# Direct Contracting 101: Understanding the Basics

The webinar will begin at 2 pm ET. Please make sure you are dialed in to the webinar on your telephone with the audio pin.

# Agenda

1. Introductions and Housekeeping
2. Presentations:
   - Timelines and Participation Options
   - Alignment
   - Financial Methodology
   - Quality and Beneficiary Engagement
   - Model Overlap
3. Audience Q&A and follow-up

# Speakers

| | |
|---|---|
|  | **David Pittman**<br>David is senior policy advisor at NAACOS where he assists the government affairs team in its legislative and regulatory affairs work, including its work around Direct Contracting. He also works on NAACOS's communications efforts. |
|  | **Dave Ault**<br>Dave is counsel at Faegre Drinker Biddle & Reath LLP where he advises clients on a range of CMS issues including those related to value-based payment. Dave regularly draws on his extensive experience at HHS and CMS, including his tenure leading the Next Generation ACO Model and working as part of the Medicare Shared Savings Program leadership team. |

# Housekeeping

1. Speakers will present for around 45 minutes
2. Q&A will take the remainder of the time
    - You can submit written questions using the Questions tab on your dashboard to the right of your screen at any time during the webinar
    - During the Q&A session, you can use the “raise hand” feature on your dashboard to ask a live question. Please make sure you have dialed in on the telephone and used your audio pin to connect so that we can hear you clearly.
3. Webinar is being recorded
    - Slides and recording will be available on the NAACOS website within 24 hours. You will receive an email when they are available.

# NAACOS Resources

- Stand-alone webpage with CMS and NAACOS resources
- Frequently Asked Questions on Direct Contracting
- In-depth analysis of Direct Contracting
- Chart comparing Direct Contracting to other high-risk ACOs
- Chart on the overlap of CMMI models and ACOs
- Summary of Direct Contracting Financial Specifications
- Overview of Direct Contracting Quality Measurement Methodology
- Hosted several webinars, town halls and learning discussions
- To continue today's discussion, we encourage use of our Direct Contracting Listserv. You must sign up first and can do so here.
  - DirContractListServ@naacos.com
- NAACOS staff is also available at DirectContracting@naacos.com

# NAACOS Advocacy

- NAACOS continues to meet with CMMI on shaping Direct Contracting
- Examples of formal letters we've written
  - NAACOS writes HHS Secretary Becerra on policy priorities for the new administration
    NAACOS calls for changes to Direct Contracting's financial methodology
  - NAACOS urges announced plans for the future of the Direct Contracting Model
  - NAACOS calls for changes to Direct Contracting and seeks more information
- We continue to address concerns around financial specifications
  - In setting benchmarks, CMS should give greater weight to the least recent year
  - CMS should add shared savings earned by a DCE back in the PY benchmark
  - CMS should give more weight to the regional rates for all DCEs
  - CMS should expand the concurrent risk adjustment model beyond the High Needs Population DCEs
- ***What else concerns or excites you about this model?***
- **Reach out to DirectContracting@naacos.com**

# NAACOS Spring Conference

There are plenty of opportunities to go further on Direct Contracting at the upcoming NAACOS Spring Conference

- **REGISTER NOW!**

**Tuesday, April 20**

- Opening Plenary with CMMI Director Liz Fowler

**Friday, April 23**

- Understanding the Opportunities and Challenges of Direct Contracting

**Thursday, April 29**

- Peer to Peer Exchange: Direct Contracting

**Friday, April 30**

- Townhall with CMS

# Direct Contracting Model


Faegre Drinker Biddle & Reath LLP

# “GloPro” Model Timeline

| | Implementation Period (PY0) Applicants | PY1 (2021) Applicants | PY2 (2022) Applicants |
|---|---|---|---|
| LOI | Closed | | |
| Application Deadline | Closed | | Spring 2021 |
| DCE Selection | Announced Summer 2020 | Announced September 2020 | Late Spring 2021 |
| Execute Participation Agreement | Executed September 2020 | March 2021 | Late 2021 |
| Start Date | October 1, 2020 | April 1, 2021 | January 1, 2022 |
| End Date | March 31, 2021 | December 31, 2026 | |

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# Direct Contracting

- Global and Professional (“GPDC”)

  4 types:

  - Standard
  - New Entrant
  - High Needs
  - MCO-based (?)

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# Risk Arrangements

## Professional Option

- Shared Savings/Losses: 50%
- Capitation: Primary Care Capitation (up to 7% capitation) → Basic + Enhanced
- Advanced Payment
  - May elect Advanced Payment for non-capitated claims
  - Reconciled at the end of each PY (similar to the Population-Based Payment mechanism in NextGen)

## Global Option

- Shared Savings/Losses: 100%
- Capitation: DCE chooses Primary Care Capitation or Total Care Capitation (100% capitation)

- Participant Providers must agree to capitation
- Capitated payments are not reconciled against actual expenditures
- The model will qualify as an AAPM

**Either model option is available to each of the three types of DCEs.**

Note: In the future, CMS may offer a third model option, the "Geographic Option," where a DCE would assume financial risk for the entire population of a particular geographic area.

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# Primary Care Capitation

- DCEs not required to participate in capitation in PY 1
- Glide path with increasing capitation minimums

| Payment Mechanism | Participant Providers | Preferred Providers |
|---|---|---|
| TCC | 100% claims reduction | Optional |
| PCC | * For primary care claims only<br>PY1: optional<br>PY2: min 5%<br>PY3: min 10%<br>PY4: min 20%<br>PY5: 100%<br>PY6: 100% | Optional |
| APO | Optional | Optional |

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# Three types of Direct Contracting Entities (DCEs)

| | Standard DCE | New Entrant DCE | High Needs Population DCE |
|---|---|---|---|
| **Description** | • This is the traditional ACO with experience in risk | • For DCEs with limited historical experience delivering care for Medicare FFS beneficiaries<br>• Available to DCEs with fewer than 50% of its providers experienced in fee-for-service risk models | • For DCEs tailored to a high needs population<br>• "High Needs" = impaired mobility and/or complex high needs<br>• DCE can care for specific sub-populations, including patients with a particular diseases, disease at a particular stage, or a combination of diseases |
| **Minimum Beneficiary Requirement** | 5,000 beneficiaries | 1,000 beneficiaries in PY1 (increases to 5,000 by PY5) | 250 beneficiaries in PY1 (increases to 1,400 by PY5) |

# Direct Contracting - “MCO-Based”

- DCEs that manage the Medicare FFS expenditures of full-benefit dually eligible beneficiaries who receive Medicaid benefits though a Medicaid Managed Care Organization (MCO).
- Allows Medicaid MCOs to participate as GloPro DCEs
- Accountable for health outcomes and Medicare fee-for-service costs for their full-benefit dually eligible Medicaid MCO enrollees
- Arrangements with Participating Providers/Preferred Providers is optional
- Minimum 3,000 aligned beneficiaries
- MCO-based DCEs will begin participating in the model in January 2022

# DCE Providers and Suppliers

| | Participant Providers | Preferred Providers |
|---|---|---|
| Used to align beneficiaries | yes | no |
| Required to accept payment from the DCE | yes | no |
| Report quality | yes | no |
| Eligible to receive shared savings | yes | yes |
| May participate in benefit enhancements and patient engagement activities | yes | yes |
| May participate in other payment models | no* | yes |

* The model will use a TIN/NPI combination for provider participation

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Two types of alignment –

- **Voluntary Alignment**
  - electronic
  - “paper-based”
- **Claims-Based Alignment**

# Beneficiary Alignment

## Voluntary Alignment

- Will take precedence over claims-based
  - MyMedicare.gov takes precedence over paper-based voluntary alignment
  - Choice of Prospective or Prospective Plus Alignment

- *Prospective Plus*: Beneficiaries that voluntarily align to a DCE during a PY will be added on a quarterly basis throughout the PY. CMS will adjust the DCE benchmark (partial year experience) and capitated payments accordingly

- DCEs joining from another model can retain their beneficiaries who previously voluntarily aligned

- *Marketing*:
  - DCEs may proactively communicate with beneficiaries (marketing materials, outreach events, etc.) regarding voluntary alignment
  - DCEs may provide gifts of nominal value to beneficiaries for the purpose of outreach regarding voluntary alignment

# Beneficiary Alignment

## Claims-Based Alignment

- Prospective
- Beneficiary is aligned if receives plurality of their Primary Care Qualified Evaluation and Management (PQEM) services from the DCE's DC Participant Providers, either from primary care practitioners or select nonprimary care specialists.
- Alignment period: 2-year period that includes two consecutive 12-month periods, with the second period ending six months prior to the start of the relevant performance year
- Ex. Alignment window for PY 2021 is 7/1/2018 – 6/30/2020

# Beneficiary Alignment – Model Overlap

- Alignment priority across models/initiatives:
  1. electronic voluntary alignment
  2. paper-based voluntary alignment
  3. claims-based alignment

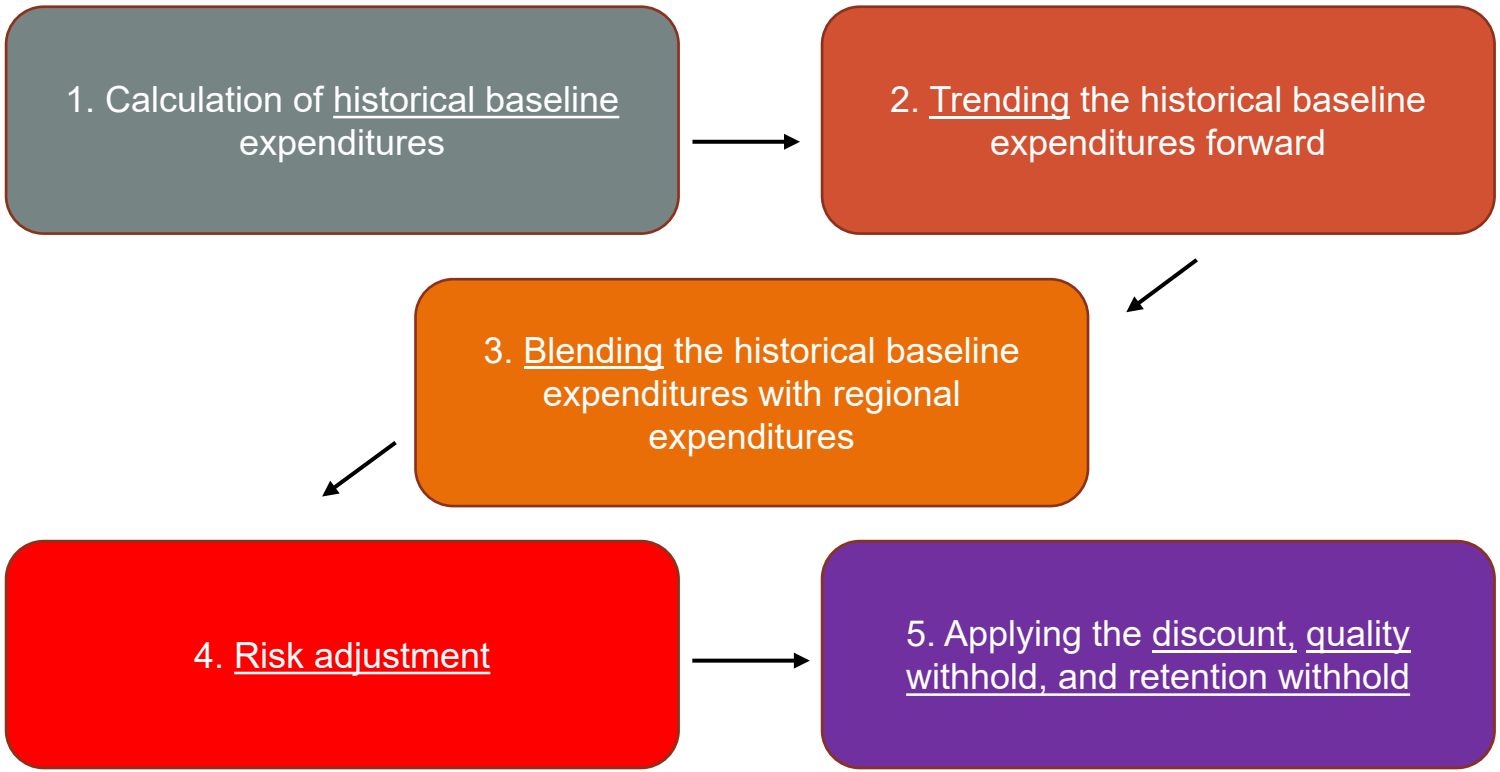
- No beneficiaries who are already prospectively aligned to another Shared Savings model for a given performance year will be aligned to a DCE

- CMS-wide guidance on model overlaps forthcoming

- If the most recent valid voluntary alignment attestation is to a provider or supplier that is not a DC Participant Provider or participant in any other shared savings initiative

# Financial Methodology - Benchmarking

**Benchmarking will follow a 5-step process (similar to NextGen)**

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## 1. Calculation of historical baseline expenditures

**Standard DCEs**:

- For *claims-based alignment*, the baseline period will be a fixed 3-year period (2017, 2018, 2019)
- For *voluntary alignment*, will not use historical baseline expenditures for PY1-4. CMS will only use regional expenditures for PY1-4 and will add in historical baseline expenditures for PY5-6

**New Entrant DCEs** and **High Needs Population DCEs**:

- CMS will not use historical baseline expenditures for PY1-4. CMS will only use regional expenditures for PY1-4 and will add in historical baseline expenditures for PY5-6. The baseline will be a 3-year base period: PY5 (2021, 2022, 2023), PY6 (2022, 2023, 2024)

## 2. Trending the historical baseline expenditures forward

- CMS will prospectively trend forward the historical baseline using the projected US Per Capita Cost (USPCC) growth trend and the ESRD USPCC growth trend
- CMS will trend to reflect the anticipated impact of changes in the regional FFS Geographic Adjustment Factors (GAFs)

## 3. Blending the historical baseline expenditures with regional expenditures

- Using an "Adjusted MA Rate Book" to blend regional expenditures with aligned beneficiary historical expenditures

| Performance Year | Historical Baseline Expenditures | Regional Expenditures |
|---|---|---|
| PY1/2/3 | 65% | 35% |
| PY4 | 60% | 40% |
| PY5 | 55% | 45% |
| PY6 | 50% | 50% |

- Limits on adjustment resulting from blending in regional expenditures:
  - Upward adjustment capped at 5% of the FFS USPCC for the PY
  - Downward adjustment capped at 2% of the FFS USPCC for the PY

## 3. Blending the historical baseline expenditures with regional expenditures

**Adjusted MA Rate Book =** DC/KCC Rate Book.

*Notable differences*:

- Uses only DCE-eligible benes
- 3 base years (not 5), 1-year interval between base year 3 and PY
- Include hospice care and IME; removes uncompensated care
- No quartile adjustment

# 4. Risk adjustment

For **Standard and New Entrant DCEs** → CMS will use the existing CMS-HCC A&D model and CMS-HCC ESRD risk adjustment model

CMMI will use a 4-step risk adjustment process:
1.Prospective estimated normalization
2.Normalization correction adjustment factor
3.Risk score cap (symmetric 3% cap on DCE-level risk score grow (per PY))
4.Retrospective Coding Intensity Factor (CIF)

For **High Needs Population DCEs** → CMS will use a new CMMI-HCC risk adjustment model and the existing CMS-HCC ESRD risk adjustment model

## 5. Applying the discount, quality withhold, and retention withhold

### Discount
- Applies only to Global DCEs (No discount for Professional DCEs)
- Applied to the PY benchmark

| Performance Year | Discount |
|---|---|
| PY1-2 | 2% |
| PY3 | 3% |
| PY4 | 4% |
| PY5/6 | 5% |

### TCC Withhold
- For TCC DCEs only
- To account for spillage

### Quality Withhold
- Applied to PY benchmark
- Quality withhold = 5% of benchmark
- DCE can earn back based on quality performance
- Amounts not earned back fund a High Performers Pool

### Retention Withhold
- Applied to PY1 benchmark only
- Retention withhold = 2% of benchmark
- DCE will earn back if stays in model for at least 2 years

# Financial Methodology – Risk Mitigation

| | Gross Savings/Losses as a percent (%) of the Final PY Benchmark | DCE Shared Savings/ Shared Losses cap | CMS Shared Savings/ Shared Losses cap |
|---|---|---|---|
| Professional DCE | Risk Band 1:<br>Gross Savings/Losses Less than 5% | 50% of savings/losses | 50% of savings/losses |
| | Risk Band 2:<br>Gross Savings/Losses Between 5% and 10% | 35% of savings/losses | 65% of savings/losses |
| | Risk Band 3:<br>Gross Savings/Losses Between 10% and 15% | 15% of savings/losses | 85% of savings/losses |
| | Risk Band 4:<br>Gross Savings/Losses Greater than 15% | 5% of savings/losses | 95% of savings/losses |
| Global DCE | Risk Band 1:<br>Gross Savings/Losses Less than 25% | 100% of savings/losses | 0% of savings/losses |
| | Risk Band 2:<br>Gross Savings/Losses Between 25% and 35% | 50% of savings/losses | 50% of savings/losses |
| | Risk Band 3:<br>Gross Savings/Losses Between 35% and 50% | 25% of savings/losses | 75% of savings/losses |
| | Risk Band 4:<br>Gross Savings/Losses Greater than 50% | 10% of savings/losses | 90% of savings/losses |

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# Financial Methodology – Risk Mitigation

## Stop-Loss Arrangement (voluntary)

- Addresses random, high-cost expenditures by protecting DCEs from financial liability for individual beneficiary expenditures that are above the stop-loss “attachment points”
- DCEs that elect the stop-loss arrangement pay for the protection through a PBPM charge to the DCE’s performance year benchmark

# Quality Measures

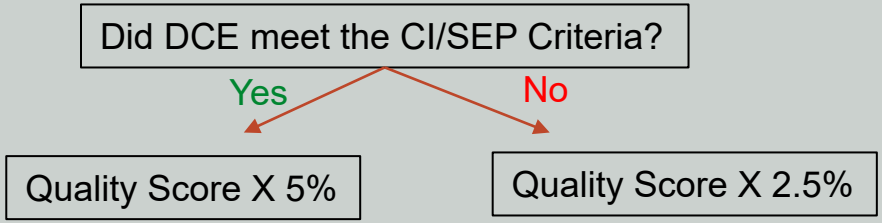
## Quality Measures and Performance

### Quality Measures

- Measures (no DCE-reported measures):
  - Risk-Standardized All-Condition Readmission
  - All-Cause Unplanned Admissions for Patients with MCC
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - Timely Follow-Up (Standard and New Entrant DCEs only)
  - Days at home for Patients with Complex Chronic Conditions (High Needs DCEs only)

### Quality Performance

- PY1-2: 4% pay-for-reporting/1% pay-for performance (so all DCEs should get the 5% withhold back so long as they report)
- PY3-6: 5% pay-for-performance. The amount of the quality withhold a DCE earns back is a product of --
  (1) Its score on the quality measures; and
  (2) Whether the DCE meets continuous improvement/sustained exceptional performance (CI/SEP) criteria



# Quality Measures

## Standard and New Entrant DCEs

| PY | P4R | P4P | Reporting-Only |
|---|---|---|---|
| PY1 | • 4% = claims-based measures (ACR, UAMCC) | • 1% = Meet benchmark with either ACR or UAMCC | — |
| PY2 | • 2% = claims-based measures (ACR, UAMCC, Timely Follow- Up)<br>• 2% = CAHPS | • 1% = Meet benchmark with either ACR or UAMCC | — |
| PY3–PY6 | — | • 1.25% = ACR<br>• 1.25% = UAMCC<br>• 1.25% = Timely Follow-Up<br>• 1.25% = CAHPS | *Only if new measure introduced for first year of use* |

## High Needs DCEs

| PY | P4R | P4P | Reporting-Only |
|---|---|---|---|
| PY1 | • 4% = claims-based measures (ACR, UAMCC, DAH) | • 1% = Meet benchmark with either ACR or UAMCC | — |
| PY2 | • 2% = claims-based measures (ACR, UAMCC, DAH)<br>• 2% = CAHPS | • 1% = Meet benchmark with either ACR or UAMCC | — |
| PY3–PY6 | — | • 1.25% = ACR<br>• 1.25% = UAMCC<br>• 1.25% = Days at Home<br>• 1.25% = CAHPS | *Only if new measure introduced for first year of use* |

# Quality Measures

## High Performers Pool (beginning PY3)

- The funds in the HPP will be distributed to the highest performing DCEs through an HPP Bonus based on quality performance or improvement.

- Criteria based on an individual DCE's performance on the specified measures in the current performance year compared to the prior performance year, or on performance against the quality measure benchmark, or a combination of both.

# Reconciliation

## Shared Savings/Losses

- Determined by CMS after comparing actual Medicare expenditures against a Final Performance Year Benchmark
- Expenditures: capitated payments, Advanced Payments, and FFS claims paid by CMS directly

## Provisional Financial Reconciliation (Optional)

- Conducted by CMS shortly after the end of a PY
- Based on expenditures first 6 months of the PY

## Final Financial Reconciliation

- Conducted by CMS after each PY after sufficient time has passed for claims processing

# Benefit Enhancements

| Current Benefit Enhancements (from NextGen) |
| --- |
| SNF 3-day rule waiver |
| Telehealth expansion |
| Post-discharge home visits |
| Care management home visits |
| Chronic disease management reward program |
| Cost-sharing support for Part B services |

| New Benefit Enhancements |
| --- |
| Waiver of homebound requirement for certain conditions |
| Allowing a nurse practitioner to certify a beneficiary for home care |
| Concurrent care for beneficiaries that elect the Medicare hospice benefit |

# Beneficiary Engagement

DCEs will be permitted to provide in-kind items or services to beneficiaries, if the following conditions are satisfied:
1) There is a reasonable connection between the items or services and the medical care of the beneficiary;
2) The items or services are preventative care items and services or advance a clinical goal for the beneficiary; and
3) The in-kind item or service is not a Medicare-covered item or service for the beneficiary

**Vouchers** for
- OTC medications
- chronic disease self-management, pain management and falls prevention programs
- meal programs
- transportation to and from an appointment
- dental care

**Wellness program** memberships, seminars, and classes.

Items and services to **support management of a chronic disease or condition**, such as home air filtering systems or bedroom air-conditioning for asthmatic patients, and home improvements such as railing installation or other home modifications to prevent re-injury.

**Electronic systems** that alert family caregivers when a family member with dementia wanders away from home or gets up from a chair or bed.

**Phone applications**, calendars or other methods for reminding patients to take their medications and promote patient adherence to treatment regimens.



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# Model Overlap

| | *Direct Contracting Model (DC)* | |
|---|---|---|
| | Providers | Beneficiaries |
| **MSSP** | Participant Providers cannot particpate in MSSP (and vice-versa). Preferred Providers may participate in both models | Beneficairies aligned to a DCE will not be aligned to a MSSP ACO |
| **Bundled Payments for Care Initiative - Advanced (BPCI-A)** | Providers may participate in both DC and BPCI-A | DC beneficiaries cannot participate in BPCI-A (beneficiaries cannot trigger an episode) |
| **Comprehensive Joint Replacement (CJR)** | DC participants may be either CJR collaborators or collaborator agents | DC beneficiaries cannot participate in CJR (beneficiaries cannot trigger an episode) |
| **Oncology Care Model (OCM)** | Providers may participate in both DC and OCM | OCM beneficiaries are not excluded from participation in DC |
| **Comprehensive ESRD Care Model (CEC)** | DC Professionals cannot participate in both CEC and DC. DC Participants who are not primary care specialsts and DC Preferred Providers may participate in both CEC and DC. | CEC beneficiaries are excluded from participation in DC |
| **Comprehensive Primary Care + (CPC+)** | Providers cannot participate in both DC and CPC+ | DC beneficiaries may not participate in CPC+. (DC has alignment preference over CPC+) |
| **Primary Care First (PCF)** | Providers cannot participate in both DC and PCF | DC beneficiaries may not participate in PCF. (DC has alignment preference over PCF). |

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**Full Agenda**

**Register Today!**

**Highlights include:**

- Mark McClellan speaking on Value-Based Care's Future Post COVID
- A fireside chat between Sachin Jain, SCAN and Clif Gaus, NAACOS on
- Plenary on Promoting Health Equity in Value-Based Care
- Four peer-to-peer networking sessions over Zoom
- A virtual exhibit hall

# Questions