current Medicare Advantage Organizations and Medicaid Managed Care Organizations may apply to participate.
- **Will CMS offer any benefit enhancements or payment rule waivers?** CMS is considering offering the same as those currently offered in the Next Gen Program (3-day SNF rule, telehealth expansion, post-discharge home visit rule, and care management home visit rule) in addition to additional enhancements and waivers, though these are under development and not yet final.
- **How will risk adjustment work?** CMS is looking to build on Next Gen risk adjustment to improve accuracy, particularly for complex patients, and to mitigate coding intensity concerns.
- **Will participants receive any data?** CMS will provide benchmark reports “on a regular basis.”
- **How do I apply?** Notices of intent to apply (NOIA) to start the Professional and/or Global Options in Jan. 2020 are due Aug. 2. NOIAs are non-binding but required to submit an application. CMS expects to collect applications in fall 2019, select participants over the winter and have participant agreements signed by early 2020. CMS expects the application process for the Geographic Option to occur in fall 2019, though that track is not yet finalized.

### Participation

Participation for the Professional and Global Options is defined at an ACO-level with Participants and Preferred Providers defined at the TIN/NPI level. **DC Participants** are the core Medicare-enrolled providers and suppliers responsible for reporting quality and patient alignment (and notifying beneficiaries of alignment at the start of each performance year). **Preferred Providers** participate in downstream arrangements with the DC Entities. They contribute to the DC Entity's goals and are covered by payment rule/beneficiary enhancement waivers but do not contribute to patient alignment.

## Patient Alignment Options

- **Prospective Alignment:** Patients would be prospectively enrolled through a combination of claims-based assignment based on qualifying E&M services and enhanced voluntary assignment.
- **Prospective Alignment Plus:** In addition to prospective alignment, beneficiaries that voluntarily align to a DC Entity will be added on a quarterly basis throughout the performance year.
- **Medicaid Managed Care Organization (MCO) Enrollment-based Alignment:** Dual beneficiaries will be aligned to a DC Entity based on enrollment in an affiliated Medicaid MCO.

## Payment Model Options

DC Entities will be at risk for a portion of or total cost of care for Parts A and B services for aligned beneficiaries through one of the three payment options described below. Savings/losses will be determined through payment reconciliation of true spending against risk-adjusted regional benchmarks. All benchmarks will be established prospectively. For the Professional and Global Options, benchmarks will be based on a blend of a DC Entity's historical spending and risk-adjusted Medicare Advantage regional expenditures segmented by aged, disabled, and ESRD patients. More information about risk adjustment methodologies is forthcoming. For the Geographic Option (which is not yet finalized) benchmarks would be based on one-year historical per capital Parts A/B FFS spending in the target region trended forward based on national spending with negotiated discounts. For the Global and Professional Options, the maximum amount of shared savings/losses that a DC Entity can receive will be capped based on a percentage of the benchmark, known as a risk corridor. There will also be a cap at the beneficiary level for unusually expensive beneficiaries, known as a stop loss.

For the Professional and Global Options, payments will be subject to quality performance. Participants and Preferred Providers would continue to submit claims to CMS, though the agency is "exploring ways to simplify administrative claims submission" for primary care services under a capitated arrangement. DC Entities may elect to have their claims reduced in exchange for advanced payment. DC Entities may also select a provisional reconciliation option, under which CMS would distribute interim shared losses/savings halfway through the year with a full reconciliation taking place once full data is available.

- **Professional:** DC Entities accept capitated, risk-adjusted monthly payments for enhanced primary care services equal to 7% of total cost of care for those services and are liable to share in 50% of any shared savings/losses following financial reconciliation against a benchmark.
- **Global:** DC Entities choose between fully capitated monthly payments for either: 1) all primary care services; or 2) all services and are 100% at risk for any shared savings/losses.
- **Geographic:** DC Entities assume full financial responsibility for total cost of care and fulfilling the health needs of a population in a defined target region. Participants choose between: 1) full financial risk with fee for service claims reconciliation; or 2) total care capitation.

## Quality

DC Entities will report a "focused, core set of relevant, actionable" quality measures. Quality scores will impact benchmark discounts in the Global Option and shared savings/losses in the Professional Option.

## CMS Resources:

- [DC Model fact sheet](#)
- [DC Model webpage](#)
- [DC Model overview slides](#)
- [Primary Cares Initiative Press Release](#)