Direct Contracting Model Financial Methodology

Global and Professional

CMS/CMMI
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Agenda

Agenda for Today

- Direct Contracting Model Overview
- April Start & Revised Glide Path
- DC/KCC Rate Book
- Payment Mechanism Policy Updates
- Risk Adjustment

Direct Contracting Model Overview

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Model Goals

Transform risk-sharing arrangements in Medicare Fee-For-Service (FFS)

Empower beneficiaries to personally engage in their own care delivery

Reduce provider burden to meet health care needs effectively

Financial Goals and Opportunities

The Direct Contracting Model builds on the Next Generation ACO Model, introducing several new model design elements including:

- **New performance year benchmark methodologies** focused on increasing benchmark stability, simplicity, and prospectivity;
- **Capitation and other advanced payment alternatives** for model participants; and
- Financial model that **supports broader participation** by entities new to Medicare Fee for Service (FFS) and/or focused on delivering care for high needs populations.

Provider Relationships

Direct Contracting Entity (DCE)

- Must have arrangements with Medicare-enrolled providers or suppliers, who agree to participate in the Model and contribute to the DCE's goals pursuant to a written agreement with the DCE.
- DCEs form relationships with two types of provider or supplier:

DC Participant Providers

- Used to align beneficiaries to the DCE
- Required to accept payment from the DCE through their negotiated payment arrangement with the DCE, continue to submit claims to Medicare, and accept claims reduction
- Report quality
- Eligible to receive shared savings
- Have option to participate in benefit enhancements and beneficiary engagement incentives

Preferred Providers

- Not used to align beneficiaries to the DCE
- Can elect to accept payment from the DCE through a negotiated payment arrangement with the DCE, continue to submit claims to Medicare, and accept claims reduction
- Eligible to receive shared savings
- Have option to participate in benefit enhancements and beneficiary engagement incentives

Risk Options

Professional

50% shared savings / shared losses risk arrangement

- Must select Primary Care Capitation (PCC)
- No discount to the Performance Year Benchmark

Global

100% shared savings / shared losses risk arrangement

- Must choose either the Total Care Capitation (TCC) or Primary Care Capitation (PCC)
- Performance Year Benchmark includes a discount that begins at 2% for PY1 and increases to 5% for PY5

Summary of DCE Types

DCE Types

	Standard	New Entrant	High Needs
	DCEs with substantial historical claims-based experience serving Medicare FFS	DCEs with limited experience delivering care to Medicare FFS beneficiaries	DCEs that focus on beneficiaries with complex, high needs, including individuals dually eligible for Medicare and Medicaid
Risk Arrangement Options	*Professional and Global are available for each DCE type*		

April Start & Revised Glide Path

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Implications of COVID-19 Flexibilities

In response to COVID-19, CMS will introduce an off-cycle April 2021 start and launch a second cohort starting in January 2022; these flexibilities have implications on the Direct Contracting Model glide path and the Performance Year (PY) 1 financial methodology

Glide Path

- Direct Contracting has a number of model features that follow a "glide path" as the model progresses, such as the:
  - Global Discount
  - Minimum Beneficiary Thresholds
  - Benchmark Calculation Methodology Update
  - Transition to Full Pay-for-Performance for Quality Measures
  - Primary Care Capitation Reduction Thresholds
- CMS has updated the glide path for these features to address the 9-month PY1 and second cohort starting in PY2

PY1 Financial Methodology

- The financial methodology is designed around a 12-month calendar year rather than the 9-month, off-cycle period for PY1
- CMS will adjust the typical, 12-month benchmark to account for seasonal differences in expenditures from April – December
- In addition, the reconciliation timeline will be delayed to allow for proper evaluation of quality performance

Revised Glide Path

The off-cycle April 2021 start and introduction of a second cohort necessitates updates to the PY1 financial methodology and the Direct Contracting Model glide path

Calendar Year	PY	Global Discount	New Entrant / High Needs Beneficiary Minimums[1]	New Entrant / High Needs Benchmark[2,3]	Quality Withhold Basis
2021 (9 mo.)	1	*2%*	*1000 / 250*	*Regional Rate*	*1% Performance, 4% Reporting*
2022	2				
2023	3	*3%*	*2000 / 500*		*5% Performance*
2024	4	*4%*	*3000 / 750*		*5% Performance*
2025	5	*5%*	*5000 / 1200*	*Blend of Regional Rate & Baseline*	*5% Performance*
2026	6	*5%*	*5000 / 1400*		*5% Performance*

1. New Entrant DCEs and High Needs Population DCEs must meet increasing minimum beneficiary threshold counts for each Performance Year
2. For the first four PYs, New Entrant DCEs and High Needs Population DCEs will use a benchmarking methodology based entirely on the regional rate from the DC/KCC Rate Book; beginning in PY5, this methodology will blend the regional rate with a baseline composed of recent historical expenditures
3. New Entrant and High Needs Population DCEs with > 3,000 claims-aligned beneficiaries will use the same benchmarking approach as Standard DCEs

PY1 Seasonality Adjustment

In order to account for the off-cycle performance period for PY1, CMS will apply a seasonality adjustment to the benchmark

- The benchmark for PY1 will continue to be calculated using the methodology for a 12-month Performance Year, with a seasonality factor applied to the resulting benchmark
- The seasonality factor will be determined based on the ratio of January – December and April – December per beneficiary per month (PBPM) expenditures for the reference population of alignable beneficiaries
- The seasonality factor for the PY will be the average of the ratios for the three baseline years (2017 – 2019)
- Separate seasonality factors will be calculated for Aged and Disabled (A&D) and End State Renal Disease (ESRD)

Sample Calculation of the PY1 Seasonality Factor

	BY 1 (2017)	BY2 (2018)	BY3 (2019)	3-Year Average (Applied to PY1)
January – December PBPM Expenditures	$922.45	$950.56	$986.21	
April – December PBPM Expenditures	$927.32	$957.36	$996.44	
Seasonality Factor (Apr-Dec / Jan-Dec)	*100.53%*	*100.72%*	*101.04%*	***100.76%***

Quality Implications for PY1

- To mitigate the impact of COVID-19, quality performance benchmarks will be developed using 2021 claims data.
- The quality performance benchmarks for the Risk-Standardized All Condition Readmission and the Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions measure will be made available in April – May 2022. The benchmarks will apply for both Performance Years 1 and 2.
- To earn back 1% of the quality withhold in PY1 and PY2 the DCE must meet the quality performance benchmarks on one of the two utilization measures listed above.

Reconciliation Options

- At reconciliation, CMS compares all Medicare expenditures for services delivered to aligned beneficiaries, against the Direct Contracting Entity's (DCE's) benchmark to determine shared savings or losses.
- For most Performance Years, CMS will provide the option for DCEs to select a provisional reconciliation option (selected at the start of the Performance Year) in addition to standard final financial reconciliation.

Provisional Reconciliation (optional)

Immediately following the performance year, reflecting cost experience through first six months (with seasonality and claims run-out adjustments), using preliminary or mid-year risk scores and placeholder quality scores

Estimated Timing: January of the following PY

Final Reconciliation

Following three months of claims run out after the performance year and availability of data for final reconciliation, reflecting complete performance year, including final resolved risk scores and quality scores

Estimated Timing: July of the following PY

PY1 Reconciliation Timing

In order to allow for proper evaluation of quality performance in PY1, final financial reconciliation will be conducted ~19 months after the end of the PY and provisional financial reconciliation will be mandatory ~7 months after the end of the PY

	Provisional Financial Reconciliation (mandatory)	Final Financial Reconciliation
Target Date for Reconciliation	July 31st of calendar year following the performance year (2022)	July 31st of calendar year two years following the performance year (2023)
Claims Included in Reconciliation	Performance year expenditures incurred through December 31, 2021	Performance year expenditures incurred through December 31, 2021
Claims Run-out	Run-out through March 31, 2022	Run-out through March 31, 2022
Risk Scores	Final risk scores	Final risk scores
Quality Scores	Preliminary quality scores	Final quality scores

DC/KCC Rate Book

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DC/KCC Rate Book Construction

The DC/KCC Rate Book consists of two components: a National Conversion Factor and County Relative Cost Index

National Conversion Factor	×	County Relative Cost Index	=	County Rate
Per Beneficiary Per Month (PBPM) measure of all Fee for Service (FFS) expenditures for which DCEs are accountable, across all beneficiaries eligible for the Direct Contracting Model		*County relative factors used to scale the national conversion factor to each individual county, based upon the ratio of the county level PBPM expenditures to the national PBPM expenditures*		*Risk-standardized PBPM measure of predicted expenditures for a given county, used to determine a DCE's regional rate*

Both the National Conversion Factor and County Relative Cost Indices are determined based on historical FFS expenditures; the historical National Conversion Factor is then trended to the Performance Year using the adjusted FFS USPCC trend

DC/KCC Rate Book Construction (cont.)

Calculating the National Conversion Factor

A National Conversion Factor is calculated for the most recent Base Year used in the DC/KCC Rate Book, and is then trended forward to the Performance Year using the adjusted USPCC trend[1]:

$$\frac{\text{FFS Expenditures for DC National Reference Population}}{\text{Number of Beneficiary Months in DC National Reference Population}} \times \text{USPCC Trend from Most Recent Base Year to Performance Year}$$

Calculating the County Relative Cost Indices

For each Base Year used to construct the DC/KCC Rate Book, the County Index for a given county is equal to:

$$\frac{\text{FFS Expenditures for DC National Reference Population in County} \times \text{GAF Index for County}}{\text{Number of Beneficiary Months in DC National Reference Population in County}}$$

The Performance Year County Relative Cost Index is the average of the three Base Year County Indices divided by three-year average normalized risk score for that county

1. The adjusted USPCC trend removes Uncompensated Care and includes Hospice, consistent with the expenditure categories included in Direct Contracting

Sample Determination of County Rates

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

Differences from MA Rate Book

The construction of the DC/KCC Rate Book parallels the MA Rate Book development process, with adjustments to make it appropriate for the Direct Contracting context

Beneficiary Population

Uses a population consistent with Direct Contracting eligibility rules

Expenditure Categories

Uses expenditure categories consistent with Direct Contracting benchmarking and savings calculations

Historical Years

Uses fewer and more recent historical years to determine the conversion factor and relative cost indices

Statutory Adjustments

Does not apply statutory adjustments specific to the Medicare Advantage program

The intent of these changes is to improve the accuracy of the regional rates for the purposes of benchmarking in the Direct Contracting Model

Differences from MA Rate Book (cont.)

Feature	DC/KCC Rate Book	MA Rate Book	Rationale
Beneficiary Population	▪ Must be enrolled in Part A and Part B ▪ Not enrolled in MA or managed care ▪ Medicare as Primary Payer ▪ US Resident	▪ All FFS Beneficiaries not enrolled in Medicare Advantage (including beneficiaries enrolled in only Part A or B, Medicare as a Secondary Payer, etc.)	*Aligns the beneficiaries used to generate the Rate Book with those eligible for the Direct Contracting Model*
Expenditure Categories	▪ Includes hospice care expenditures and IME ▪ Does not include uncompensated care payments	▪ Does not include hospice care expenditures or IME ▪ Includes uncompensated care payments	*Aligns the expenditure categories used for shared savings expenditures in the Direct Contracting Model*
Historical Years	▪ Three Base Years ▪ One-year interval between the last Base Year and the Performance Year	▪ Five Base Years ▪ Two-year interval between the last Base Year and the Performance Year	*Aligns the number of years used to develop both the historical and regional components for the blended financial benchmark, and allows for use of more recent experience*
Statutory Adjustments	▪ No statutory adjustments are applied	▪ Applies quartile adjustments ▪ Applies quality bonus adjustments	*Statutory adjustments are not required in Direct Contracting and do not achieve specific policy goals for the model*

Regional Rates for Benchmarking

- The Direct Contracting Model incorporates regional dynamics by using an adjusted version of the Calendar Year's (CY) MA Rate Book that CMS' Office of the Actuary (OACT) updates annually
- The DC/KCC Rate Book will be a component of the benchmark for all DCE types, but it will apply differently depending on the DCE type and how beneficiaries are aligned to the DCE (claims-based vs. voluntary alignment)

<table>
<tr><th>DCE Type</th><th colspan="2">Standard</th><th>New Entrant[2]</th><th>High Needs Population[2]</th></tr>
<tr><th>Alignment Option[1]</th><th>Claims-Based Alignment</th><th>Voluntary Alignment</th><th>Both Options</th><th>Both Options</th></tr>
<tr><td>PY1</td><td rowspan="6">Standard Benchmarking Approach using a blend of historical expenditures and the regional rate based on the DC/KCC Rate Book</td><td colspan="3" rowspan="3">Regional Benchmarking Approach composed entirely of the regional rate based on the DC/KCC Rate Book for the PY</td></tr>
<tr><td>PY2</td></tr>
<tr><td>PY3</td></tr>
<tr><td>PY4</td><td colspan="3" rowspan="3">Modified Standard Benchmarking Approach using a blend of recent historical expenditures and the regional rate based on the DC/KCC Rate Book</td></tr>
<tr><td>PY5</td></tr>
<tr><td>PY6</td></tr>
</table>

1. Beneficiaries who could be aligned to the same DCE via both voluntary and claims-based alignment will be treated as having claims-based alignment for benchmarking
2. New Entrant and High Needs Population DCEs with > 3,000 claims-aligned beneficiaries will use the same benchmarking approach as Standard DCEs

Regional Blend Methodology

- The Historical Baseline Expenditures will be blended with the Regional Expenditures from the DC/KCC Rate Book
- The DC/KCC Rate Book will have an increased weighting towards the PY benchmark over the model performance period

Blending the Historical Baseline Expenditures with the Regional Expenditures

	PY 1 (2021)	PY2 (2022)	PY3 (2023)	PY4 (2024)	PY5 (2025)	PY6 (2026)
DCE's Historical Baseline Expenditures	65%	65%	65%	60%	55%	50%
Regional Expenditures (DC/KCC Rate Book)	35%	35%	35%	40%	45%	50%

Regional Blend Methodology (cont.)

The blend of regional rates and historical expenditures in the Base Years will determine the DCE Regional Rate Baseline Adjustment that will be applied to the DC/KCC Rate Book in the PY

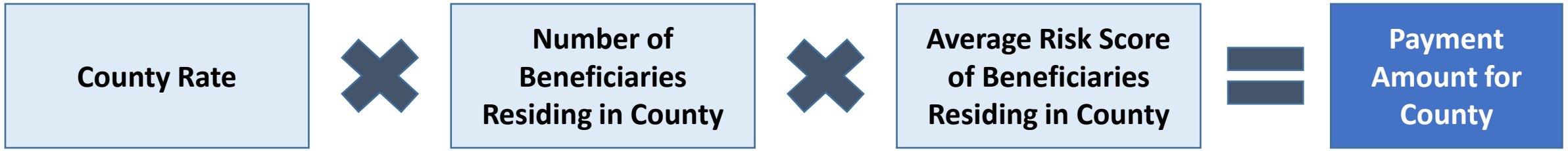
Baseline	BY 1 (2017)	BY2 (2018)	BY3 (2019)	3-Year Baseline[1]
Trended, Standardized Baseline Expenditure	$796.04	$810.78	$847.13	$831.12
Regional Rate	$858.88	$858.31	$858.66	$858.58
Blend Rate[2]	65% Baseline; 35% Regional			
Blended Benchmark[3]	-			$840.73
DCE Regional Rate Baseline Adjustment	*Represents the ratio of the Blended Benchmark to the Regional Rate*			**0.979**

Performance Year Benchmark	
PY Regional Rate from DC/KCC Rate Book	$858.29
DCE Regional Rate Baseline Adjustment	**0.979**
PY Risk Score	1.194
PY Benchmark (Before Discount or Quality)	$1,003.13

1. The 3-year baseline is blended with 10% weight given to 2017, 30% weight to 2018, and 60% weight to 2019
2. The blend rate is 65:35 in PY1-3, but the proportion of the regional rate increases for PY4-PY6, as described on the prior slide
3. The blended benchmark is limited by a ceiling of +5% / floor of -2% of the projected USPCC amount for the PY; in this example, the ceiling / floor have not been triggered by the blend

How to Use the DC/KCC Rate Book

To project a DCE's DC/KCC Rate Book payment amount for a county, multiply the County Rate by the number of aligned beneficiaries residing in that county and by the average PY risk score for those beneficiaries



Risk-standardized PBPM measure of predicted expenditures for a given county, used to determine a DCE's regional rate

The number of beneficiaries aligned to the DCE that reside in a given county

The average Performance Year risk score for the aligned beneficiaries residing in a given county, after normalization and coding intensity policies

Payment amount for a given county used to generate regional rate for benchmark

Payment Mechanism Policy Updates

Capitation Payment Mechanisms

DCEs must select one of the two Capitation Payment Mechanisms. The Capitation Payment Mechanisms available vary based on the Risk Option selected.

1	**Primary Care Capitation (PCC)**	Monthly capitation payments for primary care services furnished to aligned beneficiaries.	*Available for Global and Professional*
2	**Total Care Capitation (TCC)**	Monthly capitation payments for all services furnished to aligned beneficiaries.	*Available for Global Only*

Advanced Payment (APO)

Advanced payments function in a similar way to the population-based payments in the Next Generation ACO model.

Advanced Payment is an optional payment mechanism, only available to DCEs that select the PCC capitation payment.

Advanced Payments are a cash flow mechanism to prospectively pay DCEs the value of the non-primary care claims we estimate their DC Participant Providers and Preferred Providers will submit.

DCEs can negotiate with their DC Participant Providers and Preferred Providers to agree to FFS Medicare claims reduction (between 1 – 100% of FFS claims). In exchange, CMS will pay the DCE a prospective per beneficiary per month (PBPM) payment representing the estimated value of the reduced FFS claims and reduce FFS claims payments made to providers through the Medicare payment systems by the difference.

Unlike the Capitated Payment Mechanisms, the value of Advanced Payments made to DCEs will be reconciled against the actual value of the Medicare FFS claims after the Performance Year

PCC and APO are complementary – a given service will be subject to either, but not both

	Professional claims		Institutional claims	
	Primary Care Specialists	All other specialties	FQHCs[1] and RHCs[2]	All other institutional providers
Primary Care-Based Services	PCC	APO	PCC	APO
All other services	APO	APO	PCC	APO

- **Primary Care-Based Services**: PQEM codes used for alignment (see Financial Overview paper for comprehensive list)
- **Primary Care Specialists**:

Code	Specialty[1]
1	General Practice
8	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Clinical Nurse Specialist
97	Physician Assistant

1. FQHC = Federally Qualified Health Center
2. RHC = Rural Health Clinics
3. For Instructions for Viewing Individual Practitioner Status and Specialty Type in PECOS, please see this link: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/Instructionsforviewingpractitionerstatus.pdf

PCC Requirements

- Primary Care Capitation (PCC) is available to DCEs in either Global or Professional risk options
- DCEs that select PCC are also able to select the Advanced Payment Option (APO)
- In response to COVID-19 related challenges and stakeholder concerns, additional flexibility is permitted for DC Participant Providers and Preferred Providers in DCEs that select PCC and / or APO:

Primary Care Capitation

PY	DC Participant Providers	Preferred Providers
PY1	Optional; 1-100%	Optional; 1-100%
PY2	Mandatory; 5-100%	Optional; 1-100%
PY3	Mandatory; 10-100%	Optional; 1-100%
PY4	Mandatory; 20-100%	Optional; 1-100%
PY5	Mandatory; 100%	Optional; 1-100%
PY6	Mandatory; 100%	Optional; 1-100%

Advanced Payment Option (if selected by DCE)

PY	DC Participant Providers	Preferred Providers
PY1	Optional; 1-100%	
PY2	Optional; 1-100%	
PY3	Optional; 1-100%	
PY4	Optional; 1-100%	
PY5	Optional; 1-100%	
PY6	Optional; 1-100%	

TCC Requirements: Apply to all FFS Claims

Total Care Capitation
Available in Global Only

	DC Participant Providers	Preferred Providers
What FFS claims are capitated?	All FFS Claims - ***Mandatory***	Portion of FFS Claims (0 – 100%) - ***Optional***
What FFS claims payments are suitable for advanced payment?	None	None

Applies to all PYs

Initial Capitation Amounts Received by DCEs

Total Care Capitation

DCEs receive monthly amount representing estimated total cost of care less a withhold

Monthly TCC = PY Benchmark – Withhold for remaining FFS claims

Using a provisional benchmark calculated prior to the performance year

Accounts for (1) leakage, estimated utilization by providers not in the capitated arrangement and (2) remaining Preferred Provider claims not 100% reduced

Primary Care Capitation

DCEs receive 7%[1] of the benchmark, divided between the *Base Primary Care Capitation* and *Enhanced Primary Care Capitation*, which enables DCEs to invest in expanding their primary care capabilities

Monthly PCC (equals 7%[1] of PY Benchmark) = Base Primary Care Capitation Amount + Enhanced Primary Care Capitation Amount

Determined from historical primary care experience of aligned beneficiaries

Defined as the difference between 7%[1] of the PY benchmark and the Base Primary Care Capitation Amount

CMS will recoup the value of the enhanced amount (prior to application of the risk arrangement) at the end of the PY

1. While the default PCC amount is 7% of the benchmark, it may be higher or lower depending on DCE preference and historical utilization patterns; as such, the Enhanced PCC amount may not always equal 7% of the PY Benchmark – the Base PCC amount

Enhanced / Base PCC Selection

While the default PCC Percentage is 7% of the benchmark, certain flexibilities are allowed

Setting the Base PCC Percentage

$$\text{Base PCC (\% of benchmark)} = \frac{\text{PCC-eligible claims-based payments (CBP) in lookback period}[1] \times \text{Reduction amounts elected by participating providers}}{\text{Total CBP for aligned beneficiaries in lookback period}}$$

- Base PCC amount is allowed to be >7% of the benchmark, if historical Primary Care utilization exceeds 7% of CBP
- PCC participation and reduction amounts elected by DC Participant Providers and Preferred Providers are reflected in Base PCC

Steps for selecting the Enhanced PCC Percentage

- **Step 1:** In early January, DCE elects the maximum Enhanced PCC desired.[2]
- **Step 2:** Prior to PY, CMS quantifies and shares the DCE's CBP for PCC services, indicating the DCE's maximum Enhanced PCC allowed.[3] Once shared, the DCE is able to revise its maximum Enhanced PCC if desired (Step 1).
- **Step 3:** Enhanced PCC is set as the lower of Step 1 or Step 2 (i.e., what DCE elects and what CMS allows). This amount is set for the remainder of the PY.

CBP for PCC Services (A)	Enhanced Percentage Range (B)	Maximum Total Percentage (A+B)
0 to 5%	0 to (7% - A)	7%
> 5%	0 to 2%	A + 2%

Note that DCEs with greater than 5% Base PCC Percentage may still receive up to 2% Enhanced, and that DCEs may choose a reduced Enhanced PCC Percentage if desired.

1. Per above, PCC-eligible claims are defined as (1) PQEM services billed by Primary Care Specialists participating in PCC (for Part B) or all services billed by Federally Qualified Health Centers and Rural Health Clinics (for Part A)
2. Enhanced PCC 'floor' = 0% (DCEs can elect not to receive it)
3. Enhanced PCC 'ceiling' = the higher of 2% OR 7% - CBP PCC % (PCC participation and reduction amounts elected by DC Participant Providers and Preferred Providers are NOT reflected in CBP PCC %)

Updates to Payment Mechanism Amounts During and After Each PY

Adjustments to PCC/TCC (during and after PY)

Type of Adjustment	TCC	PCC
Adjustment for expected bene-months (prospective)	Yes	Yes
Adjustment for actual bene-months (retrospective)	Yes	Yes
Updated benchmark (risk scores, bene/county distribution)	Yes	Yes
Updated payment amount as a % of the benchmark	Yes (Withhold %)	No (Base PCC %)

Key difference

Adjustments to APO (during and after PY)

- **After PY**: Amount paid under APO is adjusted to be equal to the amount of FFS claims dollars reduced under APO during the PY
- **During PY**: Difference between amount paid under APO and amount of FFS claims dollars reduced under APO during the PY is monitored throughout the year
  - If the difference is meaningful, CMS reserves the right to make adjustments to APO payments during the year to avoid large 'true-ups' post-PY

Risk Adjustment

Risk Adjustment Methodology Goals

- Risk adjustment will be used to risk adjust expenditures and establish performance year benchmarks.
- Risk adjustment will be pivotal in determining that payments are fair and accurate, and that they reflect the true health status of the population being served.
- A risk adjustment goal will be to promote payment accuracy, with a special focus on small, high needs populations with high costs being served by High Needs Population DCEs.
- A further goal is to direct provider resources away from coding intensity activities by reducing coding intensity and increased payments resulting from higher risk scores, which do not reflect disease burden.

Risk Adjustment

CMS uses risk adjustment to adjust payments based on the demographics and health risk of a beneficiary

Risk scores are derived for a beneficiary using a combination of **demographic** and **disease-based** factors

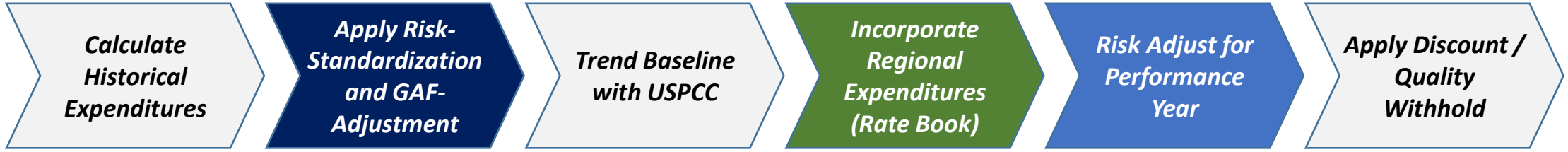
Demographic Factors
Age, Disabled Status, Medicaid Status, etc.

Disease-Based Factors
ICD-9/10 codes on claims are mapped to Hierarchical Condition Categories (HCCs)

The average Medicare beneficiary with average expenditures will have a risk score equal to 1.0. Sicker beneficiaries with predictably higher costs of care will generally have a higher risk score (e.g.,1.5 or 2.0).

Risk Adjustment in the Benchmark

Risk scores are used in up to three areas of the Benchmark calculation for Direct Contracting, depending on the type of DCE and how beneficiaries are aligned to the DCE



Standardizing historical expenditures to account for beneficiary health risk in the Base Years

Standardizing the DC/KCC Rate Book values to account for the health risk of the DC National Reference Population

Adjusting the Blended Benchmark[1] based on the health risk of the DCE's PY aligned beneficiaries

1. Capitation payments made to the DCE will also be impacted by risk adjustment as they are calculated based on the PY Benchmark, which is derived from the Blended Benchmark

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Risk Adjustment Models

Direct Contracting makes uses of two risk adjustment models

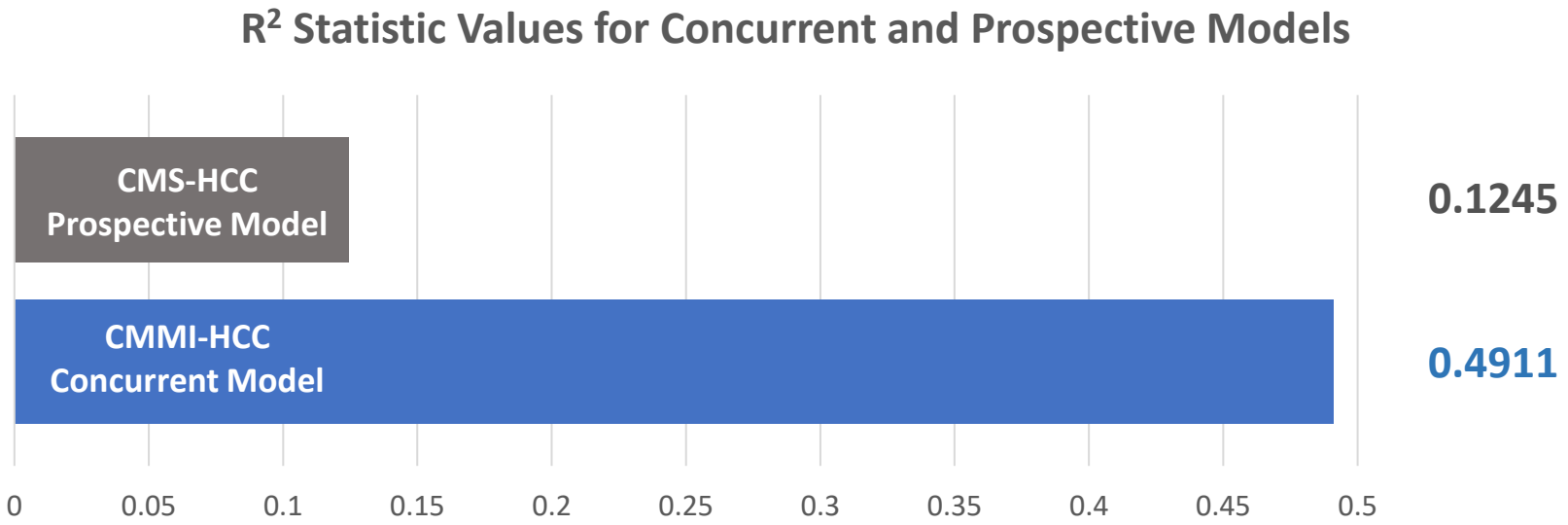
CMS-HCC Prospective Model	CMMI-HCC Concurrent Model
Used for Standard and New Entrant DCEs	**Used for High Needs Population DCEs**
The risk model is based on diagnoses from the prior year and expenditures from the current year	The risk model is based on diagnoses and expenditures from the current year
It was designed for Medicare Advantage (MA) and has been applied to adjust payment for numerous CMMI models including Next Generation ACO and Comprehensive ESRD Care	It was designed for the Direct Contracting Model, and is intended to improve payment accuracy for small populations of complex, high-risk beneficiaries

CMMI-HCC Concurrent Risk Adjustment Model

- Beneficiary risk scores for the Aged & Disabled and New Enrollees aligned to High Needs DCEs will be calculated with the CMMI-HCC concurrent model, while risk scores for ESRD beneficiaries will be calculated with the ESRD prospective model.
- The CMMI-HCC concurrent model includes most of the CMS-HCC prospective model variables and most of the 21st Century Cures Act requirements, with the key difference that it uses demographic indicators and diagnoses from the performance year to predict expenditures in the same year.
- Because this model weights acute conditions more heavily, it is expected to better capture a rapid deterioration in health *in the current year*, such as through the occurrence of acute episodes that are difficult to predict or prevent (e.g., heart attack).
- The Innovation Center will test if this model provides a more stable financial position for High Needs Population DCEs serving a small population of chronically sick and seriously ill beneficiaries with highly variable, high expenditure needs.

CMMI-HCC Concurrent Model Performance

By using diagnoses and demographic information from the same year as expenditures, concurrent risk models are better able to explain variation in individual health care spending, improving prediction for small and seriously ill populations with high disease burden



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Normalization

- Risk adjustment is designed such that the average beneficiary has a risk score of 1.0
- However, beneficiary eligibility rules and changes in coding practices or health status may result in an average risk score that is greater than or less than a 1.0
- CMS will address this by normalizing risk scores in each Performance Year and historical year used to develop the baseline and DC/KCC Rate Book so that the DC National Reference Population[1] average risk score is a 1.0
- Separate normalization factors will apply to A&D, ESRD, and new enrollee risk scores

Risk scores in each Calendar Year will be divided by the average risk score in the DC National Reference Population, which consists of all FFS beneficiaries eligible for the Direct Contracting Model.

1. To be eligible for the Direct Contracting Model, beneficiaries must (1) be enrolled in both Part A and Part B, (2) not be enrolled in MA or managed care, (3) have Medicare as Primary Payer, and (4) be a US resident

Estimated Preliminary Normalization Factors

Performance Year normalization factors will be determined retrospectively, after the year ends; for reporting and payments during the PY, CMS will apply prospectively estimated normalization factors

Normalization Factor	BY 1 (2017)	BY2 (2018)	BY3 (2019)	→	*PY1 (2021)*
A&D (CMS-HCC Prospective Model)	1.098	1.118	1.137		***1.176*** *[Projected]*
A&D (CMMI-HCC Concurrent Model)	0.993	1.013	1.037		***1.080*** *[Projected]*
ESRD	1.079	1.092	1.107		***1.136*** *[Projected]*

To estimate PY benchmarks using risk scores, raw risk scores should be divided by the normalization factor for that calendar year

Coding Intensity Policy

- CMS will address coding intensity in Direct Contracting through a retrospective Coding Intensity Factor (CIF) in combination with a symmetric 3% cap on DCE-level risk score growth
- Risk scores will first be normalized, then subject to the DCE-level cap (initially for Standard and New Entrant only), and finally the CIF will apply at the program level

DCE-Level Cap[1]

At the DCE level, risk scores will be limited from growing / declining by greater than 3% relative to each entity's historical risk scores

Coding Intensity Factor[2]

At the program level (across all DCEs), risk scores will be reduced by a CIF if growth outpaces the DC National Reference Population

These policies are designed to address the potential for changes in coding behavior driven by participation in the Direct Contracting Model

1. The DCE-level cap will initially apply only for Standard DCEs and New Entrant DCEs; however, High Needs Population DCEs may be subject to a cap later starting in PY4 if excessive coding growth is observed
2. The Coding Intensity Factor will apply for all DCE types; one CIF will apply for Standard DCEs and New Entrant DCEs and another CIF will apply for High Needs Population DCEs, which use the CMMI-HCC concurrent model

DCE-Level Cap

- A symmetric 3% cap will be applied to DCE-specific risk score growth
- For each Performance Year, risk score growth will be measured relative to each DCE's historical risk scores, using a rolling reference year two years prior
    - To avoid potential coding biases introduced by Coronavirus-2019, 2019 will be used as the risk score reference year for PY 2022 rather then 2020
- The cap will be applied separately for the A&D and ESRD populations
- Initially, the cap will be applied to Standard and New Entrant DCEs; High Needs Population DCEs will be monitored in the first three years and a cap may be applied beginning in PY4
- Voluntary aligned beneficiaries that do not also meet the claims alignment algorithm will not be subject to the cap[1]

Historical Reference Year for DCE-Level Cap

	Reference Year
PY1 (2021)	2019
PY2 (2022)	2019
PY3 (2023)	2021
PY4 (2024)	2022
PY5 (2025)	2023
PY6 (2026)	2024

1. The cap will not incorporate experience from voluntarily aligned beneficiaries, as they are not present in the reference population – however, once a beneficiary is also aligned via claims alignment, their experience will be included

Coding Intensity Factor

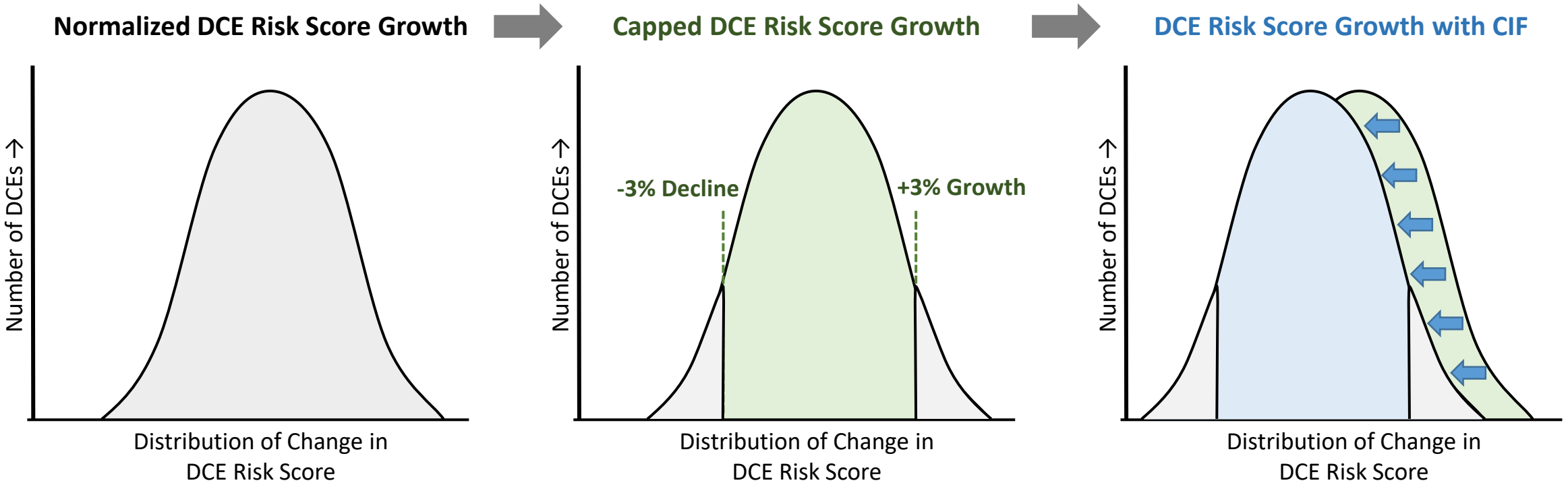
- A Coding Intensity Factor (CIF) adjustment will be retrospectively applied at the program level to DCE risk scores before final reconciliation
- If risk scores in a Performance Year across all DCEs have increased by a greater rate than the DC National Reference Population risk scores, a uniform CIF will be applied to all DCE risk scores to adjust for that increased rate of growth
    - For example, if the normalized risk score across all DCEs is 100.5% of the historical reference risk score across all DCEs, then PY risk scores will be divided by a CIF of 100.5% to account for the increased growth rate
- For A&D beneficiaries, one CIF will be applied to risk scores for Standard and New Entrant DCEs (which use the CMS-HCC model) and another will be applied to risk scores for High Needs Population DCEs (which use the CMMI-HCC model)
- For ESRD beneficiaries, a separate CIF will be applied across all DCE types
- Voluntary aligned beneficiaries that do not also meet the claims alignment algorithm will not be subject to the CIF[1]

Historical Reference Year for Coding Intensity Factor

	Reference Year
PY1 (2021)	2019
PY2 (2022)	2019
PY3 (2023)	2019
PY4 (2024)	2019
PY5 (2025)	2019
PY6 (2026)	2019

1. The CIF will not incorporate experience from voluntarily aligned beneficiaries, as they are not present in the reference population – however, once a beneficiary is also aligned via claims alignment, their experience will be included

Example of Coding Intensity Policy



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Risk Adjustment Methodology

- The Innovation Center appreciates the opportunity to partner with DCEs on the Direct Contracting risk adjustment approach.
- Direct Contracting Model Global and Professional Options provide unique challenges and opportunities to test and implement risk adjustment for benchmarking and payment purposes in FFS.
- The Innovation Center will test the newly designed CMMI-HCC concurrent risk adjustment model being applied to high needs populations and determine whether it provides more accurate financial compensation for High Needs Population DCEs.
- Risk adjustment information will be routinely made available to participants over the performance period.
- Participants are encouraged to review the Direct Contracting website, and also, MA websites for documents addressing risk adjustment models and policy.

Open Q&A

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Direct Contracting Open Q&A

Open Q&A

Please **submit questions via the Q&A box**.
Specific questions about your organization can be submitted to DPC@cms.hhs.gov

Model Timeline

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Model Timeline

Milestone	Date
Financial Methodology Question and Answer Session	September 21, 2020 1PM ET
PY 2021 Finalists Identified	September 2020
Start of Implementation Period	October 1, 2020
Final Provider List due to participate in PY 2021	October 23, 2020
PY 2021 Participation Agreements Signed	March 2021
Start of Performance Year 2021	April 1, 2021
Application Period for PY 2022	March-May 2021
Start of Performance Period 2022	January 1, 2022

This timeline may be subject to change. Please check the Direct Contracting webpage for webinar and office hour dates and times.

Contact Information

Direct Contracting Webpage

https://innovation.cms.gov/initiatives/direct-contracting-model-options/

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