

Direct Contracting: A program summary and comparison with MSSP and NGACO

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In April 2019, the U.S. Department of Health and Human Services (HHS) announced the Centers for Medicare and Medicaid Services (CMS) Primary Cares Initiative, which included a new set of payment models designed to “reduce administrative burdens and empower primary care providers to spend more time caring for patients while reducing overall health care costs.”¹

This initiative includes five new payment model options under two paths—Primary Care First (PCF) and Direct Contracting—for entities that want to take on risk for fee-for-service (FFS) Medicare beneficiary expenditures. These programs build upon existing CMS efforts to reduce healthcare expenditures while attempting to improve the quality of care for FFS Medicare beneficiaries.

This paper is designed to provide an in-depth technical evaluation of Direct Contracting, based on the CMS request for applications (RFA),² along with comparisons to its sister programs—Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) and Next Generation ACO (NGACO). It draws out distinctions that organizations may want to weigh when considering participation in this or other programs. It also explores the information that has been made available about the Direct Contracting program, makes comparisons between Direct Contracting, MSSP, and NGACO, and discusses potential implications for organizations that may be considering participation in the new Direct Contracting program. This paper is based on information available as of February 1, 2020.

High-level summary

Direct Contracting builds on its predecessor programs: Pioneer ACO, MSSP, and NGACO. We expect that many organizations considering participation in Direct Contracting will be at least somewhat familiar with these programs, and a comparison of them will be a useful perspective for understanding the opportunities and trade-offs that may come with Direct Contracting. The table in Figure 1 provides a high-level summary of key program features of NGACO, MSSP Pathways to Success, and Direct Contracting Global and Professional options.

After a careful evaluation of this program, we think that the crucial trade-off for entities considering either Direct Contracting or joining, /renewing, /or remaining in MSSP will be between the potential advantages of capitation and predictable revenue versus the challenges of the quality withhold/earn-back and the discount in the Global model. From a purely financial perspective, entities will need to consider whether there is enough marginal difference in anticipated aggregate savings under Direct Contracting to overcome the impacts of the quality withhold and the discount applied to benchmarks as compared to MSSP.

¹ CMS.gov (April 22, 2019). HHS News: HHS to deliver value-based transformation in primary care. Press release. Retrieved February 10, 2020, from <https://www.cms.gov/newsroom/press-releases/hhs-news-hhs-deliver-value-based-transformation-primary-care>.

² CMS (November 25, 2019). Direct Contracting Model: Global and Professional Options. Request for Applications. Retrieved February 10, 2020, from <https://innovation.cms.gov/Files/x/dc-rfa.pdf>.

FIGURE 1: KEY PROGRAM FEATURES

	MSSP	NGACO	DIRECT CONTRACTING - Professional	DIRECT CONTRACTING - Global
Attribution	Based primarily on evaluation and management (E&M) claims from primary care providers (PCPs).	Similar to Direct Contracting	Priority is still given to E&M claims provided by PCPs, but the requirement is less stringent. List of eligible services is slightly more limited, dropping services occurring in nursing facilities and some behavioral health codes.	
Financial Benchmark				
Baseline Period	3 years prior to contract	Fixed year	2017-2019	2017–2019
Trend	Retrospective	Prospective	Prospective	
Regional Adjustment	Retrospective, blended at 35% to 50% if ACO is more efficient, 15% to 50% if the ACO is less efficient.	Retrospective, blended at 30% to 40% if ACO is more efficient, 10% - 15% if the ACO is less efficient.	Prospective from adjusted Medicare Advantage (MA) rate book. Weight given to regional benchmark varies by year from 35% to 50% in the claims-based benchmark.	
Risk Adjustment	Capped at 3%	Capped at 3%	Currently not defined (more details anticipated).	
Benchmarking Approach for Voluntarily Aligned Population	N/A	N/A	Risk-adjusted regional expenditures	
Discount	N/A	1.25% for full risk, 0.5% for partial risk	0%	2% to 5% (increasing by PY)
Quality Withhold	N/A	2% in PY2019, 3% in PY2020	5% (may be earned back)	5% (may be earned back)
Financial Settlement				
Shared Savings Rate	Varies by track.	80% partial risk/100% full risk	50% (varies by risk corridor)	100% (varies by risk corridor)
Shared Loss Rate	Varies by track.	80% partial risk/100% full risk	50% (varies by risk corridor)	100% (varies by risk corridor)
Minimum Savings/Loss Corridors	Choice of 0%, 0.5%, 1.0%, 1.5%, or 2.0%	N/A	N/A	N/A
Maximum Savings Rate	Varies by track.	15%	N/A*	
Maximum Loss Rate	Varies by track.	15%	N/A*	
Capitation	N/A	Optional	Required. Only option is primary care.	Required. Can choose between total care capitation or primary care.

* Refer to section on Direct Contracting risk corridors below for the program approach to mitigating aggregate risk exposure.

The most important distinctions between Direct Contracting and prior Medicare FFS risk models are as follows:

- **Discount:** The Global option of Direct Contracting has a discount that starts at 2% in performance year (PY) 1 and PY2 and increases to 5% by PY5. The discount is a significant adjustment to the benchmark. There is no such discount in the Professional option of Direct Contracting or MSSP, although NGACO has comparable discounts of 1.25% (full risk) or 0.5% (partial risk).
- **Quality:** As in the NGACO program, quality is reflected in Direct Contracting as an adjustment to the benchmark. CMS will withhold 5% of the benchmark, which can be earned back through meeting various quality standards, described later in this paper. In MSSP, quality is treated as an adjustment to the shared savings or loss rate. For this reason, the financial stakes of the quality score are higher in Direct Contracting as compared to MSSP. In Direct Contracting, a low quality score could turn a would-be savings into a loss. In MSSP, a low quality score would dampen shared savings (or increase shared loss), but would not turn savings into a loss.
- **Capitation:** Direct Contracting entities (DCEs) are required to participate in capitation. DCEs participating in the Professional option will receive capitation for primary care services, and can also apply to receive capitation for other select services. In the Global option, DCEs may choose to take global capitation on all medical services or more limited primary care capitation. In either case, capitation is designed to give DCEs a more consistent flow of funds, and also may have the effect of spurring innovative payment structures internal to the DCE that are not tethered to traditional Medicare FFS reimbursement.
- **Withdrawal penalty:** CMS will assess a 2% of benchmark penalty for withdrawing prior to PY1 final settlement.

Direct Contracting program overview

Direct Contracting largely builds upon existing Medicare ACO initiatives. Direct Contracting parameters, relative to existing ACO programs, are simplified in some regards and more complex in others, with comparatively more stringent requirements. Similar to existing ACO models, Direct Contracting expands the ways in which providers can seek to engage and care for patients outside of pure FFS reimbursement structures.

Direct Contracting will consist of an optional implementation period (IP) followed by five performance years (PY1-PY5). The IP will extend from the start date of the initiative until December 31, 2020. The first performance year will be calendar year 2021, and subsequent performance years will each last 12 months. There will be two application periods for Direct Contracting: 1) organizations wishing to begin participation during the optional implementation period during 2020 must submit applications by February 25, 2020, and 2) organizations wishing to begin participation during PY1 must submit applications during the spring of 2020 (CMS has not yet specified the due date). Organizations interested in submitting a Direct Contracting application were required to submit a nonbinding Letter of Intent to CMS.³

Organizations applying to participate in Direct Contracting must choose one distinct DCE type. There are three separate DCE types for organizations participating in Direct Contracting, each with different characteristics and operational parameters. The three types of DCEs are:

1. **Standard DCEs:** Organizations that generally have experience serving Medicare FFS beneficiaries, including dual-eligible beneficiaries. These organizations may have previously participated in other ACO initiatives such as NGACO, the Pioneer ACO Model, or MSSP. Alternatively, new organizations composed of existing Medicare FFS providers and suppliers may be created to participate as this DCE type. In either case, healthcare providers and suppliers participating within these organizations would have substantial experience serving Medicare FFS beneficiaries.
2. **New entrant DCEs:** Organizations that have not traditionally provided services to Medicare FFS beneficiaries.
3. **High-needs population DCEs:** Organizations that serve Medicare FFS beneficiaries with complex needs, including dual-eligible beneficiaries. We provide further details on this DCE type later in this paper.

Healthcare providers and suppliers contracted with each DCE will be considered either DC Participant Providers or DC Preferred Providers under Direct Contracting. DC Participant Providers are the core healthcare providers for beneficiaries aligned to a DCE under Direct Contracting, and are responsible for, among other things, reporting quality through the DCE and committing to improving beneficiary care. DC Participant Providers will be identified by a combination of their Tax Identification Numbers (TINs) and National Provider Identifiers (NPIs). Preferred Providers contribute to DCE goals by extending and facilitating care relationships beyond the DCE and may enter into alternative payment arrangements with the DCE. Beneficiaries can be aligned under Direct Contracting to DCEs based on their relationship with DC Participant Providers but not based on their relationship with Preferred Providers.

Alignment

Provider organizations participating in the existing Medicare ACO programs or risk-sharing arrangements with private commercial, Medicare Advantage (MA), or Medicaid payers are likely familiar with the concept of alignment and its importance to the function and success of providers under these types of payment mechanisms. Direct Contracting builds on the alignment structures from the MSSP and NGACO programs. The table in Figure 2 summarizes the features and differences of alignment under Direct Contracting and other Medicare ACO programs.

Below, we look at various key components of alignment under Direct Contracting in greater detail. We highlight certain areas where the proposed structure differs from alignment under either the MSSP or NGACO programs, and discuss the corresponding implications for entities choosing to participate in Direct Contracting.

GENERAL ELIGIBILITY

For a beneficiary to be aligned with a specific DCE under Direct Contracting, the beneficiary must first meet the following baseline criteria.

1. Be enrolled in both Medicare Parts A and B.
2. Not be enrolled in a Medicare Advantage plan, Medicare Cost Plan under section 1876, Program of All-Inclusive Care for the Elderly (PACE) organization plan, or other Medicare health plan.
3. Have Medicare as the primary payer.
4. Be a resident of the United States.
5. Reside in a county included in the DCE's service area.

³ CMS.gov (December 20, 2019). Direct Contracting Model Options. Retrieved February 10, 2020, from <https://innovation.cms.gov/initiatives/direct-contracting-model-options/>.

FIGURE 2: ALIGNMENT STRUCTURES

Alignment Parameter	MSSP, Retrospective	MSSP, Prospective	NGACO	DIRECT CONTRACTING
Basic structure	Retrospective	Prospective	Prospective	Prospective
Voluntary alignment?	Yes	Yes	Yes	Yes
Does voluntary alignment take precedence?	Yes	Yes	Yes	Yes
Claims-based alignment	Yes	Yes	Yes	Yes
Look-back period	Aligned with performance year	One year, with the look-back window ending three months prior to the start of the performance year.	Two years, with the look-back window ending six months prior to the start of the performance year.	Two years, with the look-back window ending six months prior to the start of the performance year.
Treatment of primary care services rendered by specialists	Primary care services rendered by PCPs take precedence.	Primary care services rendered by PCPs take precedence.	While primary care services rendered by PCPs are prioritized, if nearly all primary care services are rendered by specialists then that will take precedence in attribution.	While primary care services rendered by PCPs are prioritized, if nearly all primary care services are rendered by specialists then that will take precedence in attribution.
Alignment of beneficiaries based on geography	No limitation on where beneficiary lives within United States	No limitation on where beneficiary lives within United States	Beneficiary must reside in service area	Beneficiary must reside in service area
Providers considered for alignment	All providers on the participant roster.	All providers on the participant roster.	Participant providers	DC Participant Providers (Preferred Providers are not considered)

Note: For both MSSP retrospective and prospective structures, we are describing the features of assignment consistent with version 7 of the MSSP Shared Savings and Losses and Assignment Methodology specification document. For NGACO, we are describing the features of assignment consistent with performance years 2019 and 2020.

Items 1 to 4 from these baseline criteria are also required for a beneficiary to be aligned under the MSSP program,⁴ and all five criteria are very similar in the NGACO program.⁵

For beneficiaries to be eligible for alignment to a High-Needs Population DCE under Direct Contracting, they must also (in addition to the five items above) meet at least one of the following conditions:

1. Have a condition that impairs mobility.
2. Require complex care needs as determined by having one of the following:
 - 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.
 - A CMS-HCC risk score greater than 2.0 but less than 3.0 and two or more unplanned hospital admissions in the previous 12 months.
 - 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.

VOLUNTARY ALIGNMENT

Direct Contracting places more of an emphasis on voluntary alignment of beneficiaries relative to the MSSP and NGACO programs. Direct Contracting offers additional opportunities for active beneficiary choice relating to alignment, as well as new tools for DCEs to engage and communicate with beneficiaries (including those who are not yet aligned). While voluntary alignment is offered in the MSSP and NGACO programs, there is a greater emphasis in Direct Contracting.

Under Direct Contracting's voluntary alignment mechanism, beneficiaries will communicate their desire to be aligned with a specific DC Participant Provider and these voluntary alignment choices will take precedence over claims-based alignment for all DCE types. The request for application (RFA) notes that CMS will employ a formal cross-agency governance structure to ensure that beneficiaries are aligned to just one model (i.e., under either Direct Contracting or PCF) and to resolve conflicts when they do occur. This structure is not described in detail in the RFA.

⁴ See MSSP v7, section 2.2.

⁵ RTI International (December 15, 2015). Next Generation ACO RTI Model Benchmarking Methods. Retrieved February 10, 2020, from <https://innovation.cms.gov/Files/x/nextgenaco-methodology.pdf>.

DCEs will have two choices for the frequency of prospective alignment of beneficiaries through voluntary alignment:

1. **Prospective alignment:** All claims-based and voluntary alignments will be completed prior to the start of each performance year. This is similar to how prospective alignment occurs under the NGACO model.
2. **Prospective-plus alignment:** Claims-based alignments will be completed prior to the start of each performance year but voluntary alignments will occur on a quarterly basis throughout the performance year.

Direct Contracting will permit the DCE to conduct outreach to beneficiaries and to offer enticement benefits such as reduced cost sharing for Part B services, with certain limits. DCEs will be able to ask beneficiaries to confirm their care relationships with the DCE. A beneficiary who elects to voluntarily align to a DCE will have the option to reverse that decision at any time.

CLAIMS-BASED ALIGNMENT: SPECIALTIES AND SERVICES CONSIDERED

Claims-based alignment under Direct Contracting—similar to claims-based alignment under the MSSP and NGACO programs—will be driven by primary care-related evaluation and management (E&M) services rendered by DC Participant Providers (ACO providers under MSSP and NGACO), with a priority placed on primary care services rendered by primary care providers. While the concept of claims-based alignment under Direct Contracting is similar, there are key differences between Direct Contracting and its antecedent programs (MSSP and NGACO).

- **Providers considered:** The provider specialty codes considered to be primary care versus non-primary care

under Direct Contracting will align with those already in place in the MSSP and NGACO programs. While the types of providers considered under claims-based alignment in Direct Contracting and MSSP/NGACO are the same, the way in which services furnished by these providers are considered is different. Under the MSSP and NGACO programs, primary care services rendered by primary care providers are given absolute priority in claims-based alignment; however, under Direct Contracting, the volume of primary care services rendered by primary care providers versus non-primary care providers is considered, as explained in more detail below.

- **E&M codes considered for alignment:** The Primary Care Qualified Evaluation and Management (PQEM) codes considered under Direct Contracting are more limited than those considered for the MSSP or NGACO programs. In particular, the Direct Contracting program will not use codes associated with Nursing Facility Care (99304-99310, 99315-99316, 99318), certain behavioral health codes, and Chronic Care Management (CCM) codes.

CLAIMS-BASED ALIGNMENT: LOOK-BACK PERIOD

Claims-based alignment under Direct Contracting will occur on a prospective basis only. Additionally, as with the MSSP and NGACO programs, claims-based assignment will occur via a two-step process in which claims rendered by primary care providers are prioritized. However, under Direct Contracting, for assignment to happen in step 1 of this process, at least 10% of all PQEM services rendered to a beneficiary must be done so by a primary care provider. This is in contrast to MSSP, where a single PQEM service rendered by a primary care provider in the ACO would trigger step 1 assignment. The table in Figure 3 illustrates the process.

FIGURE 3: ASSIGNMENT

		MSSP	DIRECT CONTRACTING / NGACO
Step 1	IF	A beneficiary receives any PQEM service from a primary care specialist	A beneficiary receives at least 10% of PQEM services from primary care specialists
	THEN	Assignment is driven by claims rendered by primary care specialists	Assignment is driven by claims rendered by primary care specialists
Step 2	OTHERWISE	Assignment is driven by non-primary care specialists	Assignment is driven by non-primary care specialists

Note: Provider specialty is determined by the specialty code that is assigned to the claim during claims processing, in the case of physician claims, or by the specialty associated with the NPI of the physician, or non-physician provider in the Medicare provider enrollment database in the case of certain Federally Qualified Health Center (FQHC), rural health clinic (RHC), and Method II Critical Access Hospital (CAH) claims.⁶

⁶ CMS, Direct Contracting Model: Global and Professional Options RFA, op cit.

FIGURE 4: ALIGNMENT TIME PERIODS

	2018				2019				2020				2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Retrospective (MSSP)													Performance period			
													Alignment period			
Prospective (MSSP)									Alignment period				Performance period			
Direct Contracting/ NGACO					Alignment period 1				Alignment period 2				Performance period			

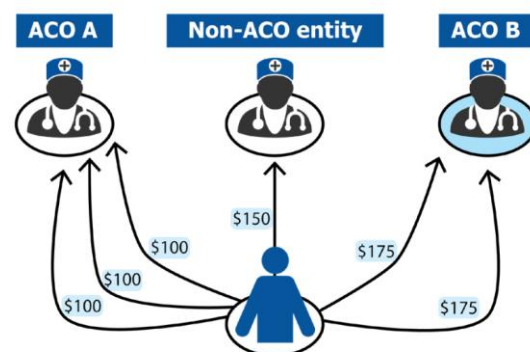
Some Medicare beneficiaries receive the bulk of their primary care from specialists they see more often than their primary care physicians (PCPs). Therefore the patient-specialist relationship represents a more accurate link for the purposes of claims-based alignment than the patient-PCP link. The approach under Direct Contracting appears to correct for the scenarios under MSSP where a beneficiary may have a substantial care link with a specialist but is aligned to an ACO based on a single service rendered by a primary care specialist.

In addition to revising the two-step process, the look-back period used for prospective claims-based assignment under Direct Contracting will include two consecutive 12-month periods ending six months in advance of the performance year. Figure 4 provides a simple illustration of the alignment time periods used for Direct Contracting and its antecedent ACO models.

Additionally, the prospective claims-based alignment mechanism under Direct Contracting will use a slightly different approach for the consideration of the “plurality of primary care services” than the MSSP program. Under MSSP, claims-based alignment is established upon where the beneficiary sought the plurality of primary care services during the alignment period, based on allowable charges. The allowable charges considered are either based on primary care services rendered by a primary care specialist (step 1) or primary care services rendered by other non-primary care specialists (step 2). The graphic in Figure 5, although developed for and used in the MSSP specification document, appropriately illustrates the process.

The concept of plurality is similar under Direct Contracting, with the key difference that allowed charges are weighted by year, so that services that occurred more recently are given more weight, even if there is a lower volume of eligible services. Specifically, year 2 claims will receive two-thirds weighting, with year 1 claims receiving one-third weighting. The idea is that this approach will give priority to patterns of care that occurred more recently. This mirrors the approach taken by NGACO in PY2019 and PY2020.

FIGURE 5: ALIGNMENT PROCESS



Plurality of Primary Care Services

Plurality of primary care services is based on allowed charges. *Plurality* refers to a greater proportion of **primary care services** as measured in allowed charges *within the ACO* compared to primary care services *outside the ACO*. The plurality is determined by the total allowed charges for primary care services and can be less than a majority of the total number of primary care services provided. In this example, the beneficiary is assigned to **ACO B**, because ACO B provided the greatest amount of allowed charges.

Source: Medicare Shared Savings Program Shared Savings and Losses and Assignment Methodology specifications document v7, page 13.

MINIMUM BENEFICIARY ALIGNMENT THRESHOLD

Similar to the MSSP and NGACO programs, Direct Contracting will require DCEs to maintain a minimum number of aligned beneficiaries during each performance year. Standard DCEs must have at least 5,000 aligned beneficiaries in each performance year. CMS is encouraging organizations new to Medicare FFS to participate in Direct Contracting by using a minimum alignment “glide path” for New Entrant and High-Needs Population DCEs. The glide path is designed to allow these entities, which may have limited experience managing care for FFS Medicare beneficiaries, to grow their populations of aligned beneficiaries over several years. Figure 6 (from Table 6.20 in the CMS Direct Contracting RFA) shows the minimum number of aligned beneficiaries for each of these DCE types during each performance year. If these DCEs do not meet the minimum alignment thresholds, they will not be allowed to continue in the program.

FIGURE 6: MINIMUM NUMBERS OF ALIGNED BENEFICIARIES

Performance Year	Calendar Year	New Entrant DCE ("glide path")	High-Needs Population DCE
PY1	2021	1,000	250
PY2	2022	2,000	500
PY3	2023	3,000	750
PY4	2024	5,000 (more than 3,000 aligned using claims-based alignment)	1,200
PY5	2025	5,000 (more than 3,000 aligned using claims-based alignment)	1,400

IMPLICATIONS

There are quite a few technical differences between the alignment methodologies under the current MSSP and NGACO programs and Direct Contracting. The following are considerations for how the Direct Contracting alignment approach may affect the way beneficiaries are aligned relative to the MSSP and NGACO programs.

- **Voluntary alignment:** Although voluntary alignment is not new in this context, it will be given a renewed emphasis in Direct Contracting. Some DCEs may use this to their advantage, particularly to target certain individuals who they believe they may be able to serve effectively. Conversely, an ACO or DCE in a region with another DCE that aggressively uses voluntary alignment may lose members.
- **Prospective alignment:** Prospective alignment typically results in assigned beneficiary totals that are approximately 6% to 7% lower than retrospective alignment.⁷ However, this differential may be dampened by the two-year look-back under Direct Contracting. This is likely to be a key consideration for smaller organizations.
- **Weighting of PQEM services:** As discussed above, at least 10% of PQEM services must be rendered by a primary care specialist to trigger alignment under step 1. This may affect DCEs that are heavily dominated by PCPs; some members currently aligned under the MSSP methodology may no longer be aligned under the Direct Contracting methodology. Conversely, DCEs with a high percentage of specialists may see an increase in the number of aligned beneficiaries.
- **Codes considered for PQEM services:** As noted above, certain nursing facility care, behavioral health, and CCM codes that were PQEM for MSSP and NGACO are not considered as PQEM for the purposes of alignment under Direct Contracting. This may affect DCEs that render a higher-than-average percentage of these services.

While there are specific circumstances where Direct Contracting's alignment parameters may affect an organization compared to MSSP's alignment parameters, we expect that for the majority of organizations the alignment changes would not be substantial, and may strengthen the linkage between provider and aligned beneficiary.

Financial settlement

Once beneficiaries are aligned, a few factors play a role in the final financial settlement with HHS, including:

- Beneficiary alignment (addressed above)
- Performance year benchmark (addressed below)
- Risk arrangement, professional versus global
- Risk corridors
- High Performers Pool (HPP)
- Stop-loss
- Capitation payment options

OVERVIEW

The process for financial settlement under Direct Contracting introduces different parameters not seen in previous programs such as MSSP and NGACO.

Figure 7 presents a comparison of financial settlement parameters between MSSP (select Pathways to Success tracks), NGACO, and Direct Contracting.

RISK ARRANGEMENT: PROFESSIONAL VS. GLOBAL

Direct Contracting will offer two risk arrangements, which determine the portion of the savings or losses in relation to the performance year benchmark.

- **Professional:** Offers a partial risk arrangement of 50% of savings/losses, with risk corridors and optional stop-loss protection.
- **Global:** Offers a full risk arrangement of 100% of savings/losses, with broader risk corridors and optional stop-loss protection.

If a DCE chooses to participate in the Global option, the benchmark will be discounted by 2% in the first year (PY1), scaling up to 5% in the final year (PY5). This discount is a reduction in the benchmark, not a reduction in the net savings rate (as it is under MSSP)—making it more challenging for a DCE to meet the benchmark relative to the MSSP methodology, particularly in the later years of the program, if the Global option is selected. Conversely, it also gives DCEs the highest shared savings rate options.

⁷ Lewis, V.A. et al. (March 2013). Attributing Patients to Accountable Care Organizations: Performance Year Approach Aligns Stakeholders' Interests. Health Affairs. Retrieved February 10, 2020, from <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2012.0489>.

FIGURE 7: FINANCIAL SETTLEMENT PARAMETERS

	MSSP		NGACO	DIRECT CONTRACTING	
	BASIC LEVEL E	ENHANCED		PROFESSIONAL	GLOBAL
Shared Savings Rate	50% x quality score	75% x quality score	80% or 100%	50%*	100%*
Shared Loss Rate	30%	Greater of 40% or (1 - shared savings rate)	80% or 100%	50%*	100%*
Tiered Savings/Loss Rates?	No	No	No	Yes	
Minimum Savings/Loss Rate	Choice of 0%, 0.5%, 1.0%, 1.5%, or 2.0%		N/A	N/A	
Maximum Savings Rate	10% of benchmark	20% of benchmark	15%	N/A	
Maximum Loss Rate	Lesser of 4% of benchmark or 8% of revenue	15% of benchmark	15%	N/A	
Stop-Loss Arrangement	Claims are truncated at 99th percentile of expenditures in each eligibility category.		Optional	Optional	
Timing of Financial Reconciliation	7-8 months after end of performance year			Provisional reconciliation on January 31 after performance year, final about six months after end of performance year.	

* Subject to risk corridor.

RISK CORRIDORS

While the Professional and Global options have base shared savings/loss rates of 50% and 100%, respectively, these amounts vary based on the gross savings or losses as a percentage of benchmark. These tiers, or “risk corridors” (as described in the RFA), effectively replace a maximum savings or loss rate, having CMS assume a greater portion of the risk for high levels of loss, or conversely assume a greater share of savings for DCEs that produce extreme levels of savings.

These risk corridors vary between the Professional and Global options and are shown in Figure 8.

FIGURE 8: RISK CORRIDORS: PROFESSIONAL VS. GLOBAL

Gross savings/losses as % benchmark	Professional	
	Retained by DCE	Retained by CMS
Risk Corridor		
< 5%	50%	50%
5% - 10%	35%	65%
10% - 15%	15%	85%
> 15%	5%	95%

Gross savings/losses as % benchmark	Global	
	Retained by DCE	Retained by CMS
Risk Corridor		
< 25%	100%	0%
25% - 35%	50%	50%
35% - 50%	25%	75%
> 50%	10%	90%

In addition to not having explicit maximum savings/losses rates, there are no minimum savings/losses rates under Direct Contracting. As a result, DCEs will retain the first-dollar savings or be responsible for first-dollar losses.

HIGH PERFORMERS POOL (HPP)

Both the Professional and Global options will test using a High Performers Pool (HPP), which will allow DCEs to qualify for bonus payments if they meet continuous improvement/sustained exceptional performance (CI/SEP) requirements and demonstrate a high level of performance or meet certain improvement standards. The HPP will be funded from quality withholds that were not earned back by DCEs that meet the CI/SEP requirements. There will not be an HPP bonus the first year of the program.

STOP-LOSS

DCEs can also choose to purchase optional stop-loss coverage from CMS as a part of their Direct Contracting financial settlement arrangements. DCEs must make their stop-loss selections prior to the start of each performance year. DCEs choosing to purchase stop-loss coverage from CMS will have a “charge” applied to their performance year benchmarks to account for beneficiary expenditures above the DCE’s chosen attachment point.

Each year CMS will prospectively develop stop-loss attachment points prior to the start of each performance year. The development of these different attachment points will be based on analyses of beneficiary expenditure data from a national reference population of FFS Medicare beneficiaries and will be adjusted to reflect regional payment rates for each DCE.

CAPITATION PAYMENT OPTIONS

The capitation payment mechanisms under Direct Contracting are designed to incentivize DCEs to invest in activities, programs, technology, and infrastructure that will support population health-focused initiatives. CMS hopes that paying DCEs monthly with capitation payments will help support these investments by providing cash flow stability and certainty.

All DCEs must select either Total Care Capitation or Primary Care Capitation, as summarized in Figure 9.

In subsequent years DCEs can move from Primary Care Capitation to Total Care Capitation, but may not move in the opposite direction. Under either capitation arrangement, DCEs will be able to enter into value-based payments internally with DC Participant Providers and Preferred Providers who have opted into the capitated arrangement. These value-based arrangements may range in scope from fee reductions to bundles or sub-capitation. In this way, CMS is giving DCEs more leeway to behave in some ways like Medicare Advantage plans (without restricting patient choice). In doing so, CMS may hope to drive down total cost of care through provider-based innovations.

The table in Figure 10 summarizes the capitation requirements by provider type for Total Care Capitation and Primary Care Capitation.

As shown above, under Primary Care Capitation, the requirements and claims reductions are similar, but only apply to Primary Care-based services. A table with the procedure codes that apply to Primary Care Capitation may be found in the Direct Contracting RFA on page 36.

Under the Primary Care Capitation (PCC) option, DCEs can also utilize the Advanced Payment mechanism, which builds on the Alternative Payment Mechanism in the NGACO Model of "Population Based Payments." In the Advanced Payment mechanism, DCEs can enter into arrangements with DC

Participant Providers and Preferred Providers to reduce the non-primary care claims payments in exchange for a monthly advanced payment to the DCE from CMS for an estimated value equivalent to the non-primary care claims reduction.

FIGURE 9: TOTAL CARE CAPITATION VS. PRIMARY CARE CAPITATION

	Total Care Capitation	Primary Care Capitation
Availability	Global only	Option for Global, required for Professional
Participant Providers	Required, 100% claims reduction	Required, 100% claims reduction for primary care services
Preferred Providers	Optional, 1% to 100% claims reduction	Optional, 1% to 100% claims reduction for primary care services
Amount of Capitation	100% of benchmark, less expected % services not expected to occur with providers or suppliers participating in capitation	7% of benchmark ⁸
Advanced Payment Mechanism	N/A	DCEs can enter into arrangements for capitation for select non-primary care services

FIGURE 10: TOTAL CARE CAPITATION AND PRIMARY CARE CAPITATION

Type	Total Care Capitation Requirements	Primary Care Capitation Requirements	Claims Reduction
DC Participant Providers	Capitation required	Capitation required for Primary Care claims	100%
DC Preferred Providers	Optional flexible capitation with prospective claims reduction	Optional flexible capitation with prospective claims reduction for Primary Care claims	1%-100%

FIGURE 11: PRIMARY CARE CAPITATION (AVAILABLE IN PROFESSIONAL AND GLOBAL OPTIONS)

PCC Available in Professional and Global		
	DC Participant Providers	Preferred Providers
What FFS claims are capitated?	All Primary Care FFS Claims	Portion of Primary Care FFS Claims (0-100%)
What FFS claims payments are suitable for advanced payment?	Non Primary Care FFS Claims	Non Primary Care FFS Claims

⁸ CMS will make payments to DCEs equal to 7% of its benchmark that CMS calls Primary Care Capitation; however, this will be the sum of a true capitation amount (called an "estimated base payment" and expected to be around 3%) and a cash flow mechanism (called an "up-front additional payment" and expected to be around 4%).

The Primary Care Capitation payment will equal 7% of the DCE's monthly performance year benchmark. CMS estimates that this overstates the actual percentage of care that will fall under the primary care procedure codes. The difference between the 7% and the actual primary care percentage will be trued up during the final financial reconciliation and will happen separately from applying the risk arrangement.

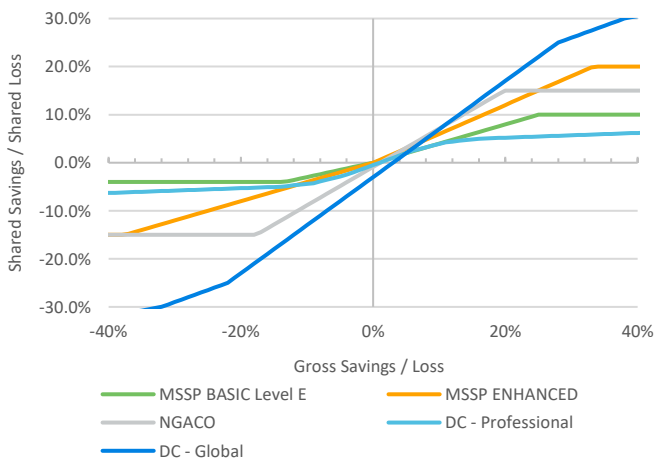
FINANCIAL OUTCOME EXAMPLES

Understanding the differences between the financial parameters of MSSP, NGACO, and Direct Contracting is best accomplished by comparing the financial outcomes for each model graphically. The graph in Figure 12 compares five tracks:

1. MSSP Basic Level E, assuming a quality score of 80%.
2. MSSP ENHANCED, assuming a quality score of 80%.
3. NGACO, assuming a shared savings/losses rate of 80% and assuming a 0.5% discount, a 3% quality withhold, and a quality score of 80%
4. Direct Contracting Professional, assuming a net adjustment to the benchmark of -1.0% because of quality withhold not earned back (consistent with a quality score of 80% in MSSP and NGACO, and assuming that CI/SEP criteria are achieved).
5. Direct Contracting Global, with a 2% discount and assuming a net adjustment to the benchmark of -1.0% because of quality withhold not earned back (consistent with a quality score of 80% in MSSP and NGACO, and assuming that CI/SEP criteria are achieved).

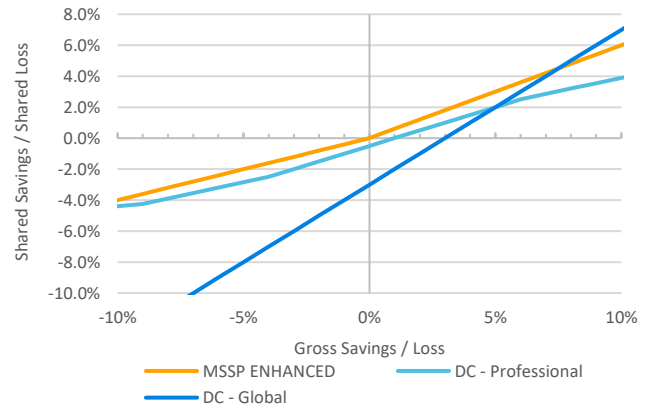
The x-axis shows the gross savings and losses as a percentage of the benchmark, prior to the application of discount or quality withhold not earned back. Figure 12 is particularly interesting to look at for the boundary conditions of extreme gross savings or losses for each option.

FIGURE 12: SHARED SAVINGS/LOSSES BY FIVE MODELS AND TRACKS



Zooming in on the graphic to a more reasonable range of gross savings or loss (+/-10%) provides a unique perspective. To simplify the visual, we have just retained the MSSP ENHANCED and Direct Contracting Professional and Global data lines.

FIGURE 13: SHARED SAVINGS/LOSSES BY THREE MODELS AND TRACKS



Perhaps what stands out the most in Figure 13 is comparing the effect of the discount/quality withhold between the three options. CMS states in the RFA that a 2% discount (or the applicable discount for a given performance year) is necessary to allow CMS to achieve first-dollar savings before the ACO retains 100% of savings above the discount (and any unearned quality withhold). In reality, the discount moves the benchmark, meaning that modest savings of less than 2% will actually result in shared losses for the DCE. In this scenario, a DCE would need to achieve gross savings of nearly 8% for the financial result to be more favorable under the Global option than MSSP ENHANCED. For modest rates of gross savings/losses and achievement of quality goals, the financial outcomes for the ENHANCED track and Direct Contracting Professional track are comparable. This analysis excludes the effect of some potentially important methodological differences between DC and MSSP, such as differences in regional adjustments and risk adjustment. The effects of those methodological differences are not known due to a lack of details released by CMS as of the time of publication of this white paper.

The importance of meeting quality goals in the Direct Contracting program should be emphasized. In MSSP, quality is reflected as an adjustment to the shared savings rate and as an adjustment to the shared loss rate in the ENHANCED track. While a low quality score may lower the rate of shared savings, it does not impact the calculation of gross savings or losses. The same cannot be said for the Direct Contracting program, where 5% of benchmark is withheld and earned back through meeting quality goals.

As a result, a DCE that falls short on quality could face significant financial consequences.

Benchmark

The benchmark is the target expenditure amount that will be compared to performance year expenditures for aligned beneficiaries, and is the basis for the risk-sharing mechanism under Direct Contracting.

Development of the performance year benchmark will include five steps (described in more detail below):

1. Calculation of historical baseline expenditures.
2. Trending historical baseline expenditures forward to the performance year.
3. Blending the trended historical baseline expenditures with regional benchmark expenditures.
4. Applying risk adjustment to blended benchmark.
5. Applying necessary adjustments for quality performance (both Direct Contracting models) and CMS-retained discount (Direct Contracting Global model only).

BASELINE EXPENDITURES

The baseline period will be static across all of the performance years of the model. However, the historical baseline expenditures will be updated each year, as CMS will use a DCE's most recent list of DC Participant Providers (participant list) to identify the beneficiaries that would have been aligned to the DCE for each of the base years and their associated expenditures.

TREND

Trend in the Direct Contracting program will build upon trend in the NGACO model. CMS will utilize a prospective trend that will be based on the projected U.S. Per Capita Cost (USPCC) growth trend.

Figure 14 compares trend approaches between MSSP, NGACO, and Direct Contracting.

FIGURE 14: TREND APPROACH COMPARISON

	MSSP	NGACO	DIRECT CONTRACTING
Prospective/Retrospective	Retrospective	Prospective	Prospective
Data Source	Actual FFS expenditures for the assignable population in a given calendar year.	Adjusted USPCC ⁹	USPCC growth trend ¹⁰
Regional Adjustment	Regional assignable and national assignable trends are blended based on the ACO's penetration in an area.	Standardized Baseline Operating Cost per beneficiary per month (PBPM) for reference beneficiaries	Adjustment to reflect anticipated changes in Geographic Adjustment Factors (GAFs) applied to Medicare FFS payments.

Additionally, CMS has provided the following details regarding how trends will be applied and how they may be adjusted:

- CMS will apply Aged & Disabled trends and end-stage renal disease (ESRD) trends to these populations separately. The collapsing of all non-ESRD categories into a single trend may pose a risk for ACOs that have a nontypical risk profile (for example, a high proportion of dual-eligibles).
- CMS may make additional adjustments under limited circumstances such as for specific populations or in the case of unforeseeable events, such as natural disasters or pandemics. This would prevent DCEs from being penalized or rewarded for major payment changes beyond their control.

REGIONAL ADJUSTMENT

As in the MSSP and NGACO, CMS will incorporate a mechanism to adjust the benchmark for regional expenditures. This adjustment serves to level the playing field for entities that are already efficient (or conversely inefficient), either as a new entrant or because of previously gained efficiencies in other CMS models. Figure 15 compares approaches to regional adjustment between MSSP, NGACO, and Direct Contracting.

⁹ RTI International (September 2018). Next Generation ACO Model: Calculation of the Performance Year Benchmark: Performance Years 2019 and 2020. Retrieved February 10, 2020, from <https://innovation.cms.gov/Files/x/nextgenaco-benchmarkmethodology-py4.pdf>.

¹⁰ USPCC growth trend is developed annually by the CMS Office of the Actuary (OACT) and announced in the annual Announcement of Calendar Year (CY) Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, released the first Monday in April of the prior calendar year.

FIGURE 15: REGIONAL ADJUSTMENT APPROACH COMPARISON

	MSSP	NGACO	DIRECT CONTRACTING
Regional Adjustment directly included in benchmark?	Yes	Yes	Yes
Data source for regional benchmark	Medicare FFS retrospective expenditures for assignable beneficiaries by county, for each of the four eligibility categories.	Standardized regional baseline operating cost	Prospectively developed adjusted MA rate book (see detail below).
Time period	Regional data is pulled for an ACO's individual benchmark year (BY) 3, then trended forward along with experience-based benchmark.	BY2	Prospectively determined for each performance year.
Weighted	Weighted by member enrollment by county and beneficiary status.	Number of months of alignment in each county	Weighted by member enrollment by county (for aged and disabled population) or state (for ESRD population).
Weight given to regional adjustment	For ACOs subject to regional adjustment for the first time, 35% if ACO expenditures are lower than the region, and 15% if ACO expenditures are higher than the region.	30% - 40% if ACO expenditures are lower than the region, 10% - 15% if ACO expenditures are higher than the region.	35% PY1, 35% PY2, 40% PY3, 45% PY4, 50% PY5
Cap on regional adjustment	+/-5% of national Medicare FFS per capita expenditures.	Upward adjustment limit: 10%, downward limit -2%.	Upward adjustment limit: flat dollar amount equal to 5% of the FFS USPPC for the performance year. Downward adjustment limit: flat dollar amount equal to 2% of the FFS USPPC for the performance year.

As noted above, CMS will use the adjusted MA rate book data to derive the DCE's regional expenditures. This is in contrast to MSSP, where the Medicare FFS expenditures for the assignable population by county are used to determine the regional adjustment. The adjusted MA rate book will establish county-level rates for MA plans for aged and disabled beneficiaries and state-level rates for ESRD beneficiaries. For purposes of Direct Contracting, CMS will make adjustments to the MA rate book as follows:

- First**, 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 (QBP) percentage based on star ratings.
- Second**, 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.
- Third**, 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 (see the beneficiary eligibility section for other differences between the DCE-aligned population and the general FFS population).

In a manner similar to MSSP, to account for where 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) based on where the aligned beneficiaries live.

Regional expenditures will then be combined with the DCE's trended, historical baseline expenditures through blending to calculate a weighted payment rate. Weighting percentages have been provided in Figure 15 above.

CMS has made some interesting choices when developing the approach to the regional adjustment, as evident in the text of the RFA as well as the general approach:

- In using the adjusted MA rate book as the basis for the regional adjustment, CMS continues to take steps to align Medicare Advantage and Medicare FFS provider risk-sharing programs, where possible.
- While CMS does not distinguish between efficient and inefficient organizations in the regional blending splits (as it does in MSSP and NGACO), the higher limit on upward adjustment allows for significant benefit for efficient organizations, while inefficient organizations are still given an avenue for participation via the lower 2% cap on downward adjustment.

RISK ADJUSTMENT

CMS will use risk adjustment to account for the underlying health status of the population of beneficiaries aligned to a DCE. In the RFA, CMS states that it will apply a modified risk adjustment methodology with the goals of limiting the coding intensity and to improve the accuracy of risk adjustment for organizations specializing in serving complex, high-risk patients. However, no additional information is provided in the RFA.

BENCHMARK FOR BENEFICIARIES WHO ARE VOLUNTARILY ALIGNED

Because CMS anticipates that a significant proportion of beneficiaries may be aligned through voluntary alignment, there is a valid concern that the characteristics of beneficiaries aligned to a DCE in the performance year may differ from those aligned in the baseline period, creating a potential for asymmetry that may under-predict or over-predict expenditures for voluntarily aligned beneficiaries.

CMS’s approach to develop a benchmark for beneficiaries who are voluntarily aligned is rather straightforward:

- For the first three years in which a beneficiary is voluntarily aligned, regional expenditures¹¹ from the adjusted MA rate book will be used, risk-adjusted to reflect the beneficiary’s health status.
- For the fourth and subsequent years in which a beneficiary is voluntarily aligned, CMS will use the beneficiary’s claims experience from performance years 1 to 3 and incorporate this experience into the benchmark. This experience will be on a different time basis than the rest of the claims-based benchmark data, and will be adjusted accordingly.

This alternative benchmarking methodology will apply only for those beneficiaries who are aligned to the DCE solely through voluntary alignment and who meet certain alignment criteria.

DISCOUNT AND QUALITY INCENTIVES

CMS applies two adjustments to the trended, regionally blended, risk-adjusted benchmark for DCEs:

1. **Discount (Global only):** As DCEs in Global will retain 100% of savings relative to the final performance year benchmark achieved during the performance year, this discount to the benchmark will provide the primary mechanism for CMS to obtain savings from DCEs participating in this option. There is no discount for the Professional option. The discount is a fixed amount each performance year and cannot be earned back by the DCE.

2. **Quality withhold:** 5% of the performance year benchmark will be held at risk, dependent on the DCE’s performance on predetermined quality and CI/SEP standards. Of the quality withhold, half will be tied to basic quality measures and half will be tied to CI/SEP criteria. Specifically, if the CI/SEP standards are not met, only half of the 5% quality withhold can be earned back.

FIGURE 16: QUALITY WITHHOLDS

	Global		Professional	
	Discount	Quality Withhold	Discount	Quality Withhold
PY1	2% of benchmark	5% of discounted benchmark	N/A	5% of benchmark
PY2	2% of benchmark	5% of discounted benchmark	N/A	5% of benchmark
PY3	3% of benchmark	5% of discounted benchmark	N/A	5% of benchmark
PY4	4% of benchmark	5% of discounted benchmark	N/A	5% of benchmark
PY5	5% of benchmark	5% of discounted benchmark	N/A	5% of benchmark

Note: In PY1 quality will be on a pay-for-reporting basis, and all DCEs that successfully report will earn a quality performance score of 100%. There will be no HPP bonus in PY1.

CMS recognizes that DCEs achieving high performance rates may have less room to show improvement. Accordingly, when establishing these continuous improvement targets, CMS will establish targets that still incentivize higher-performing DCEs to continue to improve.

The amount of the quality withhold that a DCE earns back will be calculated as a function of the DCE’s quality score for each performance year multiplied by 5% if the DCE meets the CI/SEP standard or by 2.5% if the DCE does not meet it. For example, a DCE with a 95% quality score that meets the CI/SEP will earn back 4.75% (= 95% * 5%) whereas a DCE that does not meet the CI/SEP would receive half the incentive for that same quality score. A DCE that achieves a full (100%) quality score and also meets the CI/SEP will earn back the full amount of the quality withhold for the performance year.

The CI/SEP criteria will be provided prior to the start of PY2. The highest-performing DCEs that meet or exceed the CI/SEP may also earn a bonus payment from the High Performers Pool (HPP) beginning in PY2 (calendar year 2022), as described above in the financial benchmarking methodology section.

¹¹ CMS will use the beneficiary’s county of residence during the performance year for the purposes of identifying applicable regional expenditures. CMS will distinguish between Aged & Disabled beneficiaries and ESRD beneficiaries in determining applicable regional expenditures.

Other notes:

- **New Entrant DCEs:** For new entrant DCEs, the historical baseline for all beneficiaries in the first three years of beneficiary alignment will be calculated in the same way as voluntary alignment for the standard DCE. That is, the adjusted MA rate book will form the basis for the benchmark, regardless of whether beneficiaries are aligned through claims or voluntarily. For the fourth and subsequent years of beneficiary alignment, prior experience will be used, again in the same way as the voluntarily aligned population for the standard DCE. Other components of the benchmark, including discount and quality withhold, apply.
- **High-Needs Population DCEs:** For High-Needs Population DCEs, the historical baseline for all beneficiaries will be calculated in the same way as the New Entrant DCE population.
- **Alignment for beneficiaries with partial-year experience:** If in a given month of a base year or performance year a beneficiary does not meet all of the beneficiary eligibility criteria (described above in the beneficiary eligibility section), then the beneficiary will be excluded from expenditure calculations for that month and all subsequent months of the base year or performance year, as applicable. Beneficiaries initially aligned to a DCE, who subsequently lose alignment eligibility (e.g., after enrolling in MA) will contribute partial-year experience for purposes of calculating the performance year benchmark and for purposes of financial reconciliation, up to the month prior to the month in which the beneficiary loses his or her alignment eligibility. For example, a beneficiary who loses Medicare as a primary payer in August of a performance year will contribute a total of seven months of experience to the performance year (January through July).

Patient engagement incentives and benefit enhancements

PATIENT ENGAGEMENT INCENTIVES

Providers and entities related to the DCE will be permitted to engage with beneficiaries, so long as there is a reasonable connection between the items or services and the medical care of the beneficiary, and if the items or services are preventive care items and services or advance a clinical goal for the beneficiary, including medication or treatment adherence, adherence to a follow-up care plan, or management of a chronic disease or condition.

The Direct Contracting RFA provides the following examples of patient engagement incentives that DCEs could consider offering:

1. Vouchers for over-the-counter medications recommended by a healthcare provider.
2. Blood pressure monitors to patients with hypertension in order to encourage regular blood pressure monitoring, thus educating beneficiaries and engaging them to be more proactive in their disease management.
3. Prepaid nontransferable vouchers redeemable for transportation services solely to and from an appointment with a healthcare provider.
4. 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 reinjury.
5. Wellness program memberships, seminars, and classes.
6. Electronic systems that alert family caregivers when a family member with dementia wanders away from home or gets up from a chair or bed.
7. Vouchers for those with chronic diseases to access chronic disease self-management, pain management, and falls prevention programs.
8. Vouchers for those with malnutrition to access meal programs.
9. Phone applications, calendars, or other methods for reminding patients to take their medications and promote patient adherence to treatment regimens.
10. Vouchers for dental care services, for example prior to jaw surgery to reduce the risk of infection.

These items and services would be funded by the DCE and therefore calculation of the DCE's benchmark and performance year expenditures will not account for them.

Additionally, DCEs will be able to engage in two very specific patient engagement incentives described in the RFA:

1. **Cost-sharing support for Part B services:** By offering cost-sharing support, DCEs can reduce financial barriers for certain beneficiaries and also promote the utilization of high-value services.
2. **Chronic disease management reward program:** CMS will permit DCEs to provide gift cards to eligible aligned beneficiaries up to \$75 annually for incentivizing participation in chronic disease management programs.

BENEFIT ENHANCEMENTS

The table in Figure 17 (from Table 6.22 of the Direct Contracting RFA) includes benefit enhancements that CMS anticipates for PY1, or is considering for PY1, and benefit enhancements being considered for future performance years.

FIGURE 17: BENEFIT ENHANCEMENTS

Benefit Enhancements Anticipated for PY1	Proposed Benefit Enhancements for PY1	Potential Future Benefit Enhancements and Patient Engagement Incentives Under Consideration by CMS
Skilled Nursing Facility (SNF) 3-Day Rule Waiver	Home Health Services Certified by Nurse Practitioners	Tiered Cost-Sharing Reduction
Asynchronous Telehealth	Homebound Requirement Waiver for Home Health	Alternative Sites of Care
Post-Discharge Home Visits	Concurrent Care for Beneficiaries That Elect the Medicare Hospice Benefit	Cost-Sharing Support for SNF Services
Care Management Home Visits		Long-Term Care Hospital 25-Day Average Length of Stay Requirement and Other Site of Care Restrictions

Conclusion

Organizations considering this program need to carefully weigh the options between participating in Direct Contracting, participating in other CMS-sponsored alternative payment models, or nonparticipation. For example, participation in an Advanced Alternative Payment Model (APM), including Direct Contracting or MSSP BASIC E or ENHANCED, will make an organization eligible

for qualifying participant (QP) status under the Medicare Access and CHIP Reauthorization Act (MACRA). If an organization achieves QP status, participating providers will receive a 5% bonus on Part B services in the short term, and ultimately higher fee schedule increases for Medicare FFS services.

Organizations will also need to consider the implementation of capitation, plus the specific patient engagement and benefit enhancement options available to DCEs. They are innovative options for organizations that have ideas for how to meaningfully change patient behavior and engagement through services not typically included under FFS reimbursement.

Finally, a key difference of Direct Contracting is the discount mechanism in the Global option. It is a significant hurdle to achieving savings, and organizations pursuing that option would need to feel confident that they can overcome the discount and produce additional savings. We would anticipate that in most cases this option would appeal to entities that focus on certain subpopulations that would benefit from intense management, rather than a general population.

Direct Contracting presents a new opportunity in the area of provider risk sharing. The program gives providers additional tools to potentially support them as they try to meaningfully influence the total cost of care by adjusting financial incentives for participating entities, placing additional emphasis on voluntary alignment, and setting up capitation components to provide more consistent cash flows.



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