

CMMI Direct Contracting Model HFMA Overview

Summary: On April 22, 2019, the Center for Medicare and Medicaid Innovation (CMMI) announced its Direct Contracting (DC) model. The five-year model builds on CMMI’s and providers’ experiences with the Next Generation Accountable Care Organization (ACO) program. The payment model options available under DC create opportunities for a broad range of organizations to participate with the Centers for Medicare & Medicaid Services (CMS) in testing the next evolution of risk-sharing arrangements to produce value and high-quality health care. Building on lessons learned from initiatives involving Medicare ACOs, such as the Medicare Shared Savings Program (MSSP) and the Next Generation ACO (NGACO) Model, the payment model options available under DC also leverage innovative approaches from Medicare Advantage (MA) and private sector risk-sharing arrangements. The program will begin in 2020 with an “initial alignment year” for organizations to meet the minimum beneficiary requirements with the risk bearing period, which lasts for five years, beginning on January 1, 2021.

Participation Options: The model offers three participation options. All three will qualify as an Advanced Alternative Payment model in 2021, making participating physicians/practices who meet the revenue or volume thresholds eligible for the 5 percent bonus on their payments for Part B services.

1. **Professional Population-Based Payment (PBP):** Offers the lower risk-sharing arrangement—50% savings/losses—and provides primary care capitation, a capitated, risk-adjusted monthly payment for enhanced primary care services. It is built on an ACO structure with specifically identified participants and Preferred Providers (described below) identified at the Taxpayer Identification Number/National Provider Identifier (TIN/NPI) level. The primary care capitation payments are equal to 7% of the total cost of care to support enhanced services. For most direct contracting entities (DCEs) it will require at least 5,000 aligned beneficiaries to participate.
2. **Global PBP:** Offers the highest risk sharing arrangement—100% savings/losses—and provides two payment options: primary care capitation (described above) or total care capitation, capitated, risk-adjusted monthly payment for all services provided by DC participants and preferred providers with whom the DCE has an agreement. It is built on an ACO structure with specifically identified Participants and Preferred Providers identified at the TIN/NPI level. Non-associated providers will still receive fee-for service (FFS) payments which will be factored into payment reconciliation. For most direct contracting entities (DCEs) it will require at least 5,000 aligned beneficiaries.
3. **Geographic PBP:** CMS is seeking public input on this option. A request for information (RFI), which is due on May 23rd is available [here](#) and provides additional information on the model. The Geographic PBP model will be open to entities interested in taking on regional risk and entering into arrangements with clinicians in the region. Participants will bear 100% risk with a choice between full financial risk with FFS claims reconciliation and Total Care Capitation. Geographic participants will need a minimum of 75,000 aligned beneficiaries. CMS also states it is interested in having more than one Geographic DCE in a market to promote competition.

Payment Model:

Depending on the payment option chosen (described above in the participation options section), DCEs will be at risk for either a portion or all of the total cost of care for Parts A and B services for aligned

beneficiaries. The aggregate amount of shared savings or losses that DCEs will be eligible to receive, if their actual performance year expenditures are lower or higher than their total cost of care benchmark (described below), will be determined through payment reconciliation.

Based on available information, the benchmarking methodology will vary. The benchmark for the Professional PBP and Global PBP will be a prospective blend of historical spending and adjusted Medicare Advantage (MA) regional expenditures used to develop the benchmark (segmented by aged & disabled and end-stage renal disease). Historical baseline expenditures will be trended forward by US per capita cost growth, with adjustments to account for population risk and geographic price factors. The benchmark will be risk adjusted to account for complex and chronically ill populations. However, CMS has not provided specific details on the model it will use. A discount will be applied with a potential for a quality bonus. It appears that, like in the Medicare ACO programs, quality will increase a participant's "shared savings" (or decrease shared losses) instead of earning a higher payment like in the MA program.

The proposed benchmarking methodology for the Geographic PBP will use one year of historical per capita FFS spend in the target region trended forward with negotiated discounts. CMS states the final methodology will be informed by responses to the RFI.

As discussed above, DC participants must participate in a capitated payment arrangement (Appendix I). Professional PBPs will receive primary care capitation. All Participants and Preferred Providers (described below) must continue to submit claims to CMS. CMS is exploring ways to simplify administrative claims submission for primary care services included under a capitated arrangement. CMS will continue to pay claims for services made outside of the DCE (non-associated providers) on a FFS basis. Organizations will have added flexibility to reduce FFS payments not covered under the capitation arrangements. If payments are reduced, DCE and providers must agree in writing to the percentage reduction.

CMS will offer global and professional DC participants both risk corridors and stop loss mitigation mechanisms.

- Risk Corridors define the aggregate amount of shared savings/losses a DC entity will be eligible to receive if their actual performance year expenditures are lower or higher than the benchmark. This amount will be calculated as an aggregate expenditure amount relative to the total cost of care.
- Stop Loss is intended to reduce the financial uncertainty associated with infrequent, but high-expenditures for DCE aligned beneficiaries. It will be calculated at the level of the individual beneficiary.

Similar to Next Generation and other Medicare ACO models, actual expenditures will be reconciled to the DCE's benchmark. However, in the DC model, CMS is offering optional provisional reconciliation in addition to a final reconciliation to provide more timely distribution of shared savings/losses. Provisional reconciliation will occur immediately following the performance year, reflecting cost experience through the first six months (with seasonality and claims run-out adjustments). Final reconciliation will occur following a full-claims run-out, reflecting a full performance year.

Quality Measures:

Details about the quality measures used in the program are currently limited. CMS states DCEs will report a “focused, core set” of measures comparable to Merit-based Incentive Payment System. The set will include at least one outcome measure. This reduced measure set will, according to CMS, reduce participants’ administrative burden. Performance on this focused set of measures will impact discounted benchmark amounts in Global PBP and final shared savings or losses in Professional PBP.

Data:

Under the DC model, participants may request several types of data to improve the alignment of care and improve care coordination. CMS will also provide performance management reports, which will include quarterly and annual expenditures, and beneficiary alignment. On a regular basis, CMS will provide benchmark reports to enable DCEs to maintain a national accounting system similar to private sector capitation arrangements.

Similar to other programs, beneficiaries can opt out of data sharing. DCEs will be required to notify newly aligned beneficiaries that the DCE will request their data to provide the beneficiary with the option to opt out of data sharing.

Waivers:

CMS is considering providing DCEs the same waivers as are currently afforded to Next Generation ACO participants. These include the:

- 3-Day SNF Rule Waiver
- Telehealth Expansion Waiver
- Post-Discharge Home Visits Rule Waiver
- Care Management Home Visits Rule Waiver

CMS also intends to build upon those offerings and explore additional enhancements and payment rule waivers such as:

- Allowing nurse practitioners to certify that a patient is eligible for home health service
- Allowing the provision of home health services to beneficiaries who are not “homebound”

These waivers have not been finalized, and more information will be released by CMS as it becomes available.

Beneficiary Alignment (Attribution):

The DC model will use both voluntary and prospective claims-based alignment. Voluntary alignment will take precedence over claims-based models.

CMS believes that voluntary alignment empowers beneficiary choice and promotes competition among providers. As such, CMS will permit more robust outreach and communication for DCEs to promote voluntary alignment to beneficiaries. This outreach is limited to a DCE’s service area. A beneficiary must designate a DC participant as a primary clinician for purposes of enhanced voluntary alignment. As part of the model, CMS will test an alternative approach for beneficiaries *newly aligned* (not aligned to the DCE through claims-based alignment) as part of enhanced voluntary alignment. Beneficiaries that align to a DCE through enhanced voluntary alignment will be added on a quarterly basis throughout the

performance year.

Prospective alignment is established prior to the start of the performance year. It is based on claims for qualifying evaluation and management services. Partial year beneficiary experience (a beneficiary that loses alignment eligibility during the performance year –e.g., by enrolling in MA –will contribute fewer than 12 months of experience and will not be retroactively excluded).

CMS also provides an alignment model for Medicaid Managed Care Organizations (MCOs). This provides the opportunity for MCOs to serve as, or affiliate with, a DCE to manage Medicare expenditures for full benefit, dual-eligible beneficiaries that receive their Medicaid benefits through MCOs. Dual-eligible beneficiaries are aligned to a DCE on the basis of enrollment in the affiliated Medicaid MCO. However, alignment to a DCE through enhanced voluntary alignment or claims-based alignment will take priority.

This provides an opportunity to better integrate care between Medicare FFS and Medicaid MCOs. It also minimizes incentives to cost shift between Medicare and Medicaid programs. CMS anticipates that DCEs under this option would draw from experience managing integrated Medicare and Medicaid services and spending via affiliated MCOs.

Participation Requirements:

Most Professional PGP and Global PGPs must have at least 5,000 Medicare beneficiaries aligned to its providers. However, CMS will make an exception for new Medicare DCEs and Medicaid MCOs. A single DCE cannot participate in more than one DC model. However, a large organization may have multiple DCEs, each participating in a different model. Regional DCEs will need to have a minimum of 75,000 beneficiaries.

Similar to the Next Generation ACO model, CMS defines three types of providers in relation to a DCE.

- 1) DC Participants are the core providers and suppliers who will be used to align beneficiaries to the DCE. They are responsible for reporting quality through the Direct Contracting Entity, and improving the quality of care for aligned beneficiaries.
- 2) Preferred Providers are not used to align beneficiaries to the DCE. They can, however, participate in downstream arrangements, certain enhancements, benefit or payment rule waiver, and contribute to DCE goals.
- 3) Non-Associated Providers are not engaged in the DCE as a participant or Preferred Provider. However, any claims for services provided to a beneficiary aligned to a DCE will count as part of the DCE's performance year spending.

DC Participants, Preferred Providers, and non-associated providers will be determined by TIN/NPI.

Key Dates:

Activity	Professional PBP/ Global PBP	Geographic PBP (anticipated)
Letter of Intent (LOI) Released	Spring 2019	TBD
LOI Due	8/2/2019	TBD
Request for Applications Released	Late Summer/ Fall 2019	Fall 2019
DCEs selected for participation notified	Fall/Winter 2019	Winter 2019
DCEs sign Participation Agreements	Winter 2019	4/1/2019
Performance Year 0	1/1/2020	5/1/2020
Performance Year 1 (Payments begin)	1/1/2021	1/1/2021
Performance Year 5	1/1/2025	1/1/2025

Additional Information: CMMI is posting additional materials and webinar opportunities on the model's webpage. It can be accessed at: <https://innovation.cms.gov/initiatives/direct-contracting-model-options/>

Appendix I: Payment Model Options

		What payment options are available?		
		Full Financial Risk with FFS claims processing	Primary Care Capitation	Total Care Capitation
Payment Model Options	Professional PBP		X	
	Global PBP		X	X
	Geographic PBP	X		X