Direct Contracting Model Overview

The Direct Contracting Model builds upon the successful Next Generation ACO Model and offers higher levels of risk and reward than many options under the Medicare Shared Savings Program. There are two options, Professional and Global, each with three types of Direct Contracting Entities; Standard, New Entrant and High Needs Populations. The Professional option is a lower-risk payment model option that will provide a capitated payment for enhanced primary care services. The Global option offers a higher risk sharing arrangement and provides two payment options: Primary Care Capitation and Total Care Capitation. The model offers opportunities for providers new to fee-for-service Medicare and those serving high-need patients to participate through lower beneficiary minimums. The five-year model is set to launch with an implementation period in 2020 and its first performance year in 2021.

NAACOS is excited to see CMS demonstrating its commitment to value-based care and payment by moving forward with accountable care models like Direct Contracting, which make providers accountable for patients' total cost of care and quality. We advocated on behalf of ACOs for several aspects of the model and continue to advocate for needed changes, and we are working to educate the broader ACO community about this program.

This overview provides a quick summary of the Request for Applications and related FAQs CMS released on November 25. More information, including other NAACOS-member resources, can be found on NAACOS's dedicated Direct Contracting webpage. Questions or feedback about the model are welcomed and can be sent to DirectContracting@NAACOS.com.

Timeline

	Implementation Period (PY0) Applicants	PY1 Applicants
LOI (reopened)	December 10, 2019	December 10, 2019
Application Deadline	February 25, 2020	May 2020
DCE Selection	April 2020	September 2020
Participation Agreement	Late April 2020 (for PY0) December 2020 (for PY1)	December 2020

ACOs are called Direct Contracting Entities (DCE) under this model, which is available to three types of DCEs:

- Standard DCE:
  - This is for organizations that have experience serving Medicare FFS beneficiaries, including traditional ACOs
  - Alignment: minimum 5,000 beneficiaries

- New Entrant DCE:
    - Available to organizations that have not traditionally provided services to a Medicare FFS population. The organizations cannot have more than 50 percent of the DC Participant Providers having prior experience in the Shared Savings Program, the Next Generation ACO Model, the Comprehensive ESRD Care Model, or the Pioneer ACO Model.
    - Organizations found ineligible to participate as New Entrant DCEs on the basis of this criterion will have the opportunity to participate as a Standard DCE, provided all other model requirements are met.
    - Alignment: minimum 1,000 beneficiaries in PY1 (increases by 1,000 each year); maximum of 3,000 beneficiaries assigned through claims-based alignment in the benchmark years.
    - *Note: The definition of new entrants is somewhat unclear and NAACOS is seeking clarification from the Innovation Center on this type of DCE.*
- High Needs Population DCE
    - For DCEs tailored to a high-needs population (defined as impaired mobility and/or complex high needs patient); the design is based on the PACE program
    - Can care for specific sub-populations, including patients with a particular disease, disease at a particular stage, or a combination of diseases
    - Alignment: minimum 250 beneficiaries in PY1 (increases to 1,400 by PY5)

As expected, the model will initially offer two model options (available to each of the three types of DCEs):

- Professional Option
    - Shared Savings/Losses: 50 percent
    - Capitation: 7 percent PBPM (adjusted for leakage)
        - Also, DCEs may elect Advanced Payment for any portion of the remaining 93 percent; reconciled at the end of the PY, similar to the PBP payment mechanism in NextGen.
- Global Option
    - Shared Savings/Losses: 100 percent
    - Capitation: DCE chooses 7 percent PBPM or 100 percent PBPM (both adjusted for leakage)

Alignment

- Voluntary alignment and claims-based alignment
    - DCEs can use the implementation period/PY0 in 2020 for voluntary alignment
    - Voluntary alignment will take precedence over claims-based; Voluntary alignment completed through 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.
    - Limitation: subject to laws and guidance

Financial Methodology

- There will be "first dollar" savings and losses. There is no MSR/MLR like in MSSP.
- Benchmarking
    - Follows a 5-step process similar to NextGen
        1. Calculation of *historical baseline expenditures*
            - The baseline period will be a fixed period three base years (2017, 2018, 2019)
            - It is not a rolling baseline; There is no rebasing
            - For New Entrant DCEs and High Needs Population DCEs: CMS will only use regional expenditures for PY1-3 and will add in historical baseline expenditures for PY4-5
        2. *Trending* the historical baseline expenditures forward
        3. *Blending* the historical baseline expenditures with regional expenditures using an Adjusted MA Rate Book
            - Blend is 65 percent historical expenditures/35 percent regional for PY 1, moving to 50 percent/50 percent by PY5
        4. *Risk adjustment*
            - CMS has not announced details on risk adjustment. It expects to release a detailed risk adjustment paper in late 2019.
        5. Applying *discount* and *quality withhold*
            - No discount for Professional DCEs
            - For Global DCEs: discount applied to the PY benchmark
                - 2 percent (PY1-2), 3 percent (PY3), 4 percent (PY4), 5 percent (PY5)
            - Quality withhold of 5 percent for all DCEs, beginning PY1
                - DCEs can earn the quality discount back based on quality performance if the DCE receives a 100 percent quality score and meets the continuous improvement/sustained exceptional performance criteria
                - CMS will fund a High Performers Pool with withheld funds not earned back. Available as a bonus to high performers.
- Risk Corridors
    - Apply at the aggregate savings/losses level; corridors are based on "risk bands"
    - Wider than in previous models; no upper limit; no aggregate caps (like the 5 percent of benchmark in NextGen). This means DCEs are at partial risk for ALL losses, though the share of losses decreases at certain points as losses increase relative to the benchmark.
- Stop-Loss
    - Voluntary
    - Addresses random, high cost expenditures; similar to NextGen

Quality Measures

- PY1 is pay-for-reporting (so all DCEs should get the 5 percent withhold back so long as they report)
- Small measures set = 14 measures
    - 9 CAHPS measures, 5 claims measures

Benefit Enhancements

- Using NextGen as base list of benefit enhancements (SNF 3-day waiver, asynchronous telehealth, post-discharge home visits, care management home visits).
- Two new home health benefits (waiving homebound requirement and allowing nurse practitioners to certify home health)
- Chronic Disease Management Reward Program: DCE can pay up to $75 a year to eligible beneficiaries participating in a chronic disease management program (DCE pays, not CMS)
- Concurrent care for beneficiaries that elect the Medicare hospice benefit, which would eliminate the requirement that beneficiaries who elect the Medicare hospice benefit give up their right to receive curative/conventional care. DCEs would identify the hospices with which they would partner for this benefit (similar to the SNF benefit)