



## **NAACOS Summary of Direct Contracting Financial Specifications**

### **EXECUTIVE SUMMARY**

The Centers for Medicare & Medicaid Services (CMS) Innovation Center in mid-September released long-awaited details on the financial specifications for its Direct Contracting Model. These details were included in a series of eight papers, available on this CMS [webpage](#), and are critical for Direct Contracting Entities (DCEs) interested in participating in the model. As such, NAACOS produced this resource to help DCEs better understand the details released by CMS. The papers provide long-awaited details on benchmark components, including the risk adjustment methodology and adjusted Medicare Advantage rate book, and the agency will release additional policy papers in late 2020 or early 2021 on the following model components: risk mitigation, financial guarantees, financial reconciliation, quality measures, and reporting.

Among the notable features of Direct Contracting released through the financial specifications:

- The model will go through the end of 2026 to offer five complete years for all participants.
- CMS created a special Direct Contracting Rate Book that will be based on three years, which includes hospice care utilization and only includes costs for DCE-eligible beneficiaries.
- CMS introduces a new risk adjustment model for High-Needs Population DCEs.
- Quality performance benchmarks will be developed using 2021 claims data to mitigate the impact of COVID-19.
- CMS will apply a “seasonality adjustment” to Performance Year (PY) 1 benchmarks to account for the shortened, nine-month performance period (April 1 – December 31, 2021).
- CMS will provide additional flexibility for DCEs who select Primary Care Capitation (PCC), including allowing DCEs to receive more than 7 percent of their benchmark in capitated payments.
- CMS will update capitated payments prior to every quarter based on the beneficiary experience in the current quarter.

NAACOS has been advocating to help shape the Direct Contracting Model since its inception. We met with CMS and wrote letters on the [Geographic](#) and [Professional and Global](#) Options to influence their development. NAACOS also [wrote CMS](#) asking for changes and clarifications after the Request for Applications was released in late 2019. We will continue working to secure changes to improve the model, and we request DCEs email us at [DirectContracting@naacos.com](mailto:DirectContracting@naacos.com) to share feedback or questions about the model.

In 2019, NAACOS 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. As part of the taskforce, we have developed several resources to help members better understand the model. These include:

- [Frequently Asked Questions](#) on the Direct Contracting Model,
- In-depth [analysis](#) of the Direct Contracting Model,
- [Overview](#) of Direct Contracting,
- [Chart](#) comparing Direct Contracting and other high-risk ACOS,
- [Chart](#) of CMS Innovation Center models and their overlap with ACOs, and
- A [series](#) of webinars, town halls, and learning discussions on the model.

## FINANCIAL MODEL SPECIFICATIONS

### **Benchmark Calculations**

#### **Step 1: Historical Baseline**

##### Historical Baseline Expenditure

First, for beneficiaries aligned to Standard DCEs via claims-based alignment, CMS will use a fixed three-year baseline period: 2017, 2018, and 2019. The baseline will include all Medicare Parts A and B expenditures for these beneficiaries. CMS will then weight the three years, giving greater weight to the most recent base year (i.e., 10 percent, 30 percent, 60 percent).

Note: For the first four performance years of the model, CMS will not use a historical baseline for New Entrant DCEs and High-Needs Population DCEs, or for beneficiaries voluntarily aligned to Standard DCEs. Instead, the benchmarking process will start with the application of regional rates (Step 2, below). For the last two years of the model, CMS will use a rolling three-year baseline period: PY 5 – 2021, 2022, 2023 and PY 6<sup>1</sup> – 2022, 2023, 2024.

##### Application of Prospective Trend

To make the historical baseline applicable to each performance year, CMS next will use its United States per capita cost (USPCC) annual growth trend (developed for Medicare Advantage [MA]) to calculate the prospective trend rate for each of the three base years and separately trend forward each base year.

##### Baseline Standardization

After trending the historical baseline, for each base year comprising the historical baseline, CMS will apply a risk adjustment and a Geographic Adjustment Factor (GAF) adjustment.

##### *Risk Adjustment*

CMS will risk standardize the historical baseline by applying a DCE's risk score to each base year. A DCE's risk score will be a weighted average of the risk of all aligned beneficiaries. Details are described in the "Risk Adjustment" section below.

##### *Geographic Adjustment Factors (GAF) Adjustment*

After risk standardizing the historical baseline, CMS will account for regional differences by applying the DCE's regional GAF to each base year. The GAF is a county-specific factor developed by CMS for determining Medicare fee-for-service (FFS) payments.

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<sup>1</sup> To account for the delayed start of the model (to April 1, 2021) and the impacts of COVID-19, CMS is extending the duration of the model through 2026.

## NAACOS Insights

NAACOS wants to ensure that the Direct Contracting financial methodology offers an equal opportunity for success in the model for both incumbent ACOs and organizations that are new to Medicare shared savings initiatives. We are concerned that using historical expenditures and heavily weighting the most recent base year will make it difficult for incumbent ACOs to succeed. These ACOs are experienced in managing care for their aligned populations and have already added efficiency and value to their care models. NAACOS is advocating CMS make changes to the methodology, including flipping the weighting of the base years to give greater weight to the least recent year and adding shared savings earned by a DCE back in for purposes of setting the performance year benchmark.

### Step 2: Application of Regional Expenditures

For each base year, CMS will calculate the weighted average of the county rates (or state-level rates for End-Stage Renal Disease [ESRD] beneficiaries) based on the new Direct Contracting/Kidney Care Choices (DC/KCC) Rate Book, which is an adjusted version of the MA Rate Book. A DCE's region will include all counties in which one or more beneficiaries aligned in the base period reside and will be weighted based on the county rates and number of aligned beneficiaries residing in each county in each of the base years.

#### DC/KCC Rate Book

The DC/KCC Rate Book is based on the same methodology used for the MA Rate Book with adjustments to (1) remove factors applied to the MA Rate Book that are not relevant for Direct Contracting (e.g., uncompensated care, FFS spending quartiles, and quality bonus payment percentage for star ratings), (2) add components of Medicare FFS expenditures not included in the MA Rate Book (e.g., hospice services and indirect medical education), and (3) include only the experience of FFS beneficiaries who are eligible to participate in the Direct Contracting Model. As with the MA Rate Book, this DC/KCC Rate Book will establish a county rate for the Aged and Disabled (A&D) beneficiaries and a state-level rate for ESRD beneficiaries.

#### Regional Blend

Using the weighted county rates from the DC/KCC Rate Book, CMS will blend the regional expenditures with the historical baseline for each performance year. CMS will limit the adjustment resulting from blending in regional expenditures to a percentage of the FFS USPC for each performance year (upward adjustment cap = 5 percent; downward adjustment cap = 2 percent).

For claims-aligned beneficiaries in Standard DCEs		
<u>Performance Year</u>	<u>Historical Baseline Expenditures</u>	<u>Regional Expenditures</u>
PY1/2/3	65%	35%
PY4	60%	40%
PY5	55%	45%
PY6	50%	50%

**For New Entrant DCEs, High-Needs Population DCEs, and voluntarily aligned beneficiaries in Standard DCEs**

<u>Performance Year</u>	<u>Historical Baseline Expenditures</u>	<u>Regional Expenditures</u>
PY1/2/3/4	0%	100%
PY5	55%	45%
PY6	50%	50%

**NAACOS Insights**

Based on our initial review of the DC/KCC Rate Book construction, the approach captures regional expenditures better than the standard MA rate book and is comparable to the MSSP regional benchmark. While methodologically reasonable, the regional rate calculation may not be favorable enough to overcome the large discount for Global DCEs, which ranges from 2 to 5 percent and is explained in more detail below. Additionally, this is not the actual final rate book. The DC/KCC Rate Book makes financial assumptions that may change, for example the inflation rate is currently set at 5.2 percent for 2020, which is very high given utilization disruptions that will likely result in a negative inflation rate. Moreover, we are concerned that the rate book will not capture the loss of utilization experienced by many DCEs as a result of COVID-19 and does not account for potentially uneven reductions in utilization within a county. CMS has stated that it will continue to monitor the impacts of public health emergency and remains open to additional changes to account for 2020 as an outlier year.

NAACOS has also advocated for CMS to give more weight to the regional rates for all DCEs (and less weight to historical expenditures). We appreciate that the blending of rates increases throughout the model but recommend the blend should start with a higher percentage for regional rates and increase beyond the currently set maximum of 50 percent (for the last performance year).

**Step 3: Discounts and Withholds**

Discount

For Global DCEs, CMS will apply a discount to each performance year benchmark to ensure savings to the Medicare program. The discount cannot be earned back by a DCE and increases over the life of the model.

<b>Performance Year</b>	<b>Discount</b>
PY1-2	2%
PY3	3%
PY4	4%
PY5/6	5%

## Withholds

In addition to the automatic discounts that cannot be earned back, CMS is utilizing withholds in the model. Five percent of a DCE's performance year benchmark is at risk based on quality performance and CMS will apply a quality withhold in an amount up to five percent. The actual amount withheld will be determined based on a DCE's prior year quality performance, and a DCE can earn back up the full amount. For the first two performance years, a DCE can earn back 4 percent based on pay-for-reporting and 1 percent based on pay-for-performance. Beginning with the third performance year, all 5 percent will be based on pay-for-performance. CMS will provide additional details on quality measures and reporting in a forthcoming policy paper.

For the first performance year only, CMS will also apply a 2 percent "retention withhold" to incentivize DCEs to remain in the model. If a DCE is still participating in the model at the time of final settlement for its first performance year, it will automatically earn back the full amount of the withhold.

For Global DCEs participating in Total Care Capitation (TCC), CMS will apply a TCC Withhold to account for care that aligned beneficiaries may receive from providers outside of the DCE. CMS will project this "spillage" amount based on historical claims data. CMS will reconcile this withhold during settlement.

### NAACOS Insights

NAACOS continues to believe that the discount for Global DCEs is too high, making it difficult for those DCEs (and especially incumbent ACOs/DCEs that are already high value) to succeed in the model. We appreciate that CMS needs to be guaranteed savings for the Medicare program, but we advocate for a smaller discount.

## Risk Adjustment

CMS will use aligned beneficiaries' risk scores to risk adjust multiple model components, including the historical baseline, the regional expenditures, and the capitated payments.

For Standard DCEs and New Entrant DCEs, the Innovation Center will use the same CMS-Hierarchical Condition Code (HC) prospective risk adjustment model used in MA and currently used in the Next Generation ACO model. The Innovation Center will use a newly developed risk adjustment model — the CMMI-HCC concurrent risk adjustment model — for High Needs Population DCEs' A&D beneficiaries and will use the CMS-HCC prospective risk adjustment model for ESRD beneficiaries.

The new risk adjustment model, which is broadly based on the CMS-HCC A&D prospective risk adjustment model, aims to improve payment accuracy for beneficiaries with serious or acute illness in the concurrent year by weighting acute conditions more heavily to better capture a rapid deterioration in health in the current year (events that are hard to predict, like stroke or heart attack). The model also gives weight to demographic indicators.

For Standard and New Entrant DCEs, CMS will apply a four-step risk adjustment process. The first two steps will "normalize" risk scores and the final two steps aim to address "coding intensity." For High-Needs Population DCEs, CMS will only apply the first two steps (but stated that it may apply the coding intensity steps in later model years). In its Risk Adjustment paper, CMS included an example walking through this process for a hypothetical DCE.

*Step 1: Prospective preliminary estimated normalization*

CMS will apply a normalization factor to DCE risk scores to adjust for changes in risk score growth relative to the risk model's denominator year (currently 2015). The normalization factor is the average risk score of the DC National Reference Population in that year and DCE risk scores are divided by that factor to get the normalized risk score. This adjustment results in the projected average risk score for the payment year based on the observed historical trend in risk scores for the Direct Contracting National Reference Population.

*Step 2: Retrospective normalization correction adjustment factor*

During final reconciliation of each performance year, CMS will apply a retrospective normalization correction adjustment factor in order to use the actual growth trend measured with observed data. The goal is to calibrate the population-average risk score to 1.0 in a given year.

*Step 3: Risk score cap*

In an effort to reduce the incentive for coding intensity that does not reflect the true health status burden of a DCE's aligned population, CMS will apply a symmetric +/- 3 percent cap on DCE-level risk score growth (per performance year). Under this policy, the average normalized risk score for the DCE in a performance year will be constrained to be no more than 3 percent above or below the DCE's normalized risk score for the DCE-specific reference population. The reference year for this cap is the year two years prior to a performance year, except for 2022 when CMS will use 2019 again as the reference year (to avoid 2020 anomalies from COVID-19).

*Step 4: Retrospective Coding Intensity Factor (CIF) adjustment*

During financial reconciliation of each performance year, CMS will apply a model-level adjustment to aligned beneficiary risk scores to limit the risk score growth relative to the baseline period. The retrospective CIF will ensure that the change in normalized payment risk scores across all claims aligned beneficiaries is zero between the most recent baseline year and the performance year.

Note: The experience of voluntarily aligned beneficiaries is not subject to the either the cap or the CIF in their first year of alignment.

### NAACOS Insights

Our initial review of the new concurrent risk adjustment model appears to be a much better assessor of risk for outlier populations, and we would like CMS to expand its use beyond the High-Needs Population DCEs. NAACOS believes that CMS should also use the concurrent risk adjustment model for the high-risk populations in Standard DCEs and New Entrant DCEs.

We also are concerned about application of the CIF (especially since it is applied after the 3 percent cap). If DCEs hit the cap and then CMS applies the CIF, the DCE risk score will be right back to about 1.0. While this is the policy goal CMS wants to achieve, this policy is a departure from MA and makes it more difficult for DCEs to earn shared savings.

## References and Conclusion

NAACOS continues to assess the Direct Contracting Model, including the financial specification details included in the CMMI papers below. We will continue advocating for model improvements to implement a meaningful new Medicare accountable care model.

- [Financial Operating Guide: Overview](#)
  - [Financial Companion to Operating Guide Overview: Standard DCE](#)
  - [Financial Companion to Operating Guide Overview: New Entrant DCE](#)
  - [Financial Companion to Operating Guide Overview: High-Needs Population DCE](#)
- [Financial Operating Policies: Capitation and Advanced Payment Mechanisms](#)
  - [Financial Companion to Capitation and Advanced Payment Mechanisms](#)
- [Risk Adjustment](#)
- [DCC/KCC Rate Book Development](#)