ANNUAL REPORT 2

July 2024

Evaluation of the Global and Professional Direct Contracting Model

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This project was funded by the Centers for Medicare & Medicaid Services under contract no. 75FCMC19D0092, Task Order 75FCMC21F0002. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. NORC at the University of Chicago assumes responsibility for the accuracy and completeness of the information contained in this report.

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Acknowledgements

NORC wishes to acknowledge the contributions and support of Erin Colligan, Michelle Spafford, Charles Patton, Lauren Campbell, Erin Brantley, Tim Bullock, Emily Krone, Alina Ghobadi, James Zimmerman, Isha Padhye, Nisha Mailapur, Nannette Beckley, Azam Ahmed, Srabani Das, Tarcia Johnson, Erin Ewald, and Alex Hartzman. We also wish to thank our partners Robin Bloodworth, Matthew Trombley, Derek Hoodin, and Chao Zhou of **Abt Global;** Albert Ketler, Rebecca Socarras, Jim Genuardi, and Todd Trapnell of the **Actuarial Research Corporation;** and Bryan Dowd, Roger Feldman, and Katie White of the **University of Minnesota**. Lastly, we would like to thank the CMS Innovation Center team for their review and feedback on draft materials and their support in finalizing this report and over the course of the evaluation to date.

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List of Acronyms

ACO	Accountable care organization
ACSC	Ambulatory care-sensitive condition
ADI	Area Deprivation Index
ADT	Admission, discharge, transfer
APO	Advanced Payment Option
CFIR	Consolidated Framework for Implementation Research
CMS	Centers for Medicare & Medicaid Services
CPC	Comprehensive Primary Care
DID	Difference-in-differences
E&M	Evaluation and management
ED	Emergency department
EHR	Electronic health record
FFS	Fee-for-service
GPDC	Global and Professional Direct Contracting
HCC	Hierarchical Condition Category
HIE	Health information exchange
IDS	Integrated delivery system
IRF	Inpatient rehabilitation facility
IT	Information technology
MSO	Management service organization
LTCH	Long-term care hospital
LTSS	Long-term services and supports
NGACO	Next Generation Accountable Care Organization
PAC	Post-acute care
PACE	Program of All-Inclusive Care for the Elderly
PCC	Primary Care Capitation
PCP	Primary care provider
PBPY	Per beneficiary per year
PY	Performance year
REACH	Realizing Equity, Access, and Community Health
SDOH	Social determinants of health
TCC	Total Care Capitation

Executive Summary

99 Direct Contracting Entities (DCEs) participated in GPDC in PY2022

Most participating entities were Standard DCEs, typically larger organizations where providers had more experience with Medicare fee-for-service (FFS) than their counterparts in New Entrant and High Needs DCEs. New Entrant DCEs generally had limited Medicare FFS and Center for Medicare and Medicaid Innovation (Innovation Center) model experience, and High Needs DCEs featured providers with experience serving Medicare FFS beneficiaries with complex needs. Across DCE types, most selected Global risk-sharing and Primary Care Capitation (PCC).

Approximately 1.9 million Medicare beneficiaries were aligned to the GPDC Model from PY2021 to PY2022, almost all aligned to Standard DCEs. Most DCEs prioritized changes in care delivery efforts to reduce avoidable inpatient, emergency department (ED), or post-acute care utilization. They provided or arranged for additional staff such as care managers, pharmacists, and administrative support and rated primary care touch points and complex care management as high priorities.

GPDC increased net Medicare spending in PY2022 but improved quality of care measures. High Needs and New Entrant DCEs improved utilization but results were mixed for Standard DCEs.

Gross Medicare spending and utilization in PY2022:

- Standard DCEs had gross Medicare spending increases (0.8%, $p<0.01$) across PY2021–PY2022, reflecting significant increases in PY2022 (1.0%, $p<0.01$) due to increased acute care spending and utilization and overall increases in spending among the Integrated Delivery System (IDS)/hospital system DCEs.
- New Entrant DCEs had non-significant gross spending reductions across PY2021–PY2022 (1.4%, $p>0.1$) and in PY2022 (1.6%, $p>0.1$), reflecting decreases in ED visits and observation stays.
- High Needs DCEs significantly reduced gross Medicare spending in PY2022 (3.5%, $p<0.01$), reflecting reductions in acute care utilization and spending. Cumulative PY2021–2022 estimates were not available.

Net Medicare spending in PY2022:

- Across PY2021–PY2022, net Medicare spending increased significantly for Standard and New Entrant DCEs (2.6%, and 3.8% respectively, $p<0.01$), reflecting larger net spending increases in PY2022 for both DCE types (3.0%, and 7.0%, respectively, $p<0.01$).
- In PY2022, High Needs DCEs increased net Medicare spending (9.3%, $p<0.01$).

Quality of care in PY2022:

- Standard DCEs reduced hospitalizations for ambulatory care-sensitive conditions (ACSCs) and unplanned hospital admissions for beneficiaries with multiple chronic conditions, as well as increased recommended care for diabetes.
- New Entrant DCEs had favorable increases in recommended care for diabetes.
- High Needs DCEs had unfavorable increases in hospitalizations for ACSCs but favorable decreases in all-condition readmissions.
- Beneficiaries across DCE types indicated mostly positive care experiences through long-standing relationships with clinicians who focused on care planning and communication within a care team.

The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) launched the Global and Professional Direct Contracting (GPDC) Model in April 2021. The GPDC Model was a voluntary, advanced accountable care organization (ACO) model designed to shift Medicare risk-sharing arrangements away from fee-for-service (FFS), to empower beneficiaries to engage in their health care, and to reduce providers' administrative burden. The model built on earlier CMS ACO initiatives by offering participating Direct Contracting Entities (DCEs) greater flexibility and options to take on financial risk. In each performance year (PY), each DCE selected their level of risk-sharing and payment—either the lower-risk Professional option, with Primary Care Capitation (PCC); or full-risk Global option, with either PCC or Total Care Capitation (TCC).

This report covers NORC at the University of Chicago's independent evaluation of the GPDC Model's second performance year (PY2022). As of January 2023, continuing and new participants in the model transitioned to the ACO Realizing Equity, Access, and Community Health (REACH) Model.

DCEs, Their Providers, and Aligned Beneficiaries

The GPDC Model's three types of participants—Standard, New Entrant, and High Needs DCEs—are differentiated by the numbers, characteristics, and needs of their aligned beneficiaries; the extent of their providers' experience with Medicare FFS; and how their benchmarks were calculated (**Exhibit ES.1**).

Direct Contracting Entities

DCEs were health care providers and suppliers that entered arrangements with CMS to accept financial risks and rewards calculated as a function of Medicare spending and the quality of care provided to the Medicare FFS beneficiaries aligned to the DCE.

In PY2022, three-quarters of model participants were Standard DCEs. In PY2021 Standard DCEs represented slightly more than half of all DCEs; over 80% of the DCEs that entered the model in PY2022 were Standard DCEs. Most Standard DCE providers had Medicare FFS experience, while New Entrant and High Needs DCEs had fewer providers with Medicare FFS experience. Regardless of their providers' Medicare FFS experience, most DCEs entered GPDC with experience at the organizational level in value-based care, including Medicare ACOs.

As of PY2022, approximately 1.9 million FFS Medicare beneficiaries were aligned to GPDC providers; 96% were aligned to Standard DCEs. Beneficiaries aligned to Standard and New Entrant DCEs were generally similar on demographic, coverage, clinical, and community characteristics. By comparison, High Needs DCE beneficiaries had more clinical need. High Needs DCEs also served larger percentages of beneficiaries from racial and ethnic minority groups, those dually eligible for Medicare and Medicaid, and beneficiaries living in areas of greater socioeconomic disadvantage.

Exhibit ES.1. DCE Types Were Defined by Different GPDC Model Features, the Extent of Their Prior Value-Based Care Experience, and Their Aligned Beneficiaries

	Standard DCEs	New Entrant DCEs	High Needs DCEs
DCE Features	Providers have **Medicare FFS experience,** including Innovation Center models PY benchmark is a blend of **regional expenditures** and aligned beneficiary **historical expenditure** **> 5,000 aligned beneficiaries/DCE**	Providers generally have **limited Medicare FFS / Innovation Center model experience** PY benchmark is based on **regional expenditures** (for the first 3 PYs) **2,000–5,000 aligned beneficiaries/DCE†**	Providers have experience serving **Medicare beneficiaries with complex needs** (for example, dually eligible) PY benchmark is based on **regional expenditures** (for the first 3 PYs) **250–1,250 aligned beneficiaries/DCE†**
Number of DCEs per PY	**2021 PY:** 29 **2022 PY**: 78*	**2021 PY:** 18 **2022 PY**: 13	**2021 PY**: 6 **2022 PY**: 8
Aligned Beneficiary Characteristics	1,911,957 total beneficiary population 5.9 chronic conditions on average 18.9% racial / ethnic minority groups 13.9% dually eligible 12.6% in high ADI areas	76,793 total beneficiary population 6.4 chronic conditions on average 24.9% racial / ethnic minority groups 16.7% dually eligible 10.1% in high ADI areas	7,793 total beneficiary population 12.3 chronic conditions on average 33.3% racial / ethnic minority groups 67.8% dually eligible 22.1% in high ADI areas

NOTES: Descriptive statistics summarize characteristics of the population of aligned beneficiaries over the two years of the model, including beneficiaries aligned in PY2021 alone (5%), or PY2022 alone (82%), or both (13%). Beneficiaries aligned both years are counted each year.

DCE=Direct Contracting Entity; FFS=fee-for-service; MA=Medicare Advantage; ADI=area deprivation index; PY=performance year.

* Includes one High Needs DCE and seven New Entrant DCEs from 2021.

† The minimum number of aligned beneficiaries for New Entrant DCEs will increase incrementally from 2,000 in PY2022 to 5,000 in PY2025 and PY2026 (under the ACO REACH Model); the minimum for High Needs DCEs will increase incrementally from 250 in PY2022 to 1,400 in PY2026 (under the ACO REACH Model).

In PY2022, most DCEs selected Global (full) risk-sharing and PCC. Their elections were similar to those in the previous year (PY2021), with 73% of DCEs electing Global risk and 73% selecting PCC (with or without the Advanced Payment Option [APO]). While DCEs that selected Global risk were more likely to have experience in the Medicare Shared Savings Program (Shared Savings Program),[1] DCEs that were integrated delivery system (IDS) or hospital systems were more likely to elect the lower risk Professional option regardless of prior alternative payment model (APM) experience.

In PY2022, DCEs represented diverse combinations of organizational structures and lead organizations. DCEs' characteristics provide important context for understanding participation in the model and outcomes. **Exhibits ES.2–ES.4** includes snapshots that portray the organizational characteristics of each type of DCE. Standard DCEs included a balanced mix of organizational structures, with most led by management service organizations (MSOs) or health systems. New Entrant DCEs

DCE Organizational Characteristics

Organizational structure informs the extent to which providers were integrated with the DCE via shared infrastructure, systems, and protocols.

Lead organization type reflects the degree to which the organizations steering the DCE were provider or other types of institutions

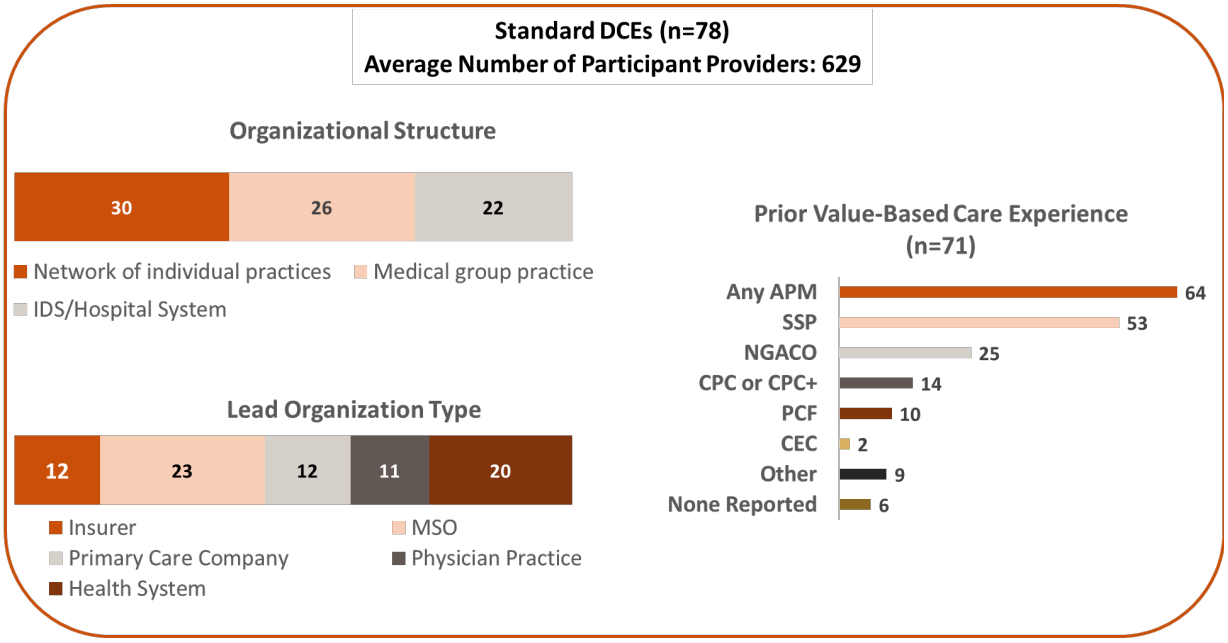
[1] For more information on the Medicare Shared Savings Program, please see: https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos.

were structured as either networks of individual practices or as medical group practices, with most led by physician practices and primary care companies. Nearly all High Needs DCEs were networks of individual practices led by MSOs or physician practices.

In PY2022, the size of provider networks varied widely across DCEs. The number of practitioners in each DCE's Participant Provider network ranged from 11 to 5,459, with an average of 517. Networks included the providers considered usual sources of care and used for claims-based alignment (Participant Providers) and those that offered valuable services beyond the DCE but not used for claims-based alignment in the DCE (Preferred Providers).

DCEs did not pass substantial financial risk on to providers. For two-thirds of DCEs, payment arrangements with providers involved FFS, often in combination with payments tied to quality, capitation, or both. DCEs tended not to pass downside financial risk to their providers, instead using positive financial incentives such as bonuses, shared savings, and upfront payments.[2]

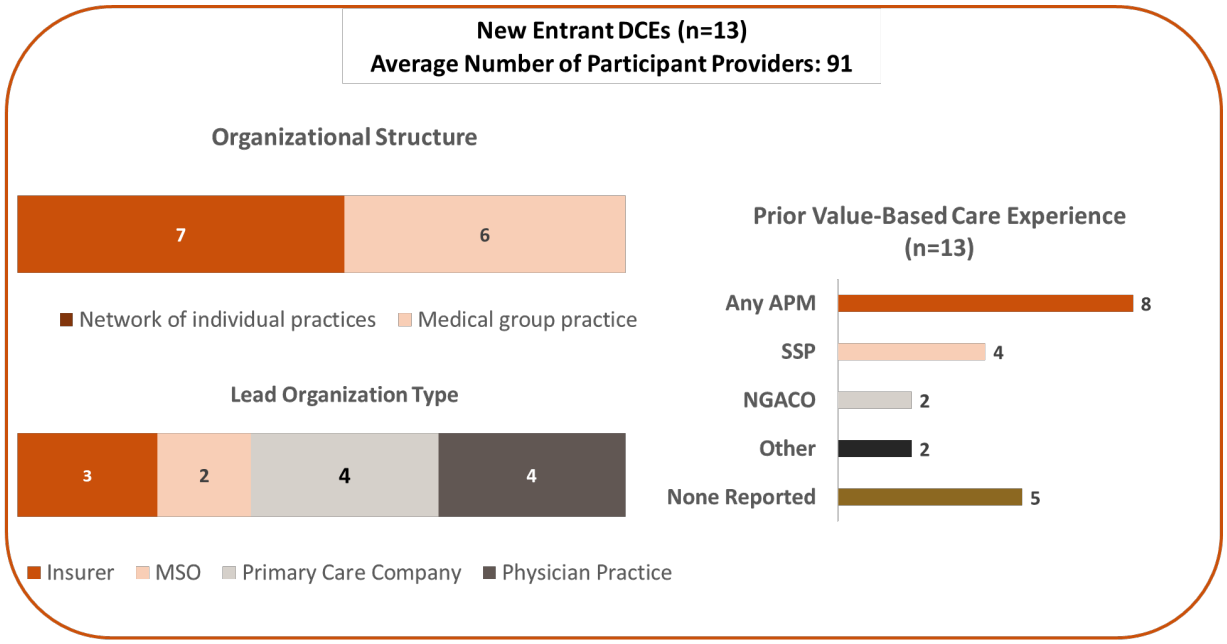
Exhibit ES.2. In PY2022, Standard DCEs Represented Diverse Groups of Organizations



SOURCE: PY2022 Financial Results (n=8); model applications and additional documentation (n=8); 2022 GPDC Pulse Check Survey (n=7).
NOTES: APM=alternative payment model; DCE=Direct Contracting Entity; IDS=integrated delivery system; MSO=management services organization; NGACO=Next Generation ACO Model; SSP=Medicare Shared Savings Program; PCF=Primary Care First Model; CPC=Comprehensive Primary Care; CPC+=Comprehensive Primary Care Plus; CEC=Comprehensive End-Stage Renal Disease (ESRD) Care Model.

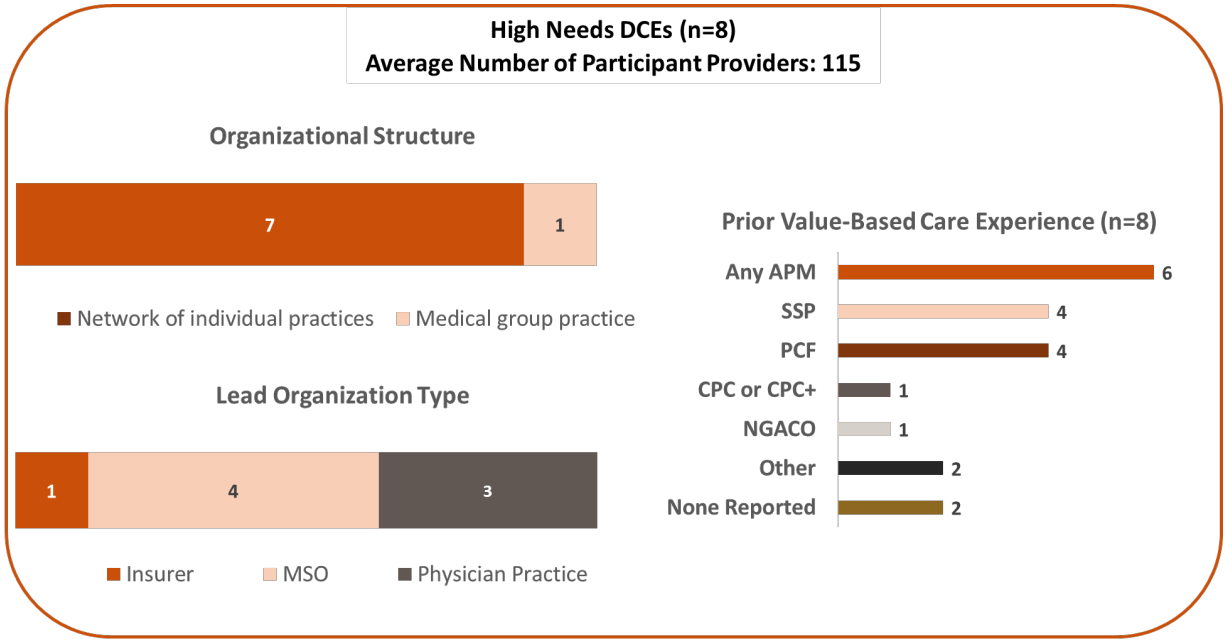
[2] Downside financial risk refers to DCEs taking on the risk for losses. If DCEs' Medicare spending costs for their aligned beneficiaries exceed the benchmark set by CMS, they share in the losses. DCEs can choose to pass along some of the shared losses to their providers.

Exhibit ES.3. New Entrant DCEs Were Organized Around Physician Practices



SOURCE: PY2022 Financial Results (n=13); model applications and additional documentation (n=13); 2022 GPDC Pulse Check Survey (n=13).
NOTES: APM=alternative payment model; DCE=Direct Contracting Entity; MSO=management services organization; NGACO=Next Generation ACO Model; SSP=Medicare Shared Savings Program.

Exhibit ES.4. Nearly All High Needs DCEs Were Networks of Individual Practices



SOURCE: PY2022 Financial Results (n=8); model applications and additional documentation (n=8); 2022 GPDC Pulse Check Survey (n=7).
NOTES: APM=alternative payment model; DCE=Direct Contracting Entity; MSO=management services organization; NGACO=Next Generation ACO Model; SSP=Medicare Shared Savings Program; PCF=Primary Care First Model; CPC=Comprehensive Primary Care; CPC+=Comprehensive Primary Care Plus.

Model Impacts on Gross and Net Total Medicare Spending

We hypothesized that the GPDC Model would reduce gross Medicare Parts A and B spending for DCE beneficiaries relative to comparison group beneficiaries aligned to non-DCE providers; however, because implementing a new model takes time, we expected that savings might not be seen in the first two PYs. We also expected that New Entrant and High Needs DCEs may have had more opportunities to achieve early reductions in gross spending, compared with Standard DCEs, which entered the model at baseline with prior accountable care experience and lower spending.

Gross Medicare spending findings were mixed across the three DCE types. The gross spending measure represents what Medicare paid for Parts A and B spending including beneficiary-level capitated payments under the GPDC Model. In two years of the GPDC Model, Standard DCEs had gross Medicare spending increases while New Entrant had non-significant gross spending reductions relative to their comparison groups. High Needs DCEs had significant reductions in gross spending in PY2022 (**Exhibit ES.5**).

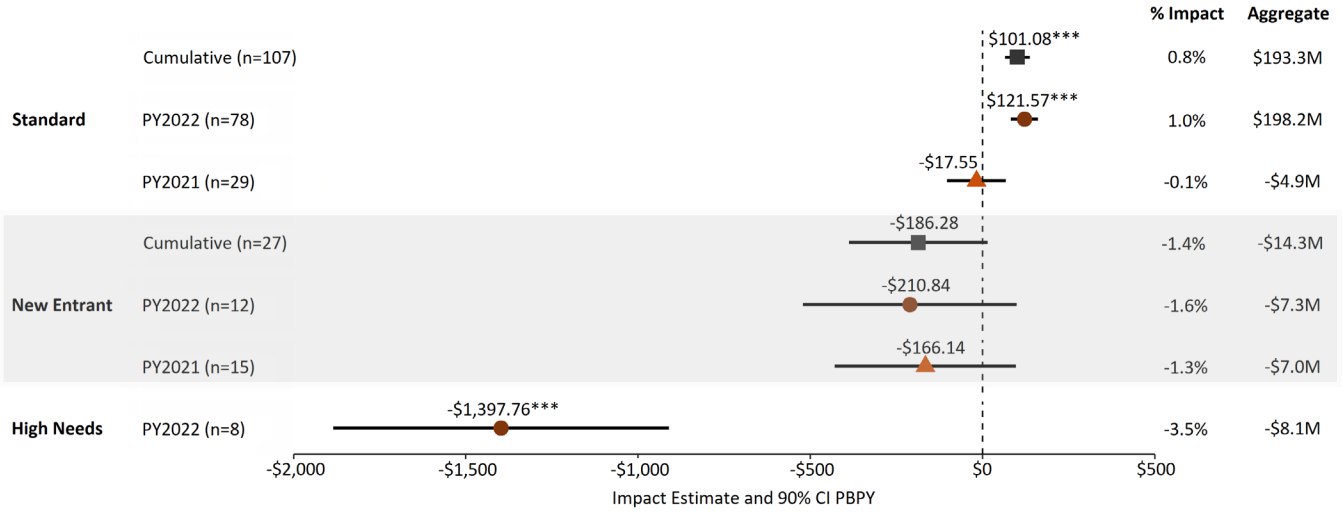
The comparison group comprised beneficiaries in GPDC DCE market areas but aligned to providers who could have been in FFS alone or in other Medicare ACO initiatives; it was well-balanced with the GPDC group.

We balanced beneficiaries in the comparison group to be like beneficiaries in the GPDC group on observed demographics, disease burden, and area-level community characteristics. The comparison group included some beneficiaries in other Medicare ACOs, because this represented the counterfactual business decision available to GPDC providers absent the model. While inclusion of such beneficiaries enhances the comparability of the comparison group, it may potentially diminish estimated effects of the GPDC model, given similar incentives and benefits in other Medicare ACOs.

- Standard DCEs increased gross Medicare spending cumulatively as of PY2022 (0.8%, $p<0.01$), reflecting significant increases in PY2022 (1.0%, $p<0.01$).
- New Entrant DCEs reduced gross spending cumulatively (1.4%, $p>0.1$) and in PY2022 alone (1.6%, $p>0.1$), but the reductions were not statistically significant.
- High Needs DCEs significantly reduced gross Medicare spending in PY2022 (3.5%, $p<0.01$), the first year in which spending impacts for this DCE type could be evaluated.

Gross spending increases for Standard DCEs reflected the influence of IDS/hospital system DCEs that contributed to about 80% of the aggregate gross spending increases as of PY2022. On the other hand, New Entrant DCEs that were network of individual practices saw larger gross spending reductions. Contrary to our hypothesis, Standard and New Entrant DCEs that elected higher levels of risk (Global risk) and capitation (TCC) did not see larger reductions in gross spending. Our findings may reflect differences in DCEs' markets, providers, beneficiaries, and other organizational or implementation factors apart from differences in their organizational characteristics.

Exhibit ES.5. As of PY2022 (Cumulatively), Standard DCEs Saw Increased Gross Medicare Spending and New Entrant DCEs Saw a Non-Significant Decrease; in PY2022, Gross Medicare Spending Decreased for High Needs DCEs



SOURCE: NORC analysis of Medicare claims, enrollment, and GPDC Model data.
NOTES: Cumulative includes PYs 2021 and 2022. Because High Needs DCEs were not evaluable in PY2021, their cumulative and PY2021 impacts are not shown. In cumulative estimates, "n" represents the number of DCE-years, while in PY estimates, "n" represents the number of DCEs. **Estimated gross impact** is the difference-in-differences (DID) estimate, or the difference between the GPDC and comparison mean-adjusted gross spending in PY(s) and the BYs. Estimates are presented as per beneficiary per year (PBPY) with 90% confidence intervals. **Estimated % impact** is the DID estimate relative to expected outcome for GPDC beneficiaries in PY(s) had the model not existed and had the beneficiaries' outcomes continued on the same trajectory since baseline. **Aggregate estimate** is the impact estimate for all aligned beneficiaries in PYs(s). Estimated impacts significant at p<0.10*, p<0.05**, p<0.01***.

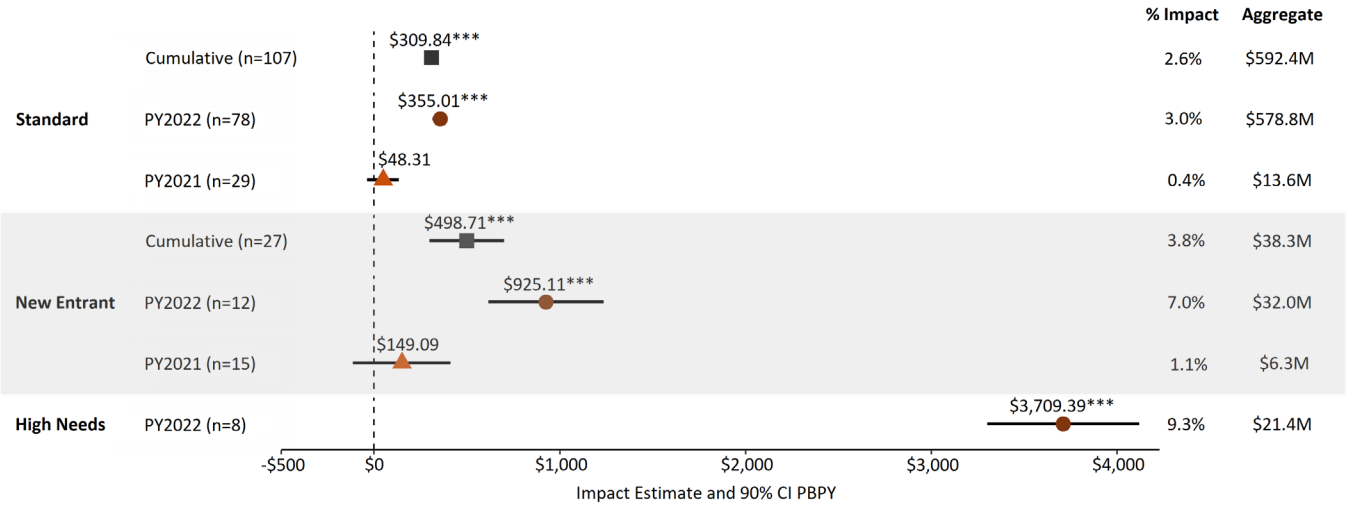
Net Medicare spending increased significantly across the three DCE types (Exhibit ES.6). CMS incentives for DCE participation through shared savings payouts (relative to financial benchmarks) exceeded reductions in gross spending (relative to comparison groups). After accounting for shared savings payouts, Standard, New Entrant, and High Needs DCEs increased net Medicare spending in PY2022 (3.0%, 7.0%, and 9.3% respectively, p<0.01), resulting in a significant increase in net Medicare spending cumulatively (as of PY2022) for Standard and New Entrant DCEs (2.6% and 3.8%, p<0.01). Our findings are likely influenced by differences between the financial benchmarking and evaluation methodology for the three DCE types. Financial benchmarks for New Entrants and High Needs DCE are wholly based on regional spending; benchmarks for Standard DCEs are a

Model financial calculations and the impact evaluation of Medicare spending differ in their purpose and methodology, which can lead to differences in findings.

- Financial calculations for determining shared savings reflect differences between DCEs' actual and benchmark Medicare spending in a PY — where the benchmark is a projection of their regional and/or historical spending before the model's initiation.
- The evaluation's impacts for understanding the GDPC Model's effects reflect differences between DCEs' actual and counterfactual Medicare spending absent the model in a PY — where the counterfactual is determined by comparing DCEs and a comparison group in their markets before and after the model's initiation.
- The time periods before the model's initiation (baseline years) used in each type of calculation also differ.

blend of historical and regional spending. The evaluation's impacts for all three DCE types are estimated considering spending both in historical baseline and PYs, relative to a comparison group. Finally, to improve evaluability of DCEs, baseline years used in the evaluation are more recent than years used for determining financial benchmarks and include years' coinciding with the COVID-19 Public Health Emergency (PHE). The evaluation's estimated spending impacts were consistent in sensitivity analyses that dropped 2020 from the baseline and adjusted for differences in county-level population COVID-19 mortality rates.

Exhibit ES.6. In PY2022, Net Medicare Spending Increased for All Three DCE Types



SOURCE: NORC analysis of Medicare claims, enrollment, and GPDC Model data.
NOTES: Cumulative includes PYs 2021 and 2022. Because High Needs DCEs were not evaluable in PY2021, their cumulative and PY2021 impacts are not shown. In cumulative estimates, "n" represents the number of DCE-years. In PY estimates, "n" represents the number of DCEs. **Estimated net impact** is the gross difference-in-differences (DID) estimate or the difference between the GPDC and comparison mean-adjusted spending in PY(s) and the BYs, less shared savings/losses to DCEs in PY(s). **Estimated percentage impact** is the DID estimate relative to expected outcome for GPDC beneficiaries in PY(s) had the model not existed and had the beneficiaries' outcomes continued along the same trajectory since baseline. Estimates are presented per beneficiary per year (PBPY). **Aggregate estimate** is the net impact estimate for all aligned beneficiaries in PY(s). Estimated impacts significant at p<0.10*, p<0.05**, p<0.01***.

Model Impacts by DCE Type and Setting—Ambulatory, Acute (Hospital-Based), and Post-Acute Care

The model's evaluation considered DCEs' population health management priorities and approaches in PY2022, as well as impacts of the model in the first two years on spending, utilization, and quality of care in specific care settings.[3]

[3] Estimates of Medicare spending in care settings reflect resource use—or what Medicare would have paid absent capitation in the GPDC Model—and thus cannot be directly compared to the findings on total spending (which include beneficiary-level capitated payments to DCEs).

Population Health Strategies

The GPDC Model offered flexibility for DCEs to invest in the infrastructure and staff needed to improve population health. For most DCEs, avoidable utilization, care management, and primary care touchpoints were high priorities (**Exhibit ES.7**).

Exhibit ES.7. Highest Priorities of DCEs for Model Implementation Included Complex Care Management or Population-Specific Care and Initiatives to Reduce Avoidable Utilization

The DCEs elected and began implementing benefit enhancements and beneficiary engagement incentives aimed at expanding service delivery flexibilities to enhance care coverage and quality. As of the close of PY2022, the most common enhancement reported as fully implemented was the skilled nursing facility (SNF) three-day rule waiver (53%), followed by the telehealth expansion waiver (26%), Part B cost-sharing support (23%), and chronic disease management reward (21%).

Setting-Specific Impacts

The GPDC Model's impacts on spending, utilization, and quality of care varied by care setting (**Exhibit ES.8**). As seen:

- In the **ambulatory care setting**, Standard DCEs improved care quality across multiple measures. New Entrant and High Needs DCEs reduced spending and utilization.
- In the **acute care setting**, Standard DCEs saw increases in spending and utilization. High Needs DCEs saw improvements across all domains (spending, utilization, and care quality). Impacts were not statistically significant for New Entrant DCEs in this setting.
- In **all other settings**, Standard DCEs reduced home health spending and utilization, and as expected, increased hospice spending. High Needs DCEs also increased hospice spending and saw SNF spending reductions.

Exhibit ES.8. Model Impacts on Spending, Utilization, and Quality of Care Varied by Care Setting

	Ambulatory Care Setting	Acute Care Setting	Other Care Settings
Standard DCEs (As of PY2022)	↑ Professional services spending ($) ↑ Specialty care spending ($) ↓ Hospitalizations for ACSCs (★) ↓ Unplanned hospital admissions among beneficiaries with MCCs (★) ↑ Use of recommended care for diabetes (★)	↑ Acute care spending ($) ↑ Acute care hospitalizations (🩺) ↑ Acute care length of stay (🩺)	↓ Home health spending ($) ↓ Home health episodes (🩺) ↑ Hospice spending ($) ⇩ Continuous hospice days prior to death (🩺)
New Entrant DCEs (As of PY2022)	↓ Specialty care visits spending ($) ↓ ED visits and observation stays (🩺) ↑ Use of recommended diabetes care (★)		⇩ Continuous hospice days prior to death (🩺)
High Needs DCEs (In PY2022)	↓ Specialty care spending ($) ↓ Outpatient spending ($) ↓ ED visits and observation stays (🩺)	↓ Acute care spending ($) ↓ Acute care hospitalizations (🩺) ↓ Acute care length of stay (🩺)	↓ SNF spending ($) ↓ SNF days (🩺) ↑ Hospice spending ($)

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: ACSC=ambulatory care-sensitive condition; ED=emergency department; MCC=multiple chronic conditions; SNF=skilled nursing facility. Only statistically significant estimates are shown. Solid arrows indicate that the direction of the impact estimate was as expected. Hollow arrows indicate that the direction of the impact estimate was not as expected. $ refers to spending outcomes, 🩺 refers to utilization outcomes, and ★ refers to quality outcomes. Spending categories represent what Medicare would have paid, absent the model's capitated payments.

Beneficiary Experience

Interviews with a modest sample of GPDC-aligned beneficiaries (n=26) found no changes as of 2022 in their perceptions of quality of health care, provider communication, or overall beneficiary satisfaction since the model's implementation. Beneficiaries positively described their care teams, care planning processes, and the communication and follow-up they received from their care teams. They appreciated their longstanding relationships with clinicians, many of which predated GPDC. Beneficiaries

Beneficiaries' Perceptions of ACOs

Beneficiaries did not recognize the GPDC Model by name; however, they cited benefits and drawbacks to ACOs as a care delivery model. Among the perceived benefits were the ability to see more doctors without limitations, better quality of care, and the possibility of lower costs. Concerns raised included limited provider networks and potential negative effects on quality.

did not recognize the GPDC Model by name and thus could not ascribe their ongoing experiences to the model itself.

Lessons Learned from the GPDC Model

Although the three DCE types had similar areas of focus, we observed different impacts by DCE type: Standard DCEs saw gross Medicare spending increases, while New Entrant and High Needs DCEs saw gross spending reductions relative to their comparison groups. Once shared savings and losses were accounted for, net Medicare spending increased significantly across all three DCE types. All DCE types experienced some degree of favorable impacts of the model on health care utilization and quality of care, with the extent of impact varying by care setting.

Understanding outcomes requires insight into the participating organizations. Organizational features and characteristics framed DCEs' potential paths to outcomes in the model, including where and when the DCEs could influence spending and quality and the levers available to achieve the goals of accountable care.

Choices of risk and payment mechanism were not associated with spending reductions. Over time, we would expect DCEs that take on greater financial risk to generate more savings, while those taking on less risk would be slower to do so.

Participant Providers were exposed to little downside risk. GPDC has been the first ACO model to use capitation and to allow DCEs to enter separate payment arrangements with all their Participant Providers.[4] DCEs tended not to pass downside risk to their providers, instead using positive financial incentives such as bonuses, shared savings, and upfront payments.

By the end of PY2022, 12 DCEs exited the GPDC Model. Exiting DCEs represented all three DCE types and different organizational characteristics. Some exiting DCEs planned to reorganize and consolidate with other ACOs to create entities with larger scale. Most exiting DCEs intended to switch to what they perceived as Medicare's lower risk Shared Savings Program or episode-based models, and at least one that reorganized intended to participate in ACO REACH as part of another ACO.

[4] In the Next Generation ACO Model, ACOs electing All-Inclusive Population-Based Payment (AIPBP) directly paid providers with whom the ACO had written arrangements regarding AIPBP.

Chapter 1: The GPDC Model Built on Previous ACO Models' Efforts to Promote Value-Based Care

The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) launched the GPDC Model in April 2021. The GPDC Model was a voluntary, advanced accountable care organization (ACO) designed to shift Medicare risk-sharing arrangements away from FFS, to empower beneficiaries to engage in their health care, and to reduce providers' administrative burden. The model built on previous CMS ACO initiatives by offering participating Direct Contracting Entities (DCEs) greater flexibility and options to take on financial risk. The model included three types of organizations (diverse groups of providers and suppliers) as Standard, New Entrant, and High Needs DCEs—reflecting their varied prior experience with value-based care. Networks of providers include those used for claims-based alignment (Participant Providers) and those not used for alignment (Preferred Providers).

In September 2021, the Innovation Center selected NORC at the University of Chicago (NORC) to conduct an independent evaluation of the model. This report covers the GPDC Model through its first (PY2021) and second (PY2022) performance years. As of January 2023, continuing and new participants in the model transitioned to the ACO REACH Model. The REACH Model has a stronger emphasis on health equity, provider leadership, and enhanced monitoring to protect beneficiaries.

This report considers several main research questions:

1. What were the characteristics of DCEs? Did DCEs differ by organizational characteristics, capitation type, or risk level? (Chapter 2)
2. How did DCEs respond to financial and quality incentives and benefit enhancements? (Chapters 2 and 4)
3. How did DCEs implement the model? (Chapters 2 and 4)
4. Did the GPDC Model result in lower health care utilization and spending for its aligned beneficiaries relative to a comparison group, and did impacts vary by care setting? (Chapters 3 and 4)
5. Did the GPDC Model result in differences in the quality of care received by beneficiaries aligned to the model relative to a comparison group, and did impacts vary by care setting? (Chapters 3 and 4)
6. What was beneficiaries' experience of care under the model? (Chapter 5)
7. Did the DCEs that exited the model early have any shared characteristics? (Chapter 6)

Our evaluation of PY2022 included 49 new DCEs, or nearly double the number participating in PY2021, generating more analytic power than in our previous year's evaluation to explore comparisons within groups of DCEs by organizational characteristics and by aligned beneficiary characteristics.

Overview of the GPDC Model

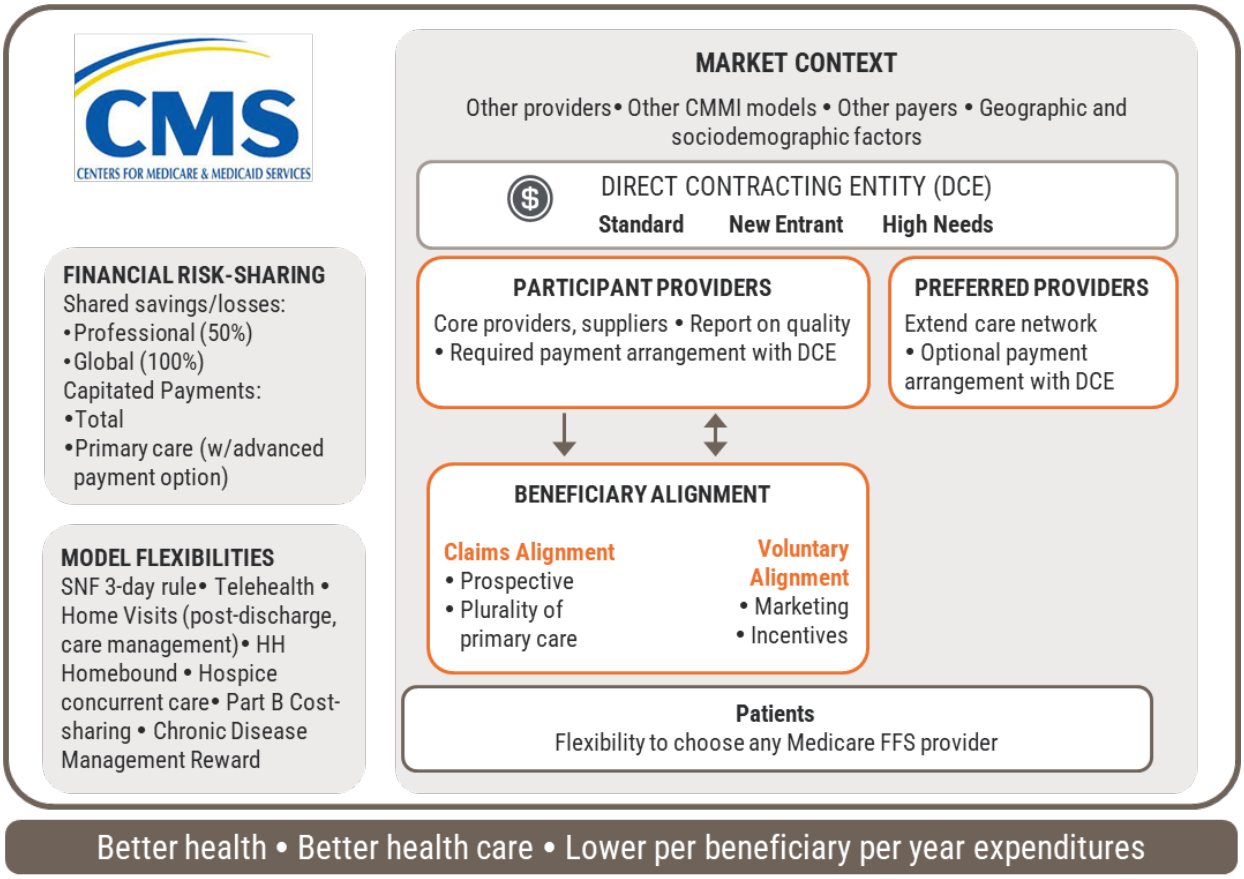
In recent years, a leading strategy for moving the Medicare FFS program toward higher-value care has been encouraging providers to organize into legal entities that voluntarily accept fiscal and quality accountability for the health of the beneficiaries under their care. Such entities aim to encourage providers to improve care coordination and reduce avoidable costs. In 2021 and 2022, the GPDC Model leveraged the collective experience of organizations and providers with accountable care before a strategic refresh by the Innovation Center that aimed to address health equity more systematically as part of the ACO REACH Model, which began in 2023.

GPDC to ACO REACH

GPDC operated for two years, with participants that started in PY2021 (n=53) and PY2022 (n=49). CMS redesigned and renamed GPDC as the ACO REACH Model, effective January 2023. ACO REACH differs from GPDC in having a stronger emphasis on addressing health equity, promoting provider leadership, and enhancing monitoring and transparency to protect beneficiaries. Several new ACOs joined ACO REACH in PY2023 (n=48), along with many former GPDC participants (n=84).

Under the GPDC Model, CMS paid fixed monthly prospective capitated payments to participating legal entities called DCEs. DCEs were health care providers and supplies that entered arrangements with CMS to accept financial risk and rewards calculated as a function of Medicare spending and the quality of care provided to the Medicare FFS beneficiaries aligned to the DCE. DCEs were given greater flexibility and control over their cash flows in exchange for taking on greater financial risk. These flexible cash flows were expected to empower DCEs to invest in needed infrastructure and care delivery improvements. Organizations that formed DCEs were diverse; CMS identified the organizations as one of three types—Standard, New Entrant, and High Needs DCEs—based on their prior experience delivering care to Medicare FFS beneficiaries and their beneficiary populations. DCEs were also positioned to set up their own value-based payment arrangements with downstream providers and suppliers. In addition, they were able to use several benefit enhancements, which waived some requirements for certain kinds of care in the FFS Medicare program, to provide greater flexibility to transform care delivery (**Exhibit 1.1**).

Exhibit 1.1. GPDC Model Components Were Designed to Reduce Cost and Improve Quality



NOTES: FFS=fee-for-service; HH=home health; SNF=skilled nursing facility.

Direct Contracting Entities (DCEs)

DCEs were health care providers and suppliers that entered arrangements with CMS to accept financial risks and rewards calculated as a function of Medicare spending and the quality of care provided to the Medicare FFS beneficiaries aligned to the DCE. Organizations that formed DCEs were diverse; CMS identifies the organizations as one of three types—Standard, New Entrant, and High Needs DCEs—based on their prior experience delivering services to Medicare FFS beneficiaries (**Exhibit 1.2**). Benchmarking, beneficiary alignment methodologies, and minimum requirements for beneficiary alignment vary across the three types, with the aim of making participation in GPDC attractive to a wide range of providers.

Model Participant Terminology: DCE Versus ACO

During 2021 and 2022, the model's participating ACOs were referred to as Direct Contracting Entities (DCEs). Beginning in 2023, under the redesigned ACO REACH Model, model participants were referred to as REACH ACOs. To ensure alignment between this report and the GPDC Model, all participating ACOs are referred to in this report as DCEs; in future reports that evaluate ACO REACH, model participants will be referred to as ACOs.

Exhibit 1.2. DCE Types Are Defined by Different GPDC Model Features and Extent of Prior Value-Based Care Experience

	Standard DCEs	New Entrant DCEs	High Needs DCEs
DCE Features	Providers have **Medicare FFS experience, including Innovation Center models** PY benchmark is a blend of **regional expenditures** and aligned beneficiary **historical expenditures** **> 5,000 aligned beneficiaries/DCE**	Providers generally have **limited Medicare FFS / Innovation Center model experience** PY benchmark is based on **regional expenditures** (for the first 3 PYs) **2,000–5,000 aligned beneficiaries/DCE†**	Providers have **experience serving Medicare FFS beneficiaries with complex needs** (for example, dually eligible) PY benchmark is based on **regional expenditures** (for the first 3 PYs) **250–1,250 aligned beneficiaries/DCE †**
Number of DCEs per PY	**2021 PY:** 29 **2022 PY**: 78*	**2021 PY:** 18 **2022 PY**: 13	**2021 PY**: 6 **2022 PY**: 8

NOTES: DCE=Direct Contracting Entity; FFS=Fee-for-service; MA=Medicare Advantage.
* Includes one High Needs DCE and seven New Entrant DCEs from PY2021.
† The minimum number of aligned beneficiaries for New Entrant DCEs will increase incrementally from 2,000 in PY2022 to 5,000 in PYs 2025 and 2026, and the minimum for High Needs DCEs will increase incrementally from 250 in PY2022 to 1,400 in PY2026.

The inclusion of High Needs DCEs reflected the goal of engaging providers focused on serving complex, high needs dually eligible beneficiaries and Medicare FFS beneficiaries at risk for becoming dually eligible—populations historically underserved by FFS accountable care models—and to test models of care tailored to these populations in a Medicare FFS context.

Participant and Preferred Providers

The GPDC Model defines two primary categories of participation for Medicare providers and suppliers:

- **Participant Providers** are individual practitioners and facilities that CMS considers to be usual sources of care. Beneficiaries are aligned to GPDC through Participant Providers, who are paid directly by the DCEs for care delivered to aligned beneficiaries (in addition to payments they may receive for furnishing services to beneficiaries not aligned to a DCE); in addition, Participant Providers are responsible for reporting quality through the DCEs.
- **Preferred Providers** are individual practitioners or facilities affiliated with provider organizations. They expanded DCEs' networks and offered valuable care relationships beyond the DCE. They may operate within the GPDC Model across multiple DCEs as well as with Medicare ACOs participating in the Medicare Shared Savings Program ("Shared Savings Program"). Preferred Providers may participate in benefit enhancements as well as alternative payment arrangements with the DCE but do not factor into beneficiary alignment.[i] Preferred Providers may elect to receive DCE payments and reduced FFS claim payments but are not required to do so.

Chapter 2 and **Appendix A** provide more information about the differences between Participant Providers and Preferred Providers under the model, and the role each provider type played for DCEs.

Financial Risk-Sharing

CMS required DCEs to have a capitated payment arrangement, under which CMS paid a capitated amount to the DCE, which the DCE could use to support population health. For example, DCEs could reimburse their Participant Providers and Preferred Providers through value-based payment arrangements or invest in population health management tools and initiatives.[ii]

Each DCE chose one of two risk-sharing options, which determined the type of capitation payments available:

1. **Professional:** Lower risk option, with 50% shared savings/losses, under which DCEs received **Primary Care Capitation (PCC)** payments (monthly capitation payments for primary care services delivered to aligned beneficiaries).
2. **Global:** Full-risk option, with 100% shared savings/losses, with DCEs choosing either PCC or monthly **Total Care Capitation (TCC)**, which consisted of monthly capitation payments for all services delivered to aligned beneficiaries.

Benefit Enhancements and Beneficiary Engagement Incentives

To support DCEs' ability to manage their beneficiaries' care, the GPDC Model offered DCEs the opportunity to waive certain FFS Medicare payment requirements and offered beneficiaries incentives to engage in their care. DCEs could choose which, if any, enhancements and incentives to implement. **Exhibit 1.3** lists the benefit enhancements available to DCEs. The GPDC Model offered the same benefit enhancements as the Next Generation ACO Model as well as two additional ones—the Homebound Home Health Waiver and Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit.[5]

Exhibit 1.3. The GPDC Model Offered Benefit Enhancements Allowing DCEs Greater Flexibility to Deliver Care

Benefit Enhancement	Description
3-Day Skilled Nursing Facility (SNF) Rule Waiver	Allowed admission to a SNF or an acute care hospital or critical access hospital with swing-bed approval (swing-bed hospital) for SNF services without prior three-day inpatient stay prior to admission.
Telehealth	Allowed payment for asynchronous telehealth services (that is, transmitting recorded health history through a secure electronic communications system) provided by dermatologists and ophthalmologists. Also allowed payment for telehealth services from non-rural originating sites, including the beneficiary's home.

[5] An additional proposed benefit enhancement, "Home Health Services Certified by Nurse Practitioners," was made permanent by Section 3708 of the CARES Act.

Benefit Enhancement	Description
Post-Discharge Home Visits	Allowed payment for certain home visits furnished to eligible, non-homebound beneficiaries by auxiliary personnel under general supervision, rather than direct supervision, incident to the professional services of physicians or other practitioners that are DCE Participant Providers or Preferred Providers.
Care Management Home Visits	Allowed payment for certain home visits that are furnished to eligible beneficiaries proactively and in advance of potential hospitalization, without direct supervision.
Homebound Home Health Waiver*	Allowed payment for home health care services for certain beneficiaries who were not homebound.
Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit*	Allowed beneficiaries who elected the Medicare Hospice Benefit to also receive concurrent curative care, also known as conventional care.

SOURCE: Centers for Medicare & Medicaid Services (CMS). Global and Professional Direct Contracting (GPDC) Model Request for Applications. November 2019. https://innovation.cms.gov/files/x/dc-rfa.pdf.
NOTES: During the COVID-19 public health emergency (PHE), CMS issued a blanket waiver of the SNF three-day rule requirement and made telehealth available to all Medicare beneficiaries (not only those living in rural areas) and accessible at home, not only in office, clinic, and other institutional settings.
* New for the GPDC Model.

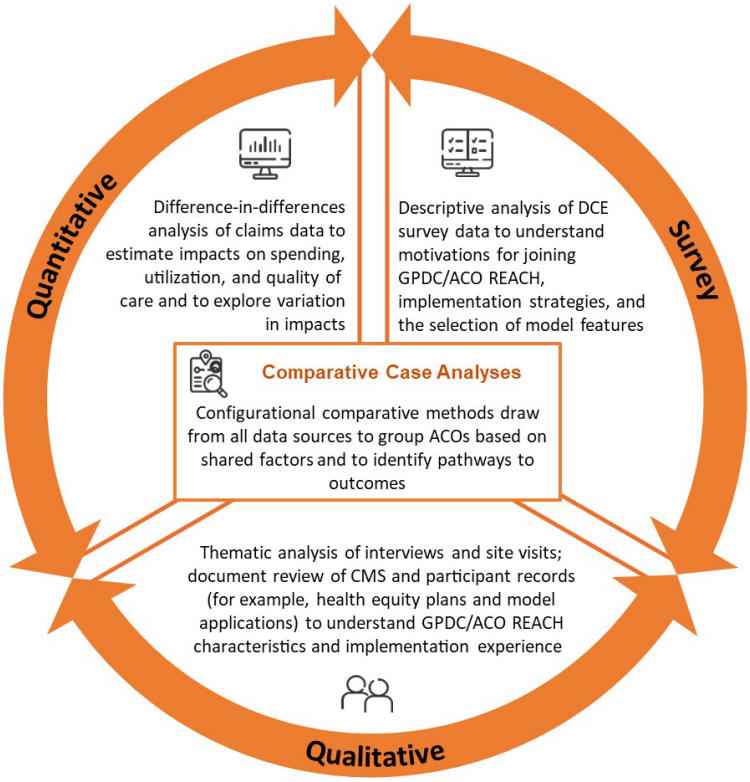
The GPDC Model offered the following beneficiary engagement incentives:

- **Cost-Sharing Support for Part B Services:** DCEs could enter into agreements with Participant Providers and Preferred Providers stipulating that they would not collect cost-sharing amounts from beneficiaries for Part B services. As part of these agreements, DCEs paid some or all the associated beneficiary cost-sharing amounts.
- **Chronic Disease Management Reward Program:** DCEs could provide beneficiaries with gift cards valued at up to an annual limit of $75 for the purpose of supporting participation in a chronic disease management program.
- **In-kind items and services:** DCEs were allowed to provide beneficiaries with in-kind items and services that could advance a clinical goal for the beneficiary (for example, blood pressure monitors for beneficiaries with hypertension).

Evaluation Overview

Our evaluation design reflects a mixed methods strategy that integrates qualitative and quantitative primary and secondary data (program administrative data, data from claims, and survey and interview findings) to address the research questions.[iii] In future reports, we will conduct comparative case analyses to relate organizational characteristics, market features, and implementation approaches to spending, quality, and utilization impacts (**Exhibit 1.4**).[iv] **Appendix B** lists our research questions, hypotheses, associated data sources, and analytic methods.

Exhibit 1.4. The GPDC Evaluation Relies on a Mixed Methods Approach to Data Collection and Analysis



NOTES: CMS=Centers for Medicare & Medicaid Services; DCE=Direct Contracting Entity; GPDC=Global and Professional Direct Contracting.

Conceptual Framework for the Evaluation

We use an evaluation framework (**Exhibit 1.5**) that draws on implementation science to consider how the implementation approach and measured impacts of an innovation are shaped by organizations' characteristics and external environments as well as the features of the model itself.[v,vi] Our evaluation is informed by a thorough understanding of DCEs, where and how they operated, and variations among them. Selected evaluation domains include the context of the market and policy environments in which DCEs operated; DCE structure, including organization, provider, and beneficiary characteristics; and implementation factors, including DCEs' election of model features and strategies for managing population health.[vii] We describe each evaluation domain in greater detail below.[viii]

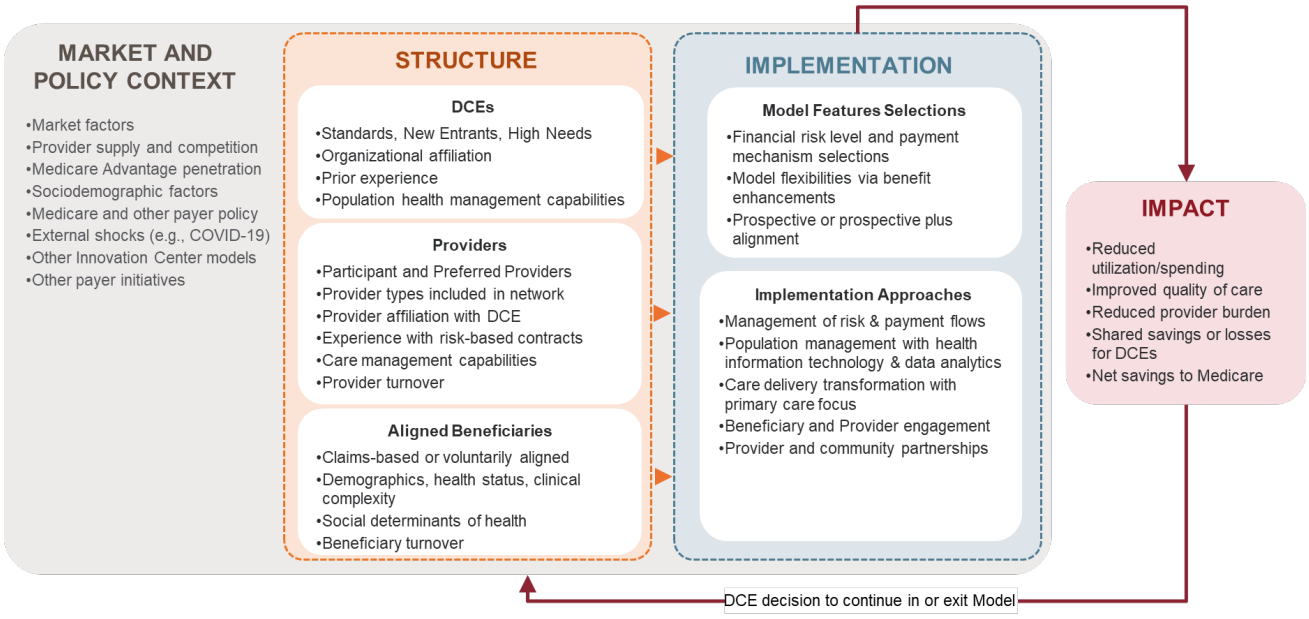
Context: The **market and policy environment**, including existing Medicare payment policies and the impacts of the COVID-19 public health emergency (PHE), may have affected DCEs' election of risk levels as well as the baseline spending used for benchmarks for shared savings and losses.

Structure: Variations in **DCEs' organizational characteristics**, such as organization type and prior experience with APMs, may have influenced individual DCEs' adaptability and response to GPDC Model features. In addition, **provider characteristics**, including their relationships with DCEs and experience with Medicare FFS and value-based care, may have affected how they responded to risk-based arrangements. Finally, the **characteristics of aligned beneficiaries** are an important structural component because beneficiaries' care-seeking behaviors may influence health care utilization and spending.

Implementation: DCEs' responses to **model features**, such as selection of risk, capitation levels, and benefit enhancements, likely shaped provider and beneficiary behavior as well as DCEs' savings or losses. Similarly, DCEs' **approaches to care transformation** may have influenced their performance within the model and inform our understanding of which interventions are associated with quality and spending impacts.

Impact: The contextual, structural, and implementation factors described above likely shaped **model outcomes** directly and indirectly. A DCE's decision to continue in the model may in turn have depended on the realization of shared savings.

Exhibit 1.5. The GPDC Model Evaluation Conceptual Framework Accounts for Market, Structure, and Implementation Factors



Overview of the Report

The report is structured as follows:

- Chapter 2 describes DCEs' characteristics, providers, and aligned beneficiaries.
- Chapter 3 summarizes our findings on the GPDC Model's impacts on gross and net spending, considering variations in findings and concordance between the findings and the model's financial performance against benchmarks.
- Chapter 4 presents findings on model implementation and impacts on spending, utilization, and quality of care by setting: ambulatory; acute or hospital-based care; and post-acute care (PAC), including home health, and hospice.
- Chapter 5 summarizes findings on beneficiary experience in the model's first two years.
- Chapter 6 offers reflections on our key findings in light of subsequent plans for the evaluation and challenges related to evaluating the model.

Chapter 2: DCEs' Characteristics Informed Their Resources, Capacity, and Approaches in the Model

Key Findings

DCEs Participating in PY2022

- Most participating organizations were Standard DCEs, and they were both larger and had providers with more experience with Medicare FFS than New Entrant and High Needs DCEs. Across DCE types, most selected Global risk sharing and PCC. From PY2021 to PY2022, DCEs expanded their numbers of beneficiaries and providers with FFS experience, reflected in greater numbers of Standard DCEs and of DCEs electing Global risk in the model.
- In PY2022, participating DCEs represented a range of organizational structures. Standard DCEs included a balanced mix of organizational structures, with most led by management service organizations (MSOs) or health systems. New Entrant DCEs were structured either as networks of individual practices or as medical group practices, with most led by physician practices and primary care companies. Nearly all High Needs DCEs were networks of individual practices led by MSOs or physician practices.

DCE Providers in PY2022

- DCE networks varied in overall composition, although their Participant Provider networks were largely focused on primary care, especially among New Entrant and High Needs DCEs.
- In PY2022, most DCEs used multiple payment approaches with their providers, often involving FFS combined with capitation and payments tied to quality thresholds. Some DCEs had only capitated payment arrangements with their providers.
- DCEs reported sharing savings with practitioners in their Participant Provider networks and, to a lesser extent, with facilities, but passed down little or no downside risk to these providers.

Characteristics of GPDC-Aligned Beneficiaries in PY2022

- Approximately 1.9 million Medicare beneficiaries were aligned to the GPDC Model, almost all of whom were aligned to Standard DCEs.
- As expected, beneficiaries in High Needs DCEs tended to be at greater risk for adverse outcomes relative to beneficiaries in Standard and New Entrant DCEs.

Understanding how the GPDC Model operated and achieved its goals requires an understanding of the organizations and providers that participated in the model and the beneficiaries they served. In this chapter, we explore two main research questions:

- What were the characteristics of DCEs? Did these characteristics vary by DCE type, capitation type, or risk level?
- How did DCEs respond to financial and quality incentives?

To address these questions, we describe the characteristics of the 99 DCEs that were active in the model in PY2022, along with their providers and beneficiaries. An understanding of DCEs' organizational characteristics provides context for the resources and infrastructure that they can leverage to engage their providers and respond to model incentives. The size and composition of their provider networks and aligned beneficiary populations in turn shaped the potential scope, scale, and reach of the DCEs' accountable care efforts.

Appendix E provides supplemental exhibits that support the summary discussion presented in this chapter.

Methods Overview

The findings in this chapter, most of which are descriptive, aim to provide a rich understanding of the DCEs and to lay the foundation for exploring hypotheses as the model, model entities, and evaluation change over time. **Appendix B** includes the research questions, hypotheses, associated data sources, and analytic methods we used in this evaluation chapter.

To address these research questions, we draw on data from multiple sources, including the DCEs' applications to the GPDC Model; the 2022 Pulse Check Survey of all participating DCEs; administrative data from the Innovation Center on DCE type, risk elections, payment mechanisms, and DCE leadership and ownership; Medicare FFS claims data on model elections and provider beneficiary counts; and publicly available data on the DCEs' websites. **Appendices C and D** provide more information on our systematic review of the DCEs' applications and documents and analysis of the 2022 Pulse Check Survey, respectively.

DCEs Participating in PY2022

Ninety-nine DCEs participated in the GPDC Model in PY2022, including 50 DCEs that started in the model in PY2021 and an additional 49 DCEs that started in PY2022.

DCE Types in PY2022

The three types of model participants in GPDC—Standard, New Entrant, and High Needs DCEs—were differentiated by the numbers, characteristics, and needs of their aligned beneficiaries; the extent of their providers' experience with Medicare FFS; and how their benchmarks were calculated (**Exhibit 1.2**). Standard DCEs were the largest type of DCE, while High Needs DCEs were a fraction of the size of Standard DCEs. High Needs DCEs served a greater share of beneficiaries with complex needs and had the highest proportion of beneficiaries dually eligible for Medicare and Medicaid.

Most providers in Standard DCEs had Medicare FFS experience, so their financial benchmarks were based on a blend of historical expenditures and county- and state-level payment rates, such as in Medicare Advantage (MA). But benchmarks for New Entrant and High Needs DCEs, with few providers with Medicare FFS experience, reflected primarily the payment rates in the early years of the model and then moved toward a blended benchmark in the later years.[ix]

Notably, while GPDC's operational parameters for New Entrant DCEs stated that no more than half of their Participant Providers could have prior experience with Medicare APMs,[6] at the organizational level, more than half of the New Entrants DCEs reported prior APM experience in their applications. The nature of this experience varied. In some cases, it included having served as partners or providers with the participating model entity. In others, the model participant had worked with a different group of providers (**Exhibits 2.5–2.7**).

In PY2022, three-quarters of DCEs were Standard DCEs. The proportion of Standard DCEs was larger in PY2022 than PY2021, with the growth stemming from both the composition of the cohort of DCEs starting in PY2022 and the DCEs that changed type between PY2021 and PY2022. Most DCEs that started in PY2022 were Standard DCEs (41 of 49), and several DCEs that started as New Entrant and High Needs DCEs in PY2021 became Standard DCEs the following year.[7] These DCEs served an increasing number of aligned beneficiaries, allowing them to meet the minimum threshold of 5,000 aligned beneficiaries for Standard DCEs.

Participating DCEs in PY2022

78 Standard DCEs
13 New Entrant DCEs
8 High Needs DCEs

Model Elections in PY2022

Under GPDC, DCEs selected their level of risk (Global or Professional) and capitation payment mechanism (TCC or PCC) before each PY. As DCEs aimed to optimize their performance in each year of the model, those that selected Global risk or TCC signaled that they were less risk-averse or better able to forecast their future performance based on their prior experience in delegated risk contracts,[8] or both. By contrast, DCEs that selected Professional risk or PCC may have had less experience in APMs or capitated payment models and thus may have needed additional time to develop the infrastructure and systems for population health management and care delivery transformation. Most DCEs selected Global risk and PCC (73%).

DCE Model Applications: Experience in APMs

In our first annual evaluation report for the GPDC Model, we found that more than half of DCEs noted that they had experience in other APMs or capitated payment models. APM experience occurred at various levels across DCEs, including for the DCE itself as a model participant or as part of another ACO, for the DCEs' Participant Providers, for lead or parent organizations, and/or for members of DCE leadership teams.

DCEs that elected Global risk were more likely to have prior experience in the Shared Savings Program compared to those that elected Professional risk (74% versus 43%). Regardless of DCE type, the Global risk option and PCC were the most common model features in PY2022 (73% each). More than half of the DCEs with PCC (42 of 72) also elected the Advanced Payment Option (APO), which provided upfront payments for services beyond

[6] Medicare APMs include the Shared Savings Program, NGACO Model, Comprehensive ESRD Care (CEC) Model, Pioneer ACO Model, Vermont All-Payer ACO Model, and Comprehensive Primary Care Plus (CPC+) Model.
[7] Seven of the eighteen New Entrant DCEs and one of the six High Needs DCEs that began the model in PY2021 became Standard DCEs in PY2022.
[8] In a delegated risk contract, the financial risk for a defined set of health care services is transferred from the payer (for example, CMS or health insurance plan) to the health care provider (for example, medical group practice, hospital, or group of physicians).

primary care. Some DCEs switched their payment and risk selections between PY2021 and PY2022, trending toward Global risk and more services covered by capitation payments.[9]

DCEs' Organizational Characteristics

DCEs' organizational characteristics shed light on the resources and capacity DCEs bring to their accountable care strategies as well as the nature of their provider networks and engagement with them. Organizational characteristics also give context for DCEs' priorities in the model and inform their ability to influence provider behavior to effect changes in spending, utilization, and quality of care. In the evaluation of the GPDC Model, we focus on selected characteristics that provide insight into how the DCEs have operated, as follows:

- **Organizational structure** informs the extent to which providers were integrated with the DCE by means of shared infrastructure; systems; and protocols for population health management, care coordination, and care delivery.
- **Lead organization type** reflects the functional and professional identity of those steering the DCE, as well as the areas of spending and utilization that the DCE had leverage or incentive to change.

Exhibit 2.1 gives more detailed definitions of each characteristic.

The DCEs participating in PY2022 reflected a range and mix of characteristics that influenced the different approaches used to achieve outcomes over model implementation. In general, we would expect DCEs with more integrated structures and that more actively supported their providers and care delivery to be better positioned to effect changes in spending and utilization. Conversely, we would expect DCEs with less integrated structures and further removed from care delivery to have relied more on financial incentives for providers and administrative supports to effect change. In sum, we would expect to see reductions in spending and utilization in settings where DCEs had leverage as well as in those that would not negatively impact their primary revenue streams. Impacts of the model on spending in the first two years by organizational structure are available in **Chapter 3**, and impacts by lead organization type and other organizational characteristics are available in **Appendix I**.

[9] From PY2021 to PY2022, five DCEs transitioned from PCC to PCC with APO; three DCEs transitioned from PCC with APO to TCC; and one DCE transitioned from TCC to PCC with APO. Four DCEs switched their risk option between PYs, transitioning from Professional risk to the full-risk option (Global). Eight DCEs increased the scope of their capitation payments by adding APO or switching to TCC, while only one DCE switched to lower capitation.

Exhibit 2.1. Organizational Characteristics Provide Insight into DCEs' Operations

DCE Organizational Characteristics

Organizational Structure

- **Network of individual practices:** partnership, association, or other network or group of physicians that distribute income from practices among members.[1]
- **Medical group practice:** single-specialty group practice with two or more physicians or multispecialty group practice with various specialty care in one organization[2]
- **IDS/Hospital System:** IDS (vertically integrated health service networks, including physicians, hospitals, and PAC)[3] or hospital system (organization with at least one hospital and group[s] of physicians)[4]

Lead Organization Type

- **Health System:** organization with at least one hospital and group(s) of physicians[4]
- **Insurer:** entity that underwrites financial risk and pays for health care services through plans[5]
- **Management Services Organization (MSO):** organization providing non-clinical administrative and operational services to providers. May also be referred to as a management company.[6]
- **Physician Practice:** medical practice with one or more physicians under same management. Can include a group, partnership, or association of physician practices [7]
- **Primary Care Company:** company that operates a network of primary care clinics

SOURCES: 1: CMS. Medicare Managed Care Manual – Chapter 6. Rev 82, 04-27-07. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c06.pdf;
2: American College of Physicians. Medical Practice Type. https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/resident-career-counseling-guidance-and-tips/medical-practice-types;
3: AcademyHealth. The performance of integrated delivery systems, July 2016. https://academyhealth.org/node/2151;
4: Agency for Healthcare Research and Quality. Defining Health Systems. January 2023. https://www.ahrq.gov/chsp/defining-health-systems/index.html;
5: Congressional Research Service. Health Insurance: A Primer. Updated January 2015. https://crsreports.congress.gov/product/pdf/RL/RL32237;
6: Vanguard Health Solutions. Management Services Organization (MSO). https://www.vanguardhealthsolutions.com/management-services-organization;
7: CMS. Physician Self-Referral Law Frequently Asked Questions. https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/FAQs-Physician-Self-Referral-Law.pdf.
NOTES: IDS=integrated delivery system; PAC=post-acute care; MSO= managed services organization.

In this section, we describe the organizational structures of DCEs and the types of organizations leading the DCEs. We derived DCE organizational characteristics from multiple data sources in an iterative process to ensure a comprehensive examination of each DCE and best-fit placement in each category. **Exhibits 2.2–2.4** summarize the types of lead organizations for each DCE organizational structure described. **Appendix C** includes additional information on the methodology and data sources used to assign these organizational characteristics and additional information on the primary function different DCEs fulfilled for their aligned providers that will be used in future analyses.

Networks of Individual Practices

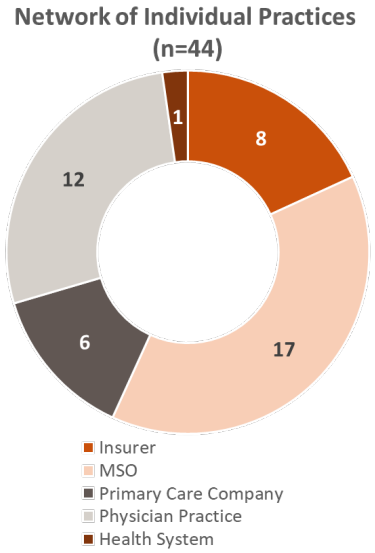
Network of individual practices was the most common organizational structure in PY2022 and accounted for 44% of DCEs. DCEs comprising a network of unaffiliated, individual practices were most often led by MSOs or physician practices, but some were led by insurers or primary care companies. Network DCEs tended to operate as organizations that convened or enabled providers with infrastructure, analytics, or staff for population health, care management, or both.

Nearly Half (45%) Of All DCEs Had MSOs in Key Roles

For many DCEs, MSOs were lead organizations, subsidiaries, or partners in the DCE, or their staff served as board members. MSOs provided administrative and financial support and population health management services such as data analytics or embedded staff members. MSOs could also facilitate risk-sharing by offering administrative tools and services such as payer contracting and practice transformation support.[x]

Network DCEs were less likely than other DCEs to have employed providers, and the dispersion of providers' employment suggests that financial and administrative incentives may be more effective tools for networks to facilitate accountable care delivery than standardized policies and procedures. While most DCEs (including network DCEs) elected PCC, network DCEs were more likely than other DCEs to elect TCC, which may reflect their experience with managed care contracts and capitation.

Exhibit 2.2. PY2022 Networks of Individual Practice DCEs Were Often Led by MSOs or Physician Practices

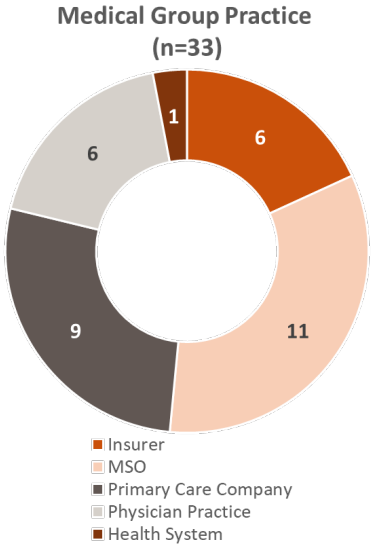


SOURCE: PY2022 Financial Results (n=99); model applications and additional documentation (n=99).
NOTE: MSO=management services organization.

Medical Group Practices

One-third of DCEs in PY2022 were medical group practices; most comprised participant practices that employed all or most of their providers. Medical group practice DCEs were often led by MSOs and primary care companies (that is, companies that operate networks of primary care clinics), but several were led by insurers or physician practices. Medical group practice DCEs served as either the provider organizations delivering care or the organizations enabling providers to deliver accountable care through supporting infrastructure, staff, or analytics for population health and care management. Given the influence of medical group practices over care delivery, we expect that these DCEs will have integrated infrastructure for population health management.

Exhibit 2.3. PY2022 Medical Group Practice DCEs Were Often Led by MSOs and Primary Care Companies



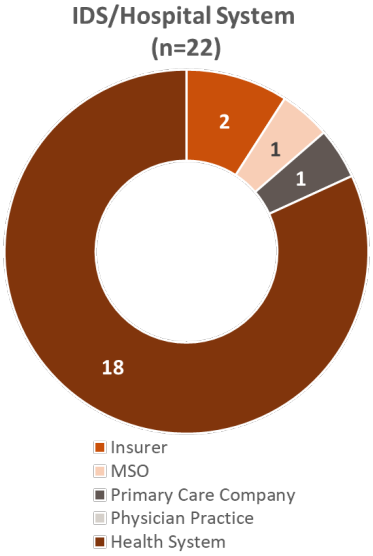
SOURCE: PY2022 Financial Results (n=99); model applications and additional documentation (n=99).
NOTE: MSO=management services organization.

IDS/Hospital Systems

Relatively few DCEs were IDS or hospital systems; most employed all or most of their providers. Less than one-quarter of all DCEs participating in PY2022 were an IDS or hospital system; all IDS/hospital system DCEs were Standard and most were led by health systems. With an average of 4.2 years of experience in Medicare ACO models, Participant Providers in IDS/hospital system DCEs had more experience than did their counterparts in other DCEs (with an average of about 3 years).

Despite their size and prior APM experience, IDS/hospital system DCEs were more likely to elect the lower risk option (Professional risk). Hospitals and health systems, with their integrated administrative structures and direct control of care delivery processes, were uniquely positioned to improve care coordination and to address spending and utilization at multiple points in the continuum of care, including inpatient services, ambulatory and post-acute care. However, operating under Global risk may have put IDS/hospital system DCEs at a disadvantage, at least in the early years of the model. Such DCEs may have preferred a greater certainty around financial outcomes in the early years of the model to account for competing incentives to reduce cost of care in inpatient settings, as well as the need to adapt complex population health management systems while navigating arrangements with physicians and post-acute care providers.[xi,xii] Future interviews with DCE leaders will explore their decisions around their risk elections.

Exhibit 2.4. PY2022 IDS/Hospital System DCEs Were Primarily Led by Health Systems



SOURCE: PY2022 Financial Results (n=99); model applications and additional documentation (n=99).
NOTE: IDS=integrated delivery system; MSO=management services organization.

Patterns in DCE Leadership

An estimated 74 organizations led the 99 DCEs participating in PY2022. Lead organizations oversaw between one and eight DCEs in PY2022, with an average of 1.34 DCEs per lead organization. Examples of organizations leading multiple DCEs included VillageMD, agilon health, UnitedHealth Group, and Intermountain Health. Overlapping leadership suggests that influential decisions—such as new partnerships or vendors, mergers and acquisitions, changes in policy, infrastructure, or systems—may have affected multiple DCEs. While DCEs with the same leadership may be exposed to similar organizational resources and shifts, it may not be the case that individual DCEs will see the same downstream experiences or outcomes.

Understanding Standard, New Entrant and High Needs DCEs

Most DCEs, regardless of type, had prior experience with value-based care, albeit through different mechanisms. Most Standard DCEs had prior APM experience, including as part of the Shared Savings Program, NGACO, or both; around one third also had prior experience with commercial plans or MA. Many New Entrant DCEs also had prior APM experience, but they were less likely than Standard DCEs to have had prior experience in the Shared Savings Program or NGACO. New Entrant DCEs were likely to have experience with managed care and capitated payments through MA or

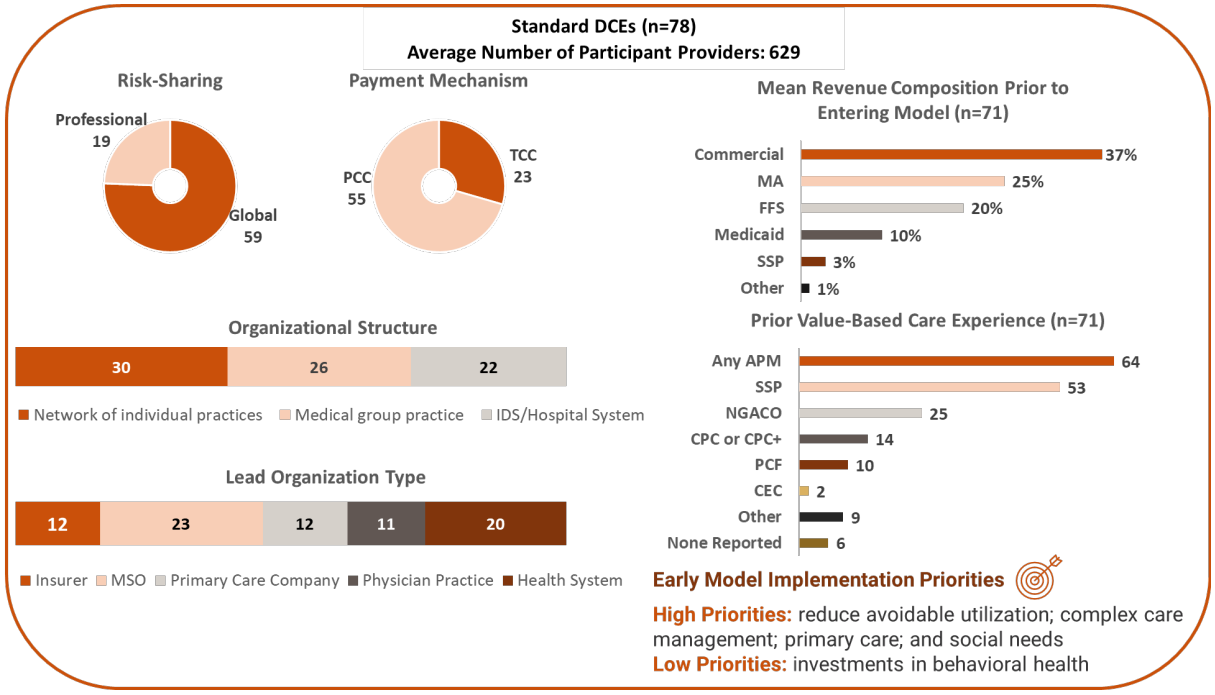
Privately Held Companies Owned or Had the Controlling Interest in 60% of DCEs

Most DCEs submitted information on their financial ownership (n=87 of 99 DCEs in PY2022). Our analysis found that privately held companies controlled 60% of DCEs, followed by "other" organizations (28%, including health systems, MSOs, and non-profit organizations); private individuals (16%); publicly traded companies (11%); and investment firms (3%).

commercial plans. High Needs DCEs' prior experience in APMs included the Shared Savings Program and Primary Care First.

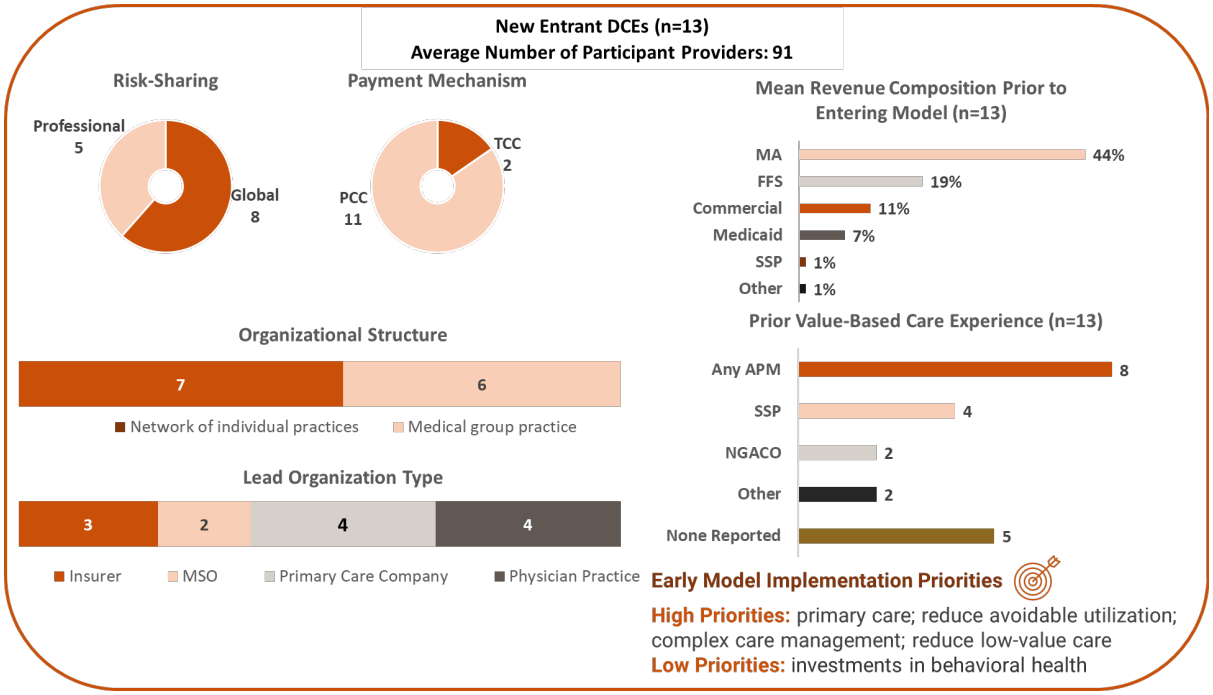
The information on each DCE type's organizational characteristics, implementation priorities, and prior APM experience captured in each snapshot (**Exhibits 2.5–2.7**) provides additional context for understanding how and why DCEs participated in the model and their outcomes. Such information will inform the analyses we present in the chapters that follow.

Exhibit 2.5. Standard DCEs Were a Heterogeneous Group that Represented the Full Range of Organizational Structures and Lead Organizations



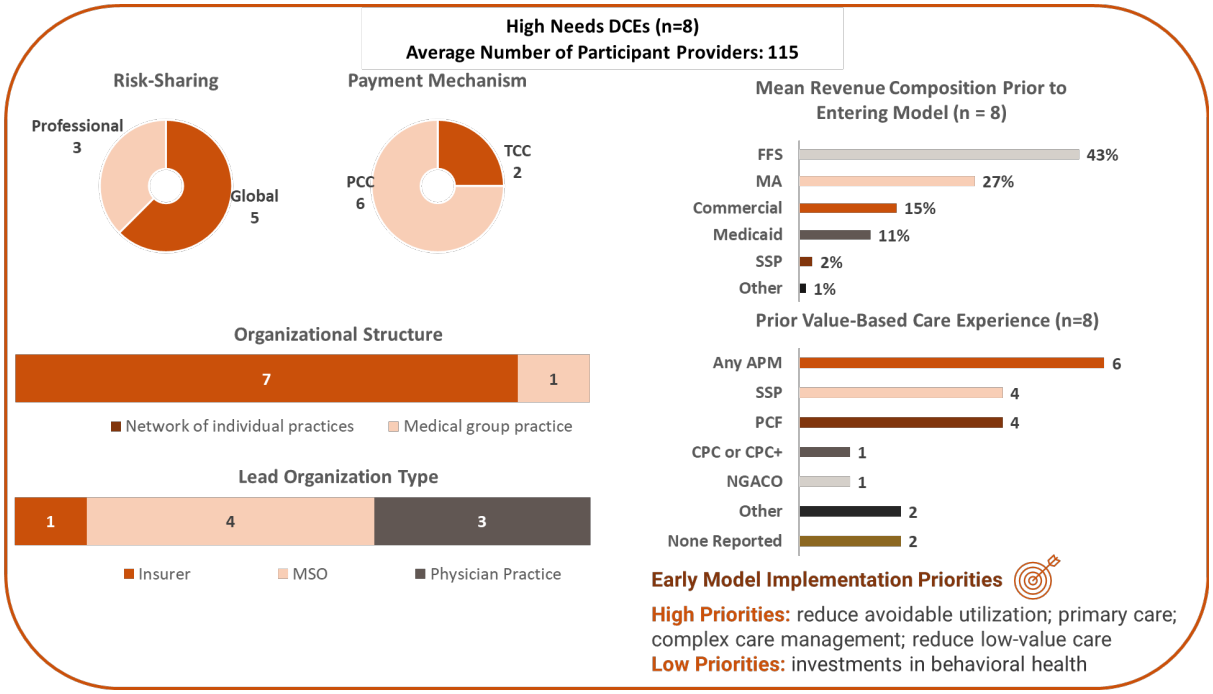
SOURCE: PY2022 financial results (n=78); model applications and additional documentation (n=78); revenue and prior experience (n=71); 2022 GPDC Pulse Check Survey (n=75).

Exhibit 2.6. New Entrant DCEs Were Organized Around Physician Practices but Led by Different Types of Organizations



SOURCE: PY2022 financial results (n=13); model applications and additional documentation (n=13); 2022 GPDC Pulse Check Survey (n=13).

Exhibit 2.7. Nearly All High Needs DCEs Were Networks of Individual Practices and Led by MSOs or Physician Practices



SOURCE: PY2022 financial results (n=8); model applications and additional documentation (n=8); 2022 GPDC Pulse Check Survey (n=7).

DCE Providers in PY2022

Providers are on the front lines of care delivery and for this reason have played a crucial role in DCEs' ability to realize the objectives of the model. The GPDC Model's capitated payments to DCEs, and direct payment arrangements between DCEs and their providers gave DCEs flexibility to use financial incentives and other mechanisms to engage their providers.

Provider Networks

Provider network characteristics, such as size and composition, influenced the potential scope, scale, and reach of DCEs' care delivery transformation efforts. In the GPDC Model, Participant Providers included primary care practitioners (PCPs) and specialists that furnished the majority of primary care services to beneficiaries aligned to the model per GPDC's alignment algorithm. Using Preferred Providers was optional in the GPDC Model and allowed DCEs to expand their networks and extend the types of providers in their networks, including specialty care not connected to primary care services. DCEs could expand or reduce the size of their provider networks each year in the model in response to beneficiary populations' needs, the model's minimum beneficiary threshold requirements, organizational changes such as mergers and acquisitions, or internal assessments based on their performance in the model. **Appendix A** provides more information about the differences between Participant Providers and Preferred Providers under the model.

In PY2022, the size of Participant Provider networks varied widely across DCEs. The number of practitioners in each DCE's Participant Provider network ranged from 11 to 5,459, with an average of 517. The number of facilities in each DCE's Participant Provider network ranged from 0 to 182, with an average of 7. The total number of Participant Providers across all DCEs in the model was 49,009, including 48,315 practitioners and 694 facilities.

Key Terms

Participant Provider: Individual practitioner, supplier, or facility participating in the model and used in beneficiary alignment and quality measure scoring.

Preferred Provider: Individual practitioner, supplier, or facility participating in the model but not used in beneficiary alignment or quality measures scoring.

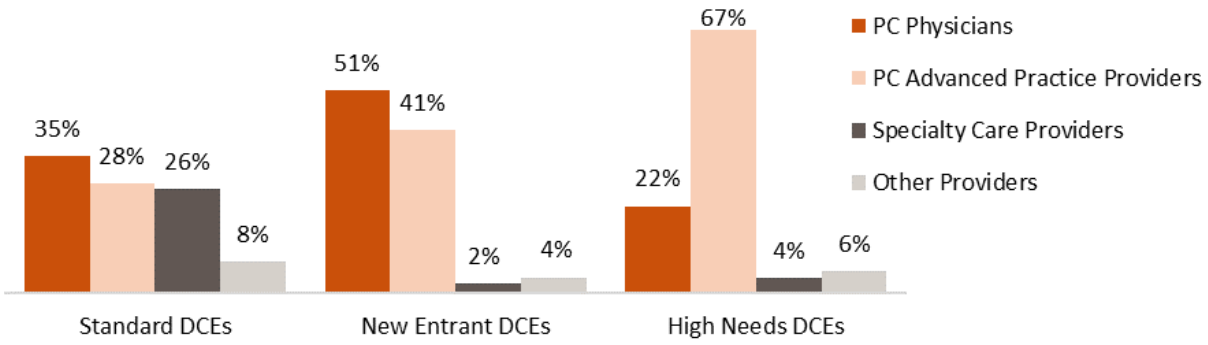
Practitioner: An individual physician, clinic or group practice, or network of practices that delivers care, either Participant or Preferred.

Facility: A facility or institutional provider that participates in the model, either Participant or Preferred.

Across all DCEs, more than half of the practitioners in their Participant Provider networks were primary care physicians or primary care advanced practice providers, although the networks varied in their overall composition (Exhibit 2.8). The practitioners in Participant Provider networks encompassed a range of provider types, including primary care physicians, primary care advanced practice providers (that is, nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists, physician assistants), specialty care providers, and other providers (that is, social workers, optometrists, dietitians/nutritionists, audiologists, dentists/oral surgeons, podiatrists, speech language pathologists, chiropractors, occupational and physical therapists, psychologists, and anesthesiology assistants). On average, Standard DCEs had more specialty care

providers among their Participant Providers than did New Entrant and High Needs DCEs. New Entrants and, even more so, High Needs DCEs had a greater proportion of primary care advanced practice providers in their networks than did their Standard DCE counterparts.

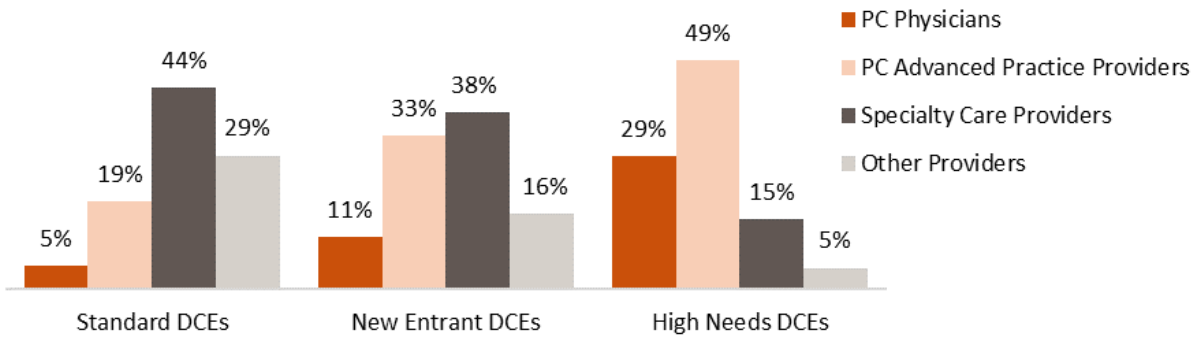
Exhibit 2.8. Practitioners in DCEs' Participant Provider Networks Focused on Primary Care



SOURCE: NORC analysis of PY2022 Alignment Data (received from RTI) (n=99 DCEs).
NOTES: DCE=Direct Contracting Entity; PC=primary care. Totals by DCE type may not add up to 100% because providers of unknown provider type (≤4%) are not shown.

DCEs' Preferred Provider networks, while smaller, tended to have more specialty care providers, although this varied by DCE type (Exhibit 2.9). Overall, nearly half of Preferred Providers in DCEs' networks were specialty care providers, although they represented a smaller proportion of High Needs DCEs' networks.

Exhibit 2.9. Practitioners in Most DCEs' Preferred Provider Networks Furnished Specialty Care or Were Other Providers



SOURCE: NORC analysis of PY2022 Alignment Data (received from RTI) (n=99 DCEs).
NOTES: DCE=Direct Contracting Entity; PC=primary care. Totals by DCE type may not add up to 100% because providers of unknown provider type (≤3%) are not shown.

DCEs tended to have smaller networks of Preferred Providers (Exhibit 2.10). The number of practitioners in each DCE's Preferred Provider network ranged from 0 to 2,370, with an average of 185. Forty-five DCEs did not have any practitioners in their Preferred Provider networks, although some in this group had facilities. The number of facilities in Preferred Provider networks ranged from 0 to 763, with an average of 51. Thirty-four

DCEs did not have any facilities among their Preferred Providers. The total number of Preferred Providers across all DCEs in the model was 23,378, including 18,299 practitioners and 5,079 facilities.

Exhibit 2.10. DCE Participant and Preferred Provider Network Sizes in PY2022

	Standard (n=78)	New Entrant (n=13)	High Needs (n=8)	All DCEs (n=99)
Participant Providers				
Practitioners				
Mean (SD)	629 (1,002)	91 (89)	115 (85)	517 (915)
Minimum	19	11	42	11
Maximum	5,459	276	263	5,459
Facilities				
Mean (SD)	7 (25)	10 (36)	0.1 (0.4)	7 (26)
Minimum	0	0	0	0
Maximum	182	130	1	182
Preferred Providers				
Practitioners				
Mean (SD)	224 (417)	50 (143)	25 (61)	185 (381)
Minimum	0	0	0	0
Maximum	2,370	519	175	2,370
Facilities				
Mean (SD)	52 (137)	55 (184)	37 (44)	51 (138)
Minimum	0	0	0	0
Maximum	763	665	115	763

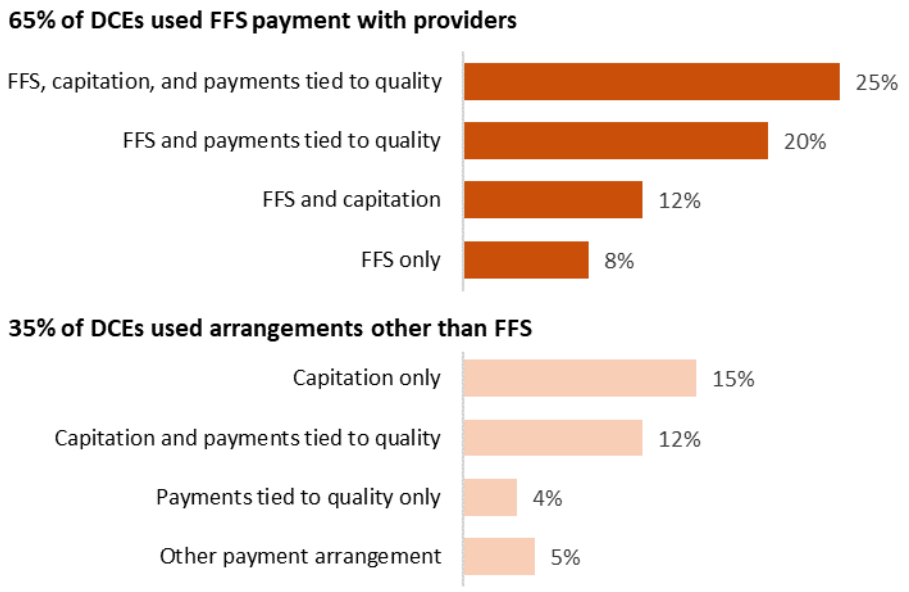
SOURCE: NORC analysis of PY2022 Alignment Data (received from RTI;n=99 DCEs).
NOTE: DCE=Direct Contracting Entity.

Provider Payment in GPDC

In the GPDC Model, Participant Providers agreed to be paid according to separately negotiated contracts with their DCE rather than by CMS. This feature provided DCEs with the latitude to engage their providers financially through various payment arrangements and the sharing of savings and losses.

DCEs continued to pay providers based on FFS. DCEs used multiple payment approaches with their Participant Providers (**Exhibit 2.11**). Two-thirds of DCEs used FFS, and in most cases, DCEs also used payments tied to quality, capitation, or both. It is unclear whether these multiple arrangements suggest that DCEs are using all payment arrangements with all providers or if they are selecting from different payment arrangements for specific providers. DCEs that did not pay their Participant Providers on a FFS basis typically used capitation, with or without quality payments. A small number reported other methods such as salaried providers.

Exhibit 2.11. DCEs Tended to Use a Combination of Payment Arrangements with Their Participant Providers



SOURCE: 2022 GPDC Pulse Check Survey (Total DCEs, n=95).
NOTES: Ten DCEs are not shown here because they did not respond to the question series. "Other payment arrangement" includes ACOs that reported their providers were salaried or that they used prospective population-based payment). Ten DCEs (eight of which had the same lead organization) did not respond to the question series.

Financial incentives that rewarded upside performance featured prominently in DCEs' efforts to engage their Participant Providers (Exhibit 2.12). Most DCEs used financial rewards with their providers, while just half used financial penalties. In general, DCEs were more prone to use financial rewards with their Participant Providers than with their Preferred Providers.

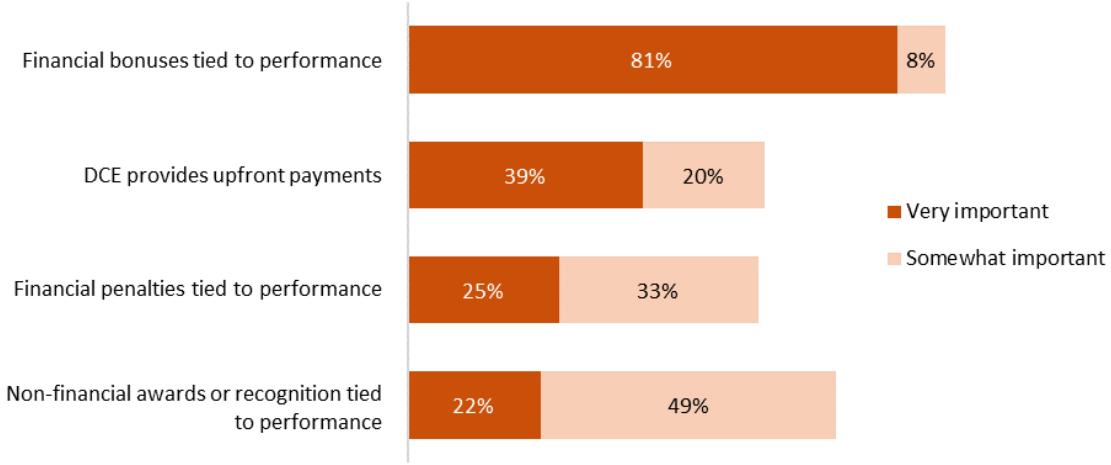
Exhibit 2.12. DCEs Were More Inclined to Use Rewards Than Penalties with Their Participant Providers

SOURCE: 2022 GPDC Pulse Check Survey (Total DCEs, n=95).
NOTE: DCE=Direct Contracting Entity.

When asked about specific incentives DCEs may have used to engage their Participant Providers, most DCEs said financial bonuses and non-financial awards or recognition were important incentives, with most DCEs rating financial bonuses as "very important." Upfront payments and financial penalties were perceived as important by more than half of DCEs, but much like non-financial incentives, DCEs tended not to perceive them as "very important," suggesting that, while DCEs saw some merit in using these other incentives, they were secondary to bonuses (**Exhibit 2.13**).

The extent to which positive financial incentives reached providers points to their perceived effectiveness. For example, DCEs that reported upfront payments and financial bonuses were very important were also likely to say that all or most of their Participant Providers received the incentive, while the smaller number of DCEs that said that non-financial awards or financial penalties were very important were less likely to say their providers received those incentives.

Exhibit 2.13. More DCEs Believed Bonuses Tied to Performance Were Very Important for Provider Engagement

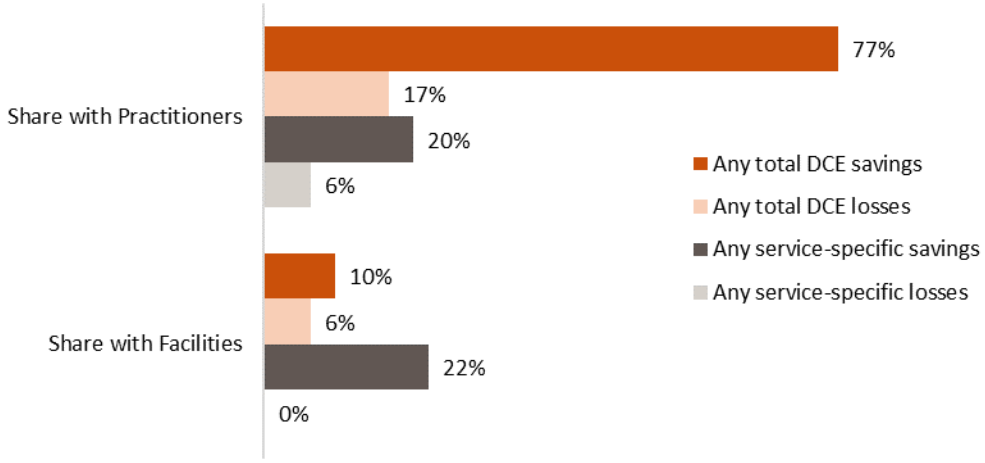


SOURCE: 2022 GPDC Pulse Check Survey (n=95 DCEs).
NOTE: DCE=Direct Contracting Entity.

DCEs were more likely to share savings than losses with their Participant Providers. DCEs participating in the model could earn shared savings or shared losses based on whether Medicare spending for their aligned beneficiaries was higher or lower than their benchmark. DCEs could then choose to pass along shared savings or losses to their providers, which could be another strategy to increase providers' investment in the model, or they could use those savings to fund operations or resources. Most DCEs shared total savings with practitioners in their Participant Provider networks, including those who were employed by health systems, part of a group or solo practices, or part of a network of practices. The percentage of total savings shared with practitioners commonly exceeded 30%, and in many cases was over 50%. Sharing total savings among facilities, such as hospitals, SNFs, or home health agencies, was much less common. When DCEs did share savings with their facilities, the savings tended to be setting-specific (**Exhibit 2.14**) and to comprise less than 5% of total savings. As seen with their limited use of financial penalties, DCEs were much less inclined to share downside risk with practitioners or facilities. Less than one-quarter of DCEs shared any losses. Patterns of risk-sharing were

consistent across all three DCE types (**Exhibit 2.14**). However, IDS/hospital system DCEs were somewhat more likely to share total savings and total losses with facilities than were DCEs with other organizational structures.

Exhibit 2.14. DCEs Were More Likely to Share Savings with Practitioners Than with Facilities



SOURCE: 2022 GPDC Pulse Check Survey (n=95 DCEs).
NOTE: DCE=Direct Contracting Entity.

Characteristics of GPDC-Aligned Beneficiaries as of PY2022

Exhibit 2.15 presents descriptive statistics for the population of aligned beneficiaries over the two years of the model.[10] As of PY2022, across all three DCE types, the model served 1.9 million Medicare FFS beneficiaries, almost all of whom (96%) were aligned to Standard DCEs and entered the model in 2022 (82%).

As of PY2022, beneficiaries aligned to Standard and New Entrant DCEs were generally similar on demographic, coverage, clinical, and community characteristics. Some small differences emerged with respect to: 1) rurality, with more Standard DCE beneficiaries living in rural ZIP codes; 2) dual eligibility, with a higher proportion of New Entrant DCE beneficiaries having dual eligibility for Medicare and Medicaid; and 3) race/ethnicity, with a higher proportion of New Entrant DCE beneficiaries identified as Black (**Exhibit 2.15**). Beneficiaries aligned to High Needs DCEs remained distinct. A larger proportion of aligned beneficiaries served by High Needs DCEs were older, were members of racial and ethnic minority groups, were dually eligible for Medicare and Medicaid, had a disability, or lived in areas of higher socioeconomic disadvantage. Consistent with the High Needs eligibility criteria, beneficiaries in High Needs DCEs also tended to be in poorer health than were their counterparts in Standard and New Entrant DCEs, with more chronic conditions, higher risk scores, and a higher likelihood of having a long-term nursing home stay in the prior year. All three DCE types served mostly urban beneficiary populations.

[10] This includes beneficiaries aligned in PY2021 alone (5%), PY2022 alone (82%), or both (13%; this group of beneficiaries are accounted for twice in the Exhibit, as the unit of observation is the beneficiary-year).

Exhibit 2.15. Characteristics of Beneficiaries Aligned to Standard, New Entrant, and High Needs DCEs as of PY2022

	Standard DCEs (n=1,911,957)	New Entrant DCEs (n=76,793)	High Needs DCEs (n=7,793)
Demographic Characteristics			
Mean (SD) Age	74.7 (10.0)	74.7 (9.6)	76.0 (14.0)
Sex (%)			
Female	57.0	59.7	60.7
Male	43.0	40.3	39.3
Race/Ethnicity (%)[a]			
Asian/Pacific Islander	4.3	5.6	2.3
Black	5.4	8.6	20.9
Hispanic	5.7	7.7	8.3
White	81.1	75.1	66.7
All Other Races/Ethnicities or Unknown	3.5	3.1	1.8
Ever Dually Eligible for Medicaid	13.9	16.7	67.8
Had Any Part D Coverage	77.0	76.3	86.5
Ever Received Part D Low-Income Drug Subsidy	15.0	17.7	67.6
Disabled Without ESRD	7.8	7.0	16.7
Clinical Characteristics			
Mean (SD) Total Number of Chronic Conditions	5.9 (3.6)	6.4 (3.8)	12.3 (4.2)
Mean (SD) Prospective HCC score	1.2 (1.1)	1.3 (1.2)	3.3 (1.9)
Nursing Home Stay of >100 Days in Prior Year (%)	1.7	2.5	48.6
GPDC High Needs Flag (%)	16.5	16.4	100
Community Characteristics			
Census Region (%)			
Northeast	16.2	9.2	15.9
Midwest	25.5	8.1	8.5
South	30.6	23.6	43.7
West	27.7	59.2	31.9
Rurality (%)			
Rural ZIP Code	5.9	2.0	3.8
Urban ZIP Code	94.1	98.0	96.2

	Standard DCEs (n=1,911,957)	New Entrant DCEs (n=76,793)	High Needs DCEs (n=7,793)
Area Deprivation Index (ADI; %)[b]			
Percent of Aligned Beneficiaries With ADI Score of 1-25 (Lowest Socioeconomic Disadvantage)	32.6	33.8	31.8
Percent Of Aligned Beneficiaries With ADI Score Of 26-50	33.1	37.4	24.0
Percent Of Aligned Beneficiaries With ADI Score Of 51-75	21.7	18.8	22.2
Percent Of Aligned Beneficiaries With ADI Score Of 76-100 (Highest Socioeconomic Disadvantage)	12.6	10.1	22.1
Mean (SD) Percent Of Population Living Below The Poverty Line	10.7 (6.6)	11.8 (7.1)	14.8 (8.8)
Mean (SD) Percent Of Population Ages 25+ With a College Degree	36.6 (17.0)	34.2 (15.4)	32.9 (17.4)

SOURCE: NORC team analysis of 2021-2022 Medicare claims and enrollment data.
NOTES: SD=standard deviation. [a]All race/ethnicity groups except Hispanic include only non-Hispanic beneficiaries. [b]2020 data were used to calculate Area Deprivation Index for PY2021, while 2021 data were used for PY2022.

Voluntary Alignment

Regardless of how they were aligned, beneficiaries interviewed in PY2022 were unfamiliar with the GPDC Model and described similar benefits and drawbacks to the concept of ACOs.

Voluntary alignment was an important feature of GPDC to empower beneficiaries to actively take part in their care decisions. Beneficiaries could voluntarily align with GPDC through Medicare.gov or by completing a CMS-developed form that designated a DCE Participant Provider as their primary clinician or main source of care.[xiii] Three-quarters of Standard and New Entrant DCEs and all High Needs DCEs reported that they conducted activities to increase voluntary alignment. Most DCEs' efforts around voluntary alignment emphasized training staff members who had direct encounters with beneficiaries, such as front desk staff members and care managers, to answer questions or supply information. DCEs also directly communicated with their beneficiaries, primarily through mail or via a patient portal or email. Communicating by voice or text messages was much less common. Some DCEs' voluntary alignment strategies included presentations for beneficiaries—such as webinars, townhalls, or information sessions—or partnerships with community-based organizations, such as Area Agencies on Aging, as potential referral sources (see **Appendix D** for survey data related to voluntary alignment). In PY2022, 51% of beneficiaries in New Entrant DCEs voluntarily aligned, followed by 6% of beneficiaries in High Needs DCEs, and 4% of beneficiaries in Standard DCEs (**Exhibit 2.16**).

Exhibit 2.16. Voluntary Alignment was Most Common Among New Entrant DCEs in PY2022

	Standard	New Entrant	High Needs	Total
Total Aligned Beneficiaries in PY2022	1,630,368	34,597	5,775	1,670,740
Voluntary Aligned Beneficiaries in PY2022	59,019	17,582	321	76,923
Voluntary Aligned Percent (%)	3.6	50.8	5.6	4.6

SOURCE: NORC analysis of GPDC Model data.

The DCEs exiting GPDC reported mixed experiences with voluntary alignment; several DCEs noted that implementing voluntary alignment was more challenging than expected, while others reported successful implementation. Some successful DCEs cited considerable investment in staff training and resources. See **Appendix L** for more information on interviews with DCEs that exited GPDC.

- One DCE invested time in multiple voluntary alignment activities, including training front office staff members in many provider offices to enroll eligible beneficiaries. The training was not enough to yield the desired level of voluntary alignment; the DCE found the only successful strategy to be having their providers meet with beneficiaries in person at the hospital before discharge.
- One DCE enrolled beneficiaries who regularly visited their centers; however, the DCE had little success with voluntary alignment when working with other, non-employed providers.
- One DCE reported signing up 5,000 of over 30,000 enrollees voluntarily. The DCE believed its efforts were successful and worthwhile, but the effort involved a considerable investment to reach that level of voluntary alignment.
- One DCE reportedly invested significant staff hours to recruit beneficiaries for voluntary alignment, including having staff members visit beneficiaries in their home. Interviewees reported that the DCE succeeded in engaging its beneficiaries and in gaining their agreement to voluntarily align with the DCE, only to find out that the beneficiaries were ineligible to be enrolled because of insufficient documentation of the beneficiaries' diagnoses and health needs during the DCE's lookback period.

Conclusion

The GPDC Model's three types of DCEs—Standard, New Entrant and High Needs DCEs—varied by design in their number of aligned beneficiaries and providers' experience serving Medicare FFS beneficiaries. We found that each DCE type could also be characterized by its prevailing organizational structures and lead organizations, which together provided important context for understanding how DCEs participated in the model.

- In PY2022, Standard DCEs were a balanced mix of individual practice networks, medical group practices, and IDS/hospital systems (most led by MSOs or health systems).
- New Entrant DCEs were networks of individual practices or medical group practices led by physician practices and primary care companies.

- High Needs DCEs were networks of individual practices led by MSOs or physician practices.

Organizational characteristics shed light on the resources and infrastructure that DCEs could use to engage their providers and respond to GPDC incentives. DCEs that were networks had providers dispersed across multiple practices, suggesting that financial and administrative incentives would be more effective mechanisms for facilitating value-based care than policies, practices, and management resources that would leverage the more integrated structures of medical group practices and IDS/hospitals systems.

We found that, regardless of differences in organizational characteristics, each DCE type was most inclined to pursue GPDC's Global risk and PCC options. This finding speaks to evidence that, regardless of their providers' experience with Medicare FFS and APMs, all three types of DCEs had experience in APMs, including Medicare ACOs.

DCEs tended not to pass downside risk on to their providers, instead using positive financial incentives such as bonuses, shared savings, and upfront payments. DCEs used multiple payment arrangements with their providers. Many used FFS with capitation, payments tied to quality, or both. A small number of DCEs strictly used capitation with their providers. We will continue to explore how DCEs use these methods with their providers in future analyses for the evaluation.

Chapter 3: Standard DCEs Increased Gross Spending, While New Entrant and High Needs DCEs Reduced Gross Spending. All DCE Types Increased Net Spending

Key Findings

Impacts on Gross Medicare Spending

- Cumulatively (in the first two years of the GPDC Model), Standard DCEs had gross Medicare spending increases, while New Entrant DCEs had gross spending reductions, relative to their comparison groups.
  - Standard DCEs increased gross Medicare spending cumulatively as of PY2022 (0.8%, $p<0.01$), reflecting significant increases in PY2022 (1.0%, $p<0.01$).
  - New Entrant DCEs reduced gross spending cumulatively (1.4%, $p>0.1$) and in PY2022 (1.6%, $p>0.1$), but the reductions were not statistically significant and were similar to the impacts observed in PY2021 (1.3%, $p>0.1$).
- High Needs DCEs significantly reduced gross Medicare spending in PY2022 (3.5%, $p<0.01$), the first year in which this DCE type could be evaluated.
- High Needs and New Entrant DCEs may have had more opportunities to achieve early reductions in gross spending, compared with Standard DCEs, which had the lowest levels of baseline spending.

Impacts on Net Medicare Spending

- Net Medicare spending increased significantly for the Standard and New Entrant DCEs as CMS supported DCEs with shared savings payouts (relative to financial benchmarks) that exceeded reductions in gross spending (relative to comparison groups). After accounting for shared savings payouts, Standard and New Entrant DCEs increased net Medicare spending cumulatively as of PY2022 (2.6% and 3.8%, respectively, $p<0.01$), reflecting larger net spending increases in PY2022 for both DCE types (3.0% and 7.0% for Standard and New Entrant DCEs, respectively, $p<0.01$).
- In PY2022, High Needs DCEs increased net Medicare spending (9.3%, $p<0.01$).
- In the first two years of the GPDC Model, a majority of Standard DCEs increased spending relative to a comparison group, as measured by our evaluation, but most did realize shared savings relative to the financial benchmark for the model. New Entrant DCEs had better concordance between the evaluation and the financial benchmarks. Concordance between the evaluation and financial benchmarking analysis was not assessed for High Needs DCEs since the small beneficiary population sample size meant that it was not feasible to estimate DCE-specific impacts.

Key Findings

Variations in Gross Spending Impacts as of PY2022 for Subgroups of Standard and New Entrant DCEs

- Counter to expectations, election of higher levels of risk and capitation by Standard and New Entrant DCEs was not associated with reductions in gross spending.
    - Standard DCEs saw significant increases in gross Medicare spending associated with all three levels of capitation and risk.
    - For New Entrant DCEs, those that elected Professional PCC—the lowest level of capitation and the smallest degree of risk exposure—were associated with significant gross spending declines (2.7%, $p<0.1$).
- Consistent with expectations, gross spending impacts varied by DCEs' organizational structure. Findings may reflect differences in DCEs' markets, providers, beneficiaries, and other organizational or implementation factors apart from their organizational structure.
    - Standard DCEs that were IDS/hospital systems were associated with gross spending increases (1.4%, $p<0.05$) and accounted for about 80% of the Standard DCEs' aggregate gross spending increases as of PY2022.
- New Entrant DCEs that were networks of individual practices (2.4%, $p<0.1$) were associated with significantly lower gross Medicare spending as of PY2022.

The GPDC Model aimed to lower Medicare spending by providing incentives to DCEs that supported their providers in different ways with respect to care delivery and population health management. In this chapter, we explore four main research questions:

- Did the model result in lower total Medicare Parts A and B spending relative to a comparison group?
- Did the model result in net savings to Medicare after accounting for the shared savings paid to DCEs?
- Did total Medicare spending impacts vary by DCEs' election of risk level and capitation?
- Did total Medicare spending impacts vary by DCEs' lead organization?

In this chapter, we first review our approach to quantitative analysis of Medicare claims and our hypotheses. Then we present estimated impacts of the GPDC Model on gross and net total Medicare Parts A and B spending—both model-wide in PY2022 for Standard, New Entrant, and High Needs DCEs and cumulatively as of PY2022 (including both PY2021 and PY2022) for Standard and New Entrant DCEs. Because High Needs DCEs were not evaluable in PY2021 due to their smaller beneficiary populations, we report their impacts for PY2022 alone. We then discuss the degree of concordance between our evaluation findings and the model's financial results used to calculate shared savings for individual Standard and New Entrant DCEs across the first two years of the model. Finally, we explain variations in gross spending impacts for Standard and New Entrant DCE subgroups based on risk level, capitation, and lead organization type but do not report regression-based estimates for individual or subgroups of High Needs DCEs because of their smaller beneficiary populations.

Appendix I provides supplemental exhibits that support the summary discussion presented in this chapter.

Methods Overview

We used a difference-in-differences (DID) design to assess how the GPDC Model affected Medicare spending, utilization, and quality of care outcomes for beneficiaries attributed to the model relative to their expected outcomes had the model not existed. For Standard and New Entrant DCEs, we estimated impacts for each DCE separately and then calculated weighted means for individual DCEs within each DCE type to generate overall impact estimates for Standard and New Entrant DCEs in PY2022 and cumulatively (as of PY2022).[11] For High Needs DCEs, we estimated impacts for the DCE type in PY2022 by pooling all individual DCEs into their respective starter cohorts, due to their smaller beneficiary populations. Our baseline period was the three years prior to the given DCE starting in the GPDC Model (that is, 2018–2020 for the 2021 cohort and 2019–2021 for the 2022 cohort). We defined beneficiaries in the GPDC group as those aligned to GPDC Participant Providers in PY2022 and in the baseline period, while beneficiaries in the comparison group were aligned to non-GPDC providers (that is, alignment-eligible providers who were not affiliated to a DCE in any PY) during the two points in time.

Estimated Impacts Capture the Effect of the GPDC Model Relative To:

- Changes that occurred in the DCE group in the baseline years (BYs), which account for effects resulting from prior participation in other APMs.
- Changes occurring in the comparison group in the PYs, which account for participation in other APMs and changes that likely would have occurred in the DCE group had beneficiaries not been attributed to the GPDC Model.

The comparison group was well-balanced with the GPDC (treatment) group. The comparison group comprised beneficiaries in GPDC DCE market areas but aligned to providers who could have been in FFS alone or in other Medicare ACO initiatives.

We balanced beneficiaries in the comparison group to be like beneficiaries in the GPDC group on observed demographics, disease burden, and area-level characteristics. The comparison group included some beneficiaries in other Medicare ACOs, because this represented the counterfactual business decision available to GPDC providers absent the model. While inclusion of such beneficiaries enhances the comparability of the comparison group, it may potentially diminish estimated effects of the GPDC model, given similar incentives and benefits in other Medicare ACOs.

We used entropy balancing to weight comparison beneficiaries in both periods, as well as GPDC beneficiaries during the baseline period (each BY for Standard and New Entrant DCEs and pooled BY for High Needs DCEs), so that comparators would be similar to GPDC beneficiaries in PY2022 on individual, community, and market characteristics. **Appendix G** provides more detail on the impact assessment methodology, and **Appendix H** details the variables used in the entropy balancing and the

[11] We calculated model-level estimates in PY2022 and as of PY2022 using DCE-level results by weighting each DCE's or DCE-year's impact estimates. For example, the model-level estimate in PY2022 reflects a weighted average of each DCE's impact estimate for that year, weighted by the proportion of total aligned beneficiaries for each DCE in that year. The model-level cumulative estimate as of PY2022, on the other hand, reflects a weighted average of the model-level estimate for each year contributing to the cumulative estimate (PY2021 and PY2022), weighted by the estimation sample used in each year's model-level estimate. Standard errors were also calculated as a weighted average, by squaring the weights used in calculating the model-level weighted averages. More details on how model-level estimates were derived are in Appendix H.3 "Analytic Approach to Estimate Impacts for Standard, New Entrant, and High Needs DCEs." One New Entrant DCE was excluded from our analysis due to inadequate sample.

regression adjustment, as well as the specifications for the outcome measures.

Evaluation Hypotheses

Exhibit 3.1 presents our hypotheses on expected gross Medicare spending impacts for DCE beneficiaries relative to comparison group beneficiaries aligned to non-DCE providers.

Exhibit 3.1 Evaluation Hypotheses for Medicare Parts A and B Gross Spending

Factors	Hypotheses
Experience	1) Because implementing a new model takes time, we would expect spending savings to likely not be achieved in the first two to three PYs. 2) New Entrant and High Needs DCEs may have had more opportunity to achieve early reductions in gross spending, compared with Standard DCEs, which entered the model with prior accountable care experience and lower spending at baseline.
Risk level[12]	1) DCEs that selected higher risk may be able to achieve greater gross Medicare spending reductions, with risk (and capitation) levels indicative of DCEs expectations to keep spending below the model's financial benchmark by engaging providers.
Organizational Structure	1) DCE structure affects organizational resources, scale, and culture, which may influence provider recruitment, model features selected, and implementation approaches, which in turn can affect outcomes. 2) DCEs are likely to lower Medicare spending by lowering spending for providers other than their own, based on findings from prior Medicare ACO evaluations.[xiv,xv] We hypothesize that IDS/hospital system DCEs would be less likely to reduce spending, while physician practice DCEs would be more likely to do so.

Our evaluation estimated model impacts on gross and net Medicare total spending, while also comparing the evaluation's findings with the model's financial results that determined whether DCEs earned shared savings or incurred shared losses relative to the benchmark.

Gross Medicare Spending by DCE Type

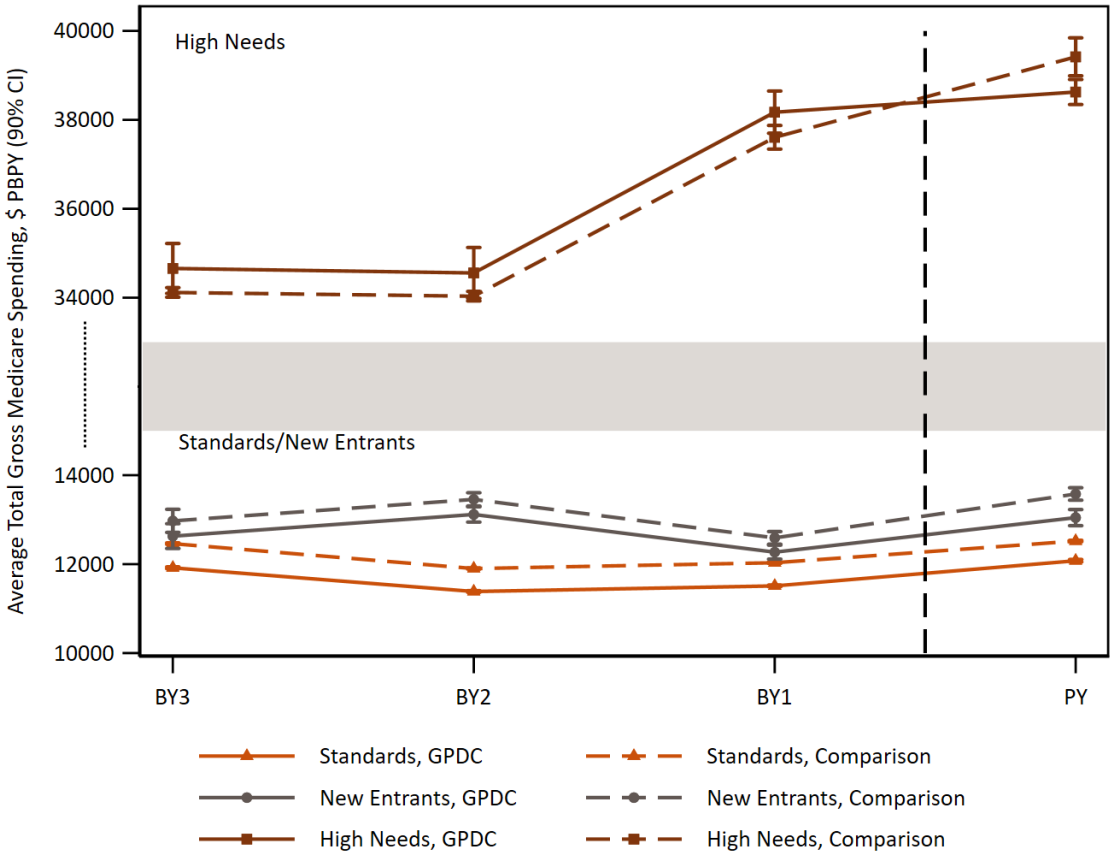
Cumulatively (as of the second PY of GPDC), gross Medicare Parts A and B spending had increased among Standard DCEs but was trending downward for New Entrant and High Needs DCEs relative to their respective comparison groups. Exhibit 3.2 shows the average adjusted gross spending estimates in baseline years (BYs) and in the PYs for beneficiaries in GPDC and comparison groups for all three types of DCEs. For Standard and New Entrant DCEs, the PY reflects the average as of PY2022 (both PY2021 and PY2022); for High Needs DCEs, the PY reflects the average in PY2022 alone. The gross spending measure represents what Medicare paid for Parts A and B spending including beneficiary-level capitated payments under the GPDC Model.

[12] Classified as follows: Global Total Care Capitation (TCC) as the highest level, Global Primary Care Capitation (PCC) with or without Advanced Payment Option (APO) as the middle level, and Professional PCC with or without APO as the lowest level.

- **Comparisons of total spending, by DCE type.** Adjusted gross Medicare spending in the BYs was highest for beneficiaries in High Needs DCEs (~$35,300 per beneficiary per year [PBPY]), followed by New Entrant DCEs (~$12,700 PBPY) and Standard DCEs (~$11,600 PBPY). The gross Medicare spending for beneficiaries in High Needs DCEs and their comparison groups was almost three times the spending for beneficiaries in Standard or New Entrant DCEs, and comparison groups reflected the greater disease burden and care needs of High Needs beneficiaries.
- **Comparisons of DCEs to their comparison group, by DCE type.** Standard DCEs had lower gross Medicare spending than their comparison group; New Entrant DCEs also had lower gross Medicare spending relative to their comparison group but to a lesser degree. High Needs DCEs had higher gross Medicare spending than their comparison group in PY2021 but not in PY2022.
- **Comparisons of DCEs to their comparison groups over time, by DCE type.** Gross Medicare spending trended downward for High Needs DCEs, increased less for New Entrant DCEs, and increased more for Standard DCEs relative to their respective comparison groups (also see **Appendix Exhibit I.1** for trends in PY2022).[13]

[13] The PY reflects the average as of PY2022 (both PY2021 and PY2022) for Standard and New Entrant DCEs. For High Needs DCEs, the PY reflects the average in PY2022 alone.

Exhibit 3.2. As of PY2022, Adjusted Gross Medicare Spending Increased for Standard DCEs But Increased Less for New Entrant and High Needs DCEs, Relative to Comparison Groups



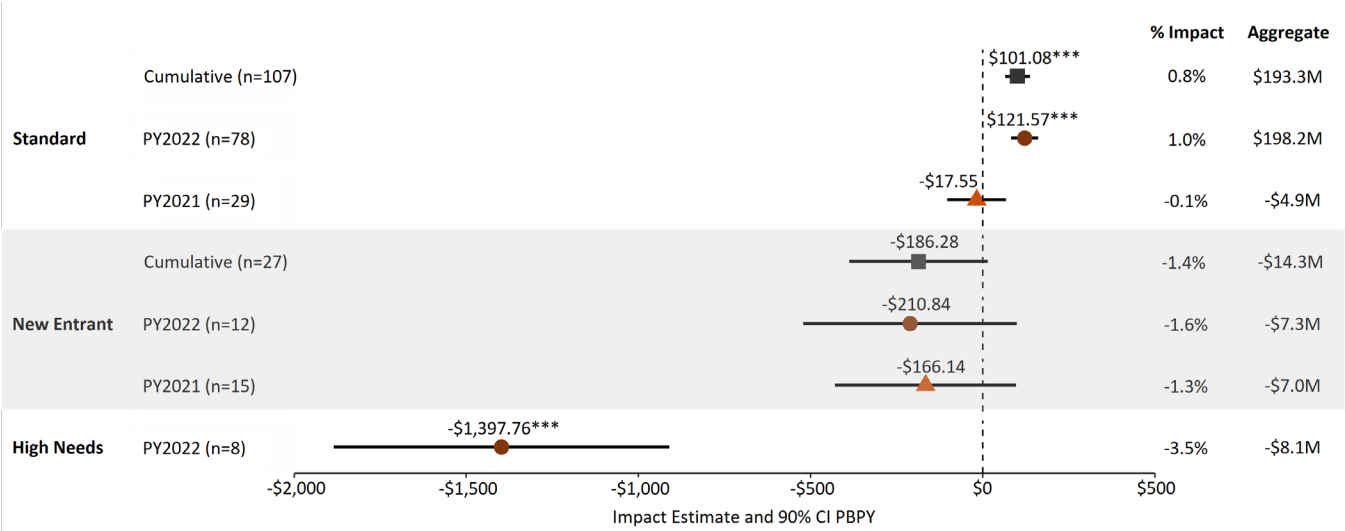
SOURCE: NORC analysis of Medicare claims, enrollment, and GPDC Model data.
NOTES: Point estimates are the adjusted gross Medicare Parts A and B spending for GPDC or comparison beneficiaries in each year. Confidence intervals at the 90% level are displayed as bars around the point estimates. PBPY=per beneficiary per year. Performance year (PY) represents "as of PY2022" for Standard and New Entrant DCEs, which includes calendar years 2021 and 2022 for the 2021 cohort DCEs and calendar year 2022 for 2022 cohort DCEs. PY represents "in PY2022" for High Needs DCEs, which includes calendar year 2022 alone for 2021 and 2022 cohort DCEs. Baseline years (BYs) BY1–BY3 span calendar years 2018–2020 for the 2021 cohort DCEs, and 2019–2021 for the 2022 cohort DCEs.

In two years of the GPDC Model, New Entrant and High Needs DCEs showed gross Medicare spending reductions, while Standard DCEs had gross Medicare spending increases, relative to their comparison groups. **Exhibit 3.3** shows the GPDC Model's PBPY and aggregate impacts on gross spending for Standard, New Entrant, and High Needs DCEs as of PY2022, as well as in PY2022 and in PY2021.[14,15]

- Standard DCEs significantly increased gross Medicare spending by an estimated $193.3 million (0.8%), or $101.08 PBPY, over PY2021 and PY2022, reflecting PY2022 results, as most Standard DCEs and aligned beneficiaries in the model entered in PY2022. In PY2022, Standard DCEs significantly increased gross Medicare spending by an estimated $198.2 million (1.0%) or $121.57 PBPY, reflecting a significant increase for the 2022 cohort (1.4%) and a non-significant increase for the 2021 cohort (0.3%; see **Appendix Exhibit I.2**). In PY2022, 45 of 78 Standard DCEs increased gross spending by 0.1–15.9%, with 18 of these DCEs having statistically significant increases. At the same time, 33 Standard DCEs decreased gross spending by 0.1–7.5%, with 8 of the DCEs seeing statistically significant decreases (see **Appendix Exhibit I.3**). More than 80% of the Standard DCEs' aggregate gross spending increases ($153.3M of $193.3M) came from IDS/hospital system DCEs, which had the largest spending increases in the model relative to their comparison groups (**Exhibit 3.8**).
- New Entrant DCEs lowered gross Medicare spending by an estimated $14.3 million (1.4%) or $186.28 PBPY over PY2021 and PY2022, but this reduction was not statistically significant. In PY2022, gross Medicare spending decreased (1.6%) non-significantly, with a significant decrease for the 2021 cohort (3.2%) but a non-significant increase (2.7%) for the 2022 cohort (see **Appendix Exhibit I.2**). In PY2022, 7 of 12 New Entrant DCEs decreased gross spending by 0.3–6.1%, while 5 New Entrant DCEs increased gross spending by 0.4–10.3% (see **Appendix Exhibit I.3).**
- High Needs DCEs lowered gross Medicare spending by an estimated $8.1 million (3.5%) or $1,397.76 PBPY in PY2022. Both cohorts of High Needs DCEs in PY2022 showed significant and consistent declines (3.4% for the 2021 cohort and 3.7% for the 2022 cohort; see **Appendix Exhibit I.2**).

[14] In Exhibits 3.2, 3.3, 3.6, and 3.7, "(n=)" in the graph represented number of DCE-years, instead of number of individual DCEs.
[15] **Appendix Exhibit I.2** shows gross spending impacts in PY2022 by cohort for each DCE type. Differences in gross spending impacts for cohorts reflect differences in their DCEs' organizations, markets, and years of experience in the model. **Appendix Exhibit I.6** shows the results of two COVID-19-related sensitivity checks to the gross spending impact estimates: 1) dropping 2020 from the baseline period, and 2) controlling for county-level COVID-19 population mortality as a covariate in the regression models. The gross spending impact estimates for all DCE types remained robust to these checks.

Exhibit 3.3. As of PY2022, Gross Medicare Spending Increased for Standard DCEs and Decreased for New Entrant DCEs, While Gross Spending Declined for High Needs DCEs in PY2022



SOURCE: NORC analysis of Medicare claims, enrollment, and GPDC Model data.

NOTES: Cumulative includes PYs 2021 and 2022. Because High Needs DCEs were not evaluable in PY2021, their cumulative and PY2021 impacts are not shown. In cumulative estimates, "n" represents the number of DCE-years. In PY estimates, "n" represents the number of DCEs. **Estimated gross impact** is the difference-in-differences (DID) estimate or the difference between the GPDC and comparison mean-adjusted gross spending in PY(s) and the BYs. Estimates are presented as per beneficiary per year (PBPY) with 90% confidence intervals. **Estimated percentage impact** is the DID estimate relative to expected outcome for GPDC beneficiaries in PY(s) had the model not existed and the beneficiaries' outcomes continued along the same trajectory since baseline. **Aggregate estimate** is the impact estimate for all aligned beneficiaries in included PY(s). Impact estimates significant at p<0.01***.

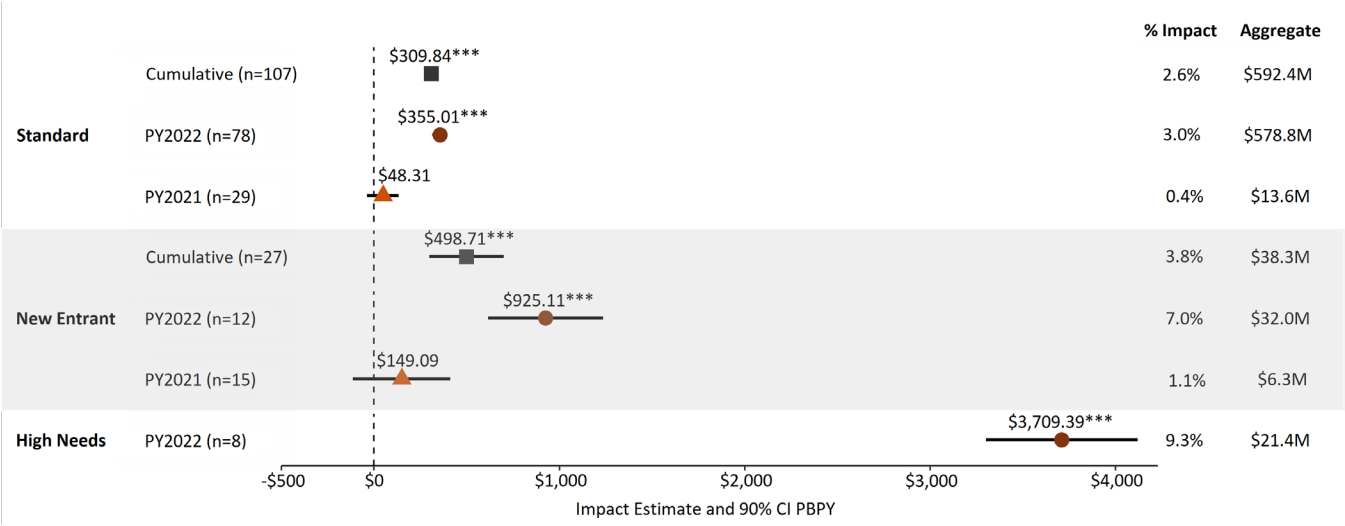
Net Medicare Spending by DCE Type

Because CMS paid shared savings to or recouped shared losses from DCEs for their financial and quality performance in the GPDC Model, we examined the model's impact on net Medicare spending. Gross spending impacts show change in Medicare Parts A and B spending for DCEs relative to changes in comparison groups over time, while net spending impacts depict the overall Medicare spending change after accounting for DCEs' shared savings outlays from CMS. **Exhibit 3.4** shows the GPDC Model's aggregate and PBPY impacts on net Medicare spending as of PY2022 (cumulatively) as well as in PY2022 and in PY2021. **After accounting for shared savings payments to DCEs, net Medicare spending significantly increased for all three DCE types in PY2022, reflected in significant increases in net spending for Standard and New Entrant DCEs cumulatively as of PY2022 (Exhibit 3.4)**. **The incentive to DCEs to participate in GPDC through shared savings payouts (relative to financial benchmarks) exceeded reductions in gross spending relative to comparison groups (Appendix Exhibit I.4).**

- As of PY2022, Standard DCEs had a significant increase in net Medicare spending of $592.4 million (2.6%), or $309.84 PBPY, reflecting significant increases in PY2022 (3.0%). In PY2022 alone, 60 of 78 Standard DCEs increased net spending by 0.4–19.9%, with 39 DCEs significantly increasing net spending; 18 Standard DCEs reduced net spending by 0.02–9.8%, with three DCEs significantly reducing net spending (**Appendix Exhibit I.4**).

- As of PY2022, New Entrant DCEs had a significant increase in net Medicare spending of $38.3 million (3.8%), or $498.71 PBPY, reflecting significant spending increases in PY2022 (7.0%). In PY2022, 8 of 12 New Entrant DCEs increased net spending by 1.1–23.4%, with 3 DCEs significantly increasing net spending; 4 New Entrant DCEs reduced net spending by 3.0–12.3%, with 2 DCEs significantly reducing net spending.
- Despite significant reductions in gross total spending, High Needs DCEs had a significant increase in net Medicare spending of $21.4 million (9.3%), or $3,709.39 PBPY, in PY2022, nearly three times the amount of gross total spending reductions.
- Both cohorts contributed to net spending increases in PY2022, except for New Entrant DCEs, where net spending increases in PY2022 reflected the 2021 cohort (10.4%); see **Appendix Exhibit I.5** for PY2022 net spending impacts in PY2022 by cohorts for each DCE type.

Exhibit 3.4. In PY2022, Net Medicare Spending Increased for All Three DCE Types, Reflected in Cumulative Net Spending Increases for Standard and New Entrant DCEs



SOURCE: NORC analysis of Medicare claims, enrollment, and GPDC Model data.
NOTES: Cumulative includes PY2021 and PY2022. Because High Needs DCEs were not evaluable in PY2021, their cumulative and PY2021 impacts are not shown. In cumulative estimates, "n" represents the number of DCE-years. In PY estimates, "n" represents the number of DCEs. **Estimated net impact** is the gross difference-in-differences (DID) estimate or the difference between the GPDC and comparison mean-adjusted spending in PY(s) and the BYs, less shared savings/losses to DCEs in PY(s). Estimates are presented per beneficiary per year (PBPY). Shared savings/losses adjusted for exclusion of beneficiaries with prospective plus voluntarily alignment from the evaluation. **Estimated percentage impact** is the DID estimate relative to expected outcome for GPDC beneficiaries in PY(s) had the model not existed and had the beneficiaries' outcomes continued along the same trajectory since baseline. **Aggregate estimate** is the net impact estimate for all prospectively aligned beneficiaries in PY(s). Impact estimates significant at p<0.01***.

Concordance Between Evaluation Findings and Model Financial Results for Standard and New Entrant DCEs

In the first two years of the GPDC Model, a majority of Standard DCEs did not reduce spending relative to a comparison group, as measured by our evaluation, but most realized shared savings relative to the financial benchmark for the model. To understand how our evaluation's results aligned with the model's financial calculations of shared savings, we compared actual shared savings and losses against each DCE's benchmark with the evaluation's estimates of each DCE's gross spending against the comparison group from its market. As of PY2022, the model was favorable for DCEs but not for the Medicare program because the shared savings payments to DCEs exceeded their Medicare spending reductions relative to the comparison group in our evaluation. For purposes of this report and discussion:

- DCEs were considered as concordant when they: 1) decreased spending according to the evaluation and earned shared savings according to the financial calculations or 2) increased spending and incurred shared losses.
    - DCEs were considered as discordant when they: 1) decreased spending but incurred shared losses or 2) increased spending but earned shared savings.

In **Exhibits 3.5–3.6**, DCEs above the diagonal line indicate increased net spending (larger shared savings than spending reduction estimates), and DCEs below the diagonal line indicate decreased net spending (larger spending reduction estimates than the shared savings amount).

We conducted this analysis for Standard and New Entrant DCEs only because model impacts could not be estimated for individual High Needs DCEs, given the small number of aligned beneficiaries in those DCEs. **Appendix I** presents the financial and evaluation results in PY2022 for individual Standard DCEs (**Appendix Exhibit I.7**) and for New Entrant DCEs (**Appendix Exhibit I.8**).

There were key differences between the evaluation's approach and the model's financial benchmark used to calculate shared savings and losses; the differences relate to the assumptions made to estimate a prospectively derived spending benchmark, differences in baseline years (BYs), and the exclusion of prospective plus voluntarily aligned beneficiaries from the evaluation. We expected greater concordance between the evaluation and financial results for Standard DCEs than for New Entrant DCEs as of PY2022. For Standard DCEs, part of the financial benchmark and evaluation's baseline relied on historical spending, but the evaluation used more recent BYs than those used for the financial benchmark.[16] As of PY2022, benchmarks for New Entrant DCEs were based solely on the county ratebook rather than on historical data specific to the beneficiaries aligned to New Entrant

[16] The benchmark for claims-aligned beneficiaries for Standard DCEs as of PY2022 was a blend of 65% historical expenditures (similar to the evaluation methodology) and 35% county ratebook. Starting in PY2024, the proportion of the benchmark based on the county ratebook will gradually increase each year. Benchmarks for voluntarily-aligned beneficiaries (regardless of DCE type) were based solely on the county ratebook as of PY2022. The evaluation's BYs were 2018–2020 for the 2021 cohort and 2019–2021 for the 2022 cohort. The model's BYs for historical expenditures were 2017–2019, while its baseline for the ratebook was 2017–2019 for PY2021 rates and 2018–2020 for PY2022 rates.

DCEs' providers.[17] However, we found less concordance for Standard DCEs than for New Entrant DCEs. The discordance observed for both DCE types likely stemmed from the evaluation using more recent BYs, including years coinciding with the COVID-19 PHE, to capture historical expenditures and using a comparison group that included Shared Savings Program ACOs and other APMs to establish the counterfactual.

In **Exhibit 3.5**, we compare evaluation findings for financial results (shared savings/losses against the benchmark) and gross spending for Standard DCEs as of PY2022. Overall, the model-wide financial results (shared savings of $208.76 PBPY) and evaluation results (increases in spending of $101.08 PBPY) indicated better performance by Standard DCEs relative to the benchmark than relative to the comparison group. When considering the 78 Standard DCEs that were in the model as of PY2022:

Model financial calculations and the impact evaluation of Medicare spending differ in their purpose and methodology, which can lead to differences in findings.

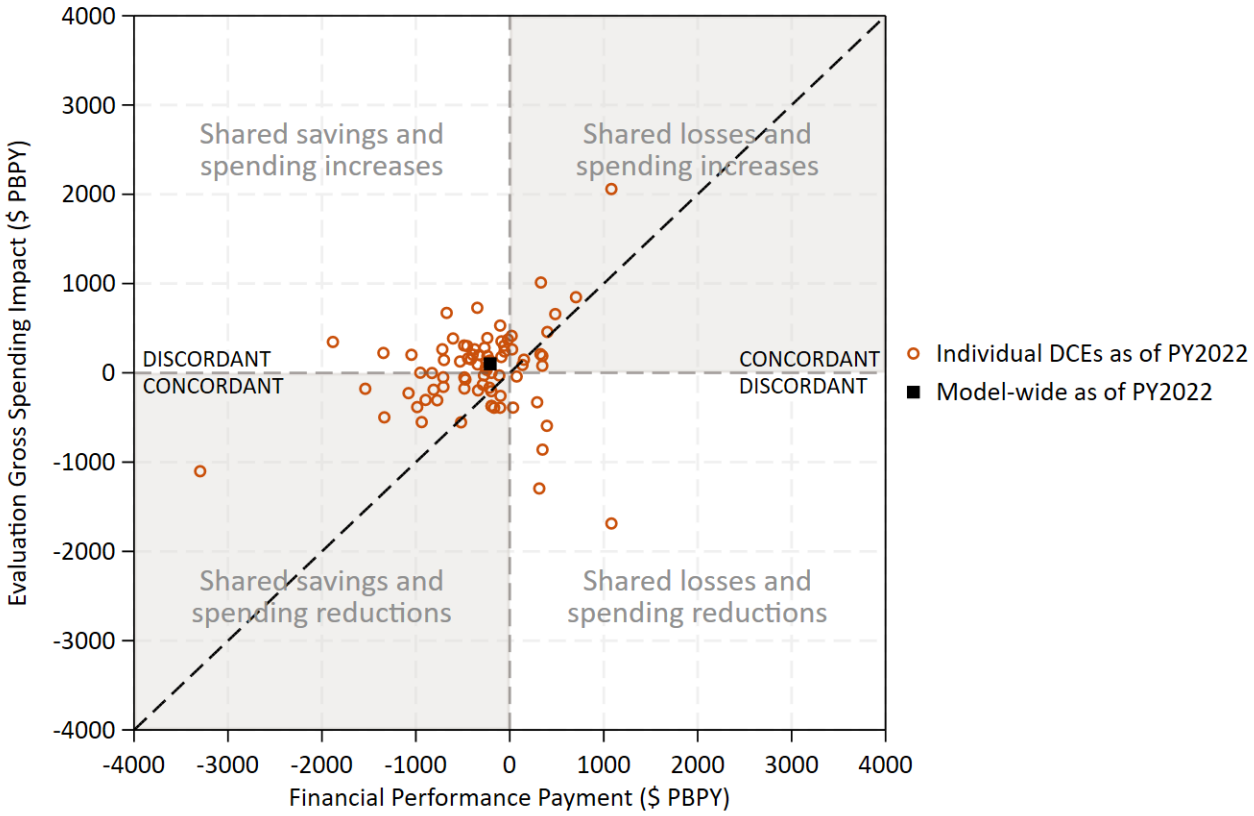
- Financial calculations for determining shared savings reflect differences between DCEs' actual and benchmark Medicare spending in a PY—where the benchmark is a projection of their regional and/or historical spending before the model's initiation.
- The evaluation's estimated impacts to understand the GDPC Model's effects reflect differences between DCEs' actual and counterfactual Medicare spending absent the model in a PY—where the counterfactual is determined by comparing DCEs and a comparison group in their markets before and after the model's initiation.
- There are differences in the time periods before the model's initiation (baseline years) used by each type of calculation.

- About half of the Standard DCEs (n=40, 51%) had concordant financial results and evaluation findings.
    - Roughly one-third of DCEs (n=28, 36%) realized shared savings relative to the benchmark and reduced spending relative to a comparison group.
    - Twelve DCEs (15%) realized shared losses relative to the benchmark and increased spending relative to a comparison group.
- About half of the Standard DCEs (n=38, 49%) had discordant financial results and evaluation findings.
    - About two-fifths of DCEs (n=31, 40%) realized shared savings relative to the benchmark but increased spending relative to a comparison group.
    - Seven DCEs (9.0%) realized shared losses relative to the benchmark but reduced spending relative to a comparison group.

Overall, 59 DCEs realized shared savings relative to the benchmark, while only 35 DCEs reduced spending relative to a comparison group, leading to an increase in net Medicare spending as of PY2022.

[17] This approach will be used through PY2024; for PY2025 and PY2026, benchmarks for New Entrant DCEs and all voluntarily aligned beneficiaries will be based on a blend of historical expenditures and the county ratebook.

Exhibit 3.5. As of PY2022, Most Standard DCEs Did Not Reduce Medicare Spending Relative to Their Comparison Group in the Evaluation but Did Earn Shared Savings for Financial Performance



SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: PBPY=per beneficiary per year; DCE=Direct Contracting Entity.

- Top left quadrant: DCEs that realized shared savings and increased spending relative to comparison.
- Top right quadrant: DCEs that realized shared losses and increased spending relative to comparison.
- Bottom left quadrant: DCEs that realized shared savings and reduced spending relative to comparison.
- Bottom right quadrant: DCEs that realized shared losses and reduced spending relative to comparison.

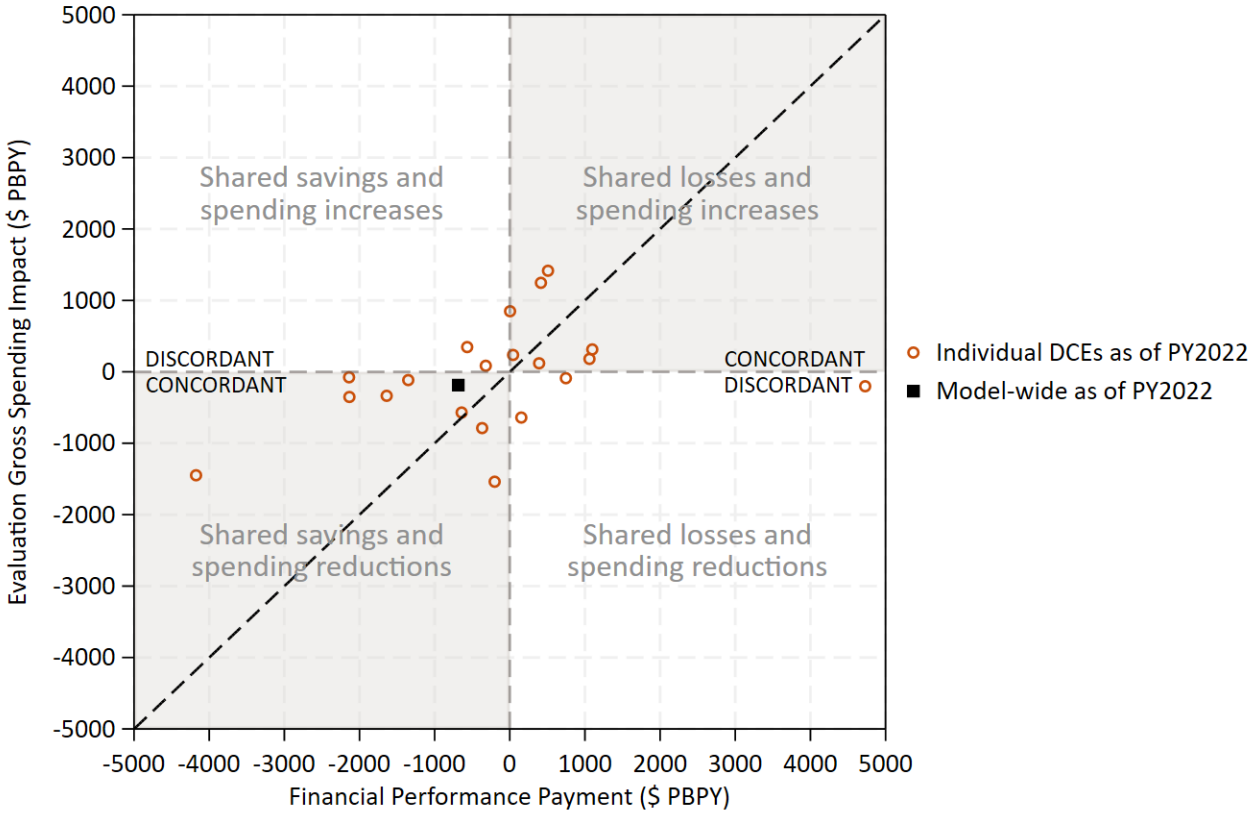
Negative values on the Y-axis represent gross spending reductions (from the evaluation) and positive values represent gross spending increases. Negative values on the X-axis represent shared savings (from the financial performance analysis) and positive values represent shared losses. Points to the right of the dashed diagonal line are financially favorable from the Medicare program's perspective because they contribute to net savings for Medicare. Points to the left of the vertical axis are financially favorable from the DCEs' perspective, as they reflect earned shared savings.

In **Exhibit 3.6**, we compare evaluation findings for gross spending and financial results (shared savings/losses against the benchmark) for New Entrant DCEs as of PY2022. Overall, the model-wide financial results (shared savings of $684.98 PBPY) and evaluation results (reductions in spending of $186.82 PBPY) indicated better performance by New Entrant DCEs relative to the benchmark than relative to the comparison group. When considering the 20 DCEs ever in the model as New Entrant DCEs (including 12 DCEs active in PY2022, 2 DCEs that exited, and 6 DCEs that joined the model in PY2021 as New Entrant DCEs but then switched to Standard DCEs in PY2022), we find the following:

- Three-quarters of the New Entrant DCEs (n=15, 75%) had concordant financial results and evaluation findings.
    - Eight DCEs (40%) realized shared savings relative to the benchmark and reduced spending relative to a comparison group.
    - Seven DCEs (35%) realized shared losses relative to the benchmark and increased spending relative to a comparison group.
- Five New Entrant DCEs had discordant financial results and evaluation findings.
    - Two DCEs realized shared savings relative to the benchmark and increased spending relative to a comparison group.
    - Three DCEs realized shared losses relative to the benchmark and reduced spending relative to a comparison group.

Overall, 10 New Entrant DCEs realized shared savings relative to the benchmark, while 11 DCEs reduced spending relative to a comparison group. But the magnitude of shared savings payouts to the former exceeded the gross spending reductions from the latter, leading to an increase in net Medicare spending as of PY2022.

Exhibit 3.6. As of PY2022 (Cumulatively), Most New Entrant DCEs Had Concordance Between Gross Spending Impacts and Financial Results



SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: PBPY=per beneficiary per year; DCE=Direct Contracting Entity.

- Top left quadrant: DCEs that realized shared savings and increased spending relative to comparison.
- Top right quadrant: DCEs that realized shared losses and increased spending relative to comparison.
- Bottom left quadrant: DCEs that realized shared savings and reduced spending relative to comparison.
- Bottom right quadrant: DCEs that realized shared losses and reduced spending relative to comparison.

Negative values on the Y-axis represent gross spending reductions (from the evaluation) and positive values represent gross spending increases. Negative values on the X-axis represent shared savings (from the financial performance analysis) and positive values represent shared losses. Points to the right of the dashed diagonal line are financially favorable from Medicare's perspective because they contribute to net savings for Medicare. Points to the left of the vertical axis are financially favorable from the DCEs' perspective as they reflect earned shared savings.

Explaining Variations in Spending Findings for Standard and New Entrant DCEs

We expected GPDC impacts on gross Medicare spending to vary by DCE characteristics, such as their election of risk level and capitation and their lead organization types. We examined how gross spending impacts as of PY2022 differed by these characteristics for subgroups of Standard and New Entrant DCEs. For each subgroup, we present the number of DCE-years and the average gross spending impacts as of PY2022. We were not able to estimate similar impacts for subgroups of High Needs DCEs because of the small number of aligned beneficiaries in those DCEs. Differences in impacts for subgroups of DCEs may reflect underlying differences in their markets,

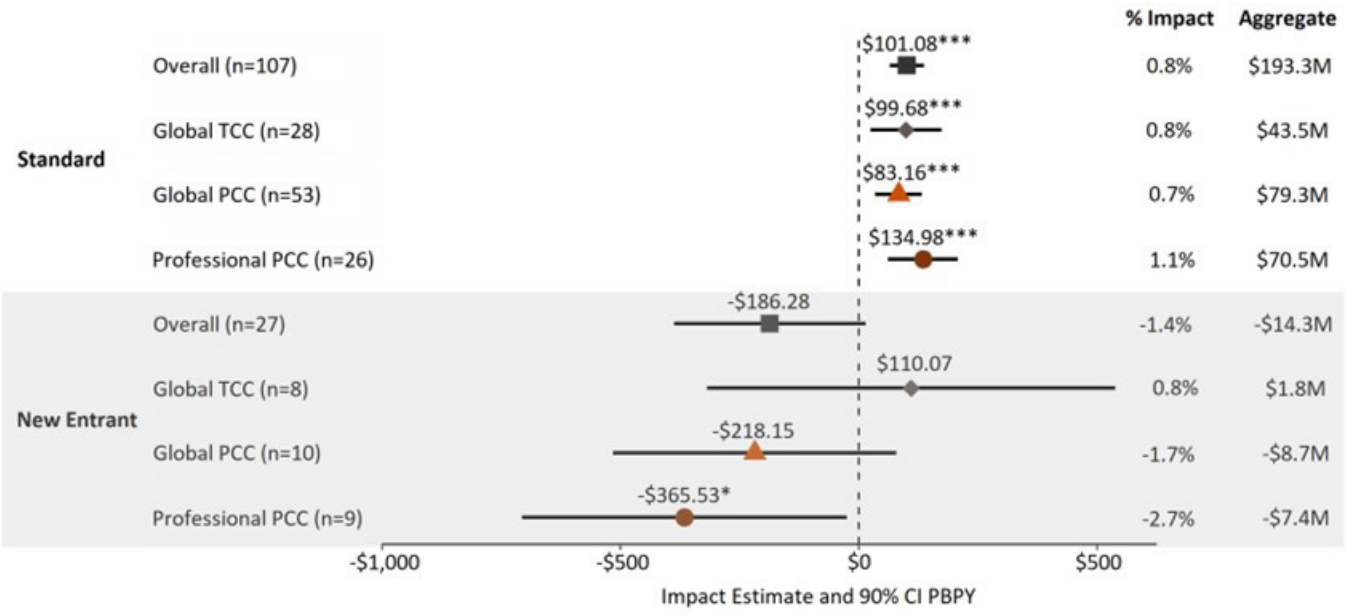
providers, beneficiaries, and implementation approaches in the model. In addition to these characteristics, we examined variation in gross spending impacts by a few other organizational characteristics (such as lead organization type), and those results are reported in **Appendix I** (see **Appendix Exhibit I.11** and **Appendix Exhibit I.12**).

Gross Spending by Level of Risk and Capitation

We hypothesized that Standard and New Entrant DCEs with higher capitation and risk levels would be associated with larger gross spending reductions. We examined gross Medicare spending impacts by three levels of risk and capitation elected by DCEs, ranging from highest to lowest: Global TCC, Global PCC, and Professional PCC. **Exhibit 3.7** shows the gross spending impacts by levels of risk and capitation for Standard and New Entrant DCEs as of PY2022. **Appendix I** shows findings by levels of risk alone (**Appendix Exhibit I.9**) and by capitation alone (**Appendix Exhibit I.10**).

- For Standard DCEs, about half elected Global PCC; the remaining DCEs were divided between those that elected Global TCC and those electing Professional PCC. Standard DCEs were associated with significant increases in gross Medicare spending regardless of risk level and capitation election, with the largest increase observed among DCEs electing Professional PCC of $134.98 PBPY (1.1%), followed by those electing Global TCC ($99.68 PBPY, 0.8%), and Global PCC ($83.16 PBPY, 0.7%).
- For New Entrant DCEs, those electing each risk level and capitation group were about evenly distributed as of PY2022. Gross Medicare spending decreased significantly among DCEs electing Professional PCC (the lowest capitation and risk exposure) by $365.53 (-2.7%); spending decreased non-significantly among DCEs electing Global PCC (-1.7%) and increased non-significantly among DCEs electing Global TCC (0.8%).

Exhibit 3.7. As of PY2022, Higher Levels of Risk and Capitation Were Not Associated with Larger Reductions in Gross Medicare Spending for Standard and New Entrant DCEs



SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: Impacts on gross Medicare spending as of PY2022 shown for all Standard and New Entrant DCEs (overall) and subgroups of DCEs based on their levels of risk and capitation: Global Total Care Capitation (TCC) is the highest level, Global Primary Care Capitation (PCC) with or without Advanced Payment Option (APO) is the middle level, while Professional PCC with or without APO is the lowest level. In cumulative estimates overall and for subgroups, "n" represents the number of DCE-years. **Estimated gross spending impact** is the difference-in-differences (DID) estimate, or the difference between the GPDC and comparison mean-adjusted gross spending in PY(s) and the BYs. Estimates are presented per beneficiary per year (PBPY) with 90% confidence intervals. **Estimated percentage impact** is the DID estimate relative to expected outcome for GPDC beneficiaries in PYs had the model not existed and had the beneficiaries' outcomes continued along the same trajectory since baseline. **Aggregate estimate** is the impact estimate for all aligned beneficiaries in PYs. Impact estimates significant at p<0.1*, p<0.01***.

Gross Spending, by Organizational Structure

We hypothesized that leadership with the capacity to implement accountable care quickly would be associated with larger gross spending reductions for DCEs. However, findings may reflect differences in DCEs' markets, providers, beneficiaries, and other organizational or implementation factors apart from differences in their capacity to quickly implement accountable care.

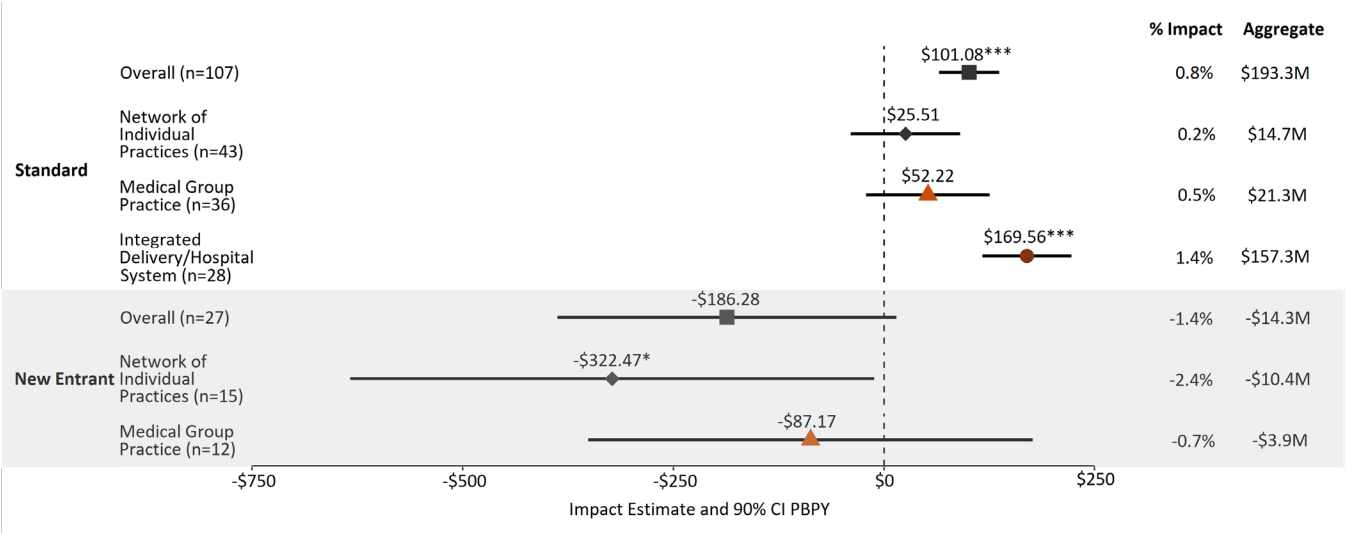
As of PY2022:

- **For Standard DCEs**
  - IDS/hospital system Standard DCEs had larger gross spending increases.
- **For New Entrant DCEs**
  - Those that were networks of individual practices had significant reductions.

Exhibit 3.8 shows the gross spending variation by **organizational structure** for Standard and New Entrant DCEs as of PY2022. Organizational structure affects available resources, scale, and culture, which in turn may influence Medicare spending through provider recruitment, selected model features, and implementation approaches. Based on prior Medicare ACO evaluations, we anticipated that DCEs that were IDS/hospital systems would have fewer reductions (or more increases) compared with physician practice DCEs.

- As expected, Standard DCEs that were IDS/hospital systems (26% of DCEs) were associated with significant gross spending increases (1.4%), while those that were medical group practices or networks of individual practices were associated with smaller, non-significant gross spending increases. The finding may reflect that IDS/hospital systems DCEs would be less likely to reduce potential revenues from lowering hospital inpatient and outpatient care, coinciding with greater demand for care in these two settings post-pandemic.
- New Entrant DCEs that were networks of individual practices (56% of DCEs) were associated with significant gross spending reductions (2.4%), while those that were medical group practices were associated with smaller, non-significant gross spending reductions. The reasons for differences among these two types of physician practice DCEs are unclear; we will examine them in future reports.

Exhibit 3.8. As of PY2022, IDS/Hospital Systems Standard DCEs Had Larger Gross Spending Increases, While New Entrant DCEs That Were Networks of Individual Practices Had Larger Gross Spending Reductions



SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: Impacts on gross Medicare spending as of PY2022 shown for all Standard and New Entrant DCEs (overall) and subgroups of DCEs based on their organizational structure. In cumulative estimates overall and for subgroups, "n" represents the number of DCE-years. **Estimated gross spending impact** is the difference-in-differences (DID) estimate, or the difference between the GPDC and comparison mean-adjusted gross spending in PY(s) and the baseline years. Estimates are presented per beneficiary per year (PBPY) with 90% confidence intervals. **Estimated percentage impact** is the DID estimate relative to expected outcome for GPDC beneficiaries in PYs had the model not existed and had the beneficiaries' outcomes continued the same trajectory since baseline. **Aggregate estimate** is the impact estimate for all aligned beneficiaries in PYs. Impact estimates significant at p<0.1*, p<0.01***.

Conclusion

We expected that DCE providers would show reductions in gross Medicare spending for their beneficiaries relative to beneficiaries of non-DCE providers over time, specifically through more efficient care from implementing DCEs' population health management strategies. In addition, DCEs that had not previously provided accountable care to their attributed beneficiaries—New Entrant and High Needs DCEs—may have had more opportunities to reduce gross Medicare spending sooner under GPDC than did Standard DCEs with prior accountable care experience. Gross Medicare spending in the BYs was highest for beneficiaries in High Needs

DCEs, followed by New Entrant DCEs, and then Standard DCEs. While prior experience with accountable care, other APMs, or managed care may help DCEs implement their population management strategies more quickly, lower baseline spending may be an impediment to further decreases in spending without adequate time for DCEs to test and adjust implementation strategies.

In the first two years of the GPDC Model, we observed the following: 1) significant increases in gross Medicare spending for Standard DCEs, reflecting increases in the second year; 2) declines in gross spending for New Entrant DCEs that were not significant; and 3) significant declines in gross spending for High Needs DCEs in the second year. Net Medicare spending increased significantly for all three DCE types in the second year, reflecting significant net spending increases for Standard and New Entrant DCEs overall. About half of Standard DCEs and three-quarters of New Entrant DCEs had concordance between their financial results and the evaluation findings; however, shared savings payouts to DCEs exceeded their Medicare spending reductions relative to the comparison group in the evaluation, increasing net Medicare spending.

As noted earlier, financial calculations and the impact evaluation of Medicare spending differ in their purpose and methodology, which can lead to differences in findings. Financial calculations for determining shared savings reflect differences between DCEs' actual and benchmark Medicare spending in a PY—where the benchmark is a projection of their regional and/or historical spending before the model's start. The evaluation's impacts for understanding the GPDC Model's effects reflect differences between DCEs' actual and counterfactual Medicare spending absent the model in a PY, where the counterfactual is determined by comparing DCEs and a comparison group in their markets before and after the model's initiation. The evaluation's comparison group included Shared Savings Program ACOs and other APMs, as these reflected alternatives for DCEs absent this model, which may be attenuating estimated spending impacts given similar incentives. Additionally, there were differences in the BYs used across the financial calculations and evaluation; the latter used more recent BYs (2018–2021), including years coinciding with the COVID-19 PHE than the BYs used for the GPDC Model's financial benchmark (2017–2019). Lower spending in the evaluation baseline years than in the financial benchmarking baseline years may have also contributed to shared savings payouts that exceeded gross spending reductions.

Gross spending impacts varied for subgroups of Standard and New Entrant DCEs, reflecting key differences among organizations in the model. In particular, the majority of gross spending increases for Standards DCEs were from IDS/hospital system; in contrast, New Entrant DCEs comprising groups of primary care practices saw spending reductions. Unexpectedly, we found no clear association between DCEs' gross Medicare spending impacts and their elections of higher risk and capitation, which might be due to other factors that affected DCEs' elections of risk and capitation, such as their prior experience, the commitment and leadership support of value-based care, and their confidence in forecasting shared savings/losses. Our findings highlight the importance of continuing to examine differences across subgroups of DCEs based on organizational structures and functions, markets, providers, and beneficiaries.

In the following chapter, we present findings to show how spending, utilization, and quality of care changed in ambulatory care, hospital-based acute care, and other care settings for each type of DCE.

Chapter 4: Standard DCEs Improved Quality But Increased Spending, While New Entrants Improved Ambulatory Care, and High Needs DCEs Reduced Utilization in High-Cost Settings

Key Findings

Model-Wide Population Health Management Approaches

- DCEs shared priorities to reduce avoidable utilization, implement robust care management approaches and bolster primary care through increased touchpoints between providers and beneficiaries or investing in capacity. Fewer DCEs gave high priority to investing in behavioral health capacity and in initiatives to encourage referral to high-quality or Preferred Providers, to reduce low-value care, or to address beneficiaries' social needs.
- DCEs provided a range of practice supports to engage their Participant Providers and improve quality including centralized population health support staff, staff embedded in practices, and supports to expand access to care.

Resource Use for Standard DCEs

- Almost all Standard DCEs noted high priorities that included reducing avoidable utilization and managing complex care.
- As of PY2022 (cumulatively), spending increased for professional services—physician, non-physician, and ancillary services, including tests, imaging, ambulance services, and Part B drugs administered in physician offices—and for specialty care visits. Because Standard DCEs already had lower spending levels in the BYs, it may take time for Standard DCEs to outperform historical spending patterns; we would expect an initial increase in spending, followed by decreased spending over time
- For Standard DCEs, there was significantly improved quality of care in the ambulatory care setting—including a decline in avoidable hospitalizations—relative to the comparison group. Changes in quality of care likely reflected past and current investments in population health management, expected to yield improvement over time.
- Standard DCEs had smaller declines relative to their comparison group for acute care spending and utilization. This finding may reflect the fact that Standard DCEs included all IDS/hospital system DCEs in the model; such organizations may have had less incentive to directly reduce acute inpatient care.
- Standard DCEs reduced home health spending and episodes and had an unexpected decline in hospice utilization despite an increasing trend in the use of advance care planning.

Key Findings

Resource Use for New Entrant DCEs

- New Entrant DCEs prioritized primary care touchpoints (for example, increasing annual wellness visits [AWVs]) and had more room for improvement in primary care compared with Standard DCEs. New Entrants also prioritized reducing avoidable utilization. They reduced spending for specialty care visits and ED visits and observation stays, relative to the comparison group. New Entrants increased diabetes-recommended care, but improvements in other quality of care measures failed to reach statistical significance, which may reflect the smaller size of the aligned beneficiary population.
- As of PY2022 (cumulatively), New Entrant DCEs did not see significant impacts in acute or post-acute care settings.
- Like Standard DCEs, New Entrants saw an unexpected decline in hospice utilization, despite an increased rate of advance care planning over time for their beneficiaries.

Resource Use for High Needs DCEs

- All High Needs DCEs gave high priority to complex care management and to initiatives to reduce avoidable utilization. In line with these investments, they reduced ED visits and observation stays, as well as spending on specialty care visits and outpatient facilities relative to their comparison group. There were no significant improvements in quality of care.
- In PY2022, High Needs DCEs reduced acute care spending, utilization, and readmissions relative to the comparison group, reflecting their priorities for reducing avoidable inpatient hospitalizations and data analytics for improved care.
- High Needs DCEs had declines in skilled nursing facility (SNF) spending and in number of SNF days, as well as an increase in hospice spending, consistent with their efforts to improve advanced illness management through palliative care.

In this chapter, we provide an overview of DCEs' population health management priorities and approaches in PY2022 and present findings by specific care settings for the model's impacts in the first two years on spending, utilization, and quality of care. Results are organized by DCE type—Standard, New Entrant, and High Needs. Specifically, this chapter explores the following research questions:

- **Implementation:** What types of transformation activities did ACOs undertake? Did activities vary by ACO type?
- **Utilization:** Did utilization patterns change under the model relative to a comparison group by ACO type? Did utilization and spending outcomes vary by setting?
- **Quality:** Did beneficiaries' quality of care improve relative to a comparison group?

Appendix J provides supplemental exhibits that support the summary discussion presented in this chapter.

At the time of this report, qualitative research was underway with DCEs and their providers to understand implementation priorities and strategies, as well as their assessment of the model's success in improving care delivery and beneficiary outcomes. Future reports will use a mixed methods approach (comparative case analysis) to identify pathways through which DCEs' characteristics and implementation approaches influenced outcomes.

Methods Overview

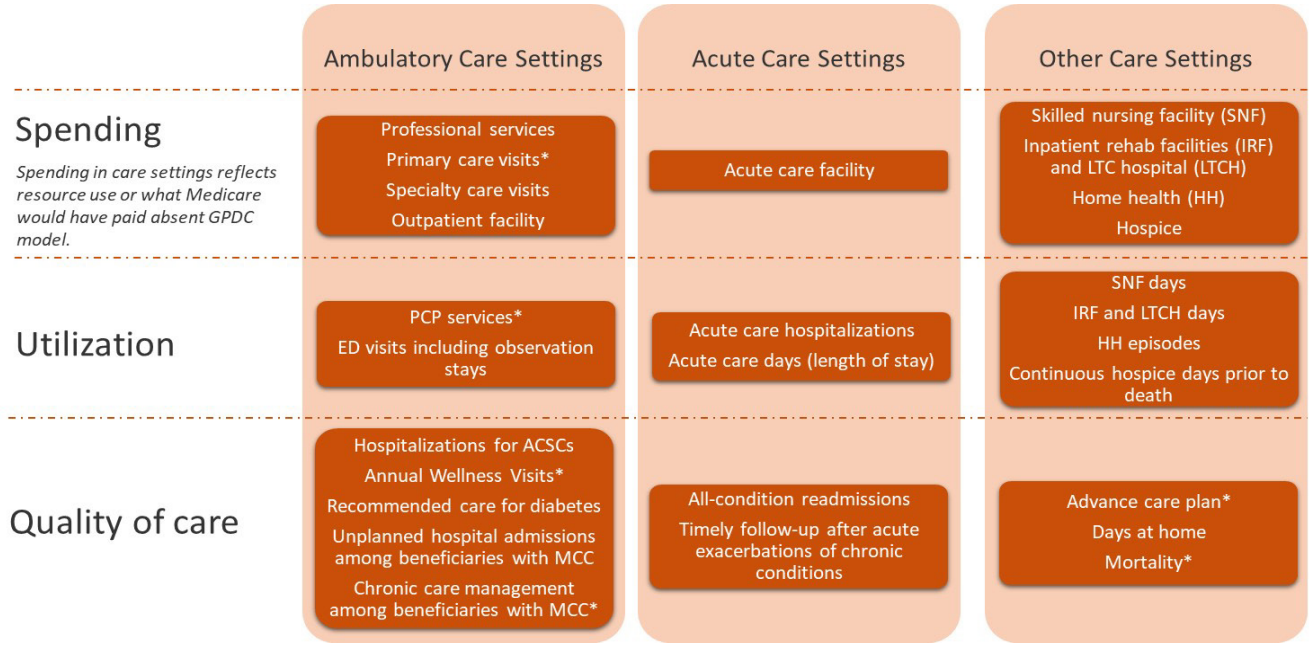
To examine participating DCEs' population health priorities and activities, we drew on the 2022 Pulse Check Survey of all participating DCEs. **Appendix D** provides the survey instrument and more detail on survey methods.

We conducted an impact analysis of Medicare spending, utilization, and quality of care outcomes for Standard, New Entrant, and High Needs DCEs across the following care settings: ambulatory care, including professional and outpatient facility; acute care (hospital-based care and related to care coordination); and other settings spanning post-acute care (PAC), home health, and hospice. **Exhibit 4.1** provides an overview of the measures.[18] Spending in care settings reflects resource use or what Medicare would have paid absent the GPDC Model, in contrast to total gross spending, which reflects what Medicare actually paid, including capitation. For Standard and New Entrant DCEs, in addition to presenting cumulative impact estimates as of PY2022 (to reflect impacts through the first two years of the model), we also present impact estimates for PY2022 alone.[19] As noted earlier in the report, for High Needs DCEs, we only present impact estimates for PY2022; small sample sizes in PY2021 meant that High Needs could not be evaluated in that year.

[18] **Chapter 3** provides additional detail on the impact analysis approach. **Appendix F** provides more information on the data sources used in the quantitative analyses, **Appendix G** provides specifications for the variables and outcomes used in the quantitative analyses, and **Appendix H** details our analytic methodology.

[19] Appendix J provides detailed findings for spending, utilization, and quality of care (including impact estimates for PY2021) for Standard and New Entrant DCEs.

Exhibit 4.1. Measures Spanned Ambulatory Care, Acute Care, and Other Care Settings



NOTE: *Measure is considered a secondary measure and not included in impact analyses, because trends in baseline years were expected to differ for DCE and comparison groups rendering impacts uninterpretable. Instead, trends over time for the measure were examined for the GPDC group. ACSC=ambulatory care-sensitive hospitalization; ED=emergency department; LTCH=long-term care; MCC=multiple chronic conditions; PCP=primary care provider.

Exhibit 4.2 presents the hypotheses we aimed to address for spending, utilization, and quality of care, by care setting or outcome. Later in the chapter, we present the hypothesized direction of impact for each outcome measure alongside their impacts, by DCE type.

Exhibit 4.2. Hypotheses Related to Medicare Utilization and Quality of Care

Domain	Hypothesis
Ambulatory care settings	**Spending on professional services and specialty care may initially increase** while DCEs increase access to care and engage beneficiaries in chronic disease management. Over time, spending may decrease as DCEs expand access to care through non-physicians (for example, care coordinators) and providers outside of regular office hours. Beneficiaries aligned to DCE providers may have **lower outpatient spending and fewer emergency department visits** as DCEs improve primary care and population management. We expect **improvements in beneficiaries' quality of care over time**, particularly for outcomes tied to the model's financial incentives, as DCEs become financially responsible for improving quality of care, care coordination, and disease management for aligned beneficiaries.

Domain	Hypothesis
Acute care hospital settings	DCEs would apply their population management approaches to keep high-risk beneficiaries out of hospitals, resulting in **fewer acute care hospitalizations and shorter acute care lengths of stay** for aligned beneficiaries. We expect **improvements in beneficiaries' quality of care over time**, particularly for outcomes tied to the model's financial incentives, as DCEs become financially responsible for improving quality of care, care coordination, and disease management for aligned beneficiaries. Beneficiaries aligned to High Needs DCEs would be higher users of acute care, compared with the general beneficiary populations aligned to New Entrant and Standard DCEs; for this reason, **High Needs DCEs might be more likely to see improvements in acute care spending, utilization, and quality of care for their beneficiary populations**.
Other settings	DCEs may establish partnerships with SNFs to **reduce SNF spending and lengths of stay**, and aligned beneficiaries may have **fewer days in intensive post-acute care settings** as DCEs shift beneficiaries toward less resource-intensive care settings such as SNFs or the home. DCEs may foster **appropriate use of home health and hospice services** by reducing waste and encouraging more appropriate alternatives to higher-cost institutional settings. It is possible that service use could increase or decrease, depending on each individual DCE's care delivery strategy, such as use of the unique model waivers in this setting, to address beneficiaries' health needs.

NOTES: DCE=Direct Contracting Entity; SNF=skilled nursing facility.

Model-Wide Population Health Management Strategies

Our conceptual framework (**Exhibit 1.1**) illustrates a process to understand model implementation—including care transformation, population management, health information technology (IT) and data analytics, and provider and community partnerships—in the context of market, organizational, provider, and beneficiary characteristics, as well as model features selected. In this section, we use data from the 2022 Pulse Check Survey to describe DCEs' implementation priorities, investments, and initiatives.[20]

[20] **Appendix D** provides the complete results of the 2022 Pulse Check Survey.

Priority Strategies and Practice Supports

On entering the model, DCEs' initial priorities may have indicated how they planned to direct their resources and, as a result, where changes in utilization and spending would be most likely to be observed. The GPDC Model does not prescribe a uniform approach to care delivery transformation that all DCEs should implement. As such, DCEs have the flexibility to pursue implementation efforts informed by their and their providers' resources, capacity, and prior experience in delivering value-based care.

In general, we find that DCEs share priorities around reducing avoidable utilization, implementing robust care management and bolstering primary care through increased touchpoints between providers and beneficiaries or through investing in capacity. In the 2022 Pulse Check Survey, nearly all (95%) DCEs described **efforts to reduce avoidable inpatient, emergency department, or PAC utilization** as a high priority strategy for their DCE, and over three-quarters of DCEs gave high priority to **complex care management or population-specific care management programs** (88%) or **emphasis on primary care touchpoints** such as AWVs **(**85%). **Exhibit 4.3** highlights the top strategies for managing population health.

Examples of DCEs' priority strategies and practice supports

- **Evidence-based protocols** for high-need and high-acuity patients with **chronic conditions** (such as chronic heart failure, chronic obstructive pulmonary disease [COPD], chronic kidney disease, diabetes) to **meet treatment goals and to reduce hospitalizations**
- **Interdisciplinary care teams,** including care navigators or managers, clinical pharmacists, social workers, and other clinical and non-clinical providers
- **Comprehensive assessments and screenings** (for example, for depression, addiction, cancer)
- **Medication management programs**
- Outreach for **transitional care management and robust referral network** with PAC providers, community-based organizations, home health providers, and other providers
- Proprietary analytics and systems for **population health management** and **predictive modeling**

Other approaches were less common across DCEs. Approximately half of DCEs indicated as high priority strategies **investments in primary care capacity** (for example, non-physician providers and after-hours care; 55%); **initiatives to address beneficiaries' social needs** (for example, food insecurity, housing, and transportation; 49%); and **initiatives to reduce low-value care** (46%).

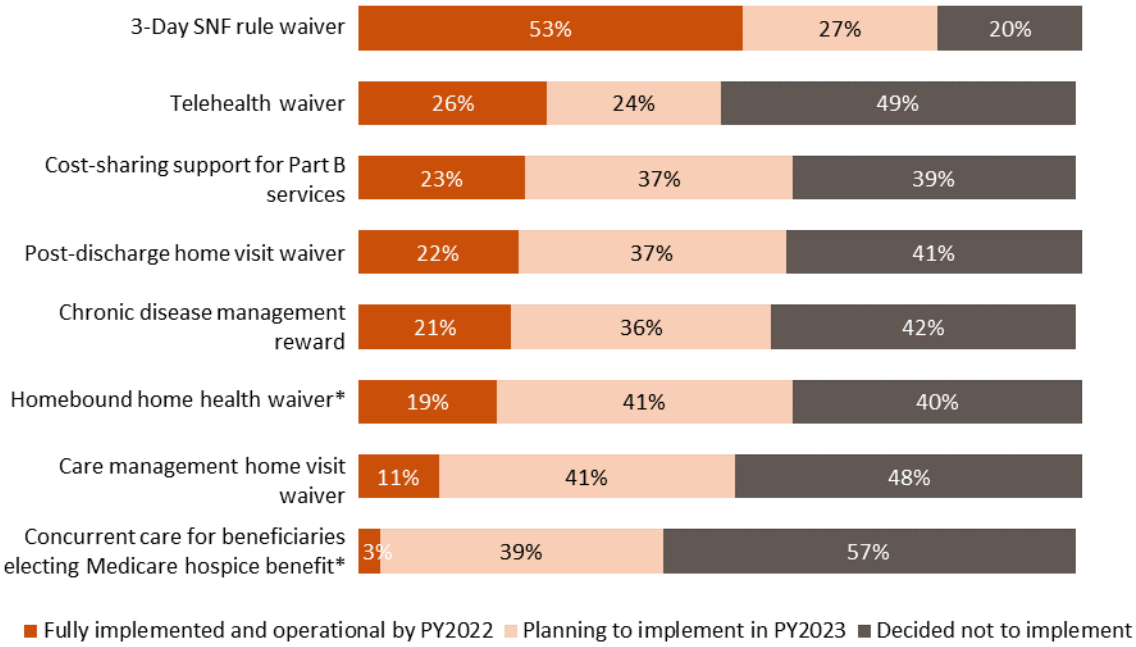
Exhibit 4.3. Highest Priorities for Model Implementation Included Complex Care Management or Population-Specific Care and Initiatives to Reduce Avoidable Utilization

Additionally, DCEs reported offering a range of practice supports to engage Participant Providers, to improve quality, and to extend access to care. Most frequently, DCEs indicated that they offered, funded, and provided **centralized population health support staff** (for example, care managers, pharmacists, schedulers/ administrators; 87%). These staff members were especially common among Standard DCEs, with 93% offering such supports, compared to 62% of their New Entrant and 71% of their High Needs counterparts. Almost three-quarters (72%) of all DCEs reported providing or arranging for **staff embedded in practices** (for example, administrative staff, care managers, health educators/coaches, or social workers), which was also more common among Standard DCEs than among New Entrants. About half of all DCEs indicated that they offered, funded, and supported **extended or weekend hours for practices** or **urgent or extended care** (51% each), with these types of supports more common among High Needs DCEs (86%) than among other DCE types.

Implementation of Benefit Enhancements and Beneficiary Engagement Incentives

As discussed in **Chapter 1**, DCEs had the option to implement several benefit enhancements and beneficiary engagement incentives aimed at expanding service delivery flexibility; specifically, the enhancements and incentives were intended to help DCEs prevent hospitalizations, increase access to services, and manage and coordinate care for beneficiaries. In the 2022 Pulse Check Survey, DCEs indicated that they had implemented or intended to implement a range of benefit enhancements and beneficiary engagement incentives. The **three-day SNF rule waiver** (53%) was most often reported as fully operational by the end of PY2022, followed by the **telehealth expansion waiver** (26%), **Part B cost-sharing support** (23%), and the **chronic disease management reward** (gift card; 21%). DCEs reported intentions to implement additional enhancements and incentives in PY2023 (**Exhibit 4.4**).

Exhibit 4.4. At the End of PY2022, the 3-Day SNF Rule Waiver Was the Most Widely Implemented Benefit Enhancement



SOURCE: 2022 GPDC Pulse Check Survey (n=95 DCEs).
NOTES: * Benefit enhancements that were new for GPDC and not available under the Next Generation ACO Model. Fully implemented and operational by PY2022 includes those who said the benefit enhancement/beneficiary engagement incentive was "Fully implemented and operational in PY2021" or "Fully implemented and operational in PY2022." Values may not sum to 100%, as not all respondents answered every question in the series.

Standard DCEs: Unfavorable Spending Increases in Ambulatory and Acute Care Settings While Improving Quality

This section presents impact findings—on spending, utilization, and quality of care—for Standard DCEs, by care settings.

Ambulatory Care

Both cumulatively (as of PY2022) and in PY2022 alone, **spending for professional services**—all physician, non-physician, and ancillary services, including tests, imaging, ambulance services, Part B drugs administered in physician offices—and **specialty care visits** increased for both Standard DCE and comparison beneficiaries relative to average baseline spending, but the increase was larger for Standard DCE beneficiaries (**Exhibit 4.5**). Specifically, through the first two years of the model, we estimated an increase of 1.2% for professional services spending and 1.4% for specialty care spending, with similar results in each year alone (**Appendix Exhibit J.1**). Results were in line with our hypothesis that it may take time for Standard DCEs to outperform historically lower spending patterns (see **Exhibit 3.2** where Standard DCEs had low baseline levels of spending). In other words, we expect initial increases in spending followed by decreases as the model evolves for Standard DCEs.

Additionally, as shown in **Appendix Exhibits J.3 and J.4,** PCP services, and spending on primary care visits for Standard DCE beneficiaries generally rose over time, which may have contributed to the findings on ambulatory care spending. In the Pulse Check survey, most (85%) Standard DCEs also noted an emphasis on primary care touchpoints as a high priority.

Although the model is hypothesized to lower **outpatient facility spending and ED visits**, we did not see statistically significant differences in these outcomes between Standard DCEs and the comparison group (**Exhibit 4.5**). This is despite the finding from the Pulse Check Survey that the vast majority of Standard DCEs (similar to the other two types) highly prioritized population health initiatives aimed at reducing avoidable utilization. However, they were not as focused on initiatives to reduce low-value care, which only 44% of Standard DCEs reported as a high priority.

For Standard DCEs, as of PY2022, the Model Was Associated With:

- Increased **spending** on professional services, specialty visits, and acute care but reduced spending on home health.
- Increased **utilization** of acute care but reduced use of home health. Unexpectedly, the model reduced hospice utilization, although use of advanced care planning has been trending higher over time for Standard DCE beneficiaries.
- Higher **quality of care** by increasing the use of diabetes-recommended care and decreasing ambulatory care-sensitive condition (ACSC) hospitalizations and unplanned hospitalizations for beneficiaries with multiple chronic conditions (MCCs).

Both cumulatively (as of PY2022) and in PY2022 alone, Standard DCEs significantly improved **quality of care**, including increasing the use of **diabetes-recommended care**, decreasing **ACSC hospitalizations**, and decreasing **unplanned hospitalizations for beneficiaries with multiple chronic conditions (MCCs)**, relative to the comparison group (**Exhibit 4.5**). For example, cumulatively as of PY2022, Standard DCEs had a statistically significant reduction in **hospitalizations for ACSCs** (1.8%) and in **unplanned hospitalizations among beneficiaries with MCCs** (1.3%) relative to the comparison group. Improvements in quality of care were also seen in greater utilization of **diabetes-recommended care** among Standard DCE beneficiaries, relative to the comparison group (by 0.7%). Observed improvements are consistent with findings from the Pulse Check Survey, in which most DCEs (and especially Standard DCEs) prioritized population health strategies related to care coordination and disease management. Findings may also reflect observed favorable trends for AWVs over time for Standard DCE beneficiaries (**Appendix Exhibit J.5**) and in chronic care management activities for beneficiaries with MCCs (**Appendix Exhibit J.6**). Improved quality of ambulatory care by Standard DCEs may reflect both past and current investments in this area, as such improvements usually take time to be fully realized.

Exhibit 4.5. As of PY2022, Standard DCEs Increased Ambulatory Care Spending and Quality of Care

Measure Category	Impact As of PY2022				Impact In PY2022			
Measure (Hypothesized Direction of Impact)	% Impact	Impact Estimate (90% CI)	BYs to PY(s) Change		% Impact	Impact Estimate (90% CI)	BY to PY Change	
			GPDC	Comp.			GPDC	Comp.
Professional Services, Primary and Specialty Care Visits								
Professional services spending (↓)	1.1	$32.85*** ($22.73, $42.96)	↑	↑	1.2	$35.81*** ($24.73, $46.89)	↑	↑
Specialty care visits spending (↓)	1.4	$2.66*** ($2.16, $3.16)	↑	↑	1.4	$2.65*** ($2.11, $3.18)	↑	↑
Outpatient/ED Facility								
Outpatient facility spending (↓)	0.0009	$0.02 (-$9.92, $9.96)	↑	↑	0.2	$4.37 (-$6.66, $15.39)	↑	↑
ED visits and observation stays (↓)	-0.2	-0.9 (-2.3, 0.5)	↑	↑	-0.05	-0.2 (-1.7, 1.3)	↑	↑
Quality of Care								
Hospitalizations for ACSCs (↓)	-1.8	-0.3*** (-0.5, -0.1)	↓	↓	-1.5	-0.3** (-0.5, -0.05)	↓	↓
Recommended care for diabetes (↑)	0.7	2.7*** (1.3, 4.1)	↑	↑	0.6	2.3** (0.7, 3.9)	↑	↑
Unplanned hospital admissions among beneficiaries with MCCs (↓)	-1.3	-2.8*** (-4.3, -1.3)	↓	↓	-1.2	-2.7*** (-4.4, -1.1)	↓	↓

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: ACSC=ambulatory care-sensitive conditions; ED=emergency department; MCC=multiple chronic conditions. Spending estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY). Utilization and quality estimates and CI are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). **Estimated percentage impact** is the difference-in-differences (DID) estimate relative to expected outcome for GPDC beneficiaries in PY2022 had the model not existed and had the beneficiaries' outcomes continued along the same trajectory since baseline. Arrows in the "Measure" column represent the hypothesized direction of change.
The professional services spending measure includes all physician, non-physician, and ancillary services (for example, tests, imaging, ambulance services, Part B drugs administered in physician offices). The specialty care visits spending measure includes paid evaluation and management (E&M) services for specialty care practitioners. The recommended care for diabetes measure was calculated for beneficiaries with diabetes. The unplanned hospitalization among beneficiaries with MCC measure was calculated for beneficiaries with at least two of eight chronic conditions: acute myocardial infarction, Alzheimer's disease and related disorders or senile dementia, atrial fibrillation, chronic kidney disease, chronic obstructive pulmonary disease (COPD) or asthma, depression, heart failure, and stroke and transient ischemic attack (TIA). Unplanned hospital admissions among beneficiaries with MCCs is a GPDC quality measure used to calculate benchmark in final financial results reconciliation for Standard DCEs. It was a pay-for-reporting (P4R) and pay-for-performance (P4P) measure in both PY2021 and PY2022 and will be a P4P measure only starting from PY2023.
Impact estimates significant at p<0.1*, p<0.05**, p<0.01***.

Acute Care

As of PY2022, **acute care hospital spending** decreased for both Standard DCE beneficiaries and for the comparison group, relative to average baseline spending (**Exhibit 4.6**). However, the spending decrease was smaller for Standard DCE beneficiaries, leading to the observed positive percentage impact of 1.2%. A similar pattern for acute care hospital spending was seen for PY2022 alone. With respect to **acute care utilization**, both cumulatively and in PY2022, the number of acute care hospitalizations (as well as the average length of stay) fell for both Standard DCE and comparison beneficiaries; however, the decline was smaller for Standard DCE beneficiaries than for the comparison group.

According to our hypothesis, participating DCEs would show reductions in acute care utilization and spending, reflecting care management strategies that prioritized resource efficiency, preventive primary care, and clinical decision support tools and data. While most Standard DCEs gave high priority to primary care touchpoints (85%) and initiatives to reduce avoidable utilization (95%), other strategies were less frequently described as high priority, namely, investments in primary care capacity (55%) and initiatives to reduce low-value care (46%). Also, while all DCE types gave high priority to efforts to reduce avoidable utilization, we did not see improved outcomes from such efforts uniformly across DCE types. These unexpected findings may be explained in part by the fact that 28% (n=22) of the 78 Standard DCEs were led by an IDS/hospital system. IDS/hospital systems may have had less incentive to directly reduce delivery of acute inpatient care and forgo potential revenue, despite the high priority given to reducing avoidable inpatient utilization. Additionally, cumulative impacts of the model on acute care spending and utilization for Standard DCEs (relative to the comparison group) reflected increases in PY2022, likely reflecting the 2022 cohort who were ramping up model implementation; Standard DCEs had relative decreases in spending and utilization in PY2021.

Results for **quality of care measures** in the acute care setting were not statistically significant for Standard DCEs.

Exhibit 4.6. As of PY2022, Standard DCEs Increased Acute Care Spending and Utilization

Measure Category	Impact As of PY2022				Impact in PY2022			
Measure (Hypothesized Direction of Impact)	% Impact	Impact Estimate (90% CI)	Bys to PY(s) Change GPDC	Bys to PY(s) Change Comp.	% Impact	Impact Estimate (90% CI)	BY to PY Change GPDC	BY to PY Change Comp.
Acute Care Hospital Spending and Utilization								
Acute care facility spending (↓)	1.2	$38.72*** ($19.88, $57.56)	↓	↓	1.6	$55.36*** ($34.67, $76.05)	↓	↓
Acute care hospitalizations (↓)	0.5	1.0* (0.1, 1.8)	↓	↓	0.8	1.6*** (0.6, 2.5)	↓	↓
Acute care length of stay (days) (↓)	0.7	9.3** (1.8, 16.9)	↓	↓	0.9	11.6** (3.4, 19.8)	↑	↓
Acute Care Hospital Quality of Care								
All-condition readmissions (↓)	0.4	0.6 (-1.1, 2.3)	↑	↑	0.7	1.1 (-0.8, 2.9)	↑	↑
Timely follow-up after exacerbations of chronic conditions (↑)	0.2	1.8 (-1.4, 5.0)	↓	↓	0.2	1.4 (-2.1, 4.9)	↓	↓

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: Spending estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY). Utilization and quality estimates and CI are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). **Estimated percentage impact** is the difference-in-differences (DID) estimate relative to expected outcome for GPDC beneficiaries in PY2022 had the model not existed and had the beneficiaries' outcomes continued along the same trajectory since baseline. Arrows in the "Measure" column represent the hypothesized direction of change.

The all-condition readmissions measure was calculated for beneficiaries with at least one acute care hospitalization. The timely follow-up measure was calculated for beneficiaries with one or more acute events related to one of six chronic conditions: hypertension, asthma, heart failure, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and diabetes. Both quality measures are GPDC quality measures used to calculate benchmark in final financial reconciliation for Standard DCEs. All-condition readmission was a pay-for-reporting (P4R) and pay-for-performance (P4P) measure in both PY2021 and 2022. Timely follow-up after exacerbations of chronic conditions was a P4R measure in PY2022. Both measures will be P4P measures only starting from PY2023.

Impact estimates significant at p<0.1*, p<0.05**, p<0.01***.

Other Care Settings

Both cumulatively and in PY2022 alone, PAC spending and utilization—in SNF and inpatient rehabilitation facilities (IRF)/long-term care hospitals (LTCH)—were not statistically different between Standard DCEs and the comparison group (**Exhibit 4.7**). These findings were unexpected, given that the vast majority of Standard DCEs (96%) noted reducing post-acute care utilization as a high priority. In PY2022, Standard DCEs saw limited uptake of benefit enhancement waivers to support such initiatives; many implemented the SNF 3-day waiver (59%), but fewer implemented the post-discharge home visit (23%), home health for homebound (20%), and care management home visit (11%) waivers.

In the home health setting, through the first two years of the model, decreases in spending and utilization were larger for Standard DCE beneficiaries than for comparison beneficiaries (1.1% for home health spending and 1.1% for home health episodes). Findings were similar for PY2022 alone and in PY2021 as well: Standard DCEs had reductions in home health spending and utilization (**Appendix Exhibit J.9**).

Cumulatively (as of PY2022), spending for hospice care fell for both Standard DCEs and the comparison group, but the decline was 1.9% greater in the comparison group. Results were similar in PY2022. Standard DCEs had a decline in hospice utilization (as measured by the number of continuous days of hospice) relative to the comparison group both as of PY2022 (3.7%) and in PY2022 alone (4.5%). This finding was unexpected, given an increase over time in advance care planning for Standard DCE beneficiaries (**Appendix Exhibit J.11**).

Exhibit 4.7. As of PY2022, Standard DCEs Decreased Home Health Spending and Utilization and Increased Hospice Spending

Measure Category	Impact As of PY2022 (Cumulative)				Impact in PY2022			
Measure (Hypothesized Direction of Change)	% Impact	Impact Estimate (90% CI)	BYs to PY(s) Change		% Impact	Impact Estimate (90% CI)	BY to PY Change	
			GPDC	Comp.			GPDC	Comp.
Post-Acute Care								
SNF spending (↓)	-0.3	-$2.88 (-$11.38, $5.63)	↑	↑	0.02	$0.15 (-$9.25, $9.55)	↑	↑
SNF days (↓)	-0.3	-4.1 (-18.5, 10.2)	↓	↓	-0.01	-0.2 (-15.9, 15.5)	↑	↑
IRF and LTCH spending (↓)	1.4	$5.31 (-$1.09, $11.72)	↑	↑	2.2	$8.62** ($1.63, $15.60)	↑	↑
IRF and LTCH days (↓)	1.4	2.9 (-0.6, 6.4)	↓	↓	2.1	4.4* (0.6, 8.2)	↑	↓
Home Health								
HH spending (↓)	-1.1	-$6.87*** (-$10.20, -$3.53)	↓	↓	-0.9	-$5.54** (-$9.21, -$1.86)	↓	↓
HH episodes (↓)	-1.1	-3.4*** (-5.1, -1.6)	↓	↓	-0.8	-2.4** (-4.4, -0.5)	↓	↓
Hospice								
Hospice spending (↑)	1.9	$7.93** ($2.61, $13.26)	↓	↓	1.8	$7.69** ($1.93, $13.45)	↓	↓
Continuous hospice days prior to death (↑)	-3.7	-0.9*** (-1.3, - 0.5)	↓	↑	-4.5	-1.1*** (-1.5, 0.7)	↓	↑

Measure Category	Impact As of PY2022 (Cumulative)				Impact in PY2022			
Measure (Hypothesized Direction of Change)	% Impact	Impact Estimate (90% CI)	BYs to PY(s) Change		% Impact	Impact Estimate (90% CI)	BY to PY Change	
			GPDC	Comp.			GPDC	Comp.
Other Quality Measures								
Percent days at home (↑)	0.03	0.03 (-0.01, 0.07)	↓	↓	0.02	0.02 (-0.02, 0.07)	↓	↓

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: HH=home health; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital; SNF=skilled nursing facility.
Spending estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY). Utilization and quality estimates (except for "percent healthy days at home" and "continuous hospice days prior to death") and CI are presented as rate of the outcome per 1,000 beneficiaries per year (BPY).
Estimated percentage impact is the difference-in-differences (DID) estimate relative to expected outcome for GPDC beneficiaries in PY2022 had the model not existed and had the beneficiaries' outcomes continued along the same trajectory since baseline. Arrows in the "Measure" column represent the hypothesized direction of change.

Impact estimates significant at p<0.1*, p<0.05**, p<0.01***.

New Entrant DCEs: Favorable Reductions in Specialty Care Spending and ED Visits While Increasing Recommended Diabetes Care

This section presents impact findings—including spending, utilization, and quality of care—for New Entrant DCEs for all care settings.

Ambulatory Care

Cumulatively (as of PY2022), **spending for specialty care visits** increased for both New Entrant DCEs and the comparison group, but the increase was smaller for the New Entrant DCEs (**Exhibit 4.8**), leading to the observed decrease of 1.6% in specialty care spending. While the impact estimate for **professional services spending** was also negative (as expected), it did not reach statistical significance. Similar findings were seen for PY2022 alone.

For New Entrant DCEs, as of PY2022, the Model Was Associated With:

- Reduced **spending** on specialty visits.
- Decreased **utilization** of ED visits and observation stays (perhaps in part from greater priority placed by this DCE type on primary care-focused strategies, as survey findings showed). Unexpectedly, the model reduced hospice utilization; however, for this DCE type, descriptive trends in the use of advanced care planning showed a rise over time.
- Improvements in **quality of care** by increasing the use of diabetes-recommended care.

Results for **outpatient facility spending** were not statistically significant for New Entrant DCEs. However, as of PY2022 (and in PY2022 alone), we observed a larger reduction in **ED visits and observation stays** for New Entrant DCE beneficiaries than for the comparison group (**Exhibit 4.8**); over the first two years of the model, New Entrant DCEs had a reduction of 2.9% in ED visits (translating to 11.4 per 1,000 BPY). Reductions in ED visits and observation stays for New Entrant DCEs were consistent with corresponding reductions also seen in PY2021 (**Appendix Exhibit J.2**). Findings from the 2022 Pulse Check Survey revealed that New Entrant DCEs prioritized primary care-focused strategies, which may help explain the observed reduction in ED visits, although similar prioritization by Standard DCEs did not appear to result in lower ED utilization for that DCE type.

As of PY2022, New Entrant DCEs had greater utilization of **diabetes-recommended care** relative to the comparison group (increase of 3.7%; **Exhibit 4.8**). No other statistically significant impacts were seen for quality of care measures. While limited improvements in quality were observed for this DCE type, the direction of impact for all measures was as hypothesized, implying that the model did not have detrimental effects on care quality. Further, New Entrant DCEs were also trending in the hypothesized direction on other quality measures that we explored descriptively. For example, **Appendix Exhibit J.5** shows a rising trend in AWVs for this population (which is consistent with 92% of New Entrant DCEs placing a high priority on primary care touchpoints); the limited impacts on quality may have reflected the smaller size of the New Entrant DCE beneficiary population.

Exhibit 4.8. As of PY2022, New Entrant DCEs Decreased Ambulatory Care Spending and Utilization, With Limited Improvements in Quality of Care

Measure Category	Impact As of PY2022				Impact in PY2022			
			BYs to PY(s) Change				BY to PY Change	
Measure (Hypothesized Direction of Impact)	% Impact	Impact Estimate (90% CI)	GPDC	Comp.	% Impact	Impact Estimate (90% CI)	GPDC	Comp.
Professional Services, Primary and Specialty Care Visits								
Professional services spending (⬇)	-0.2	-$8.15 (-$63.72, $47.41)	⬆	⬆	-0.3	-$8.90 (-$91.59, $73.80)	⬆	⬆
Specialty care visits spending (⬇)	-1.6	-$3.32** (-$5.99, -$0.64)	⬆	⬆	-3.3	-$6.74*** (-$10.64, -$2.84)	⬆	⬆
Outpatient Facility and ED								
Outpatient facility spending (⬇)	-1.7	-$30.66 (-$75.11, $13.79)	⬆	⬆	-1.5	-$28.42 (-$100.33, -$43.48)	⬆	⬆
ED visits and observation stays (⬇)	-2.9	-11.4*** (-18.6, -4.1)	⬇	⬇	-3.2	-12.3** (-22.4, -2.1)	⬇	⬇
Quality of Care								
Hospitalizations for ACSCs (⬇)	-0.5	-0.1 (-1.2, 1.0)	⬇	⬇	-6.1	-1.2 (-2.9, 0.4)	⬇	⬇
Recommended care for diabetes (⬆)	3.7	13.3*** (6.3, 20.4)	⬆	⬆	5.2	19.0*** (8.1, 29.9)	⬆	⬆
Unplanned hospital admissions among beneficiaries with MCCs (⬇)	-2.8	-6.3 (-14.2, 1.7)	⬇	⬇	1.7	3.9 (-9.0, 16.7)	⬇	⬇

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: ACSC=ambulatory care-sensitive conditions; ED=emergency department; MCC=multiple chronic conditions. Spending estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY). Utilization and quality estimates and CI are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). **Estimated percentage impact** is the difference-in-differences (DID) estimate relative to expected outcome for GPDC beneficiaries in PY2022 had the model not existed and had the beneficiaries' outcomes continued along the same trajectory since baseline. Arrows in the "Measure" column represent the hypothesized direction of change.

The professional services spending measure includes all physician, non-physician, and ancillary services (for example, tests, imaging, ambulance services, Part B drugs administered in physician offices). The specialty care visits spending measure includes paid evaluation and management (E&M) services for specialty care practitioners. The recommended care for diabetes measure was calculated for beneficiaries with diabetes. The unplanned hospitalization among beneficiaries with MCC measure was calculated for beneficiaries with at least two of eight chronic conditions: acute myocardial infarction, Alzheimer's disease and related disorders or senile dementia, atrial fibrillation, chronic kidney disease, chronic obstructive pulmonary disease (COPD) or asthma, depression, heart failure, and stroke and transient ischemic attack (TIA). Unplanned hospital admissions among beneficiaries with MCCs is a GPDC quality measure used to calculate benchmark in final financial results reconciliation for New Entrant DCEs. It was a pay-for-reporting (P4R) measure in both PY2021 and PY2022 and will be a pay-for-performance (P4P) measure starting from PY2023.

Impact estimates significant at p<0.1*, p<0.05**, p<0.01***.

Acute Care

Results were not statistically significant for any acute care measure (spending, utilization, or quality of care) for New Entrant DCEs as of PY2022 (**Exhibit 4.9**). However, most outcomes were trending in the hypothesized direction between the PY and BYs for beneficiaries attributed to New Entrant DCEs. Additionally, the impact estimates for acute care spending and timely follow-up were in the expected direction but did not reach statistical significance. We hypothesize that because all New Entrant DCEs are either network of individual practices or group practices they may have lesser control over where their beneficiaries go after hospital discharge, thereby limiting their ability to influence rates of readmissions or spending & utilization for PAC.

Exhibit 4.9. As of PY2022, New Entrant DCEs Did Not Have Significant Impacts in the Acute Care Setting

Measure Category	Impact As of PY2022				Impact in PY2022			
Measure (Hypothesized Direction of Impact)	% Impact	Impact Estimate (90% CI)	BYs to PY(s) Change		% Impact	Impact Estimate (90% CI)	BY to PY Change	
			GPDC	Comp.			GPDC	Comp.
Acute Care Hospital Spending and Utilization								
Acute care facility spending (↓)	-0.7	-$23.98 (-$117.71, $69.74)	↓	↓	0.6	$20.02 (-$130.13, $170.16)	↓	↓
Acute care hospitalizations (↓)	0.05	0.1 (-4.5, 4.7)	↓	↓	1.2	2.5 (-4.2, 9.1)	↓	↓
Acute care length of stay (days) (↓)	1.3	17.0 (-19.8, 53.7)	↓	↓	2.4	31.0 (-25.1, 87.1)	↑	↓
Acute Care Hospital Quality of Care								
All-condition readmissions (↓)	-0.5	-0.8 (-9.6, 8.0)	↑	↑	-1.8	-3.0 (-16.3, 10.2)	↑	↑
Timely follow-up after exacerbations of chronic conditions (↑)	1.1	9.1 (-6.2, 24.3)	↑	↓	1.3	10.7 (-12.0, 33.4)	↑	↓

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: Spending estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY). Utilization and quality estimates and CI are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). Estimated percentage impact is the difference-in-differences (DID) estimate relative to expected outcome for GPDC beneficiaries in PY2022 had the model not existed and had the beneficiaries' outcomes continued along the same trajectory since baseline. The all-condition readmissions measure was calculated for beneficiaries with at least one acute care hospitalization. The timely follow-up measure was calculated for beneficiaries with one or more acute events related to one of six chronic conditions: hypertension, asthma, heart failure, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and diabetes. Both quality measures are GPDC quality measures used to calculate benchmark in final financial reconciliation for New Entrant DCEs. All-condition readmission was a pay-for-reporting (P4R) and pay-for-performance (P4P) measure in both PY2021 and 2022. Timely follow-up after exacerbations of chronic conditions was a P4R measure in PY2022. Both measures will be P4P measures only starting from PY2023. Arrows in the "Measure" column represent the hypothesized direction of change. Impact estimates significant at p<0.1*, p<0.05**, p<0.01***.

Other Care Settings

As of PY2022, there was no significant difference in changes between the New Entrant DCEs and comparison group for most outcomes in the **PAC and home health** settings; however, the sign of the impact estimate was in the hypothesized direction for many outcomes (**Exhibit 4.10**). Increases in IRF & LTCH spending and utilization for New Entrants stem from their limited influence on PAC placement for their beneficiaries. After these DCEs implement their strategies to manage care transitions including coordination with hospitals and PACs- they may be able to move the needle on IRF & LTCH spending and utilization in the hypothesized direction. Cumulatively

(as of PY2022), New Entrant DCEs showed a significant decrease in hospice days (11.9%) relative to the comparison group, counter to our hypothesis; at the same time, New Entrant DCEs increased use of advance care planning over time for their beneficiaries (**Appendix Exhibit J.11**).

Exhibit 4.10. As of PY2022, New Entrant DCEs Unexpectedly Decreased Hospice Days

Measure Category	Impact As of PY2022				Impact in PY2022			
Measure (Hypothesized Direction of Change)	% Impact	Impact Estimate (90% CI)	BYs to PY(s) Change		% Impact	Impact Estimate (90% CI)	BY to PY Change	
			GPDC	Comp.			GPDC	Comp.
Post-Acute Care								
SNF spending (↓)	-1.8	-$16.43 (-$59.89, $27.03)	↓	↑	1.1	$11.12 (-$59.47, $81.71)	↑	↑
SNF days (↓)	-1.7	-26.1 (-97.7, 45.6)	↓	↓	0.02	0.3 (-109.7, 110.3)	↓	↓
IRF and LTCH spending (↓)	12.6	$48.41 (-$15.75, $112.56)	↑	↓	13.2	$56.34 (-$65.12, $177.81)	↑	↑
IRF and LTCH days (↓)	8.1	15.3 (-2.0, 32.5)	↓	↓	9.2	18.0 (-10.6, 46.5)	↑	↓
Home Health								
HH spending (↓)	-0.6	-$3.67 (-$20.83, $13.49)	↓	↓	-5.8	-$36.69** (-$62.36, -$11.01)	↓	↓
HH episodes (↓)	0.2	0.6 (-7.8, 9.1)	↓	↓	-5.3	-16.1** (-28.2, -4.0)	↓	↓
Hospice								
Hospice spending (↑)	-1.0	-$5.38 (-$38.49, $27.72)	↓	↓	1.8	$8.95 (-$38.15, $56.06)	↓	↓
Continuous hospice days prior to death (↑)	-11.9	-3.9** (-7.1, -0.7)	↓	↑	-9.8	-2.9 (-6.5, 0.7)	↓	↑
Other Quality Measures								
Percent days at home (↑)	0.05	0.04 (-0.2, 0.3)	↑	↓	-0.04	-0.04 (-0.4, 0.3)	↓	↓

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: HH=home health; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital; SNF=skilled nursing facility. Spending estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY). Utilization and quality estimates (except for "percent healthy days at home" and "continuous hospice days prior to death") and CI are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). **Estimated percentage impact** is the difference-in-differences (DID) estimate relative to expected outcome for GPDC beneficiaries in PY2022 had the model not existed and had the beneficiaries' outcomes continued along the same trajectory since baseline. Arrows in the "Measure" column represent the hypothesized direction of change. Impact estimates significant at p<0.1*, p<0.05**, p<0.01***.

High Needs DCEs: Favorable Reductions in Ambulatory, Acute, and Post-Acute Care Utilization and Spending

This section presents impact findings—spending, utilization, and quality of care—for High Needs DCEs in PY2022 for all care settings. PY2022 is the first model year in which the High Needs DCEs could be evaluated. We expected High Needs DCEs to be able to show larger reductions in spending and utilization across multiple care settings because the population they serve are sicker. This is consistent with findings from the Next Generation ACO model evaluation wherein reductions were greater for beneficiaries with multiple chronic conditions. [xvi]

Ambulatory Care

In PY2022, **spending on specialty care visits** increased for both High Needs DCE and comparison beneficiaries relative to average baseline spending, but the increase was smaller for High Needs DCE beneficiaries (**Exhibit 4.11**), reflecting a decrease (as expected) of 8.9% for specialty care spending.

The model also resulted in decreased **ED visits and observation stays** for High Needs DCEs (by 5.0%). As seen in **Exhibit 4.11**, in PY2022, ED visits and observation stays went up for both beneficiary groups, but the increase was smaller for High Needs DCE beneficiaries. Spending in outpatient facilities also went down for High Needs DCEs (by 14.4%). The Pulse Check Survey results revealed that 71% of High Needs DCEs indicated that investments in primary care capacity were a high priority, with 85% reported offering, funding, or otherwise supporting extended or weekend hours for practices and urgent or extended care to Participant Providers in their practices. This emphasis on enhancing access to care may have contributed to the model's (expected) favorable impacts for High Needs DCE beneficiaries on multiple measures related to ambulatory care utilization and spending.

For High Needs DCEs, in PY2022, the Model resulted in:

- Reduced spending on specialty visits, in outpatient facilities, on acute care, and in SNF facilities.
- Decreased utilization of ED visits and observation stays, as well as acute care hospitalizations. Survey findings showed that most High Needs DCEs (5 of 7) indicated primary care investments as a high priority. Additionally, all High Needs DCEs said that initiatives to reduce avoidable utilization were a high priority, as well as initiatives for complex care management.
- Some improvements in quality of care by decreasing ACSC hospitalizations and all-condition readmissions.

Regarding **quality of care**, in PY2022 High Needs DCEs had no statistically significant differences for quality-of-care measures relative to the comparison group, although estimates were in the hypothesized direction. Despite the limited impacts of High Needs DCEs on quality measures, aligned beneficiaries saw an increasing trend in AWV. The increase in AWVs was consistent with the high priority that all High Needs DCEs placed on complex care management and that most (5 of 7) placed on primary care touchpoints and chronic care management for beneficiaries with MCC, as reported in the Pulse Check Survey. See **Appendix Exhibits J.5 and J.6**, respectively.

Exhibit 4.11. In PY2022, High Needs DCEs Decreased Ambulatory Care Spending and Utilization, With Limited Improvements in Quality of Care

Measure Category	Impact in PY2022			
			BY to PY Change	
Measure (Hypothesized Direction of Change)	% Impact	Impact Estimate (90% CI)	GPDC	Comp.
Professional Services, Primary and Specialty Care Visits				
Professional services spending (↓)	-3.9	-$210.99 (-$418.83, -$3.16)	↑	↑
Specialty care visits spending (↓)	-8.9	-$27.40* (-$47.20, -$7.61)	↑	↑
Outpatient Facility and ED				
Outpatient facility spending (↓)	-14.4	-$529.67*** (-$703.36, -$355.97)	↑	↑
ED visits and observation stays (↓)	-5.0	-0.04** (-0.07, -0.02)	↑	↑
Quality of Care				
Hospitalizations for ACSCs (↓)	-0.8	-0.8 (-5.5, 3.8)	↓	↓
Unplanned hospital admissions among beneficiaries with MCCs (↓)	-1.4	-4.6 (-0.02, 0.01)	↑	↓

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: ACSC=ambulatory care-sensitive conditions; ED=emergency department, MCC=multiple chronic conditions. Spending estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY). Utilization and quality estimates and CI are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). **Estimated percentage impact** is the difference-in-differences (DID) estimate relative to expected outcome for GPDC beneficiaries in PY2022 had the model not existed and had the beneficiaries' outcomes continued along the same trajectory since baseline. Arrows in the "Measure" column represent the hypothesized direction of change.
The professional services spending measure includes all physician, non-physician, and ancillary services (for example, tests, imaging, ambulance services, Part B drugs administered in physician offices). The specialty care visits spending measure includes paid evaluation and management (E&M) services for specialty care practitioners. The unplanned hospitalization among beneficiaries with MCC measure was calculated for beneficiaries with at least two of eight chronic conditions: acute myocardial infarction, Alzheimer's disease and related disorders or senile dementia, atrial fibrillation, chronic kidney disease, chronic obstructive pulmonary disease (COPD) or asthma, depression, heart failure, and stroke and transient ischemic attack (TIA). Unplanned hospital admissions among beneficiaries with MCCs is a GPDC quality measure used to calculate benchmark in final financial results reconciliation for High Needs DCEs. It was a pay-for-reporting (P4R) and pay-for-performance (P4P) measure in both PY2021 and PY2022 and will be a pay-for-performance (P4P) measure starting from PY2023.
Impact estimates significant at p<0.1*, p<0.05**, p<0.01***.

Acute Care

In PY2022, High Needs DCEs reduced **acute care spending** by 6.6% relative to the comparison group (**Exhibit 4.12**). The model also saw a decrease in **acute care hospitalizations** (6.1%) and **lengths of stay in acute care facilities** (7.7%) for High Needs DCE beneficiaries. The Pulse Check Survey showed that High Needs DCEs prioritized initiatives to reduce avoidable inpatient utilization and leveraged data analytics such as the generation of real-time data on admissions, discharges, and transfers, which may have contributed to the favorable reductions in utilization. However, similar prioritization by Standard DCEs did not appear to have translated similarly into improvements in utilization; the finding may be explained by lower baseline rates of hospitalizations and acute care spending among beneficiaries.

Regarding quality of care in acute care settings, High Needs DCEs had no statistically significant differences relative to the comparison group, although estimates were in the hypothesized direction.

Exhibit 4.12. In PY2022, High Needs DCEs Decreased Acute Care Spending and Utilization, With Limited Improvements in Quality of Care

Measure Category	Impact in PY2022			
			BYs to PY Change	
Measure (Hypothesized Direction of Change)	% Impact	Impact Estimate (90% CI)	GPDC	Comp.
Acute Care Hospital Spending and Utilization				
Acute care facility spending (↓)	-6.6	-$733.87** (-$1,190.56, -$277.17)	↓	↑
Acute care hospitalizations (↓)	-6.1	-43.7** (-0.07, -0.02)	↓	↓
Acute care length of stay (days) (↓)	-7.7	-404.3** (-0.6, -0.2)	↓	↓
Acute Care Hospital Quality of Care				
All-condition readmissions (↓)	-5.0	-11.7 (-24.0, 0.5)	↓	↓
Timely follow-up after exacerbations of chronic conditions (↑)	3.0	19.6 (-0.03, 0.07)	↑	↑

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: Spending estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY). Utilization and quality estimates and CI are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). **Estimated percentage impact** is the difference-in-differences (DID) estimate relative to expected outcome for GPDC beneficiaries in PY2022 had the model not existed and had the beneficiaries' outcomes continued along the same trajectory since baseline. Arrows in the "Measure" column represent the hypothesized direction of change.
The all-condition readmissions measure was calculated for beneficiaries with at least one acute care hospitalization. The timely follow-up measure was calculated for beneficiaries with one or more acute events related to one of six chronic conditions: hypertension, asthma, heart failure, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and diabetes. All-condition readmissions is a quality measure used to calculate benchmark in final financial results reconciliation for High Needs DCEs. It was a pay-for-report (P4R) and pay-for-performance (P4P) measure in both PY2021 and PY2022, and will be a P4P measure only starting from PY2023.
Impact estimates significant at p<0.1*, p<0.05**, p<0.01***.

Other Care Settings

For High Needs DCEs, we found significant changes in two PAC outcomes: SNF spending and SNF days (**Exhibit 4.13**). As expected, **spending in SNF facilities** decreased by 10.2% while **SNF days** decreased by 12.3% for High Needs DCE beneficiaries relative to the comparison group in PY2022. In addition, findings on **hospice spending** were, as expected, favorable for High Needs beneficiaries; spending increased by 17.5% in PY2022, consistent with DCE efforts to improve advanced illness management and to focus on timely palliative care through their provider partnerships. High Needs DCEs consistently increased the use of advance care planning over time; see **Appendix Exhibit J.11**.

Exhibit 4.13. In PY2022, High Needs DCEs Decreased SNF Spending and SNF Days and Increased Hospice Spending

Measure Category	Impact in PY2022			
Measure (Hypothesized Direction of Change)	% Impact	Impact Estimate (90% CI)	BY to PY Change GPDC	BY to PY Change Comp.
Post-Acute Care				
SNF spending (↓)	-10.2	-$690.90* (-$1209.25, $172.56)	↑	↑
SNF days (↓)	-12.3	-1467.8*** (-2235.2, -700.2)	↑	↑
IRF and LTCH spending (↓)	-1.8	-$40.03 (-$508.88, $428.81)	↑	↑
IRF and LTCH days (↓)	-9.6	-108.9 (-0.4, 0.1)	↓	↓
Home Health				
HH spending (↓)	-1.2	-$35.51 (-$191.21, $120.19)	↑	↑
HH episodes (↓)	-5.1	-73.6 (-0.2, 0.04)	↑	↑
Hospice				
Hospice spending (↑)	17.5	$386.56** ($186.59, $586.52)	↑	↓
Continuous hospice days prior to death (↑)	4.6	1.6 (-1.4, 4.5)	↑	↑
Other Quality Measures				
Percent days at home (↑)	0.7	0.01 (0.003, 0.01)	↑	↑

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: HH=home health; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital; SNF=skilled nursing facility. Spending estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY). Utilization and quality estimates (except for "percent healthy days at home" and "continuous hospice days prior to death") and CI are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). **Estimated percentage impact** is the difference-in-differences (DID) estimate relative to expected outcome for GPDC beneficiaries in PY2022 had the model not existed and had the beneficiaries' outcomes continued along the same trajectory since baseline. Arrows in the "Measure" column represent the hypothesized direction of change.
Days at home for patients with complex chronic conditions is a quality measure used to calculate benchmark in final financial results reconciliation for High Needs DCEs. It was a pay-for-report (P4R) and pay-for-performance (P4P) measure in both PY2021 and PY2022 and will be a P4P measure only starting from PY2023.
Impact estimates significant at p<0.1*, p<0.05**, p<0.01***.

Conclusion

In this chapter, we assessed whether the GPDC Model affected spending, utilization, and quality of care in distinct settings, including ambulatory care, acute care, PAC, home health, and hospice. Over the first two years of the model's implementation, there were varied impacts on these measures—depending on the DCE type considered—and not all observed changes were in the hypothesized direction.

In general, **Standard DCEs**, which comprised three-quarters of all participating DCEs, increased spending in many categories, such as acute care, professional services, and specialty visits. While spending increases ran counter to our hypotheses, it was not entirely surprising because it may take time for Standard DCEs to outperform their

lower baseline levels of spending. In particular, Standards DCEs that were IDS/hospital systems may have had less incentive to reduce delivery of acute inpatient care in the early years post-pandemic. Therefore, spending outcomes for Standard DCEs may follow an inverse U-shaped pattern over the first two years of the model, with spending in PY2022 on the rising part of the curve. Noteworthy for Standard DCEs is that, both cumulatively as of PY2022 and in PY2022 alone, quality of care improved significantly in the ambulatory care setting, for example, by increasing the use of diabetes-recommended care and decreasing ACSC hospitalizations. Improved quality of ambulatory care by Standard DCEs may reflect both their past (pre-GPDC) and current investments (during the first two performance years), as such improvements usually take time to be fully realized.

New Entrant DCEs were organized exclusively around physician practices, structured either as networks of individual practices or as medical group practices. For New Entrant DCEs, the first two years of the model saw few statistically significant impacts on outcomes across care settings. The DCEs had reductions in spending on specialty visits, ED visits, and observation stays, as well as limited improvements in quality of care (for example, an increase in the use of diabetes-recommended care). Such impacts likely reflected the smaller size of the New Entrant DCE beneficiary population, in turn a product of smaller provider networks. The findings for most outcomes moved in their hypothesized direction, with overall impacts modest in their estimated size and statistical significance.

Finally, the eight **High Needs DCEs** experienced favorable impacts in PY2022 across multiple measures of spending and utilization. The findings were consistent with the Pulse Check Survey, which showed that, of all DCE types, High Needs DCEs—nearly all of which were networks of individual practices—were highly likely to prioritize investments in primary care capacity, practice-level infrastructure, complex care management, and enhanced primary care. Beneficiaries assigned to High Needs DCEs had the highest spending levels in the BYs, affording these DCEs greater potential to reduce spending than Standard or New Entrant DCEs. Of note, compared with other DCE types, High Needs DCEs had the highest proportion of beneficiaries who were dually eligible for Medicare and Medicaid. The aligned beneficiary populations of High Needs DCEs were also a fraction of the size of those served by Standard DCEs, with the number of beneficiaries attributed to High Needs DCEs ranging from 200 to 1,250.

There were substantive differences between our approach to calculating total spending and the setting-specific spending measures; for this reason, we cannot draw direct comparisons between the two sets of results. The total spending measure represents what Medicare paid including beneficiary-level capitated payments under the GPDC Model, while the setting-specific spending measures represent what Medicare would have paid DCEs based on billed claims absent capitation across care settings. That said, gross spending increases for Standard DCEs largely reflected increases in spending for acute care and for professional services. These categories, along with outpatient facility spending, are the top three spending categories for Medicare beneficiaries in our evaluation. Additionally, the impacts on setting-specific spending can inform a clearer understanding of utilization changes under the model and how DCEs approached their care delivery transformation efforts.

Chapter 5: Beneficiaries Noted Positive Experience With Their Care But Were Not Familiar With the GPDC Model

Key Findings

Beneficiaries' Perceptions of Changes Related to GPDC Model Impacts

- **A sample of beneficiaries interviewed (n=26) found descriptions of care teams, care planning processes, and communication and follow-up from care teams to be generally positive**, with no changes in perceived quality of care related to the GPDC Model. Beneficiaries described longstanding relationships with their clinicians.
- As of PY2022, **beneficiaries did not perceive any *changes in care delivery* related to the GPDC Model.** More than half of all beneficiaries reported having had telehealth visits in the past two years, although most expressed a preference for in-person visits over telehealth. Few beneficiaries noted experience with home visits or remote monitoring of chronic conditions.

Beneficiaries' Perceptions of ACOs as a Care Delivery Model

- **Beneficiaries interviewed did not recognize the GPDC Model by name**; however, when provided a description of ACOs as a care delivery model, they described both benefits and drawbacks. Perceived benefits of ACOs included the ability to see more doctors without limitations, higher quality of care, and the possibility of lower costs. Concerns related to limited provider networks and to negative effects on quality.

In this chapter, we present findings from interviews with a sample of beneficiaries aligned to participating Standard, New Entrant, and High Needs DCEs. Beneficiary perspectives on experiences with DCE population health initiatives and related changes in provider behavior can help us understand the ways in which the GPDC Model may affect health care utilization and quality. Specifically, the interviews were conducted to answer the following research questions:

- Did the model improve quality of care as perceived by beneficiaries themselves?
- How did beneficiaries respond to changes in care delivery stemming from the model's incentives (financial and quality incentives and benefit enhancements)?
- How did beneficiaries experience the option of voluntary alignment?

Methods Overview

Between October 2022 and January 2023, we conducted 30-minute, semi-structured phone interviews with 26 beneficiaries who were aligned to a DCE in PY2021, had a chronic condition and thus would benefit from care management, and had enough physician visits to be able to speak in detail about their care experiences. See **Appendix K** for a detailed description of our sampling and recruitment approach and analytic methods.

Interview questions focused on measuring beneficiary familiarity with the GPDC Model and ACOs; in addition, the interviews examined beneficiaries' perceptions of the model's impact on quality of care; communication with care teams; beneficiary involvement in care planning processes; and changes in care delivery through telehealth, remote patient monitoring, and home visits. We analyzed the collected responses overall and by DCE type, alignment mode, dual eligibility status, and demographic characteristics.

We identified several limitations of the sampling and recruitment for the beneficiary interviews, including: sample size; voluntary participation; recruitment overlap with open enrollment; health care system disruptions resulting from the Covid-19 PHE; recent changes in beneficiaries' providers; and lack of knowledge about whether beneficiaries were aligned continuously since PY2021. **Appendix K** includes additional details regarding limitations.

Findings

The 26 beneficiaries we interviewed had generally positive impressions of their care experiences. Beneficiaries noted few changes to their care experiences since the inception of the GPDC Model, and changes that the beneficiaries did observe could not necessarily be attributed to the model (for example, increased use of telehealth during the COVID-19 PHE).

Did the Model Improve Beneficiaries' Perceptions of Quality of Care?

We identified three broad themes in the interview data on quality of care, related to: 1) consistency of the beneficiary's care team; 2) care planning processes and beneficiary involvement; and 3) communication.

Consistency of Care Team

The Medicare beneficiaries we interviewed—whom we selected because they had a chronic condition and thus higher-than-average use of health care services—shared their experiences receiving care from their usual care providers. Nearly all of these beneficiaries had a practitioner whom they saw consistently for their regular care and who was familiar with them and their health situation. Beneficiaries were generally able to schedule PCP appointments at a time of their choosing.

Care Planning Processes and Beneficiary Involvement

Nearly all of the beneficiaries we interviewed noted that their health care providers spoke with them regularly about managing their chronic conditions, with six mentioning that they regularly received written instructions from their practitioners. In addition, nine beneficiaries felt that their practitioners considered their personal preferences during care planning. For example, one noted feeling comfortable discussing their care options with their practitioner, *"If they say something that I don't particularly want to go along with, I'll tell them 'Let's do something else'."* In contrast, one beneficiary told us that her PCP did not talk with her about managing chronic pain, but rather referred her to a neurologist who did not consider her preferences when the treatment was ineffective. As she said, *"So, now they just left me out there hanging in the wind. They didn't tell me what to do next…I don't want them [injections for pain], they don't work."*

Four of the beneficiaries described specifically how their PCP coordinated care with other health care providers. For example, one mentioned how her doctor had coordinated with specialists, saying, "*She basically manages all the other doctors to make sure that nobody is…doing something that would impact what another doctor is doing."* By contrast, three beneficiaries described poor coordination among their health care providers. One of these three individuals mentioned that his PCP had referred him to a specialist outside of the health system where the PCP practiced. After several visits with the specialist, he returned to the PCP who did not have any information about the specialty care he had received.

DCEs Supported Primary Care Providers in Managing Care for Beneficiaries

In the 2022 Pulse Check Survey, 86% of DCEs reported providing or arranging for centralized population health support staff for Participant Providers, while 72% reported providing or arranging for staff who were embedded in practices. These staff included care managers, health educators/coaches, and social workers. Most DCEs (89%) also provided or arranged for investments in infrastructure at the practice level, including electronic health records, care delivery tools such as shared decision-making aids, and data analytic support.

Communication

Most interviewees felt positive about their communication with their health care providers. Three beneficiaries explained that they especially appreciated that their practitioner seemed concerned about them. Another two interviewees told us that their provider listened to them, and another two added that they appreciated that their health care providers got back to them quickly when they called with questions.

Two beneficiaries identified ways in which their providers could improve communication. One beneficiary wished that her health care provider had enough time to discuss all her concerns during a single visit. *"I may have a list of seven or eight things I want to ask her about, but it seems like more recently she's kind of locked me down to like three things because I know they allow so much time for a person."* Another interviewee, whose preferred language is Spanish, noted that not all of her health care providers speak Spanish, so she relies on bilingual ancillary staff members or her grandson to translate.

Most beneficiaries interviewed communicated with their health care providers between visits, with the beneficiaries (not practitioners) typically initiating communication between visits. However, two interviewees described situations in which a practitioner had contacted them between visits.

What Are Beneficiaries' Experiences with Voluntary Alignment and Perceptions of Accountable Care Models?

We asked beneficiaries about their familiarity with the GPDC Model and the factors most salient to voluntarily aligned beneficiaries in influencing their alignment decisions. Because interviewees were generally unaware of the GPDC Model or whether they were voluntarily aligned, we provided a description of ACOs during the interviews and asked their opinion of ACOs in general as a model for organizing health care services.

Beneficiaries Could Align Voluntarily With a DCE Through Medicare.gov or by Completing a Form Designating a Main Doctor or Source of Care

Three-quarters of Standard and New Entrant DCEs and all High Needs DCEs reported that they conducted activities to increase voluntary alignment. The activities included training front-line staff to answer questions and provide information, communicating with beneficiaries through mail or patient portal, conducting presentations, and partnering with community-based organizations.

Awareness of the GPDC Model

None of the beneficiaries we interviewed were aware of the GPDC Model. When asked, *"Have you heard of a Medicare program called Global and Professional Direct Contracting?,"* beneficiaries consistently replied, "*No*." Beneficiaries did not ask follow-up questions regarding the GPDC Model or volunteer any knowledge about other Medicare models.

Views on Selecting a Main Doctor

Beneficiaries may align voluntarily with a DCE by completing a form that designates a main doctor, provider, or place where they receive care.[21] Those who had designated a main doctor identified benefits and few drawbacks of the process. Among the 26 beneficiaries we interviewed, eight had voluntarily aligned by selecting a main doctor. The reported benefits of having a main doctor included the ability to contact that doctor's office with a concern and the doctor's familiarity with the beneficiary's conditions and history. Two beneficiaries mentioned seeing multiple specialists in addition to their PCP within one practice. A few beneficiaries who reported benefits also felt that there were no drawbacks to having a main doctor. However, two beneficiaries mentioned drawbacks related to communication: difficulty communicating with their primary doctor due to the increased use of technology and concerns about reaching a substitute if their main doctor was on vacation.

[21] See: https://www.cms.gov/priorities/innovation/files/x/dc-rfa.pdf

Perceived Benefits and Drawbacks of ACOs in General

Beneficiaries shared mixed opinions on ACOs as a care delivery model. When provided a description of ACOs, interviewees saw both benefits and drawbacks of ACO arrangements and were unsure how an ACO would ultimately affect their care.[22] Interviewees cited several perceived benefits of ACOs, including the ability to see more doctors without limitations, higher quality of care, and the possibility of lower costs. One interviewee explained how ACOs might improve access, saying, "*[Y]ou've got doctors that you can go to without a hassle. I mean, you got a doctor that's in a sort of group that you could go to that you don't have to go switching [health systems] for them*." Another beneficiary positively assessed the incentives ACOs provide: *"I think that rewarding physicians and physicians' groups for positive outcomes is a very good thing…."* Finally, one beneficiary suggested that ACOs' incentives could lead to *"better health outcomes."*

Beneficiaries also described a range of concerns about ACOs. A few beneficiaries thought ACOs might interfere with their freedom to choose their physicians and limit participation by doctors who have a genuine concern for their beneficiaries. One beneficiary explained, *"It's taken me a long time to put together this group of doctors that take care of my whole body…. I would just be concerned about can I keep all my doctors and would they be willing to stay with me if I was a part of this ACO?"* Another beneficiary noted, "*It sounds like a corporate plan to me. It doesn't sound like your doctors will be individuals. That would worry me a little bit."* Two respondents feared negative effects on quality of care if ACOs viewed cost reduction as a primary goal. The respondents, both former educators, drew parallels between ACO quality measures and teacher pay-for-performance systems that rely on student test scores and questioned whether ACO quality measures would assess quality fairly. One beneficiary suggested that ACOs sounded like health maintenance organizations (HMOs): "*That's kind of what it sounds like, like an HMO. And I am not a big fan of HMOs.*"

Subgroup Analyses

We assessed whether beneficiary subgroups reported differing care experiences, including beneficiary communication with physicians, awareness of the GPDC Model, use of telehealth services, and overall satisfaction with care. We considered DCE type, alignment type (voluntary or claims), Medicare-Medicaid dual eligibility, and beneficiary demographics. We found limited differences across subgroups among the small sample of 26 beneficiaries. **Appendix K** includes additional findings regarding differences in care experiences by beneficiary subgroup.

[22] Interviewers provided the following description of ACOs during interviews: "*Some Medicare doctors have chosen to join an Accountable Care Organization, or ACO. An ACO is a group of doctors, hospitals, and other providers who share responsibility for the cost, quality, and coordination of patients' care. The ACO gets paid more when quality scores improve and when it saves money overall. Medicare beneficiaries whose doctors are part of a Medicare ACO keep Original Medicare and can see any Medicare doctor they want, inside or outside the ACO.*"

Conclusion

Interviews with a sample of DCE-aligned beneficiaries (n=26) found no changes as of 2022 in their perceptions of quality of health care, provider communication, or overall beneficiary satisfaction since the model's implementation. Importantly, **beneficiaries did not recognize the GPDC Model by name and thus could not ascribe their ongoing experiences or the lack of perceived changes in quality to the model itself.** Beneficiaries positively described their care teams, care planning processes, and the communication and follow-up they received from their care teams. They also appreciated their longstanding relationships with practitioners. Over half of the beneficiaries we interviewed reported having had a telehealth visit in the previous two years, although most expressed a preference for in-person visits. By contrast, few beneficiaries had used home visits or remote monitoring of chronic conditions.

While beneficiaries did not recognize the GPDC Model by name, they did raise both potential benefits and drawbacks when provided with a description of ACOs as a care delivery model. Among the perceived benefits of ACOs were the ability to see more doctors without limitations, better quality of care, and the possibility of lower costs. However, other beneficiaries noted concerns related to limited provider networks and potential negative effects on quality.

Chapter 6: Lessons Learned from the GPDC Model

In the first two years of GPDC, most DCEs shared priorities around reducing avoidable utilization and bolstering primary care through increased touchpoints between providers and beneficiaries or investing in capacity. Standard and High Needs DCEs also emphasized implementing robust care management approaches. Although the three DCE types had similar areas of focus, we observed different impacts by DCE type: Standard DCEs saw gross Medicare spending increases, while New Entrant and High Needs DCEs saw gross spending reductions relative to their comparison groups. Once shared savings and losses were accounted for, net Medicare spending increased significantly across all three DCE types. All DCE types experienced some degree of favorable impacts of the model on health care utilization and quality of care, with the extent of impact varying by care setting.

Understanding Outcomes Requires Insight into the Participating Organizations

The GPDC Model established three types of DCEs that enabled Medicare ACO participation for providers with varied experience in Medicare FFS and that served distinct beneficiary populations with respect to size and clinical profile. Importantly, each DCE type had features and characteristics not dictated by the model and that provided context to understand the resources, capacity, and strategies available to DCEs for engaging providers and responding to GPDC incentives. For example, DCEs differed in their organizational structure (a feature that reflects how providers were integrated into the DCE) and in their lead organization type (whether or not provider-based). Such features and characteristics framed DCEs' potential paths to outcomes in the model, including where and when the DCEs could influence spending and quality and the levers available to achieve the goals of accountable care.

In the two years of GPDC, Standard DCEs increased gross Medicare spending by a small but statistically significant 0.8%. Standard DCEs were the predominant DCE type and had the largest numbers of providers, many with considerable Medicare FFS experience and experience participating in other Medicare ACO programs. Most Standard DCEs were led by MSOs or health systems and were positioned to provide hands-on support, resources, and in some cases, control over their providers' care delivery processes. Standard DCEs generally focused on centralized population health support, complex care management, and referral to high-quality providers.

Standard DCEs increased spending for professional services and specialty care visits; an overall decrease in acute care spending was less than decreased spending seen for the comparison group. At the same time, Standard DCEs improved quality of care in the ambulatory care setting, including through decreased avoidable hospitalizations. This finding may reflect both past and current investments in this area, as such improvements usually take time. Notably, the only DCEs in GPDC that were IDS/hospital systems were Standard DCEs. The presence of IDS/hospital systems, coupled with providers' experience in FFS and Medicare ACOs, specifically suggests that Standard DCEs may have encountered a longer, more nuanced trajectory than other DCEs as they

worked to outperform their own historical spending patterns and to achieve changes in large spending categories such as acute care; such work would be both challenging in the short term and consistent with findings from the NGACO Model evaluation. In addition, IDS/hospital systems may have been challenged to reduce spending in acute hospital settings because of conflicting incentives. Many also elected the lower risk, Professional option and PCC, which is surprising as they should have been well-positioned for Global risk and TCC.

New Entrant DCEs reduced gross cumulative Medicare spending by 1.4%, but this reduction was not statistically significant. New Entrant DCEs had lower threshold requirements for the number of aligned beneficiaries served and for this reason were smaller than Standard DCEs. New Entrant providers were also less likely to have experience with Medicare FFS. As networks of individual practices or medical group practices, New Entrant DCEs were primarily physician practice organizations led either by the practices themselves or by primary care companies. New Entrant DCEs comprised a small segment of GPDC's participating organizations; DCEs that started as New Entrants became Standard DCEs as their number of aligned beneficiaries grew.

New Entrant DCEs prioritized primary care-focused strategies such as increasing AWVs. They reduced specialty care visits, ED visits, and observation stays. They significantly increased diabetes-recommended care and saw improvements (reductions) in avoidable hospitalizations, suggesting that their performance was headed in the hypothesized direction—even if not statistically significant—over their two years of GPDC participation. Similarly, most acute care outcomes (spending, utilization, and quality) were in the hypothesized direction.

In PY2022, the first year in which High Needs DCEs could be evaluated, the DCEs significantly reduced gross Medicare spending by 3.5%. High Needs DCEs were the smallest of the DCE types, and their aligned beneficiaries had complex clinical and social needs. Providers for High Needs DCEs had experience in Medicare APMs but were less likely to have had experience in Medicare FFS. In PY2022, High Needs DCEs comprised networks of individual practices led by MSOs or physician practices. The network structure suggests that financial and administrative incentives would be effective ways to facilitate value-based care among providers dispersed across multiple practices, in contrast with incentives (whether policies, practices, or management resources) that would exert more leverage for more highly integrated structures such as medical group practices and IDS/hospital systems. For High Needs DCEs, the complexity of beneficiaries' needs suggests many opportunities to improve the cost effectiveness and quality of care.

High Needs DCEs prioritized investments in primary care capacity, practice-level infrastructure, complex care management, and enhanced primary care, including behavioral health and extended hours. They reduced ED visits and observation stays, as well as spending on specialty care visits and outpatient facilities. They had no notable improvements in quality of care in the ambulatory care setting. In the acute care setting, High Needs DCEs prioritized initiatives to reduce avoidable inpatient hospitalizations and data analytics for improved care and reduced acute care spending, utilization, and readmissions. Consistent with their efforts to improve advanced illness management through palliative care, High Needs DCEs saw declines in SNF spending and increases in hospice spending.

High Needs and New Entrant DCEs may have had more opportunities to achieve early reductions in gross spending, compared with Standard DCEs that entered the model with prior accountable care experience and lower spending at baseline.

As of PY2022, 12 DCEs Exited the Model[23]

The evaluation team interviewed representatives from DCEs that exited the model to understand the experience of the DCEs that decided to exit the model before the transition and challenges that DCEs encountered with GPDC. See **Appendix L** for a summary of detailed organizational characteristics and interview findings.

Organizations Cited Multiple Reasons for Exiting the Model
DCE leadership gave one or more reasons for leaving the model, as follows:

- Unanticipated financial losses, representing millions of dollars
- Challenges meeting the minimum threshold of 5,000 aligned beneficiaries
- The GPDC model was not the right fit for their organization

Exiting DCEs Described Challenges in Model Operations
DCE leadership noted several administrative and operational difficulties related to GPDC participation. Respondents explained that no single issue motivated the decision to leave the model. Challenges included a lack of clear and timely communication around program requirements, shifts in benchmark adjustments that complicated financial forecasting, changes in patient attribution that complicated population health management, the volume and inaccuracy of CMS data and reports, and delayed or inaccurate claims payments. Some respondents indicated that they did not see additional value to their programs from benefit enhancements that came with the transition to ACO REACH (for example, in-home primary care) and expressed concern that these benefit enhancements could pose an administrative burden.

Individual DCEs Conveyed Positive Lessons Learned
Half of DCEs that exited GPDC planned to join the Medicare Shared Savings Program. For at least one-third of the exiting organizations, their departure reflected organizational consolidation into another accountable care entity rather than fully leaving CMS ACOs.

[23] In addition to the 12 DCEs that chose to exit the model, CMS terminated participation of six DCEs in PY2022.

Choices of Risk and Payment Mechanism Were Not Associated with Reductions in Spending

The DCEs themselves, regardless of type, tended to have APM experience. Many Standard and High Needs DCEs had experience in the Shared Savings Program, while New Entrant DCEs were more likely to have experience through MA or commercial plans. Despite differences in ACO-specific experience and other organizational traits, most DCEs elected GPDC's Global risk and PCC features, suggesting their confidence operating under higher risk as they gain experience in managing capitation. Most IDS/hospital system DCEs, on the other hand, elected Professional risk. High levels of risk and total capitation were not associated with spending reductions. Over time, we would expect DCEs that take on greater financial risk to generate more savings, while those taking on less risk would be slower to do so. Qualitative research planned for subsequent work in our evaluation will explore the ACO leaders' rationale for the risk and payment options they selected. Future reports will also assess whether spending, utilization, and quality of care impacts in specific care settings vary by risk and capitation elections.

Participant Providers Were Exposed to Little Downside Risk

GPDC has been the first ACO model to use capitation and to allow DCEs to enter separate payment arrangements with all their Participant Providers[24]; DCEs tended not to pass downside risk to their providers, instead using positive financial incentives such as bonuses, shared savings, and upfront payments. Most DCEs reported using multiple payment arrangements with their providers. FFS was mentioned by many but was not the sole approach. A small number of DCEs used only capitation with their providers. Further research is needed to understand payment arrangements between DCEs and their providers; in future reports, we will present findings from our monitoring of how payment arrangements with providers have changed during model implementation.

Limitations of the Evaluation to Date

There are limitations to interpreting our evaluation findings. Because the GPDC Model is voluntary, there may be unobserved selection effects related to participants' decisions to join or stay in GPDC and DCE risk and payment options. In addition, there may be unmeasured provider-level differences—for example, dynamics regarding leadership and provider motivation between GPDC and comparison groups—that contributed to outcomes. Our DID design accounts for differences between providers that do not change from baseline to performance years. Any differences between providers that do change (if related to their decisions to participate in the model) could influence subsequent outcomes in a manner not captured by our design. As of PY2022, the COVID-19 pandemic continued to influence practice patterns and individual care-seeking behavior. Our evaluation assumed that the COVID-19 pandemic's influence affected the GPDC and comparison groups in

[24] In the Next Generation ACO Model, ACOs electing All-Inclusive Population-Based Payment (AIPBP) directly paid providers with whom the ACO had written arrangements regarding AIPBP.

similar ways; both groups were balanced on key characteristics related to the pandemic at both the beneficiary and the area level.

Further, evaluation findings focus on the early years of implementation for many organizations, before the outputs of those efforts were likely yet to be fully realized for all DCEs. Information on DCEs' priorities and activities were drawn from comprehensive document review and a survey of all participating DCEs in PY2022. In some cases, we do not have survey data from DCEs that exited in PY2021, as participation in the survey was voluntary. Explanation of some quantitative findings can be drawn from interviews with ACO leaders and providers begun in PY2023 with DCE leaders and providers; the findings will be included in future reports.

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