Bamboo Health

CMS Direct Contracting

EXPLAINING THE MODEL & HOW TO SUCCEED WITH REAL-TIME DATA

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Direct Contracting Model Overview

The Centers for Medicare and Medicaid Services' (CMS) Direct Contracting Model, a voluntary payment model, began on April 1, 2021. The model builds upon learnings from the Next Generation Accountable Care Organization (ACO) Model, offers participants increased risk options, and is an integral component of CMS's strategy to redesign primary care as a platform to drive reductions in costs. In addition, the high-risk model is an opportunity for participants to drive consistent revenue, improve patient outcomes, and lower global utilization and costs. As participants prepare for success within Direct Contracting, it is important to evaluate care coordination strategies and resources that help support proactive patient engagement and care interventions.

PERFORMANCE PERIODS

CMS released two performance period start dates for the Direct Contracting Model, both of which are scheduled to run through December 2026. Additionally, there is a voluntary implementation period, which offers participants the opportunity to prepare for the first performance period of the model.

MODEL GOALS

The Direct Contracting Model builds upon learnings and innovations from the Next Generation ACO Model, innovations from Medicare Advantage, and commercial payer risk arrangements. Below are the high-level goals for the program:

- Transform risk-sharing arrangements in Medicare fee-for-service (FFS)
- Broaden participation in the Center for Medicare & Medicaid Innovation (CMMI) models
- Empower beneficiaries to engage in their own care delivery
- Reduce provider burden to meet healthcare needs effectively

Voluntary Implementation Period:

October 1, 2020 - March 31, 2021

First Performance Cohort:

Begins April 1, 2021

Second Performance Cohort:

Begins January 1, 2022

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Direct Contracting Participants

Under the model, there are three types of Direct Contracting Entities (DCEs) that can initially participate in the program: Standard DCEs, New Entrant DCEs, and High Needs Population DCEs. CMS also announced a Medicaid Managed Care Organization (MCO) DCE type, which is eligible to participate as of January 2022.

PARTICIPANT TYPES OVERVIEW

TYPE 1: STANDARD DCE

Standard DCEs are established ACO participants. Standard DCEs must have experience serving Medicare FFS beneficiaries and are required to have a minimum of 5,000 aligned beneficiaries to be eligible for participation in the model, starting in the first performance year.

TYPE 2: NEW ENTRANT DCE

New Entrant DCEs are participants that have limited experience delivering care to Medicare FFS beneficiaries. Specifically, no more than 50% of Participant Providers within these DCEs may have prior experience in CMS shared savings models. These participants are required to have to a minimum of 5,000 aligned beneficiaries by the 5th performance year, with a glide path that starts with 1,000 aligned beneficiaries required in year 1 and increasing by 1,000 beneficiaries each year until the fifth year.

TYPE 3: HIGH NEEDS POPULATION DCE

High Needs Population DCEs are participants that are tailored to Medicare FFS beneficiaries with complex needs. High needs beneficiaries must have conditions that impair their mobility or meet one of the complex high needs special conditions for eligibility, which includes: significant chronic or other serious illness and an Hierarchical Condition Categories (HCC) risk score greater than 3, an HCC risk score greater than 2 and less than 3 but with two or more unplanned hospital admissions in the previous 12 months, or signs of frailty as evidenced by a claim for a hospital bed or transfer equipment for use in home.

High Needs Population DCE participants are required to have demonstrated capabilities in coordination of services that emphasize patient-centered care. The number of required beneficiaries is lower for these DCEs, with 1,400 required by the 6th performance year plus a glide path starting at 250 beneficiaries required for the first two performance years and incremental increases until the 6th year where they must have 1,400 aligned beneficiaries.

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Direct Contracting Beneficiary Alignment

Beneficiaries can be aligned to DCEs in two ways: voluntarily or through claims. Supporting one of the model's goals of empowering beneficiaries to engage in their own care delivery, voluntary alignment will take precedence over claims-based alignment.

VOLUNTARY ALIGNMENT

- Medicare beneficiaries choose to align to a DCE by electing a Direct Contracting Participant Provider as their primary clinician.
- DCEs are permitted to proactively perform outreach to beneficiaries for engagement within guidelines of permitted activities provided by CMS.

CLAIMS-BASED ALIGNMENT

- Alignment is based on primary care services provided by Direct Contracting Participant Providers.
- Two-year look back period is used.

RISK OPTIONS

Direct Contracting entities will have two initial risk options: Professional and Global.

1. **Professional Risk Option:** The Professional Risk Option is the lower risk option within the Direct Contracting Model. With this option, DCEs will have 50% shared savings/losses with CMS and receive a capitation payment for primary care services only at roughly 7% of the benchmark target. DCEs will also have the option to elect for an Advanced Payment for the remaining 93% of the payment.
2. **Global Risk Option:** The Global Risk Option is a full risk option where DCEs will have 100% shared savings/losses with CMS. DCEs will have the option to choose between primary care capitation or total care capitation. If DCEs select primary care capitation, they will have the option to elect for an Advanced Payment for the remainder of the payment.

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Performance Year Benchmark Methodology

The benchmark methodology for the Direct Contracting Model is grounded in Historical & Regional expenditures. Benchmarking for Standard DCE beneficiaries carry some nuances based on how they are aligned. Below is the benchmark methodology outline for all DCEs.

HISTORICAL & REGIONAL EXPENDITURES

	Standard DCEs		New Entrant DCEs	High Needs Population DCEs
	Claims Aligned Beneficiary	Voluntarily Aligned Beneficiary	Claims & Voluntarily Aligned Beneficiary	Claims & Voluntarily Aligned Beneficiary
PY 1-4	Blend of Historical & Regional	Regional		
PY 5-6	Blend of Historical & Regional			

RISK ADJUSTMENT

DISCOUNT & QUALITY WITHHOLD

DISCOUNT
- Applies only to Global DCEs
- 2% in PY1 (2-5% in PY2 - PY6)
- Ensures CMS obtains savings

QUALITY WITHHOLD
- Applies to all DCEs
- 5% of benchmark
- Can be earned back based on quality performance

FINAL PERFORMANCE YEAR BENCHMARK

PERFORMANCE YEAR BENCHMARK CONSIDERATIONS

- For Standard DCEs, voluntarily aligned beneficiaries may carry higher payment benchmarks in PY1-4 than claims aligned beneficiaries, assuming Standard DCEs have reduced the historical spend for beneficiaries below the regional averages.
- DCEs will need to evaluate resources and operational capabilities to drive success for quality measures to earn back the 5% withhold.

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Preparing for Success

As participants prepare for the Direct Contracting Model, several key considerations should be reviewed to help ensure success. Specifically, participants should evaluate care coordination strategies and resources, particularly those that provide real-time information on patient care events and help support proactive patient engagement and care interventions.

KEY CONSIDERATIONS

- Implement strategies that help drive voluntary beneficiary alignment.
- Engage beneficiaries to support retention.
- Create processes that help maximize quality scores.
- Assess current care management functions and processes to ensure optimal care coordination.
- Review relationship with providers and care teams responsible for managing beneficiary care journeys.

At the end of 2022, the Direct Contracting Model covered in this paper will become the ACO Realizing Equity, Access, and Community Health (REACH) model. If you would like to discuss this model with our team, email us at connect@bamboohealth.com.

HOW BAMBOO HEALTH HELPS

With Bamboo Health's real-time notifications on patients' care events across acute and post-acute settings, plus interactive performance dashboards on SNF utilization, readmissions, and multi-visit patients, DCEs can:

- Enable rapid post-discharge follow ups to support beneficiary engagement strategies for increasing voluntary alignment and beneficiary retention.
- Power strategies and care team workflows to minimize avoidable hospital and post-acute utilization and potential readmissions.
- Ensure timely post-discharge follow ups to support transitional care management workflows and engagement for preventative services.

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