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CHEAT SHEET

# Direct Contracting

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An introduction to CMMI's new voluntary alternative payment model

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- Direct Contracting builds on concepts in the Next Generation ACO and Medicare Advantage risk models to give providers a downside risk model with flexible cash flow, more predictable cost targets, and fewer quality measures.
- The model offers two capitation arrangements—primary care services or all services—and both participating and preferred providers can receive capitated payments.
- Providers should carefully evaluate participation in the Direct Contracting model based on their experience with risk, patient population, and the model's financial methodology.

# What is it?

Direct Contracting (DC) is a five-year, Accountable Care Organization (ACO)-like risk model that runs from 2021 to 2025. It's the Center for Medicare & Medicaid Innovation's (CMMI) most aggressive downside risk model yet. The model builds on concepts in Next Generation ACO (NGACO) and Medicare Advantage (MA) risk sharing models to give providers a downside risk model with flexible cash flows, more predictable cost targets, and fewer quality measures.

There are currently two options for participating in DC:

## Professional

- Primary care capitation and infrastructure payment equal to 7% of performance year benchmark
- 50% shared savings/losses

## Global

- Either a primary care or total care capitation available
- 100% shared savings/losses

Those best poised to participate in DC will be current NGACO or Medicare Shared Savings Program (MSSP) participants, due to their experience with risk. Providers selected to participate in DC will not be able to simultaneously participate in other total cost of care and primary care models. See the table below for a summary.

Eligibility to participate in DC, based on current risk-based contracts				
Shared Savings ACOs, NGACO	Bundled payments: BPCI <sup>1</sup> Advanced, CJR <sup>2</sup> , and OCM <sup>3</sup>	CPC <sup>4+</sup> /PCF <sup>5</sup>	Direct Contracting (a second contract)	Maryland total cost of care model; Vermont all-payer ACO model
✗	✓	✗	✗	✗

1. Bundled Payments for Care Improvement.  
 2. Comprehensive Care for Joint Replacement.  
 3. Oncology Care Model.  
 4. Comprehensive Primary Care Plus.  
 5. Primary Care First.

Source: CMS, "Direct Contracting Model: Global and Professional Options – Requests for Applications," Nov. 2019; Advisory Board research and analysis.

# Why does it matter?

## For CMS

One of Medicare’s primary goals is to save money through value based payment. A 2018 analysis by CMS found ACOs that take on downside-risk are more likely to realize shared savings than ACOs in upside-only arrangements. To drive savings, CMS has doubled down on its efforts to produce new and appealing downside risk models, and CMS has encouraged providers to enter capitated payment arrangements to control spending long-term. Ultimately, CMS wants to tie 100% of Medicare payments to alternative payment models—as opposed to fee-for-service (FFS)—by 2025.

## For providers

- The Covid-19 pandemic renewed provider interest in capitated payment models as more stable sources of revenue for physician groups and systems grappling with low FFS volumes.
- The DC model intends to replace NGACO, which ends in 2021. For 2022, NGACO participants who want to maintain their participation in downside risk with Medicare can choose to participate in either the DC model, or in the MSSP Enhanced Track.
- Overall, the DC model is a good option for providers who are experienced in taking on downside-risk, are committed to population health, and believe capitated payments will improve their ability to care for patients.

1. In June, [Seema Verma announced](#) several payment model flexibilities in response to Covid-19, including the extension of NGACO from 2020 to 2021.

Source: CMS, “Direct Contracting Model: Global and Professional Options – Requests for Applications,” Nov. 2019; LAN, “While progress continues, the LAN launches new goals to increase reach and impact of value-based payment reform,” Oct. 2019; Advisory Board research and analysis.

# How does it work?

## How providers are paid in Direct Contracting

Participants in DC are paid based on cost and quality performance. There are several types of payments in the DC model. Participants in Professional DC receive primary care capitation. Participants in Global DC can opt for primary care capitation or total care capitation. Capitated payments are paid out over the course of the year. The DC entity (DCE) is the participant provider, but contracts may include preferred providers. Below is breakdown of the capitation payment options for participants in DC.

### Payments for participant providers

	Primary care services	Non-primary care services	Other
<b>Primary care capitation<sup>1</sup></b>	<p><b>Base primary care capitated payment</b></p> <p>Monthly payment based on historic experiences of aligned beneficiaries; participants receive \$0 FFS claims</p>	<p><b>Advanced payment (optional)<sup>2</sup>:</b></p> <p>Amount is an estimate of non-primary care spending based on historic utilization</p> <p><b>FFS payment</b></p> <p>Paid % of claims not reduced by advanced payment option</p>	<p><b>Enhanced Primary Care Payment:</b></p> <p><i>Difference between 7% of PY benchmark and base capitation; intended to be infrastructure investment</i></p>
<b>Total care capitation</b>	<p><b>Total care capitation</b></p> <p>DCEs receive monthly amount for estimated total cost of care, minus a withhold for FFS claims; participants receive \$0 FFS claims</p>		N/A

### Preferred and other provider payments

Preferred providers have the option to participate in capitated payments. Those who opt for capitated payments will have their FFS claims reduced 1-100%, based on negotiation. Otherwise, preferred providers will be paid FFS for services provided. Providers outside of the DC contract will be paid FFS, but count towards expenditures. DC participants should make sure all providers are closely aligned and set expectations to appropriately manage utilization.

1. The monthly primary care capitation payment DCEs receive is equal to 7% of the PY benchmark. It's comprised of two components: the base primary care capitation amount and the enhanced primary care capitation amount.

2. Advanced payments are reconciled against actual claims expenditures; capitation payments are not reconciled against actual claims expenditure.

Source: CMS, "Direct Contracting Model: Global and Professional Options – Requests for Applications," Nov. 2019; Advisory Board research and analysis.

# A closer look

## Financial reconciliation and quality

At the end of the performance year, the DCE’s expenditures for aligned beneficiaries is compared to the benchmark, and beneficiary risk is applied to determine shared savings or losses<sup>1</sup>. Quality incentives in DC will be structured as a 5% withhold that providers can earn back, based on performance. Starting year two, participants must meet a pre-defined Continuous Improvement/Sustained Exceptional Performance threshold to earn back all of the withhold. Those who don’t meet the threshold can earn up to half of the withhold, based on their scores. High-performers may be eligible for bonuses funded by low-performers.

## How DC compares to Next Generation ACO

Direct Contracting (DC) was designed based upon the feedback from organizations participating in the NGACO model or other shared savings initiatives, but DC is distinct in several ways.

### Differences between DC & NGACO

**Fewer lives at risk:** Standard DCE requires 5,000 lives at risk compared to 10,000 for NGACO; New Entrant and High-Needs DCEs have even lower thresholds

**Capitation required:** While NGACO offered an option for capitated payments, participants in DC must choose either primary care or total capitation

### Similarities between DC & NGACO

**Popular benefit enhancements<sup>2</sup>:** Including 3-day SNF<sup>3</sup> rule waiver, asynchronous telehealth, post-discharge home visits, and care management home visits

**Elements of financial methodology:** Including stop-loss methodology, voluntary beneficiary alignment

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on this topic, visit [Direct Contracting Model Options](#)

1. In comparison to Next Generation ACO, DC uses a new risk adjustment strategy and financial benchmarks based on the MA rate-book. See the [rate book](#) and technical paper on [risk adjustment](#) for more detail.

2. Benefit enhancements are still in development and not yet finalized.

3. Skilled nursing facility.

Source: CMS, "Direct Contracting Model: Global and Professional Options – Requests for Applications," Nov. 2019; Advisory Board research and analysis.

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# Conversations you should be having

**01** Assess readiness to take on significant downside risk.


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**02** Determine if Direct Contracting is the right risk downside-risk model for our organization, based on your experience and patient population.

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**03** What is the impact of our participation on our Medicare reimbursement landscape?


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Direct Contracting is not the right risk-based model for every provider. Beyond experience and patient population, providers should also consider what it means to be an early adopter of a new payment model. Keep in mind, being in the first cohort of a payment model means you won't have best practices for program participation to lean on and CMS might make adjustments to the program, as the cohort progresses. 

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