

# Medicare FFS Direct Contracting: Financial benchmark observations

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The financial benchmark in the CMS Direct Contracting (DC) payment model will share key attributes with the Medicare Shared Savings Program (MSSP) financial benchmark. In this white paper, we compare and contrast the financial benchmark methodology between DC and MSSP.

On November 25, 2019, the Centers for Medicare and Medicaid Services (CMS) released the request for applications (RFA) for the Direct Contracting model's Professional and Global options.<sup>1</sup> The RFA contains a significant amount of important information for program participants. Some key program details, e.g., how risk adjustment will operate, have not been published as of the publication of this white paper. This new payment model gives participating provider organizations two options for risk-sharing arrangements, as well as the opportunity to receive a prospectively determined, more predictable revenue stream.

The DC payment model options are conceptually similar to the other CMS accountable care organization (ACO) options, the MSSP and the Next Generation ACO Model. Participants take on risk and earn potential rewards based on the efficiency and quality of care for aligned beneficiaries. The application window for the DC 2020 performance year closes on February 25, 2020, and the application window for the 2021 performance year will open in spring 2020, so provider organizations should be evaluating which payment model is the best fit for them in early 2020. The 2020 contract year offers a no-risk option for participants, or Direct Contracting entities (DCEs), to test out the program, and then risk sharing begins in 2021.

Once risk sharing begins, DCEs share in 50% of savings/(losses) in the Professional option, and 100% of savings/(losses) in the Global option. A financial benchmark is calculated for each DCE and compared to the actual performance year costs to calculate the settlement. Therefore, understanding the financial benchmark and settlement methodology is crucial for program participants.

## DCEs will largely compete against themselves

For organizations familiar with MSSP, the use of adjusted historical experience to calculate the benchmark will look familiar. In MSSP, an ACO's benchmark is driven in large part by its historical experience. In the MSSP methodology, an ACO's trended historical experience accounts for 50% to 85% of its benchmark, depending on its agreement period and cost relative to its region. In the DC methodology, historical cost relative to the region is not factored into the historical benchmark weight. Instead, trended historical experience for each DCE will make up 65% of its benchmark in performance year (PY) 1 (2021), decreasing to 50% in PY5 (2025). Figure 1 shows the historical experience weight for each performance year in DC.

**FIGURE 1: HISTORICAL BASELINE EXPERIENCE WEIGHT IN PERFORMANCE YEAR BENCHMARK**

PERFORMANCE YEAR	BASELINE EXPERIENCE WEIGHT
PY1 (2021)	65%
PY2 (2022)	65%
PY3 (2023)	60%
PY4 (2024)	55%
PY5 (2025)	50%

Note: These percentages are used in the benchmark calculation for beneficiaries aligned to a DCE using claims-based alignment. Historical baseline experience for voluntarily aligned beneficiaries receives 0% weight for PY1, PY2, and PY3.

In both MSSP and DC, the historical baseline years remain static throughout the entire performance period. However, the baseline period for all DCEs will be the same (2017-2019). In MSSP, the baseline period is the three calendar years prior to the first year of each agreement period, and is rebased at the start of a new agreement period. For DC, CMS proposed a single agreement period from 2021 through 2025, and a three-year historical baseline period for all DCEs from calendar year (CY) 2017 through CY 2019. In both programs, baseline experience is restated annually for participant list changes. While the baseline years themselves do not change, the historical experience (membership, expenditures, risk score, etc.) may change due to revisions in the DCE's participant list from year to year.

<sup>1</sup> The RFA is available at <https://innovation.cms.gov/Files/x/dc-rfa.pdf>.

The historical base year weighting for the baseline period in DC also mirrors the methodology that is used for an ACO's first agreement period under MSSP. Baseline years (BY) 1, 2, and 3 (2017, 2018, and 2019) will have 10%, 30%, and 60% weight, respectively, for the component of the benchmark determined by historical expenditures. This is consistent with an MSSP ACO's first agreement period, in which the same weights apply (10%/30%/60% for BY1/BY2/BY3).

Additionally, CMS will apply a number of adjustments to the risk-adjusted, trended, and regionally blended performance year benchmark. Under the Global model, a discount will be applied to the benchmark. The discount is equivalent to 2% of the benchmark for PY1 and PY2. The discount will increase by 1% each subsequent year (increasing to 5% by PY5). Thus the benchmark will decrease over time for the Global model, all else being equal.

As with MSSP, participants in DC will largely compete against themselves because the majority of the financial benchmark will be determined from the DCE's experience. DCEs with favorable historical baselines (i.e., higher 2017 through 2019 expenditures) may be in a good position to succeed in DC.

## There is a partial reward for efficiency attained before the agreement period

The DC model will incorporate regional expenditures into the historical baseline expenditures. Unlike in the Next Generation ACO model, there will be no explicit adjustment for "efficient organizations" (i.e., those with lower costs than their region) or "inefficient organizations" (i.e., those with higher costs than their region). However, regional expenditures will be blended with the DCE's historical benchmark expenditures. If a DCE's historical expenditures are lower than the regional average expenditures, blending the regional expenditures into the historical baseline experience will favor the DCE by increasing the benchmark. In that way, the DCE will be rewarded for efficiency attained before the agreement period. This same reward exists in MSSP, where the ACO's historical baseline expenditures are blended with regional experience.

A DCE's regional expenditures will be blended into historical baseline expenditures with a weight of 35% for PY1 (i.e., CY 2021). This percentage will grade up over time, reaching 50% by PY5 (CY 2025). Unlike MSSP, these percentages will not be based on whether the DCE has higher or lower per capita spending than its region. For DC, CMS will limit the upward regional adjustment at 5% of the fee-for-service (FFS) U.S. per Capita Cost (USPCC) for the performance year, and will limit the downward adjustment at 2% of FFS USPCC. This contrasts with the symmetrical limit in MSSP of  $\pm 5\%$  of national assignable per

capita expenditures. A DCE may be eligible for a 5% reward for efficiency relative to its region, just as an MSSP ACO is, but a DCE is not subject to as large of a potential downward regional adjustment to the benchmark as in MSSP.

For the DC program, regional expenditures will come from a new "Adjusted MA Rate Book," with the goal of further aligning Medicare FFS and Medicare Advantage (MA) payment policies. The Adjusted MA Rate Book contains county-level Medicare Advantage plan payments. It is expected to differ from the current MA Rate Book in three key ways:

1. CMS will omit adjustments that are not relevant to DC, such as the Quality Bonus Payment (QBP) for MA star ratings.
2. CMS will adjust for differences in expenditure types that are not relevant to DC. For example, in the MA Rate Book, county benchmarks are set at one of four quartile levels. For 2020, each county's benchmark was set at 95%, 100%, 107.5%, or 115% of the FFS projected rate for that county. The percentage is set based on the county's quartile for average per capita Medicare FFS spending in the most recent data year. The 95% adjustment is applied to the quartile with the highest per capita Medicare FFS spending, 100% for the second-highest, and so forth. CMS has stated that it might not apply this quartile rule in the Adjusted MA Rate Book. The quartile adjustment has a dampening effect on county-level projections, decreasing the benchmark for counties with higher per capita allowed amounts and increasing the benchmark for counties with lower per capita allowed amounts. If the quartile adjustments are not removed, the effect of regional adjustments will be dampened.
3. CMS will adjust for the fact that the MA Rate Book is based on experience for all Medicare FFS beneficiaries. DCE-aligned beneficiaries must be enrolled in both Medicare Parts A and B, so FFS enrollees who are not enrolled in both Medicare Parts A and B may be excluded from the Adjusted MA Rate Book.

When determining the benchmark, the definition of a region used for DC is the same as the definition for MSSP: it consists of a membership-weighted average of all counties in which at least one aligned beneficiary resides.

In DC, like in MSSP, provider organizations are rewarded for historical experience efficiencies relative to their regional averages. However, in DC these benchmark adjustments are based on a new Adjusted MA Rate Book, rather than average FFS expenditures for an assignable population. The methodology details for the Adjusted MA Rate Book are still uncertain as of the date of publication for this article and could be a significant consideration for prospective participants.

## Depending on the risk track, a significant amount of revenue is at risk

Like MSSP and Next Generation ACO participants, DCEs are at risk for the total cost of care. DCEs will share in 50% of savings/(losses) in the Professional option and 100% in the Global option. Both options include caps on the percentage of shared savings/(losses) that vary based on performance and election of optional stop-loss arrangements.

Both DC options will have capitated and Advanced Payment components that DCEs will be required to select. The two capitation options available for DCEs, Total Care Capitation and Primary Care Capitation, are summarized in Figure 2.

Each DCE will be comprised of DCE Participant Providers and may include Preferred Providers. CMS will use only DC Participant Providers to determine beneficiary alignment; Preferred Providers do not drive alignment or report quality metrics. DCE Participant Providers will be required to participate in the capitated model selected by the DCE. Capitated payments will be for all DCE Participant Providers and those Preferred Providers who have opted into the capitated arrangement. Preferred Providers identified by the DCE can opt into the capitation arrangement and select the percentage of claims payments they would like to have reduced under the capitated model.

As noted in Figure 2, DCEs selecting Primary Care Capitation will receive capitated payments equal to 7% of the estimated total cost of care. CMS anticipates this payment will be greater than actual historical primary care expenditures for a DCE. The difference between the Primary Care Capitation and historical primary care expenditures is intended to be used to fund enhanced primary care services, e.g., infrastructure, technology, and tools. However, this amount will be recouped by CMS in the Final Reconciliation.

The Advanced Payment is an optional component, only applicable to DCEs electing Primary Care Capitation, applying to non-primary care FFS claims that are not under the capitated arrangements. DCEs can negotiate with their providers to agree to CMS reducing their FFS claims by a certain percentage, from 1% to 100%. In exchange, CMS will make a monthly Advanced Payment to the DCE for an equivalent amount based on historical utilization for aligned members. The DCE is then responsible for paying those providers based on the agreement with those providers. The payments made to the DCE will be reconciled against actual FFS claims during the final financial reconciliation.

The capitation and Advanced Payment are significantly different from the MSSP methodology, in which the actual total cost of care is compared to a risk-adjusted, trended, and regionally blended benchmark with only relatively minor adjustments.

Under both the Professional and Global models, 5% of the Performance Year Benchmark will be withheld by CMS each year for quality performance. DCEs will have the opportunity to earn back the quality withhold based on performance relative to a set of quality measurements and continuous improvement or sustained exceptional performance (CI/SEP) criteria. CI/SEP targets will be designed to incentivize high-performing DCEs to continue to improve. PY1 will be based on a pay-for-reporting structure while actual quality results will be used in PY2 through PY5. To determine the quality bonus payment, the quality score (QS) will be multiplied by 5% if CI/SEP is achieved and by 2.5% if CI/SEP is not achieved.

In addition, CMS plans to create a High Performers Pool (HPP) funded by quality withholds that are not earned back by DCEs that achieve CI/SEP. Because PY1 will be based on reporting only, the HPP will not apply until PY2. Details regarding the criteria to qualify for HPP payments are not yet defined. Figure 3 shows examples of the flow of funds under the discount and quality incentive programs. Note that Figure 3 does not incorporate savings or losses due to a DCE's total cost of care performance compared to the Performance Year Benchmark. The illustrations in Figure 3 are intended only to show the impacts of the quality incentive programs.

**FIGURE 2: CAPITATION OPTIONS UNDER DC**

CAPITATION	DESCRIPTION	AVAILABLE TO PROFESSIONAL?	AVAILABLE TO GLOBAL?
Total Care Capitation	Capitated payment per beneficiary per month (PBPM) for all services. Payment will reflect the estimated total cost of care* for the aligned population.	No	Yes
Primary Care Capitation	Capitated payment PBPM for primary care services. Payment will equal 7% of estimated total cost of care* for the aligned population.	Yes	Yes

\* Total cost of care defined as the risk-adjusted, trended, and regionally blended benchmark.

**FIGURE 3: DC QUALITY WITHHOLD ILLUSTRATION**

CI/SEP CRITERIA ACHIEVED?	YES	NO
Quality Withhold	5%	5%
Quality Withhold Returned to DCE	QS x 5%	QS x 2.5%
Contribute Unearned Withhold to HPP?	Yes	No
Revenue to HPP	5% - (QS x 5%)	0%
Revenue to CMS	0%	5% - (QS x 2.5%)
Quality-Based Revenue to DCE	(QS x 5%) + HPP bonus	QS x 2.5%

**FIGURE 4: ILLUSTRATIVE COMPARISON OF QUALITY SCORE AND DISCOUNT EFFECT IN MSSP AND DC**

	MSSP	DC PROFESSIONAL	DC GLOBAL
Preliminary revenue to DCE/ACO	100% of FFS	95% of FFS	95% of FFS
QS	80%	80%	80%
Preliminary revenue after QS	100% of FFS	95% + 80% x 5% = 99% of FFS	95% + 80% x 5% = 99% of FFS
Discount off benchmark	n/a	0%	2%
Maximum shared savings rate	50%	50%	100%
Shared savings after QS	50% x 80% = 40%	50%	100%

Note: The illustrative examples in Figure 4 are based on a sample DCE/ACO with an 80% quality score. The examples also use the MSSP BASIC Level C maximum shared savings of 50%, and the PY1 DC Global discount of 2%. The DC columns assume that CI/SEP criteria is achieved. These values will vary for organizations in different risk tracks and/or performance years.

Figure 4 compares the effect of the quality score for providers under MSSP and DC. Under the DCE model, the quality program is separate from the settlement of final savings/(losses). This is significantly different from the quality mechanism in the current MSSP program, where the final shared savings rate is equal to the quality score multiplied by the maximum shared savings rate for each specific risk track. Because the DC quality recoveries and bonus are separate from the shared savings/(losses), DCEs may recover the quality withhold even in a loss position.

## Conclusion

Although the full methodology has not yet been published, the performance year benchmark under both the Professional and Global options has significant financial risk. The DC model offers a unique blend of concepts from FFS risk models and MA, which we will explore in more detail in future papers. The DC model may provide an attractive option for providers that want to take advantage of the unique features of the DC methodology, and other entities that have not traditionally participated in Medicare risk-sharing models.



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