Global and Professional Direct Contracting (GPDC) Model
Summary of Quality Performance, Financial Performance, and Model Payments
Updated 08/15/22

The Centers for Medicare & Medicaid Services (CMS) routinely conducts ongoing monitoring of the quality and financial performance of models. Note that the data in this document are for model monitoring purposes, and are not evaluation results. This document will be updated regularly to provide information on the quality and financial performance of the Direct Contracting Entities (DCEs) participating in the Global and Professional Direct Contracting (GPDC) Model.

1. Quality Performance

Summary: CMS is sharing performance data on the All-Condition Readmission (ACR) and Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC) measures for the first performance year (PY) of the GPDC Model (April to December, 2021). The GPDC Model focuses quality measurement on a small set of critically important quality measures, including CAHPS® (beneficiary experience of care surveys)[1], ACR, UAMCC, Days At Home (High Needs Population DCEs only), and Timely Follow-Up After Acute Exacerbations of Chronic Conditions (Standard and New Entrant DCEs only)[2]. However, in PY2021 and PY2022, only the ACR and UAMCC measures are treated as pay-for-performance measures. The remaining measures are pay for reporting. Currently, only performance data from PY2021 (April – December 2021) is available for ACR and UMCC due to the lag time required for data accuracy. CMS intends to share quality performance data for PY2022 on a quarterly basis as it becomes available. Because all claims-based measures have a 12-month performance period, CMS shares performance measure data based on 12-month rolling periods for quarterly reports. For example, performance data for quarter 2 of 2021 are therefore based on a performance period from July 1, 2020 through June 30, 2021.

ACR data should be read as the “percent of initial hospital admissions that resulted in an unplanned readmission.” Lower values for unplanned hospital readmissions indicate higher quality. For the 12-month period ending in December of 2021, the ACR score across all Standard and New Entrant GPDC Model participants (known as DCEs) was 14.98% (i.e., 14.98% of hospital admissions resulted in an unplanned readmission for beneficiaries aligned to a DCE). For reference, the ACR score across all non-DCE TINs (including TINs participating in traditional Medicare, the Medicare Shared Savings Program, and the Next Generation ACO (NGACO) Model) was 14.96%. This difference is not statistically significant.

UAMCC data should be read as the “number of unplanned hospital admissions per 100 beneficiaries with multiple chronic conditions per year.” Lower values for unplanned hospital admissions indicate higher quality. For the 12-month period ending in December of 2021, the UAMCC score across all Standard and New Entrant DCEs was 30.75 (i.e., for every 100 beneficiaries with multiple chronic conditions aligned to a participant in the GPDC Model there were 30.75 unplanned hospital admissions). For reference, the ACR score across all non-DCE TINs (including TINs participating in traditional Medicare, the Medicare Shared Savings Program, and the NGACO Model) was 32.58. This difference is statistically significant (i.e., GPDC Model participants scored statistically better on the UAMCC measure).

[1] Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] For more information on the GPDC Model quality policy, please see the PY2022 Quality Measurement Methodology paper available on our website: https://innovation.cms.gov/media/document/gpdc-py2022-qual-meas-meth

Table 1. GPDC Quality Data - April through December 2021

12-Month Period Ending:	DCE[1] count	ACR[2]		UAMCC[3]	
		All DCE TINs	All Non-DCE TINs[4]	All DCE TINs	All Non-DCE TINs[4]
June 2021	47[5]	13.42%	13.46%	27.01	28.38
September 2021	47	14.27%	14.30%	29.29	30.63
December 2021	47	14.98%	14.96%	30.75	32.58

(1) DCE = Participants in GPDC Model, referred to as Direct Contracting Entities (DCEs)
(2) ACR = All-Condition Readmission; this data should be interpreted as "percent of initial hospital admissions that resulted in an unplanned readmission." Lower values are more favorable.
(3) UAMCC = Unplanned Admissions for Patients with Multiple Chronic Conditions; this data should be interpreted as "number of unplanned hospital admissions per 100 beneficiaries with multiple chronic conditions per year." Lower values are more favorable.
(4) All Non-DCE TINs = All non-DCE TINs participating in traditional Medicare, the Medicare Shared Savings Program, and the NGACO Model with at least 1,000 eligible beneficiaries.
(5) Data excludes 6 High Needs Population DCEs given small sample size and lack of comparability to a general reference population (like all non-DCE TINs).

This data is based on performance data collected for purpose of quality measurement in the model and does not represent formal evaluation data. In general, the statistically significant findings on the UAMCC measure, while early, indicate that quality may be improving and we look forward to evaluation findings.

2. Financial Performance

Summary: CMS is releasing summary statistics of DCE financial performance. Across the 53 DCEs participating in the GPDC Model in PY2021, the total number of aligned beneficiaries was approximately 344,000 beneficiaries. The total dollars under risk (also known as the sum of the Performance Year Benchmark across all 53 PY2021 DCEs), which is a cumulative year-to-date (YTD) figure from April 2021 through December 2021, increased in line with expectations and is consistent with an average per-beneficiary-per-month (PBPM) benchmark of approximately $1,150 (varying slightly throughout the year). Combined, all 53 DCEs that participated in the GPDC Model in PY2021 produced a roughly 1.7% reduction in Medicare spending compared to their combined Performance Year benchmarks in PY2021 based on the latest data available. Combined with the capitation data (see below), this is analogous to a Medical Loss Ratio (MLR) of 98.07%[3].

Average reduction in Medicare spending fluctuated over the 9-month Performance Year in a pattern that is consistent with the results of other ACO-based initiatives. It is important to caveat that this data is not final and is subject to change. For the 39 DCEs that are taking 100% risk (the 'Global' option) in PY2021, CMS applies a discount of 2% (in PY2021) to ensure savings for CMS; this adjustment has already been removed from the Performance Year Benchmarks in this data, so reductions in expenditures reported are in addition to the savings for CMS.[4]

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[3] MLR generally refers to the percent of health care premiums spent on medical claims. Because the GPDC Model exists within traditional Medicare and model participants are not functioning as payers, this terminology is generally not used in the context of ACO-based models like the GPDC Model. However, for comparison purposes, MLR may be considered analogous to the reduction in spending compared to the benchmark (1.7% - see Table 2, most recent data for PY2021) combined with the percent of the benchmark comprised of capitation payments (2.5% - see Table 3, most recent data for PY2021) and the percentage of those payments that is not spent on Medicare Covered Services (1 – 90.8% = 9.2% - see Table 3, most recent data for PY2021). For PY2021, MLR could be estimated to be 100% - 1.7% - (2.5% * 9.2%) = 98.07%.

[4] For a full explanation of the benchmark methodology, please see the Financial Operating Guide: Overview paper available on our website: https://innovation.cms.gov/media/document/gpdc-py2022-fin-op-guide-ovw

Based on the first quarter of PY2022, the 99 participating DCEs have produced a roughly 4.5% reduction in spending compared to their combined Performance Year benchmarks based on the latest data available. Due to seasonal effects (e.g., the Part B deductible), spending reductions may be larger in the first three months than the rest of the year. Preliminary data from the first quarter is also subject to higher fluctuations, given the timing of the reporting period compared to the entire performance year.

This data is not formal model evaluation data, but is collected for purposes of monitoring the Model's financial methodology and performance.

Table 2. GPDC Financial Performance Data

Period covered	Data as of	DCE Count	Avg. aligned beneficiaries across all DCEs	Total dollars under risk across all DCEs (cumulative YTD)	Average reduction (increase) in spending compared to benchmark	Standard Deviation[1]
PY2021						
Apr-Jun 2021	July, 2021	53	344,390	$1,158,839,004	2.2%	10.6%
Apr-Sep 2021	October, 2021	53	343,495	$2,400,603,391	1.8%	9.9%
Apr-Dec 2021	January, 2022	53	343,423	$3,612,885,015	1.5%	9.6%
Apr-Dec 2021	May, 2022	53	338,938	$3,514,813,246	1.7%	10.1%
PY2022						
Jan-Mar 2022, YTD	May, 2022	99	1,768,708	$5,749,697,246	4.5%	8.8%

(1) Standard Deviation in average reduction (increase) in spending compared to benchmark across all 53 DCES participating in PY2021

3. Capitation

CMS is publishing available data on capitation in the GPDC Model. In PY2021, only 2.5% of total services provided to aligned beneficiaries were impacted by capitation (i.e., 97.5% of all Medicare payments for services to aligned beneficiaries were not impacted by capitation). Capitation in the GPDC Model functions differently than capitation in other health care contexts, for example in Medicare Advantage (MA). In Medicare Advantage, CMS pays MA plans capitation payments covering the total cost of care and MA plans take on responsibility for contracting a provider network and adjudicating and paying all claims that those providers send to the plan. In the GPDC Model, capitation payments cover only a portion of total cost of care: Medicare Part A and Part B services rendered by health care providers participating in the Model who agree to participate in capitation. CMS retains responsibility for adjudicating all claims, including those covered by capitation, and for paying approved claims, as appropriate. Beneficiaries maintain the freedom of choice to see any Medicare-enrolled provider or supplier. Capitation in the GPDC Model enables participating health care providers to forgo a portion of their fee-for-service (FFS) claim payments in exchange for receiving compensation from the

DCE, for example a greater share in savings, with the goal of better aligning financial incentives at the point of care.

There are two capitation options (called 'capitation payment mechanisms') in the GPDC Model. Primary Care Capitation (PCC) is a payment mechanism in which participating primary care providers in the GPDC Model agree to forgo between 1-100% of FFS claims payments for a specific set of services rendered to aligned beneficiaries by participating health care providers (see Table B.6.3 in the Financial Operating Guide: Overview paper for a list of these services). Total Care Capitation (TCC) is a payment mechanism in which participating health care providers in a DCE agree to forgo 100% of FFS claims payments for services rendered to aligned beneficiaries.

Health care providers who are not participating in the GPDC Model do not have their claim payments adjusted in any way under the Model, even when providing services to aligned beneficiaries. Further, health care providers who are participating in TCC or PCC do not have their claims payments adjusted in any way under the Model when providing services to beneficiaries who are not aligned to their DCE.

Because capitation only affects participating health care providers, it generally impacts a small percentage of Medicare Covered Services provided to aligned beneficiaries. Health care providers participating in DCEs that had selected to participate in PCC were not required to receive payment through capitation in PY2021 due to the Public Health Emergency. Despite capitation being optional for many health care providers participating in DCEs during PY2021, 36 of 53 DCEs included health care providers that chose some form of capitation, with 25 opting for PCC and 11 for TCC. Across all 36 DCEs (i.e., excluding the 17 DCEs with no health care providers participating in capitation), capitation impacted on average 2.5% of total cost of care (i.e., 97.5% of all Medicare payments for services furnished to aligned beneficiaries were not impacted by capitation). Further, the total amount of forgone FFS claim payment due to TCC and PCC in PY2021 was equal to 90% of the total TCC and PCC payments made to DCEs. I.e., the amount of Medicare payments withheld (not paid out as they would have been outside of the model) was 90% of the capitation dollars paid, which can be interpreted as 90% of capitation dollars paid being spent on Medicare Covered Services.

For PY2022, we estimate that approximately 3.5% of total cost of care for all aligned beneficiaries will be impacted by capitation. This represents a small but marked increase compared to the PY2021 data of approximately 2.5%, which is expected because (1) all health care providers participating in a DCE were required to participate in capitation in PY2022 and (2) a higher average claims reduction amount for PCC was required in PY2022 (1-100% permitted in PY2021 vs 5-100% in PY2022). We plan to publish data on the percent of these payments 'spent' on Medicare Covered Services once it becomes available.

It is important to caveat that this data is not final and is subject to change. Further, this data is not formal model evaluation data, but data collected for the purposes of monitoring the Model's financial methodology and performance.

Table 3. GPDC PY2021 Capitation Data (PCC and TCC combined)

Period covered	Data as of	DCE Count[1]	Average % of Performance Year Benchmark paid via capitation	Preliminary % of capitation payments spent on Medicare Covered Services
PY2021				
Apr-Jun 2021	January, 2022	36	2.5%	91.4%
Apr-Sep 2021	January, 2022	36	2.5%	90.3%
Apr-Dec 2021	May, 2022	36	2.5%	90.8%
PY2022				
Jan-Mar 2021	May, 2022	99	3.5%	Available in Fall 2022 (pending full claims runout)

(1) PY2021 DCE count excludes 17 DCEs that had no participating health care providers that chose to participate in capitation.