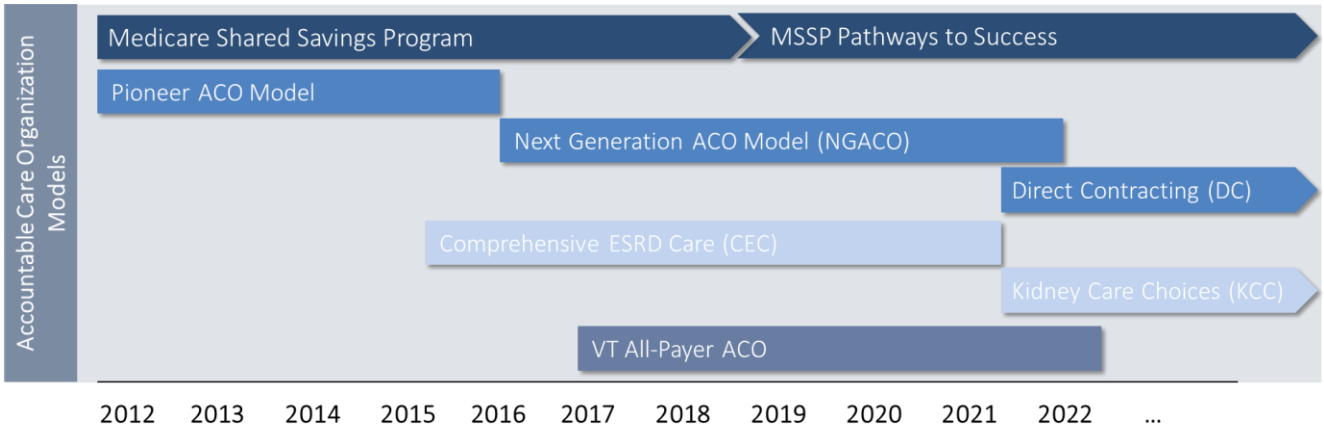
Choosing Your Path in Value: Direct Contracting vs. MSSP

A Comprehensive Evaluation of Both Risk-Based Options

January 25, 2021 – Accountable care organization (ACO) models have been the Center for Medicare & Medicaid Services' (CMS) primary vehicle for value transformation since the start of the movement. Under an ACO model, coalitions of providers agree to assume responsibility for the cost and quality outcomes of a defined population of patients. While the specific methodologies, terminology, and model policies vary, all ACO programs are population-based and include total cost of care (TCoC) accountability.

The Medicare Shared Savings Program (MSSP) is the agency's cornerstone ACO program, however CMS has continued to test new and advanced accountable care approaches via the CMS Innovation Center (CMMI). Each iteration applies lessons from its predecessor model, industry input, and increasingly Medicare Advantage (MA). Direct Contracting (DC), including the recently announced and highly anticipated DC Geographic model, represents the latest iteration of CMMI's advanced ACO models.



In addition to developing new advanced model iterations, CMS incorporates lessons from the Innovation Center's limited pilots into the MSSP for broader adoption. These periodic improvements are included among the MSSP's frequent updates, often made through the Medicare Physician Fee Schedule or other annual rulemaking. Since its latest major update, the Pathways to Success overhaul, the MSSP now includes attractive risk-based tracks that offer higher levels of downside risk along with some methodological 'perks' that were previously limited to the more advanced CMMI demonstrations (e.g., prospective attribution, beneficiary waivers). ACOs are increasingly moving into these two-sided risk options – BASIC E and ENHANCED – with some ACOs even electing to move before they are required to do so. In its latest installment – Direct Contracting – CMMI introduces new opportunities and flexibilities that are not included in its other models or through the MSSP.

Among providers who are ready to take on greater levels of downside risk for population cost and quality outcomes, there are now multiple options within Medicare's ACO portfolio. What's more, MSSP

BASIC Level E, ENHANCED, Next Generation ACO (NGACO; to sunset at end of 2021), and DC Professional and Global all qualify as Advanced APMs under the Quality Payment Program (QPP). Prospective participants must act now to evaluate their model options in preparation for the 2022 performance year, with both MSSP and DC application cycles quickly approaching. After a COVID-caused moratorium on new entrants, CMS will soon reopen the MSSP for the 2022 performance year, though the specific application window has yet to be announced. Similarly, the application period for DC's second and final cohort is not yet finalized but expected to open around March-May 2021, according to CMMI's latest timeline. No LOI is required and all eligible entities are welcome to apply.

This brief is designed to help provider organizations who are ready to take on significant levels of downside risk to judiciously evaluate the available options, considering the general opportunities and risk associated with the models, comparing the methodological differences between **MSSP BASIC Level E** and **MSSP ENHANCED** with **DC Professional** and **DC Global,** and assessing organizational fit. A high-level overview is provided below, while Appendix A includes more in-depth comparisons and analysis on participant eligibility, structures, and types; beneficiary attribution; financial benchmarking; quality performance; payment model; financial settlement; and additional benefits. A checklist to help guide strategic decision making is included in Appendix B.

MSSP BASIC Level E	MSSP ENHANCED	DC Professional	DC Global
Similar to Track 1+, this final track at the end of the MSSP's BASIC glidepath offers up to 50% shared savings and 30% shared losses.	*Built on Track 3, this most advanced MSSP track offers up to 75% shared savings and 40-75% shared losses.*	*This model option, the lowest risk DC pathway, offers partial capitation for primary care services and 50% shared savings/losses.*	*This global risk option offers a choice between partial primary care capitation or total care capitation and 100% shared savings/losses.*

Weighing General Opportunities and Risks

Prior to evaluating the appropriateness of a model for a specific organization, prospective participants should start by carefully studying the parameters of each model option and considering the general opportunities afforded by their differences, as well as the risks inherent to each. More detailed information on some key differences is contained within Appendix A.

The major opportunity provided by the MSSP, in comparison to DC, is the greater sense of security. Not only is the degree of shared risk literally lower, but the MSSP is a 'safer' bet – tested for multiple years and by many previous participants. Some of the risks associated with selecting the MSSP over the new DC options include leaving generated savings on the table, business model and investment constraints caused by the FFS-based chassis, and falling behind/leaving room for competitors or new entrants to capture market share via voluntary alignment. Further, DC offers more incentives to both providers and

beneficiaries to support care coordination and alignment within a managed care-like benefit design to drive down unnecessary medical costs.

Similarly, there are general opportunities and risks associated with DC's innovative model policies. For example, a condensed list of high-level opportunities and risks could include:

DC Opportunities	DC Risks
• Cash flow mechanisms smooth revenues • Increased capitalization to invest in non-revenue generating services and improvements • Fosters creativity and customization in downstream value-based contracts and incentivizes the network to manage to DCE's intentions • Allows providers to attract and compete for the loyalty of beneficiaries • Entry into Traditional Medicare market by new organizations • Incentivizes long-term investment • Tune up the network for MA	• New model with many unknowns • More likely than MSSP to change mid-PY, which has been known to happen in some CMMI models (i.e. NGACO) • Discount methodology within Global makes the model more difficult to achieve savings • Symmetrical risk corridors • Quality withhold implications • Withdrawal penalty • Additional administrative costs to invest in cash flow mechanism technology

Evaluating Organizational Fit

Assessing Needed Capabilities

Organizations must understand the specific competencies and infrastructure investments that are necessary for success under each model option. Prospective ACOs or DCEs must have many of the same population health management capabilities that are foundational to any population-based model, including participant roster/network management, risk stratification, care gap analyses, and proactive care management, among many others. Organizations that are considering DC must also assess whether they have the additional capabilities specific to capitation. The checklist in Appendix B can help guide organizational thinking in key areas.

Capabilities Specific to DCEs:

- **Manage higher levels of risk**, including up to 100%.
- **Forecast performance.** Per the tables in Appendix A, Direct Contracting introduces new benchmarking methodologies to determine capitation amounts to the DCE, and ramps these up over the course of the model, making accurate performance forecasting that much more difficult and important.
- **Engage beneficiaries,** including via compliant marketing activities and increased outreach/interaction. DC offers additional opportunities for active beneficiary choice regarding alignment, and new tools for DCEs to engage and communicate with beneficiaries (including those who are not yet aligned), leveraging tools successfully applied within MA. This will be a

key factor for both retaining existing aligned beneficiaries as well as strengthening position against other DCEs and other models.

- **Work with and develop a high performing network**. Health systems or plans with an established, robust provider network who already have insight into various practices' capabilities and performance and have optimized their in-network utilization will have an advantage. DCEs will have to establish who would fall into the participant and preferred provider networks prior to and ongoing throughout the contract period.
- **Understand and effectively manage leakage.** Open access population leakage is expected. However, instituting programs and technology to appropriately coordinate the network based on quality and efficiency is important to managing the benchmark and total cost of care.
- **Structure and negotiating downstream VBP provider contracts**. In addition to the technical and legal contracting capabilities needed, DCEs must be able to devise a contracting strategy that drives specific, targeted outcomes and that matches preferred and participating providers. Additionally, health systems with effective physician compensation and incentive models will have insights into incorporating value-based mechanisms to drive behavior change among individual clinicians. Lastly, some organizations, such as those with employed physicians or with strong physician leadership that is aligned with the operations of participant practices, may have an easier time adopting DC's cash flow mechanisms.
- **Distribute payments for services to providers.** Organizations must be able to ingest monthly PBPM payments from CMS, take a post-adjudicated weekly utilization report and distribute a portion or all of the lump sum to pay downstream providers (by NPI or at the TIN level for practices) and this could be done via various payment methodologies. Many prospective DCEs may be underestimating the operational capabilities needed to take on DC's post-adjudicated payment distribution, as this is not even a typical functionality or approach among dedicated 'claims shops' (e.g., TPAs, payers).
- **Leverage provider-sponsored health plan or other payer assets**. DCEs will have to take on many payer-like or MSO functions (network management, actuarial/underwriting, compliance and audit, risk adjustment programs, quality management, concurrent review and utilization management, etc.).
- **Leverage strong brands or name recognition in the community** to help with voluntary alignment efforts.
- **Institute reinsurance or stop loss with an informed perspective on cost/benefit.** DCEs will need to analyze reinsurance needs with a comprehensive assessment prior to paying a premium.
- **Hold the DCE and network accountable through analytics.** DCEs must continue to track performance at the DCE, practice, and provider level and make interventions, if necessary, in real-time. Tracking a host of ongoing performance and quality measures via claims, EMR, and network data is critical.

Modeling Projected Performance

Tables 1 – 7 outlined in Appendix A show the major design differences between the MSSP's advanced tracks and DC's Global and Professional model options. While the DC models have many attractive elements, providers will need to analyze the potential advantages of capitation and predictable revenue versus the challenges of the quality withhold and discount in DC's Global option. For example, the discount methodology under DC Global is progressively more challenging, ultimately requiring

participants to generate major gross savings to do better than they would in the MSSP. Furthermore, with DC Global's discount and quality withhold taken together, even modest gross *savings* could actually result in shared losses for the DCE. However, depending on the market regional benchmark and organizational claims history, the Global savings could be massive given the managed care controls the organization can place on the network in managing the total cost of care. For organizations who achieve the program quality goals and generate modest rates of gross savings/losses, the financial outcomes for MSSP ENHANCED and DC Professional may be comparable. Prospective DCEs will need to determine whether there is enough marginal difference in anticipated aggregate savings to overcome methodological barriers associated with DC Global versus MSSP ENHANCED.

To evaluate their likely performance under the model parameters, prospective participants must understand their performance compared to other providers in their region. Regional efficiency plays a bigger role in DC benchmarks. Organizations might struggle if they meaningfully over- or under-perform relative to their region, as DC uses a blend of historical and regional performance to set benchmarks. Additionally, competitive dynamics have important implications for the DC model, given its emphasis on voluntary attribution. Prospective participants should assess the competitive dynamics in their markets prior to joining DC. Providers in market with several competing CIN/ACO-like organizations could struggle if their Medicare beneficiary populations overlap with other providers. Meanwhile, for those who defer to MSSP, new entrants or other ACOs that graduate to DC will have more levers to attract an MSSP ACO's beneficiaries away to their DCE, which will be a competitive threat.

Evaluating Broader Organizational VBP Strategy

The new DC model offers a variety of risks and opportunities for organizations to carefully evaluate. For those that are ready to graduate from MSSP, there are substantially more opportunities in DC, including the ability to customize the provider complement; a glidepath for non-traditional organizations that are new to serving Medicare beneficiaries; access to new patient engagement incentives; a more flexible patient alignment methodology; regional adjustment methodology that favors efficient organizations; and broader options with respect to saving/loss rates. Through programs such as voluntary alignment, beneficiary engagements and compensation distribution, DC provides health systems the opportunity to increase mindshare with both physicians and beneficiaries for meaningful downside risk-based programs and provides a glidepath to MA. This can be advantageous for organizations with extant MA plans to reinforce their existing programs and take advantage of operational efficiencies of shared services across the populations, as well as those that are seeking to pursue MA as part of their long-term risk expansion plans.

NGACOs may want to consider the opportunities for savings that are less constrained by NPI/TIN methodologies. Prospective participants should consider how the selected ACO model would fit into their organization's broader VBP strategic interests, including its past/ongoing activities, investments, contracts, and its interests in future areas of growth. The introduction of DC – which represents the next logical step along the risk continuum and is a key part of CMS' long-term plan to curb growth in medical costs – is yet another example of the need for organizations to have a clear Medicare strategy.

Organizations should evaluate their past, current, and intended future value-based payment and delivery transformation efforts to determine which of the MSSP or DC model options offer the optimal path forward, keeping in mind that DC is only available on a limited basis (see Checklist of Strategic Questions to Guide Decision-Making). By making model selections based on a broader Medicare

strategy, rather than choosing simply based on current organizational readiness, providers can proactively align their investments, seek optimal partners, and identify which models offer the best opportunities in the short- and longer-term. For example, if an organization lacks the operational capabilities needed to move to total capitation but intends to develop those competencies through direct investment or with the help of industry partners, they might consider joining DC Global under the Primary Care Capitation arrangement. CMMI will allow DCEs in subsequent years of the model to move from the Professional Model to the Global Model but not in the opposite direction. Organizations who are not yet ready for Global but are actively working toward that aim may consider applying to join under the Professional Model and prepare to migrate.

About the ACLC

The Accountable Care Learning Collaborative (ACLC) is a non-profit organization with a mission to accelerate the readiness of healthcare organizations to assume value-based payment models. Founded by former Secretary of Health and Human Services Mike Leavitt, and former Administrator of the Centers for Medicare and Medicaid Services Mark McClellan, the ACLC serves as the foundation for healthcare stakeholders across the industry to collaborate on improving the care delivery system. To learn more about the ACLC, visit accountablecareLC.org.

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Appendix A: Comparing MSSP vs DC Methodologies

The tables below outline many of the major design differences between the MSSP BASIC Level E and ENHANCED tracks and the DC Professional and Global model options. Specifically, the tables compare model parameters regarding **1) Participant Eligibility, Structures, & Types, 2) Beneficiary Attribution, 3) Financial Benchmarking, 4) Quality Performance, 5) Payment Models, 6) Financial Settlement,** and **7) Additional Benefits**. In addition to a comparison of the methodologies, the tables include some commentary on the potential implications of the differences *in red italicized text* woven throughout.

Table 1: Participant Eligibility, Structures, & Types

	MSSP BASIC LEVEL E	MSSP ENHANCED	DC Professional	DC Global
Eligibility	ACO professionals in group practice arrangements, networks of individual practices, partnerships or joint venture (JV) arrangements between hospitals and ACO professionals, etc.		Health care providers under common governance structure (including but not limited to existing Medicare ACOs), along with an expanded list of eligible participants, such as MA organizations, Medicaid Managed Care Organizations (MCOs), and non-traditional vendors and suppliers, that haven't previously engaged in Traditional Medicare APMs.	
Participant Structures	**Accountable Care Organizations (ACOs)** are required to have contractual agreements with their ACO participants, which are entities identified by a Medicare-enrolled billing TIN that, alone or together with one or more other ACO participants, compose an ACO; the ACO participant and each ACO provider/supplier billing through the TIN of the ACO participant agrees to the requirements of the MSSP. *(All providers within a TIN must participate.)*		**Direct Contracting Entities (DCEs)** are umbrella entities that contract with CMS and are responsible for performance; comprised of Participants and Preferred Providers identified by TIN/NPI (much like NGACO). *(TIN/NPI combination allows medical groups with large primary care or specialty components to customize their provider complement based on geography or for other reasons.)* **Participants:** Receive reimbursement through capitation (either Primary Care Capitation or Total Care Capitation), historical claims are considered in beneficiary alignment with DCE. **Preferred Providers:** Optional amount of reimbursement to be received through capitation and are not considered for beneficiary alignment.	
Participant Types	At the start of each participation agreement, ACOs are evaluated based on the following criteria: **New vs Renewing**: Whether an ACO is joining the MSSP for the first time or renewing an existing contract. **High vs Low Revenue**: ACOs whose total Medicare A & B revenue is greater than 35% of beneficiary expenditures are considered High Revenue; those with less than 35% of expenditures for assigned beneficiaries are considered to be Low Revenue. **Experienced vs Inexperienced**: Whether an ACO has experience participating in a performance-based Medicare ACO initiative. *(These classifications are primarily used to determine track eligibility and duration under certain no-/low-risk tracks.)*		Three DCE Types: **Standard**: Organizations or clinicians with substantial experience serving Medicare beneficiaries; will rely on voluntary and claims-based alignment. **New Entrant**: Organizations that have not traditionally served Medicare fee for service (FFS) beneficiaries; will primarily rely on voluntary alignment initially. *(Allows non-traditional organizations who haven't historically served Medicare beneficiaries to participate, organizations which would not be eligible if they relied purely on claims-based alignment.)* **High Needs Population**: Organizations that serve Medicare beneficiaries with complex needs; will rely on voluntary and claims-based alignment.	
Withdrawal Penalty	N/A		CMS will assess a 2% of benchmark penalty for DCEs that drop out prior to performance year one (PY1) final settlement.	

Capital Requirements	Lesser of: - 1% of the total per capita Parts A & B FFS spend for its assigned beneficiaries, or - 2% of total Parts A & B FFS revenue of ACO participants Can include funds placed in escrow, lines of credit, surety bonds (or a combination of these)	Required financial guarantee + retention withhold + state risk-based capital requirements, if any Required financial guarantee: - 2.5% in Professional - 3% in Global non-TCoC track - 4% in Global TCoC Can include funds placed in escrow, lines of credit, or surety bonds Retention withhold = 2% of benchmark (returned during PY2) The final rule also offers a one-time opportunity for eligible ACOs that renewed their agreement periods beginning on July 1, 2019, or January 1, 2020 to elect to decrease the amount of their repayment mechanisms if the ACO's recalculated repayment mechanism amount for performance year 2021 is less than their existing repayment mechanism amount.

Table 2: Beneficiary Attribution

	MSSP BASIC LEVEL E	MSSP ENHANCED	DC Professional	DC Global
Minimum Beneficiary Threshold	Must have at least 5,000 assigned beneficiaries in each of the three years prior to the start of its agreement period and during each PY.		**Standard DCE:** 5,000 beneficiaries **New Entrant DCE:** 1,000 beneficiaries at the beginning of the performance period, gradually increased to 5,000 **High Needs DCE:** 250 beneficiaries at the beginning of the performance period, gradually increased to 1,400	
Timing	Choose between retrospective and prospective attribution at the start of each agreement period. *(Trade-offs with both approaches, retrospective favors accuracy while prospective favors predictability.)*		Choose between: **Prospective alignment**: All claims-based and voluntary alignments will be completed prior to the start of each PY. **Prospective-plus alignment**: Claims-based alignments will be completed prior to the start of each PY but voluntary alignments will occur on a quarterly basis throughout the PY.	
Voluntary Alignment	Must notify beneficiaries of their ability and the process to identify or change the primary clinician chosen for the purposes of voluntary alignment. If a beneficiary selects a primary clinician on MyMedicare.gov, CMS will use that selection to take priority over the claims-based assignment methodology. *(Included but not emphasized or heavily utilized by ACOs. Voluntary alignment will be assessed annually by CMS for benchmarking purposes.)*		Beneficiaries will communicate their desire to be aligned with a specific DC Participant Provider and these voluntary alignment choices will take precedence over claims-based alignment for all DCE types. *(DC places more emphasis on voluntary alignment relative to the MSSP and NGACO, encouraging beneficiaries to take a more active role in choosing their provider relationships. CMS is giving DCEs additional tools, called patient engagement incentives, to engage beneficiaries. These tools, such as dental vouchers, wellness memberships, and phone apps, largely align to supplemental benefits currently available in MA.)*	
Claims-based Alignment	Based primarily on Primary Care Qualified E&M (PQEM) claims from PCPs where primary care services rendered by PCPs take precedence. A single PQEM service rendered by an ACO PCP would trigger assignment. If there are multiple PQEM services		Priority is given to PQEM claims provided by PCPs, but the requirement is less strict than MSSP. If nearly all primary care services are rendered by non-primary care specialists, then that will take precedence in attribution *(like NGACO).*	

	rendered by multiple PCPs, assignment will be based on the plurality of care. *(Under the MSSP, primary care services rendered by PCPs are given absolute priority in claims-based alignment.)*	At least 10% of all PQEM services rendered to a beneficiary must be provided by a PCP. *(Under DC, the volume of primary care services rendered by PCPs vs non-PCPs is considered. This would affect DCEs that are heavily dominated by PCPs, as some beneficiaries currently aligned under MSSP methodology may no longer be aligned under DC. Conversely, specialist-heavy DCEs may see an increase in alignment.)*
Look-back Period	**When retrospective**: Look-back period aligns with the PY. **When prospective**: One-year look-back period with the window ending three months prior to the start of the PY.	Two-year look-back period with the window ending six months prior to the start of the PY *(like NGACO).* Allowed charges are weighted by year, so services that occurred more recently are given more weight (i.e., Year 2 claims receive two-thirds weighting, and Year 1 claims receive one-third weighting) even if there's a lower volume of eligible services *(like NGACO).* *(Longer look-back period for claims-based attribution, weighted by year to prioritize patterns of care that occurred more recently.)*
Providers Considered for Alignment	All qualifying providers on the participant roster are considered for beneficiary attribution.	Only Participant Providers are used for attribution (Preferred Providers are not considered).
Alignment Based on Beneficiary Geography	No limitations on beneficiary geography for attribution.	Beneficiaries must reside in the DCE's service area (defined by counties in which the DCE's Participant Providers have physical office locations) to be attributed *(like NGACO).*

Table 3: Financial Benchmarking

	MSSP BASIC LEVEL E	MSSP ENHANCED	DC Professional	DC Global
Baseline Period	Three years prior to contract.		Three-year baseline is blended with 10% weight given to baseline year one (BY1; 2017 for first cohort), 30% weight to BY2 (2018 for first cohort), and 60% weight to BY3.	
Trend	Retrospective, using actual FFS expenditures for the attributable population in a given calendar year. CMS uses a "national-regional blend" approach for trending the benchmark in all agreement periods, based on the ACO's share of total assignment-eligible beneficiaries in each county. The weight of the national component of the blend will increase as the ACO's penetration in its regional service area increases.		Prospective, based on the projected U.S. Per Capita Cost (USPCC) growth trend. USPCC growth trend is announced each year in the annual Announcement of CY MA Capitation Rates and MA and Part D Payment Policies.	
Regional Adjustment	Retrospective, using Medicare FFS expenditures for assignable beneficiaries by county, for each of the four eligibility categories. Weighted by member enrollment by county and beneficiary status. For ACOs new to regional adjustment, 35% weight if ACO costs are below region, and 15% if ACO expenditures are above. Blended at 35-50% if		Prospectively determined for each PY from a DC/KCC Rate Book. Regional benchmarks will be used to create a beneficiary-weighted average of all counties in which the DCE has at least one beneficiary. Weighted by member enrollment by county for Aged & Disabled beneficiaries or state for end stage renal disease (ESRD) beneficiaries. Weight given to regional benchmark varies by year (PY1 35%, PY2 35%, PY3 40%, PY4 45%, PY5 50%) in the claims-based benchmark.	

	the ACO is more efficient, 15-50% if the ACO is less efficient relative to its region.	*(More predictable, prospective spending target that capitalizes on DC rate calculations. Higher limit on upward regional adjustment compared to MSSP allows for significant benefit for efficient organizations.)* The DC/KCC Rate Book (based heavily on the MA 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. Voluntarily aligned beneficiaries will have an entirely regionally-based benchmark.	
Risk Adjustment	CMS uses the CMS-HCC risk adjustment model and will allow for modest risk score growth, capped at +3% over the five-year agreement period.	DC uses two risk adjustment models - **CMS-HCC Prospective Model:** Used for Standard and New Entrant DCEs; risk model is based on diagnoses from prior year and expenditures from current year; designed for MA and has been applied to numerous CMMI APMs. - **CMMI-HCC Concurrent Model:** Used for High Needs Population DCEs; risk model is based on diagnoses and expenditures from current year; designed for the DC model and intended to improve payment accuracy for small populations of complex, high-risk beneficiaries. *(New High Needs risk adjustment model aims to better capture rapid deterioration in health in the current year, focusing on acute care needs over chronic.)* Risk adjustment subject to a 3% cap on a rolling basis and a coding intensity factor (CIF).	
Discount	N/A	No discount to the performance year benchmark	Discount applied to the performance year benchmark from 2-5% increasing over PYs. *(Discount is a reduction to the benchmark, not a reduction in the net savings rate (as it is under MSSP) making it more challenging for a DCE to meet the benchmark particularly in the later years of the program. However, it also gives DCEs the highest shared savings rate options.)*

Table 4: Quality Performance

	MSSP BASIC LEVEL E	MSSP ENHANCED	DC Professional	DC Global
Quality Metrics	For the 2021 performance year: a (reduced) set of 23 quality metrics spanning four domains: Patient/Caregiver Experience, Care Coordination/Patient Safety, Preventive Health, and At-Risk Population.		Core set of claims-based quality measures and CAHPS ACO surveys. DCEs may choose to implement Patient Activation Measure surveys, but scores will not be considered in final performance score.	
Quality Impact on Savings/ Losses	Quality is reflected as an adjustment to the shared savings/loss rate.		CMS to withhold 5% of the benchmark that DCEs have to earn back. Of the 5%, half is tied to basic quality measures and half is tied to Continuous Improvement/ Sustained Exceptional Performance (CI/SEP) criteria. (If	

	(While a low quality score may lower the rate of shared savings, it does not impact the calculation of gross savings or losses.)	the CI/SEP standards are not met, only half of the 5% quality withhold can be earned back). *(Financial stakes of the quality score are higher in DC compared to MSSP. In DC, a low quality score could turn a would-be savings into a loss.)*
Additional Bonus Opportunity	N/A	Additional bonus opportunity available through the High Performers Pool (HPP). Beginning in Year 2, DCEs can qualify for bonus payments if they meet CI/SEP requirements and demonstrate a high level of performance or meet certain improvement standards. (HPP will be funded by quality withholds that were not earned back by DCEs that meet the CI/SEP requirements but not the basic Quality Measures).

Table 5: Payment Models

	MSSP BASIC LEVEL E	MSSP ENHANCED	DC Professional	DC Global
Payment Mechanisms	Traditional Medicare FFS reimbursement claims paid by CMS. *(FFS cash flow is less predictable and inherently challenging within a shared savings model that requires reductions in FFS utilization to be successful; limits investments in non-revenue-generating services/interventions. Sustainability in value-based care will be more closely aligned with capitation in the future.)*		Primary Care Capitation: A capitated, risk-adjusted monthly payment totaling ~7% of the DCE's total cost of care benchmark for enhanced primary care services. - 100% primary care claims reduction for Participant Providers (required). - 1-100% primary care claims reduction to Preferred Providers based on signed risk agreements (optional). - Receiving monthly guaranteed cash flows allows the DCE to align incentives within the network towards the payment model imposed to downstream providers to promote optimal clinical outcomes.	Choice between Primary Care Capitation or Total Care Capitation: A capitated, risk-adjusted monthly payment for all services provided by DC Participant and Preferred Providers with whom the DCE has an agreement. - 100% claims reduction for Participant Providers (required). - 1-100% claims reduction to Preferred Providers based on signed risk agreements (optional). - Receiving monthly guaranteed cash flows allows the DCE to align incentives within the network towards the payment model imposed to downstream providers to promote optimal clinical outcomes.
Advanced Payment	N/A		DCEs can enter into arrangements for capitation for select non-primary care services. *(An option for providers interested in building out the capabilities for Total Care Capitation, but not yet ready to take on full risk. Allows providers to receive predictable cash flow for non-primary care services.)*	N/A

Downstream Provider Contracts	N/A	Ability to structure and negotiate downstream value-based contracts with Preferred Providers and Participant Providers (e.g., fee reductions, bundles, negotiated cap rates). *(Predictable revenue streams for Participants, network-like predictable volume for Preferred Providers.)*

Table 6: Financial Settlement

	MSSP BASIC LEVEL E	MSSP ENHANCED	DC Professional	DC Global
Shared Savings Rate	50% x quality score	75% x quality score	50% (subject to risk corridor)	100% (subject to risk corridor)
Shared Loss Rate	30%	40-75%	50% (subject to risk corridor)	100% (subject to risk corridor)
Minimum Savings / Loss Rates	Gives ACOs the ability to select symmetrical rates from a menu of options (choice of 0%, 0.5%, 1.0%, 1.5%, or 2.0%). *(This offers flexibility but also more certainty.)*		No minimum savings/losses rates. *(Resulting in first-dollar savings to DCEs, after CMS' discount.)*	
Maximum Savings Rate	10% of the updated benchmark	20% of the updated benchmark	No explicit maximum savings/loss rates. *(Risk corridors effectively replace max savings/loss rates, having CMS assume a greater portion of the risk for significant losses as well as a greater share of savings for DCEs that produce major savings.)*	
Maximum Loss Rate	Loss sharing limit is the lesser of*: – 8% of ACO participant Parts A & B revenue (not to exceed % revenue specified by QPP) or – 4% of updated benchmark (capped at 1 % point higher than nominal amount standard)	15% of the benchmark		
Risk Corridor	N/A		Gross savings/losses as % of benchmark: - <5% = 50% retained by DCE - 5-10% = 35% retained - 10-15% = 15% retained - >15% = 5% retained	Gross savings/losses as % of benchmark: - <25% = 100% retained by DCE - 25-35% = 50% retained - 35-50% = 25% retained - >50% = 10% retained
Stop-Loss Arrangement / Reinsurance	Claims are truncated at 99th percentile of expenditures in each eligibility category.		Prior to each PY, DCEs have the option to purchase stop-loss coverage from CMS as part of their financial settlement arrangements. DCEs that opt to purchase coverage will have a "charge" applied to their PY benchmarks to account for beneficiary expenditures above the DCEs' chosen attachment point.	
Timing of Financial Recon-ciliation	Seven to eight months after end of PY. *(Longer waiting period for shared savings bonus.)*		Provisional reconciliation on Jan 31st after PY, final reconciliation occurs about six months after PY end. (Longer for PY1 – 18-20 months.)	

*Historically, an MSSP ACO's financial loss exposure is based upon a percentage of its benchmark, which can make smaller and physician-led ACOs subject to unsustainable losses. To help facilitate the movement toward downside risk for these

participants, CMS finalized a new approach for determining a BASIC track ACO's loss limit, using the lesser of either a benchmark-based or revenue-based cap. This change intends to create a shared risk model that better accommodates various ACO structures.

Table 7: Additional Benefits

	MSSP BASIC LEVEL E	MSSP ENHANCED	DC Professional	DC Global
Benefit Enhancements	– Telehealth expansion (ACOs that choose prospective attribution may bill for certain services without the geographic limitations that usually apply to FFS telehealth coverage.) – Post-discharge home visits – Care management home visits – 3-Day SNF rule waiver		Available PY1 – Telehealth expansion – Post-discharge home visits – Care management home visits – 3-Day SNF rule waiver – Home health services certified by NPs Proposed for PY1 – Homebound requirement waiver for home health – Concurrent care for beneficiaries that elect the Medicare Hospice Benefit	
Patient Engagement Incentives	ACOs are permitted to establish Beneficiary Incentive Programs (BIPs). ACOs approved to operate an incentive program can give assigned beneficiaries up to $20 per qualifying primary care service and may also use certain vouchers/certificates/gift cards, as long as the items or services are related to the beneficiary's medical care. These are paid by the ACO infrastructure cost.		DCEs are permitted to offer enticement benefits and patient engagement incentives, as long as there is a reasonable connection to beneficiary care or clinical goals. DCEs could consider offering vouchers for OTC meds, blood pressure monitors, prepaid transportation vouchers, items and services to support management of a chronic disease or condition in the home, wellness program memberships, meal programs, phone applications, etc. (Patient engagement incentives are part of DCE infrastructure cost, and each should be actuarily priced out against a marketing budget to determine cost/benefit.) Additionally, DCEs can engage in two specific incentives: – Chronic Disease Management Reward (up to $75) – Cost-Sharing support for Part B Services	

Appendix B: Checklist of Strategic Questions to Guide Program Decision Making

Checklist of Strategic Questions to Guide Program Decision Making

Corporate Strategy Alignment

- ☐ What is my organization's value proposition for participating in a CMS model? (i.e., curate primary care network, recruit physicians, align Medicare beneficiaries, accelerate move to value)

Value-based Care Strategy

- ☐ Does my organization have a strong, established commitment to value transformation and defined risk expansion for the long term?
- ☐ Has my organization defined its Medicare strategy?

Financial, Network and Operational Readiness

- ☐ What is my organization's risk tolerance?
- ☐ How much capital is available for financial assurance and to deploy resources? What is my organization's tolerance for potential losses?
- ☐ Has my organization conducted a thorough assessment of its operational, clinical, and financial capabilities? How recently?
- ☐ Does my organization have the ability to distribute payments throughout the network?
- ☐ Does my organization have a defined network strategy for our senior population?
- ☐ Does my organization's network infrastructure support population/demographic segmentation for managed care contracting or government payer programs?

Market Considerations

- ☐ What are my organization's regional growth plans? How quickly is it looking to expand market share and/or scale market presence?
- ☐ What is the state of competitors in my organization's market? Are new entrants aggressively moving into the market that could potentially take away Medicare aligned beneficiaries and influence the Medicare referrals in my market away from owned services?
- ☐ Is my organization strategically at risk if regional/national payers gain more influence on the Medicare dollar in my market?