NORC at the University of Chicago

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Global and Professional Direct Contracting Model Evaluation

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Table of Contents

List of Exhibits

List of Acronyms

ACO	Accountable care organization
ACSC	Ambulatory care-sensitive condition
ADI	Area Deprivation Index
ADT	Admission, discharge, transfer
APO	Advanced Payment Option
CFIR	Consolidated Framework for Implementation Research
CMMI	Center for Medicare & Medicaid Innovation; Innovation Center
CMS	Centers for Medicare & Medicaid Services
CPC	Comprehensive Primary Care
DID	Difference-in-differences
E&M	Evaluation and management
ED	Emergency department
EHR	Electronic health record
FFS	Fee-for-service
GPDC	Global and Professional Direct Contracting
HCC	Hierarchical Condition Category
HIE	Health information exchange
IDS	Integrated delivery system
IRF	Inpatient rehabilitation facility
IT	Information technology
MSO	Management service organization
LTCH	Long-term care hospital
LTSS	Long-term services and supports
NGACO	Next Generation Accountable Care Organization
PAC	Post-acute care
PACE	Program of All-Inclusive Care for the Elderly
PCC	Primary Care Capitation
PCP	Primary care provider
PBPY	Per beneficiary per year
PY	Performance year
REACH	Realizing Equity, Access, and Community Health
SDOH	Social determinants of health
TCC	Total Care Capitation

Executive Summary

KEY TAKEAWAYS	
	**No impacts on gross or net Medicare expenditures.** In Performance Year (PY) 2021, the Global and Professional Direct Contracting (GPDC) Model did not significantly change total Medicare spending, in either gross terms or net of model incentive payments. New Entrant Direct Contracting Entities (DCEs) saw larger trends in spending reductions than did Standard DCEs, which may reflect more room for improvement among less-experienced DCEs.
	**Standard DCEs reduced acute care hospital spending and utilization. Both Standard and New Entrant DCEs reduced emergency department visits.** Standard DCEs also reduced spending in outpatient facilities (including EDs) and skilled nursing facilities (SNF) spending (with non-significant reductions in SNF utilization).
	**Standard DCEs reduced hospitalizations for ambulatory care sensitive conditions,** but without notable impacts on other quality measures.
	DCE leaders reported being **highly motivated to join the GPDC Model by financial factors** and focusing on initiatives to reduce avoidable utilization, manage care for complex populations, and strengthen primary care.
	**Most DCEs provided centralized population health support staff** to providers and offered multiple financial and non-financial incentives to engage them.

GPDC Model Overview

The Global and Professional Direct Contracting (GPDC) model is an advanced alternative payment model (AAPM) designed to shift Medicare risk-sharing arrangements away from fee-for-service (FFS), empower beneficiaries to engage in their own health care, and reduce providers' administrative burden.[1,2] GPDC builds upon CMS' previous Accountable Care Organization (ACO) initiatives by offering model participants, known as Direct Contracting Entities (DCEs), greater flexibility and options to take on financial risk. GPDC provided capitated payments to DCEs, which were designed to give participating health care providers more flexibility and control over cash flows in exchange for taking on greater financial risk, and several model benefit enhancements. The Center for Medicare & Medicaid Innovation (the 'Innovation Center') launched the GPDC model in April 2021. GPDC operated for two years, prior to CMS redesigning and renaming the model as the ACO Realizing Equity, Access, and Community Health (REACH) Model, effective January 2023.[3] See **Exhibit ES.1** for an overview of the GPDC Model.

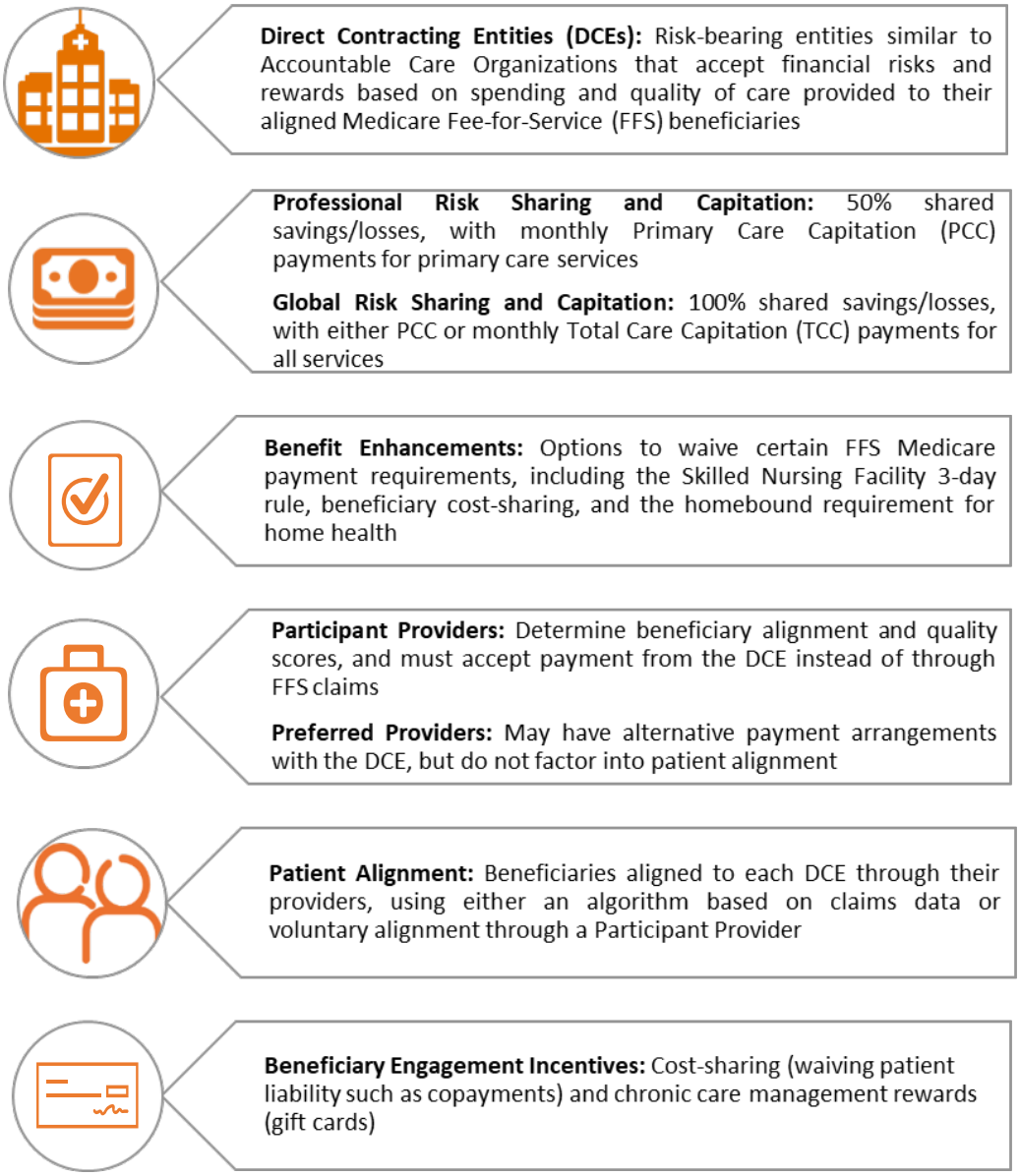
This evaluation report covers the GPDC model's first performance year (PY) with 53 DCEs serving 357,606 Medicare fee-for-service (FFS) beneficiaries participating in PY 2021. Future evaluation reports will include additional participants that joined the model in PY 2022 and PY 2023.

GPDC created three types of DCEs to facilitate various paths for participation:[a]

- **Standard DCEs** have substantial experience with Medicare value-based payment models;
- **New Entrants DCEs** have less experience serving Medicare fee-for-service (FFS) beneficiaries; and
- **High Needs DCEs** have experience serving beneficiaries with complex health needs.

[a] As of the transition to ACO REACH in January 2023, these entities are called "REACH ACOs."

Exhibit ES.1. Overview of the Global and Professional Direct Contracting Model



GPDC Model Evaluation

In September 2021, the Innovation Center selected NORC at the University of Chicago to conduct the independent evaluation of the GPDC Model, which will continue through the ACO REACH Model. This first annual report to emerge from NORC's evaluation describes the DCEs participating in the GPDC Model in PY 2021, including their approaches to implementation and, for Standard and New Entrant DCEs, impacts on Medicare spending, utilization, and quality of care.

We use an evaluation framework that considers how the implementation approach and measured impacts of the model intervention are shaped by the DCEs' external environments and organizational characteristics, as well as the model's features themselves. We focus on multiple domains, including the market and policy environments in which DCEs operate; DCEs' structure, including organization, provider, and beneficiary characteristics; and implementation factors, including DCEs' election of model features and strategies for managing population health. See **Section 1.2** in the full report for more details on the evaluation's conceptual framework.

This evaluation leverages quantitative, qualitative, and survey data and analysis using a mixed-methods approach that integrates and rigorously synthesizes multiple, complementary data sources to address the research questions at hand. Analyses of Medicare claims data will estimate the model's impact on utilization, spending, and quality of care. To provide additional context for these impact estimates, we examine participating DCEs' organizational characteristics and implementation approaches through descriptive analyses of DCE-submitted documentation and data from an annual Pulse Check survey. In subsequent years, we will conduct qualitative interviews with DCEs and their beneficiaries and integrate the findings with quantitative and survey data to tell the story of whether, how, and for whom the GPDC Model achieved its intended outcomes.

PY 2021 DCE Characteristics and Model Implementation Approaches

The resources, capacity, and experiences that DCEs bring to GPDC shape their strategic decisions around model implementation and their approaches to managing population health, transforming care delivery, and engaging providers and aligned beneficiaries. These factors also influence DCE's decisions about which financial risk and payment mechanism options to elect. Understanding DCEs' structural characteristics and implementation strategies and priorities provides critical insight into the outcomes observed in GPDC and the successes and challenges associated with participation in the model.

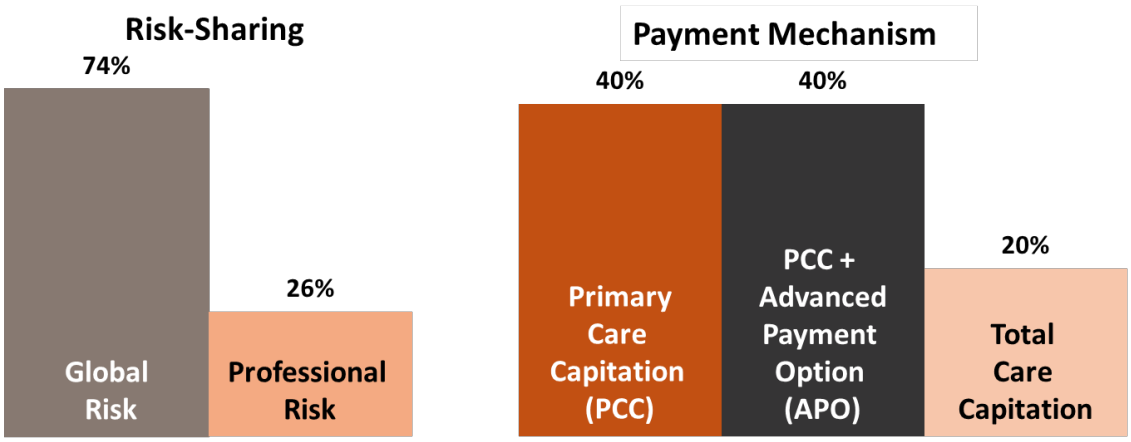
Regardless of type, most DCEs:

- Were affiliated with physician practices
- Had prior ACO experience
- Were highly motivated to join by financial factors

DCE Types and Model Features Selected

Of the 53 2021 DCEs, 29 were Standard DCEs, 18 were New Entrant DCEs, and 6 were High Needs DCEs. By the end of 2021, three DCEs voluntarily exited the model at the end of PY 2021: two New Entrants and one High Needs. Most DCEs chose Global risk-sharing and selected Primary Care Capitation (PCC) as their payment mechanism (**Exhibit ES.2**).

Exhibit ES.2. Most DCEs Elected Global Risk Sharing and Primary Care Capitation in PY 2021.



Provider Characteristics

The size of DCEs' provider networks and providers' characteristics varied by DCE type. Participant Providers accounted for a larger proportion (78%) of DCEs' total provider networks than did Preferred Providers (22%). Provider employment status also varied by DCE type, which is important insofar as it likely affects their response to incentives. For example, DCEs feel that their non-employed Participant Providers are more influenced by performance incentives than are their employed providers. DCEs that elected Global risk were more likely to employ all of their Participant Providers (56%, as compared to 21% among those opting for Professional risk).

Median Number of Participant Providers (Practitioners and Facilities)

- Standard: 112
- New Entrant: 66
- High Needs: 44

Beneficiary Characteristics

In PY 2021, across all three DCE types, the model served a total of 357,606 aligned Medicare FFS beneficiaries s, approximately 84% of whom were aligned to Standard DCEs. Most beneficiaries in Standard DCEs resided in the Northeast region of the United States, whereas most beneficiaries in New Entrant DCEs resided in the Midwest and South, and most in High Needs DCEs were located in the South and West.

Median Number of Aligned Beneficiaries, by DCE Type

- Standard: 7,184
- New Entrant: 2,128
- High Needs: 295

The majority of beneficiaries across the model were claims-aligned based on their pre-existing care relationships with Participant Providers. Beneficiaries who voluntarily aligned by attesting to a care relationship with a Participant Provider comprised over 30% of New Entrant DCEs' beneficiaries, versus only 2% and 7% of those

served by Standard and High Needs DCEs, respectively **(Exhibit ES.3)**. Relative to Standard and New Entrant DCEs, High Needs DCEs served a larger percentage of aligned beneficiaries from racial and ethnic minority groups; beneficiaries who were dually eligible for Medicare and Medicaid; and beneficiaries residing in areas of greater socioeconomic disadvantage, as measured by the Area Deprivation Index (ADI).[b]

Exhibit ES.3. Key Characteristics of Beneficiaries Aligned to GPDC Varied by DCE Type.

Standard DCEs	New Entrant DCEs	High Needs DCEs
• 299,392 total aligned beneficiaries • 2.4% voluntarily aligned • 18.3% in racial/ethnic minority groups • 12.4% dually eligible • Most reside in the Northeast • 13.8% in areas with high ADI	• 56,054 total aligned beneficiaries • 30.4% voluntarily aligned • 26.0% in racial/ethnic minority groups • 16.8% dually eligible • Most reside in the Midwest or South • 12.6% in areas with high ADI	• 2,160 total aligned beneficiaries • 7.0% voluntarily aligned • 39.5% in racial/ethnic minority groups • 68.1% dually eligible • Most reside in the South or West • 29.3% in areas with high ADI

NOTES: ADI = Area Deprivation Index

Population Health Management Approaches

Most 2021 DCEs identified as high priorities population health initiatives focusing on avoidable utilization, complex or population-specific care management, and primary care. To address them, DCEs leveraged various data analytic tools to support care management and risk stratification, while offering financial and material support to providers to foster expanded access to care.

Most Common Priorities

- Reducing avoidable utilization (90%)
- Applying complex or population-specific care management (90%)
- Improving primary care (90%)

Most Frequent Approaches

- Centralized population health management staff (86%)
- Extended or weekend hours (53%)
- Telehealth capacity (53%)

DCEs provided multiple forms of support to their Participant Providers, including centralized population health support staff such as care managers, pharmacists, and schedulers and administrative support. Most DCEs also offered multiple financial and non-financial incentives, citing financial bonuses tied to performance as a "very important" strategy for engaging providers. DCEs also perceived that their contracted Participant Providers were more likely to be influenced by performance incentives, with more DCEs (19 out of 29) noting that the behavior

[b] The ADI is an index that measures socioeconomic disadvantage at the Census Block Group level, based on American Community Survey data on income, education, employment, and housing quality. ADI: Kind AJH, Buckingham W. Making Neighborhood Disadvantage Metrics Accessible: The Neighborhood Atlas. New England Journal of Medicine, 2018. 378: 2456-2458. DOI: 10.1056/NEJMp1802313. PMCID: PMC6051533

of their contracted Participant Providers was influenced "to a great extent" as compared to employed Participant Providers (15 out of 38).

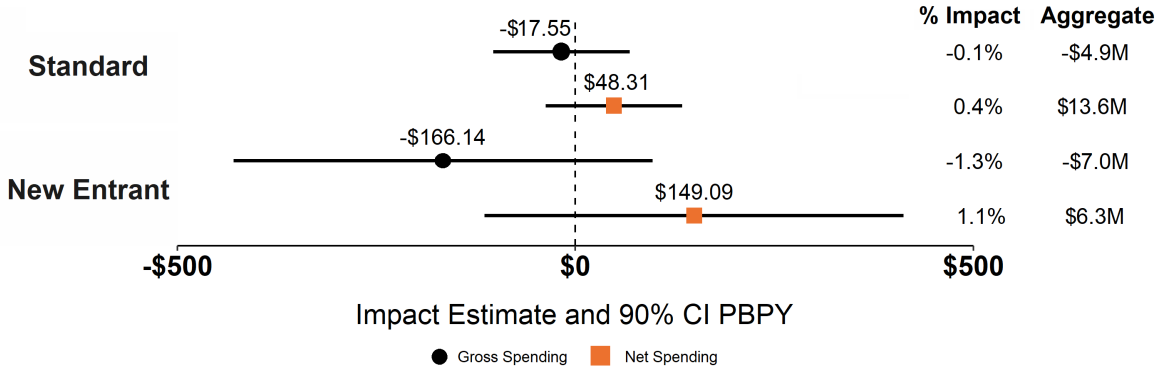
PY 2021 DCE Impact Estimates

To estimate the impact of the GPDC Model on spending, utilization, and quality of care for Standard and New Entrant DCEs,[c] we used a difference-in-differences (DID) design with a comparison group of similar beneficiaries within each DCE's market to assess how the GPDC Model affected outcomes for beneficiaries relative to what would be expected in the absence of the model.

Total Medicare Spending

Neither Standard nor New Entrant DCEs significantly changed gross or net Medicare spending in PY 2021 relative to the comparison group **(Exhibit ES.4)**. This lack of impact may reflect the time needed to develop care delivery resources and strategies, particularly for entities without prior ACO experience. DCEs with past ACO experience, which represented more than half of PY 2021 participants, may have been limited by prior efforts in their ability to gain additional efficiencies relative to what they had previously achieved. While not statistically significant, New Entrant DCEs did have larger spending reductions than did Standard DCEs. This finding may also reflect greater opportunities to reduce spending for organizations without prior ACO experience. It could also reflect the fact that most New Entrant DCEs operated in higher-cost markets, relative to Standard DCEs, affording them more opportunities to produce savings.

Exhibit ES.4. PY 2021 Gross and Net Spending Impacts Were Not Significant for Standard nor New Entrant DCEs.



NOTES: CI = Confidence Interval; M = Million; PBPY = per beneficiary per year.

[c] It was not feasible to generate impact estimates for High Needs DCEs for this report due to small sample size.

Setting-Specific Medicare Spending and Utilization

The model saw significant reductions in spending and utilization within selected settings, with some variations by DCE type **(Exhibit ES.5)**. It is important to note that there are substantial differences between how we calculated total spending and setting-specific spending measures. The total spending measure represents what Medicare actually paid, including beneficiary-level capitated payments under the GPDC Model. The setting-specific spending measures represent what Medicare would have paid DCEs absent capitation, across a variety of care settings.

Standard DCEs:

- In line with the model's goals, significantly reduced spending and utilization in acute care hospitals and outpatient facilities (including emergency department (ED) visits and observation stays), while also significantly reducing skilled nursing facility (SNF) spending (with non-significant reductions in SNF utilization);
- Significantly reduced utilization and spending in the home health setting, impacts that could have stemmed from prior partnerships with home health agencies aiming to mitigate waste; and
- Significantly increased spending for professional services, which was in line with the model's goal of enhancing primary care.

New Entrant DCEs:

- In keeping with the model's goals, significantly reduced ED visits and observation stays; and
- Significantly increased home health spending without significantly reducing spending or utilization in other categories.

Exhibit ES.5. Standard DCEs Reduced Acute Care Spending and Utilization and Both DCE Types Reduced ED Visits in PY 2021.

	Standard DCEs		New Entrant DCEs	
	Spending	**Utilization**	**Spending**	**Utilization**
Acute care setting	⬇	⬇	⇩	⇩
Skilled nursing facility	⬇	⇩	⇩	⇩
Outpatient facility (including emergency department visits and observation stays)	⇩	⬇	⇩	⬇
Inpatient rehabilitation facility and long-term care hospital	⇩	⇩	⇧	⇧
Primary care	⬆	N/A*	Unclear^	N/A*
Home health	⬇	⬇	⬆	⇧
Hospice	⇧	⇧	⇩	⇩

NOTES: N/A=not applicable. Outpatient facility utilization includes emergency department visits and observation stays. Orange arrows indicate significant findings at p<0.10; white arrows indicate non-significant findings, or could not be confirmed in sensitivity analyses. *A measure of primary care visits is being developed for inclusion in future reports . ^Impact on primary care spending for New Entrants was unclear because impacts diverged in direction in sensitivity analyses.

Quality of Care

In PY 2021, Standard DCEs saw a significant reduction in hospitalizations for ambulatory care sensitive conditions (ACSCs), which may be related to DCEs' efforts to improve care coordination and chronic disease management **(Exhibit ES.6)**. New Entrant DCEs did see a significant reduction in mortality, which was an unexpected finding and complicated in that mortality rates declined for both beneficiaries served by providers in the model and those in the comparison group. However, those in the model saw larger declines, perhaps reflecting a difference between the two groups in the extent to which they saw a return to pre-pandemic mortality rates after the first year of the COVID-19 pandemic, a trend that may or may not persist in future years. One quality outcome assessed in PY 2021, all-condition readmissions, was among the measures tied to financial incentives in the model.[d] Contrary to what we expected, we found no improvement in either measure for Standard or New Entrant DCEs.

Exhibit ES.6. Standard DCEs Reduced ACSCs and New Entrant DCEs Reduced Mortality in PY 2021.

	Standard DCEs	New Entrant DCEs
All-condition readmissions	⇩	⇧
Mortality	⇩	⬇
Hospitalizations for ambulatory care sensitive conditions	⬇	⇧
Timely follow-up after acute exacerbation of chronic conditions	⇧	⇧

NOTES: Solid orange arrows indicate a significant finding at p<0.10; white arrows indicate a non-significant finding.

Conclusion

The GPDC Model did not achieve statistically significant impacts on gross or net spending in its first performance year, which may reflect the time needed for Standard DCEs to adjust to a new payment model and for New Entrants to fully implement and refine such a dramatic transformation in care delivery. Spending and utilization in acute and post-acute care (PAC) settings declined for Standard DCEs, reflecting their efforts and approaches to reduce avoidable inpatient, ED, and PAC utilization. Standard DCEs may also be leveraging their prior experience in similar risk-sharing models to identify and manage beneficiaries at risk of avoidable utilization and to improve transitions in care. However, it may be challenging for Standard DCEs to continue to lower spending and utilization or improve quality, after having already done so in previous care transformation initiatives. The larger, albeit nonsignificant, gross spending reductions for New Entrant DCEs may reflect greater opportunities to lower spending given their lack of prior ACO experience and their location in high-cost markets. Future reports will include subgroup analyses by relevant factors that could be driving impacts and explore differences in care transformation approaches. Reports will also incorporate findings for additional participants that joined the GPDC model in PY 2022 and, in PY 2023, lessons learned throughout the transition to ACO REACH.

[d] For this measure, the model used pay-for-reporting in PY 2021 but required no action on the part of DCEs.

Chapter 1: Overview of Global and Professional Direct Contracting Model and Evaluation

The Centers for Medicare & Medicaid Services (CMS) Center for Medicare & Medicaid Innovation (Innovation Center) launched the Global and Professional Direct Contracting (GPDC) Model in April 2021. The GPDC Model is an advanced alternative payment model designed to shift Medicare risk-sharing arrangements away from fee-for-service (FFS), empower beneficiaries to engage in their health care, and reduce providers' administrative burden.[4] GPDC builds upon CMS' previous Accountable Care Organization (ACO) initiatives by offering model participants, known as Direct Contracting Entities (DCEs), greater flexibility and options to take on financial risk. GPDC provided capitated payments to DCEs, which were designed to give participating health care providers more flexibility and control over cash flows in exchange for taking on greater financial risk, and several model benefit enhancements.[5] GPDC operated for two years, prior to CMS redesigning and renaming the model as the ACO Realizing Equity, Access, and Community Health (REACH) Model, effective January 2023.

In September 2021, the Innovation Center selected NORC at the University of Chicago to conduct an independent evaluation of the GPDC Model, which will be known in future years as the ACO REACH Model. This is the first annual report on findings from NORC's evaluation. It describes the DCEs participating in the GPDC Model in the first PY, including their implementation approaches and outcomes. This report focuses on three main research questions regarding the GPDC Model's performance during PY 2021:

1. How did model participants, referred to as DCEs, launch the model and how did implementation approaches differ based on DCE characteristics?
2. Did the GPDC Model result in lower health care utilization and spending for its aligned beneficiaries relative to a comparison group?
3. Did the GPDC Model result in differences in the quality of care received by beneficiaries aligned to the model relative to a comparison group?

The data and analyses in this report aim to provide an important foundation for future examination of additional research questions focused on the GPDC and ACO REACH Model. The report is structured as follows:

- **Chapter 1** provides a brief overview of the GPDC Model and NORC's evaluation approach.
- **Chapter 2** presents our findings on DCEs' organizational characteristics and their approaches to launching the model.
- **Chapter 3** summarizes our findings on the GPDC Model's impact on spending, utilization, and quality.
- **Chapter 4** discusses our key findings in greater depth and points to areas for further research as the evaluation unfolds.

1.1 Overview of GPDC Model

In recent years, a leading strategy for moving the Medicare program toward higher-value care has been encouraging providers to organize into legal entities that voluntarily accept fiscal and quality accountability for the health of the beneficiaries under their care. They aim to encourage providers to both improve care coordination and reduce avoidable costs. The Medicare Shared Savings Program (Shared Savings Program) and models including the Advance Payment, ACO Investment, Pioneer ACO, and Next Generation ACO (NGACO) Models have tested novel features that increase model participants' exposure to financial risk while maintaining accountability for performance on a set of quality measures. Payment mechanisms have included advance payments, infrastructure payments, population-based payments (PBPs), and all-inclusive PBPs, with risk in the form of shared savings alone (upside risk only) or shared savings and losses (upside and downside risk). As financial risk levels have increased, so too have the financial amounts at risk as a percentage of each ACO's performance benchmark.

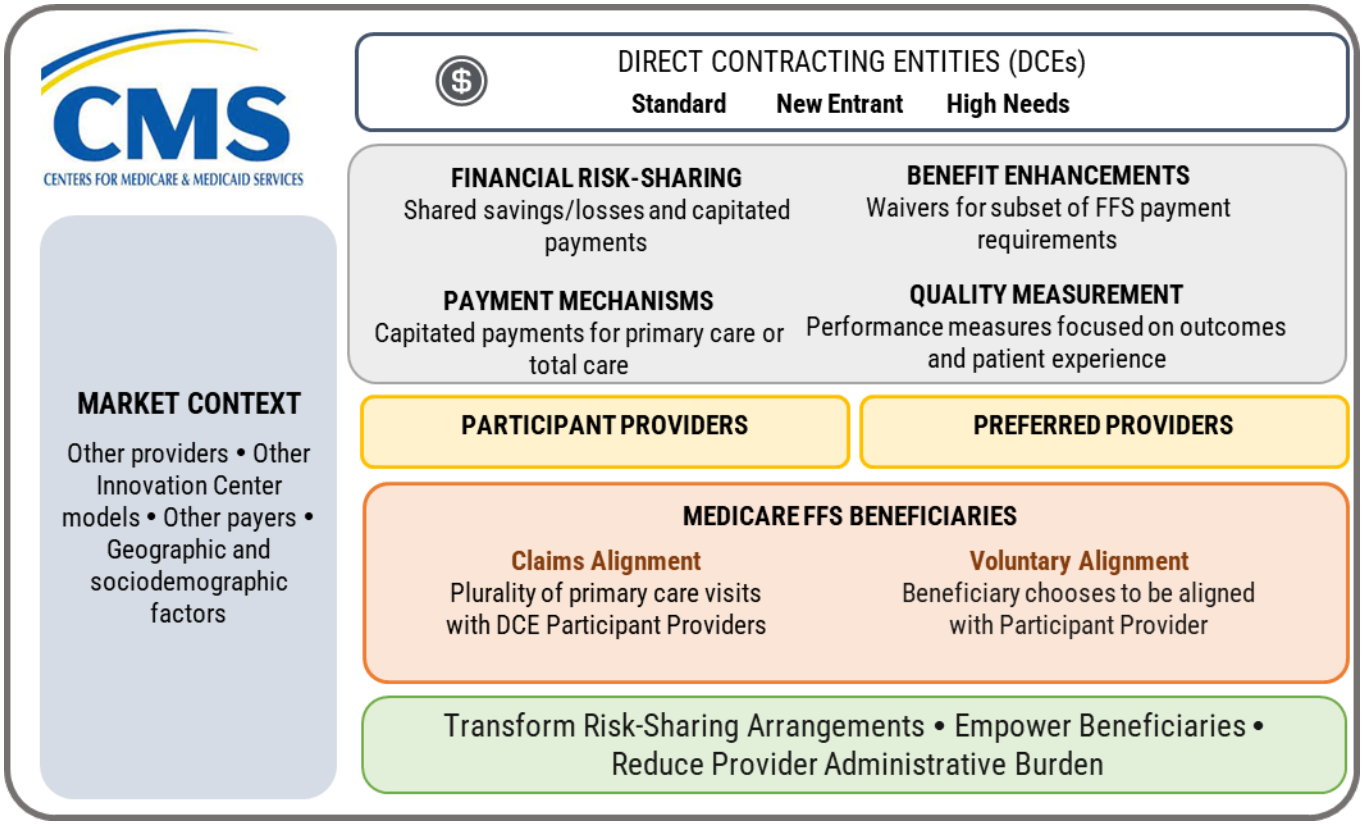
GPDC to ACO REACH

GPDC operated for two years, with participants that started in PY 2021 (n=53) and PY 2022 (n=49). In response to stakeholder feedback and the Biden-Harris Administration's priority of improving health equity, CMS redesigned and renamed GPDC as the ACO REACH Model, effective January 2023. Several new ACOs joined the model in PY 2023 (n=48), along with many former GPDC participants (n=83).[e] ACO REACH differs from GPDC in its stronger emphasis on addressing health equity, promoting provider leadership, and enhancing monitoring and transparency to protect beneficiaries.

GPDC takes accountable care one step further than recent models. Under GPDC, fixed, monthly prospective capitated payments provide DCEs with greater flexibility and control over their cash flows in exchange for taking on greater financial risk. Flexible cash flows are expected to empower DCEs to invest in needed infrastructure and care delivery improvements as they deem appropriate. DCEs are also positioned to set up their own value-based payment arrangements with downstream providers and suppliers. In addition, they may use several benefit enhancements, which waive some requirements for certain kinds of care in the FFS Medicare program, in keeping with the notion that greater flexibility can help transform care delivery **(Exhibit 1.1)**.

[e]Participants were originally referred to as "DCEs." As of the launch of ACO REACH in 2023, they are now referred to as "ACOs." To ensure accurate representation of model design features and the organizations participating in the model throughout the time covered by this report (PY 2021), all participants are referred to herein as "DCEs" and the model is referred to as "GPDC."

Exhibit 1.1. GPDC Model Components are Designed to Reduce Cost and Improve Quality.

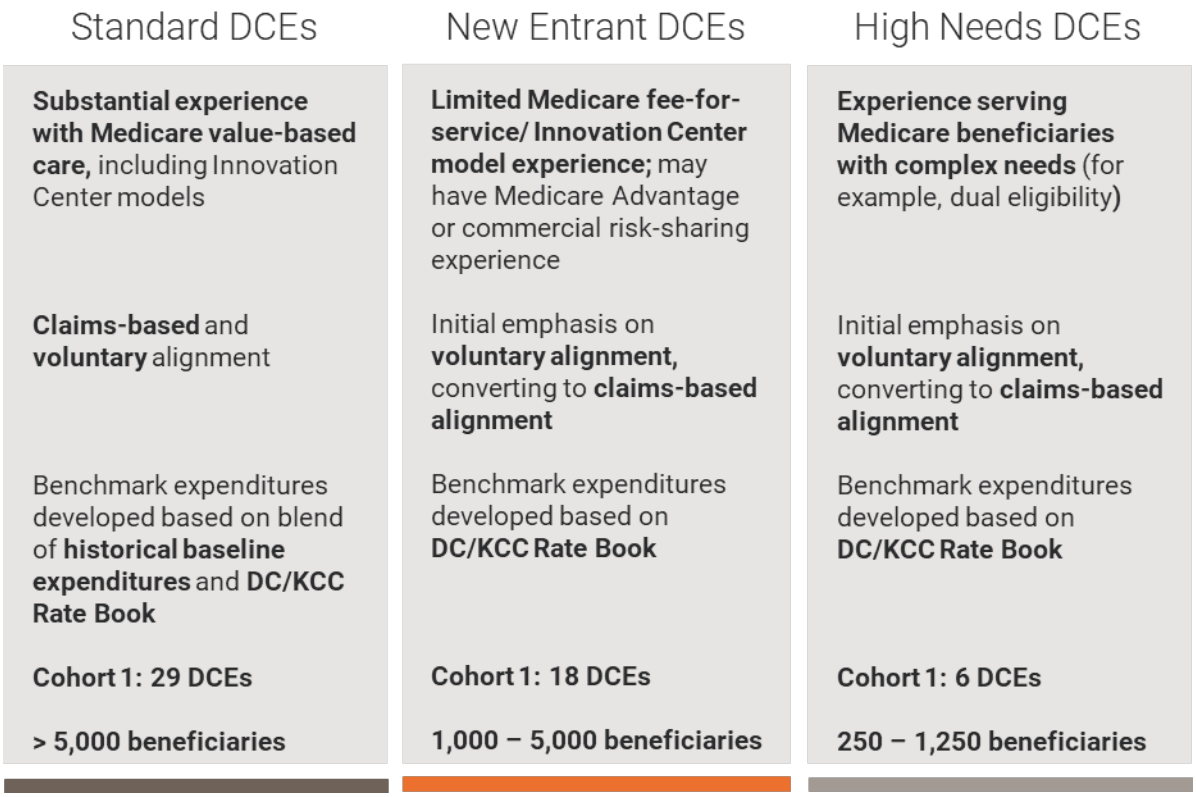


NOTES: FFS = Fee-for-Service.

Direct Contracting Entities

DCEs are health care providers and suppliers that enter arrangements with CMS to accept financial risks and rewards calculated as a function of Medicare spending and the quality of care provided to the Medicare FFS beneficiaries aligned to the DCE. Organizations that form DCEs are diverse; CMS identifies the organizations as one of three types based on their prior experience delivering services to Medicare FFS beneficiaries and the beneficiaries they serve. These include Standard, New Entrant, and High Needs DCEs, as described in **Exhibit 1.2**. Benchmarking, beneficiary alignment methodologies, and minimum requirements for beneficiary alignment vary across the three types to make participation in GPDC attractive to a wide range of providers.

Exhibit 1.2. DCE Experience and GPDC Model Features Vary by DCE Type.



NOTES: DCE = Direct Contracting Entity. DC/KCC Rate Book = Direct Contracting and Kidney Care Choices Rate Book. The DC/KCC Rate Book establishes regional health care expenditures for the calculation of DCEs' financial benchmarks. For Standard DCEs the minimum number of aligned beneficiaries prior to the start of each PY is 5,000. The minimum number of aligned beneficiaries prior to the start of each PY will increase incrementally for New Entrant DCEs from 1,000 in PY 2021 to 5,000 in PY 2026 and the minimum for High Needs DCEs will increase incrementally from 250 in PY 2021 to 1,250 in PY 2026.

Financial Risk-Sharing

Each DCE may choose one of two risk options:

1) **Professional:** This is the lower-risk option with 50% shared savings/losses under which DCEs receive **Primary Care Capitation (PCC)** payments (monthly capitation payments for primary care services delivered to aligned beneficiaries).
2) **Global:** This is the full-risk option with 100% shared savings/losses, with DCEs choosing either PCC or monthly **Total Care Capitation** (TCC), which consists of monthly capitation payments for all services delivered to aligned beneficiaries.

Benefit Enhancements and Beneficiary Engagement Incentives

To allow flexibility in care coordination and support the delivery of high-value services, the GPDC Model offers DCEs the opportunity to waive certain FFS Medicare payment requirements and to offer beneficiaries incentives

for engaging in their care. For example, DCEs may use the expanded telehealth waiver to allow their beneficiaries increased access to telehealth services. **Exhibit 1.3** lists all of the benefit enhancements available to DCEs.

Exhibit 1.3. The GPDC Model Offers Benefit Enhancements Allowing DCEs Greater Flexibility to Deliver Care.[6]

Benefit Enhancement	Description
3-Day Skilled Nursing Facility (SNF) Rule Waiver	Allows admission to a SNF or an acute care hospital or critical access hospital with swing-bed approval (swing-bed hospital) for SNF services without prior three-day inpatient stay prior to admission.
Telehealth	Allows payment for asynchronous telehealth services (that is, transmitting recorded health history through a secure electronic communications system) provided by dermatologists and ophthalmologists. Also allows payment for telehealth services from non-rural originating sites including the beneficiary's home.
Post-Discharge Home Visits	Allows payment for certain home visits furnished to eligible, non-homebound beneficiaries by auxiliary personnel (as defined in 42 CFR § 410.26(a)(1)) under general supervision, rather than direct supervision, incident to the professional services of physicians or other practitioners that are DC Participant Providers or Preferred Providers.
Care Management Home Visits	Allows payment for certain home visits that are furnished to eligible beneficiaries proactively and in advance of potential hospitalization, without direct supervision.
Home Health Homebound Waiver	Allows payment for home health care services for certain beneficiaries who are not homebound.
Concurrent Care for Beneficiaries Who Elect the Medicare Hospice Benefit	Allows beneficiaries who elect the Medicare Hospice Benefit to also receive concurrent curative care (sometimes referred to as "conventional care").

The GPDC Model offers the following beneficiary engagement incentives:

- **In-Kind Items and Services:** DCEs may provide beneficiaries with in-kind items and services that advance a clinical goal for the beneficiary (e.g., blood pressure monitors for beneficiaries with hypertension).
- **Cost-Sharing Support for Part B Services:** DCEs may enter into agreements with Participant and Preferred Providers stipulating that they will not collect cost-sharing from beneficiaries for Part B services. As part of these agreements, DCEs pay for some or all of the associated beneficiary cost-sharing amounts.
- **Chronic Disease Management Reward Program:** DCEs may provide beneficiaries with gift cards valued at up to an annual limit of $75 for the purpose of incentivizing participation in a chronic disease management program.

Participant and Preferred Providers

The GPDC Model defines two primary categories of participation for Medicare providers and suppliers: Participant Providers and Preferred Providers.

- **Participant Providers** are the DCEs' core providers and suppliers. Beneficiaries are aligned to GPDC through Participant Providers, who are paid directly by the DCEs and are responsible for reporting quality through the DCEs**.**
- **Preferred Providers** contribute to the fulfillment of DCEs' goals by extending and facilitating valuable care relationships beyond the DCE. Preferred Providers may participate in benefit enhancements as well as alternative payment arrangements with the DCE, but do not factor into beneficiary alignment.[7] Preferred Providers may elect to receive DCE payments and reduced FFS claim payments but are not required to do so, similar to the payment mechanisms for the Next Generation ACO (NGACO) Model. **Appendix A** provides more information about the differences between Participant and Preferred Providers under the model.

1.2 Conceptual Framework for the Evaluation

We use an evaluation framework **(Exhibit 1.4)** that draws from implementation science to consider how the implementation approach and measured impacts of an innovation are shaped by an organization's external environments and organizational characteristics, as well as the features of the innovation itself.[8,9] Our evaluation is informed by a thorough understanding of DCEs, where and how they operate, and variations among them. Selected evaluation domains include the context of the market and policy environments in which DCEs operate; DCE structure, including organization, provider, and beneficiary characteristics; and implementation factors, including DCEs' election of model features and strategies for managing population health.[10] We describe each evaluation domain below.[11]

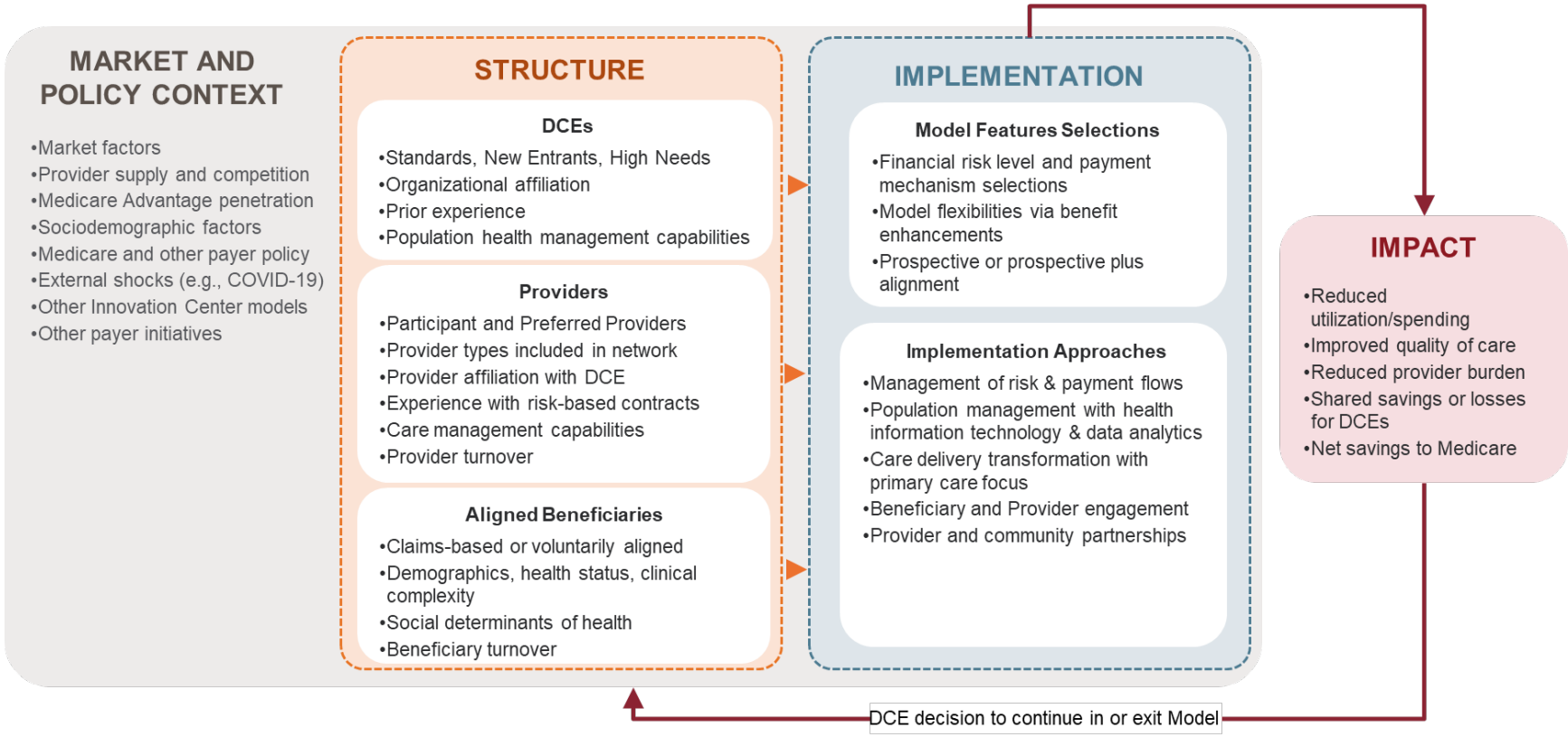
Context: The **market and policy environment,** including existing Medicare payment policies and the impacts of the COVID-19 public health emergency, may affect DCEs' election of risk levels as well as the baseline spending used for benchmarks of shared savings and losses.

Structure: Variations in **organizational characteristics,** such as organization type and experience, may influence individual DCE adaptability and response to GPDC Model features. In addition, **provider characteristics,** including providers' relationships with DCEs and experience with Medicare FFS and value-based care, may affect how they respond to risk-based arrangements. Finally, **aligned beneficiary characteristics** and beneficiaries' care-seeking behaviors may influence health care utilization and spending.

Implementation: DCEs' responses to **model features**, such as selection of risk, capitation levels, and benefit enhancements, likely shape provider and beneficiary behavior as well as DCEs' savings or losses. Similarly, DCEs' **approaches to care transformation** may influence their performance within the model and inform our understanding of which interventions are associated with quality and spending impacts.

Impact: The contextual, structural, and implementation factors described above likely shape **model outcomes** both directly and indirectly. A DCE's decision to continue in the model may in turn depend on the realization of shared savings.

Exhibit 1.4. The GPDC Model Evaluation Conceptual Framework Accounts for Market, Structure, and Implementation Factors Affecting Impact.

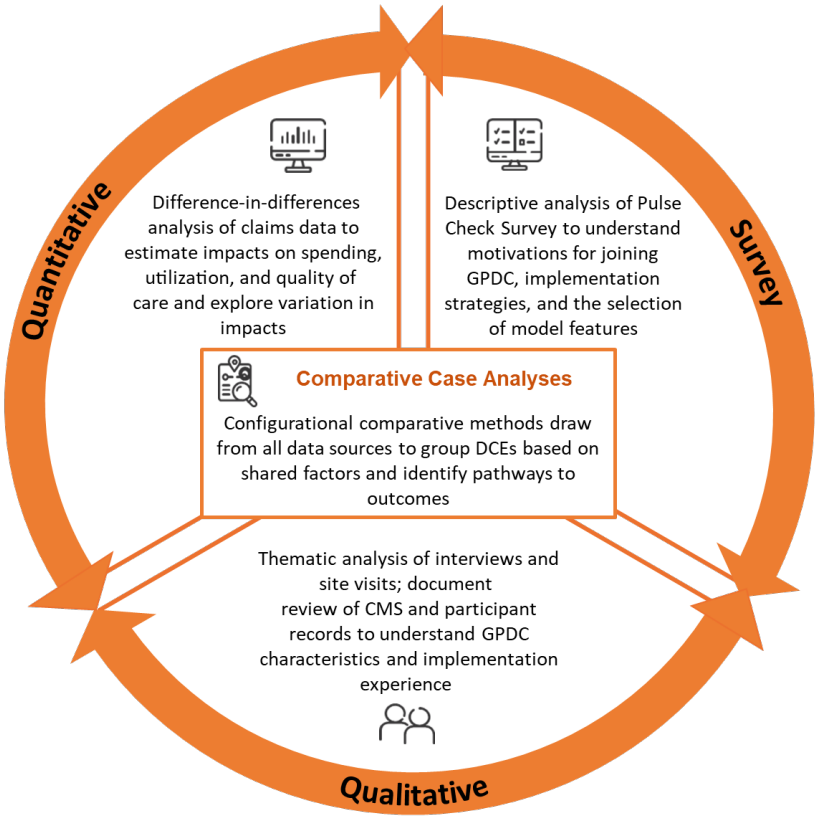


NOTES: DCE = Direct Contracting Entity.

1.3 Overview of Evaluation

Our evaluation design reflects a concurrent, embedded, mixed methods strategy that integrates qualitative and quantitative, primary and secondary data to address the research questions.[12] In future years, we will conduct qualitative multi-case analyses to relate key implementation features to spending, quality, and utilization impacts **(Exhibit 1.5)**.[13] **Appendix B** lists our research questions, hypotheses, and associated data sources—and the analytic methods we are using to address them.

Exhibit 1.5. The GPDC Evaluation Relies on a Mixed Methods Approach to Data Collection and Analysis.



NOTES: GPDC = Global and Professional Direct Contracting. DCE = Direct Contracting Entity. CMS = Centers for Medicare & Medicaid Services.

1.4 Performance Year 2021 Evaluation Methodology

For the first PY, we focused on laying a foundation for the evaluation by describing the structure and characteristics of the DCEs, why they joined the model, and what they are doing in response to the model's features, while capturing an early snapshot of their impact to date. To provide an overview of the participating

organizations and additional context for our impact estimates, we summarized the organizational characteristics and implementation approaches of participating DCEs through descriptive analyses of DCE-submitted documentation and data from the Pulse Check Survey administered to participating DCEs. We analyzed claims data to estimate the model's impact on utilization, spending, and quality of care.

Descriptive Analysis of DCE Structure and Implementation

Our descriptive analyses for the evaluation addressed research questions focused on DCEs' approaches and responses to model features. These analyses then provide context for quantitative findings on utilization, spending, and quality. For this first annual report, we present a systematic analysis of DCE-submitted GPDC Model applications and findings from the Pulse Check Survey administered to DCEs **(Appendices C and D)**.

Quantitative Analysis of Beneficiary Characteristics and Model Impacts

We conducted descriptive analyses of the characteristics of beneficiaries aligned to Standard, New Entrant, and High Needs DCEs during PY 2021, including sociodemographic characteristics, Medicare enrollment status, clinical indicators, and market characteristics. For Standard and New Entrant DCEs, we also assessed these characteristics in the years leading up to GPDC and relative to a weighted comparison group.

Our main approach for the impact evaluation of Standard and New Entrant DCEs was a two-group, pre-post design, also known as difference-in-differences (DID). We estimated the causal impact of the GPDC Model on beneficiary outcomes relative to a comparison group, using DID to control for a subset of time-variant observed and time-invariant unobserved differences between the groups. As there was a relatively low number of High Needs DCEs in PY 2021, and they tended to serve smaller beneficiary populations, we will include impact estimates for DCEs in that group in future evaluation reports.

Intervention and Comparison Groups. We defined the GPDC DCE and comparison groups for the evaluation based on insights from GPDC Model operational data and lessons learned from prior evaluations of alternative payment models (APMs). Beneficiaries aligned to providers in each DCE type (the intervention group) were matched to an appropriate comparison group of beneficiaries aligned to comparison non-GPDC providers (the comparison group). These methods—described in more detail in **Appendices F, G, and H**—allow us to describe DCEs' organizational characteristics and implementation approaches and explore the GPDC Model's impacts on health care utilization, cost, and quality of care.

Chapter 2: 2021 GPDC Model Participants and Implementation

Key Findings

DCE Characteristics

- More than half of DCEs were Standard DCEs, with prior experience serving Medicare FFS beneficiaries at the provider level or risk-bearing entity level or both.
- A total of 357,606 beneficiaries were aligned with DCE providers, with the number of beneficiaries served by any single DCE varying across and within DCE types.
- Most DCEs elected Global risk (74%) and Primary Care Capitation (PCC) (79%); few DCEs elected Total Care Capitation (TCC) (21%).
- Most DCEs were affiliated with physician practices (81%); one was affiliated with hospitals.
- Most DCEs had experience with financial risk-sharing and capitation with Medicare Advantage (MA) or commercial plans.

Motivations for Participating in GPDC

- DCE leaders were highly motivated to form a DCE or transition to the model for financial reasons, including the appeal of expanded value-based payment portfolios and high potential for shared savings.

DCE Implementation Strategies

- Most DCEs prioritized initiatives for avoidable utilization, complex or population-specific care management, and primary care.
- DCEs entered the model able to share and receive data with providers inside and outside of their network and to use various data analytic tools.
- DCEs had prior experience with care management, including for beneficiaries with chronic conditions and those dually eligible for Medicare and Medicaid.

DCE Providers and Provider Engagement

- Participant Provider network size varied across and within DCE type.
- Most DCEs provided centralized population health support staff to providers and offered multiple financial and non-financial incentives to engage them.
- DCEs most often paid their providers using payments tied to quality thresholds, with little sharing of downside risk.
- Non-financial incentives including provider training, regular meetings with the DCE, data analysis, and centralized staff were considered important ways to engage providers.

In this chapter, we set the stage for the evaluation of the GPDC Model as a whole. We focus on describing the DCEs' characteristics and approaches, their reasons for joining the model, and how they are responding thus far to the model's features. Understanding these factors offers key insights into GPDC Model outcomes and the

successes and challenges associated with participation in the model. Specifically, this chapter explores following overarching research question:

- **How did model participants, referred to as DCEs, launch the model and how did their implementation approaches differ based on DCE characteristics?**

We describe the characteristics and strategies of the 53 DCEs that entered the GPDC Model in PY 2021 ("2021 DCEs"). We focus on DCE characteristics such as size and the types of organizations they represented, risk and payment mechanism elections, and prior experience with value-based care. We also describe DCEs' motivations for joining GPDC as well as their implementation priorities and approaches to engaging providers in the model. **Appendix E** provides supplemental exhibits that support the summary discussion presented in this chapter.

2.1 Overview of Methods

Throughout this chapter, we focus on the 2021 DCEs[f] and draw on data from a systematic review of their applications to the GPDC Model; a Pulse Check Survey of all participating DCEs, conducted in the fall of 2022; Medicare claims and administrative data; and Innovation Center data on DCE type, risk election, and payment mechanisms. **Exhibit 2.1** provides an overview of the different data and analyses that inform this chapter, with **Appendices C and D** providing additional technical detail.

[f] The DCEs that joined the model in 2022 will be included in our Second Annual Report, which will focus on PY 2022 in GPDC.

Exhibit 2.1. Multiple Data Sources Inform Our Understanding of DCE Characteristics and Implementation.

Systematic Review of 2021 DCE Applications (n=53)

- Using a tool based on the conceptual framework **(Exhibit 1.2)** and the Consolidated Framework for Implementation Research (CFIR), we systematically extracted, coded, and synthesized data from 2021 DCEs' model applications.[14, 15]
- As all data were self-reported, the quality and content of this information vary across the DCEs.

2022 GPDC Pulse Check Survey (n=95, including 49 2021 DCEs and 46 2022 DCEs)

- We developed a brief, web-based survey to help identify the status and evolution of activities and priorities that DCEs described in their applications.
- We conducted descriptive analyses, including frequency distributions and cross-tabulations by DCE characteristics (including DCE type, risk-sharing election, and payment mechanism).
- We achieved a completion rate of 100% for the 49 2021 DCEs active when we fielded the survey (Fall 2022).

Claims and Administrative Data (n=53)

- We analyzed administrative data received from the Innovation Center and Medicare FFS claims data on model elections, general DCE information (for example, websites and parent organization) and provider and beneficiary counts.

NOTES: DCE = Direct Contracting Entity. CFIR is a comprehensive framework that is commonly used in implementation research. It comprises constructs associated with effective implementation. The Pulse Check Survey, conducted in PY 2022, collected responses from both 2021 and 2022 DCEs that were active in the model at the time of the survey. As such, four 2021 DCEs that either exited the model at the end of PY 2021 or were terminated in PY 2022 prior to the survey were not included among the respondents. For this evaluation report, we present findings from only the 2021 DCEs' responses. The second Annual Report will cover findings based on the 2022 DCEs' responses.

Appendix B lists the research questions, hypotheses, and associated data sources and analytic methods we use to address them in this evaluation. The research questions reflect the high-level priorities of the GPDC Model and provide an understanding of the model's impact on utilization, spending, quality, and implementation measures. Most of the findings featured in this chapter are descriptive and provide a rich understanding of the DCEs and lay the foundation to explore hypotheses as both the model and the evaluation evolve. Some of the hypotheses that we touch upon in this chapter include:

- DCEs' organizational affiliation may be considered a proxy for their resources, infrastructure, and incentives for accountable care.
- DCEs may respond to model features with investments in health information technology (health IT) and data analytics for population health management, supports for providers, and diverse beneficiary engagement strategies.
- Providers' behavior under the model may be affected by their financial relationship with both the DCE and their degree of engagement with the model's goals and objectives.

2.2 DCE Characteristics

DCEs' characteristics—related to organizational structures, partnerships, relationships with providers, and prior experience in Medicare ACOs or other value-based care initiatives—speak to the extent of their available resources and capacity to implement the GPDC Model. These factors in turn shape DCEs' strategic decisions around model implementation and approaches to managing population health, transforming care delivery, and engaging providers and aligned beneficiaries. Below, we analyze data provided by the Innovation Center after final financial results and reconciliation, as well as claims data and DCEs' model applications to identify variations in DCE characteristics. This analysis lays the groundwork for understanding how such variation may relate to individual DCEs' adaptability and responses to GPDC Model incentives in future performance years.

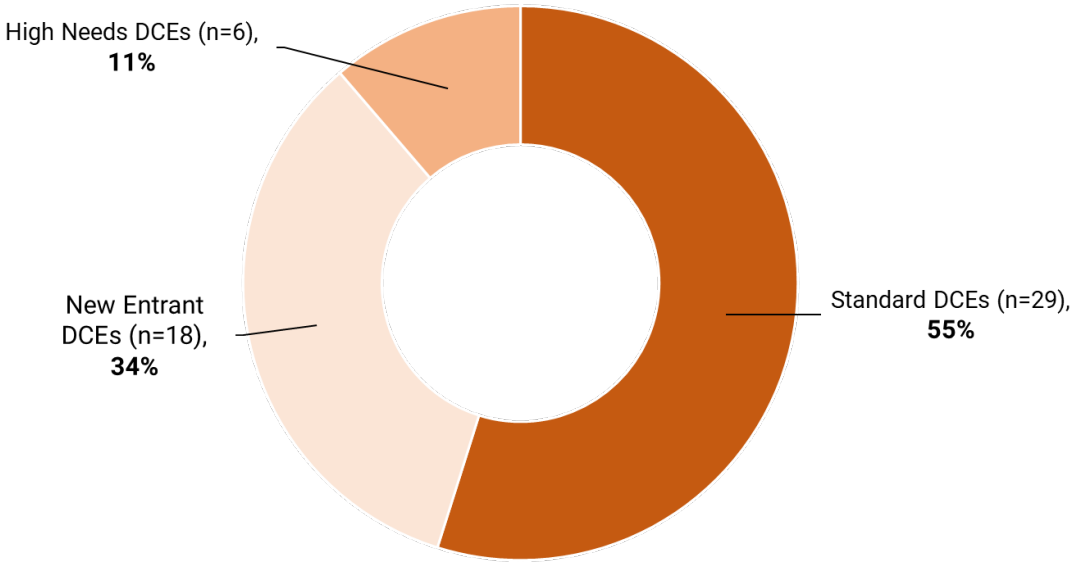
DCE Type and Size

As described in **Chapter 1**, the GPDC Model includes three types of DCEs (Standard, New Entrant, and High Needs). DCE type is based on both the number of beneficiaries aligned to the DCE and DCE providers' prior experience with Medicare FFS. Beneficiaries are aligned to each DCE through their Participant Providers, using either an algorithm based on claims data or voluntary alignment.[g] High Needs DCEs are also characterized by the attributes of their beneficiary population, with these DCEs serving individuals with complex health needs. In general, DCEs with larger beneficiary populations may have greater potential to scale their care improvement efforts and realize returns on their investments in population health management. DCEs with more voluntarily aligned beneficiaries may have greater engagement with their beneficiaries and therefore more influence on their care-seeking behavior.

Of the **53 2021 DCEs, more than half were Standard DCEs.** One-third were New Entrant DCEs and, by comparison, few were High Needs DCEs **(Exhibit 2.2)**. By the end of 2021, three DCEs chose to exit the model (two New Entrants and one High Needs).

[g] In claims-based alignment, beneficiaries are aligned to providers from which they have received the plurality of their primary care services (as evidenced in claims data) during the lookback period used for alignment. In voluntary alignment, beneficiaries choose to align to a DCE by designating a participant provider affiliated with the DCE as their primary clinician or main source of care. In instances where both types of alignment apply, voluntary takes precedence over claims-based alignment.

Exhibit 2.2. In PY 2021, More Than Half of DCEs Were Standard DCEs.



SOURCE: GPDC PY 2021 Financial Results (n=53 DCEs).
NOTES: DCE = Direct Contracting Entity.

In the first year of the GPDC Model, 357,606 beneficiaries were aligned with DCE providers, with the number of beneficiaries served by any single DCE varying across and within DCE types. The size of the populations served by the 2021 DCEs ranged from 214 to 64,085 aligned beneficiaries, with the smallest DCE being a High Needs DCE and the largest a Standard DCE. Population size also varied within DCE type, with Standard DCEs serving between approximately 3,000 and 64,000 beneficiaries, and New Entrant DCEs serving between approximately 400 and 9,600 beneficiaries **(Exhibit 2.3)**.

Over 90% of beneficiaries in 2021 were aligned through claims, with beneficiaries in New Entrant DCEs more likely than others to align voluntarily. Most Standard and High Needs DCE beneficiaries were claims-aligned (98% and 93%, respectively), compared with 70% of New Entrant DCE beneficiaries.[h] In their model applications, many Standard DCEs mentioned that they would leverage existing beneficiary networks or networks of beneficiaries from past models (for example, NGACO) in their outreach for voluntary alignment. In our PY 2022 Pulse Check Survey, most New Entrant and Standard DCEs reported that they conducted various activities to increase voluntary alignment.

[h] While voluntarily aligned beneficiaries were expected to account for most New Entrant DCEs' beneficiaries, they comprise around 30% of their aligned beneficiary populations.

Exhibit 2.3. Total Number of Aligned Beneficiaries Varied Widely Across and Within DCE Types, with Most Beneficiaries Aligned Through Claims.

Beneficiaries	Standard	New Entrant	High Needs	All DCEs
Total Aligned Beneficiaries				
Minimum	3,269	429	214	214
Median	7,184	2,128	295	5,635
Maximum	64,085	9,683	624	64,085
Claims-Aligned Beneficiaries				
Minimum	3,196	0ǂ	193	0ǂ
Median	7,043	1,935	233	5,243
Maximum	62,368	7,026	624	62,368
Voluntarily Aligned Beneficiaries				
Minimum	4	0ǂ	0ǂ	0ǂ
Median	41	109	2	41
Maximum	1,720	5,889	125	5,889

SOURCE: NORC analysis of PY 2021 alignment data (received from RTI, August 23, 2022) (n=53 DCEs).

NOTES: DCE = Direct Contracting Entity. ǂ Any 0 values refer to DCEs that opted to align all beneficiaries using one method of alignment. For example, DCEs with no claims-aligned beneficiaries chose only voluntary alignment. Each DCE type was required to have a minimum number of aligned beneficiaries prior to the start of each performance year; however, counts of aligned beneficiaries may appear lower than the minimum threshold based on requirements related to the specific beneficiaries included in the final determination of financial results.

GPDC Model Features That DCEs Selected

In each performance year, DCEs choose a full (Global) or partial (Professional) risk-sharing arrangement with CMS.[i] Those opting for Global risk receive either Total Care Capitation (TCC) or Primary Care Capitation (PCC) payments. Those choosing the Professional risk option may receive PCC payments.[j,k] DCEs that elect PCC

[i] Global risk is the full risk option with 100% shared savings and losses. Professional risk has 50% shared savings and losses. In PY 2021, the Global risk had a 2% discount applied to the benchmark; both Professional and Global had 5% of the discounted benchmark subject to a quality withhold, which may be earned back based on the DCE's quality performance score.

[j] Capitated payments are required for all aligned participant providers in the model. This requirement was relaxed for providers in PY 2021 and required for PY 2022.

[k] The PCC payment amount includes a Base PCC amount (an estimated payment that approximates the primary care-based services provided to aligned beneficiaries) and an Enhanced PCC amount (an additional percentage amount that DCEs select, with the options for the amount determined by the difference between 7% of the PY Benchmark and the Base PCC amount with 100% claims reduction for all participant providers). The Enhanced PCC amount aims to provide upfront additional payments to invest in DCEs' primary care capabilities.

payments may opt for advanced payments for some services not covered by the PCC payments under the Advanced Payment Option (APO). Participant and Preferred Providers who opt into the APO arrangement agree to reduced payments for APO-eligible claims; in exchange, CMS makes a monthly advanced payment to DCEs equal to the estimated amount of claims reductions.[m] The additional flexibility under APO allows for more predictable monthly revenue to support investments in population health management tools, health IT, or value-based payment arrangements with providers.[16]

The choice of risk and payment mechanism may be driven in part by DCEs' prior experience with similar arrangements or their existing population health management capacity. Decisions regarding risk (Global or Professional) and capitation (TCC or PCC) shape both provider incentives and the savings or losses DCEs may earn at the end of a performance year, which in turn influences provider behavior.

Benefit Enhancements and Beneficiary Engagement Incentives[l]

For the 2021 DCEs,

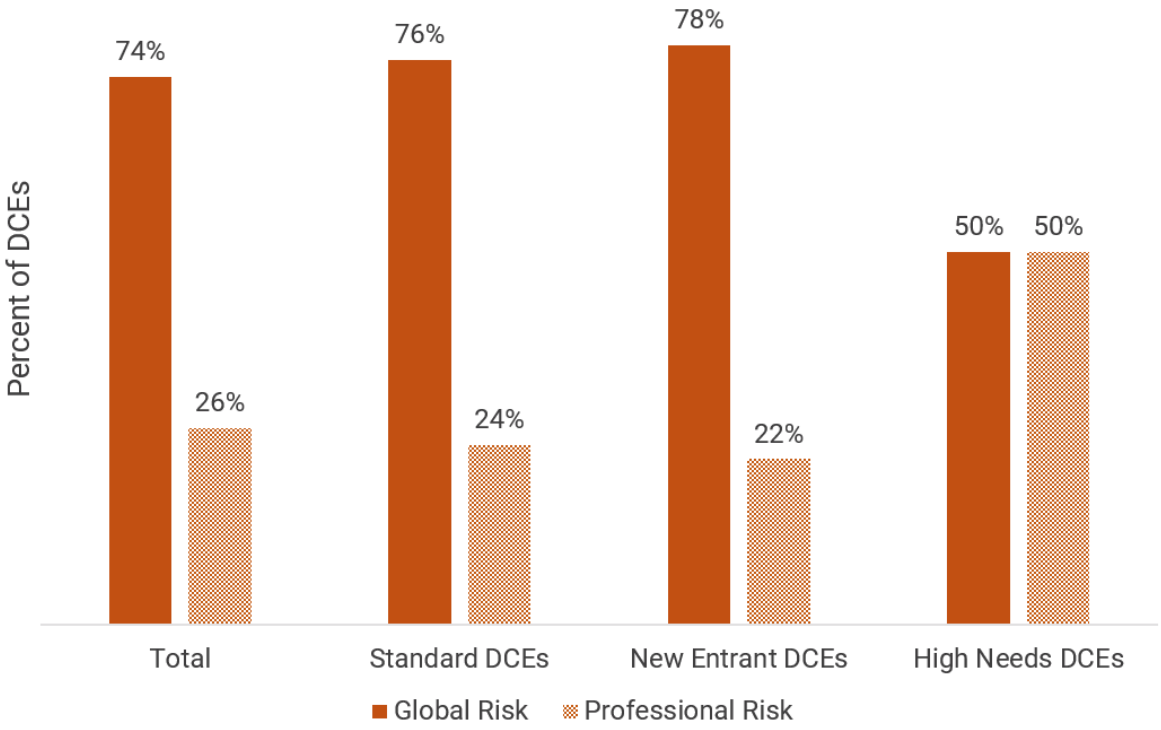
- At least half have implemented or plan to implement most Benefit Enhancements and Beneficiary Engagement Incentives, with the three-day SNF waiver and chronic disease management reward the most implemented Benefit Enhancements.
- New Entrant DCEs were less likely than Standard DCEs to implement or plan to implement Benefit Enhancements.
- The most frequently cited challenges to implementation included not being able to offer the same benefit to all beneficiaries, the complexity of the requirements, and insufficient staff.

Most 2021 DCEs opted for Global risk-sharing. Risk-level elections were similar across DCE types and appear unrelated to experience in prior risk-based models such as NGACO, Shared Savings Program, and Comprehensive Primary Care Plus (CPC+) **(Exhibit 2.4).**

[l] Benefit enhancements for PY 2021 include: 3-Day SNF Rule Waiver; Telehealth; Home Health Homebound Waiver; Post-Discharge Home Visits; Care Management Home Visit waiver; and Concurrent Care for Beneficiaries Who Elect the Medicare Hospice Benefit. Beneficiary engagement incentives for PY 2021 include: In-Kind Incentives, the Chronic Disease Management Reward, and Part B Cost-Sharing Support.

[m] APO-eligible services dispensed by participating providers include primary care-based services by (non-primary care) specialists and institutional providers and services other than primary care delivered by primary care clinicians. For more detail on APO-eligible service, see Global and Professional Direct Contracting Model Financial Operating Policies: Capitation and Advanced Payment Mechanisms.

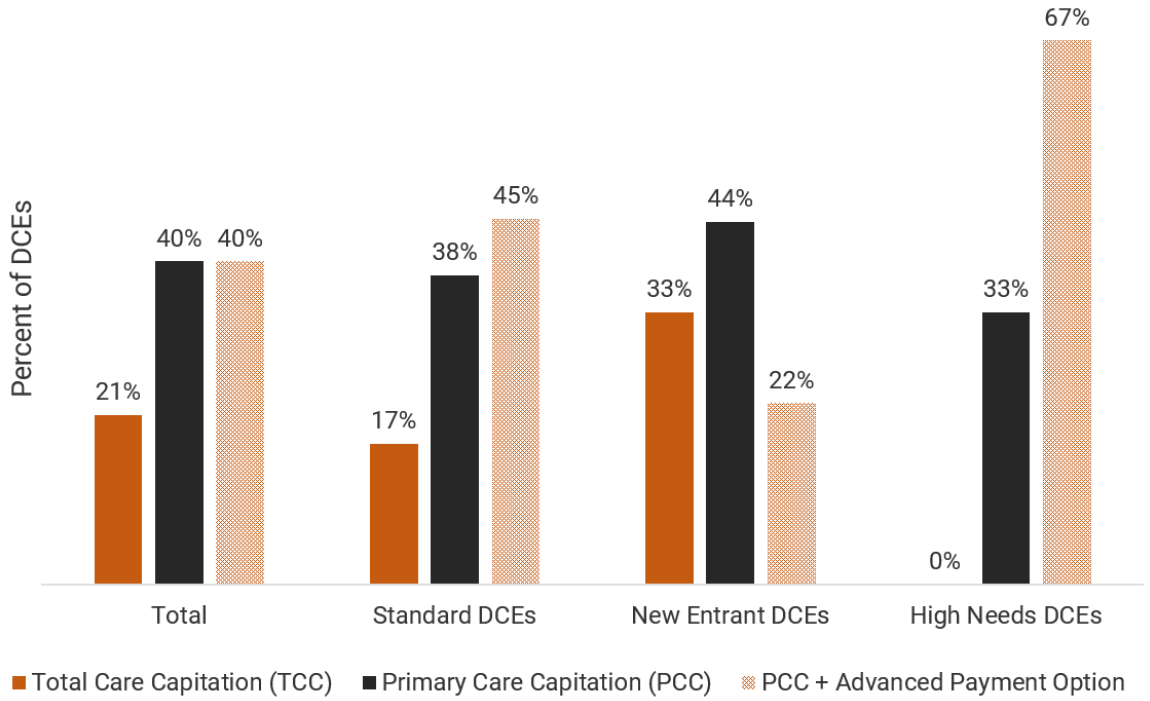
Exhibit 2.4. Most 2021 DCEs Opted for Global Risk-Sharing, Overall and Standard and New Entrant DCEs.



SOURCE: PY 2021 Financial Results (Total DCEs, n=53; Standard DCEs, n=29; New Entrant DCEs, n=18; High Needs DCEs, n=6).
NOTES: DCE = Direct Contracting Entity.

Most 2021 DCEs opted for PCC. Most DCEs, regardless of type, elected PCC, and half of those with PCC also elected the APO. The TCC option was slightly more common among New Entrant DCEs as compared with Standard DCEs, which may reflect the New Entrant DCEs' experience with capitation in MA or commercial plans **(Exhibit 2.5)**.

Exhibit 2.5. Most DCEs Opted for PCC, Regardless of DCE Type.



SOURCE: PY 2021 Financial Results (Total DCEs, n=53; Standard DCEs, n=29; New Entrant DCEs, n=18; High Needs DCEs, n=6).
NOTES: DCE = Direct Contracting Entity.

Regardless of the risk-sharing and payment arrangements that DCEs pursued, as discussed further below, Participant Providers accepted reduced Medicare claims payments and agreed to receive some compensation from their DCEs through separately negotiated arrangements.

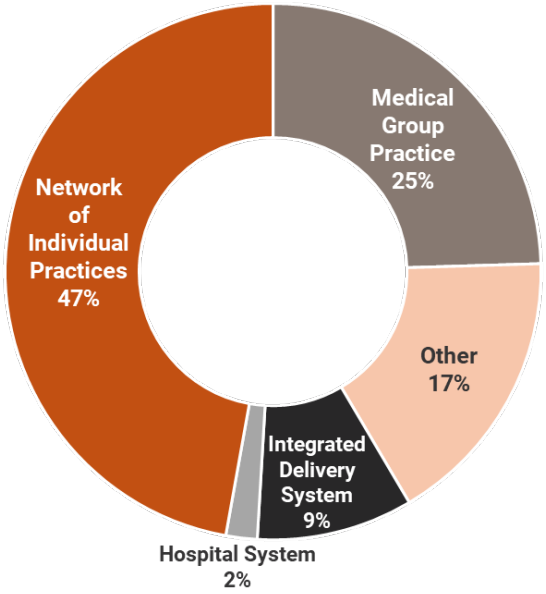
DCE Organizational Type

Organizational affiliation or type likely influences the resources and infrastructure available to DCEs to implement accountable care activities under the model. For example, networks of independent practices may have multiple electronic health records (EHRs) and challenges with interoperability, while integrated delivery systems (IDSs) and hospital systems may have a single or integrated EHR system.

In addition, organizational type may determine the care delivery sites that a DCE has the incentive or leverage to modify. For example, IDSs and hospital systems have more control over the care provided in inpatient and outpatient facilities, while physician practices control only the care delivered in their offices. Findings from the NGACO evaluation suggest that DCEs will likely adopt strategies that enable them to reduce overall spending, while preserving their revenue streams.[17] Further, organizational type may influence the types of partnerships, providers, and health care extenders (non-physician health care professionals such as nurse practitioners, pharmacists, and community health workers)[18] affiliated with the DCE. For our analysis, we use each DCE's self-designated organizational type as provided in their GPDC Model applications.

Three-quarters of 2021 DCEs identified as physician practice organizations, with some differences by DCE type. Close to half of the 2021 DCEs identified as networks of individual practices and another quarter as medical group practices **(Exhibit 2.6)**. A small subset of DCEs identified as an IDS (5 out of 53) or hospital system (1 out of 53). These were all Standard DCEs and accounted for about one-quarter of DCEs of that type. Nearly all New Entrant and High Needs DCEs identified as either medical group practices or networks of individual practices. Other organization types include management services organizations (MSOs), MA plans, and partnerships between primary care providers (PCPs) and MSOs.[n]

Exhibit 2.6. Three-Quarters of PY 2021 DCEs Identified as Physician Practice Organizations.



SOURCE: NORC analysis of 2021 Starter DCEs' model applications (Total DCEs, n=53; Standard DCEs, n=29; New Entrant DCEs, n=18; High Needs DCEs, n=6).

Experience in Value-Based Care and Partnerships

DCEs with prior relationships with other care providers and community-based organizations (CBOs) may bring adaptability and expanded capacities for care delivery transformation and cost efficiency. Current research finds that ACOs with prior experience in value-based care and risk-sharing may be more familiar with payment reform, preventive care, and novel care delivery strategies.[19] As a result, such ACOs may be more likely to elect higher risk and achieve greater efficiencies. At the same time, prior success in reducing spending and increasing quality may pose challenges for further improvement.

[n] All six Standard DCEs that identified as a partnership between PCPs and MSOs formed and operated under the same parent organization that partnered with different regional PCPs.

In this section, we analyze the data that DCEs provided in their GPDC Model applications concerning their prior value-based care experience and partnerships to expand service delivery to their beneficiaries. The DCEs noted differing levels of experience with value-based care and risk-sharing, with a wide range of past partnerships with CBOs and care providers in their health care systems.

Most DCEs highlighted their risk-sharing and capitation experience through contracts with MA and commercial plans prior to joining GPDC. Nearly every DCE mentioned prior experience with capitated payments, including under MA, commercial plans, or other unspecified arrangements. Some DCEs also mentioned experience with risk-sharing in Medicaid, with Standard and New Entrant DCEs equally likely to do so.

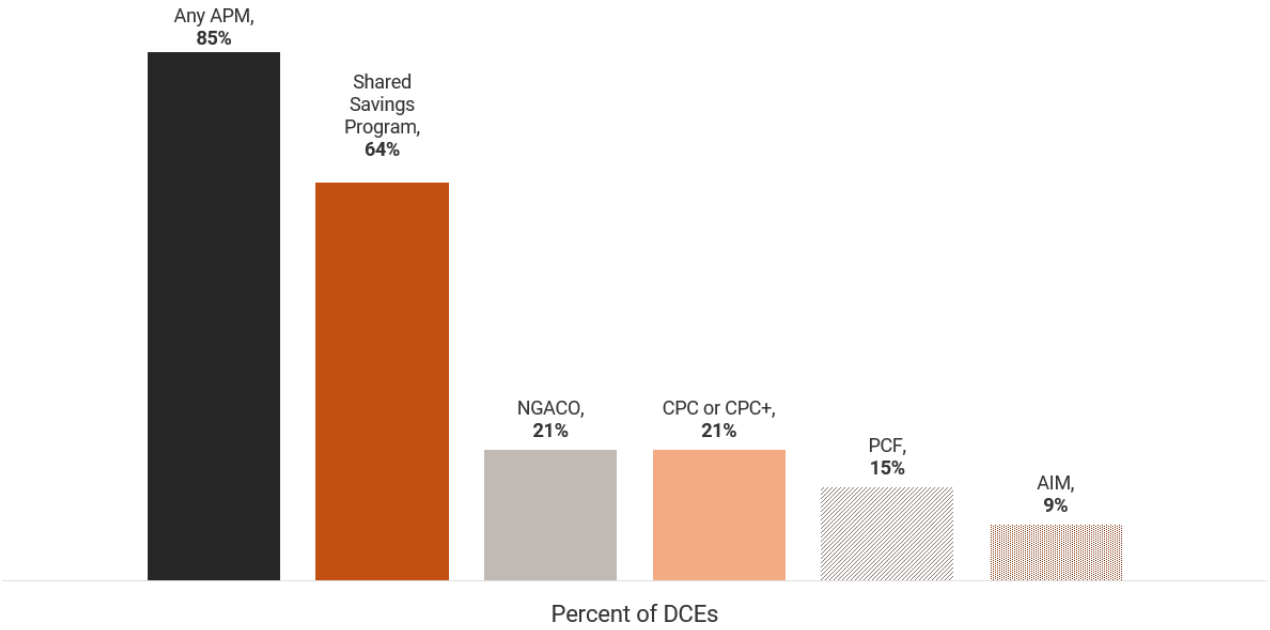
Most DCEs' participating providers, risk-bearing entities, or both had Medicare FFS experience, including experience with APMs. Of the 53 DCEs, 45 noted prior experience with at least one APM in the Medicare program when applying for the GPDC Model. Past participation in the Shared Savings Program was most common, both overall and across DCE types. All DCEs that reported experience with the Comprehensive Primary Care Initiative (CPC) or CPC Plus (CPC+) were Standard DCEs. Similarly, most of the DCEs that reported experience with NGACO were Standard DCEs. No High Needs DCEs noted prior experience with NGACO. **Exhibit 2.7** tabulates DCEs' reported past participation in selected APMs, based on their model applications.

DCE Model Applications: Experience in APMs

More than half of DCEs noted that they had experience in other APMs, with the nature of that experience taking several different forms:

- DCE had participated in another model as the same entity
- DCE had participated in another model as part of another ACO
- Participant providers had experience in other models
- Lead or parent organizations had experience in other models
- Leadership teams had experience in other models

Exhibit 2.7. Most DCEs Had Prior Experience with at Least One Alternative Payment Model, with Shared Savings Program the Most Common.



SOURCE: NORC analysis of 2021 Starter DCEs' model applications (Total DCEs, n=53; Standard DCEs, n=29; New Entrant DCEs, n=18; High Needs DCEs, n=6).

NOTES: Data are self-reported by the DCEs and reflect what each DCE interprets as relevant past experience, which could be at the ACO level, as a key Participant Provider, or as another lead entity. DCE = Direct Contracting Entity. APM = alternative payment model. NGACO = Next Generation Accountable Care Organization. CPC/CPC+ = Comprehensive Primary Care. PCF = Primary Care First. AIM = ACO Investment Model.

All DCEs described existing partnerships with large care organizations and networks and many referenced partnerships with CBOs. All DCEs mentioned partnerships with other care providers—including hospital systems, medical groups, dialysis clinics, lab groups, and PCPs—that could be leveraged for GPDC. For example, DCEs commonly reported prior collaboration with post-acute care (PAC) providers in their model applications. All types of DCEs also mentioned behavioral health care providers (for example, clinical social workers, therapists, and psychologists). In addition to care providers, DCEs described partnerships with clinics, a local housekeeping provider, a state department of aging, and research universities. In addition, some DCEs highlighted partnerships with transportation organizations, including Lyft and Uber, to make it easier for beneficiaries facing transportation challenges to attend appointments.

DCE Model Applications: Examples of Community Partnerships

Nonprofit CBOs are resource hubs that provide specific services to the community or targeted populations within the community.[20] Many DCEs described partnerships with different types of CBOs, such as:

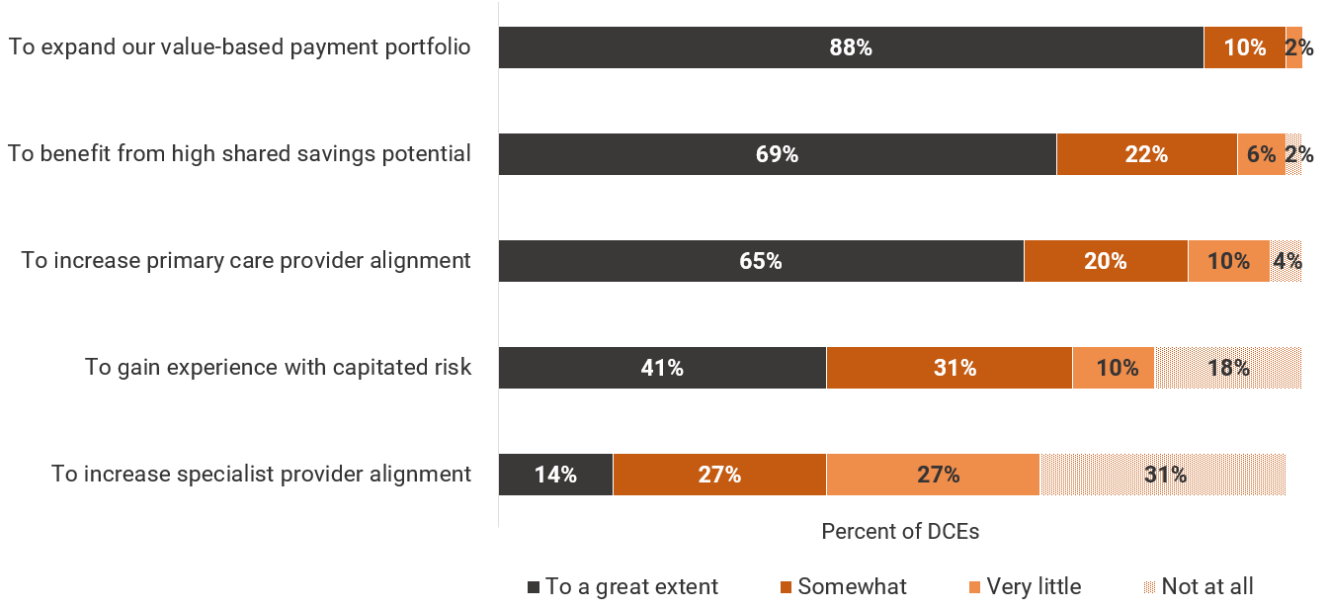
- Food assistance organizations (food banks, food pantries, and Meals on Wheels)
- Aging and disability networks (Area Agencies on Aging, local disability programs)
- Community centers and shelters (homeless shelters, adult care centers, YMCA, and faith-based organizations)

2.3 Motivations for Participating in GPDC

Prior to the start of GPDC, CMS had value-based initiatives underway, such as the Shared Savings Program and various APM tests. Similar efforts were underway among commercial and state payers as well. Given the breadth of the value-based care arrangements available to DCEs, each offering different levels of risk and payment options, different entities may have been drawn to some arrangements over others based on the needs and experience of their providers and the perceived likelihood of success. In this context, we expect that DCEs consider financial benefits, provider readiness, and improved outcomes for beneficiaries when deciding: 1) whether to form a DCE; 2) which specific type of model to join; and 3) upon their approach to model participation, including the selection of model features and Participant and Preferred Providers. In this section, we analyze data from the 2022 Pulse Check Survey to identify the motivating factors and model characteristics that influenced DCEs' decisions to join GPDC.

For most DCEs, financial factors motivated the decision to form a DCE or transition to the GPDC Model, including the appeal of expanded value-based payment portfolios and the high potential for shared savings. In addition to financial reasons, increasing PCP alignment with organizational priorities was a common motivating factor, especially among Standard DCEs. Interest in gaining experience with capitated risk was more common among High Needs DCEs than other DCE types. Increasing alignment with specialists was less commonly noted by any DCE type as a motivating factor **(Exhibit 2.8)**.

Exhibit 2.8. Expanding a Value-Based Payment Portfolio Was the Most Common Reason to Form a DCE or Transition to the GPDC Model.



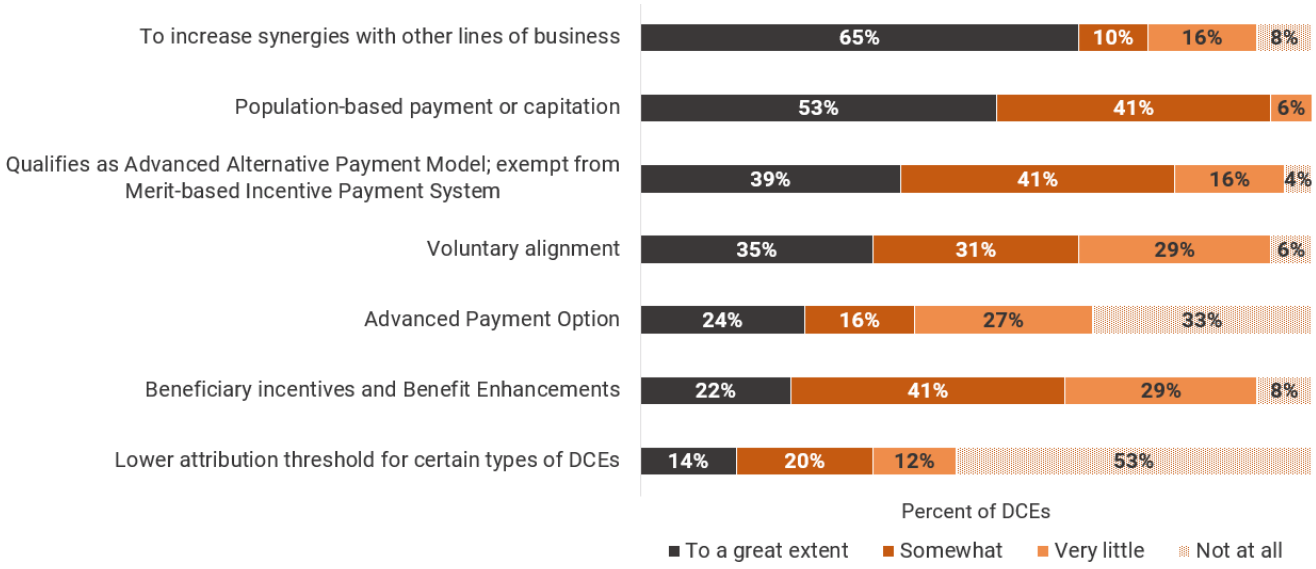
SOURCE: 2022 GPDC Pulse Check Survey (n=49 respondents)

NOTES: DCE = Direct Contracting Entity. Values for "To increase specialist provider alignment" do not sum to 100% as one respondent did not answer this question.

DCEs that reported being motivated by the opportunities to both expand their value-based payment portfolio and benefit from high shared-savings potential were more likely to opt for Global risk, full capitation (TCC).

Most DCEs reported that leveraging the model and associated payment streams to increase synergies with business lines greatly influenced their decision to join GPDC. More than half of DCEs also noted that another key motivation to join the model was to secure population-based or capitated payments **(Exhibit 2.9)**. Among New Entrant DCEs, two-thirds cited population-based payments or capitation and half cited voluntary alignment among the aspects of the model that influenced their decision to join to a great extent. Among Standard DCEs, fewer than half specified population-based payments or capitation and one-third cited voluntary alignment.

Exhibit 2.9. The Opportunity to Increase Synergies with Other Lines of Business Was the Most Commonly Cited Aspect of the Model Influencing DCEs' Decision to Join the GPDC Model.



SOURCE: 2022 GPDC Pulse Check Survey (n=49 respondents).
NOTES: DCE = Direct Contracting Entity.

2.4 DCE Implementation Strategies

Our conceptual framework **(Exhibit 1.4)** illustrates a process for understanding model implementation—including care transformation, population management, health IT and data analytics, and provider and community partnerships—in the context of the market, organizational, provider and beneficiary characteristics, and the model features selected. A solid understanding of model implementation can inform both shared learning within the GPDC Model and the development of future models. Below, we use data from the 2022 Pulse Check Survey and DCE model applications to describe DCEs' implementation priorities, capacity, and infrastructure to support expanded access to care. We also highlight any differences between Standard DCEs and New Entrant DCEs, where applicable.

DCEs' Implementation Priorities

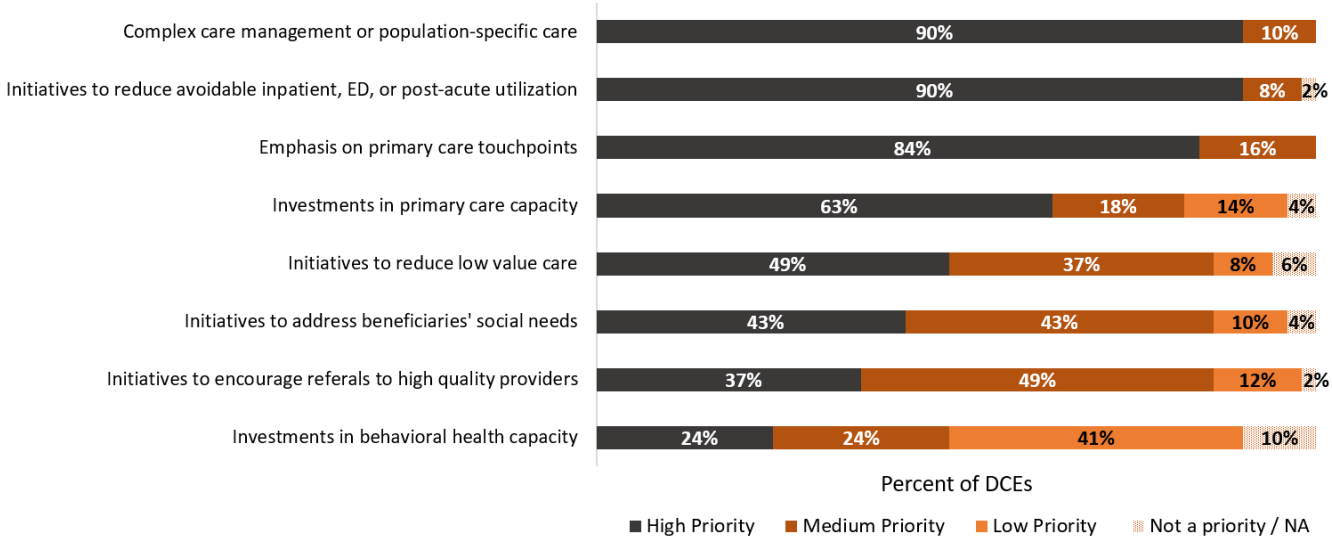
DCEs' initial priorities upon entering the model may have indicated how they planned to direct their resources and where any changes in utilization and spending would therefore be most likely to be observed. This section uses data from the 2022 Pulse Check Survey to highlight the care delivery initiatives and investments that DCEs chose to prioritize, recognizing their potential to shift over time with additional experience in the model.

The 2021 DCEs' high priorities included initiatives focused on complex or population-specific care management, primary care (investments in primary care capacity or an emphasis on primary care touchpoints), and avoidable utilization. Most DCEs (n=39) identified all three areas as high priorities for implementation. In addition, they prioritized initiatives to reduce low-value care (20 out of 35). Most DCEs (n=44) identified at least one of the primary care initiatives (emphasis on touchpoints or investments in capacity) as a high priority. Standard DCEs were more likely than were New Entrant DCEs to focus on investments in primary care capacity, such as non-physician providers and after-hours care. Initiatives to address beneficiaries' social needs and encourage referrals to high-quality providers were either medium- or high-priority strategies, while investments in behavioral health capacity tended to be lower priority for most DCEs **(Exhibit 2.10)**.

DCE Model Applications: Examples of Care Management Strategies

- Home visits to enhance transitional care management and post-emergency department (ED) care
- Expanding upon the beneficiary-centered medical home model
- Provider-led roundtable meetings to identify avoidable admissions/re-admissions and determine care and engagement strategies for beneficiaries with high historical use of ED or inpatient stays
- Evidence-based care guidelines and plans tailored to common chronic conditions
- ED predictive models to identify beneficiaries at higher risk for ED visits

Exhibit 2.10. Highest Priorities for Model-Related Implementation Included Complex Care Management or Population-Specific Care and Initiatives to Reduce Avoidable Utilization.



SOURCE: 2022 GPDC Pulse Check Survey (n=49 respondents).

NOTES: ED = Emergency Department. DCE = Direct Contracting Entity. NA = Not Applicable.

Capacity and Infrastructure to Support Implementation

DCEs' resources and capacities can have a significant impact on care delivery. For example, robust information systems can improve real-time access to data and data analytics, which in turn lend critical support to providers to improve quality of care, target care management, and reduce gaps in care. Strong care management programs can also help providers improve outcomes for high-risk beneficiaries and other underserved communities.[21, 22, 23]

DCEs can use existing or new infrastructure—such as health IT systems, data analytic technologies, risk stratification, and data sharing—to support population health and care management activities in GPDC and to communicate across care teams. DCEs that entered the model with such capacities may leverage the model's flexibility and incentives to continue efforts to improve health outcomes. In addition, model participation may itself expand DCEs' capacities and the scope of the care their providers can support. Below, we present findings from the systematic review of DCEs' applications to GPDC to describe the infrastructure DCEs planned to use to support implementation activities.

Data Sharing and Analytic Tools and Strategies

Most 2021 DCEs entered the model with the ability to share and receive data with providers both within and outside their networks. The DCEs reported having the capacity to receive information from providers in their networks through data warehouses; EHRs; and internal admission, discharge, transfer (ADT) notifications. In addition, DCEs highlighted their capacity to use health information exchanges (HIEs), disease registries, regional and local data sharing platforms, and external ADT notifications to share information with health systems outside of the DCE. Access to HIEs varied among DCEs, as did the extent to which all Participant and Preferred Providers had access to the HIE(s) or whether their access was limited.

DCE Model Applications: Examples of Data Sharing and Analytic Tools

- Built-in risk score coding/risk stratification software and clinical decision support tools that are integrated into EHRs or care management platforms
- EHRs or care management platforms that receive clinical data from HIEs, vendors, and internal and external providers (including ADT notifications), and then triage the data for targeted care
- Platforms with other analytic capabilities for population health management and predictive analytics to support care management interventions
- Use of business software to review and analyze metrics such as readmission rates and care gaps

The 2021 DCEs could leverage data analytic tools to support care management or risk stratification. Most DCEs reported having the capacity to use decision support tools or population health management platforms to support the management of care, population health, or both. The DCEs also described having access to evidence-based clinical practice processes and using predictive analytics to guide population health management strategies. Most often, DCEs reported using clinical data—from medical records, utilization data, diagnoses, or medications—to guide population health strategies. Most DCEs also reported the ability to incorporate clinical data into their risk stratification processes and used social service/social determinants of health (SDOH) and behavioral/mental health data, along with clinical data, to identify people at high risk, rising risk,[o] or both.

[o] Rising-risk populations are beneficiaries who are not yet labeled high-risk or high-need, but are considered on track to becoming high-risk. ACOs use different criteria to identify rising-risk populations.

Care Management Infrastructure

DCEs provided care management to groups of beneficiaries, including those with chronic conditions and those dually eligible for Medicare and Medicaid, prior to GPDC. Most DCEs described past or current experience providing chronic care management to beneficiaries using tools such as evidence-based protocols, follow-ups, and care gap screenings for beneficiaries with specific conditions. More than half of DCEs described prior experience managing care for dually eligible beneficiaries, including those enrolled in Dual Eligible Special Needs Plans, and leveraging existing social worker teams, long-term services and supports (LTSS), a Program of All-Inclusive Care for the Elderly (PACE), and other specific care coordination processes to address needs. Some DCEs described plans to focus care management activities on specific groups, including those with identified social needs (for example, beneficiaries in PACE); those with specific demographic characteristics based on rurality, income level, race/ethnicity, and gender identity; and those with condition-related characteristics (for example, impaired mobility, reduced care engagement, and being deaf/hard of hearing). Most DCEs discussed plans to use a mix of initial assets and capitated payments to fund care management strategies and care delivery transformations.

DCE Model Applications: Examples of Care Management for Social or Behavioral Health Needs

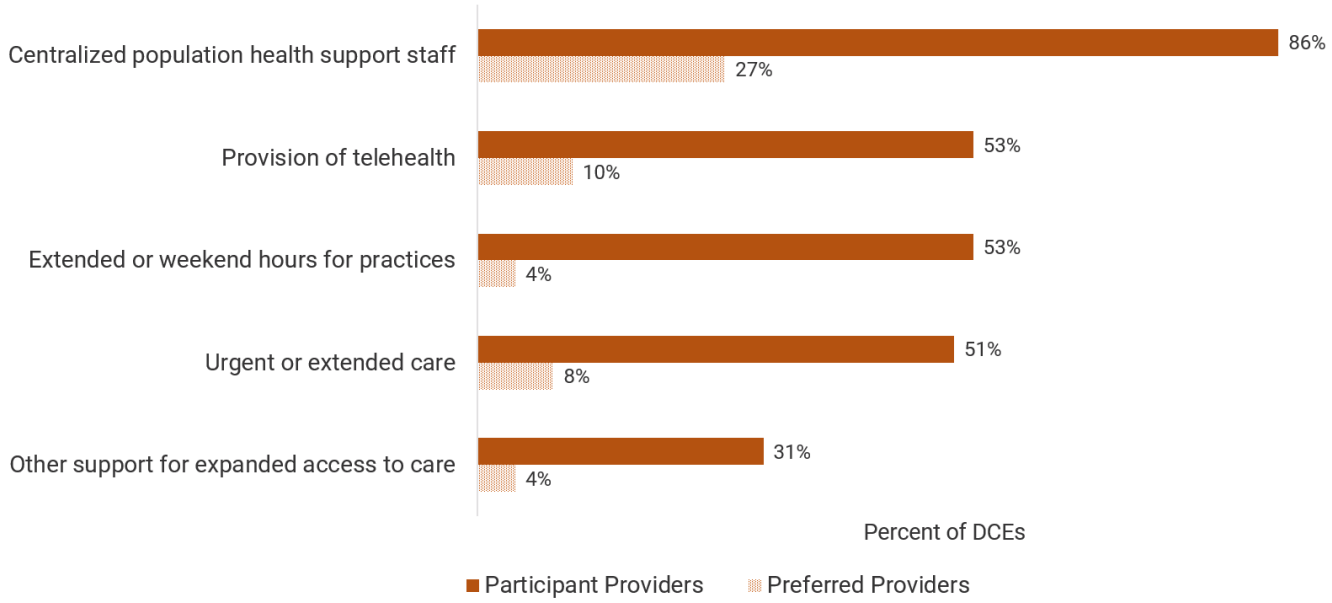
- Partnerships with local organizations that provide community health workers who provide services such as social needs assessments, referrals to supportive services, environmental assessments, or behavioral health screenings
- DCE-led trainings for providers to give beneficiary assessments that include social needs, barriers to care, falls risk, disease-specific questions, other SDOH, and behavioral health screenings
- Collaborations with CBOs to address unmet needs (such as transportation, legal services, food assistance, housing, or interventions for violence in the home)

Approaches to Expanding Access to Care

Barriers to health care access include a wide range of financial, geographic, cultural, and social challenges. However, DCEs could leverage the financial and care delivery flexibilities under the GPDC Model to address disparities in access to care, for example, by adjusting available resources to increase access for people who have been traditionally underserved. These approaches include extending hours, offering telehealth services, embedding population health staff, and providing care gap screening.[24] Below, we present findings from analysis of our 2022 Pulse Check Survey and systematic review of DCEs' applications to GPDC related to their ongoing efforts to expand access to care.

The DCEs supported their Participant Providers in expanding access to care through multiple types of centralized population health support. Most DCEs focused on providing centralized population health support staff, such as care managers, pharmacists, and schedulers and administrative support **(Exhibit 2.11)**. In addition, DCEs supported providers' extended hours, telehealth, or urgent or extended care. However, most DCEs did not provide additional support to expand access to their Preferred Providers.

Exhibit 2.11. DCEs Offer, Fund, or Support Multiple Population Health Supports to Participant Providers to Expand Access to Care.



SOURCE: 2022 GPDC Pulse Check Survey (n=49 respondents).

NOTES: DCE = Direct Contracting Entity.

In their model applications, some DCEs described strategies to reduce barriers to care for aligned beneficiaries. Such strategies included plans to address structural or physical barriers to care, such as increasing operational hours, providing 24/7 access to providers, and establishing new clinics/facilities in remote areas. The DCEs also discussed strategies to address personal or cultural barriers to care, including hiring translators or health care workers who speak languages predominantly spoken by their beneficiaries and providing beneficiary education materials in multiple languages.

2.5 DCE Providers and Provider Engagement

Providers are a critical component of the care delivery transformation process. For this reason, the financial and non-financial approaches that DCEs use to engage providers in value-based care are an important part of the implementation process. The power of such approaches to improve care delivery and outcomes may reflect both the number and composition of providers in a DCE network and the nature of providers' employment or contractual relationships with the DCE. Below, we analyze administrative and claims data, as well as the 2022 Pulse Check Survey, to describe the characteristics of PY 2021 GPDC providers and the different approaches DCEs used in this first year to engage their providers.

DCE Provider Networks

The size of provider networks and providers' relationships to their DCE may influence the DCEs' ability to support changes in practice.[25, 26] For example, smaller networks may have flexible and decentralized organizational structures conducive to fostering relationships across providers, beneficiaries, and staff, while also promoting beneficiary engagement, care management, and better health outcomes.[27] Conversely, DCEs with larger networks have the potential to scale efforts for greater impact, but achieving buy-in across a large network may pose more of a challenge. At the same time, DCEs with salaried providers may be better positioned to directly implement changes in process and care delivery, while contracted providers may be more responsive to financial incentives. Below, we present findings from our assessment of administrative and claims data and 2022 Pulse Check Survey data to highlight variations in provider network and provider employment.

The number of Participant Providers in a DCE's network ranged from 6 to 1,450 and varied by DCE type. In general, the number of Participant Providers corresponded with the number of beneficiaries aligned to a DCE. Standard DCEs had a higher minimum number of beneficiaries required at the beginning of the model and, for this reason, had more Participant Providers than did New Entrant or High Needs DCEs, which had lower required beneficiary minimums. In PY 2021, three outlying Standard DCEs had more than 1,000 Participant Providers, while all other DCEs had more than 463 Participant Providers.

Overall, Preferred Provider networks were relatively small in PY 2021, with a median network size of 18 Preferred Providers. Three Standard DCEs had especially large networks of Preferred Providers, with 819 to 1,735 providers. The remaining Standard DCEs had between 0 and 208 Preferred Providers **(Exhibit 2.12)**.

Exhibit 2.12. DCE Participant and Preferred Provider Network Sizes for PY 2021 Varied Overall and by DCE Type, with Relatively Small Preferred Provider Networks.

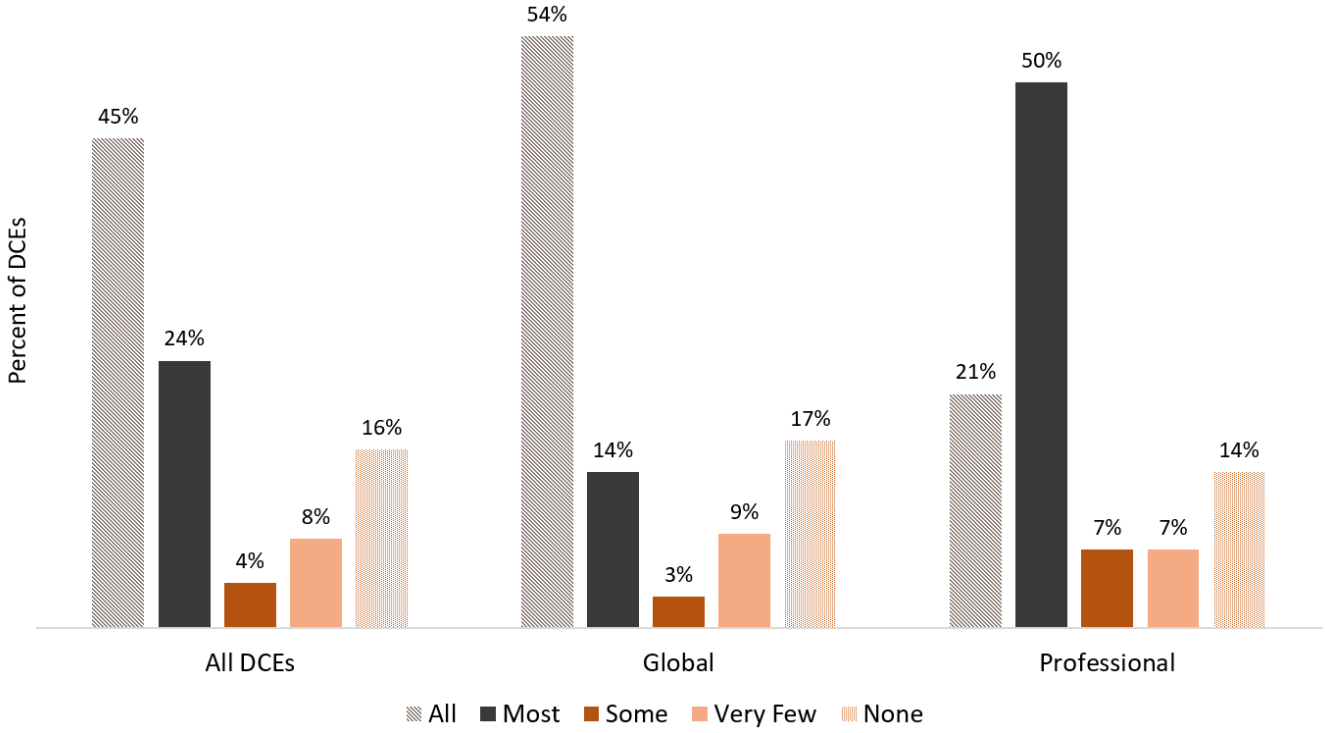
Participant Providers	Standard	New Entrant	High Needs	All DCEs
Median	112	66	44	**76**
Minimum	18	6	18	**6**
Maximum	1,450	363	157	**1,450**
Preferred Providers				
Median	28	4	20	**18**
Minimum	0	0	0	**0**
Maximum	1,735	642	150	**1,735**

SOURCE: NORC analysis of PY 2021 Alignment Data (received from RTI August 23, 2022) (n=53 DCEs).

NOTES: DCE = Direct Contracting Entity.

Most DCEs reported that all or most of their Participant Providers were directly employed by a health system or practice participating in the model. DCEs that elected the Global risk option were more likely to employ all their Participant Providers than the DCEs that elected the lower-risk, Professional option **(Exhibit 2.13)**.

Exhibit 2.13. Most DCEs Reported That All or Most of Their Participant Providers Were Directly Employed in PY 2021, Overall and by Risk-Sharing Election.



SOURCE: 2022 GPDC Pulse Check Survey (Total DCEs, n=49; Global DCEs, n=35; Professional DCEs, n=14).

NOTES: DCE = Direct Contracting Entity. Values for All DCEs and Global DCEs do not sum to 100% as one respondent did not answer this question.

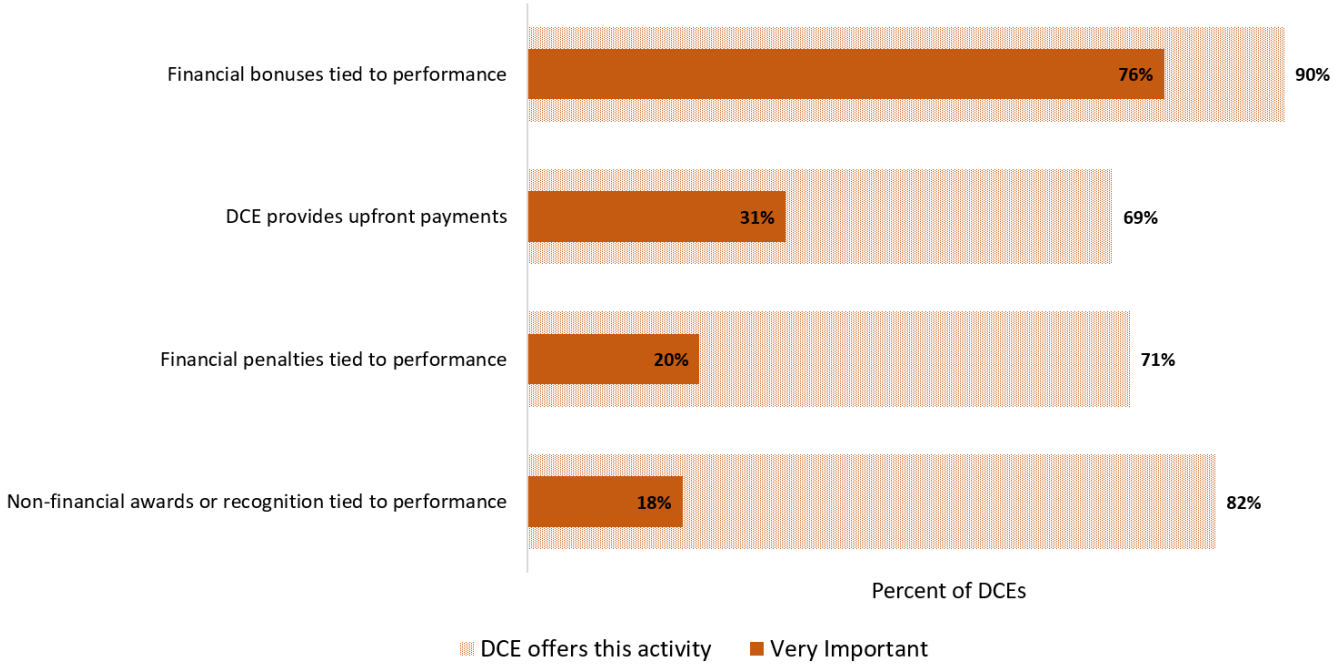
Provider Engagement

Success in value-based care requires the meaningful engagement of physicians and other providers in the model. Developing operational and technical supports and effective financial incentives for providers can be a resource-intensive process; however, provider engagement strategies can also improve providers' capacity to facilitate improved health and spending outcomes for DCEs.[28, 29] In PY 2021, DCEs used various financial incentives and other tools, including performance feedback, population health management systems, and additional practice support, to encourage providers to engage with their organization under the model. Using data from the 2022 Pulse Check Survey, we explored DCEs' financial and non-financial approaches to engaging providers in the model.

Most DCEs offered multiple financial and non-financial incentives, with financial bonuses tied to performance perceived as "very important" to engaging providers. Non-financial awards or recognition, upfront payments, and financial penalties were also commonly used but were not reported as "very important" engagement strategies **(Exhibit 2.14)**. Typically, DCEs that deemed a particular type of incentive as "very important" also indicated that all or most of their Participant Providers received the incentive. Standard DCEs were the most likely to offer financial bonuses, as well as multiple types of performance incentives.

In addition, DCEs noted that providers under contract, rather than those who were employed and salaried, may be more likely to be influenced by performance incentives; 66% of DCEs thought that performance incentives influenced their contracted providers' behavior "to a great extent," while 39% of DCEs thought similarly about their employed providers.[p]

Exhibit 2.14. Financial Incentives Offered by DCEs to Providers in the Model Were the Most Common Engagement Strategy and Considered the Most Important for Provider Engagement.



SOURCE: 2022 GPDC Pulse Check Survey (n=49 respondents).
NOTES: DCE = Direct Contracting Entity.

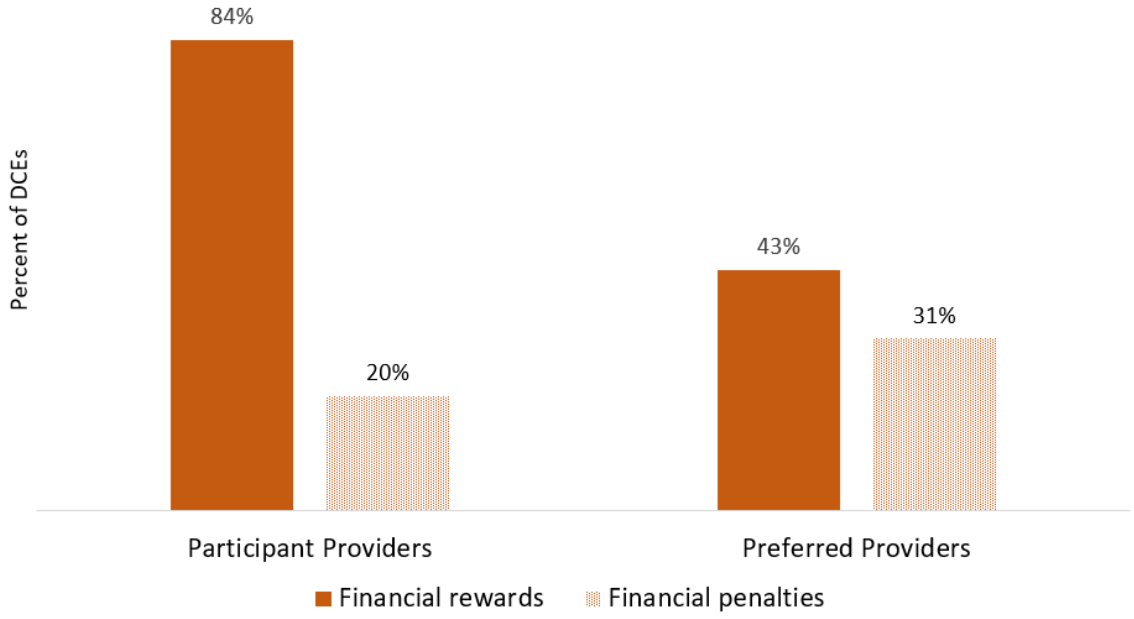
Financial Engagement of Providers

Commonly cited approaches to engaging providers included both positive and negative financial incentives.[30] However, evidence of the impact of financial incentives on physician performance is mixed and inconclusive, with some studies suggesting that financial incentives alone are insufficient to successfully engage providers in care delivery transformation.[31, 32, 33, 34, 35]

DCEs were more likely to use financial rewards than penalties. Further, the use of rewards was much more common with Participant Providers than with Preferred Providers **(Exhibit 2.15)**.

[p] Twenty-nine DCEs responded to this question for their contracted providers, while 38 DCEs responded for their employed providers.

Exhibit 2.15. Most DCEs Reported Using Financial Rewards, but Not Penalties for Participant and Preferred Providers

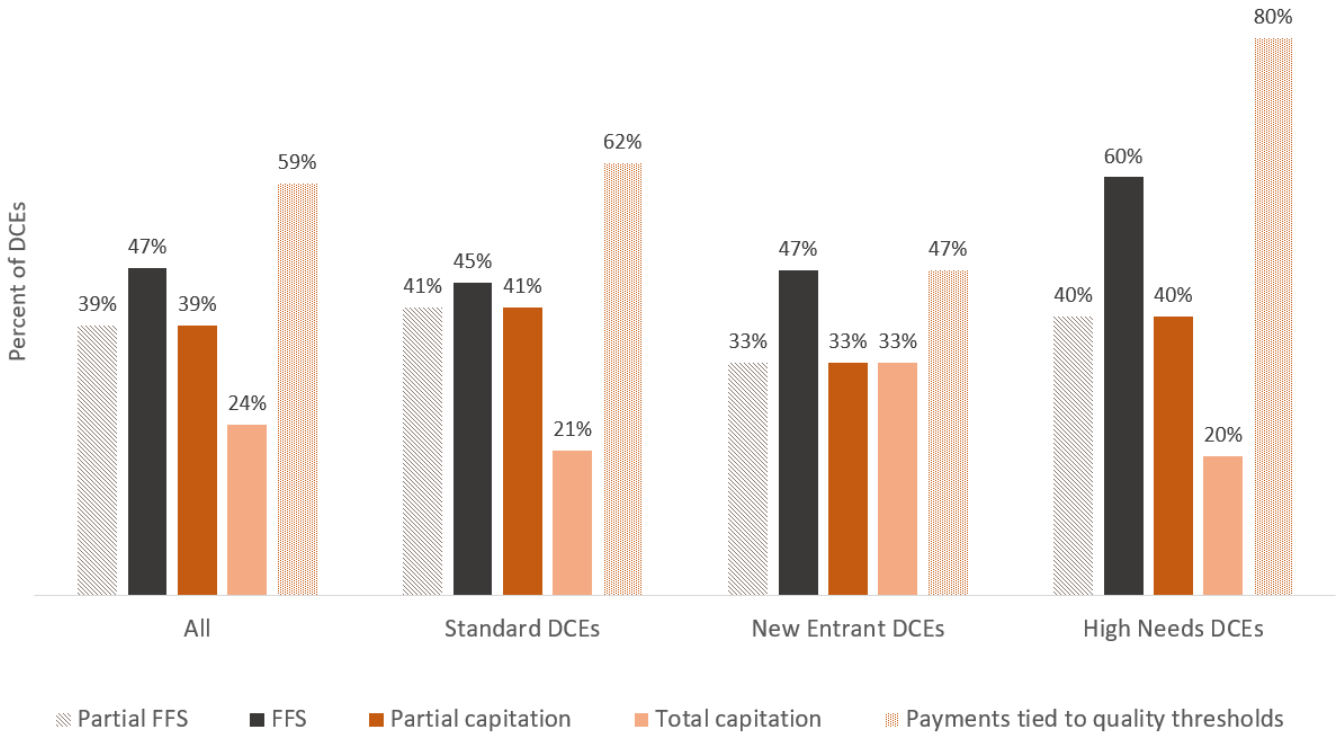


SOURCE: 2022 GPDC Pulse Check Survey (n=49 respondents).

NOTES: DCE = Direct Contracting Entity. One respondent did not answer this survey question.

DCEs reported that payments tied to quality thresholds were the most common method of paying their Participant Providers, followed by FFS and partial capitation. Total capitation was less common, used by only about one-quarter of DCEs. Some DCEs reported other payment arrangements, such as care coordination payments; salaried with performance-based bonus plans; payments for participating in activities, utilization, and care management; and relative value units **(Exhibit 2.16)**.

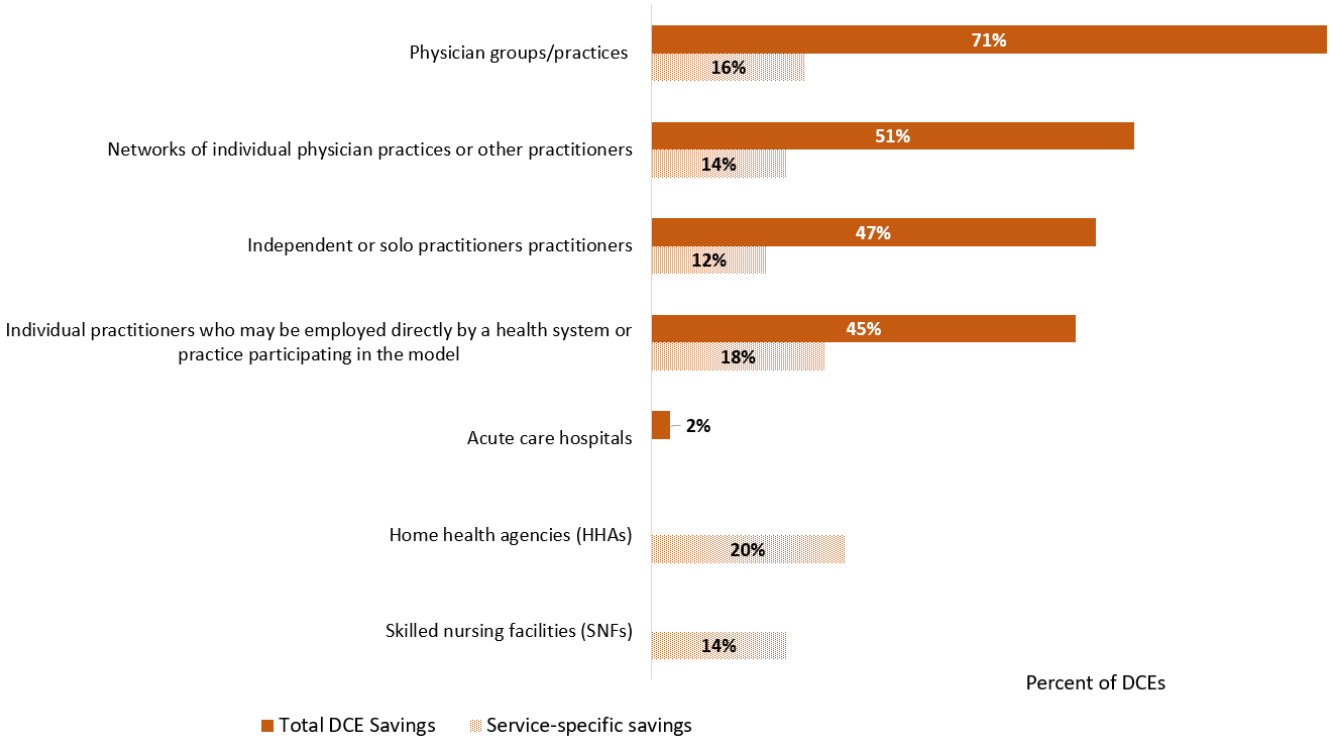
Exhibit 2.16. DCEs Mostly Commonly Reported Paying their Participant Providers Using Payments Tied to Quality Thresholds.



SOURCE: 2022 GPDC Pulse Check Survey (Total respondents, n=49; Standard DCEs, n=29; New Entrant DCEs, n=15; High Needs DCEs, n=5).
NOTES: DCE = Direct Contracting Entity. FFS = Fee-for-Service. Six respondents did not answer this survey question.

DCEs tended to share savings with physician Participant Providers, but not with institutional Participant Providers. Most DCEs reported sharing savings—total or service-specific—with physician groups, networks of individual practitioners, independent practices, or physicians employed by participating health systems. The portion of total savings DCEs shared with physician groups or practices was generally 30% or more. Few DCEs shared savings with hospitals or long-term care providers; however, DCEs were more inclined to share about 5% of their service-specific savings with SNFs and home health agencies (HHAs). Standard DCEs were more likely than New Entrant DCEs to share savings with their physician Participant Providers (**Exhibit 2.17**).

Exhibit 2.17. Most DCEs Shared Savings with Physician Participant Providers, But Not with Institutional Participant Providers.



SOURCE: 2022 GPDC Pulse Check Survey (n=49 respondents).

NOTES: DCE = Direct Contracting Entity. No DCE reported sharing savings with long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs). One respondent did not answer this survey question.

Few DCEs shared losses with their Participant Providers. The DCEs' applications contained limited and mixed information about their experience with sharing downside risk with providers. In model applications, Standard DCEs were more likely than New Entrant DCEs to discuss plans to share downside risk with providers. In the 2022 Pulse Check survey, only 2-6% of DCEs reported sharing total DCE losses with their physician Participant Providers. One DCE reported sharing total DCE losses with an acute care hospital. Four to 10% of DCEs reported sharing service-specific losses with a physician Participant Provider, and no DCE reported sharing service-specific losses with an institutional Participant Provider. Respondent DCEs that did note sharing losses tended to be Standard DCEs, those that had elected Global risk, or both. Of the 10 DCEs that reported sharing losses with their Participant Providers, 8 shared information on the percentage of the risk that they shared, of which 6 reported that they shared more than 50% losses. These DCEs tended to have experience sharing downside risk with their providers prior to entering the GPDC Model.

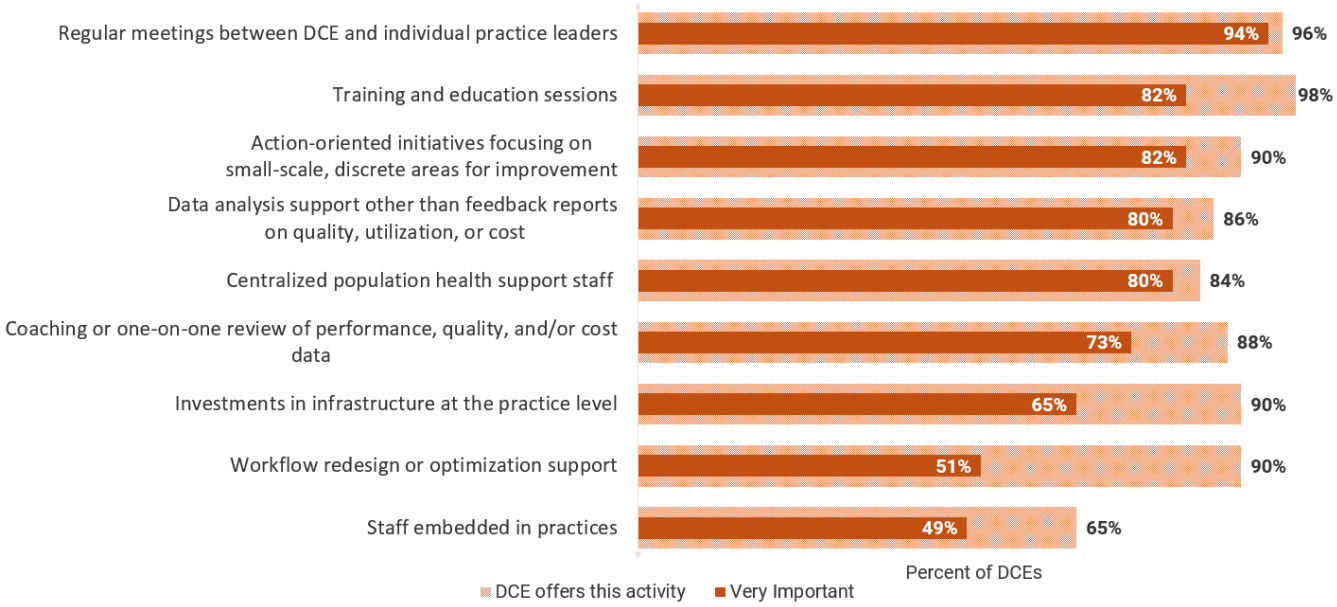
Non-Financial Engagement of Providers

Provider engagement also included non-financial incentives, such as providing feedback and data to improve care, physician education and training, and enhancing practice-level infrastructure and practice transformation

resources. Non-financial incentives are intended to support physicians and to minimize the administrative burden associated with model participation. For example, practice transformation assistance through one-on-one assistance or learning collaboratives in Medicaid ACOs helped providers meeting ACO performance expectations in four states with State Innovation Model Initiative awards.[36] Additionally, ACO leaders in the NGACO Model emphasized the effectiveness of sharing comparative performance data with physicians.[37]

2021 DCEs used many non-financial practice support and improvement strategies, which they considered "very important" to their provider engagement efforts. Most DCEs offered regular meetings; training and education; small-scale, action-oriented initiatives; and coaching and feedback to their Participant Providers **(Exhibit 2.18)**. They considered such strategies "very important" to provider engagement. DCEs also offered infrastructure supports such as centralized population health staff, data analysis, workflow redesign, and (less commonly) embedded staff. More DCEs perceived strategies that involved direct interaction with providers as very important for engaging providers than they did infrastructure supports, with the exceptions of centralized population health staff and data analysis. Further, DCEs noted that uptake of "very important" activities was high among their providers, with most DCEs reporting all or most of their Participant Providers as having used these non-financial supports.

Exhibit 2.18. DCEs Shared Many Non-Financial Practice Support and Improvement Activities with Participant Providers for Provider Engagement.

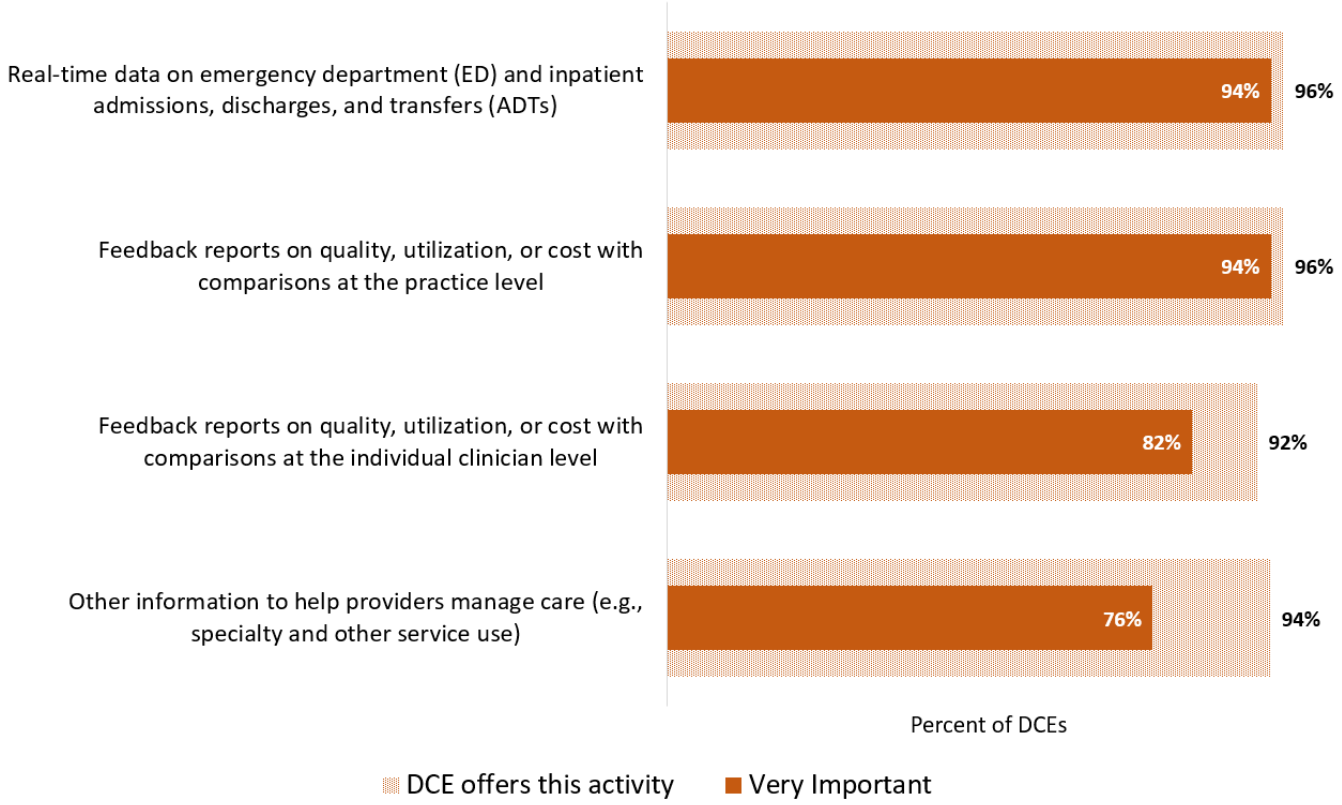


SOURCE: 2022 GPDC Pulse Check Survey (n=49 respondents).
NOTES: DCE = Direct Contracting Entity.

The PY 2021 DCEs deemed sharing real-time ED and inpatient ADTs as well as practice-level feedback reports with their Participant Providers, as "very important" to provider engagement. Additionally, almost all DCEs provided information for care management and individual clinician feedback reports **(Exhibit 2.19)**. As with

other practice supports, a majority of DCEs noted that most or all their Participant Providers used the information-sharing resources that were made available.

Exhibit 2.19. DCEs Implemented Many Information-Sharing Activities, Including Sharing Real-Time ED and Inpatient ADTs and Practice-Level Feedback Reports, Which DCEs Considered "Very Important" in Engaging Participant Providers



SOURCE: 2022 GPDC Pulse Check Survey (n=49 respondents).

NOTES: DCE = Direct Contracting Entity. One respondent did not answer this survey question.

2.6 Conclusion

In the first performance year of the GPDC Model, the DCEs and their provider networks entered the model with varying accountable care experience, implementation priorities, capacity, and infrastructure to support population health, care management, and provider engagement activities. All of these efforts are important to consider when interpreting model performance. Specifically, the 2021 DCEs had robust data sharing capacity, analytic tools, and experience with care coordination and population health management. DCEs' priorities focused on avoidable utilization, complex or population-specific care management, and primary care. The DCEs considered approaches that they believed would have a direct impact on quality and cost of care in selecting model features, implementation activities, and both financial and non-financial incentives to engage providers. care. Based on DCEs' capacities, priorities, and implementation strategies, we expect to see reduced utilization

and spending in acute care and outpatient settings, improvements in quality of care, and a reduction in gross Medicare spending. In the following chapter, we provide an early snapshot of the impact of DCEs on these and other outcomes thus far in the model. However, as this report reflects the very early phases of the model, the findings in this chapter are primarily intended to lay the foundation for future emerging findings around the experience and impact of the GPDC Model, including analysis of data from interviews with DCEs, providers, and beneficiaries; Pulse Check Surveys; and claims.

Chapter 3: The GPDC Model in PY 2021: Beneficiary Characteristics and Impacts on Cost, Utilization, and Quality

Key Findings

Characteristics of Aligned Beneficiaries in PY 2021

- All three DCE types served primarily urban beneficiary populations in PY 2021.
- Compared to Standard and New Entrant DCEs, beneficiaries aligned to High Needs DCEs had more chronic conditions and were more likely to be from a racial or ethnic minority group or dually eligible for Medicare and Medicaid.

Medicare Total Spending in PY 2021

- Standard and New Entrant DCEs did not significantly reduce total gross or net Medicare spending in PY 2021 for their aligned beneficiaries relative to the comparison group. Impact estimates for High Needs DCEs were not calculated because of their small number and size.
- Overall, both Standard and New Entrant DCEs received shared savings (by incurring lower spending than the Model benchmark) and showed lower spending in PY 2021 relative to the comparison group.
- Results from our evaluation and the model's financial results were concordant (with both indicating spending reductions or spending increases) for most DCEs (73%).

Medicare Setting-Specific Spending and Utilization in PY 2021

- While both Standard and New Entrant DCEs reduced ED visits (1.2% and 2.8%, respectively), their impact on spending and utilization differed for several care settings.
- Standard DCEs reduced acute care spending (1.7%), hospitalizations (1.2%), home health spending (2.5%), home health utilization (2.7%), and increased spending overall on primary care (2.5%) and specialty care (1.3%) visits.
- New Entrant DCEs increased home health spending (3.8%).

Medicare Quality of Care in PY 2021

- Overall, we observed no negative effects on quality of care for beneficiaries aligned to Standard and New Entrant DCEs in PY 2021.
- Standard DCEs reduced hospitalizations for ambulatory care-sensitive conditions (3.5%) relative to the comparison group.

In this chapter, we expand on the descriptive analyses presented in **Chapter 2** to assess early impacts for the Model. We address the following key research questions:

- Did the GPDC Model result in lower health care spending and utilization for its aligned beneficiaries relative to a comparison group?
- Did the GPDC Model result in differences in the quality of care received by aligned beneficiaries relative to a comparison group?

We first examine beneficiary characteristics by DCE type, then report the impacts of the GPDC Model in PY 2021 on gross and net total Medicare Parts A and B spending, individual spending categories, utilization, and quality of care for Standard and New Entrant DCEs. We present aggregate results for Standard and New Entrant DCEs, along with total spending impacts for individual DCEs. Regression-based estimates for High Needs DCEs will be presented in future reports, given the low number of High Needs DCEs and their smaller beneficiary populations in PY 2021.

3.1 Methods and Evaluation Hypotheses

Our approach includes a descriptive analysis of aligned beneficiaries in all three DCE types (Standard, New Entrant, High Needs), and an impact analysis of Medicare spending, utilization, and quality of care outcomes for Standard and New Entrant DCEs. **Appendix F** provides more information on the data sources used in the quantitative analyses, **Appendix G** details our analytic methodology and results, and **Appendix H** provides specifications for the variables and outcomes used in the quantitative analyses.

Descriptive Analysis of Aligned Beneficiaries

To better understand differences among the three DCE types, we conducted descriptive analyses of the characteristics of beneficiaries aligned to Standard, New Entrant, and High Needs DCEs during PY 2021. We assessed beneficiaries' sociodemographic characteristics and enrollment information; clinical indicators, including Hierarchical Condition Category (HCC) scores used to determine High Needs eligibility; and market characteristics, including Census region, urban/rural location, and ranking on the Area Deprivation Index (ADI).[38] **Appendix G** provides more details on the descriptive analysis, and **Appendix H** includes a list of the variables used for the descriptive analyses in this report.

Impact Analysis for Standard and New Entrant DCEs

For Standard and New Entrant DCEs, we used a difference-in-differences (DID) design to assess how the GPDC Model's providers affected total Medicare spending, utilization, and quality of care outcomes for their beneficiaries relative to their expected outcomes had the model not existed. We estimated impacts for each DCE separately and then calculated weighted means for individual DCEs within each DCE type to generate overall impact estimates for Standard and New Entrant DCEs in PY 2021.[q] Our baseline period was the three years prior to GPDC Model implementation (2018-2020). We defined beneficiaries in the GPDC group as those aligned to GPDC Participant Providers in PY 2021 and in the baseline period, while beneficiaries in the comparison group were aligned to non-GPDC providers. We used entropy balancing to weight comparison beneficiaries to be similar to GPDC beneficiaries on individual and market characteristics. **Appendix G** provides more detail on the impact assessment methodology, and **Appendix H** details the variables used in the entropy balancing and the regression adjustment, as well as the specifications for the outcome measures.

Estimated Impacts of DID Models Capture the Effect of the GPDC Model Relative to:

- Changes that occurred in the treatment group in the baseline years, which account for effects resulting from prior participation in other APMs for half of the treatment group, and
- Changes occurring in the comparison group in the PY, which account for changes that likely would have occurred in the treatment group had they not participated in the GDPC Model

Evaluation Hypotheses

Exhibit 3.1 presents the hypotheses we aimed to address for spending, utilization, and quality of care, by care setting and/or outcome. For a more detailed list of evaluation hypotheses, including descriptions of potential mechanisms of action for each hypothesis, see **Appendix B**.

[q] Three New Entrant DCEs were excluded from our analyses because they had insufficient data in the baseline period.

Exhibit 3.1. Hypotheses Related to Medicare Spending, Utilization, and Quality of Care.

Domain	Hypothesis
Total Medicare spending	Beneficiaries aligned to DCE providers will **show reductions in gross total Medicare spending** relative to those aligned to non-DCE providers, which will be achieved through more efficient inpatient and outpatient care.
Acute care hospital settings	DCEs will apply their population management approaches to keep high-risk beneficiaries out of hospitals, resulting in **fewer acute care hospitalizations and shorter acute care lengths of stay** for aligned beneficiaries.
Post-acute care settings	DCEs may establish partnerships with SNFs to **reduce SNF spending and lengths of stay**, and aligned beneficiaries may have **fewer days in intensive post-acute care settings** as DCEs shift beneficiaries toward lower-resource care settings such as SNFs or the home.
Outpatient facility and emergency department settings	Beneficiaries aligned to DCE providers may have **lower outpatient spending and fewer emergency department visits** as DCEs improve primary care and population management.
Professional services	**Spending on professional services and primary care may initially increase** while DCEs increase access to care and engage in chronic disease management. Over time, spending on both primary and specialty care services may decrease as DCEs expand access to care through non-physicians (e.g., care coordinators) and providers outside of regular office hours.
Home health and hospice services	DCEs may foster **appropriate use of home health and hospice services** by mitigating waste and encouraging more appropriate alternatives to higher-cost institutional settings. It is possible that service use could increase or decrease, depending on each individual DCE's care delivery strategy, such as use of the unique model waivers in this setting, to address their beneficiaries' health needs.
Quality of care	We expect **improvements in beneficiaries' quality of care over time**, particularly for outcomes that are tied to the Model's financial incentives, as DCEs become financially responsible for improving the quality of care for aligned beneficiaries and care coordination and disease management.

NOTES: DCE = Direct Contracting Entity. SNF = Skilled Nursing Facility. PCC = Primary Care Capitation.

3.2 Variations in Beneficiary Characteristics Across DCE Type

The majority of beneficiaries aligned to Standard, New Entrant, and High Needs DCEs in PY 2021 were claims-aligned based on their pre-existing care relationships with DCEs' Participant Providers, per the Model's PY 2021 alignment data. Beneficiaries who voluntarily aligned by attesting to a care relationship with a Participant Provider comprised over 30% of New Entrant DCEs' beneficiaries, versus only 2% and 7% of those served by Standard and High Needs DCEs, respectively.

Exhibit 3.2 displays descriptive characteristics for the beneficiaries aligned to the three types of DCEs (Standard, New Entrant, and High Needs) included in our analytic population (see **Appendix G** for details on our approach to identifying the populations used in our analyses). While beneficiaries aligned to Standard and New Entrant DCEs were generally similar on demographic, coverage, clinical, and community characteristics, beneficiaries

aligned to High Needs DCEs were different along dimensions relevant to their inclusion in this type of DCE. A larger proportion of aligned beneficiaries were served by High Needs DCEs who were in racial and ethnic minority groups, dually eligible for Medicare and Medicaid, had a disability, or lived in areas of higher socioeconomic disadvantage. Consistent with the High Needs type eligibility criteria, beneficiaries in High Needs DCEs also tended to be in poorer health and frailer than their counterparts in Standard and New Entrant DCEs, with more chronic conditions, higher risk scores, and a higher likelihood of having a long-term nursing home stay in the prior year. All three DCE types served mostly urban beneficiary populations.

Exhibit 3.2. Characteristics of Beneficiaries Aligned to Standard, New Entrant, and High Needs DCEs Varied in PY 2021.

	Standard DCEs (n=281,589)	New Entrant DCEs (n=42,196)	High Needs DCEs (n=2,018)
Demographic Characteristics			
Mean (SD) Age (years)	74.5 (9.8)	74.5 (9.7)	72.3 (14.6)
Sex (%)			
Female	56.9	59.5	54.6
Male	43.1	40.5	45.4
Race/Ethnicity (%)			
Asian/Pacific Islander	2.2	4.7	2.9
Black	6.3	10.6	27.5
Hispanic	6.5	7.8	7.5
White	81.7	74.0	60.5
All Other Races/Ethnicities or Unknown	3.3	2.9	1.7
Health Care Coverage Characteristics			
Ever Dually Eligible for Medicaid (%)	12.4	16.8	68.1
Had Any Part D Coverage (%)	76.2	75.5	87.8
Ever Received Part D Low-Income Drug Subsidy (%)	13.7	17.9	69.3
Disabled Without End-Stage Renal Disease (ESRD) (%)	7.8	7.6	25.4
Clinical Characteristics			
Mean (SD) Total Number of Chronic Conditions	6.1 (3.6)	6.4 (3.8)	12.6 (4.7)
Mean (SD) Prospective HCC score	1.2 (1.1)	1.3 (1.1)	3.5 (2.0)
Nursing Home Stay of >100 Days in Prior Year (%)	1.7	3.2	47.6
GPDC High Needs Flag (%)	10.8	12.6	100

	Standard DCEs (n=281,589)	New Entrant DCEs (n=42,196)	High Needs DCEs (n=2,018)
Community Characteristics			
Census Region (%)			
Northeast	44.5	11.5	0.0
Midwest	19.9	38.1	24.7
South	29.0	39.7	40.1
West	5.2	5.5	35.0
Rurality (%)			
Rural ZIP Code	3.5	1.8	1.4
Urban ZIP Code	96.5	98.2	98.6
Area Deprivation Index (ADI; %)			
Percent of aligned beneficiaries with ADI score of 1-25 (lowest socioeconomic disadvantage)	29.5	29.2	22.1
Percent of aligned beneficiaries with ADI score of 26-50	33.3	37.5	21.4
Percent of aligned beneficiaries with ADI score of 51-75	22.4	19.8	23.6
Percent of aligned beneficiaries with ADI score of 76-100 (highest socioeconomic disadvantage)	13.8	12.6	29.3
Mean (SD) percent of population living below the poverty line	11.0 (6.8)	11.9 (7.2)	15.0 (9.1)
Mean (SD) percent of population ages 25+ with a college degree	35.7 (16.4)	31.9 (14.7)	30.8 (17.1)

NOTES: For additional details on measures in this table, see **Appendix F and Appendix H.1**. For additional details on the eligibility criteria for High Needs DCEs, see the Global and Professional Direct Contracting Financial Operating Guide: Overview. Rurality is defined based on Rural-Urban Commuting Area (RUCA) Codes, with codes 7-10 categorized as rural. Area deprivation index (ADI) scores are national percentile rankings (1-100). Lower scores indicate lower levels of socioeconomic disadvantage. Quartile categorization thresholds for ADI are based on the national distribution; ADI percentages do not add to 100 due to Census block-level suppression criteria. Estimates for the percentages of the population living below the poverty line and age 25+ with a college degree are measured at the ZIP code tabulation area (ZCTA) level and represent the mean and standard deviations of those percentages in ZCTAs where aligned beneficiaries reside. SD=standard deviation; HCC=Hierarchical Condition Category.

Only six High Needs DCEs participated in PY 2021. High Needs DCEs were required to align only a minimum of 250 beneficiaries and had more narrow eligibility criteria than Standard and New Entrant DCEs; as a result, only 2,018 beneficiaries were aligned to High Needs DCEs in PY 2021.[r] With a relatively small number of aligned beneficiaries there was insufficient statistical power to conduct reliable impact estimates for this group. In future reports, we plan to include impact estimates for High Needs DCEs, pending a sufficient sample size to produce robust estimates. **Appendix G** includes additional descriptive results for the 2,018 aligned High Needs beneficiaries, including greater detail on demographic, Medicare coverage, and clinical characteristics.

SDOH Strategies Highlighted by High Needs DCEs in Model Applications

Some High Needs DCEs highlighted the following in their applications:

- Helping beneficiaries identify social support resources such as support groups
- Using SDOH assessments to identify unmet social needs and services designed to address SDOH
- Connecting beneficiaries to local and community organizations for resources and support

3.3 Impact on Medicare Spending, Utilization, and Quality of Care

Our evaluation estimated model impacts on gross and net total Medicare spending, eight setting-specific Medicare spending outcomes, seven setting-specific utilization outcomes, and four quality of care measures. There are several caveats to interpreting the PY 2021 results presented in this chapter for this initial annual report.

- The model used a 9-month performance period in PY 2021 (starting April 1, 2021); however, **our evaluation reflects impacts for the entire calendar year (starting January 1, 2021).** We chose to include the entire calendar year in our analysis for the following two reasons: 1) Future evaluation reports will measure performance on the full calendar year. Including 2021 in full will remove any seasonality effects, thus aligning with the future reports and allowing us to assess performance across Model performance years; and 2) Because the GPDC Model was originally slated to start in January 2021 (but was delayed because of the COVID-19 public health emergency) and some DCEs participated in an optional implementation period, many DCEs were engaged in activities to voluntarily align beneficiaries and ramp-up for the model between January and April 2021, making it reasonable to include those months in the performance year.
- DCEs may have had **limited time to launch and hone their approaches to managing their populations during the abridged (9-month) performance period**. Prior evaluations of APMs find that care transformation and its resultant changes take time.[39]
- **During PY 2021, COVID-19 still played a key role** in influencing provider practice patterns and individual beneficiary care-seeking behavior. The DCEs participating in GPDC's first performance year may be meaningfully different from the non-DCE comparison group in ways that specifically related to their

[r] For additional details on the eligibility criteria for High Needs DCEs, see the Global and Professional Direct Contracting Financial Operating Guide: Overview.

responses to the pandemic, even though the two groups were drawn from the same markets, with similar rates of COVID-19. Our estimated impacts were robust to adjusting for differences in county-level populations' COVID-19 mortality rates **(Appendix G)**.

- **Other Medicare ACOs also operated in the same market areas as DCEs,** including Shared Savings Program and GPDC's predecessor, the NGACO Model, which operated during PY 2021. For this reason, some beneficiaries aligned to these ACOs are included in our comparison group.[5] Given similar incentives and benefits in other Medicare ACOs, including Shared Savings Program and NGACO beneficiaries in the comparison group may attenuate our estimates, potentially diminishing any observed model effects. As NGACO ended in 2021, there will be no NGACO beneficiaries in the comparison group starting in PY 2022; however, NGACO beneficiaries will still be present in the comparison group in baseline years.

Impact on Total Medicare Spending

Our evaluation estimated model impacts on gross and Medicare total spending, while also comparing the evaluation's findings with the model's financial results that determined whether DCEs earned shared savings or incurred shared losses relative to the benchmark. Overall, we observed no significant decreases in gross or net spending, contrary to our hypothesis that DCEs would reduce total spending through more efficient inpatient and outpatient care. The evaluation's results relative to the comparison group were generally consistent with DCEs' financial performance relative to the benchmark, especially for Standard DCEs.

Gross Medicare Spending

Neither Standard nor New Entrant DCEs significantly lowered gross Medicare spending in PY 2021 relative to the comparison group. Across the baseline (2018-2020) and PY 2021, GPDC beneficiaries incurred relatively lower Medicare spending than comparison beneficiaries for both DCE types **(Exhibit 3.3)**. We observed that:

- For Standard DCEs, spending in PY 2021 was higher than in 2020 for both GPDC and comparison beneficiaries and was similar to 2018 and 2019 levels.

Spending Measures

Gross Medicare total spending represents *what Medicare actually paid* by including beneficiary-level capitated payments under the GPDC Model.

Medicare spending category measures represent *what Medicare would have paid* DCEs absent capitation, across a variety of care settings. The measures also capture resource use by care setting and service type.

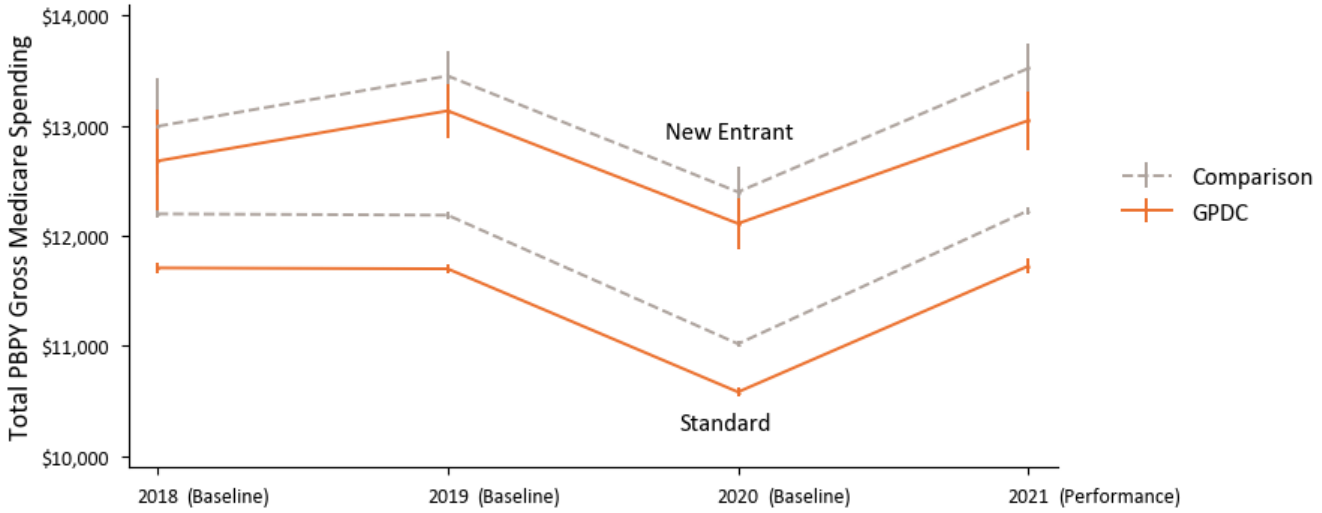
The spending category measures are not mutually exclusive and do not include a category for durable medical equipment (DME) spending; thus, even if the measures were calculated in the same way, the total spending measure would not be equivalent to the sum of the spending category measures.

See **Appendix H** for detailed definitions of these spending measures.

[5] For Standard DCEs in PY 2021, 3.1% of the evaluation's comparison beneficiaries were also in the NGACO Model, and 40.3% were also in the Shared Savings Program. For New Entrant DCEs in PY 2021, 5.7% of the evaluation's comparison beneficiaries were also in the NGACO Model, and 37.7% were also in the Shared Savings Program. For more detail about the overlap with other APMs, see **Appendix Exhibits G.14** and **G.15**.

- For New Entrant DCEs,[t] spending in PY 2021 increased less for GPDC beneficiaries than it did for comparison beneficiaries relative to 2020, although the difference was not statistically significant.
- Overall, New Entrant DCEs and their comparison group had higher average spending than did Standard DCEs and their comparison group, suggesting that New Entrant DCEs may be located in higher spending markets. Differences in the model benchmark calculations (county rate book only for New Entrant DCEs vs. a blend of county rate book and historical experience for Standard DCEs) may have also influenced DCEs' decisions to participate in certain markets.

Exhibit 3.3. Adjusted Gross Medicare Spending Increased at a Slightly Lower Rate for DCEs Than it Did for the Comparison Group Between Baseline and PY 2021.



SOURCE: NORC analysis of 2018-2021 Medicare claims and enrollment data.

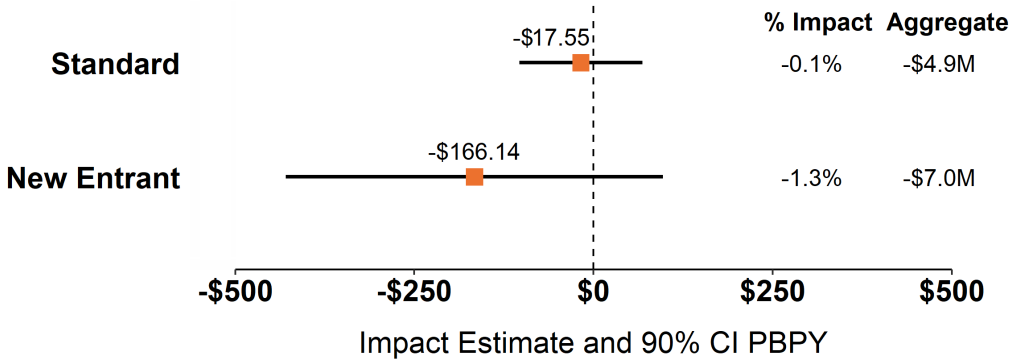
NOTES: Point estimates are the adjusted total Medicare spending for GPDC or comparison beneficiaries in each year. Confidence intervals at the 90% level are displayed as bars around the point estimates. PBPY=per beneficiary per year.

Exhibit 3.4 shows the GPDC Model's per beneficiary per year (PBPY) and aggregate impacts on gross spending for Standard and New Entrant DCEs.

- Standard DCEs lowered gross Medicare spending an estimated $4.9 million (0.15%), or $17.55 PBPY, in PY 2021, but the difference was not statistically significant.
- New Entrant DCEs lowered gross Medicare spending by an estimated $7.0 million (1.26%), or $166.14 PBPY, in PY 2021, with this difference also not statistically significant.
- Larger gross spending reductions for New Entrant DCEs may have reflected greater opportunities to reduce spending in markets with higher baseline expenditures.

[t] Three New Entrant DCEs were excluded from our analyses because of insufficient data in the baseline period.

Exhibit 3.4. New Entrants Had Larger Gross Spending Impact Estimates Than Did Standard DCEs in PY 2021.



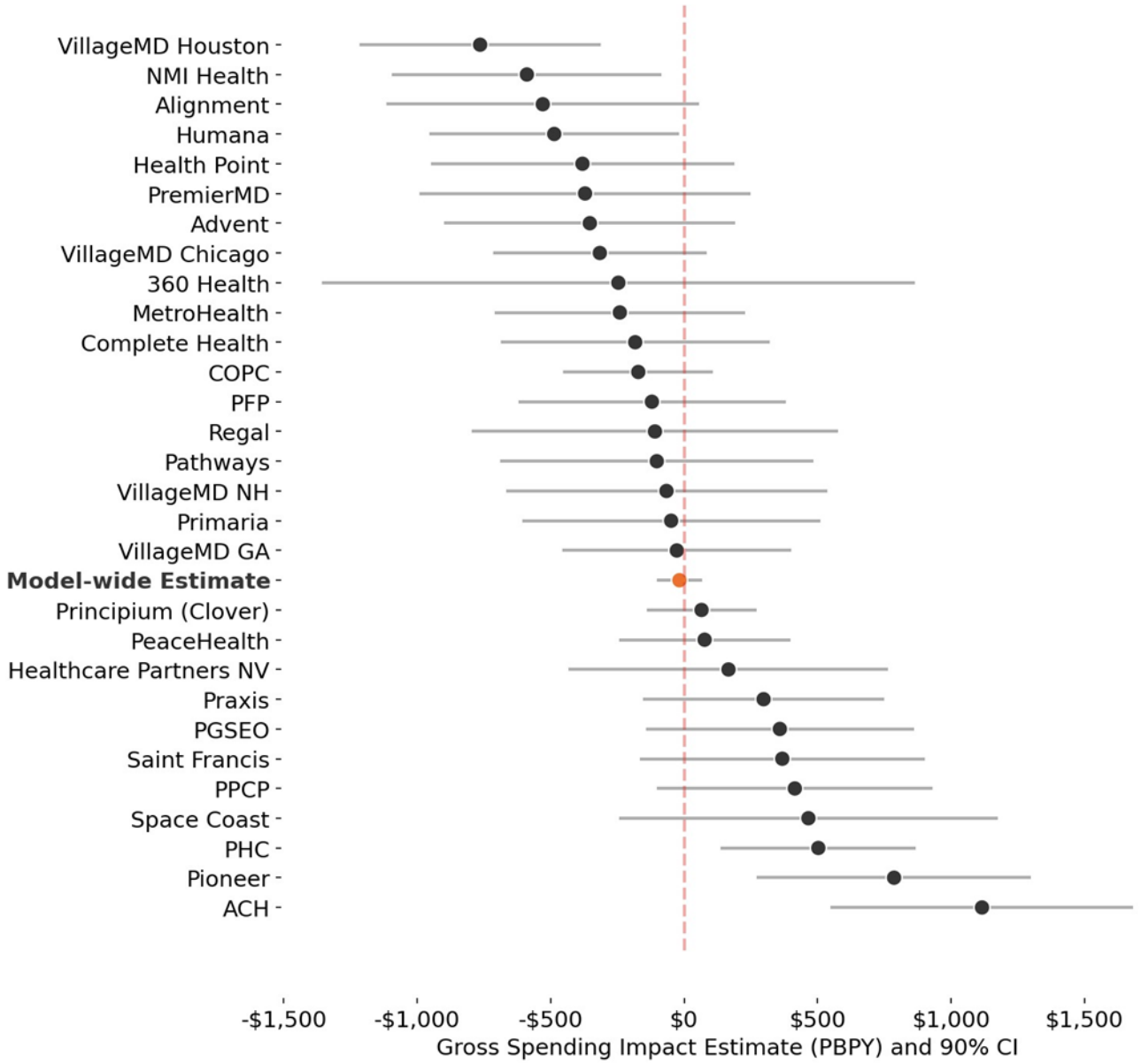
SOURCE: NORC analysis of 2018-2021 Medicare claims and enrollment data.

NOTES: Estimated gross impact is the DID estimate, or the difference between the GPDC and comparison mean-adjusted spending in PY 2021 and the baseline years. Aggregate estimate is the impact estimate for all aligned beneficiaries in PY 2021. Estimated percentage impact is the DID estimate relative to expected outcome for GPDC beneficiaries in PY 2021 had the model not existed and had the beneficiaries' outcomes continued on the same trajectory since baseline. Estimates are presented per beneficiary per year (PBPY). *p<0.10; **p<0.05; ***p<0.01.

Below, we present impact estimates for gross Medicare spending for each individual DCE as well as the overall estimates for Standard DCEs **(Exhibit 3.5)** and New Entrant DCEs **(Exhibit 3.6)**. **Three Standard DCEs and one New Entrant DCE showed statistically significant spending reductions in PY 2021.**

- For Standard DCEs, impacts on gross spending ranged from a non-significant 6.4% reduction to a significant 8.2% increase (p<0.05). In addition to the three Standard DCEs with significant spending reductions (4.0% to 6.2%; p<0.10), three DCEs had significant increases in spending (5.4% to 8.2%; p<0.05) in PY 2021.
- For New Entrant DCEs, impacts on gross spending ranged from a non-significant 17.0% reduction to a non-significant 9.2% increase. One New Entrant DCE had significantly lower spending (11.5%; p<0.01), but no New Entrant DCEs had significantly increased Medicare spending relative to the comparison group in PY 2021.
- Differences in gross spending impacts across DCEs may reflect variations in DCEs' financial risk and payment mechanism elections, organizational types, implementation approaches, market context, providers, and aligned beneficiaries. In future reports, we plan to investigate impacts for key DCE subgroups along these dimensions.

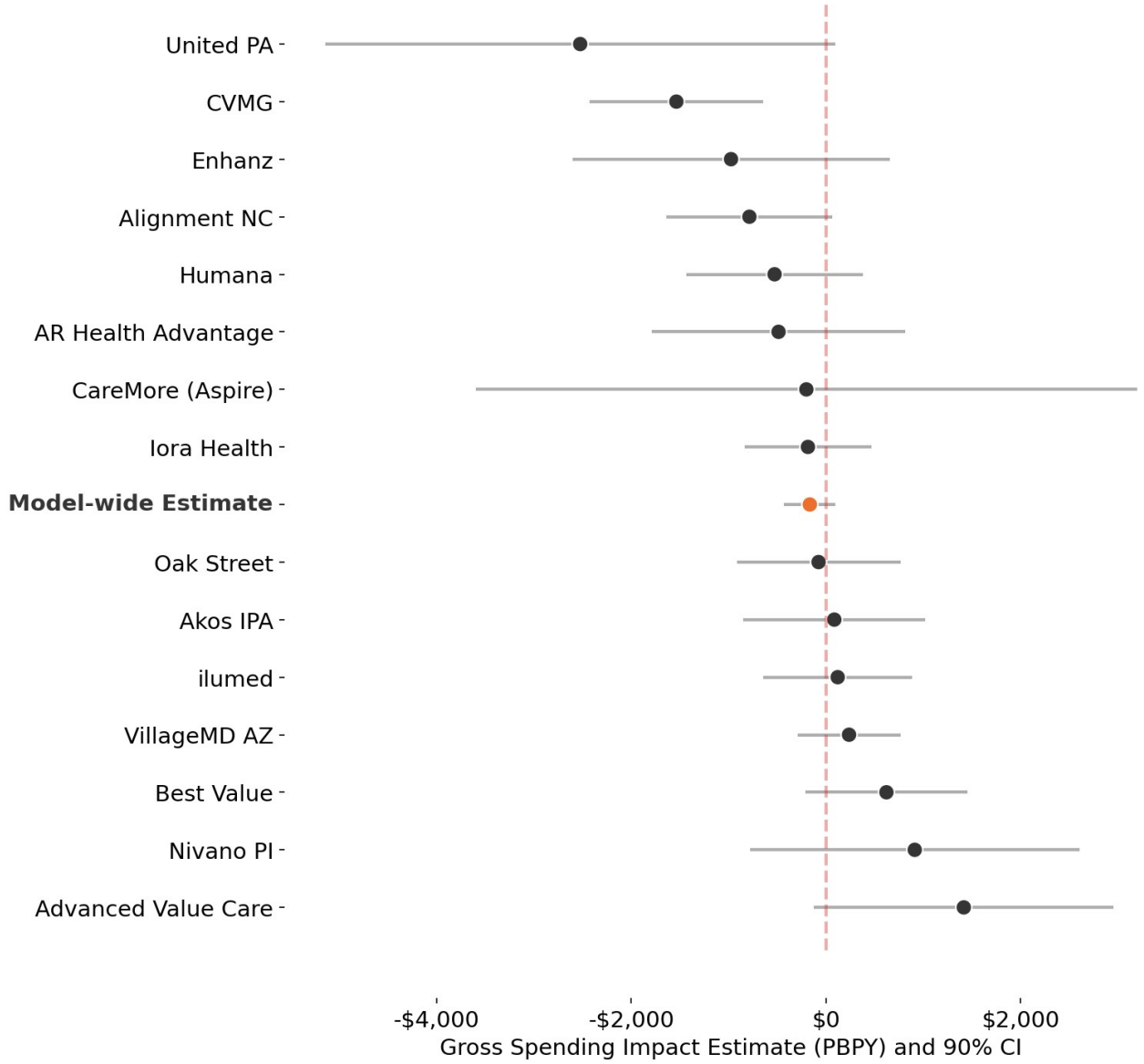
Exhibit 3.5. Standard DCEs' Gross Spending Impact Varied by DCE in PY 2021.



SOURCE: NORC analysis of 2018-2021 Medicare claims and enrollment data.

NOTES: Estimated gross impact per beneficiary per year (PBPY) is the DID estimate or the difference between the GPDC and comparison mean-adjusted spending in PY 2021 and the baseline years. Estimated percentage impact is the DID estimate relative to the expected outcome for GPDC beneficiaries in PY 2021 had the model not existed and had the beneficiaries' outcomes continued on the same trajectory since baseline. Abbreviations for DCE names: NMI = Northern Michigan; COPC = Central Ohio Primary Care; PFP = Premier Family Physicians; NH = New Hampshire; GA = Georgia; NV = Nevada; PGSEO = Physicians Group of South Eastern Ohio PPCP = Preferred Primary Care Physicians; PHC = Physicians Healthcare Collaborative; ACH = American Choice Healthcare. *p<0.10; **p<0.05; ***p<0.01.

Exhibit 3.6. New Entrant DCEs' Gross Spending Impact Varied by DCE in PY 2021.



SOURCE: NORC analysis of 2018-2021 Medicare claims and enrollment data

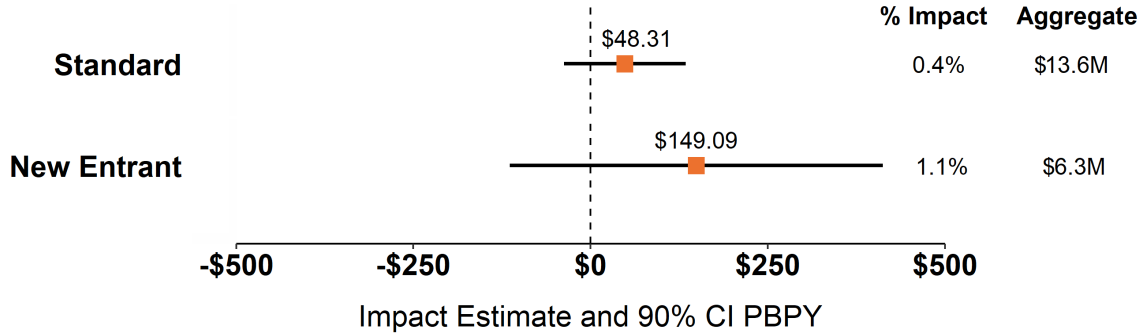
NOTES: Estimated gross impact per beneficiary per year (PBPY) is the DID estimate or the difference between the GPDC and comparison mean-adjusted spending in PY 2021 and the baseline years. Estimated percentage impact is the DID estimate relative to expected outcome for GPDC beneficiaries in PY 2021 had the model not existed and had the beneficiaries' outcomes continued on the same trajectory since baseline. Three New Entrant DCEs were excluded from our analyses because of insufficient data in the baseline period. Abbreviations for DCE names: PA = Physicians Association; CVMG = Central Valley Medical Group; NC = North Carolina; AR = Arizona; IPA = Independent Physician Association; AZ = Arizona; PI = Physicians Incorporated. *p<0.10; **p<0.05; ***p<0.01.

Net Medicare Spending

Exhibit 3.7 shows the GPDC Model's aggregate and PBPY impacts on net Medicare spending**. After taking shared savings payouts into account, neither Standard nor New Entrant DCEs demonstrated significant net savings to Medicare in the model's first year.**

- For Standard DCEs, we observed a non-significant increase in net Medicare spending of $13.6 million (0.41%), or $48.31 PBPY, in PY 2021.
- For New Entrant DCEs, we observed a non-significant increase in net Medicare spending of $6.3 million (1.13%), or $149.09 PBPY, in PY 2021.

Exhibit 3.7. Net Spending Impact Estimates Were Larger for New Entrant DCEs in PY 2021.



SOURCE: NORC analysis of 2018-2021 Medicare claims and enrollment data.

NOTES: Estimated net impact is the gross DID estimate or the difference between the GPDC and comparison mean-adjusted spending in PY 2021 and the baseline years, less shared savings/losses to DCEs in PY 2021. Aggregate estimate is the net impact estimate for all aligned beneficiaries in PY 2021. Estimated percentage impact is the DID estimate relative to expected outcome for GPDC beneficiaries in PY 2021 had the model not existed and had the beneficiaries' outcomes continued on the same trajectory since baseline. Estimates are presented per beneficiary per year (PBPY). *p<0.10; **p<0.05; ***p<0.01.

Concordance Between Evaluation Findings and Model's Financial Results

To understand how our evaluation's results align with the model's financial calculations of shared savings, we compared actual shared savings and losses against the benchmark with the evaluation's estimates of gross spending impact for each DCE. These findings point to the potential feasibility of the model from the perspectives of both Medicare and the DCEs.

- DCEs were considered "concordant" when they: 1) decreased spending according to the evaluation and had shared savings according to the financial calculations; or 2) increased spending and had shared losses.
- DCEs were considered "discordant" when they: 1) decreased spending and had shared losses; or 2) increased spending and had shared savings.

Financial and evaluation results for each DCE type and individual DCEs can be found in **Appendix G.**

Despite key differences between the evaluation's approach and the model's financial benchmark used to calculate shared savings and losses (including certain assumptions made to estimate a prospectively derived spending benchmark), we would expect greater concordance between the evaluation and financial results for Standard DCEs than for New Entrant DCEs in PY 2021 because the financial benchmark and evaluation's baseline rely on historical spending for Standard DCEs. [u,40] Benchmarks for New Entrant DCEs in PY 2021 were based solely on the county rate book rather than historical data specific to the beneficiaries aligned to New Entrant DCEs' providers.[v]

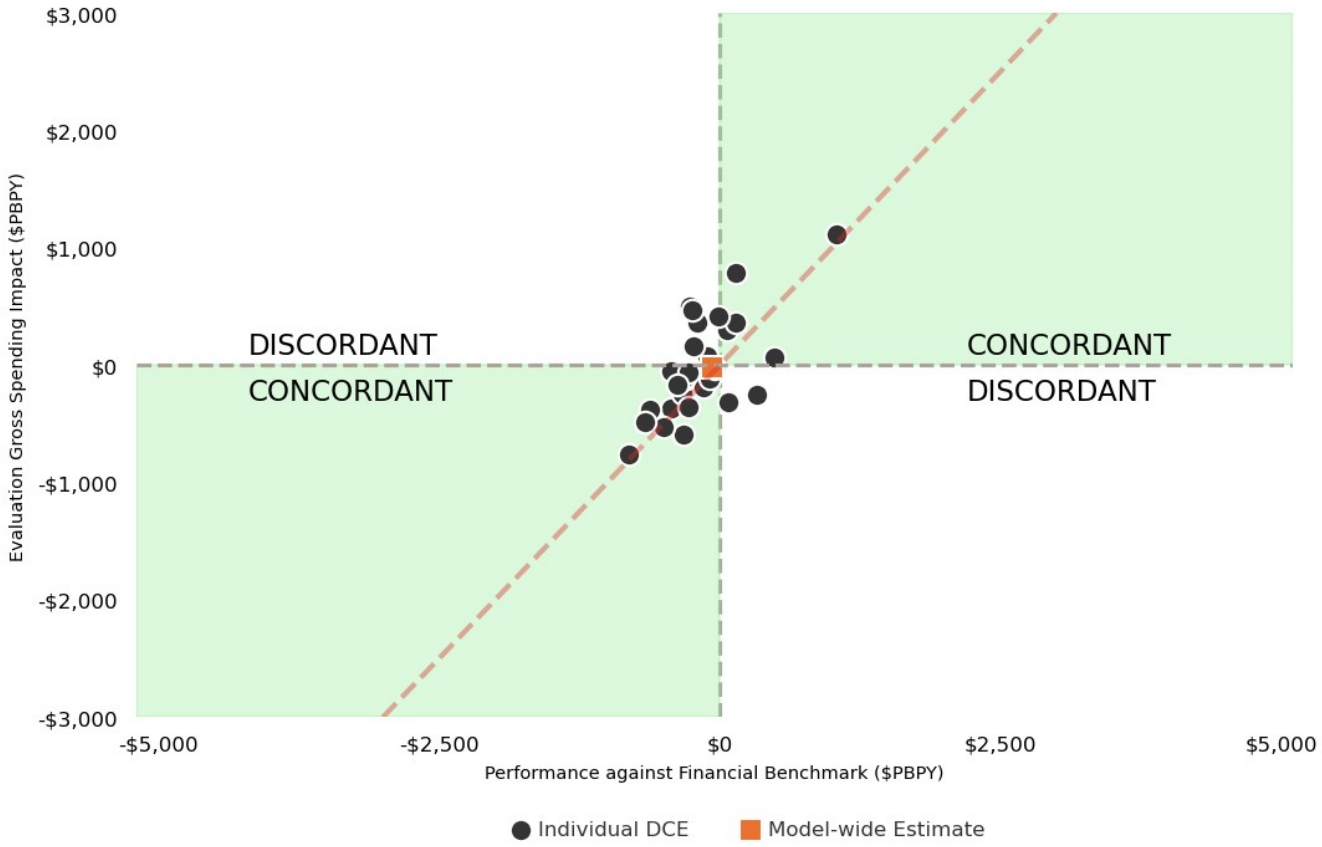
In **Exhibit 3.8**, we compare evaluation findings for gross spending and financial results (shared savings/losses against the benchmark) for Standard DCEs. Overall, financial results (shared savings of $65.86 PBPY) and evaluation results (reductions in spending of $17.55 PBPY) indicated better performance by Standard DCEs relative to the benchmark than relative to the comparison group. When considering the 29 Standard DCEs only:

- Over two-thirds of Standard DCEs (21 DCEs; 72.4%) had concordant financial results and evaluation findings.
  - Over half (16 DCEs; 55.2%) realized **shared savings** relative to the benchmark and **reduced spending** relative to a comparison group.
  - Five DCEs (17.2%) realized **shared losses** relative to the benchmark and **increased spending** relative to a comparison group.
- Almost one-third of Standard DCEs (8 DCEs; 27.6%) had discordant financial results and evaluation findings.
  - Two DCEs (6.9%) realized **shared losses** relative to the benchmark and **reduced spending** relative to a comparison group.
  - Six DCEs (20.7%) realized **shared savings** relative to the benchmark and **increased spending** relative to a comparison group.
- Overall, 22 Standard DCEs (75.6%) earned shared savings, while only 18 (62.1%) reduced spending relative to a comparison group, contributing to an increase in net spending for Medicare.

[u] The benchmark for claims-aligned beneficiaries for Standard DCEs in PY 2021 is a blend of 65% historical expenditures (similar to the evaluation methodology) and 35% county rate book. Starting in PY 2024, the proportion of the benchmark based on the county rate book will gradually increase each year. Benchmarks for voluntarily aligned beneficiaries (regardless of DCE type) are based solely on the county rate book in PY 2021.

[v] This approach will be used through PY 2024; for PY 2025 and PY 2026, benchmarks for New Entrant DCEs and all voluntarily aligned beneficiaries will be based on a blend of historical expenditures and the county rate book.

Exhibit 3.8. Most Standard DCEs Had Concordance Between Gross Spending Impacts and Financial Results in PY 2021.



SOURCE: NORC analysis of 2018-2021 Medicare claims and enrollment data.

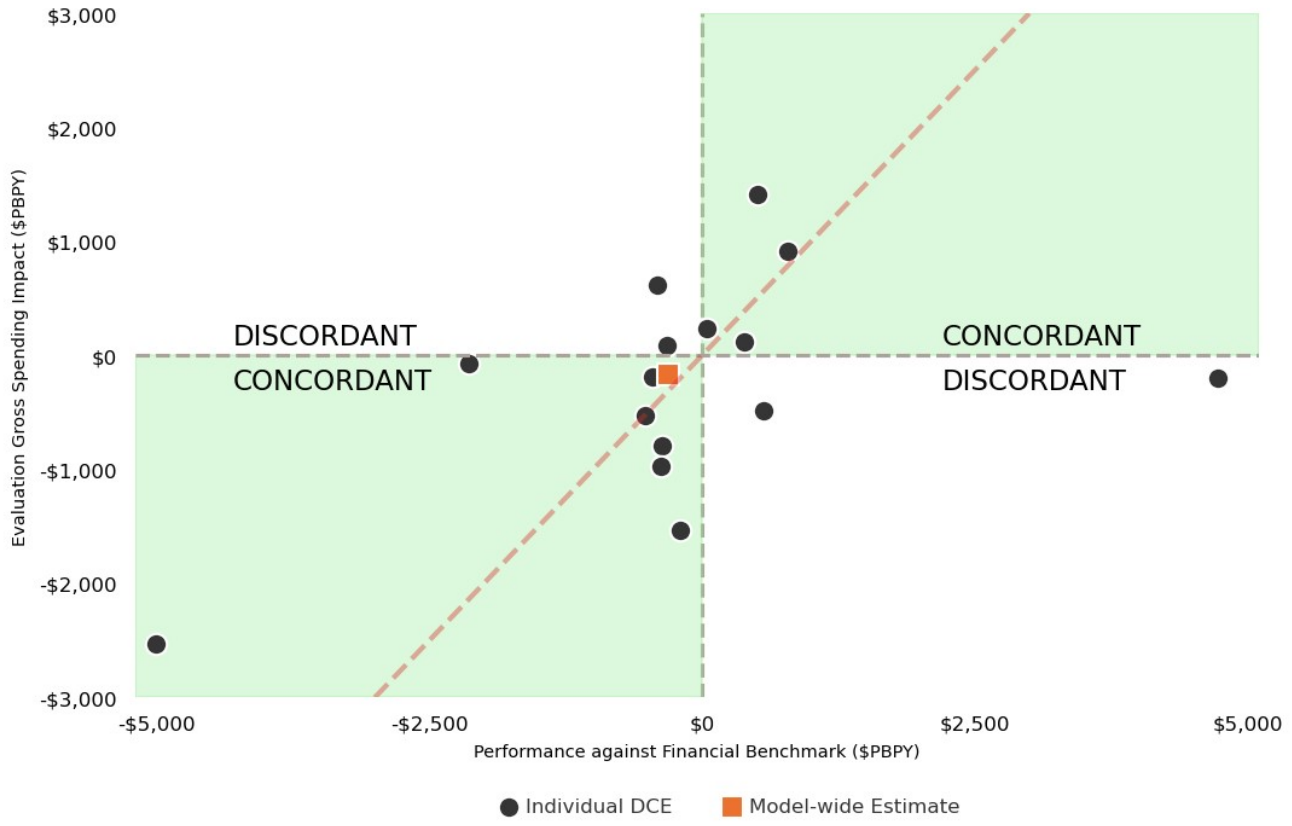
NOTES: Top left quadrant: DCEs that realized shared savings and increased spending relative to comparison. Top right quadrant: DCEs that realized shared losses and increased spending relative to comparison. Bottom left quadrant: DCEs that realized shared savings and reduced spending relative to comparison. Bottom right quadrant: DCEs that realized shared losses and reduced spending relative to comparison. Points to the right of the dashed diagonal line are financially feasible from Medicare's perspective because they contribute to net savings for Medicare. Points to the left of the vertical axis are financially feasible from the DCEs' perspective as they reflect earned shared savings. PBPY = per beneficiary per year. DCE = Direct Contracting Entity.

In **Exhibit 3.9**, we compare evaluation findings for gross spending and financial results (shared savings/losses against the benchmark) for New Entrant DCEs. Overall, the financial results (shared savings of $315.23 PBPY) and evaluation results (reductions in spending of $166.14 PBPY) indicated better performance by New Entrant DCEs relative to the benchmark used for the financial calculations than relative to the comparison group used for the evaluation. This is consistent with the model's efforts to encourage participation among new DCEs through benchmarks determined entirely by regional expenditures. By contrast, Standard DCEs' benchmarks were a blend of historical baseline and regional expenditures. When considering the 15 New Entrant DCEs only:

- Most New Entrant DCEs (11 DCEs; 73.3%) had concordant financial results and evaluation findings.

  - Seven DCEs (46.7%) realized **shared savings** relative to the benchmark and **reduced spending** relative to a comparison group. The magnitude of shared savings paid out to two of these DCEs exceeded their spending reductions, contributing to increases in net spending.
  - Four DCEs (26.7%) realized **shared losses** relative to the benchmark and **increased spending** relative to a comparison group.
- Relatively few New Entrant DCEs (4 DCEs; 26.7%) had discordant financial results and evaluation findings.
  - Two DCEs (13.3%) realized **shared losses** relative to the benchmark and **reduced spending** relative to a comparison group.
  - Two DCEs (13.3%) realized **shared savings** relative to the benchmark and **increased spending** relative to a comparison group. These DCEs also contributed to increases in net spending.

Exhibit 3.9. Most New Entrant DCEs Had Concordance Between Gross Spending Impacts and Financial Results in PY 2021.



SOURCE: NORC analysis of 2018-2021 Medicare claims and enrollment data.

NOTES: Top left quadrant: DCEs that realized shared savings and increased spending relative to comparison. Top right quadrant: DCEs that realized shared losses and increased spending relative to comparison. Bottom left quadrant: DCEs that realized shared savings and reduced spending relative to comparison. Bottom right quadrant: DCEs that realized shared losses and reduced spending relative to comparison. Points to the right of the dashed diagonal line are financially feasible from Medicare's perspective because they contribute to net savings for Medicare. Points to the left of the vertical axis are financially feasible from the DCEs' perspective as they reflect earned shared savings. PBPY = per beneficiary per year. DCE = Direct Contracting Entity.

Impact on Setting-Specific Medicare Spending and Utilization

Our evaluation estimated impacts on spending and utilization measures across six settings: acute care hospital facility, PAC, outpatient facility, professional services (including primary care and specialty care visits), home health, and hospice. Given the model's focus on enhanced primary care, we expected services covered under the PCC to initially increase, with a decrease in utilization and spending associated with acute care. In addition, we expected that, as DCEs began to establish partnerships with SNFs in their networks and leverage SNF benefit enhancements, inpatient rehabilitation facility (IRF) and long-term care hospital (LTCH) utilization and spending would decrease. For our analysis, utilization measures include acute care hospitalizations, acute care length of stay, SNF days, ED visits, home health episodes, IRF and LTCH days, and continuous hospice days prior to death. It is important to note that there are substantive differences between how the total spending and setting-specific spending measures were calculated. The total spending measure represents what Medicare actually paid by including beneficiary-level capitated payments under the GPDC Model, whereas the setting-specific spending measures represent what Medicare would have paid DCEs absent capitation, across a variety of care settings.[w] The impacts on setting-specific spending are shown to inform our understanding of utilization changes and how DCEs are approaching their care delivery transformation efforts.

Primary Care Focus in the Model and PAC Partnerships

In our 2022 survey, 90% of DCEs reported that strategies to emphasize primary care touchpoints or investments in primary care were "high" priorities for them.

More than half of DCEs also mentioned prior partnerships or collaboration with PAC providers in their model applications.

Acute Care Hospital Settings

Standard DCEs had significantly lower spending in acute care hospital facilities (1.70%; p<0.05), along with a decrease in acute care hospitalizations (Exhibit 3.10). These findings are consistent with our hypothesis that DCEs' population management strategies would prevent hospitalizations. Both Standard DCE and comparison beneficiaries decreased acute care hospitalizations in PY 2021 relative to average utilization in the baseline years; however, the decrease was larger for Standard DCE beneficiaries than it was for comparison beneficiaries. Because Standard DCEs have organizational experience with incentives similar to those in the GPDC Model for Medicare FFS beneficiaries, they may have been well-positioned to implement processes designed to reduce

Examples of Standard DCEs' Acute Care Strategies from Model Applications

- Provider trainings and education on implementing benefit enhancements under the model
- Grand Rounds, in which care team members discuss avoidable inpatient admissions or readmissions
- Frequent contact and follow-up with high-risk/high-needs beneficiaries
- Triage service lines that allow trained ED staff to manage acute illnesses outside of the ED

[w] Direct comparisons between total spending and spending categories are not feasible given differences in how these measures were constructed and analyzed.

utilization in high-cost areas such as hospitalizations. For New Entrant DCEs, there was no significant impact on spending or utilization for acute care hospital services.

Exhibit 3.10. Standard DCEs Reduced Acute Care Spending and Utilization in PY 2021.

Setting	% Impact	Impact Estimate	90% CI	Baseline to PY 2021 Change	
				GPDC	Comparison
Standard DCEs					
Acute care setting spending^	**-1.70**	**-$57.64****	**-$102.5, -$12.78**	↓	↓
Acute care hospitalizations^	**-1.18**	**-2.48***	**-4.74, -0.23**	↓	↓
Acute care length of stay (days)^	-0.29	-4.07	-23.72, 15.57	↓	↓
New Entrant DCEs					
Acute care setting spending	-1.82	-$60.06	-$178.12, $58.01	↓	↓
Acute care hospitalizations^	-0.91	-1.84	-8.07, 4.39	↓	↓
Acute care length of stay (days)	0.42	5.56	-43.26, 54.38	↓	↓

SOURCE: NORC analysis of 2018-2021 Medicare claims and enrollment data.

NOTES: Spending estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY). Utilization estimates and CI are presented as rate of the outcome per 1,000 beneficiaries per year (PBY). Estimated percentage impact is the DID estimate relative to expected outcome for GPDC beneficiaries in PY 2021 had the model not existed and had the beneficiaries' outcomes continued on the same trajectory since baseline. ^Finding verified from sensitivity analyses, as at least one DCE included in the pooled estimate did not have parallel trends in the baseline period. When excluding DCEs that did not have parallel trends in the baseline period, the impact was similar in direction, magnitude, and significance for Standard and New Entrant DCEs (Appendix G, Exhibits G.21-G.22). *p<0.1, **p<0.05, and ***p<0.01. DCE = Direct Contracting Entity.

Post-Acute Care Settings

Standard DCEs had significantly lower spending in the SNF setting (2.33%; p<0.10), but did not see a corresponding reduction in SNF days **(Exhibit 3.11)**. The reduction in SNF spending is consistent with our hypothesis that DCEs would partner with SNFs and direct PAC toward lower-intensity settings. However, we also expected to see a corresponding reduction in SNF days as well as IRF and LTCH spending and days, which did not materialize in 2021.

The reduction in SNF spending may reflect a preference by providers to keep beneficiaries out of facilities in PY 2021 to limit exposures in the context of the COVID-19 PHE. Additionally, the 3-day SNF rule waiver benefit enhancement may also impact PAC spending (Exhibit

Examples of Standard DCEs' PAC Strategies from Model Applications

- Transitional care managers who ensure smooth transitions from the hospital to PAC and home
- Robust data sharing processes for sharing care team updates
- Post-discharge follow-up phone calls with care review, medication reconciliation, risk assessment, and follow-up visit scheduling
- Embedded care coordinators in partner PAC provider facilities

1.3). For New Entrant DCEs, there was no evidence of impact on spending or utilization in the SNF setting. Overall, there were no significant impacts on IRF and LTCH measures for Standard or New Entrant DCEs.

Exhibit 3.11. Standard DCEs Reduced SNF Spending; No Changes for New Entrant DCEs in PY 2021.

Setting	% Impact	Impact Estimate	90% CI	Baseline to PY 2021 Change	
				GPDC	Comparison
Standard DCEs					
SNF spending^	**-2.33**	**-$20.41***	**-$39.78, -$1.03**	↓	↓
SNF days^	-1.72	-26.98	-62.37, 8.4	↓	↓
IRF and LTCH spending^	-3.29	-$13.80	-$29.8, $2.19	↑	↑
IRF and LTCH days^	-2.56	-5.89	-14.92, 3.14	↓	↓
New Entrant DCEs					
SNF spending^	-4.61	-$39.02	-$92.93, $14.88	↓	↑
SNF days^	-3.26	-47.67	-141.76, 46.41	↓	↓
IRF and LTCH spending^	11.97	$41.90	-$19.04, $102.83	↓	↓
IRF and LTCH days^	7.15	13.05	-8.01, 34.10	↓	↓

SOURCE: NORC analysis of 2018-2021 Medicare claims and enrollment data.

NOTES: Spending estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY). Utilization estimates and confidence intervals are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). Estimated percentage impact is the DID estimate relative to what we would expect the outcome to be for GPDC beneficiaries in PY 2021 had the model not existed and had beneficiaries' outcomes continued on the same trajectory since baseline. ^Finding verified from sensitivity analyses, as at least one DCE included in the pooled estimate did not have parallel trends in the baseline period. When excluding DCEs that did not have parallel trends in the baseline period, the impact was similar in direction, magnitude, and significance for Standard and New Entrant DCEs (Appendix G, Exhibits G.21-G.22). *p<0.1, **p<0.05, and ***p<0.01. DCE = Direct Contracting Entity. SNF = Skilled Nursing Facility. IRF = Inpatient Rehabilitation Facility. LTCH = Long Term Care Hospital.

Outpatient Facility and Emergency Department Settings

Both Standard and New Entrant DCEs saw reductions in ED visits and observation stays. Standard DCEs saw a reduction in outpatient facility spending (1.35%; p<0.10) that was not statistically significant in sensitivity analyses **(Exhibit 3.12)**.[x] Outpatient facility spending in PY 2021 increased relative to average spending in the baseline years for both Standard DCE and comparison beneficiaries, although the increase was smaller for

[x] Standard DCEs' impact on outpatient facility was similar in direction, but was smaller in magnitude and not statistically significant (1.07%) in sensitivity analyses, after excluding two DCEs that did not have parallel trends during the baseline years, which comprised approximately 9.6% of all aligned beneficiaries. See Appendix G, Exhibit G.21.

Standard DCE beneficiaries. These findings align with our hypotheses that beneficiaries in the GPDC Model would have lower outpatient spending and fewer emergency department visits as DCEs worked to improve primary care and population management.

For both DCE types, GPDC and comparison beneficiaries saw decreased ED visits relative to the average baseline utilization, but the decrease was larger for GPDC beneficiaries, leading to the observed reduction in ED visits. Nearly all DCEs reported prioritizing investments in primary care capacity and avoidable utilization in PY 2021, and Standard DCEs had prior organizational experience in value-based care models such as NGACO or the Shared Savings Program. For this reason, the DCEs may have been well-positioned to implement processes for reducing utilization in high-cost areas such as hospitalizations and ED visits.

Examples of Standard and New Entrant DCEs' ED Prevention Strategies from Model Applications

- Robust ADT notification systems for real-time alerts and coordinated transitions from ED to other care settings
- ED predictive models to identify beneficiaries at higher risk for ED visits
- Programs to identify preventable reasons for ED admissions and conduct targeted care management
- Targeted outreach for high ED utilizers

Exhibit 3.12. Both Standard and New Entrant DCEs Reduced ED Visits and Observation Stays in PY 2021.

Setting	% Impact	Impact Estimate	90% CI	Baseline to PY 2021 Change	
				GPDC	Comparison
Standard DCEs					
Outpatient facility spending^	**-1.35**	**-$25.17***	**-$47.06, -$3.27**	↑	↑
ED visits and observation stays^	**-1.23**	**-4.64****	**-8.09, -1.18**	↓	↓
New Entrant DCEs					
Outpatient facility spending	-1.90	-$32.49	-$87.88, $22.90	↑	↑
ED visits and observation stays^	**-2.76**	**-10.62***	**-20.84, -0.41**	↓	↓

SOURCE: NORC analysis of 2018-2021 Medicare claims and enrollment data.

NOTES: Spending estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY). Utilization estimates and CI are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). Estimated percentage impact is the DID estimate relative to expected outcome for GPDC beneficiaries in PY 2021 had the model not existed and had the beneficiaries' outcomes continued on the same trajectory since baseline. ^Finding verified from sensitivity analyses, as at least one DCE included in the pooled estimate did not have parallel trends in the baseline period. When excluding DCEs that did not have parallel trends in the baseline period, the impact for ED visits and observation stays was similar in direction, magnitude, and significance for Standard and New Entrant DCEs; the impact for outpatient facility spending was similar in direction, but smaller in magnitude and not statistically significant for Standard DCEs (Appendix G, Exhibits G.21-G.22). *p<0.1, **p<0.05, and ***p<0.01. DCE = Direct Contracting Entity. ED = emergency department.

Professional Services

Spending for primary and specialty care visits significantly increased for both Standard DCE and comparison patients in PY 2021 relative to average baseline spending. The spending increase was larger for Standard DCE beneficiaries in PY 2021, relative to a comparison group (2.49% and 1.27%; p<0.01) **(Exhibit 3.13).**[y] The increase likely reflects the model's focus on enhanced primary care and may result from Participant Providers conducting targeted outreach to aligned beneficiaries. The finding also aligns with our hypothesis **(Exhibit 3.1)** regarding a likely initial increase in primary care. As noted in **Chapter 2**, Standard DCEs were also more likely than were New Entrant DCEs to focus on investments in primary care capacity, such as non-physician providers and after-hours care, which may have further increased the utilization of those services.

By contrast, spending for specialty care visits did not increase for New Entrant DCEs and their impact on spending for primary care visits was unclear. Estimates for New Entrant DCEs were unclear due to divergent findings in our sensitivity analyses (**Exhibit 3.13**).[z] While both New Entrant DCE and comparison beneficiaries increased spending for primary care visits in PY 2021 relative to average baseline spending; the overall impact on spending on primary care visits for New Entrant DCEs was unclear due to mixed findings that changed direction in sensitivity analyses. We plan to delve deeper into understanding impacts for this outcome in future reports.

Results for the professional services spending measure were not statistically significant for either Standard or New Entrant DCEs. This measure captures a broader set of professional services than solely the primary and specialty care visits spending measures.

[y] We observed consistent results for impacts of Standard DCEs on spending for primary and specialty care visits in sensitivity analyses, after excluding DCEs that did not have parallel trends during the baseline years. For spending on primary care visits, this affected 13 of 29 DCEs, comprising approximately 46% of all aligned beneficiaries; for spending on specialty care, this affected 5 of 29 DCEs, comprising approximately 41% of all aligned beneficiaries. See Appendix G, Exhibit G.21.

[z] We observed divergent results for impacts of New Entrant DCEs on spending on primary care visits in sensitivity analyses. Five of the 15 New Entrant DCEs, comprising approximately 38% of all aligned beneficiaries, did not have parallel trends during the baseline years. When those five DCEs were excluded from our analysis, the impact on spending on primary care visits for New Entrants changed from a significant decrease of 1.65% ($11.10 PBPY, p<0.05) to a significant increase of 3.86% ($27.11 PBPY, p<0.01). See Appendix G, Exhibit G.22.

Exhibit 3.13. Standard DCEs Increased Spending on Primary Care; New Entrant DCEs' Impact on Spending on Primary Care Visits Was Unclear.

Setting	% Impact	Impact Estimate	90% CI	Baseline to PY 2021 Change	
				GPDC	Comparison
Standard DCEs					
Professional services spending	0.49	$15.66	-$8.93, $40.26	↑	↑
Primary care visits spending^	**2.49**	**$15.46*** **	**$12.26, $18.66**	↑	↑
Specialty care visits spending^	**1.27**	**$2.76*** **	**$1.41, $4.12**	↑	↑
New Entrant DCEs					
Professional services spending	-0.21	-$7.54	-$82.57, $67.49	↑	↑
Primary care visits spending^	**Unclear**	**Unclear**	**Unclear**	↑	↑
Specialty care visits spending	-0.23	-$0.51	-$4.18, $3.17	↑	↑

SOURCE: NORC analysis of 2018-2021 Medicare claims and enrollment data.

NOTES: Spending estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY). Utilization estimates and CI are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). Estimated percentage impact is the DID estimate relative to expected outcome for GPDC beneficiaries in PY 2021 had the model not existed and had the beneficiaries' outcomes continued on the same trajectory since baseline. The professional services spending measure includes all physician, non-physician, and ancillary services (e.g., tests, imaging, ambulance services, Part B drugs administered in physician offices). The primary care visits spending measure includes paid E&M services for primary care clinicians; the specialty care visits spending measure includes paid E&M services for specialty care clinicians (Appendix H). ^Finding verified from sensitivity analyses, as over one-quarter of the DCEs included in the pooled estimate did not have parallel trends in the baseline period. When excluding DCEs that did not have parallel trends in the baseline period, the impact was similar in direction, magnitude, and significance for Standard DCEs; New Entrant DCEs' impact on spending on primary care visits was unclear as they diverged in sensitivity analyses (Appendix Exhibits G.21--G.22). *p<0.1, **p<0.05, and ***p<0.01. DCE = Direct Contracting Entity.

Home Health Services

Standard DCEs had significantly lower spending (2.45%; p<0.01) and utilization (2.68%; p<0.01) for home health services (Exhibit 3.14). Both Standard DCE and comparison beneficiaries decreased their home health spending and home health episodes in PY 2021 relative to the respective average values in baseline years, but the decrease for Standard DCE beneficiaries was greater. Prior hypotheses related to this measure indicated that service use could decrease or increase, depending on each DCE's care delivery strategy and use of unique model waivers in this setting (Exhibit 3.1). Some DCEs entered the model with established strategies and partnerships focused on home health service provision, suggesting that service use could decrease if DCEs aim to create efficiencies in their provision, or increase if DCEs expand home health services as a lower-cost alternative. We will explore home health service strategies, spending, and utilization in future analyses to evaluate whether the trends observed in early years continue and what factors might be contributing to such trends.

Examples of Standard and New Entrant DCEs' Home Health Strategies from Model Applications

- Partnerships with home health providers and transitional care managers
- Post-discharge home visits for risk and needs assessment and medication reconciliation
- In-home models with community care programs with CBO partnerships
- Remote beneficiary monitoring technology
- In-home lab and radiology testing

Conversely, New Entrant DCEs increased their home health spending (3.75%; p<0.10) and their increase in episodes (4.47%; p<0.05) was not statistically significant in sensitivity analyses.[aa] New Entrant DCE beneficiaries experienced increases in home health spending and home health episodes in PY 2021 relative to the respective average values in baseline years, while comparison beneficiaries had lower home health spending and fewer home health episodes in PY 2021 relative to baseline. The model's benefit enhancements for post-discharge home visits, care management home visits, and the home health homebound waiver may also impact home health spending and utilization, particularly in future years as uptake and use of these benefit enhancements increase (Exhibit 1.3).

[aa] New Entrant DCEs' impact on home health episodes was similar in direction but smaller in magnitude and was not statistically significant (3.33%) in sensitivity analyses, after excluding one DCE that did not have parallel trends during the baseline years, comprising approximately 2.6% of all aligned beneficiaries. See Appendix G, Exhibit G.22.

Exhibit 3.14. Standard DCEs Decreased and New Entrant DCEs Increased Home Health Spending and Utilization.

Setting	% Impact	Impact Estimate	90% CI	Baseline to PY 2021 Change	
				GPDC	Comparison
Standard DCEs					
Home health spending^	**-2.45**	**-$14.57*** **	**-$22.31, -$6.84**	↓	↓
Home health episodes^	**-2.68**	**-8.83*** **	**-13.19, -4.47**	↓	↓
New Entrant DCEs					
Home health spending	**3.75**	**$23.40***	**$0.33, $46.47**	↑	↓
Home health episodes^	**4.47**	**14.33** **	**2.56, 26.11**	↑	↓

SOURCE: NORC analysis of 2018-2021 Medicare claims and enrollment data.

NOTES: Spending estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY). Utilization estimates and confidence intervals are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). Estimated percentage impact is the DID estimate relative to expected outcome for GPDC beneficiaries in PY 2021 had the model not existed and had the beneficiaries' outcomes continued on the same trajectory since baseline. ^Finding verified from sensitivity analyses, as at least one DCE included in the pooled estimate did not have parallel trends in the baseline period. When excluding DCEs that did not have parallel trends in the baseline period, the impact for home health spending and episodes was similar in direction, magnitude, and significance for Standard DCEs; the impact for home health episodes was similar in direction for New Entrant DCEs with smaller magnitude that was not statistically significant (Appendix G, Exhibits G.21-G.22).*p<0.1, **p<0.05, and ***p<0.01. DCE = Direct Contracting Entity.

Hospice Services

Overall, there were no significant impacts on hospice measures for Standard or New Entrant DCEs (Exhibit 3.15). Prior hypotheses related to this measure indicated that service use could increase or decrease, depending on each DCE's care delivery strategy, and use of unique benefit enhancements in this setting (**Exhibit 3.1**). Like home health, we do not have a sense of whether increases or decreases in hospice use are desirable, given that hospices are historically underused, but may also represent an area of inefficient spending. We will continue to monitor changes in these measures over time in subsequent reports. For example, in future performance years, DCEs will have more years of experience with the model's hospice benefit enhancement, and more DCEs may also take on the enhancement. This enhancement allows beneficiaries who elect the Medicare Hospice Benefit to receive concurrent curative care and may increase utilization and/or spending in the hospice setting.

Exhibit 3.15. Neither Standard nor New Entrant DCEs Had an Impact on Hospice Utilization or Spending.

Setting	% Impact	Impact Estimate	90% CI	Baseline to PY 2021 Change	
				GPDC	Comparison
Standard DCEs					
Hospice spending	2.16	$9.33	-$4.66, $23.32	↑	↓
Continuous hospice days prior to death^	3.21	0.76	-0.37, 1.89	↓	↓
New Entrant DCEs					
Hospice spending^	-3.10	-$17.14	-$63.39, $29.11	↑	↑
Continuous hospice days prior to death^	-13.46	-4.87	-10.05, 0.31	↓	↑

SOURCE: NORC analysis of 2018-2021 Medicare claims and enrollment data.

NOTES: Spending estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY). Utilization estimates and confidence intervals are presented as rate of the outcome per 1,000 beneficiaries per year (BPY) except for continuous hospice days prior to death which is presented as PBPY. Analytic sample for continuous hospice days prior to death only included deceased beneficiaries. Estimated percentage impact is the DID estimate relative to expected outcome to be for GPDC beneficiaries in PY 2021 had the model not existed and had the beneficiaries' outcomes continued on the same trajectory since baseline. ^Finding verified from sensitivity analyses, as at least one DCE included in the pooled estimate did not have parallel trends in the baseline period. When excluding DCEs that did not have parallel trends in the baseline period, the impact was similar in direction, magnitude, and significance for Standard and New Entrant (Appendix G, Exhibits G.21-G.22). *p<0.1, **p<0.05, and ***p<0.01. DCE = Direct Contracting Entity.

Impact on Quality of Care

Our evaluation estimated model impacts on four quality of care measures: all-condition readmissions, mortality, hospitalizations for ambulatory care-sensitive conditions (ACSC), and timely follow-up after acute exacerbation of chronic conditions. Overall, we observed no results suggesting adverse quality of care for beneficiaries aligned to the GPDC Model in PY 2021 and only limited improvements on quality of care. We expect to see improvements in beneficiaries' quality of care as DCEs become financially responsible for improving the quality of care for aligned beneficiaries and care coordination and disease management, but there was limited evidence supporting this hypothesis in PY 2021.

One Quality Measure (All-Condition Readmissions) Was Tied to Model Payment Incentives in PY 2021.

As the all-condition readmissions measure was primarily pay-for-reporting in PY 2021, we did not expect to see any associated improvement or change **(Exhibit 3.16)** on this measure.[bb]

In future performance years, when quality measures become primarily pay-for-performance and DCEs are financially responsible for performance, we might expect larger improvements. Future evaluation reports will include additional Model quality measures to continue tracking the effects of financial incentives on DCE performance.

[bb] Because all-condition readmissions have been a performance measure tied to financial incentives in many initiatives for over a decade, including in the Hospital Readmissions Reduction Program and the Shared Savings Program, there may be limited room for DCEs to further improve their performance on this measure.

Standard DCEs had significantly lower rates of ACSC hospitalizations (3.46%; p<0.05) (Exhibit 3.16). Hospitalizations for ACSCs decreased for both Standard DCE and comparison beneficiaries in PY 2021 relative to the average baseline rate. The observed decrease in impact reflected a larger decrease for Standard DCE beneficiaries. In their model applications, most Standard DCEs noted their robust IT infrastructure for beneficiary monitoring and population health management, especially for beneficiaries with complex needs, which may have enabled them to identify and manage beneficiaries at a higher risk for hospitalization for ACSCs and thereby keep them out of the hospital.

Exhibit 3.16. Standard DCEs Reduced Hospitalizations for ACSCs in PY 2021.

Setting	% Impact	Impact per 1,000 BPY	90% CI	Baseline to PY 2021 Change	
				GPDC	Comparison
All-condition readmissions^	-1.14	-1.82	-5.96, 2.31	↑	↑
Mortality^	-0.35	-0.08	-0.47, 0.3	↓	↓
Hospitalizations for ambulatory care-sensitive conditions	**-3.46**	**-0.61****	**-1.08, -0.14**	↓	↓
Timely follow-up after acute exacerbation of chronic conditions^	0.50	4.02	-3.55, 11.58	↓	↓

SOURCE: NORC analysis of 2018-2021 Medicare claims and enrollment data.

NOTES: Estimates are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). Analytic sample for all-condition readmissions includes beneficiaries with one or more index hospitalizations. Analytic sample for timely follow up after acute exacerbation of chronic conditions includes beneficiaries with one or more acute events related to one of six chronic conditions (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, and diabetes). Estimated percentage impact is the DID estimate relative to expected outcome for GPDC beneficiaries in PY 2021 had the model not existed and had the beneficiaries' outcomes continued on the same trajectory since baseline. ^Finding verified from sensitivity analyses, as at least one DCE included in the pooled estimate did not have parallel trends in the baseline period. When excluding DCEs that did not have parallel trends in the baseline period, the impact was similar in direction, magnitude, and significance for Standard DCEs (Appendix G, Exhibit G.21). *p<0.1, **p<0.05, and ***p<0.01.

New Entrant DCEs showed significantly decreased mortality (7.07%; p<0.01) relative to the comparison group **(Exhibit 3.17)**, with no other significant impacts seen for quality of care. The reduced mortality for New Entrant DCEs was relatively large and unexpected, particularly in the first performance year. Of course, this result may reflect the fact that the mortality rate for New Entrant DCE beneficiaries returned to its baseline level after the COVID-19 pandemic more rapidly than it did for comparison beneficiaries. New Entrant DCEs may simply have more beneficiaries who were new to ACO models in 2021; thus, additional care management and coordination efforts may have had a large impact on the return of their mortality rates to pre-pandemic levels.

Exhibit 3.17. New Entrant DCEs Reduced Mortality in PY 2021.

Setting	% Impact	Impact per 1,000 BPY	90% CI	Baseline to PY 2021 Change	
				GPDC	Comparison
All-condition readmissions	0.65	1.10	-10.59, 12.78	↑	↑
Mortality	**-7.07**	**-2.15 *****	**-3.47, -0.82**	↓	↓
Hospitalizations for ambulatory care sensitive conditions^	4.39	0.83	-0.64, 2.3	↓	↓
Timely follow-up after acute exacerbation of chronic conditions^	1.01	7.81	-12.79, 28.41	↑	↓

SOURCE: NORC analysis of 2018-2021 Medicare claims and enrollment data.

NOTES: Estimates are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). Analytic sample for all-condition readmissions includes beneficiaries with one or more index hospitalizations. Analytic sample for timely follow up after acute exacerbation of chronic conditions includes beneficiaries with one or more acute events related to one of six chronic conditions (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, and diabetes). Estimated percentage impact is the DID estimate relative to expected outcome for GPDC beneficiaries in PY 2021 had the model not existed and had the beneficiaries' outcomes continued on the same trajectory since baseline. ^Finding verified from sensitivity analyses, as at least one DCE included in the pooled estimate did not have parallel trends in the baseline period. When excluding DCEs that did not have parallel trends in the baseline period, the impact was similar in direction, magnitude, and significance for New Entrant DCEs (Appendix G, Exhibit G.22). *p<0.1, **p<0.05, and ***p<0.01.

3.4 Conclusion

In sum, in PY 2021, there were no reductions in total gross or net Medicare spending for Standard or New Entrant DCEs relative to their comparison groups. As noted throughout, these results should be interpreted with caution due to the several caveats attached to the impact estimates in this initial annual report reflecting this early phase of the model, which was occurring during the public health emergency. At the same time, we did observe changes in setting-specific spending and utilization categories, although these were not all in the directions we would have expected. Standard DCEs reduced both spending and utilization in acute care services, and both Standard and New Entrant DCEs reduced ED visits. As expected, Standard DCEs increased spending for primary and specialty care visits. In terms of quality of care, we observed no negative impacts on beneficiaries aligned to Standard and New Entrant DCEs with only limited improvements.

It is important to note that there are substantive differences between the calculation of the total spending and setting-specific spending measures and direct comparisons between these two sets of results are not feasible. The total spending measure represents what Medicare actually paid by including beneficiary-level capitated payments under the GPDC Model, whereas the setting-specific spending measures represent what Medicare would have paid DCEs absent capitation, across a variety of care settings. Impacts on setting-specific spending can inform our understanding of utilization changes and how DCEs are approaching their care delivery transformation efforts. In future years of the evaluation, we will examine total spending effects with and without beneficiary-level capitated payments to understand the influence of capitation on the model's overall

impacts. In addition, we will continue to study the GPDC Model's impacts for DCEs types, including High Needs DCEs if feasible, and understand their effects on setting-specific spending and utilization, as well as quality of care. Finally, we will explore factors contributing to observed impacts as GPDC evolves into ACO REACH.

Chapter 4: Conclusions

In the first performance year of the GPDC Model, while we did not observe any overall gross or net spending reductions, we did gain valuable insights regarding the structural composition of DCEs, the context in which they are operating, the populations they serve, and their implementation approaches. We also observed some early impacts on utilization and quality that lend insight into how the model is working thus far and what impacts we can expect in future years. These findings inform our understanding of the domains laid out in our conceptual framework and set the stage for interpreting outcomes as they emerge over the course of the evaluation.

The DCEs' implementation strategies focused on avoidable utilization, population-specific care management, and primary care through improved data sharing and analytic tools as well as support for care management infrastructure. We found that DCEs' implementation strategies aligned with our hypothesis that DCEs would respond to model features with investments in health IT. We expected such investments would be reflected in lower overall spending, fewer ED visits and acute care hospitalizations, greater utilization of primary care, and fewer days in intensive PAC settings as DCEs shifted beneficiaries toward less resource-intensive care settings.

Consistent with our hypotheses, **Standard DCEs significantly reduced acute care spending, utilization, and length of stay, SNF spending, ED visits and observation stays, and hospitalizations for ACSCs while increasing primary care spending and visits.** New Entrants also reduced ED visits. Standard DCEs' greater impact relative to New Entrant DCEs on these measures may reflect their experience participating in similar models such as NGACO, and the continuation of population health management efforts started under previous models.

Despite the impacts on select utilization and quality outcomes, our findings showed no statistically significant reductions in total spending across Standard or New Entrants DCE types. Given the aforementioned differences between the methods used to calculate total spending versus spending within categories, these findings may reflect the fact that care transformation takes time to achieve high-level impacts. DCEs were working to implement their population management approaches with the resources available in an abridged performance year. We expect to see more meaningful changes in future years of the model as care networks mature, DCEs invest resources to improve their population management approaches, and strategies for engaging providers and beneficiaries alike evolve. Nonsignificant gross spending reductions were larger for New Entrant DCEs, which may reflect greater opportunities for spending reductions for new organizations and those in markets with higher spending.

The GPDC Model impact estimates for PY 2021 may have been affected by several contextual factors. During PY 2021, with the COVID-19 pandemic still driving patterns in health care utilization, DCEs participating in the GPDC Model in 2021 may be meaningfully different from the comparison group in their response to the pandemic, even though the groups were drawn from the same markets. Most of the organizations and providers participating in DCEs had prior experience with at least one APM, which may have helped them develop the infrastructure and practices to effectively respond to the pandemic. In addition, some of the beneficiaries

included in our comparison group were aligned to the NGACO Model, which was still operating in GPDC's baseline years and first year, as well as to ACOs in the Shared Savings Program. Given the similarities in incentives and benefits among the GPDC Model and ACO models, providers serving beneficiaries in the comparison group who were aligned to ACOs may be more efficient than other FFS providers, attenuating any effects of the GPDC Model. Because the NGACO Model ended in 2021, no NGACO beneficiaries will be in the PY comparison group in PY 2022 and beyond.

Building on insights from our findings in PY 2021, we will continue to explore implementation strategies and impacts of the GPDC Model over time. We will delve deeper into the interplay among contextual, structural, and implementation factors that may affect utilization and cost outcomes, investigating the differences in impacts by DCE type we observed in PY 2021 and other notable differences that emerge. For PY 2022, approximately 50 additional DCEs will be included in our analyses, providing additional power to explore comparisons of interest. The PY 2022 starters also changed the landscape of the providers, beneficiaries, and markets served in GPDC Model, which may further alter the direction or magnitude of outcomes. We also plan to include High Needs DCEs in these analyses as sample size allows. Finally, we will track the transition to ACO REACH in terms of the increased size of the model, the mechanics of a model undergoing significant midstream changes, how ACOs are responding to the new requirements, and whether the model is having an impact on health disparities.

References

[1] Centers for Medicare & Medicaid Services [CMS]. Global and Professional Direct Contracting (GPDC) Model. https://innovation.cms.gov/innovation-models/gpdc-model

[2] Centers for Medicare & Medicaid Services [CMS]. Global and Professional Direct Contracting (GPDC) Model Frequently Asked Questions. https://innovation.cms.gov/media/document/gpdc-model-general-faqs

[3] Centers for Medicare & Medicaid Services [CMS] ACO REACH Model. https://innovation.cms.gov/innovation-models/aco-reach

[4] Ibid at 1.

[5] Ibid at 2.

[6] Centers for Medicare & Medicaid Services [CMS]. Global and Professional Direct Contracting (GPDC) Model Request for Applications. November 2019. https://innovation.cms.gov/files/x/dc-rfa.pdf

[7] Ibid at 6.

[8] Fisher ES, Shortell SM, and Savitz LA. Implementation science: A potential catalyst for delivery system reform. *JAMA.* 2016; 315(4): 339–340. doi: 10.1001/jama.2015.17949

[9] Damschroder, LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice. *Implement Sci.* 2009; 4: 50. https://doi.org/10.1186/1748-5908-4-50

[10] Creswell JW. Research design: Qualitative, quantitative, and mixed methods approaches. 3rd Edition. *Sage Publications.* 2009.

[11] Ibid at 10.

[12] Ibid at 10.

[13] Ibid at 10.

[14] Ibid at 9.

[15] Center for Clinical Management Research. Consolidated Framework for Implementation Research. 2023. https://cfirguide.org/.

[16] Ibid at 6.

[17] NORC at the University of Chicago. Fourth Evaluation Report: NGACO Model Evaluation. October 2021. https://innovation.cms.gov/data-and-reports/2021/nextgenaco-fourthevalrpt

[18] Centers for Disease Control [CDC]. Indicators Spotlight: Health Care Extenders. https://www.cdc.gov/dhdsp/docs/health_care_extenders_indicators.pdf

[19] Peck KA, Usadi B, Mainor AJ, Fisher ES, Colla CH. ACO Contracts with Downside Financial Risk Growing, But Still In The Minority. *Health Affairs.* 2019; 38(7). https://doi.org/10.1377/hlthaff.2018.05386

[20] US Dept of Health and Human Services. Engaging Community-Based Organizations. February 26, 2021. https://www.phe.gov/Preparedness/planning/abc/Pages/engaging-CBO.aspx

[21] Berkowitz SA, Pahira JJ. Accountable care organization readiness and academic medical centers. *Acad Med.* 2014 Sep; 89(9): 1210-5. Doi: 10.1097/ACM.0000000000000365.

[22] Lewis VA, Tierney KI, Colla CH, Shortell SM. The new frontier of strategic alliances in health care: New partnerships under accountable care organizations. *Soc Sci Med.* 2017 Oct; 190: 1-10. Doi: 10.1016/j.socscimed.2017.04.054.

[23]Ibid at 21.

[24] Chernew ME, McWilliams JM. The Case for ACOs: Why Payment Reform Remains Necessary. Health Affairs Forefront. January 24, 2022. https://www.healthaffairs.org/content/forefront/case-acos-why-payment-reform-remains-necessary

[25] Bleser WK, Saunders RS. ACO Quality Over Time: The MSSP Experience and Opportunities for System-Wide Improvement. *Am J Accountable Care*. 2018; 6(1).

[26] Muhlestein D, Saunders RS, McClellan MB. Medicare Accountable Care Organization Results For 2015: The Journey To Better Quality And Lower Costs Continues. Health Affairs Blog. September 9, 2016. https://www.healthaffairs.org/content/forefront/medicare-accountable-care-organization-results-2015-journey-better-quality-and-lower

[27] Gonzalez-Smith J, Crook H, Singletary E, Bleser W, Saunders R. How to Better Support Small Physician-led Accountable Care Organizations: Recent Program Updates, Challenges, and Policy Implications. Margolis Center for Health Policy, Duke. February 2020. https://healthpolicy.duke.edu/sites/default/files/2020-07/How%20to%20Better%20Support%20Small%20Physician-Led%20ACOs.pdf

[28] Ibid at 19.

[29] Rutledge RI, Romaire MA, Hersey CL, Parish WJ, Kissam SM, Lloyd JT. Medicaid Accountable Care Organizations in Four States: Implementation and Early Impacts. *Milbank Q*. 2019 June; 97(2): 583-619. doi: 10.1111/1468-0009.12386.

[30] Ouayogodé MH, Colla CH, Lewis VA. Determinants of success in Shared Savings Programs: An analysis of ACO and market characteristics. *Healthcare*, 2017; 5(1–2). doi: 10.1016/j.hjdsi.2016.08.002.

[31] Phipps-Taylor M, Shortell SM. More than money: Motivating physician behavior change in accountable care organizations. *Milbank Q*. 2016; 94(4): 832-861. doi:10.1111/1468-0009.12230.

[32] Roland M, Dudley RA. How financial and reputational incentives can be used to improve medical care. *Health Serv Res*. 2015;50: 2090-2115. doi:10.1111/1475-6773.12419

[33] Ibid at 31.

[34] Herzer KR, Pronovost PJ. Physician motivation: Listening to what pay-for-performance programs and quality improvement collaboratives are telling us. *Jt Comm J Qual Patient Saf*. 2015;41(11): 522-528. doi:10.1016/s1553-7250(15)41069-4

[35] Berenson RA, Rice T. Beyond measurement and reward: Methods of motivating quality improvement and accountability. *Health Serv Res*. 2015; 50:2155-2186. doi:10.1111/1475-6773.12413.

[36] Rutledge RI, Romaire MA, Hersey CL, Parish WJ, Kissam SM, Lloyd JT. Medicaid Accountable Care Organizations in Four States: Implementation and Early Impacts. *Milbank Q*. 2019 June; 97(2): 583-619. doi: 10.1111/1468-0009.12386.

[37] NORC at the University of Chicago. Third Evaluation Report: NGACO Model Evaluation. September 2020. https://innovation.cms.gov/data-and-reports/2020/nextgenaco-thirdevalrpt-fullreport

[38] Kind AJH, Buckingham W. Making Neighborhood Disadvantage Metrics Accessible: The Neighborhood Atlas. New England Journal of Medicine, 2018. 378: 2456-2458. doi: 10.1056/NEJMp1802313.

[39] Ibid at 17.

[40] Centers for Medicare & Medicaid Services [CMS]. Global and Professional Direct Contracting (GPDC) Model Financial Operating Guide: Overview. December 1, 2021. https://innovation.cms.gov/media/document/dc-financial-op-guide-overview