Direct Contracting Global and Professional Options: An Overview for State Regulators

The Center for Medicare and Medicaid Innovation (Innovation Center) is launching a new model called Direct Contracting (tested under section 1115A of the Social Security Act), which builds on lessons learned from initiatives involving Medicare Accountable Care Organizations (ACOs), such as the Medicare Shared Savings Program (MSSP) and the Next Generation ACO (NGACO) Model.

Direct Contracting (referred to in the table below as 'DC') includes two voluntary payment model options called 'Professional' and 'Global' which are aimed at reducing expenditures and preserving or enhancing quality of care for beneficiaries in Medicare fee-for-service (FFS). Both options are launching in April 2021.

Direct Contracting Global and Professional Options also seek to provide new opportunities for a variety of different organizations to participate in value-based care arrangements in Medicare FFS. Accordingly, we have introduced different 'Direct Contracting Entity (DCE) Types'. In addition to organizations that have traditionally provided services to a Medicare FFS population ('Standard DCEs'), Direct Contracting will provide opportunities for organizations without significant experience in FFS to enter into value-based care arrangements ('New Entrant DCEs') and entities that focus on providing care to beneficiaries with complex needs ('High Needs DCEs').

This document is intended to provide a brief overview of Direct Contracting Global and Professional Options for state insurance boards and contextualize its design relative to prior models (e.g., NGACO) to help provide background information in the event that entities in your state seek to participate in the model.

Key Features of Direct Contracting Compared to NGACO

The table below highlights key features of Direct Contracting, which are compared to NGACO for context. While this table is not exhaustive, it is intended to cover all key model features.

MODEL FEATURE	NGACO	DC PROFESSIONAL	DC GLOBAL
PARTICIPANTS	ACO: legal entity with Taxpayer Identification Number (TIN)	'Direct Contracting Entity' (DCE): legally identical to an ACO (just different terminology)	Same as DC Professional
ROLE OF PROVIDERS	Medicare-enrolled providers contract with ACO and are used for alignment, quality reporting, etc.	Same as NGACO, though requirements of providers vary slightly (e.g., FFS payment reductions required – see below)	Same as DC Professional
KEY LEGAL AGREEMENT	Participation Agreement between CMS and ACO	Participation Agreement between CMS and DCE	Same as DC Professional
ALIGNMENT	Prospective alignment of beneficiaries to an ACO on a voluntary basis or using claims history	Prospective alignment of beneficiaries to a DCE on a voluntary basis or using claims history	Same as DC Professional
MINIMUM NUMBER OF ALIGNED BENEFICIARIES	10k (7.5k for rural ACOs)	Standard: 5k New Entrant: 1k growing to 5k High Needs: 250 growing to 1,400	Same as DC Professional

MODEL FEATURE	NGACO	DC PROFESSIONAL	DC GLOBAL
BENCHMARK CALCULATION	Prospectively set benchmark covering all Part A and B Medicare expenditures	Same as NGACO, though exact methodology differs, especially for DCEs that are smaller or may not have sufficient claims history	Same as DC Professional
PROSPECTIVE PAYMENTS / SHIFT AWAY FROM FFS	Optional; choice of FFS, Population-Based Payment (PBP) or All-Inclusive PBP (AIPBP); in PBP/AIPBP, providers agree to FFS claim payment reductions and instead contract with ACO for payment; ACO receives monthly payments from CMS	Primary Care Capitation (PCC) is required. PCC functions similarly to PBP, though focuses on primary care services only (see below for details). DCEs can choose Advanced Payment Option (APO) for non-primary care services which functions like PBP in NGACO.	DCEs must choose between PCC and Total Care Capitation (TCC). TCC functions like PCC but applies to all Part A and B services. See below for details.
SHARED SAVINGS / LOSS RATE	Choice between 80% and 100% risk	50% risk	100% risk
BENCHMARK DISCOUNT	1.25% for 100% risk 0.5% for 80% risk	None	2-5% (increases throughout model)
BENCHMARK QUALITY WITHHOLD	2-3% May be earned back	5% May be earned back	Same as DC Professional
QUALITY REPORTING & PERFORMANCE	Annually	Annually	Same as DC Professional
RISK MITIGATION	• Cap on gross savings/losses • Stop-Loss (optional)	• Tiers reducing DCE's risk as gross savings/losses increase[1] • Stop-Loss (optional)	Same as DC Professional
FINANCIAL ASSURANCE	Financial Guarantee = 2% of benchmark	Financial Guarantee = 2.5% of benchmark	Financial Guarantee = 3-4% of benchmark[2]
INCENTIVE TO PARTICIPATE FOR AT LEAST TWO YEARS	No	Yes[3]	Yes[5]

Shift from Fee-For-Service (FFS) and Capitation in Direct Contracting

Requiring a shift away from FFS payments for the core providers connected to a DCE, which was optional in NGACO, is a key feature of Direct Contracting. Operationally, the payments function very similarly to NGACO: providers continue to submit claims, accept reduced FFS claim payments, and contract with DCEs to be compensated for those payment reductions (DCEs will receive monthly prospective payments based on the providers accepting claims reductions). In Direct Contracting, these payments are referred to as

[1] Tiers are referred to as 'Risk Corridors'; Risk Corridor attachment points differ between Professional and Global.

[2] 3% if a DCE takes Primary Care Capitation and 4% if a DCE takes Total Care Capitation.

[3] DCEs will be incentivized to participate in the model for a minimum of two performance years by instituting a "retention withhold" equal to 2% of the first performance year's benchmark which will be released if the DCE participates in its second performance year.

‘capitation’ because the amount paid prospectively to the DCE will count against the benchmark during final reconciliation independent of the amount of FFS payments reduced (this approach differs from NGACO, where prospective payments are ‘trued up’ with the amount of reduced claims prior to reconciliation). Providers that are not connected to the DCE will continue to be paid FFS and will not be affected by the capitation payments or claims reductions (same as NGACO).

There are two capitation payment mechanisms in Direct Contracting: PCC and TCC. DCEs that choose Professional are required to take PCC whereas DCEs that choose Global can choose between PCC and TCC. As noted above, PCC focuses specifically on primary care services whereas TCC applies to all Part A and B claims. DCEs that choose PCC will have the ability to engage in Advanced Payment which covers non-primary care services and otherwise functions exactly like PBP in NGACO (i.e., is trued up with the actual FFS claim payment reductions and therefore not considered capitation).

Financial Risk Mitigation
DC employs two risk mitigation features: risk corridors and stop loss. Risk corridors are required and apply to all DCEs, with attachment points varying based on risk option (Professional or Global). Risk corridors reduce the DCE responsibility as gross savings or losses increase. Specific (i.e., beneficiary-level) stop loss is optional and available to DCEs for a PBPM charge.

Consumer and Provider Protections
CMS will deploy a robust monitoring program to ensure program integrity and patient safety are protected. A CMS contractor will provide oversight and audits throughout the model to enforce compliance with the terms of the Participation Agreement and to safeguard aligned beneficiaries’ access to innovative, affordable, and quality care. A few examples of the auditing CMS may perform include, but are not limited to:

- Quality reporting and performance reviews
- Public reporting audits
- Marketing reviews
- Home health and hospice utilization appropriateness
- Targeted financial audits
- Direct referral appropriateness
- Financial Guarantee reviews

While CMS plans to monitor all DCEs, CMS will not define the threshold for most downstream operations. As part of the Participation Agreement, the DCE shall comply with applicable state licensure requirements regarding risk-bearing entities in each state in which it operates unless it has provided a written attestation to CMS that it is exempt from such state laws. CMS is not responsible for overseeing or defining:

- Minimum cash-to-claims ratio
- Tangible Net Equity
- Processes for providers to file grievances
- Projected financial statements

If there are further questions, please email the Direct Contracting Model mailbox: DPC@cms.hhs.gov.