NAACOS In-depth Review of the Medicare Direct Contracting Model

EXECUTIVE SUMMARY

As the Centers for Medicare & Medicaid Services (CMS) moves forward with its commitment to transitioning our healthcare system to one based on value, the agency is developing new payment and delivery models. One of particular importance is the Direct Contracting Model, which builds upon the Next Generation ACO Model (Next Gen) and incorporates elements of Medicare Advantage (MA). This new alternative payment model (APM) includes higher levels of risk and reward than many others, allows flexibility with payments through capitation, increases beneficiary engagement and aims to attract new players to Medicare fee-for-service (FFS).

Direct Contracting was initially announced in April 2019 and on November 25, 2019, CMS released the Request for Applications (RFA), available here. The RFA provides many details about the model's policies and operations. Direct Contracting is a five-year payment model, with its first performance year (PY) starting January 1, 2021. As detailed in this document, the RFA focuses on two program options, Professional and Global. These options are available for different types of Direct Contracting Entities (DCEs), which are the equivalent of ACOs, and the DCE types are Standard, New Entrants and High Needs Population. The program options dictate the level of risk and reward and the type of DCE determines other aspects of participation such as the necessary number of aligned beneficiaries and how the financial benchmark is set, which is the bar against which the DCE's expenditures will be compared. A third DC model option, the Geographic Option, is being considered by CMS and would include full financial risk for the entire population of a particular geographic area.

NAACOS has been advocating to help shape the Direct Contracting model since its inception. For example, we met with CMS and wrote letters on the Geographic and Professional and Global Options to help shape their development. Additionally, **NAACOS recently launched a new Direct Contracting Taskforce to strengthen our advocacy efforts and to increase provider education and engagement.** NAACOS members automatically receive all benefits of the Taskforce. For those net yet members of NAACOS, we are offering complimentary access to the Taskforce. Direct Contracting Taskforce benefits include:

- Webinars and resources reviewing key details of Direct Contracting
- Listserv dedicated to discussing and asking questions about the model
- Dedicated webpage with NAACOS and CMS resources
- NAACOS advocacy to shape the model
- Discount rates for in-person NAACOS conferences and boot camps with sessions focused on Direct Contracting and other new payment models
- Opportunities to engage with those evaluating the model to and learn from one another
- Perspectives of actuaries evaluating this model compared to others
- Opportunities to pose questions for NAACOS to get answered by Innovation Center staff *NAACOS email address for questions: DirectContracting@naacos.com*

MODEL DETAILS

Timeline

Direct Contracting is a five-year payment model, with its first performance year (PY) starting January 1, 2021. Prior to the start of the first performance year, participating organizations have the opportunity to participate in an Implementation Period (IP).

The IP is the preparation year, during which participating organizations may conduct beneficiary alignment activities and work to build their clinical infrastructure and care coordination networks. The model's financial operations will not begin until the start of PY1 on January 1, 2021. During the IP, organizations may participate in both Direct Contracting and other payment initiatives (i.e. may participate in IP and Next Gen or the Medicare Shared Savings Program (MSSP)).

	Implementation Period (PY0) Applicants	PY1 Applicants
LOI	Closed December 12, 2019	Closed December 12, 2019
Application Deadline	February 25, 2020	May 2020
DCE Selection	April 2020	September 2020
Execute Participation Agreement	Late April 2020	December 2020
Model Start Date	May 2020	January 1, 2021

Types of Direct Contracting Entities

Direct Contracting Entity (DCE) is the new name for an accountable care organization (ACO) under this model. Like ACOs, a DCE must be a legal entity formed under applicable state, federal, or tribal law, and authorized to conduct business in each state in which it operates for purposes of the receiving and distributing monies from CMS, repaying monies determined to be owed to CMS, and establishing, reporting, and ensuring its providers' compliance with model requirements. Since DCEs will be receiving capitated payments from CMS, they must make sure they meet all state licensure and insurance requirements necessary to make downstream payments to their providers.

The model provides for three types of DCEs: Standard, New Entrant, and High Need Population.

Standard DCEs: This is for organizations that have experience serving Medicare fee-for-service (FFS) beneficiaries, including traditional ACOs and those with experience in alternative payment models and/or value-based contracting. CMS will require Standard DCEs to maintain a minimum of 5,000 aligned beneficiaries.

New Entrant DCEs: This is for entities with limited historical experience delivering care for Medicare FFS beneficiaries. New Entrant DCEs must also have fewer than 50 percent of their providers experienced in FFS risk models. This type of DCE may be attractive to Medicare Advantage (MA) plans, commercial plans, payers and non-health entities. CMS will require a lower aligned beneficiary minimum, starting with 1,000 beneficiaries and increasing each year (PY1: 1,000 beneficiaries, PY2: 2,000 beneficiaries, PY3: 3,000 beneficiaries, PY4/5: 5,000 beneficiaries, with more than 3,000 aligned using claims-based alignment). New Entrant DCEs may not have more than 3,000 beneficiaries that are "alignable" through claims-based alignment in any of the base years (calendar years (CY) 2017, 2018, and 2019).

High Needs Population DCEs: This is available to organizations that that focus on high-needs populations. CMS will require an aligned beneficiary minimum that starts with 250 beneficiaries and increases each year (PY1: 250 beneficiaries, PY2: 500 beneficiaries, PY3: 750 beneficiaries, PY4: 1,200 beneficiaries and PY5: 1,400 beneficiaries). Beneficiaries qualify as "high needs" if they have:

1. Conditions that impair their mobility (see RFA Appendix F for an illustrative ICD-10 code list, which will be finalized for inclusion in Direct Contracting Participation Agreement); and/or
2. Complex, high needs:
    a. Significant chronic or other serious illness (defined as having a risk score of 3.0 or greater using the CMS Hierarchical Condition Category (CMS-HCC) methodology); or
    b. A CMS-HCC risk score greater than 2.0 and less than 3.0 AND two or more unplanned hospital admissions in the previous 12 months; or
    c. Signs of frailty, as evidenced by a claim submitted by a provider or supplier specifically for a hospital bed or transfer equipment for use in the home.

As discussed below, financial benchmarking for New Entrant DCEs and High Needs Population DCEs places significantly less weight on historical expenditures and more weight on regional rates (as compared to Standard DCEs).

Model Options and Payment Mechanisms

The DC model offers two different options, Professional Option and Global Option, which will be available to all three types of DCEs.[1] Both options will qualify as Advanced Alternative Payment Models for purposes of the Quality Payment Program (QPP).

Professional Option

DCEs participating in the Professional Option will be financially responsible for 50 percent of all shared savings and losses recognized by the DCE for each PY. The DCE will participate in Primary Care Capitation and receive monthly, per-beneficiary-per-month capitated payment from CMS in an amount equal to 7 percent of its prospective financial benchmark. Additionally, DCEs may voluntarily elect to participate in Advanced Payment and elect for CMS to withhold an additional amount (up to 93 percent) of its providers' claims, which CMS would pay to the DCE as a monthly payment mechanism. Unlike Primary Care Capitation, Advance Payments will be reconciled against claims during financial reconciliation after each PY.

Global Option

DCEs participating in the Global option will be financially responsible for 100 percent of all shared savings and losses recognized by the DCE for each PY. The DCE will elect to participate in either Total Care Capitation and receive monthly per-beneficiary-per-month capitated payment from CMS in an amount equal to 100 percent of its prospective financial benchmark, or Primary Care Capitation.

Capitation Operations

Each of a DCE's Participant Providers must agree to participate in capitation. A DCE will not be required to pay its Participant Providers an amount equal to the FFS claims and may creatively contract with these providers. However, the negotiated agreement must be formalized in the contracts between the DCE and its Participant Providers.

Under the capitated payment methodology, providers will continue to submit all claims to CMS as they currently do. Once submitted, CMS will "zero out" all claims for which it has made capitated payments to the DCE. For purposes of Primary Care Capitation, this means CMS will not directly pay participating

[1] In the future, CMS may offer a third model option, the "Geographic Option," where a DCE would assume full financial risk for the entire population of a particular geographic area. CMS previously issued a Request for Information seeking input on this option.

providers for Primary Care Qualified Evaluation and Management (PQEM) services. For Total Care Capitation, CMS will not directly pay participating providers for any claims.

DCE Providers and Suppliers
The model offers two categories of providers and suppliers, similar to Next Gen.

Participant Providers are the core providers, through which beneficiaries are aligned to the DCE. These providers will also report quality through the DCE and are eligible to be Qualified Alternative Payment Model Participants (QPs) under the QPP. Participant Providers generally cannot participate in other shared-savings initiatives. However, like, Next Gen, Direct Contracting identifies providers through a combination of the provider's Tax Identification Number (TIN) and National Provider Identifier (NPI) and, therefore, other providers in a TIN that do not participate in Direct Contracting may participate in another shared-savings initiative.[2]

Preferred Providers are the "extended network" and are not used for beneficiary alignment. They do not report quality through the DCE and cannot qualify as QPs under the QPP based on their affiliation with the DCE. Preferred Providers are not prohibited from participating in multiple payment models.

Both Participant Providers and Preferred Providers may receive shared savings (and be responsible for shared losses) and may participate in the model's benefit enhancements and patient engagement incentives.

	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 shared-savings initiatives	no	yes

DCE Participant and Preferred Providers must be Medicare-enrolled providers or suppliers and identified on the DCE's provider lists by name, NPI, TIN, CMS Certification Number (CCN), and Legacy TIN or CCN (if applicable). Participant and Preferred Providers may include but are not limited to:

- Physicians or other practitioners in group practice arrangements
- Network of individual practices of physicians or other practitioners
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Critical Access Hospitals (CAHs)

Alignment and Marketing
Medicare FFS beneficiaries will prospectively align to DCEs using both voluntary alignment and claims-based alignment. In Direct Contracting, CMS gives new significance to voluntary alignment, giving it precedence over claims-based alignment. Specifically, if a beneficiary would align to one DCE through claims-based alignment but voluntarily aligns to another DCE, the beneficiary will be assigned to the DCE for which it voluntarily aligned. Beneficiaries will be eligible for alignment to a DCE if the meet the following criteria:

[2] This policy differs from the Medicare Shared Savings Program's "full-TIN exclusion" policy.

- Are enrolled in both Medicare Parts A and B;
- Are not enrolled in a Medicare Advantage plan, Medicare Cost Plan, PACE organization, or other Medicare health plan;
- Have Medicare as their primary payer;
- Are a resident of the United States; and
- Reside in a count included in the DCE's Service Area

Voluntary Alignment
Beneficiaries will voluntarily align to a DCE if they elect one of the DCE's Participant Providers as their primary caregiver through either MyMedicare.gov or paper-based selection. Notably, DCEs joining from another model (such as MSSP or Next Gen) may retain their beneficiaries who previously voluntarily aligned to one of the DCE's Participant Providers.

DCEs may also elect to participate in Prospective Plus alignment, whereby beneficiaries that voluntarily align during a PY will be added on a quarterly basis throughout the PY. CMS will adjust the DCE benchmark and capitated payments according. However, DCEs should be aware that this option reduces the predictability of prospective benchmarks.

CMS will also allow DCEs to market to beneficiaries for purposes of voluntary alignment and has stated that the marketing rules will be "influenced by" the MA marketing guidelines. DCEs may proactively communicate with beneficiaries (marketing materials, outreach events, etc.) and provide gifts of nominal value to beneficiaries for the purpose of outreach regarding voluntary alignment. While marketing is a policy that is welcomed by DCEs, the scope of the marketing allowed in DC remains uncertain. CMS and the Office of the Inspector General will issue payment rule waivers as well as fraud and abuse waivers to enact the policy. The breadth of these waivers will dictate the usefulness of this engagement.

Claims-Based Alignment
Building upon NextGen, beneficiaries will be aligned to a DCE if they receive the plurality of their PQEM services from the DCE's Participant Providers, either from primary care practitioners or select nonprimary care specialists. If 10 percent or more of the allowable charges incurred for PQEM services received by a beneficiary during the 2-year alignment period are billed by physicians and practitioners with a primary care specialty, then alignment is based on the allowable charges incurred for PQEM services provided by primary care specialists. If it's less than 10 percent, then alignment is based on the allowable charges incurred for PQEM services provided by physicians and practitioners with certain non-primary specialties.

CMS will use a 2-year "alignment period" that includes two consecutive 12-month periods, with the second period ending six months prior to the start of the relevant performance year (i.e., the alignment window for PY1 is July 1, 2018 – June 30, 2020).

Beneficiary alignment takes place within the DCE Service Area, which consists of a Core Service Area (all counties in which DC Participant Providers have office locations) and an Extended Service Area (all counties in which DC Participant Providers have office locations). DCEs can operate in multiple, non-contiguous service areas including in the same state or multiple states. The DCE Service area is distinct form the DCE's region, which is used to determine the financial benchmark.

Financial Methodology

Benchmarking
DCEs will earn savings or pay losses based on their performance each PY as compared to a prospectively set financial benchmark. Similar to the methodology used in Next Gen, Direct Contracting will follow a 5-step process for benchmarking:

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). The baseline year will not change over the life of the model and will be weighted (10 percent, 30 percent/60 percent, respectively). CMS will set the benchmark using two beneficiary categories: End-Stage Renal Disease (ESRD) and Aged & Disabled (non-ESRD). For beneficiaries aligned through voluntary alignment, CMS will not use historical baseline expenditures for PY1-3. Instead, CMS will only use regional expenditures for PY1-3 (benchmarking will start at step 3) and will add in historical baseline expenditures for PY4-5.

   New Entrant DCEs and High Needs Population DCEs:
   CMS will not use historical baseline expenditures for PY1-3. CMS will only use regional expenditures for PY1-3 (benchmarking will start at step 3) and will add in historical baseline expenditures for PY4-5 using a fixed 2-year base period (2021, 2022)

2. Trending the historical baseline expenditures forward
   CMS will prospectively trend forward the historical baseline forward using the projected U.S. Per Capita Cost (USPCC) growth trend and the ESRD USPCC growth trend, which are calculated annually by CMS's actuaries. CMS will also trend the baseline to reflect the anticipated impact of changes in the regional FFS Geographic Adjustment Factors.

3. Blending the historical baseline expenditures with regional expenditures
   CMS will blend historical baseline expenditures with regional expenditures. The regional expenditures are based on each DCE's region, which includes all counties where DCE-aligned beneficiaries reside. The blend gives decreased weight to the historical baseline expenditures over time.

Performance Year	Historical Baseline Expenditures	Regional Expenditures
PY1/2	65%	35%
PY3	60%	40%
PY4	55%	45%
PY5	50%	50%

   CMS will use an "adjusted" MA rate book to blend regional expenditures with aligned beneficiary historical expenditures. The MA rate book contains the county-level rates used in setting MA benchmarks (i.e. the maximum amount that CMS will pay an MA plan). CMS has not released specifics on the adjustments it will make to the rate book for Direct Contracting, but the RFA generally discusses 3 adjustments:
   1. CMS will remove the impact of certain adjustments that are incorporated into the MA Rate Book for purposes of MA plan payment, but that are not relevant to Direct Contracting, such as the Quality Bonus Payment percentage based on star ratings.
   2. CMS will make adjustments to account for differences in expenditure types that are included for purposes of the MA Rate Book, but are not relevant for purposes of Direct Contracting, for example, the FFS quartile assignment rules may not apply.
   3. CMS will make adjustments to account for differences between the subset of FFS beneficiaries eligible to be aligned to DCEs and Medicare FFS beneficiaries generally. For example, DCE aligned beneficiaries must be enrolled in both Medicare Parts A and B.

To account for where the aligned beneficiaries live for the calculation of a DCE's regional expenditures, CMS will calculate a weighted average of the county rates (or state level rates for ESRD beneficiaries) from the Adjusted MA Rate Book that correspond to where the aligned beneficiaries live. CMS will make use of the most recently available Adjusted MA Rate Book data to derive these rates.

Finally, Direct Contracting imposes limits on the adjustment resulting from blending in regional expenditures. Upward adjustment will be capped at 5 percent of the FFS USPCC and downward adjustment capped at 2 percent of the FFS USPCC for the PY. The caps apply to each PY and not over the life of the model. For example, a DCE may have a 4 percent upward adjustment in PY2 and an additional 3 percent upward adjustment in PY3, for a total upward adjustment of 7 percent.

4. Risk adjustment
   Risk adjustment is another big unknown for the DC model. The RFA does not provide the risk adjustment methodology and CMS has indicated for some time that the agency would like to test a brand new methodology to account for the underlying health status of a DCE's aligned beneficiaries. The new risk adjustment will aim to mitigate the influence of coding intensity on risk adjustment and improve its accuracy for DCEs serving complex, high-risk patients. CMS has noted it plans to release details on the risk adjustment methodology in early 2020.

5. Applying a discount and payment withholds
   CMS will apply a discount to Global Option DCEs to ensure that the agency recognizes savings. The discount will increase from 2 percent in PY1 to 5 percent in PY5 (PY1/2: 2 percent, PY3: 3 percent, PY4: 4 percent, PY5: 5 percent. The discount will not apply to Professional Option DCEs (since CMS will already recognize at least 50 percent of any savings).

   For PY1 only, CMS will withhold 2 percent of the benchmark as a "retention withhold" to incentivize DCEs to remain in the model for at least two years. If a DCE remains in the model at the time of final PY reconciliation (which will occur during PY2), the DCE will earn back the full amount of the withhold.

   CMS will also withhold 5 of the benchmark each PY, which a DCE may earned back based on its quality performance.

Risk Mitigation
The DC model provides DCEs with two risk mitigation tools: risk corridors and risk mitigation.

Risk Corridors:
CMS will apply risk corridors at the aggregate savings/losses level for each DCE. The risk corridors for the Professional Option have lower cutoffs than for the Global Option, with DCEs responsible for a lower proportion of savings or losses in every corridor. However, CMS is not capping savings/losses so there is no limit on the amount of losses for which a DCE will be responsible (and no limit on the savings it may earn).

	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: Gross Savings/Losses Less than 5%	50% of savings/losses	50% of savings/losses
	Risk Band 2: Gross Savings/Losses Between 5% and 10%	35% of savings/losses	65% of savings/losses
	Risk Band 3: Gross Savings/Losses Between 10% and 15%	15% of savings/losses	85% of savings/losses
	Risk Band 4: Gross Savings/Losses Greater than 15%	5% of savings/losses	95% of savings/losses
Global DCE	Risk Band 1: Gross Savings/Losses Less than 25%	100% of savings/losses	0% of savings/losses
	Risk Band 2: Gross Savings/Losses Between 25% and 35%	50% of savings/losses	50% of savings/losses
	Risk Band 3: Gross Savings/Losses Between 35% and 50%	25% of savings/losses	75% of savings/losses
	Risk Band 4: Gross Savings/Losses Greater than 50%	10% of savings/losses	90% of savings/losses

Stop-Loss Arrangement

DCEs may also elect to participate in a voluntary stop-loss arrangement to address random, high-cost expenditures by protecting DCEs from financial liability for individual beneficiary expenditures that are above the stop-loss "attachment points." DCEs may change their election to participate in the stop-loss arrangement each PY, and CMS will provide DCE with the attachment points in advance of the annual election. DCEs that elect the stop-loss arrangement pay for the protection through a per-beneficiary, per-month charge to the DCE's performance year benchmark.

Reconciliation

Following each PY, CMS will determine whether a DCE has any savings/losses by comparing actual Medicare expenditures against a final PY benchmark. CMS will include the following expenditures: capitated payments, Advanced Payments, and FFS claims paid by CMS directly. If DC follows a similar timeline to Next Gen, CMS will complete final reconciliation roughly 7-9 months following the conclusion of a PY. Based on feedback from Next Gen ACOs, CMS will offer DCEs the option to receive Provisional Financial Reconciliation, which will be conducted shortly after the end of each PY and will be based on the DCE's expenditures for the first six months of that PY. DCEs that elect this option will receive final reconciliation on the same schedule as other DCEs.

Quality

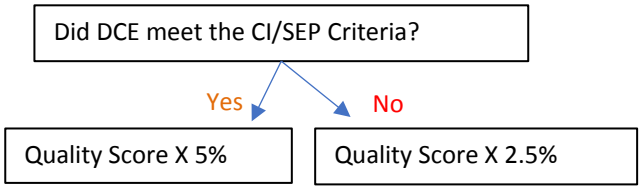
Quality Measures

The DC model will include set of quality measures that is significantly smaller than the measures reported in other payment models. The measure set includes nine Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures and five claims measures. There are no clinical measures. While the smaller set of measures based heavily on beneficiary-provided data will likely reduce reporting burden, the measures pose new risk to DCEs. Specifically, each measure will carry more weight and CAHPS measures are out of the DCE's control. CMS has indicated that they may give greater weight to certain measures but the agency is still finalizing how it will calculate the quality score.

Quality Performance

A DCE's quality performance will be based on the score it receives on the pay-for-performance quality measures and on whether or not the DCE meets continuous improvement/sustained exceptional performance (CI/SEP) criteria. A DCE will only get 100 percent of its withhold back if it gets a 100 percent quality score and meets the CI/SEP criteria. Accordingly, 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 CI/SEP criteria



CMS has not yet announced the criteria for the CI/SEP requirement but states that the targets will be tied to reducing unnecessary or avoidable health service utilization. The addition of the CI/SEP in DC is notable as quality performance is heavily weighted by this requirement. For instance, if a DCE earns a 95 quality score but doesn't meet CE/SEP criteria, the DCE will earn back 2.4 percent of its withhold. However, if the DCE only earns an 80 quality score but meets the CI/SEP criteria, it will earn back 4 percent of the withhold.

The first PY is pay-for-reporting so a DCE will earn back the full 5% withhold so long as it successfully completes quality reporting.

High Performers Pool

The DC model also introduces a High Performers Pool for DCEs with high quality performance. CMS will use a portion of withheld quality funds not earned back by DCEs to fund the pool. The pool funds will be distributed to the highest performing DCEs through High Performers Pool bonus based on quality performance or improvement. CMS has not yet announced the specific criteria, but the RFA states that it will be 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.

Benefit Enhancements and Beneficiary Engagement

Benefit Enhancements

The DC model will offer all of the benefit enhancements currently available in Next Gen, including:

- Skilled Nursing Facility 3-Day Rule Waiver
- Telehealth Expansion (waiver of geographic and originating site requirements, ability to provide asynchronous telehealth)
- Post-Discharge Home Visits
- Care Management Home Visits
- Chronic Disease Management Reward Program (up to $75 per beneficiary per year)
- Cost-Sharing Support for Part B Services

In addition, CMS will initially offer three additional benefit enhancements:

- Waiver of homebound requirement for certain conditions
- Allowing a nurse practitioner to certify a beneficiary for home care
- Allowing concurrent care for beneficiaries that elect the Medicare hospice benefit (available to Global DCEs only)

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.

The RFA provides a non-exhaustive list demonstrating some of the allowed engagement tools, which includes:

- Vouchers for over-the-counter medications, chronic disease self-management, pain management and falls prevention programs, meal programs, transportation to and from an appointment, and dental care
- 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.
- Wellness program memberships, seminars, and classes.
- 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.

Model Overlaps
During the IP, DCEs and providers may participate in both Direct Contracting and other payment models (such as MSSP). However, beginning with PY1, a DCE's Participant Providers cannot simultaneously participate in other shared-savings initiatives (including MSSP, Comprehensive Primary Care +, Primary Care First, the Maryland Total Cost of Care Model, and the Vermont All-Payer Model).

Participation in DC is at the TIN/NPI level so a DCE may split a TIN, with some providers participating DC as Participant Providers and other providers within the same TIN participating in other shared savings initiatives. However, because MSSP participation is based at the TIN level, a TIN with any providers participating in MSSP will be prohibited from having other providers participate in Direct Contracting (and vice-versa). There is no prohibition on a DCE's Preferred Providers participating in multiple initiatives, including MSSP.

With respect to CMS's Bundled Payments for Care – Advanced (BPCI-A) initiative, providers may participate in both Direct Contracting and BPCI-A. Beneficiaries cannot participate in BPCI-A (meaning that beneficiaries aligned to a DCE will not trigger a BPCI-A episode).

Key Takeaways and Outstanding Questions
The RFA details many of the much-anticipated policies for the new model. While much of the model resembles Next Gen, there are a few components that stand out as significant for organizations making a decision about participating in the model.

- *Implementation Period (2020)*
    - The IP is a great opportunity to conduct voluntary alignment using new marketing guidelines. This is particularly important since voluntary alignment is given precedence over claims-based alignment and beneficiaries voluntarily aligned to a Standard DCE are not included in the historical expenditure baseline for benchmarking in the first three PYs.

- *Move to MA rate book for regional adjustment*
    - While the regional cost in the MA rate book is knowable for a DCE, details are limited on the "adjusted" MA rate. Moreover, the maximum regional benchmark component never exceeds 50 percent
- *Risk*
    - While the risk corridors provide some protection against significant losses, there is no complete cap on losses.
    - Global DCEs will initially receive a significantly reduced portion of their benchmark after factoring in the discount, the quality withhold, and the retention withhold (91percent of the benchmark in PY1, 93 percent (PY2), 92 percent (PY3), 91 percent (PY4), 90 percent (PY5)).
    - A DCE's participation decision will be based significantly on the benchmarking methodology and the importance of the new risk adjustment methodology cannot be overstated.
- *Quality*
    - The 5 percent withhold is quite high, especially on top of the discount taken from the Global DCE's benchmark.
    - It will be crucial for DCEs to meet the CI/SEP criteria.
    - We do not yet know how CMS will weight the quality measures.
- *Licensure*
    - DCEs will need to pay attention to state licensure requirements because they will be paying downstream claims; may require a third-party administrator or insurer.
- *Marketing*
    - While marketing alignment is a win for DCEs, it is not yet known how broad this will be. CMS has said it will follow MA guidelines but the RFA states it will be limited by applicable laws and guidance. Key questions remain on whether and how CMS will waive regulations and if and how the OIG will waive beneficiary inducement prohibitions.

Resources and References

- CMS webpage on Direct Contracting, which includes resources such as:
    - Fact sheet
    - Request for Applications
    - FAQ document
- NAACOS Direct Contracting web page which includes resources such as:
    - NAACOS Direct Contracting model overview
    - Comparison of high-level accountable care models