# Global and Professional Direct Contracting and Kidney Care Choices Models

# PY2022 DC/KCC Rate Book Development

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Reference Documents

| Title |
|---|
| Global and Professional Direct Contracting Model: Financial Operating Guide: Overview |
| Global and Professional Direct Contracting Model: Financial Companion to Operating Guide Overview: Standard DCE |
| Global and Professional Direct Contracting Model: Financial Companion to Operating Guide Overview: New Entrant DCE |
| Global and Professional Direct Contracting Model: Financial Companion to Operating Guide Overview: High Needs Population DCE |
| Global and Professional Direct Contracting Model: Financial Operating Policies: Capitation and Advanced Payment Mechanisms |
| Global and Professional Direct Contracting Model: Financial Companion to Capitation and Advanced Payment Mechanisms |
| Global and Professional Direct Contracting and Kidney Care Choices Models: Risk Adjustment |
| Global and Professional Direct Contracting Model: Financial Reconciliation Overview |
| Kidney Care Choices Model: Financial Operating Guide: Overview |

## Acronyms

| | |
|---|---|
| A&D | Aged & Disabled |
| BY | Base year |
| CKCC | Comprehensive Kidney Care Contracting |
| CKD4/5 | Stage 4 and 5 Chronic Kidney Disease |
| CMMI | Center for Medicare & Medicaid Innovation |
| CMS | Centers for Medicare & Medicaid Services |
| CY | Calendar year |
| DCE | Direct Contracting Entity |
| DoD | Department of Defense |
| ESRD | End-Stage Renal Disease |
| FFS | Fee-for-service |
| FIPS | Federal Information Processing Standard |
| GAF | Geographic Adjustment Factors |
| GPDC | Global and Professional Direct Contracting |
| HCC | Hierarchical Condition Category |
| KCC | Kidney Care Choices |
| KCE | Kidney Contracting Entity |
| MA | Medicare Advantage |
| PBPM | Per beneficiary per month |
| PY | Performance year |
| USPCC | United States per capita costs |
| VA | Veterans Administration |

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## 1.0 Overview of DC/KCC Rate Book

In the Global and Professional Direct Contracting (GPDC) Model and the Comprehensive Kidney Care Contracting (CKCC) Options within the Kidney Care Choices (KCC) Model, a DC/KCC Rate Book will be used to construct benchmarks. This DC/KCC Rate Book is either blended with aligned providers' historical expenditures or used standalone to establish the Performance Year (PY) Benchmark's Baseline.

This document describes the development process of the DC/KCC Rate Book. Both GPDC and the KCC Model will share the same DC/KCC Rate Book methodology for use in benchmark construction. The DC/KCC Rate Book is constructed using a modification of the methods used to construct MA Rate Book which is published annually and establishes county-level payment rates for Medicare Advantage (MA) Plans for Aged & Disabled (A&D) beneficiaries and state-level payment rates for End-Stage Renal Disease (ESRD) beneficiaries.[1]

The DC/KCC Rate Book removes factors applied to the MA Rate Book that are not relevant in the GPDC and the KCC Models (e.g., fee-for-service [FFS] spending quartiles, quality bonus payment percentage for star ratings), adds components of Medicare FFS expenditures that are not included in the MA Rate Book (e.g., hospice services), and mirrors GPDC[2] eligibility requirements. This document highlights the differences between the DC/KCC Rate Book and the MA Rate Book development methodology in each section. A non-exhaustive listing of the major differences is presented in **Appendix Table 1**. The DC/KCC Rate Book will be used in the calculation of the regional component of the PY Benchmark for Direct Contracting Entities (DCEs) and Kidney Contracting Entities (KCEs). The detailed overview of the benchmarking methodology for GPDC and the KCC Model can be found in the ***Global and Professional Direct Contracting Model: Financial Operating Guide: Overview*** paper and *Companion Documents* and ***Kidney Care Choices: Financial Operating Guide: Overview*** paper, respectively.

There are two main components of the DC/KCC Rate Book:

(1) The National Conversion Factor for the population eligible for the GPDC Model (which is comparable to the United States Per Capita Costs [USPCC] used in the MA Rate Book). The National Conversion Factor is a per beneficiary per month (PBPM) measure of all FFS expenditures, excluding uncompensated care payments under the inpatient Prospective Payment System, for beneficiaries eligible for GPDC. A National Conversion Factor is calculated based on historical data and then trended to the performance year using the trend from an adjusted version of the USPCC.

(2) County Relative Cost Indices are used to convert the National Conversion Factor into county rates. The County Relative Cost Indices are based upon the ratio of the county-level PBPM

[1] The MA Rate Book development methodology for CY2022 is available at **https://www.cms.gov/medicarehealth-plansmedicareadvtgspecratestatsratebooks-and-supporting-data/2022**.

[2] Both the GPDC and KCC Models will use the same National Conversion Factor to construct benchmarks. The National Conversion Factor will include expenditures for beneficiaries who meet DC eligibility criteria. Medicare beneficiaries will not be required to meet the KCC Model's additional eligibility requirements in order to have their expenditures contribute to the National Conversion Factor.

expenditures and the DC National Reference Population PBPM expenditures, risk standardized and adjusted to reflect the geographic payment adjustments applied by Medicare FFS payment systems.

Each county rate is calculated by multiplying the National Conversion Factor by the County Relative Cost Index for that county. Each section in this document describes the different steps of the calculation of the DC/KCC Rate Book.

**Section 2** focuses on the calculation of the DC/KCC Rate Book National Conversion Factor, which in the DC/KCC Rate Book is analogous to USPCC used in the MA Rate Book. This includes documentation of the differences between the DC/KCC Rate Book National Conversion Factor and USPCC.

**Section 3** addresses the construction of the County Relative Cost Indices. This includes subsections dedicated to the development of Geographic Adjustment Factors (GAF), the risk scores used to standardize county expenditures, and the overall development of the Average County Relative Cost Indices.

**Section 4** describes additional adjustments made to county rates to improve applicability to the models and/or meet CMS policy goals. These include zero claims, Veterans Affairs/Department of Defense expenditures, and credibility adjustments, where appropriate.

**Section 5** specifies the final combination of all the previous components into the production of the final DC/KCC Rate Book.

## 2.0 DC/KCC Rate Book National Conversion Factor

### 2.1 FFS Expenditure

The DC/KCC Rate Book is developed using data for the three most recent years for which complete Medicare FFS claims data are available, referred to as the DC/KCC Rate Book base years (BYs). Construction of the DC/KCC Rate Book excludes one calendar year (CY) between the latest DC/KCC Rate Book BY and CY for which the DC/KCC Rate Book will be used to develop benchmarks. This allows for the inclusion of the most recent three complete calendar years of historical experience to construct the DC/KCC Rate Book for each PY. This is a change from the MA Rate Book, which uses five years of data and excludes two CYs between the latest MA Rate Book BY and CY in which the MA Rate Book is used. **Table 2.1** summarizes CYs that will be used as the DC/KCC Rate Book's BYs to develop the DC/KCC Rate Book for each PY of the model.

**Table 2.1. Construction of DC/KCC Rate Book**

| Performance year | Calendar year | DC/KCC Rate Book base years<br>*Data used for DC/KCC Rate Book development* |
|---|---|---|
| 2021 | 2021 | 2017, 2018, 2019 |
| 2022[1] | 2022 | 2017, 2018, 2019 |
| 2023[1] | 2023 | 2019, 2020, 2021 |
| 2024[1] | 2024 | 2020, 2021, 2022 |
| 2025 | 2025 | 2021, 2022, 2023 |
| 2026 | 2026 | 2022, 2023, 2024 |

1 Due to the impact of COVID-19, CMS determined that 2020 is not appropriate as a BY. CMS will determine the BYs that will be used for each PY prior to publication of the DC/KCC Rate Book for each year.

Note that CMS is continuing to monitor the potential impact of COVID-19 on BYs for use in the DC/KCC Rate Book and may revise BYs used to establish appropriate county rates for a given CY. For example, for PY2022 CMS determined that 2020 is not appropriate as a BY because of the impact of COVID-19 on patterns of utilization and expenditure. For PY2022, 2017, 2018, and 2019 will therefore be used as the three BYs instead of 2018, 2019, and 2020. CMS will determine the BYs that will be used for each PY prior to the publication of the DC/KCC Rate Book for each year.

Expenditures that are included in the DC/KCC Rate Book—referred to as DC/KCC Expenditures—are all FFS Medicare claim payment amounts, plus sequestration amounts, plus reductions made to provider payments due to participation in alternative payment arrangements (e.g., Population-Based Payments in the Next Generation Accountable Care Organization Model, and Total Care Capitation or Primary Care Capitation payments in the GPDC Model), minus hospital uncompensated care payments. This is a change from the MA Rate Book, which does include uncompensated care costs but excludes claims related to hospice care. DC/KCC Expenditures are defined the same way for A&D and ESRD populations (further defined in Section 2.2). For the ESRD population, costs associated with transplants that are captured through Medicare FFS claims are included; additional costs such as organ procurement are not. Any changes to the ESRD MA rates that may come to the MA program in future years will not change the definition of DC/KCC Expenditures for the ESRD population for the DC/KCC Rate Book.

The MA Rate Book includes payments that are attributable to Innovation Center models and other CMS programs (*Innovation Payment Adjustments*). These adjustments are added or subtracted to the claims

expenditure when constructing the DC/KCC Rate Book. Consequently, the DC/KCC Rate Book reflects the shared savings and losses from other CMS Accountable Care Organization models, including GPDC and CKCC, and the payment mechanisms from the KCC Model (the Adjusted Monthly Capitation Payment and the Quarterly Capitation Payment). However, the DC/KCC Rate Book will not include Kidney Transplant Bonus payments under the KCC Model.[3]

The differences in the expenditures included in the DC/KCC Rate Book and the MA Rate Book are presented in **Table 2.2**.

**Table 2.2. DC/KCC Expenditure compared with MA Rate Book Expenditure**

| DC/KCC Rate Book | MA Rate Book |
|---|---|
| *Included* | *Included* |
| FFS Claim Payment Amounts | FFS Claim Payment Amounts |
| Sequestration amounts | Sequestration amounts |
| Reductions made to providers due to alternative payment arrangement participation | Reductions made to providers due to alternative payment arrangement participation |
| Adjustments for Innovation Center models and other CMS programs | Adjustments for Innovation Center models and other CMS programs |
| *Removed* | *Removed* |
| FFS Expenditure for beneficiaries enrolled in a managed care plan | FFS Expenditure for beneficiaries enrolled in a managed care plan |
| Uncompensated care payments | Hospice Care for FFS Beneficiaries |

CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MA = Medicare Advantage.

## 2.2 DC/KCC Rate Book Eligibility

The DC/KCC Rate Book incorporates expenditures for Medicare beneficiaries eligible to participate in GPDC. GPDC Model eligibility for Medicare beneficiaries is determined for each month of the three DC/KCC Rate Book BYs (2017-2019 in PY2022). A beneficiary month is eligible for the GPDC Model if it meets all the following criteria:

- The beneficiary is alive on the first day of the month.
- The beneficiary is enrolled in Part A.
- The beneficiary is enrolled in Part B.
- The beneficiary is enrolled in Traditional FFS Medicare (e.g., not enrolled in MA).

[3] Due to the different BYs between the MA Rate Book and the DC/KCC Rate Book, typically only BY1 and BY2 of the DC/KCC Rate Book use the exact innovation adjustments from the corresponding CY from the most recently available FFS data files released with MA Rate Book. For example, in PY2021, the 2017 and 2018 adjustments would be the same dollar amounts for each county as those used in the MA Rate Book. Because adjustments for what would be BY3 (e.g., 2019 for PY2021) are not available before the DC/KCC Rate Book is published for a given PY, the DC/KCC Rate Book applies the same adjustments from BY2 in BY3. However, in the case of 2022 we have data for all three BYs (2017, 2018, and 2019).

- Medicare is not secondary to coverage under a group health plan.
- The beneficiary is a U.S. resident.

The beneficiary months that meet these criteria are referred to as the DC National Reference Population. The DC/KCC Rate Book uses GPDC's eligibility criteria, rather than the KCC Model's more restrictive eligibility criteria, to determine beneficiary expenditures that will contribute to the DC/KCC Rate Book.

The population that contributes to the DC/KCC Rate Book differs from the MA Rate Book population. Unlike the DC/KCC Rate Book, the MA A&D Rate Book is based on the experience of all Medicare FFS beneficiaries. The MA ESRD Rate Book is based on the experience of all FFS beneficiaries except those who do not have Medicare as their primary payer. The differences between the MA Rate Book and the DC/KCC Rate Book are summarized in **Table 2.3**.

**Table 2.3. GPDC National Reference Population compared with MA Rate Book population inclusion criteria**

| DC/KCC Rate Book | MA Rate Book (Aged & Disabled) | MA Rate Book (Dialysis End-Stage Renal Disease) |
|---|---|---|
| Alive on the first day of the month | *Consistent Approach* | *Consistent Approach* |
| Enrolled in Part A and in Part B | All FFS beneficiaries (enrolled in Part A *or* Part B) | *Consistent Approach* |
| Enrolled in Traditional FFS Medicare (e.g., not enrolled in MA) | *Consistent Approach* | *Consistent Approach* |
| Medicare listed as primary payer | All FFS Beneficiaries | *Consistent Approach* |
| Is a U.S. resident | *Consistent Approach* | *Consistent Approach* |

FFS = fee-for-service; MA = Medicare Advantage.

For the DC/KCC Rate Book, a month is classified as ESRD if the beneficiary received dialysis services as renal replacement therapy for chronic kidney failure in the month or received a kidney transplant in the past three months, including the month of transplant. All other months accrue to the A&D experience for the DC/KCC Rate Book. A beneficiary-month is based on the Federal Information Processing Standard (FIPS) county code where the beneficiary resides in either the first month within a CY that a beneficiary meets GPDC eligibility criteria or the FIPS county code where the beneficiary resides in the first month where there is a record for that beneficiary.

## 2.3 Construction of National Conversion Factor

The National Conversion Factor is constructed using a combination of the DC/KCC Expenditure data and the GPDC eligibility data.

The calculation of the National Conversion Factor is performed for the most recent BY used to construct the DC/KCC Rate Book and is conducted separately for the A&D and ESRD populations. The DC/KCC Rate

Book National Conversion Factor is calculated by dividing the DC/KCC Expenditures for the DC National Reference Population by the number of beneficiary months included in the expenditures.

The National Conversion Factor calculated for the most recent BY is then trended forward to the PY using an adjusted OACT[4] FFS USPCC trend (with the removal of uncompensated care payments and addition of hospice expenditures) to determine the National Conversion Factor for the PY. For example, in PY2022, a National Conversion Factor will be calculated using 2019 data and trended forward to PY using the growth rate in this adjusted FFS USPCC from 2019 through 2022.

[4] CMS Office of the Actuary (OACT).

## 3.0 County Relative Cost Indices

The County Relative Cost Index is comparable to the average geographic adjustment (AGA) in the MA Rate Book. The County Relative Cost Indices are based upon the ratio of the GAF-adjusted county level PBPM expenditure and the DC National Reference Population PBPM expenditure, risk standardized.

Because three rates are calculated for each county in each PY, three County Relative Cost Indices are calculated for each county: (1) an A&D index for A&D experience making use of the CMS Hierarchical Condition Category (HCC) A&D Prospective Risk Adjustment Model; (2) an A&D Index for A&D experience making use of the new CMMI-HCC A&D Concurrent Risk Adjustment Model; and (3) an ESRD Index making use of the CMS-HCC ESRD Prospective Risk Adjustment Model.

The section describes the development of the GAFs, the risk score models used in each rate book, and the calculation of the County Relative Cost Indices.

### 3.1 Construction of GAFs

Medicare FFS claim payment amounts reflect adjustments that have been made to payment amounts for geographic variations in the cost of doing business. These adjustments vary by FFS payment system. They include Area Wage Indices that are applied by various Prospective Payment Systems and the Geographic Practice Cost Indices that are applied by the Physician Fee Schedule. These geographic adjustments vary by geographic unit, and are updated annually. The DC/KCC Rate Book includes a GAF Index for each county. The GAF Index estimates the impact of differences between the geographic adjustments that were applied to historical expenditures in each of the three years used to construct the rate book and the geographic adjustments that will be applied in the performance year. GAFs are calculated separately for the A&D and ESRD Benchmarks.

To develop the GAF Index, claims data for each of the DC/KCC Rate Book's BYs are repriced using the most recently published FFS geographic price adjustments. Generally, these will be the geographic price adjustments that are used in the year prior to the GPDC/KCC performance year. For example, in developing the 2022 DC/KCC Rate Book, claims for 2017, 2018, and 2019 were repriced using the FFS geographic adjustments that are applied in CY2021. Repricing claims involves a two-step process. First, the impact of the geographic adjustments that were made in the CY in which those claims were incurred is removed, resulting in GAF-Standardized Payment. Second, the GAF-Standardized Payment is repriced using the most recently published FFS geographic adjustments to calculate a GAF-Adjusted Payment. The repricing of claims is "budget neutral" in the sense that the total repriced claim payment amounts are equal, at the national level, to the original claim payment amounts.

For each year, the repriced claims are summed by beneficiary county of residence, separately for beneficiary months that accrue to the A&D and ESRD Benchmarks. Finally, PY GAF Trend Indices are calculated for each county for A&D and for each state for ESRD, in each CY. GAF Trend Indices are calculated as follows:

$$GAF\ Trend\ Index = \frac{GAF\ Adjusted\ Expenditure}{Incurred\ Expenditure}$$

A total of three GAF Trend Indices are used for each benchmark (Aged & Disabled / ESRD), one for each BY, as shown in **Table 3.1**, using PY2022 as an example.

**Table 3.1. GAF Indices used for GPDC PY2022[1]**

| Calendar Year[2] | PY GAF Index |
|---|---|
| 2017 | $\frac{\text{2017 Expenditure Adjusted to 2021}}{\text{2017 Incurred Expenditure}}$ |
| 2018 | $\frac{\text{2018 Expenditure Adjusted to 2021}}{\text{2018 Incurred Expenditure}}$ |
| 2019 | $\frac{\text{2019 Expenditure Adjusted to 2021}}{\text{2019 Incurred Expenditure}}$ |

GAF = Geographic Adjustment Factors; PY = performance year.

[1] For PY2022, the data used for the PY GAF Index are from 2021, which is the most currently available year. The PY GAF will always be repriced based upon $PY_{N-1}$.

[2] Note that due to the impact of COVID-19, 2020 is not being used as a base year for PY2022.

The ESRD rates utilize a second GAF adjustment in order to account for county-level variation in Area Wage Indices within a state. This second index estimates the amount by which county-level spending PBPM would differ from state-wide spending because of differences between the Medicare FFS PY GAF Indices that are used to calculate payments for services provided to beneficiaries residing in the county in the performance year. This is referred to as the ESRD County PY GAF Adjustment and is applied to the statewide ESRD rate in order to determine a county-specific ESRD rate. The ESRD county rates reflect the average expenditure PBPM in the state during the baseline period adjusted for the impact of county-level FFS GAF factors.

The PY GAF Index calculates the impact of the PY GAF by comparing Medicare PBPM expenditures during the performance year to what they would have been if no geographic adjustment had been applied in the performance or baseline year. This adjustment is calculated as:

$$PY\ GAF\ Index = \frac{GAF\ Adjusted\ Expenditure}{GAF\ Standardized\ Expenditure}$$

Cross-sectional variation in Medicare FFS PBPM expenditures by county within a state is then calculated as follows:

$$ESRD\ County\ PY\ GAF\ Adjustment = \frac{County\ ESRD\ PY\ GAF\ Index}{Statewide\ Average\ ESRD\ PY\ GAF\ Index}$$

### 3.2 Risk Scores Used for DC/KCC Rate Book Standardization

To develop the DC/KCC Rate Book, risk scores are used to standardize expenditures so that the County Relative Cost Indices do not reflect differences in the demographic characteristics and health status of beneficiaries residing in each county. The county-level expenditures are risk standardized such that an average beneficiary included in the DC/KCC Rate Book's expenditures has a risk score of 1.0.

The county-level risk scores used in the development of the DC/KCC Rate Book will be calculated using a risk score methodology consistent with the MA Rate Book in the payment year.[5] However, for each CY used in the DC/KCC Rate Book construction, risk scores will be normalized with respect to the DC National Reference Population to account for any difference in the average risk score within this specific population. The DC Reference Population Normalization Factor applied in the DC/KCC Rate Book development is simply:

$$DC\ Reference\ Population\ \ Normalization\ Factor_{Year} = \frac{1}{Average\ DC\ Reference\ Pop\ Risk\ Score\ Produced\ by\ Payment\ Year\ Model_{Year}}$$

This will ensure that the risk scores used to develop GPDC and KCC Benchmarks and calculate payment reflect the cost of beneficiary care relative to the average cost of a beneficiary eligible for the models.

Risk standardization of the DC/KCC Rate Book is achieved by dividing the county rates by the three-year weighted average risk score for each county.

The DC/KCC Rate Book uses three different types of risk scores: 1) CMS-HCC A&D prospective risk scores, which are used for Standard DCEs, New Entrant DCEs, and CKD4/5 beneficiaries in the CKCC Options of the KCC Model; 2) CMMI-HCC A&D concurrent risk scores, which are used for High Needs Population DCEs and are based on a new CMMI-HCC concurrent risk adjustment model; and 3) CMS-HCC ESRD prospective risk scores, which are used for ESRD beneficiaries in all DCE types and CKCC. These three risk scores will be used to develop the three different County Relative Cost Indices for each county.

For additional details on these risk scores, see the **Global and Professional Direct Contracting and Kidney Care Choices Models: Risk Adjustment** document.

### 3.3 County Relative Cost Indices

The County Relative Cost Index for each BY is the ratio of the GAF-adjusted and risk-standardized DC/KCC Expenditure PBPM of each county to the national average (weighted by eligible months) risk-standardized DC/KCC Expenditure PBPM in that year.

The process of calculating the final County Relative Cost Index for each county is illustrated in **Table 3.2**. For each DC/KCC Rate Book BY, the county-level DC/KCC Expenditure PBPM is multiplied by the GAF Index for that county for that DC/KCC Rate Book BY and divided by the DC Reference Population PBPM for that DC/KCC Rate Book BY. The result is the DC/KCC Rate Book BY County Index. Then, each of those county indices are averaged and divided by both the 3-year weighted average of the normalized risk scores and the national average geographic adjustment.

[5] The one exception is the risk scores used for A&D beneficiaries in High Needs Population DCEs. See Section 5.2 for additional details.

**Table 3.2. Illustration of County Relative Cost Indices for three counties, Performance Year 2**

| Input | County A | County B | County C |
|---|---|---|---|
| 2017 County DC/KCC Expenditure PBPM | $982 | $1,032 | $892 |
| TIMES: 2017 GAF Index | 0.982 | 0.984 | 0.986 |
| DIVIDE BY: DC National Reference Population PBPM 2017[1] | $980 | $980 | $980 |
| EQUALS: 2017 County Index | 0.984 | 1.036 | 0.897 |
| 2018 County DC/KCC Expenditure PBPM | $1,003 | $1,108 | $901 |
| TIMES: 2018 GAF Index | 1.036 | 1.038 | 1.040 |
| DIVIDE BY: DC National Reference Population PBPM 2018[1] | $990 | $990 | $990 |
| EQUALS: 2018 County Index | 1.050 | 1.162 | 0.947 |
| 2019 County DC/KCC Expenditure PBPM | $960 | $1,190 | $924 |
| TIMES: 2019 GAF Index | 0.991 | 0.993 | 0.995 |
| DIVIDE BY: DC National Reference Population PBPM 2019[1] | $995 | $995 | $995 |
| EQUALS: 2019 County Index | 0.956 | 1.187 | 0.924 |
| AVERAGE: 2017, 2018, and 2019 County Indices (calculated above) | 0.997 | 1.129 | 0.923 |
| DIVIDE BY: 3-Year Weighted Average Normalized Risk Scores | 0.830 | 1.060 | 0.982 |
| DIVIDE BY: National Index[2] | 0.989 | 0.989 | 0.989 |
| **EQUALS: County Relative Cost Index** | **1.215** | **1.076** | **0.950** |

GPDC = Global and Professional Direct Contracting; GAF = Geographic Adjustment Factors; KCC = Kidney Care Choices; PBPM = per beneficiary per month.

[1] DC National Reference Population PBPM is equivalent to the National Conversion Factor for a single DC/KCC Rate Book Base Year

[2] National Index: The national average geographic adjustment, calculated as a weighted average of all the County Relative Cost Indices (uses 2019 enrollment). Dividing by this factor will ensure that the national average geographic adjustment is 1.0 across the 3 years.

For the ESRD Benchmark, DC/KCC Expenditures, the GAF Index, and risk scores are calculated at the state level. Therefore, the County Relative Cost Indices for the ESRD Benchmark reflect state averages. In a subsequent step, the County GAF Adjustment is applied to ESRD rates to account for differences in Area Wage Indices within each state.

## 4.0 Adjustments to County Rates

As with the MA Rate Book, several additional adjustments are applied to the county rates to achieve policy goals and improve accuracy for the model. Each of the adjustments described below are applied at the county level. The following equation illustrates the components of the county-level rates and how these additional adjustments are applied to produce the final rates.

$$County\ Rate\ =\ (National\ Conversion\ Factor)\ \times\ (County\ Relative\ Index)\ \times\ (Zero\ Claims)\ \times\ (VADOD)\ \times\ (Credibility\ Adjustment)$$

*Zero Claims Adjustment*
The proportion of beneficiaries in the Puerto Rico FFS population incurring no FFS claims in each county is significantly higher than in the rest of the United States. To account for the disproportionate number of beneficiaries with no FFS claims in Puerto Rico, CMS Office of the Actuary (OACT) applies a factor to the standardized per capita FFS costs in Puerto Rico. For purposes of making this adjustment to the MA Rate Book, OACT evaluated experience exclusively for beneficiaries that are enrolled in both Parts A and B and are not also eligible for Veterans Administration (VA) coverage.

The same logic applies to the GPDC and KCC Models (beneficiaries with no FFS claims are less likely to be enrolled in a DCE/KCE since claims-based alignment and voluntary alignment require some interaction with healthcare providers), and the percentage adjustment that is applied to the standardized Puerto Rico FFS rates in the MA Rate Book is also applied to Puerto Rico FFS rates in the DC/KCC Rate Book.

*VA/Department of Defense (DoD) Adjustments*
The DC/KCC Rate Book applies the same VA and DoD (U.S. Family Health Plan) adjustments to the county level PBPM FFS rates using the ratios reported in the MA Rate Book that applies to the model PY. This adjustment removes the impact of VA/DoD beneficiaries' experience on the county-level rates because these beneficiaries have care expenditure patterns that vary from FFS beneficiaries who are not covered by VA/DoD benefits. As with the zero claims adjustment above, this is included in the DC/KCC Rate Book because the same logic applies to GPDC and the KCC Model as to MA.

*Credibility Adjustments*
Although 3 years of experience are used to set County Relative Cost Indices, expenditures in small counties may have sufficient volatility that additional experience should be incorporated in setting the county benchmark. Similar to the MA Rate Book,[6] a credibility adjustment will be applied to small counties in the DC/KCC Rate Book. For counties with fewer than 1,000 members, county experience is blended with experience from the applicable Medicare Core Based Statistical Area (CBSA). If a county is not associated with a CBSA, the county experience will be blended with statewide experience.

The credibility formula applied is:

[6] For documentation of the methodology, see the file *Medicare_FFS_Glossary_2022.pdf* (included in the *FFS Data 2019* download from the CMS website: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data)

$$Credibility\ (Z) = \sqrt{\frac{Average\ A\ \&\ B\ Beneficiaries}{1000}}\ ^{7}$$

The credibility-adjusted county rate is then:

$$Credibility\ Adjusted\ PBPM = Pre\text{-}Credibility\ PBPM^{8} \times\ Z + CBSA\ PBPM \times (1 - Z)$$

Once the county-level rates are adjusted to account for credibility, a second adjustment is applied to counties with credibility less than 1.0 in order to maintain budget neutrality relative to the pre-credibility adjusted rates.[9] These budget neutrality factors are calculated at the state level.

$$Credibility\ Budget\ Neutral\ Factor_{State}\ = \frac{a}{b}, where$$

$$a = \sum_{all\ ctys\ cred<1} (Pre\text{-}Credibility\ PBPM \times Average\ Part\ A\ \&\ B\ Enrollment)$$

$$b = \sum_{all\ ctys\ cred<1} Credibility\ Adjusted\ PBPM \times Average\ Part\ A\ \&\ B\ Enrollment$$

[7] Average A & B Beneficiaries corresponds to the average number of FFS beneficiaries enrolled in Parts A & B in a given county, during the applicable year. For purposes of the credibility adjustment, we consider only beneficiaries in the DC National Reference Population.

[8] Pre-Credibility PBPM = (National Conversion Factor) x (County Relative Index) x (Zero Claims) x (VADOD)

[9] The budget neutrality adjustment is needed to prevent the credibility adjustment from resulting in rates that would, if applied to the entire GPDC-eligible population, result in a national average payment rate that is higher or lower than the average payment rate prior to applying the credibility adjustment.

## 5.0 Final Performance Year DC/KCC Rate Book

The DC/KCC Rate Book is comprised of three rates for each county. There are two rates for the A&D DC National Reference population, one based upon the CMS-HCC prospective risk scores (for A&D beneficiaries in Standard and New Entrant DCEs and CKD4/5 beneficiaries in KCEs), and one based upon the CMMI-HCC concurrent risk scores (for A&D beneficiaries in High Needs Population DCEs). There is also a rate for the ESRD DC National Reference population based upon the CMS-HCC prospective risk scores for ESRD beneficiaries in all types of DCEs and KCEs.

### 5.1 Construction of Final County Rate

Aged & Disabled county rates are the product of the National Conversion Factor and the County Relative Cost Index. This is illustrated in **Table 5.1**. Each rate is the regional rate component of the benchmark that would apply to a beneficiary with a risk score of 1.000.

**Table 5.1. Construction of A&D DC/KCC Rate Book**

| County | County Relative Cost Index | National Conversion Factor | Calculation | County Rate |
|---|---|---|---|---|
| County A | 0.953 | $850.00 | = $850.00 x 0.953 | $809.63 |
| County B | 1.190 | $850.00 | = $850.00 x 1.190 | $1,011.84 |
| County C | 0.936 | $850.00 | = $850.00 x 0.936 | $795.94 |
| County D | 0.833 | $850.00 | = $850.00 x 0.833 | $708.22 |
| County E | 0.909 | $850.00 | = $850.00 x 0.909 | $772.99 |

ESRD county rates are the product of the National Conversion Factor, the State Relative Cost Index, and the County GAF Adjustment, as illustrated in **Table 5.2**. Each rate is the regional rate component of the benchmark that would apply to a beneficiary with a risk score of 1.000.

**Table 5.2. Construction of ESRD DC/KCC Rate Book**

| County | State Relative Cost Index | National Conversion Factor | County GAF Adjustment | Calculation | County Rate |
|---|---|---|---|---|---|
| County A | 0.953 | $7300.00 | 0.9839 | = $7300.00 x 0.953 x 0.9839 | $6,844.89 |
| County B | 0.953 | $7300.00 | 0.9616 | = $7300.00 x 0.953 x 0.9616 | $6,689.76 |
| County C | 0.953 | $7300.00 | 1.0215 | = $7300.00 x 0.953 x 1.0215 | $7,106.47 |
| County D | 1.019 | $7300.00 | 0.9950 | = $7300.00 x 1.019 x 0.9950 | $7,401.51 |
| County E | 1.019 | $7300.00 | 1.0152 | = $7300.00 x 1.019 x 1.0152 | $7,551.77 |

For certain smaller counties, there may not be available baseline data to calculate a county-level GAF adjustment for ESRD rate. In these scenarios, the following hierarchy is used to determine the ESRD county rate:

1. If the county is part of a Core-Based Statistical Area (CBSA), a CBSA rate is assigned to the county. This CBSA rate is calculated as the eligible month-weighted average of the GAF-Adjusted County Rates for other counties within the CBSA.
2. If the county is not part of a CBSA, the county rate is equal to the state rate for the county.

### 5.2 Use of the DC/KCC Rate Book in the GPDC and KCC Model Financial Operations

As described above, there are three rates per county in the DC/KCC Rate Book. The use of each county rate is summarized by DCE/KCE type in **Table 5.3**.

**Table 5.3. DC/KCC Rate Book rates and use in GPDC and Kidney Care Choices Models**

| County rate | Risk scores | DCE/KCE type | Use |
|---|---|---|---|
| A&D | CMS-HCC Prospective | Standard DCE | • Regional blend in benchmark for claims-aligned A&D beneficiaries (PY2021–2026)<br>• Benchmark for voluntarily aligned A&D beneficiaries (PY2021–2024)<br>• Regional blend in benchmark for voluntarily aligned A&D beneficiaries (PY2025, PY2026) |
| | | New Entrant DCE | • Benchmark for all A&D beneficiaries (PY2021–2024)<br>• Regional blend in benchmark for all A&D beneficiaries (PY2025, PY2026) |
| | | CKCC | • Regional blend in benchmark for all aligned Chronic Kidney Disease beneficiaries (PY2021–2025) |
| ESRD | CMS-HCC Prospective for ESRD | Standard DCE | • Regional blend in benchmark for claims-aligned ESRD beneficiaries (PY2021–2026)<br>• Benchmark for voluntarily aligned ESRD beneficiaries (PY2021–2024)<br>• Regional blend in benchmark for voluntarily aligned ESRD beneficiaries (PY2025, PY2026) |
| | | New Entrant DCE | • Benchmark for all ESRD beneficiaries (PY2021–2024)<br>• Regional blend in benchmark for all ESRD beneficiaries (PY2025, PY2026) |
| | | High Needs Population DCE | • Benchmark for all ESRD beneficiaries (PY2021–2024)<br>• Regional blend in benchmark for all ESRD beneficiaries (PY2025, PY2026) |
| | | CKCC | • Regional blend in benchmark for all aligned ESRD beneficiaries (PY2021–2025) |
| A&D | CMMI-HCC Concurrent | High Needs Population DCE | • Benchmark for all A&D beneficiaries (PY2021–2024)<br>• Regional blend in benchmark for all A&D beneficiaries (PY2025, PY2026) |

A&D = Aged & Disabled; CMS = Centers for Medicare & Medicaid Services; CKCC = Comprehensive Kidney Care Contracting; CMMI = Center for Medicare & Medicaid Innovation; GPDC = Global and Professional Direct Contracting;

DCE = Direct Contracting Entity; ESRD = End-Stage Renal Disease; HCC = Hierarchical Condition Category;
KCC = Kidney Care Choices; KCE = Kidney Contracting Entity; MA = Medicare Advantage; PY = Performance Year

The benchmarking methodologies for the GPDC and KCC Models, including the incorporation of the DC/KCC Rate Book into the benchmark, are detailed in the ***Global and Professional Direct Contracting Model: Financial Operating Guide: Overview*** paper and its *Companion Documents* and the ***Kidney Care Choices: Financial Operating Guide: Overview*** paper, respectively.

## Appendix

**Appendix Table 1. Comparison between MA Rate Book and DC/KCC Rate Book construction**

| Feature | MA Rate Book | DC/KCC Rate Book | Reason for difference |
|---|---|---|---|
| Base years used to develop County Relative Cost Indices | 5 base years, 2-year interval between base year 5 and the performance year | 3 base years, 1-year interval between base year 3 and the performance year | This change aligns the number of years used to develop both the historical and regional components of the GPDC and KCC financial benchmarks. |
| Expenditure | Removes hospice care expenditure for FFS beneficiaries | Includes hospice care expenditure for FFS beneficiaries; removes uncompensated care payments | Hospice care is provided under the GPDC and KCC Models, so hospice expenditures are included in the county rates. Uncompensated care is not included in expenditures for the GPDC and KCC Models so are removed from the county rates. |
| Reference sample | All FFS beneficiaries (A&D: enrolled in Part A *or* Part B, ESRD: enrolled in Part A *and* Part B), not enrolled in MA; for ESRD, must have Medicare as primary payer | Beneficiaries must be enrolled in Part A and Part B, *not* enrolled in MA, have Medicare listed as the primary payer, and be a U.S. resident | This change aligns the reference sample for the DC/KCC Rate Book to the population of Medicare beneficiaries eligible to participate in the GPDC and KCC Models. |
| Geographic Adjustment Factors | County level expenditures are adjusted using Geographic Adjustment Factors | | Not applicable |
| Risk scores used to develop County Relative Cost Indices | Normalized risk scores, calculated using the payment year risk adjustment model, are used to risk-standardize base year expenditures. Average county level PBPM indices are risk-standardized based on the weighted average normalized risk scores | | Not applicable |
| Puerto Rico adjustment | Zero Claims Adjustment to counties in Puerto Rico | | Not applicable |
| Veterans Administration/ Department of Defense adjustment | County-level per beneficiary per month adjustment to remove the impact of Veterans Administration/Department of Defense beneficiaries' experience on county-level rates | | Not applicable |

| Feature | MA Rate Book | DC/KCC Rate Book | Reason for difference |
|---|---|---|---|
| Credibility adjustment | For counties with fewer than 1,000 members, county experience is blended with experience from the applicable Core-Based Statistical Area | | Not applicable |
| GME adjustment | Adjustment to remove GME expenditures from MA county rates | GME is not included in county rates | Not applicable |
| IME adjustment | Adjustment to phase-out IME expenditures from MA county rates | IME is included in county rates without a phase-out | IME expenditures are included in GPDC and KCC Model Benchmarks and therefore need to be in the county rates for consistency. |
| Kidney Acquisition Cost adjustment | Adjustment to remove Kidney Acquisition Costs from county rates | | Not applicable |
| Quartile adjustment | Statutory adjustment to county rates based on rate quartile | Not applied to county rates | There is no statutory requirement to adjust rates based on quartiles for the GPDC or KCC Models, nor are there specific GPDC or KCC Model policy goals achieved by including them in the DC/KCC Rate Book. |
| Quality bonus | Adjustment to county rates based on MA organization achievement of quality standards | Not applied to county rates | There is no quality bonus payment mechanism in the GPDC or KCC Models. |

FFS = fee-for-service; GPDC = Global and Professional Direct Contracting; GME = Graduate Medical Education; IME = Indirect Medical Education; KCC = Kidney Care Choices; MA = Medicare Advantage.