April 2020

Direct Contracting

Jonathan Staloff, MD, MSc, Joshua M. Liao, MD, MSc, Ryan Clodfelter, MD, Leah M. Marcotte, MD

VSSL Briefs are a series of documents written and led by trainees and learners with the goal of providing background information about policies and programs related to focus areas for the Lab. Please see the bottom of this brief for additional disclaimers.

In January 2021, The Centers for Medicare and Medicaid Services (CMS) plans to launch its Direct Contracting (DC) payment model, a five-year program designed to foster innovative care delivery, with particular focus on primary care, by interested provider organizations. DC aims to include organizations that may not have previously been eligible for participation in CMS alternative payment model programs and to provide participants with flexibility in managing population health.[1] Drawing on lessons learned from CMS's existing Accountable Care Organization (ACO) models, the DC model will engage organizations as one of three types of participants, i.e., Direct Contract Entities (DCEs) .

DCE Types.[1] The three DCE types are distinguished by: a) prior experience in the Medicare program, b) required number of aligned beneficiaries (based on a combination of voluntary beneficiary alignment and claims based assignment), and c) complexity of beneficiary population in the DC Model.

Table 1.

DCE Type	Intended Organizations	Required Aligned Beneficiaries
Standard	Those with significant prior experience caring for Medicare beneficiaries and/or previously participated in Medicare ACO programs	≥5,000
New Entrant	Those with limited prior experience caring for Medicare FFS beneficiaries and that have < 3,000 aligned beneficiaries prior to PY3	PY1 (2021): ≥1,000 and <3,000 PY2 (2022): ≥2,000 and <3,000 PY3 (2023): ≥3,000 PY4 (2024): ≥5,000 PY5 (2025): ≥5,000
High Needs Population	Those that care for Medicare beneficiaries with complex care needs, including Medicare/Medicaid dual eligible populations	PY1 (2021): 250 PY2 (2022): 500 PY3 (2023): 750 PY4 (2024): 1,200 PY5 (2025): 1,400

PY= Performance Year

Payment Strategy. There are several components to the payment strategy used in the DC Model.

Capitated Payment.[1,2] All DCEs will receive some form of a monthly capitated payment, intended to provide a predictable cash flow and allow them to more easily invest in population health. Capitation may come in one of the following two forms:

Total Care Capitation: a Per Beneficiary Per Month (PBPM) payment amounting to 100% of expected Medicare Parts A and B spending minus a "Total Care Capitation Withhold." Calculated at the beginning of each performance year based on aligned beneficiary utilization patterns, the withhold reflects CMS's expectation that it will pay for services to providers who are not participating in the Total Care Capitation arrangement, but who are providing healthcare services to a DCE's aligned beneficiaries.

Primary Care Capitation: a PBPM payment for enhanced primary care services equal to 7% of expected Medicare Parts A and B spending. DCEs that receive Primary Care Capitation may also elect for **Advanced Payment** for their non-primary care FFS services, which would be reconciled against actual claims expenditures.

Shared Savings/Losses Payment. In addition to monthly capitated payments, all DCEs will receive shared savings or shared losses payments based on a risk-adjusted Performance Year Benchmark. The financial benchmark will be calculated based on a combination of a DCE's historical expenditures and the DCE's regional expenditures (determined by the Adjusted Medicare Advantage Rate Book), with the contribution from regional expenditures increasing each year: in Performance Year 1, the benchmark will be based 65% on historical expenditures and 35% on regional expenditures; by Performance Year 5, historical and regional expenditures will contribute equally (50%/50%) to the benchmark.

To protect DCEs from burdensome financial risk, the DC model will employ risk corridors (which limit aggregate shared losses) and stop loss (optional protection against individuals with unexpectedly high cost expenditures) as financial risk mitigation strategies.

Quality Strategy.[Error! Reference source not found.,2] The DC model ties quality performance to payment. For all DCEs, 5% of funds from the Performance Year Benchmark will be withheld (i.e., a "quality withhold"). DCEs may recoup this sum based on their score on a limited quality measure set (score out of 100), and on whether they meet criteria for continuous improvement. DCEs that meet continuous improvement criteria will recoup an amount equal to their quality score multiplied by 5%; DCEs that do not will recoup an amount equal to their quality score multiplied by 2.5%.

To further incentivize high quality care, the DC model will feature a bonus payment for a **high performers pool.** DCEs that are deemed high performers on quality measures will be eligible for a bonus payment drawn from quality withhold payments not recuperated by other DCEs. The core set of quality measures will include nine measures from the CAHPS® ACOs survey, all cause unplanned admissions for patients with chronic conditions, risk standardized all condition readmission, and an advance care planning measure. Although not yet developed, CMS proposes incorporating a "Days at Home" measure for DCEs with an overall HCC risk score ≥ 2 into its core quality measure set. DCEs will also be able to opt to test a "gains made in the Patient

Activation Measure over a 12 month period" measure, although performance on this measure will not influence quality performance.

Participation Options. To appeal to organizations with different interest in and preparedness to accept downside financial risk, Medicare will initially offer two DC participation options, as outlined in **Table 2.** Each option is associated with different payment types and amount of shared savings/losses. Additionally, CMS plans to eventually create a third, "geographic" option, the details for which are not yet finalized.[3]

Table 2.

Participation Option	Payment Type	Shared Savings/Losses
Professional	Primary Care Capitation	Up to 50% shared savings / shared losses
Global	Choice of Primary Care Capitation or Total Care Capitation	Up to 100% shared savings / shared losses after a 2% discount applied to PY Benchmark recouped by CMS

PY= Performance Year

Benefit Enhancements.[1,4] The DC Model uses various enhancements to provide DCEs flexibility in managing population health – a key goal of the payment model. CMS anticipates incorporating the following benefit enhancements in the first year of the programs while considering others for future years:

Skilled Nursing Facility (SNF) 3-Day Rule Waiver: DCEs will be able to admit patients directly to a skilled nursing facility without the requirement for a minimum two-midnight hospital admission. For example, this would allow DCEs to admit patients directly from home to SNFs that are DC Participate Providers or Preferred Providers without a preceding hospital admission.

Asynchronous Telehealth: DCEs will be able to receive reimbursement for telehealth dermatology and ophthalmology services that are not provided in person or in real time. For example, asynchronous telehealth reimbursement will permit transmission of recorded health history (e.g., retinal scanning images) to a specialist who will use that data remotely to evaluate a case and make recommendations outside of a real time interaction. DCE Participant Providers or designated Preferred Providers will be able to use specific asynchronous telehealth codes (G9868-G9870) for reimbursement.

Post-Discharge Home Visits. DCEs will be eligible for reimbursement for up to nine home visits by auxiliary personnel [defined as "any individual who is acting under the supervision of a physician (or other practitioner)" under 42 CFR 410.26(a)(1)] in the 90 days following the discharge of a patient from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehab facility, long-term care hospital, or SNF, provided that the patient does not qualify for Medicare home health services. Further, auxiliary personnel can perform home visits under general supervision of a physician, as opposed to previously required direct supervision involving a physician's physical presence.[4]

Care Management Home Visits. Similar to the Post-Discharge Home Visit benefit, CMS will waive the requirement for direct supervision to allow for payment of up to 12 care management home visits by auxiliary personnel in a calendar year period. Care

management home visits intend to supplement care provided by a patient's primary care clinician and to provide services when a patient is deemed to be at risk for hospitalization. This benefit will only be applied to patients who do not qualify for Medicare home health services and not currently utilizing the Post-Discharge Home Visit benefit.

cite as: Staloff J, Liao JM, Clodfelter R, Marcotte LM. Direct Contracting. VSSL Briefs. 2020; 1:5.

References

1 "Direct Contracting Model: Global and Professional Options Request for Applications" Centers for Medicare and Medicaid Services, November 25, 2019. https://innovation.cms.gov/Files/x/dc-rfa.pdf

2 "Webinar: Direct Contracting Model Options- Direct Contracting Entity (DCE) Types/Alignment," Centers for Medicare and Medicaid Services, December 11, 2019. https://innovation.cms.gov/resources/dc-model-options-proglboverview.html

3 "Delivering Value Based Transformation in Primary Care" Centers for Medicare and Medicaid Services. https://innovation.cms.gov/Files/x/primary-cares-initiative-onepager.pdf

4 "42 CFR 410.26- Services and supplies incident to a physician's professional services: Conditions." Legal Information Institute, Cornell Law School. https://www.law.cornell.edu/cfr/text/42/410.26