# Medicare FFS Direct Contracting: Financial benchmark observations

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The financial benchmark for the Global and Professional options in CMS's Direct Contracting (DC) payment model will share key attributes with the Medicare Shared Savings Program (MSSP) financial benchmark. In this white paper, we compare and contrast the financial benchmark methodology[1] between DC Global and Professional options and MSSP.

In 2019, the Centers for Medicare and Medicaid Services (CMS) released the request for applications (RFA) for the Direct Contracting model's Professional and Global options. In 2020, CMS has released a significant amount of additional detail regarding the program methodology.[2] This new payment model gives participating provider organizations two options for risk-sharing arrangements, as well as the opportunity to receive a prospectively determined, more predictable revenue stream.

The DC payment model options are conceptually similar to the other CMS accountable care organization (ACO) options, the Medicare Shared Savings Program (MSSP) and the Next Generation ACO Model. Participants take risk and earn potential rewards based on the efficiency and quality of care for aligned beneficiaries. The application window for the 2022 performance year will open in the first quarter of 2021, so provider organizations should be evaluating which payment model is the best fit for their organization in early 2021.

DC entities (DCEs) will share in 50% of savings/losses in the Professional option, and 100% of savings/losses in the Global option. A financial benchmark is calculated for each DCE and compared to the actual performance year costs to calculate the settlement. Therefore, understanding the financial benchmark and settlement methodology is crucial for program participants.

## DCEs will largely compete against themselves

For organizations familiar with MSSP, the use of adjusted historical experience to calculate the benchmark will look familiar. In MSSP, an ACO's benchmark is driven in large part by its historical experience. In the MSSP methodology, an ACO's trended historical experience accounts for 50% to 85% of its benchmark, depending on its agreement period and cost relative to its region. In the DC methodology, historical cost relative to the region is not factored into the historical benchmark weight. Instead, trended historical experience for each DCE will make up 65% of its benchmark in performance year (PY) 1 (2021), decreasing to 50% in PY6 (2026). Figure 1 shows the historical experience weight for each performance year in DC. The other portion of the benchmark is determined using the Direct Contracting/Kidney Care Choices (DC/KCC) Rate Book.

**FIGURE 1: HISTORICAL BASELINE EXPERIENCE WEIGHT IN PERFORMANCE YEAR BENCHMARK**

| PERFORMANCE YEAR | BASELINE EXPERIENCE WEIGHT |
|---|---|
| PY1 (2021) | 65% |
| PY2 (2022) | 65% |
| PY3 (2023) | 65% |
| PY4 (2024) | 60% |
| PY5 (2025) | 55% |
| PY6 (2026) | 50% |

Note: These percentages are used in the benchmark calculation for beneficiaries aligned to a DCE using claims-based alignment. Historical baseline experience for voluntarily aligned beneficiaries receives 0% weight for PY1, PY2, PY3, and PY4.

In both MSSP and DC, the historical baseline years remain static throughout the entire performance period. In MSSP, the baseline period is the three calendar years prior to the first year of each agreement period, and is rebased at the start of a new agreement period. For DC, CMS is implementing a three-year historical baseline period for all DCEs from calendar year (CY) 2017 through CY 2019. In both programs, baseline experience is

[1] Financial benchmark methodology in this paper is specific to Standard DCEs (organizations with substantial experience with risk-based contracts). The other types of DCEs include New Entrant DCEs (organizations with limited experience with risk-based FFS contracts) and High Needs Population DCEs (organizations serving Medicare FFS beneficiaries with complex needs, including dually eligible beneficiaries). Each of the three DCE types has a specific approach to benchmark calculations.

[2] CMS. Direct Contracting Model Options. Retrieved December 22, 2020, from https://innovation.cms.gov/innovation-models/direct-contracting-model-options.

restated annually for participant list changes. While the baseline years themselves do not change, the historical experience (membership, expenditures, risk score, etc.) may change due to revisions in the DCE's participant list from year to year.

The historical base year weighting for the baseline period in DC also mirrors the methodology that is used for an ACO's first agreement period under MSSP. Baseline years (BYs) 1, 2, and 3 (2017, 2018, and 2019) will have 10%, 30%, and 60% weight, respectively, for the component of the benchmark determined by historical expenditures. This is consistent with an MSSP ACO's first agreement period, in which the same weights apply (10%/30%/60% for BY1/BY2/BY3). The weights applied in an MSSP ACO's second and subsequent agreement periods are 33%/33%/33% for BY1/BY2/BY3.

Additionally, CMS will apply a number of adjustments to the risk-adjusted, trended, and regionally blended performance year benchmark. Under the Global model, a discount will be applied to the benchmark. The discount is equivalent to 2% of the benchmark for PY1 and PY2. The discount will increase by 1% each subsequent year (increasing to 5% for PY5 and PY6), resulting in an increasingly high bar for achieving savings through the agreement period under the Global model.

As with MSSP, participants in DC will largely compete against themselves because the majority of the financial benchmark will be determined from the DCE's experience. DCEs with favorable historical baselines (i.e., higher 2017 through 2019 expenditures) may be in a good position to succeed in DC.

## There is a partial reward for efficiency attained before the agreement period

The DC model will incorporate regional expenditures into the calculation of the benchmark. Unlike in the Next Generation ACO model, there will be no explicit adjustment for "efficient organizations" (i.e., those with lower costs than their regions) or "inefficient organizations" (i.e., those with higher costs than their regions). However, regional expenditures will be blended with the DCE's historical benchmark expenditures. If a DCE's historical expenditures are lower than the regional average expenditures, blending the regional expenditures into the historical baseline experience will favor the DCE by increasing the benchmark. In that way, the DCE will be rewarded for efficiency attained before the agreement period. This same reward exists in MSSP, where the ACO's historical baseline expenditures are blended with regional experience.

A DCE's regional expenditures will be blended into the benchmark with a weight of 35% for PY1 (i.e., CY 2021). This percentage will grade up over time, reaching 50% by PY6 (CY 2026). Unlike MSSP, these percentages will not be based on whether the DCE has higher or lower per capita spending than its region. For DC, CMS will limit the upward regional adjustment at 5% of the fee-for-service (FFS) U.S. per capita cost (USPCC) for the performance year, and will limit the downward adjustment at 2% of FFS USPCC. This contrasts with the symmetrical limit in MSSP of ±5% of national assignable per capita expenditures. A DCE may be eligible for a 5% reward for efficiency relative to its region, just as an MSSP ACO is, but a DCE is not subject to as large of a potential downward regional adjustment to the benchmark as in MSSP.

For the DC program, regional expenditures will come from a new DC/KCC Rate Book with the goal of further aligning Medicare FFS and Medicare Advantage (MA) payment policies. The DC/KCC Rate Book differs from the MA Rate Book in six key ways:

1. The DC/KCC Rate Book is based on three years of FFS spending data, with a one-year gap between the last year of data used and the year the DC/KCC Rate Book will be used. In contrast, the MA Rate Book uses five years of data with a two-year gap.
2. CMS omits adjustments that are not relevant to DC, such as the Quality Bonus Payment (QBP) for MA star ratings.
3. CMS adjusts for differences in expenditure types that are not relevant to DC. For example, in the MA Rate Book, county benchmarks are set at one of four quartile levels. For 2020, each county's benchmark was set at 95%, 100%, 107.5%, or 115% of the FFS projected rate for that county. The percentage is set based on the county's quartile for average per capita Medicare FFS spending in the most recent data year. The 95% adjustment is applied to the quartile with the highest per capita Medicare FFS spending, 100% for the second-highest, and so forth. CMS does not apply this quartile rule in the DC/KCC Rate Book. The quartile adjustment in the MA Rate Book has a dampening effect on county-level projections, decreasing the benchmark for counties with higher per capita allowed amounts and increasing the benchmark for counties with lower per capita allowed amounts.
4. CMS adjusts for the fact that the MA Rate Book is based on experience for all Medicare FFS beneficiaries. DCE-aligned beneficiaries must be enrolled in both Medicare Parts A and B, so FFS enrollees who are not enrolled in both Medicare Parts A and B are excluded from the DC/KCC Rate Book.
5. The DC/KCC Rate Book includes hospice care expenditures, which are excluded in the MA Rate Book.
6. The MA Rate Book data includes uncompensated care payments, which are excluded in the DC/KCC Rate Book.

When determining the benchmark, the definition of a region used for DC is the same as the definition for MSSP: it consists of a membership-weighted average of all counties in which at least one aligned beneficiary resides.

In DC, like in MSSP, provider organizations are rewarded for historical experience efficiencies relative to their regional averages. However, in DC these benchmark adjustments are based on a new DC/KCC Rate Book, rather than average FFS expenditures for an assignable population.

## Depending on the risk track, a significant amount of revenue is at risk

Like MSSP and Next Generation ACO participants, DCEs are at risk for the total cost of care. DCEs will share in 50% of savings/losses in the Professional option and 100% in the Global option. Both the Global and Professional options include risk corridors that scale down the percentage of shared savings/losses applied as total cost of care varies farther from the benchmark. They also include optional stop-loss arrangements.

### CAPITATION OPTIONS

Both the Global and Professional options have capitation payment mechanisms. The Global option has a choice between Total Care Capitation (TCC) and Primary Care Capitation (PCC), and the Professional option has PCC. These capitation options are summarized in Figure 2. Additionally, DCEs selecting PCC can choose whether to participate in the Advanced Payments Option.

Each DCE will be comprised of DCE Participant and Preferred Providers. CMS will use only DC Participant Providers to determine beneficiary alignment; Preferred Providers do not drive alignment or report quality metrics. DCE Participant Providers will be required to participate in the capitated model selected by the DCE. Under PCC, capitation is optional for Participant Providers in PY1 and mandatory for PY2 through PY6. Capitated payments will be for all DCE Participant Providers and those Preferred Providers who have opted into the capitated arrangement. Preferred Providers identified by the DCE can opt into the capitation arrangement and select the percentage of claims payments they would like to have reduced under the capitated model.

As noted in Figure 2, DCEs selecting PCC will receive capitated payments equal to 7% of the estimated total cost of care, with some exceptions. CMS anticipates this payment will be greater than actual historical primary care expenditures for most DCEs. The difference between the PCC and historical primary care expenditures (i.e., the enhanced PCC amount) is intended to be used to fund enhanced primary care services, e.g., infrastructure, technology, and tools. DCEs will be able to opt out of receiving this enhanced amount, and it will be recouped by CMS in the final financial reconciliation.

The Advanced Payment[3] is an optional component, only applicable to DCEs electing PCC, applying to non-primary care FFS claims that are not under the capitated arrangements. DCEs can negotiate with their providers to agree for CMS to reduce their FFS claims by a certain percentage, from 1% to 100%. In exchange, CMS will make a monthly Advanced Payment to the DCE for an equivalent amount based on historical utilization for aligned members. The DCE is then responsible for paying those providers based on the agreement with those providers. The payments made to the DCE will be reconciled against actual FFS claims during the final financial reconciliation.

The capitation and Advanced Payment methodology of DC are significantly different from the MSSP methodology, in which ACOs have no capitation options available.

### QUALITY METHODOLOGY

Under both the Professional and Global models, 5% of the PY benchmark will be withheld by CMS each year for quality performance. This withhold is applied as a reduction to the PY benchmark. DCEs will have the opportunity to earn back the quality withhold based on performance relative to a set of quality measurements and continuous improvement or sustained exceptional performance (CI/SEP) criteria. CI/SEP targets will be designed to incentivize high-performing DCEs to continue to improve. In PY1 and PY2, 4% of the 5% withheld will be based on a pay-for-reporting structure while only actual quality results will be used in PY3 through PY6. Starting in PY3, the quality score (QS) will be multiplied by 5% if CI/SEP is achieved and by 2.5% if CI/SEP is not achieved to determine the quality bonus payment.

In addition, CMS plans to create a High Performers Pool (HPP) funded by quality withholds that are not earned back by DCEs achieving CI/SEP targets. Because the CI/SEP does not apply in PY1 and PY2, the HPP will not apply until PY3. Details regarding the criteria to qualify for a HPP payment are not yet defined. Figure 3 shows examples of the flow of funds under the discount and quality incentive programs. Note that Figure 3 does not incorporate savings or losses due to a DCE's total cost of care performance compared to the PY benchmark. The illustrations in Figure 3 are intended only to show the impacts of the quality incentive programs.

[3] Additional information on the Advanced Payment option can be found here: https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/direct-contracting-aco-opportunity.ashx.

**FIGURE 2: CAPITATION OPTIONS UNDER DC**

| CAPITATION | DESCRIPTION | AVAILABLE TO PROFESSIONAL? | AVAILABLE TO GLOBAL? |
|---|---|---|---|
| Total Care Capitation | Capitated payment per beneficiary per month (PBPM) for all services. Payment will reflect the estimated total cost of care* for the aligned population, with a reduction for utilization by providers not in the capitation arrangement. | No | Yes |
| Primary Care Capitation | Capitated payment PBPM for primary care services. The default payment will equal 7% of estimated total cost of care* for the aligned population. | Yes | Yes |

* Total cost of care defined as the risk-adjusted, trended, and regionally blended benchmark.

**FIGURE 3: DC QUALITY WITHHOLD ILLUSTRATION (PY3+)**

| CI/SEP CRITERIA ACHIEVED? | YES | NO |
|---|---|---|
| Quality Withhold | 5% | 5% |
| Quality Withhold Returned to DCE | QS x 5% | QS x 2.5% |
| Contribute Unearned Withhold to HPP? | Yes | No |
| Revenue to HPP | 5% - (QS x 5%) | 0% |
| Revenue to CMS | 0% | 5% - (QS x 2.5%) |
| Quality-Based Revenue to DCE | (QS x 5%) + HPP bonus | QS x 2.5% |

**FIGURE 4: ILLUSTRATIVE COMPARISON OF QUALITY SCORE AND DISCOUNT EFFECT IN MSSP AND DC**

| | MSSP | DC PROFESSIONAL | DC GLOBAL |
|---|---|---|---|
| Preliminary revenue to DCE/ACO | 100% of FFS | 100% of FFS | 100% of FFS |
| QS | 80% | 80% | 80% |
| Discount off benchmark | n/a | 0% | 2% |
| Quality withhold from benchmark | n/a | 5% | 5% |
| Earned quality withhold | n/a | 80% x 5% = 4% | 80% x 5% = 4% |
| Total discount off benchmark | n/a | 0% + 5% - 4% = 1% | 2% + 5% - 4% = 3% |
| Maximum shared savings rate | 50% | 50% | 100% |
| Shared savings after QS | 50% x 80% = 40% | 50% | 100% |

Note: The illustrative examples in Figure 4 are based on a sample DCE/ACO with an 80% quality score. The examples also use the MSSP BASIC Level C maximum shared savings of 50%, and the PY1 DC Global discount of 2%. The DC columns assume that CI/SEP criteria is achieved and HPP is not. These values will vary for organizations in different risk tracks and/or performance years.

Figure 4 compares the effect of the quality score for providers under MSSP and DC. Under the DCE model, the quality program is applied to the benchmark prior to the settlement of final savings/losses. This is significantly different from the quality mechanism in the current MSSP program, where the final shared savings rate is equal to the quality score multiplied by the maximum shared savings rate for each specific risk track. Because the DC quality recoveries and bonus are applied before the calculation of shared savings/losses, DCEs may recover the quality withhold even in a loss position.

## Conclusion

While the financial benchmark methodology for the MSSP and DC models have many similarities, the differences can be material to the financial outcome of a given organization. The DC model's benchmark methodology offers a unique blend of concepts from FFS risk models and MA, with a unique profile of potential risks and incentives. The DC model may provide an attractive option for providers that want to take advantage of the features of the DC methodology, and other entities that have not traditionally participated in Medicare risk-sharing models.

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