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Direct Contracting Model RFA: Global and Professional Options

OVERVIEW

On November 25th, the Centers for Medicare and Medicaid Services (CMS) released a Request for Applications (RFA) for the Direct Contracting (DC) Model's Professional and Global Options. The DC Model expands opportunities to participate in Medicare risk-sharing, drawing from Medicare Accountable Care Organization (ACO) initiatives, particularly the Next Generation ACO (NGACO) Model, as well as innovative approaches from Medicare Advantage (MA) and private sector risk-sharing arrangements.

The summary below describes major sections of the RFA. Additional guidance can be found within the Direct Contracting Professional and Global Options RFA, available here.

APPLICATION PROCESS

This RFA opens one of two application periods for the first performance year in 2021, and re-opens the window for the Letter of Interest (LOI). The first application submission period is for those interested in participating in the optional implementation period (IP), and the second is for those interested in skipping the implementation period and starting the model in the first performance year (PY). The application for participation in the IP opened on November 25th, 2019 and will close on February 25th, 2020, though CMS indicates that the application for organizations interested in taking part in the IP will not be made available until early December. The application period for PY1 will open in Spring 2020.

Organizations applying for the IP will sign a Participation Agreement for this period and a second Participation Agreement prior to the start of PY1. Organizations applying for PY1, but not the IP, will only sign one participation agreement prior to the start of PY1.

Additionally, the Letter of Intent (LOI) for the Professional and Global options has been re-opened from November 25th to December 10th. The LOI is mandatory but non-binding for organizations that would like to apply to the DC Model.

The application tool will be available here. The LOI is available here.

Screening, Scoring, and Selection

Applications will be screened to determine eligibility for further review. The program integrity screening may include:

- Confirmation of current Medicare enrollment status for participating providers and history of adverse enrollment actions;
- Identification of delinquent debt;
- Review of performance in, and compliance with the terms of, other CMS models, demonstration programs, and initiatives;
- Review of compliance with Medicare and Medicaid program requirements;
- Review of billing history and any administrative audits, investigations, or other activities conducted regarding suspicious billing or other potential program fraud and abuse; and
- Review of any civil or criminal actions related to participation in a federal health care program.

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CMS will assess applications in accordance with specific criteria in five key areas:

1. Organizational structure;
2. Leadership and management;
3. Financial plan and risk-sharing experience;
4. Patient centeredness and beneficiary engagement; and
5. Clinical care.

Applicants with prior participation in a CMS program, demonstration, or model will be asked to demonstrate routine compliance with the terms of such CMS programs, demonstrations, or models.

GENERAL INFORMATION

The DC model is part of a strategy by the CMS Center for Medicare and Medicaid Innovation (CMMI) to allow entities and providers new ways to take on risk with prospective payments, and include entities that were ineligible under prior models. New types of entities may apply, and the models may allow for a lower number of aligned Medicare fee-for-service (FFS) beneficiaries than is permitted under existing ACO models.

CMS will test three voluntary risk-sharing arrangements. This RFA focuses on two of those options:

1. Professional Option - 50% Shared Savings/Shared Losses and a Primary Care Capitation equal to 7% of the Performance Year Benchmark for enhanced primary care services.
2. Global Option - 100% Shared Savings/Shared Losses and either Primary Care Capitation or Total Care Capitation.

The third proposed option, Geographic Population-Based Payment, was presented as a Request for Information in April 2019, and is excluded from this RFA.

CMS will begin an Implementation Period (IP) in 2020, during which Direct Contracting Entities (DCEs) electing to do so will conduct beneficiary alignment, engagement and other activities. Following that, all DC models will have five performance years (PYs) from 2021 through 2025.

DCEs may not participate in more than one Direct Contracting payment option during the model test, nor may they participate in any other CMMI shared savings model, such as an ACO. Further, DCEs may not participate in the CPC+ program. DCEs participating in one option during the IP cannot switch to another option before signing the PY1 participation agreement or any time after that.

In order to participate in Direct Contracting, a DCE must demonstrate compliance with all applicable state licensure requirements regarding risk-bearing entities. Sachs Policy Group is reviewing the application of New York State Division of Financial Services Regulation 164 and other NYS regulations that may impact participants in the DC Model, on topics such as required financial reserve levels and self-referrals.

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Direct Contracting Entity Types

Under Direct Contracting, there are three types of DCEs:

1. *Standard* – DCEs comprised of organizations that generally have experience serving Medicare FFS beneficiaries, including dually eligible beneficiaries, that will rely on voluntary alignment and claims-based alignment.
2. *New Entrant* – DCEs comprised of organizations that have not traditionally provided services to a Medicare FFS population and that will primarily rely on voluntary alignment, with some claims-based alignment.
3. *High Needs Population* – DCEs that serve Medicare FFS beneficiaries with complex needs, including dually eligible beneficiaries, who are aligned to the DCE through voluntary alignment or claims-based alignment.

Both the New Entrant and High Needs Population options are intended to create new avenues for organizations to participate in CMMI models that have not been able to take risk on Medicare FFS enrollees before, such as physician-managed organizations that have participated in Medicare Advantage risk contracting, and Medicaid Managed Care organizations that have experience with integrated dual-eligible plans. Both models reduce the number of aligned beneficiaries required, particularly at the beginning of the demonstration period.

The High Needs Population DCE is expected to involve enhanced care coordination services specific to a chronically-ill, frail population with complex needs, similar to the model of care employed by PACE plans in Medicare.

A DCE’s service area consists of two parts. CMS will identify the DCE’s service area for purposes of beneficiary alignment. The two service areas are:

1. Core Service Area - Includes the counties in which the DCE’s DC Participant Providers have physical office locations.
2. Extended Service Area - Includes counties contiguous to the Core Service Area.

Eligible Providers and Suppliers

A Direct Contracting Entity (DCE) must be a legal entity that contracts with CMS, with DC Participant Providers and (optionally) with Preferred Providers. DC Participant Providers may include, but are not limited to:

- Physicians or other practitioners in group practice arrangements
- Networks of individual practices of physicians or other practitioners
- Hospitals employing physicians or other practitioners
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Critical Access Hospitals (CAHs)

DC Participant Providers are considered the core providers and suppliers in both the Professional and Global Models. Beneficiaries are aligned to the DCE through the DC Participant Providers and these providers and suppliers are responsible for reporting quality through the DCE and beneficiary care improvement. Preferred Providers contribute to DCE goals by providing extended care beyond the DCE,

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including benefit enhancements and alternative payment arrangements with the DCE. Preferred Providers are not responsible for reporting quality through the DCE.

BENEFICIARY ALIGNMENT

Beneficiaries will be considered alignment-eligible in a given month across all options for DCE alignment if they meet the following criteria:

- Are enrolled in both Medicare Parts A and B;
- Are not enrolled in an MA plan, or other Medicare health plan;
- Have Medicare as the primary payer;
- Are a resident of the United States;
- Reside in a county included in the DCE's service area; and
- For individuals to be aligned to a High Needs Population DCE, they must be dual-eligible for Medicare and Medicaid or at risk of becoming dual-eligible, and meet at least one of the following conditions:
  - have conditions that impair their mobility; or
  - have a CMS-HCC risk score of 3.0 or greater; or
  - have a CMS-HCC risk score between 2.0 and 3.0, and two or more unplanned hospital admissions in the last 12 months; or
  - show 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.

CMS prospectively aligns beneficiaries to a DCE for each performance year, and uses beneficiary alignment to determine an organization's historical baseline expenditure for purposes of calculating the Performance Year Benchmark. Beneficiaries may be aligned to a DCE in two ways:

1. Claims-based alignment - Beneficiaries are aligned based on the amount of primary care services received from a DC Participant Provider.
2. Voluntary alignment - Beneficiaries communicate their desire to be aligned with a DC Participant Provider.

In general, voluntary alignment will take precedence over claims-based alignment, limited by the beneficiary alignment options available to the DCE type. Another proposed alignment method based on MCO enrollment was not included in the final RFA, though MCOs serving Medicaid and duals populations are still encouraged to apply.

Claims-Based Alignment and Voluntary Alignment

Claims-based alignment will occur for each performance year prospectively based on historical claims for certain primary care services furnished by the DC Participant Providers, as identified by a tax identification number (TIN) and a national provider identifier (NPI) combination. Specifically, CMS will align a beneficiary to a DCE if the beneficiary has historically received a majority of their Primary Care Qualified Evaluation and Management (PQEM) services from the DCE's DC Participant Providers.

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Beneficiaries will also be able to choose to align to a DCE voluntarily by designating a DC Participant Provider affiliated with the DCE as their primary clinician or main source of care on MyMedicare.gov or by completing a paper-based form using a template developed by CMS. Beginning in the IP, DCEs may take steps to ask beneficiaries to affirm their care relationships with DCE participating providers. Outreach activities may be conducted only within the DCE's service area, and CMS will expect aligned beneficiaries to have a "meaningful" primary care relationship with the DCE. DCEs will have two choices for the frequency of prospective alignment of beneficiaries through voluntary alignment:

1. Prospective Alignment - All alignment will be completed prior to the start of each performance year.
2. Prospective Plus Alignment - Beneficiaries will be aligned on a quarterly basis throughout the performance year.

Beneficiaries may choose to change their primary care provider and other providers at any time, and DCEs must inform beneficiaries that they have this freedom of choice. Any benefit enhancements provided through the DCE compared to Medicare FFS must be communicated to all aligned beneficiaries, and such materials must be approved by CM prior to use. Community outreach marketing efforts may include gifts of nominal value that do not violate applicable laws. Additional guidance on marketing will be provided in the Participation Agreement.

Minimum Beneficiary Alignment Threshold

In order to participate in Direct Contracting, DCEs will be required to have a minimum number of aligned beneficiaries prior to the start of each performance year, varying by DCE Organization Type, as specified in the following chart:

	Minimum Number of Aligned Beneficiaries by DCE Organization Type		
	Standard DCE	New Entrant DCE	High Needs Population DCE
PY1 (2021)	5,000	1,000	250
PY2 (2022)	5,000	2,000	500
PY3 (2023)	5,000	3,000	750
PY4 (2024)	5,000	5,000	1,200
PY5 (2025)	5,000	5,000	1,400

FINANCIAL METHODOLOGIES

Direct Contracting will offer two risk arrangements, depending on whether the DCE is participating in the Professional or the Global option:

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

Neither option will have a Minimum Saving Rate (MSR) or Minimum Loss Rate (MLR) applied to aggregate savings/losses.

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Risk Corridors

The aggregate amount of savings or losses that DCEs in Global or Professional options may experience will be constrained by a series of risk corridors. DCEs will receive a progressive portion of Shared Savings, or be liable for a portion of Shared Losses, above each risk band, with the portion of gross savings/losses decreasing with each risk band, as illustrated in the following chart.

	Professional Option		Global Option	
	Gross Savings / Losses as a Percent of Final PY Benchmark	Shared Savings / Shared Losses Cap	Gross Savings / Losses as a Percent of Final PY Benchmark	Shared Savings / Shared Losses Cap
Risk Band 1	Less than 5%	50%	Less than 25%	0%
Risk Band 2	Between 5-10%	35%	Between 25-35%	50%
Risk Band 3	Between 10-15%	15%	Between 35-50%	75%
Risk Band 4	Greater than 15%	5%	Greater than 50%	90%

So, for example, if a DCE participating in the Professional Option were to experience total costs 20% higher or lower than the risk-adjusted benchmark, it would receive or owe 26.25% of the difference from the benchmark, which is 5.25% of the total benchmark amount. If a DCE participating in the Global Option were to experience total costs 20% higher or lower than the benchmark, it would receive or be liable for the entire 20% difference from the benchmark.

Stop-Loss Arrangements

Both Global and Professional Options will feature optional stop-loss arrangements for rare, catastrophic expenses that may put financial strains on DCEs despite risk-adjustment. The stop-loss arrangement must be selected by the DCE prior to the start of each Performance Year. Once a stop-loss option is selected, CMS will develop stop-loss attachment points based on expenditure data derived from a national reference population of Medicare FFS beneficiaries and adjusted to reflect regional differences in Medicare payment rates for each DCE, using the same DCE-specific Geographic Adjustment Factors (GAFs) that will be used in calculating the Performance Year Benchmarks. Under the stop-loss arrangement, DCEs will retain liability for a portion of expenditures above each attachment point. To pay for this protection for very high cost beneficiaries, CMS will apply a per-beneficiary per-month (PBPM) stop loss “charge” to the DCE’s Performance Year Benchmark, based upon the percent of expenditures above each of the DCE’s attachment points in the baseline period.

Financial Reconciliation

Final Financial Reconciliation for costs above or below the benchmark will be conducted for all DCEs approximately six months after the PY has ended, however, prior to the start of each PY, DCEs will also have the option to select Provisional Financial Reconciliation, which will be conducted shortly after the end of the PY and allow a more timely distribution of estimated shared savings.

A table outlining the provisional and full financial reconciliations follows:

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	Provisional Financial Reconciliation	Full Financial Reconciliation
Target Date for Reconciliation	January 31st of calendar year following the Performance Year	July 31st of calendar year following the Performance Year
Claims Included in Reconciliation	Performance year expenditures incurred through June 30th	Performance year expenditures incurred through December 31st
Claims Run-out	Through December 31st of the Performance Year	Through March 31st of the calendar year following Performance Year
Risk Scores	Initial risk scores	Final risk scores

Payment Mechanisms

In Direct Contracting, Medicare Parts A and B expenditures for aligned beneficiaries will be compared to the DCE's PY benchmark to determine the DCE's savings or losses. In addition, CMS is introducing a series of Direct Contracting Payment Mechanisms, including capitation and Advanced Payment, that will allow for prospectively determined revenue streams to be paid on a monthly basis to DCEs. All DCEs are required to select a Capitation Payment Mechanism and may also select the Advanced Payment option. The two Capitation Payment Mechanisms available to DCEs are:

1. *Total Care Capitation* - A PBPM capitated payment reflecting the estimated total cost of care for the DCE's aligned population. Total Care Capitation will only be offered to DCEs participating in the Global option. Under Total Care Capitation, DC Participant Providers will be required to agree to prospective 100% claims reductions. The monthly capitation amount will equal 1/12 of the PY Benchmark, adjusted for the "Total Care Capitation Withhold," or a portion of the monthly Total Care Capitation amount to offset the expected payments that CMS will make to providers and suppliers who serve the aligned beneficiaries but are not participating in the Total Care Capitation arrangement. (Note that this withhold percentage could be a majority of the total cost of care, especially if few or no hospitals are included in the DCE.)

2. *Primary Care Capitation* - A PBPM capitated payment for primary care services provided, equal to 7% of the estimated total cost of care for the DCE's aligned population. Under Primary Care Capitation, CMS pays the DCE the capitated payment for primary care services and then the DCE is responsible for entering into payment arrangements with its DC Participant Providers and, if applicable, Preferred Providers, who provide primary care services to aligned beneficiaries. This Capitation Payment Mechanism is required for all DCE participating in the Professional option. DCEs participating in the Global option may choose between either form of capitation.

Optional Advanced Payment with Prospective Claims Reduction

DCEs that choose Primary Care Capitation will be able to contract with DC Participant Providers and Preferred Providers under a claims reduction mechanism, similar to NGACO "Population Based Payments." Under this mechanism, DCEs can enter into arrangements for non-primary care services in which CMS would reduce the remaining non-primary care claims payment amount between 1% and 100% of the value of the FFS claims payment amount. In exchange, CMS would make a monthly Advanced Payment to the DCE equal to the estimated value of the FFS claims reductions for non-primary care services.

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Standard DCE Benchmarking Methodology for Claims-Based Alignment

In general, the benchmarking methodology for Standard DCEs serves as the framework for the benchmarking methodology for the other two DCE types. In Standard DCEs, there are two separate methodologies, depending on the type of beneficiary alignment.

For benchmarking beneficiaries with claims-based alignment under both Global and Professional options, CMS will use a prospective benchmarking methodology to determine the PY Benchmark for Standard DCEs, using five steps:

1. Calculation of the historical baseline expenditures;
2. Trending the historical baseline expenditures forward;
3. Blending the historical baseline expenditures with regional expenditures using an Adjusted MA Rate Book;
4. Risk adjustment, and
5. Applying necessary adjustments for quality performance and the discount (Global only).

In both Global and Professional, a portion of the Performance Year Benchmark will be held “at risk,” dependent on the DCE’s performance on a predetermined set of quality measures and continuous improvement/sustained exceptional performance (CI/SEP). This quality incentive will be structured as a quality “withhold,” set at 5% of the benchmark value, and the DCE would then have the opportunity to “earn back” some or all of it, depending on the DCE’s performance on the quality measure set and CI/SEP. The Professional and Global options will also test the use of a High Performers Pool (HPP) to further incentivize high performance and continuous improvement on quality measures. The HPP will be funded from quality withholds not earned back by the DCEs who met the CI/SEP. HPP funds will be distributed to the highest performing DCEs through an HPP Bonus based on quality performance or improvement.

Standard DCE Benchmarking Methodology for Voluntarily Alignment

CMS will also test a new prospective benchmarking methodology to calculate a PY Benchmark for voluntarily-aligned beneficiaries. This approach will seek to:

- Test a benchmarking approach that uses fully regional rates.
- Provide an incentive for organizations to compete for and engage with beneficiaries in managing their care.
- Provide the basis for the financial methodology for New Entrant DCEs, as these organizations will not have sufficient FFS experience to establish a historical baseline.

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. CMS will incorporate the experience of voluntarily aligned beneficiaries into the historical baseline used to develop the PY benchmark after PY3. Before PY4, only the regional rates will be used to establish the historical baseline for these beneficiaries. A risk score will be calculated for each beneficiary who is voluntarily aligned to the DCE for a specific performance year.

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New Entrant DCEs and High Needs Population DCEs Benchmarking Methodology

CMS Beneficiary alignment to a New Entrant DCE will be driven primarily by voluntary alignment, and CMS expects a low volume of aligned beneficiaries for High Needs Population DCEs. Therefore, payments for both DCEs will be heavily based on regional expenditures and an adjusted MA Rate Book. In the initial three performance years, CMS will use regional expenditures to determine the PY benchmark for all beneficiaries. Regional expenditures will be determined through the use of an Adjusted MA Rate Book.

Beginning in PY4, CMS will establish a historical baseline period which uses expenditure data for CY 2021 and CY 2022. These base years will be weighted at one-thirds for CY 2021 and two-thirds for CY 2022. In PY 5, the baseline period will encompass CY 2021, CY 2022, & CY 2023, which will be weighted at 10%, 30%, and 60%, respectively. In establishing the historical spending during this baseline period, CMS will incorporate both beneficiaries who were aligned on the basis of claims, and beneficiaries who aligned voluntarily to the DCE during those base years. CMS will risk adjust the regional expenditures and recent historical expenditures (incorporated in PY4 and PY5) to establish the PY benchmark for these aligned beneficiaries.

OTHER INFORMATION

Benefit Enhancements

CMS is anticipating that a number of benefit enhancements will be available for year one, including:

- 3-Day Skilled Nursing Facility Rule Waiver - A conditional waiver of the three-day inpatient stay requirement prior to admission to a skilled nursing facility (SNF), acute-care hospital, or critical access hospital with swing-bed approval for SNF services.
- Asynchronous Telehealth - A conditional waiver of the interactive telecommunications system requirement with respect to otherwise covered dermatology and ophthalmology services furnished using asynchronous store and forward technologies.
- Post-Discharge Home Visits - A conditional waiver of the requirement for direct supervision to allow payment for certain home visits furnished to eligible, non-homebound beneficiaries by auxiliary personnel.
- Care Management Home Visits - A conditional waiver of the requirement for direct supervision to allow for payment for certain home visits that are furnished to eligible beneficiaries in advance of potential hospitalization.

Patient Engagement Incentives

CMS is allowing DCEs to provide certain patient engagement incentive to enhance beneficiary engagement and coordination of care. Incentives could include medication and transportation vouchers, wellness program memberships and classes, electronic devices, phone applications, and meal programs. The allowed incentives and services are similar to, though not as extensive as, new supplemental benefits for the chronically ill allowed under Medicare Advantage starting in 2020. DCEs will be permitted to provide in-kind items or services to aligned beneficiaries if the following conditions are satisfied:

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- There is a reasonable connection between the items or services and the medical care of the beneficiary; and
- The items or services are preventative care items and services, or advance a clinical goal for the beneficiary; and
- The in-kind item or service is not a Medicare-covered item or service for the beneficiary on the date the in-kind item or service is furnished to that beneficiary

The in-kind gifts and services must conform to federal anti-kickback law, though under the recently proposed regulations, providers in risk arrangements with substantial downside risk like Direct Contracting will have wide latitude in such donations. Additionally, CMS is permitting DCEs to provide up to $75 gift cards (annually) to eligible aligned for the purpose of incentivizing participation in a chronic disease management program.

Quality, Compliance, and Evaluation

Direct Contracting will include the assessment of DCE quality performance based on claims-based quality measures, as well as information from administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Accountable Care Organizations surveys. DCEs will be required to report quality measures beginning in PY1, but may also opt to implement a Patient Activation Measure (PAM) survey CMS may conduct data validation audits of DCE quality data, including ad hoc or scheduled desk reviews, focused audits, or full audits. Participants will be required to monitor their compliance with the terms of the DC model and to comply with rigorous safeguards that will be specified in the participation agreement, and to develop a compliance plan prior to the start of model participation.

As part of testing the DC model, CMS will implement a monitoring plan, and use a range of methods to assess compliance by DCEs and DC Participant Providers and Preferred Providers. CMS will conduct comprehensive annual audits related to compliance with the Participation Agreement and identifying potential program integrity risks, with more limited targeted or ad-hoc audits as necessary. Noncompliance with the terms of the Participation Agreement will trigger appropriate actions based on the type of issue, degree of severity, and the DCE's compliance record while in the model. All DCEs will be required to cooperate with efforts to conduct an independent, federally funded evaluation of the model by CMS, which may include: participation in surveys; interviews; site visits; and other activities that CMS determines necessary to conduct a comprehensive formative and summative evaluation.