ANNUAL REPORT 2: APPENDICES

July 2024

Evaluation of the Global and Professional Direct Contracting Model

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Appendix A: Provider Affiliation Types

The GPDC Model allowed for two possible types of affiliations for providers with Direct Contracting Entities (DCEs): Participant or Preferred Providers.

Participant Providers were individual practitioners and facilities to which DCE beneficiaries were directly aligned, either because the beneficiary has historically received the plurality of their primary care services from the DCE Participant Providers or has designated a DCE Participant Provider as their primary care provider. These providers were alignment-eligible individual practitioners or facilities or suppliers. Providers were only permitted to act as Participant Providers for one participating DCE. Beneficiaries were aligned to the DCE through the DCE Participant Providers and these providers and suppliers were responsible for reporting quality through the DCE and committing to beneficiary care improvement. During each performance year, DCEs and their DCE Participant Providers are prohibited from simultaneously participating in GPDC and the Medicare Shared Savings Program (Shared Savings Program), Next Generation ACO (NGACO) Model, Comprehensive ESRD Care (CEC) Model, Maryland Total Cost of Care (MD TCOC) Model, Vermont All-Payer ACO Model (VTAPM), Kidney Care Choices (KCC) Model, Primary Care First (PCF) Model, Comprehensive Primary Care Plus (CPC+) Model, Independence at Home (IAH) Demonstration, or any other Medicare initiative that involves shared savings. Participant Providers could include but were not limited to:

- Physicians or other practitioners in group practice arrangements
- Networks of individual practices of physicians or other practitioners
- Hospitals employing physicians or other practitioners
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Critical Access Hospitals (CAHs)

Preferred Providers, on the other hand, could operate both within the GPDC Model across one or more DCEs, as well as with Medicare ACOs participating in the previously mentioned risk-based initiatives, including the Shared Savings Program, with the exception of the MD TCOC Model. While DCEs were not required to have Preferred Providers, Preferred Providers enabled a DCE to extend its network by supplementing and complementing the types of care that Participant Providers delivered to its aligned beneficiaries. Preferred Providers could be individual practitioners or facilities affiliated with provider organizations. In addition to the types of providers that can be Participant Providers, Preferred Providers could include the following:

- Physicians or other practitioners in group practice arrangements
- Networks of individual practices of physicians or other practitioners
- Ambulatory surgery centers

- Acute and long-term care hospitals (LTCH)
- Skilled nursing facilities (SNFs)
- Home health agencies (HHAs)
- Hospices

Appendix B: Research Questions

Exhibit B.1 outlines the research questions examined in this report and the analytic methods used to address them. These research questions reflect the high-level priorities of the GPDC Model evaluation and provide an understanding of the model's impact on utilization, cost, and quality measures as well as DCEs' organizational characteristics and implementation approaches.

Exhibit B.1. Research Questions and Analytic Methods in Annual Report 2

Research Question	Analytic Methods
Utilization/Costs	
Did **utilization patterns change** under the model relative to a comparison group by **DCE type**? Did this vary by **capitation level**, **risk level or setting**?	• Descriptive analyses of claims-based utilization and spending measures • DID analysis of claims-based utilization and spending measures for all DCE types • DID for subgroups of DCEs based on capitation and risk level (Standard DCEs and New Entrant DCEs only) • Net savings analysis including CMS incentive payments to DCEs in performance years
Did the model result in **lower total Medicare spending** (Parts A and B) relative to a comparison group by DCE type? Did this vary by **capitation, risk level, setting, or individual DCEs**? Did the model **result in net savings** to Medicare?	
Quality of Care	
Did **beneficiaries' experience of care** improve, decline, or remain unchanged?	• Thematic analysis of beneficiary interviews
Did the model **improve quality of care** for **additional measures** (e.g., care coordination, mortality rates)?	• Descriptive analyses of claims-based quality of care measures • DID of claims-based measures for all DCE types
Implementation	
What are the **characteristics of DCEs**? Do DCEs differ by **organizational characteristics**, **capitation type, or risk level**?	• Descriptive analyses of data extracted from applications, programmatic data • Descriptive analysis of Pulse Check survey data
How did **DCEs respond** to **financial** and **quality incentives** and **BEs**?	
How did **DCEs implement the model**? What types of **transformation activities** did DCEs undertake? Did this **vary by DCE type**?	• Descriptive analysis of Pulse Check survey data
Did the **DCEs that exited the model** early have any **shared characteristics?**	• Descriptive analysis of data extracted from applications, programmatic data • Thematic analysis of interviews with DCEs exiting the model

NOTES: DCE=Direct Contracting Entity; DID=difference-in-differences; BE=benefit enhancements.

Appendix C: Content Analysis of DCE Applications and Model Documents

C.1: Methodology

Leveraging data from DCEs' model applications, the NORC team developed a series of measures on DCE characteristics and implementation approaches that systematically account for the complex nature and organization of DCEs. These measures were incorporated in cross-DCE analyses designed to examine variation in utilization and costs and implementation.

Applications and additional documentation. In calendar year (CY) 2020, DCEs applied to the model for PY2021 and 2022 in response to a request for applications.[1] The application included both categorical questions and open-ended questions. Toward the end of PY2022, 2021 and 2022 Starter DCEs continuing into PY2023 were asked to submit additional documentation, including an updated organization chart and ownership table. Our team conducted an additional review of these documents to better understand the structure of the DCEs and the types of organizations with ownership of and leadership roles in DCEs.

Model application document review. We systematically reviewed, extracted, and synthesized data from these applications and additional documents to understand DCE organizational characteristics. Employing a directed content approach,[2] we reviewed the applications and extracted data into a Microsoft Access database, which was then output into an Excel spreadsheet. Data extraction was performed using a document review tool that we developed based on the evaluation's conceptual framework (**Exhibit 1.5**), Consolidated Framework for Implementation Research (CFIR), and the evaluation team's subject matter expertise on how DCEs operate. **Exhibit C.1** provides a comprehensive overview of CFIR and conceptual framework domains and associated data elements derived from both primary and secondary qualitative and survey data sources, including the model applications. Prior to starting our systematic review of applications, we piloted and further refined the tool. The document review tool captured data on the following:

- **Structure:** DCEs' structural characteristics provided insight into the different resources and capacities that DCEs brought into the model, including: 1) types of organizations leading each DCE, the organizational structure of DCEs (for example, health systems, physician practices, or networks of providers), DCEs' relationship and affiliation with Participant Providers and Preferred Providers (for example, does the DCE directly employ providers), and other partnerships with vendors and community-based organizations; 2)

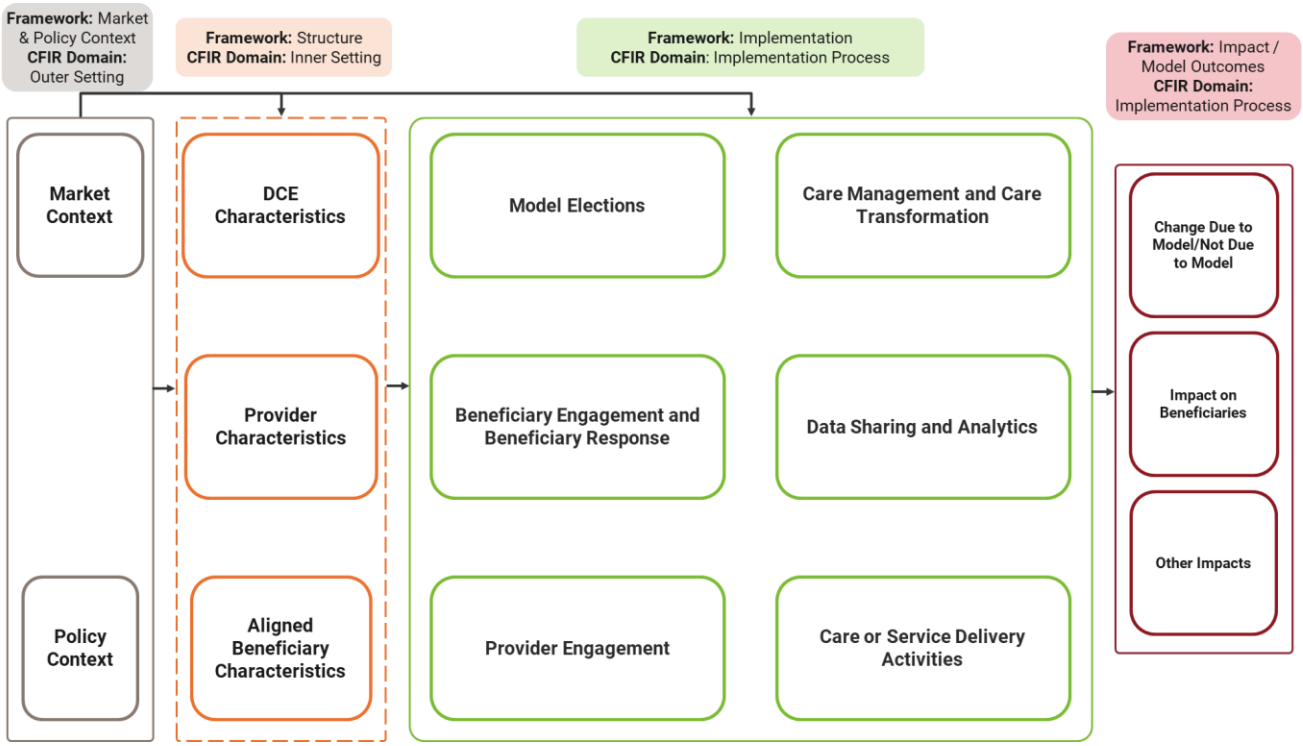
[1] The 2022 Starter DCEs include DCEs who applied in CY 2020 but chose to delay implementation of the model until PY2022 and seven DCEs who submitted an abbreviated application in CY 2021 to transition directly from the NGACO Model (which ended in CY 2021) to the GPDC Model in PY2022.

[2] Directed content approach is an approach that starts with an existing framework and uses data to support and/or build upon that framework. We leveraged the CFIR and our understanding of DCEs to develop our larger evaluation design. The evaluation design (informed by CFIR and our prior research on DCEs) was the framework that was the basis for our review.

prior experience in Innovation Center models and delegated risk contracts[3]; and 3) the use of existing and/or new infrastructure to support population health and care management activities, including health IT systems, data analytic technologies, risk stratification, quality measures, and staff.

- **Implementation:** DCEs' planned implementation approaches included planned care management activities and strategies (such as population health management with proprietary software and evidence-based guidelines, financial incentives tied to performance, beneficiary engagement tools like patient portals and shared decision-making processes, and training resources available to aligned providers) to engage Participant Providers and beneficiaries.

Exhibit C.1. Overview of CFIR and Conceptual Framework Domains with Associated Data Elements and Sources



NOTE: DCE=Direct Contracting Entity.

After the initial extraction of data from open-ended application questions, our team conducted additional qualitative syntheses with the raw application data to reveal common themes and relationships by domain. We also used an R program we developed to extract closed-ended numerical and categorical data from participant applications. Given that the application template had pre-defined categorical and numerical values from which applicants could select, we were able to extract these data uniformly and efficiently. To facilitate cross-DCE analysis, qualitative research analysts coded the string text into categories, as described in the following section, and maintained links to the source data, so that the detailed description remained intact and easily available to the analytic team.

[3] 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).

Data collected from DCE applications were used to develop an initial understanding of DCEs and their implementation plans in our first annual report. Additionally, these data and our initial understanding of the DCEs (and remaining unknowns) informed the development of our Pulse Check Survey conducted in PY2022 (more information on the survey instrument and results is available in **Appendix D**). Pulse Check Surveys and other data sources (like DCE websites and additional documentation) allowed us to verify and update this information—and resolved any missing or conflicting data. With each round of data collection, we updated time-varying data elements to capture how model implementation changed. In cases where data appeared to conflict, we employed different strategies to ensure that the data are accurate, including: deferring to information provided by DCE leadership in surveys and more recent additional documentation; triangulating data with additional sources; and adapting primary data collection efforts to verify or probe deeper when there are significant conflicts in the data.

DCE Functional Role. In addition to the metrics included in the report, the NORC team also developed a typology of the DCEs based on their relationships with aligned providers and their capacity to support, facilitate, and/or lead care delivery and population health management. While these metrics were not included in the main body of this report, additional analyses incorporating functional roles are available in **Appendices D, E, I, and L**. These functional role types include:

- **Convener**: DCE primarily serves to bring together disparate providers (individuals or practices) to participate in value-based payment arrangements. The DCE may be a joint association or equal partnership of completely independent physician practices or associations, or it may be an organization that provides a conduit for providers to be part of an expanded network and receive administrative, non-clinical support for value-based arrangements (for example, an MSO). These DCEs help reduce overhead and increase economies of scale/network for aligned Participant Providers, but Participant Providers retain clinical autonomy.
- **Enabler**: In addition to convening providers, the DCE provides infrastructure, capacity, and/or staff to build providers' capacity for care management, population health management, and value-based care delivery. Examples of services include gaps-in-care reports, embedded care management staff, proprietary analytic software or platforms, and access to third-party vendors or partners that provide analytic or care management support. These services go beyond administrative support (for example, filing and reimbursing claims) and model-related activities such as feedback reports on utilization/spending metrics, shared savings/losses calculations, and waiver implementation.
- **Direct Care Provider: The** DCE owns the care delivery assets and therefore directly controls where and how care is delivered and managed (for example, the settings, technology, software, platforms, processes, and staff). Direct Care Provider DCEs can also directly influence the implementation and scale of care models. Typically, the DCE is led by a physician practice or health system. Participant Providers may not have been decision-makers regarding participation the model, because Direct Care Provider DCEs are more likely to employ their Participant Providers.

Appendix D: Pulse Check Survey

This appendix presents background information and methodology for the 2022 Pulse Check Survey. The survey instrument used in 2022 is in **Appendices D.1**. **Appendix D.2.1** through **D.2.3** include selected tables displaying 2022 Pulse Check Survey results, with results presented by DCE type (**Appendix D.2.1**), organizational structure (**Appendix D.2.2**) and functional role (**Appendix D.2.3**). Tables include results of significance testing using chi-square and Fisher's exact tests of independence, where appropriate. Significance at certain threshold levels is indicated by asterisks.

The primary goal of the first Pulse Check Survey, an online questionnaire, was to gather data on the status and evolution of the model-related activities that DCEs identified in their applications. The 2022 survey focused on motivation to participate in the model and implementation efforts to date, specifically around beneficiary engagement and provider engagement activities. The survey was fielded to all DCEs that were active in the GPDC Model during performance year (PY) 2022. Participation in the survey was a requirement for currently active DCEs and optional for five DCEs who were involuntarily terminated during PY2022 prior to survey implementation. Respondents included all active DCEs that entered the model in either PY2021 or PY2022. This report focuses on responses for all DCEs participating in the model in PY2022.

- **Timing.** The survey launched on October 20, 2022, and closed on December 7, 2022.
- **Population.** The survey was fielded to all DCEs participating in the GPDC Model during PY2022 (required, n=94; optional, n=5[4]). The total number of respondents was 95 DCEs, representing all DCEs still participating in the GPDC Model at the time of survey fielding. Forty-nine 2021 DCEs and 46 2022 DCEs completed the survey.
- **Mode.** The online survey was fielded using Qualtrics. Each DCE received a unique link to the survey to enable tracking of DCE responses and follow-up with non-respondents. Respondents were able to exit and restart the survey where they left off.
- **Completion rates.** We received a completion rate of 100% from the 94 DCEs required to complete the survey, and one response from an optional respondent.
- **Instrument Development.** The survey was developed deductively by focusing on topics and research questions connected to two domains of the evaluation's conceptual framework—Model Features and Implementation Approaches. The survey questions were organized into three sections and addressed topics listed in **Exhibit D.1**.

[4] The survey was optional for 5 DCEs because they had either left the model or had plans to leave the model.

Exhibit D.1. Pulse Check Survey Sections

Survey Section	Domain of Inquiry
Background Information	Motivation to join the GPDC Model
	Activities related to model participation
Beneficiary Engagement	Beneficiary satisfaction
	Beneficiary engagement
	Access to care
	Collection of beneficiary data
	Voluntary alignment
	Benefit enhancements/Beneficiary engagement incentives
Provider Engagement	Participant Provider engagement activities
	Participant Provider payment
	Preferred Provider payment
	Financial risk-sharing

Building from the research questions, we refined the instrument using qualitative data from a content analysis of DCE applications. The instrument went through multiple rounds of internal revision and CMS review. This iterative process also included discussion around initial questions important to ask during the evaluation as the first primary data collection effort versus during subsequent surveys.

To test whether question wording and content accurately measured the intended evaluation constructs, we carried out several cognitive interviews with members of the target population (five DCE representatives and one ACO affiliate not participating in the GPDC Model) using the draft survey instrument. NORC incorporated the feedback gathered during the cognitive interview process into the final survey instrument. NORC also conducted usability testing to ensure correct functionality with respect to survey flow, question display logic, and other programmed features intended to enhance user experience.

Survey Outreach. NORC downloaded contact information for the DCEs from the Innovation Center's internal website, 4innovation (4i). Since each DCE had multiple points of contact, NORC requested that Innovation Center Regional Officers (ROs) identify the primary contact at each of their DCEs. In the initial survey invitation to the DCEs, NORC included an overview of the evaluation and language on the purpose of the survey. The initial invitation also noted the estimated time to complete the survey and whom to contact for assistance, including NORC's Institutional Review Board, the NORC evaluation team, and the GPDC evaluation COR. NORC encouraged DCEs to share the survey link with others in the DCE to assist with completing it.

Two of the DCEs that participated in the cognitive interviews completed the initial survey during pre-testing. Instead of asking these DCEs to retake the revised survey in its entirety, these two DCEs were sent an abbreviated supplemental survey containing only the questions that were modified as a result of pre-tester feedback. This supplemental survey went through the same usability testing as the main Pulse Check Survey. NORC used several methods to encourage participation in and raise awareness of the first Pulse Check Survey.

First, the Innovation Center included language about the survey in its weekly newsletter to all DCEs participating in the GPDC Model. Second, NORC also posted a PDF version of the survey on the Innovation Center internal website, 4i, for the DCE's initial review and reference. Third, NORC sent customized outreach language to the survey respondents who were the primary contact for multiple DCEs, were involuntarily terminated from the model, or completed the pre-testing process for the survey. Survey respondents who had not started or completed the survey received a follow-up email on November 1, 2022, eight business days after the survey launch. Throughout the fielding of the survey, NORC sent reminder emails and conducted phone calls to those who had not yet completed the survey. NORC also reached out to CMS ROs to request they follow up with their DCEs who had not yet completed the survey. Lastly, NORC's survey team regularly monitored a help-desk email account to address questions from the DCEs.

Recoding, Cleaning, and Analytic File Preparation. NORC recoded the data collected during fielding to produce a final analytic file. During this process, text-based responses and Likert scale values were assigned numeric values to allow for more efficient data analysis. Respondent skips, as well as intentional question skips due to survey programming logic, were also assigned numeric values. NORC reviewed the recoded data to evaluate the appropriateness and completeness of responses. Using the recoded data, NORC created summary tables for each survey question. The summary tables included counts for each response option as well as the percentage of respondents selecting a given response option. Counts and percentages were calculated across and within DCE type.

Data Dictionary. NORC developed a data dictionary to serve as a road map for those analyzing the survey data. The data dictionary included variable names for each question, variable type (for example, numeric or character), and the question wording. The data dictionary also provided a list of all response option labels and values associated with a given question.

Descriptive Statistical Analysis. Given that the Pulse Check Survey followed a census design with a 100%response rate for the required DCEs, survey weighting and imputation were not necessary. For the purposes of this annual report, only responses from DCEs participating in the model in PY2022 were analyzed. Descriptive percentages were calculated for ordinal and nominal responses along with their respective standard deviations and confidence intervals. Additional cross-tabulations were generated to evaluate relationships between certain DCE characteristics (for example, DCE organizational structure, and functional role) and survey responses.

D.1: 2022 Instrument

INTRODUCTION

Welcome!

We sincerely appreciate your participation in the first Global and Professional Direct Contracting Model (GPDC) Pulse Check. Pulse Checks are annual surveys conducted as part of the independent evaluation of GPDC. The Centers for Medicare & Medicaid Services' (CMS's) Center for Medicare and Medicaid Innovation (Innovation Center) has contracted NORC at the University of Chicago to lead the evaluation of GPDC. NORC is conducting this Pulse Check with partners at L&M Policy Research.

Thank you very much for your assistance and cooperation on this important effort!

What is the purpose of this survey?

The purpose of the survey is to capture information about DCEs' early implementation experiences to help CMS and other audiences understand the different strategies DCEs undertake in the model. This Pulse Check primarily covers topics related to beneficiary and provider engagement.

How will survey results be used?

Survey data will be used for the purpose of model evaluation and to inform learning system needs. Responses will be analyzed in aggregate and at the DCE-level and presented in public reports of the model's results. At the end of the survey, you have the option of downloading a copy of your responses.

Survey results are for GPDC evaluation purposes and will not be used for auditing individual DCEs.

Who is responsible for responding to this survey?

Participation in evaluation activities, including this survey, is required of all GPDC participants. This survey is administered to all DCEs participating in GPDC at any time in the 2022 performance year. The survey link has been shared with the person identified as our primary contact regarding the survey. However, we anticipate that others in the DCE may have information needed to answer the questions. To facilitate consulting with others, you may stop and save your responses to the survey and resume later. You may also share the link to the survey with others in the DCE to assist with completing it. You may also access a PDF version of the survey here.

How long will the survey take to complete? When is it due?

The survey is expected to take approximately 30 minutes to complete. To reduce your burden, please feel comfortable responding with your best estimate rather than producing additional reports to obtain precise figures. We ask that you submit your responses no later than November 11, 2022.

INSTRUCTIONS

Please use the "Continue" and "Previous" survey buttons **on the bottom of the screen** to navigate through the questions in the survey. You must use the "Continue" button on the screen after you have responded to a question for your answer to be saved. **Please do not use your browser buttons**.

To exit the survey at any time, simply close your internet browser window. Any responses you have entered before closing will be saved. Reopening the survey later will allow you to return to the same location and finish completing the survey. Please feel free to consult with others in the DCE who may have information needed to answer the questions. You can share the link to the survey with others in the DCE to assist with completing it.

Lastly, we have provided definitions on certain terms throughout the survey. When available, you can click the lightbulb icon next to the term for more information (for example, Term).

Again, we greatly appreciate your time and participation. Let's get started!

SECTION I: BACKGROUND INFORMATION

This survey will be asking about the functions and services performed by the **DCE itself as an entity or its parent company**.

When responding, please do not include functions that may be performed by some practices or providers participating in the DCE but were not initiated at the DCE level.

The following questions explore your DCE's motivations for participating in GPDC.

Motivation to Join

1. To what extent were each of the following reasons a motivating factor for forming a DCE or transitioning to GPDC? Select one response per row.

	Not at all	Very little	Somewhat	To a great extent
To gain experience with capitated risk.				
To benefit from high shared savings potential				
To expand our value-based payment portfolio				
To increase primary care provider alignment.				
To increase specialist provider alignment.				
Other (please specify):				

2. To what extent did each of the following aspects of the model influence your DCE's (or its parent company's) decision to join GPDC? Select one response per row.

	Not at all	Very little	Somewhat	To a great extent
Lower attribution threshold for certain types of DCEs				
Beneficiary incentives and benefit enhancements				
Population-based payment or capitation				
Qualifies as Advanced Alternative Payment Model; exempt from Merit-Based Incentive Payment System				
Advanced Payment Option[1]				
Voluntary alignment				
To increase synergies with other lines of business				
Other (please specify):				

[1] **Advanced Payment Option (APO):** A supplemental payment mechanism available for selection by the DCE for a performance year if the DCE also has selected PCC Payment for that performance year. If the DCE selects the APO, CMS will make a prospective monthly APO payment to the DCE for APO Eligible Services furnished to aligned beneficiaries by those Participant Providers and Preferred Providers to opt into the APO arrangement.

Activities Related to Model Participation

1. Now we would like to know about different strategies that your DCE may or may not be focused on. For each of the items listed below, please select the response option that most accurately reflects the perspective of your DCE.

	Not a priority / Not applicable	Low priority	Medium priority	High priority
Investments in primary care capacity such as non-physician providers, after-hours care				
Investments in behavioral health capacity such as behavioral health professionals, telehealth appointments				
Initiatives to encourage referrals to high-quality or Preferred Providers				
Complex care management or population-specific care management programs				
Initiatives to reduce low value care				
Initiatives to reduce avoidable inpatient, emergency department, or post-acute care utilization				
Initiatives to address beneficiaries' social needs, such as food insecurity, housing, and transportation				
Emphasis on primary care touchpoints (e.g., annual wellness visits)				
Other (please specify):				

SECTION II: BENEFICIARY ENGAGEMENT

The next questions explore activities your DCE may use to engage beneficiaries.

When answering, please consider the activities initiated by the DCE itself as an entity. Please do not include activities that may be initiated by practices or providers participating in the DCE.

Your responses should reflect only the functions or services that your DCE **currently** performs, not those the DCE plans to implement.

Beneficiary satisfaction

1. **Aside from the required Consumer Assessment of Healthcare Providers and Systems (CAHPS)**, does your DCE assess beneficiary satisfaction using the following activities? Please check "Yes" or "No" for each item listed below.

(If DCE answers 'No' to every item in the list, SKIP to question 6a)

	Yes	No
Surveys (other than CAHPS)		
Focus groups		
Interviews		
Patient/caregiver advisory group		
Communication with beneficiaries during visits		
Other (please specify):		

2. Does your DCE use the beneficiary satisfaction data that are collected (**other than CAHPS**) in any of the following ways? Please check "Yes" or "No" for each item listed below.

	Yes	No
To inform broad (DCE-wide) changes		
To follow up with individual patients		
To follow up with DCE providers or practices		
To determine performance-based incentives/bonuses for Participant Providers		
To determine performance-based incentives/bonuses for Preferred Providers		
Other (please specify):		

Beneficiary engagement

6a. Aside from their required participation on the board, does your DCE engage beneficiaries in DCE governance and/or leadership activities?

I. Yes
II. No *(Skip to Question 7)*

6b. Below is a list of methods that your DCE may use to engage beneficiaries in DCE governance and leadership. Please indicate the effectiveness of each of these methods or if your DCE does not use a given method. Select one response per row.

	Don't use this method	Not effective	Somewhat effective	Very effective
Testing communications with small group of beneficiaries to confirm messaging resonates				
Offering DCE-supported affinity or work group				
Having additional beneficiary representatives on the DCE board				
Having a DCE patient advisory council				
Other (please specify):				

Access to care

7. How does your DCE support Participant and Preferred Provider practices to offer expanded access to care? Select all that apply.

	Participant Providers	Preferred Providers	DCE does not provide this type of support
DCE offers, funds, or supports centralized population health support staff (e.g., care managers, pharmacist, schedulers /administrative support)			
DCE directly provides or funds the provision of telehealth			
DCE offers, funds, or supports extended or weekend hours for practices			
DCE offers, funds, or supports urgent or extended care[2]			
DCE offers, funds, or provides other support for expanded access to care, (please specify):			

[2] Extended care refers to services offered by the DCE (not just select practices in the DCE) beyond those offered in a typical primary care practice. Examples include IV fluids, ultrasound, and x-rays.

Beneficiary data collection

8a. Below is a list of different types of beneficiary data that your DCE may encourage or require Participant and Preferred Providers to collect. For each one, please indicate whether your DCE emphasizes collection of this type of beneficiary data.

(If DCE selects 'Does not collect' for all rows, skip to question 9)

	Collects electronically	Collects on paper	Does not collect
Race and ethnicity			
Preferred language			
Sexual orientation and/or gender identity			
Housing, food security, and/or transportation needs			
Marital / partnership status or living alone			
Screening for other risk factors such as tobacco or alcohol use, depression			
Other data collected (please specify):			

8b. Does your DCE use the information collected from Participant and Preferred Providers in any of the following ways? Please select all that apply.

	Yes	No	Don't Know
Informing staffing assignments and patient interactions			
Focusing quality improvement initiatives			
Analyzing performance metrics			
Other use (please specify):			

Voluntary alignment

9a. Does your DCE currently conduct activities to increase voluntary alignment?

I. Yes
II. No *(Skip to question 10)*

9b. Below is a list of different approaches that your DCE may use to increase voluntary alignment. For each one, please indicate whether your DCE uses this approach.

	Yes	No
Communicates to beneficiaries through the DCE portal or via email		
Communicates to beneficiaries via mail		
Communicates to beneficiaries via voice or text messages		
Training for care managers, other care team members (e.g., social workers), or DCE providers to conduct outreach or educate beneficiaries about voluntary alignment		
Training for office or front desk staff to respond to beneficiary questions about voluntary alignment		
Presentations for beneficiaries (e.g., via webinar, town hall, information session)		
Partner/collaborate with potential referral sources (for example, community-based organizations such as Area Agencies on Aging)		
Other strategy (please specify):		

Benefit Enhancements (BEs) and Beneficiary Engagement Incentives (BEIs)

10. Select the option that best reflects your DCE's implementation status for each BE or BEI.[3] Fully implemented and operational means that your DCE is offering BE/BEI services and billing for them to the extent they are used by beneficiaries.

	Select all that apply per row			
	Fully implemented and operational in PY2021	**Fully implemented and operational in PY2022**	**Planning to implement in PY2023**	**Decided not to implement**
Telehealth expansion waiver				
Three-day skilled nursing facility (SNF) rule waiver				
Post-discharge home visit waiver				
Care management home visit waiver				
Home health homebound waiver				
Concurrent care for beneficiaries that elect Medicare hospice benefit				
Part B cost sharing support (cost sharing)				
Chronic disease management reward (gift card)				
Nurse practitioner services benefit enhancement*				

***Tool Tip: Nurse Practitioner Services Benefit Enhancement**

Beginning in PY2023, the ACO Realizing Equity, Access, and Community Health (REACH) Model plans to make available a new Benefit Enhancement to model participants to help reduce barriers to care access, particularly for beneficiaries in areas with limited access to physicians: The Nurse Practitioner Services Benefit Enhancement. This Benefit Enhancement is intended to allow ACOs to increase flexibility in care delivery and improve care coordination for their aligned beneficiary populations. Under this Benefit Enhancement and to the extent permitted under applicable state law, Nurse Practitioners will be able to assume certain responsibilities or furnish certain services that would otherwise require physician supervision under current Medicare law. Specifically, CMS intends to issue waivers as necessary to test the ACO REACH Model to allow Nurse Practitioners:

- To certify a REACH Beneficiary's need for hospice care
- To certify a REACH Beneficiary's need for diabetic shoes
- To order and supervise cardiac rehabilitation for a REACH Beneficiary

- To establish, review, sign, and date a REACH Beneficiary's home infusion therapy plan of care
- To refer a REACH Beneficiary for medical nutrition therapy

[3] **Tool Tip**: DCEs may choose benefit enhancements (BEs) and beneficiary engagement incentives (BEIs) to implement and support their ability to manage the care of beneficiaries. BEs are conditional waivers of certain Medicare payment rules. BEIs permit DCE providers to give in-kind items or services to beneficiaries if certain conditions are satisfied.

11a. Does your DCE track BE/BEI utilization, performance, or outcomes?

I. Yes
II. No *(Skip to question 12)*

11b. *[IF 11a. = YES]* What measures does your DCE use to track BE/BEI utilization, performance, and outcomes? Please select "Yes" or "No" for each response option.

	Yes	No
Number of BE/BEI visits or services		
Nature of BE/BEI visit or service		
Cost of BE/BEI care		
Total cost of care		
Demographics of beneficiaries receiving the BE/BEI		
Hospital admissions/readmissions		
Emergency department (ED) utilization		
Disease-specific outcome measures		
Medication adherence		
Patient/caregiver satisfaction		
Barriers to care		
Other measures (please specify):		

11c. *[IF 11a. = YES]* For each item listed below, indicate which, if any, challenges your DCE experiences in implementation. Please select "Yes" or "No" for each response option.

	Yes	No
Insufficient staff		
Complexity of requirements		
Lack of clarity about requirements		
Not offering the same benefit to all patients		
Other (please specify):		

11d. *[IF 11a. = YES]* What does your DCE find challenging about tracking these BE/BEI utilization, performance, and outcome measures? Please select "Yes" or "No" for each response option.

	Yes	No
Time consuming to enter data		
Time consuming to pull data		
Lack of staff to track and manage data		
Data stored in multiple sources		
Inconsistent data collection or data entry		
Difficulty revising current systems to track measures		
Difficulty distinguishing between BE/BEI services and non-BE/BEI services		
Other (please specify):		

12. *[If question 10 response option = Nurse practitioner services benefit enhancement = Planning to implement in PY2023]* What challenges does your DCE anticipate in implementing the NP Services BE? Click here (pages 75-77) for more information. Please select "Yes" or "No" for each response option.

	Yes	No
Complexity of NP BE policy		
Currently do not utilize NPs		
Need to hire or train NPs		
Not offering the same benefit to all patients		
Competing priorities		
Do not need BE		
Other (please specify):		

SECTION III: PROVIDER ENGAGEMENT

The questions presented in this final section explore your DCE's efforts to engage providers.

When answering, please consider the provider engagement activities initiated by the **DCE itself as an entity.** Please do not include activities that may be initiated by practices and providers participating in the DCE. We understand there are a variety of different provider arrangements so some of these questions may be challenging to answer precisely. Please answer to the best of your ability.

Your responses should reflect only the functions or services that your DCE **currently** performs, not those the DCE plans to implement.

Provider engagement activities at the Participant Provider level

13a. As part of the DCE's efforts to engage Participant Providers, how important is each of the following practice support and improvement activities? Select one response per row.

Practice Support & Improvement				
	Not important	**Somewhat important**	**Very important**	**DCE does not offer this activity**
DCE provides or arranges for centralized population health support staff (e.g., care managers, pharmacist, schedulers/ administrative support)				
DCE provides or arranges for staff embedded in practices (e.g., administrative, care manager, health educator/coach, social worker)				
DCE provides or arranges for investments in infrastructure at the practice level (Electronic Health Record software, hardware, data analytic support, care delivery tools [e.g., shared decision-making aids, patient survey instruments], and licenses to access tools)				
Coaching or one-on-one review of performance, quality and/or cost data				
Data analysis support other than feedback reports on quality, utilization, or cost				
Regular meetings between DCE and individual practice leaders				

Practice Support & Improvement				
	Not important	Somewhat important	Very important	DCE does not offer this activity
Action-oriented initiatives focusing on small-scale, discrete areas for improvement (e.g., improve completion rates for flu vaccine, increasing number of annual wellness visits)				
Training and education sessions				
Workflow redesign or optimization support				
Other practice support and improvement activities (please specify):				

13b. *[If question 13a response option = VERY IMPORTANT]* Please estimate the portion of Participant Providers that use the DCE's practice support and improvement activities listed below. Your best estimate is fine.

Practice Support & Improvement					
	None	Some	Most	All	Don't know
DCE-provided centralized population health support staff (e.g., care managers, pharmacist, schedulers/ administrative support)					
DCE-provided staff embedded in practices (e.g., administrative, care manager, health educator/coach, social worker)					
DCE-provided investments in infrastructure at the practice level (Tool tip: Electronic Health Record software, hardware, data analytic support, care delivery tools [e.g., shared decision-making aids, patient survey instruments], licenses to access tools)					
Coaching or one-on-one review of performance, quality and/or cost data					
Data analysis support other than feedback reports on quality, utilization, or cost					
Regular meetings between DCE and individual practice leaders					
Action-oriented initiatives focusing on small-scale, discrete areas for improvement (e.g., improve completion rates for flu vaccine, increasing number of annual wellness visits)					
Training and education sessions					

Practice Support & Improvement					
	None	Some	Most	All	Don't know
Workflow redesign or optimization support					
Other practice support and improvement activities (please specify):					

14a. How important are each of the following information sharing activities for engaging your DCE's Participant Providers? Select one response per row.

Information Sharing				
	Not important	Somewhat important	Very important	DCE does not offer this activity
Feedback reports on quality, utilization, or cost with comparisons at the practice level				
Feedback reports on quality, utilization, or cost with comparisons at the individual clinician level				
Other information to help providers manage care (e.g., specialty and other service use)				
Real time data on emergency department (ED) and inpatient admissions, discharges, and transfers (ADTs)				
Other information sharing activities (please specify):				

14b. *[Drop down response options from question 14a that = 'VERY IMPORTANT']* Please estimate the portion of Participant Providers that use the DCE's information sharing activities listed below. Your best estimate is fine.

Information Sharing					
	None	Some	Most	All	Don't Know
Feedback reports on quality, utilization, or cost with comparisons at the practice level					
Feedback reports on quality, utilization, or cost with comparisons at the individual clinician level					
Real time data on emergency department (ED) and inpatient admissions, discharges, and transfers (ADTs)					
Other information sharing activities (please specify):					

15a. How important are each of the following incentives for engaging your DCE's Participant Providers? Select one response per row.

Incentives				
	Not important	**Somewhat important**	**Very important**	**DCE does not offer this activity**
Financial bonuses tied to performance				
Financial penalties tied to performance				
Non-financial awards or recognition tied to performance				
DCE provides upfront payments				
Other incentives (please specify):				

15b. *[Drop down response options from question 15a that = 'VERY IMPORTANT']* Please estimate the portion of Participant Providers that receive the DCE's incentives listed below. Your best estimate is fine.

Incentives					
	None	**Some**	**Most**	**All**	**Don't know**
Financial bonuses tied to performance					
Financial penalties tied to performance					
Non-financial awards or recognition tied to performance					
DCE provides upfront payments					
Other incentives (please specify):					

Participant Provider Payment

We are interested in understanding your DCE's payment arrangements with Participant Providers.

16. Which of the following methods does your DCE use to pay Participant Providers? Please select all that apply.

- Partial fee-for-service
- Fee-for-service
- Partial capitation
- Total capitation
- Payments tied to quality thresholds.
- Other (please specify):

17. Not including any capitated payments the DCE may make to providers, does your DCE use financial rewards and/or penalties with its Participant Providers?

	Yes	No
DCE uses financial rewards		
DCE uses financial penalties		

18a. How many of your DCE's Participant Providers are employed directly by a health system or practice participating in the model?

- All
- Most
- Some
- Very few
- None *(Skip to question 19)*

18b. To what extent do you think your Participant Providers' behavior is influenced by GPDC performance incentives? Select one response per row.

	Not at all	Very little	Somewhat	To a great extent	Provider type not applicable
Employed Participant Providers					
Non-employed Participant Providers					

Preferred Provider Payment

The next question is about payment arrangements with your DCE's Preferred Providers.

19. Does your DCE use financial rewards and/or penalties with its Preferred Providers?

	Yes	No
DCE uses financial rewards		
DCE uses financial penalties		

Sharing Financial Risk

The next set of questions ask about financial risk-sharing arrangements that your DCE may have with certain Participant Providers.

20a. Does your DCE share upside financial risk (savings) directly with the Participant Provider types listed below? Select one response per row.

	Total DCE savings	Service-specific savings	Provider type does not participate in DCE	Does not share savings with this type of provider
Individual practitioners who may be employed directly by a health system or practice participating in the model				
Physician groups / practices				
Networks of individual physician practices or other practitioners				
Independent or solo practitioners				
Acute care hospitals				
Skilled nursing facilities (SNFs)				
Home health agencies (HHAs)				
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)				
Other provider type (please specify):				

20b. *[IF 20a. = YES for "Total DCE Savings" or "Service-Specific Savings"]* For upside risk (savings), what portion is shared with each provider type? Select one response per row.

	1-5%	6-10%	11-30%	31-50%	More than 50%
Individual practitioners who may be employed directly by a health system or practice participating in the model					
Physician groups / practices					
Networks of individual physician practices or other practitioners					
Independent or solo practitioners					
Acute care hospitals					
Skilled nursing facilities (SNFs)					
Home health agencies					

	1-5%	6-10%	11-30%	31-50%	More than 50%
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)					
Other provider type (please specify):					

20c. Does your DCE share downside financial risk (losses) directly with the Participant Provider types listed below? Select one response per row.

	Total DCE losses	Service-specific losses	Does not share losses with this type of provider
Individual practitioners who may be employed directly by a health system or practice participating in the model			
Physician groups / practices			
Networks of individual physician practices or other practitioners			
Independent or solo practitioners			
Acute care hospitals			
Skilled nursing facilities (SNFs)			
Home health agencies (HHAs)			
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)			
Other provider type (please specify):			

20d. *[IF 20c. = YES for "Total DCE Losses" or "Service-Specific Losses"]* For downside risk (losses), what portion is shared with each provider type? Select one response per row.

	1-5%	6-10%	11-30%	31-50%	More than 50%
Individual practitioners who may be employed directly by a health system or practice participating in the model					
Physician groups / practices					
Networks of individual physician practices or other practitioners					
Independent or solo practitioners					
Acute care hospitals					
Skilled nursing facilities (SNFs)					

	1-5%	6-10%	11-30%	31-50%	More than 50%
Home health agencies					
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)					
Other provider type (please specify):					

21. You have reached the end of the survey. Please list the names and titles of those who helped complete the survey. Please also let us know which DCE you are submitting this survey for.

We thank you for your time spent taking this survey. Your response has been recorded. (Your respondent's response summary

D.2: 2022 Pulse Check Survey Results

Exhibit D.2. Selected 2022 Pulse Check Survey Results by DCE Type

3. Now we would like to know about different strategies that your DCE may or may not be focused on. For each of the items listed below, please select the response option that most accurately reflects the perspective of your DCE.

Question	Overall, N=95[1]	DCE Type			p-value (Standards and New Entrants only)[2]
		Standard, N=75[1]	New Entrant, N=13[1]	High Needs, N=7[1]	
Investments in primary care capacity such as non-physician providers, after-hours care					0.6
High priority	52 (55%)	41 (55%)	6 (46%)	5 (71%)	
Medium priority	27 (28%)	21 (28%)	5 (38%)	1 (14%)	
Low priority	12 (13%)	10 (13%)	1 (8%)	1 (14%)	
Not a priority / Not applicable	4 (4%)	3 (4%)	1 (8%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Investments in behavioral health capacity such as behavioral health professionals, telehealth appointments					0.2
High priority	31 (33%)	25 (33%)	3 (23%)	3 (43%)	
Medium priority	24 (25%)	20 (27%)	3 (23%)	1 (14%)	
Low priority	33 (35%)	26 (35%)	4 (31%)	3 (43%)	
Not a priority / Not applicable	7 (7%)	4 (5%)	3 (23%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Initiatives to encourage referrals to high-quality or Preferred Providers					0.035**
High priority	35 (37%)	32 (43%)	2 (15%)	1 (14%)	
Medium priority	48 (51%)	35 (47%)	8 (62%)	5 (71%)	
Low priority	7 (7%)	3 (4%)	3 (23%)	1 (14%)	
Not a priority / Not applicable	5 (5%)	5 (7%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Complex care management or population-specific care management programs					<0.001***
High priority	84 (88%)	70 (93%)	7 (54%)	7 (100%)	
Medium priority	10 (11%)	4 (5%)	6 (46%)	0 (0%)	
Low priority	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not a priority / Not applicable	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Initiatives to reduce low value care					>0.9
High priority	44 (46%)	33 (44%)	7 (54%)	4 (57%)	
Medium priority	37 (39%)	29 (39%)	5 (38%)	3 (43%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Low priority	10 (11%)	9 (12%)	1 (8%)	0 (0%)	
Not a priority / Not applicable	4 (4%)	4 (5%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Initiatives to reduce avoidable inpatient, emergency department, or post-acute care utilization					0.2
High priority	90 (95%)	72 (96%)	11 (85%)	7 (100%)	
Medium priority	4 (4%)	2 (3%)	2 (15%)	0 (0%)	
Low priority	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not a priority / Not applicable	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Initiatives to address beneficiaries' social needs, such as food insecurity, housing, and transportation					0.082*
High priority	47 (49%)	41 (55%)	3 (23%)	3 (43%)	
Medium priority	37 (39%)	26 (35%)	7 (54%)	4 (57%)	
Low priority	9 (9%)	6 (8%)	3 (23%)	0 (0%)	
Not a priority / Not applicable	2 (2%)	2 (3%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Emphasis on primary care touchpoints (e.g., annual wellness visits)					>0.9
High priority	81 (85%)	64 (85%)	12 (92%)	5 (71%)	
Medium priority	13 (14%)	10 (13%)	1 (8%)	2 (29%)	
Low priority	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not a priority / Not applicable	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other, please specify:					0.3
High priority	14 (15%)	10 (13%)	1 (8%)	3 (43%)	
Medium priority	3 (3%)	3 (4%)	0 (0%)	0 (0%)	
Low priority	1 (1%)	0 (0%)	1 (8%)	0 (0%)	
Not a priority / Not applicable	19 (20%)	14 (19%)	4 (31%)	1 (14%)	
Respondent skip	58 (61%)	48 (64%)	7 (54%)	3 (43%)	

7. How does your DCE support Participant and Preferred Provider practices to offer expanded access to care? Select all that apply.

DCE offers, funds, or supports centralized population health support staff (e.g., care managers, pharmacist, schedulers/administrative support)					
Participant Providers	83 (87%)	70 (93%)	8 (62%)	5 (71%)	0.005***
Preferred Providers	28 (29%)	22 (29%)	3 (23%)	3 (43%)	0.8
DCE does not provide this type of support	10 (11%)	3 (4%)	5 (38%)	2 (29%)	0.001***
DCE directly provides or funds the provision of telehealth					
Participant Providers	47 (49%)	38 (51%)	7 (54%)	2 (29%)	0.8

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Preferred Providers	7 (7%)	5 (7%)	1 (8%)	1 (14%)	>0.9
DCE does not provide this type of support	48 (51%)	37 (49%)	6 (46%)	5 (71%)	0.8
DCE offers, funds, or supports extended or weekend hours for practices					
Participant Providers	48 (51%)	37 (49%)	5 (38%)	6 (86%)	0.5
Preferred Providers	6 (6%)	3 (4%)	1 (8%)	2 (29%)	0.5
DCE does not provide this type of support	47 (49%)	38 (51%)	8 (62%)	1 (14%)	0.5
DCE offers, funds, or supports urgent or extended care (Tooltip: Extended care refers to services offered by the DCE (not just select practices in the DCE) beyond those offered in a typical primary care practice. Examples include IV fluids, ultrasound, and x-rays.)					
Participant Providers	48 (51%)	38 (51%)	4 (31%)	6 (86%)	0.2
Preferred Providers	10 (11%)	6 (8%)	1 (8%)	3 (43%)	>0.9
DCE does not provide this type of support	46 (48%)	36 (48%)	9 (69%)	1 (14%)	0.2
DCE offers, funds, or provides other support for expanded access to care (please specify):					
Participant Providers	36 (38%)	29 (39%)	3 (23%)	4 (57%)	0.4
Preferred Providers	6 (6%)	6 (8%)	0 (0%)	0 (0%)	0.6
DCE does not provide this type of support	34 (36%)	27 (36%)	6 (46%)	1 (14%)	0.5
9a. Does your DCE currently conduct activities to increase voluntary alignment?					
Yes	70 (74%)	53 (71%)	10 (77%)	7 (100%)	0.8
9b. Below is a list of different approaches that your DCE may use to increase voluntary alignment. For each one, please indicate whether your DCE uses this approach. *(Asked of those who said "Yes" to Q9a)*					
Communicates to beneficiaries through the DCE portal or email					0.7
Yes	48 (51%)	38 (51%)	6 (46%)	4 (57%)	
No	22 (23%)	15 (20%)	4 (31%)	3 (43%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	22 (29%)	3 (23%)	0 (0%)	
Communicates to beneficiaries via mail					>0.9
Yes	56 (59%)	41 (55%)	8 (62%)	7 (100%)	
No	14 (15%)	12 (16%)	2 (15%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	22 (29%)	3 (23%)	0 (0%)	
Communicates to beneficiaries via voice or text messages					0.8
Yes	14 (15%)	11 (15%)	1 (8%)	2 (29%)	
No	56 (59%)	42 (56%)	9 (69%)	5 (71%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	22 (29%)	3 (23%)	0 (0%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Training for care managers, other care team members (e.g., social workers), or DCE providers to conduct outreach or educate beneficiaries about voluntary alignment					0.9
Yes	61 (64%)	46 (61%)	9 (69%)	6 (86%)	
No	9 (9%)	7 (9%)	1 (8%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	22 (29%)	3 (23%)	0 (0%)	
Training for office or front desk staff to respond to beneficiary questions about voluntary alignment					0.4
Yes	63 (66%)	47 (63%)	9 (69%)	7 (100%)	
No	2 (2%)	1 (1%)	1 (8%)	0 (0%)	
Respondent skip	5 (5%)	5 (7%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	22 (29%)	3 (23%)	0 (0%)	
Presentations for beneficiaries (e.g., via webinar, town hall, information sessions)					0.7
Yes	16 (17%)	13 (17%)	1 (8%)	2 (29%)	
No	54 (57%)	40 (53%)	9 (69%)	5 (71%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	22 (29%)	3 (23%)	0 (0%)	
Partner/collaborate with potential referral sources (e.g., community-based organizations such as Area Agencies on Aging)					0.4
Yes	14 (15%)	10 (13%)	0 (0%)	4 (57%)	
No	56 (59%)	43 (57%)	10 (77%)	3 (43%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	22 (29%)	3 (23%)	0 (0%)	
Other strategy, please specify:					0.8
Yes	12 (13%)	9 (12%)	2 (15%)	1 (14%)	
No	21 (22%)	16 (21%)	4 (31%)	1 (14%)	
Respondent skip	37 (39%)	28 (37%)	4 (31%)	5 (71%)	
Not asked	25 (26%)	22 (29%)	3 (23%)	0 (0%)	

10. Select the option that best reflects your DCE's implementation status for each BE or BEI. (Tooltip: DCEs may choose benefit enhancements (BEs) and beneficiary engagement incentives (BEIs) to implement and support their ability to manage the care of beneficiaries. BEs are conditional waivers of certain Medicare payment rules. BEIs permit DCE providers to give in-kind items or services to beneficiaries if certain conditions are satisfied.)					
Telehealth expansion waiver					0.9
Fully implemented and operational in PY2021	18 (19%)	15 (20%)	3 (23%)	0 (0%)	
Fully implemented and operational in PY2022	7 (7%)	4 (5%)	0 (0%)	3 (43%)	
Planning to implement in PY2023	23 (24%)	19 (25%)	2 (15%)	2 (29%)	

Question	Overall, N=95[1]	DCE Type			p-value (Standards and New Entrants only)[2]
		Standard, N=75[1]	New Entrant, N=13[1]	High Needs, N=7[1]	
Decided not to implement	47 (49%)	37 (49%)	8 (62%)	2 (29%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Three-day skilled nursing facility (SNF) rule waiver					0.002***
Fully implemented and operational in PY2021	31 (33%)	29 (39%)	2 (15%)	0 (0%)	
Fully implemented and operational in PY2022	19 (20%)	15 (20%)	0 (0%)	4 (57%)	
Planning to implement in PY2023	26 (27%)	20 (27%)	3 (23%)	3 (43%)	
Decided not to implement	19 (20%)	11 (15%)	8 (62%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Post-discharge home visit waiver					0.14
Fully implemented and operational in PY2021	11 (12%)	11 (15%)	0 (0%)	0 (0%)	
Fully implemented and operational in PY2022	10 (11%)	6 (8%)	1 (8%)	3 (43%)	
Planning to implement in PY2023	35 (37%)	30 (40%)	3 (23%)	2 (29%)	
Decided not to implement	39 (41%)	28 (37%)	9 (69%)	2 (29%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Care management home visit waiver					0.8
Fully implemented and operational in PY2021	3 (3%)	3 (4%)	0 (0%)	0 (0%)	
Fully implemented and operational in PY2022	7 (7%)	5 (7%)	0 (0%)	2 (29%)	
Planning to implement in PY2023	39 (41%)	31 (41%)	5 (38%)	3 (43%)	
Decided not to implement	46 (48%)	36 (48%)	8 (62%)	2 (29%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Home health homebound waiver					0.054*
Fully implemented and operational in PY2021	8 (8%)	8 (11%)	0 (0%)	0 (0%)	
Fully implemented and operational in PY2022	10 (11%)	7 (9%)	1 (8%)	2 (29%)	
Planning to implement in PY2023	39 (41%)	33 (44%)	2 (15%)	4 (57%)	
Decided not to implement	38 (40%)	27 (36%)	10 (77%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Concurrent care for beneficiaries that elect Medicare hospice benefit					0.020**
Fully implemented and operational in PY2021	2 (2%)	2 (3%)	0 (0%)	0 (0%)	
Fully implemented and operational in PY2022	1 (1%)	0 (0%)	0 (0%)	1 (14%)	
Planning to implement in PY2023	37 (39%)	30 (40%)	1 (8%)	6 (86%)	
Decided not to implement	54 (57%)	43 (57%)	11 (85%)	0 (0%)	
Respondent skip	1 (1%)	0 (0%)	1 (8%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Part B cost sharing support (cost sharing)					0.3
Fully implemented and operational in PY2021	6 (6%)	6 (8%)	0 (0%)	0 (0%)	
Fully implemented and operational in PY2022	16 (17%)	12 (16%)	2 (15%)	2 (29%)	
Planning to implement in PY2023	35 (37%)	29 (39%)	4 (31%)	2 (29%)	
Decided not to implement	37 (39%)	28 (37%)	6 (46%)	3 (43%)	
Respondent skip	1 (1%)	0 (0%)	1 (8%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Chronic disease management reward (gift card)					0.10*
Fully implemented and operational in PY2021	6 (6%)	5 (7%)	1 (8%)	0 (0%)	
Fully implemented and operational in PY2022	14 (15%)	13 (17%)	1 (8%)	0 (0%)	
Planning to implement in PY2023	34 (36%)	27 (36%)	2 (15%)	5 (71%)	
Decided not to implement	40 (42%)	30 (40%)	8 (62%)	2 (29%)	
Respondent skip	1 (1%)	0 (0%)	1 (8%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Nurse practitioner services benefit enhancement					0.3
Fully implemented and operational in PY2021	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Fully implemented and operational in PY2022	6 (6%)	6 (8%)	0 (0%)	0 (0%)	
Planning to implement in PY2023	36 (38%)	26 (35%)	4 (31%)	6 (86%)	
Decided not to implement	51 (54%)	42 (56%)	8 (62%)	1 (14%)	
Respondent skip	1 (1%)	0 (0%)	1 (8%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
11a. Does your DCE track BE/BEI utilization, performance, or outcomes?					
Yes	68 (72%)	57 (76%)	6 (46%)	5 (71%)	0.043**
11b. What measures does your DCE use to track BE/BEI utilization, performance, and outcomes? *(Asked of those who said "Yes" to Q11a)*					
Number of BE/BEI visits or services					0.10*
Yes	65 (68%)	54 (72%)	6 (46%)	5 (71%)	
No	3 (3%)	3 (4%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Nature of BE/BEI visit or service					0.031**
Yes	49 (52%)	38 (51%)	6 (46%)	5 (71%)	
No	19 (20%)	19 (25%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Cost of BE/BEI care					0.092*
Yes	50 (53%)	42 (56%)	4 (31%)	4 (57%)	
No	18 (19%)	15 (20%)	2 (15%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Total cost of care					0.093*
Yes	56 (59%)	47 (63%)	5 (38%)	4 (57%)	
No	12 (13%)	10 (13%)	1 (8%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Demographics of beneficiaries receiving the BE/BEI					0.2
Yes	33 (35%)	26 (35%)	3 (23%)	4 (57%)	
No	34 (36%)	30 (40%)	3 (23%)	1 (14%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Hospital admissions/readmissions					0.093*
Yes	56 (59%)	47 (63%)	5 (38%)	4 (57%)	
No	12 (13%)	10 (13%)	1 (8%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Emergency department (ED) utilization					0.082*

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Yes	55 (58%)	46 (61%)	5 (38%)	4 (57%)	
No	13 (14%)	11 (15%)	1 (8%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Disease-specific outcome measures					0.084*
Yes	29 (31%)	22 (29%)	3 (23%)	4 (57%)	
No	39 (41%)	35 (47%)	3 (23%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Medication adherence					0.087*
Yes	27 (28%)	21 (28%)	3 (23%)	3 (43%)	
No	41 (43%)	36 (48%)	3 (23%)	2 (29%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Patient/caregiver satisfaction					0.13
Yes	23 (24%)	18 (24%)	2 (15%)	3 (43%)	
No	45 (47%)	39 (52%)	4 (31%)	2 (29%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Barriers to care					0.092*
Yes	21 (22%)	15 (20%)	2 (15%)	4 (57%)	
No	47 (49%)	42 (56%)	4 (31%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Other, please specify:					0.2
Yes	11 (12%)	9 (12%)	1 (8%)	1 (14%)	
No	20 (21%)	17 (23%)	2 (15%)	1 (14%)	
Respondent skip	37 (39%)	31 (41%)	3 (23%)	3 (43%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
11c. For each item listed below, indicate which, if any, challenges your DCE experiences when implementing BE/BEI. *(Asked of those who said "Yes" to Q11a)*					
Insufficient staff					0.2
Yes	37 (39%)	29 (39%)	4 (31%)	4 (57%)	
No	23 (24%)	20 (27%)	2 (15%)	1 (14%)	
Respondent skip	8 (8%)	8 (11%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Complexity of requirements					0.2
Yes	43 (45%)	36 (48%)	4 (31%)	3 (43%)	
No	17 (18%)	13 (17%)	2 (15%)	2 (29%)	
Respondent skip	8 (8%)	8 (11%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Lack of clarity about requirements					0.2
Yes	24 (25%)	19 (25%)	3 (23%)	2 (29%)	
No	36 (38%)	30 (40%)	3 (23%)	3 (43%)	
Respondent skip	8 (8%)	8 (11%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Not offering the same benefit to all patients					0.2
Yes	38 (40%)	32 (43%)	4 (31%)	2 (29%)	
No	22 (23%)	17 (23%)	2 (15%)	3 (43%)	
Respondent skip	8 (8%)	8 (11%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Other, please specify:					0.2
Yes	11 (12%)	9 (12%)	1 (8%)	1 (14%)	
No	15 (16%)	12 (16%)	2 (15%)	1 (14%)	
Respondent skip	42 (44%)	36 (48%)	3 (23%)	3 (43%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	

11d. What does your DCE find challenging about tracking these BE/BEI utilization, performance, and outcome measures? *(Asked of those who said "Yes" to Q11a)*

Time consuming to enter data					0.12
Yes	42 (44%)	34 (45%)	4 (31%)	4 (57%)	
No	26 (27%)	23 (31%)	2 (15%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Time consuming to pull data					0.094*
Yes	41 (43%)	34 (45%)	3 (23%)	4 (57%)	
No	27 (28%)	23 (31%)	3 (23%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Lack of staff to track and manage data					0.12
Yes	40 (42%)	32 (43%)	3 (23%)	5 (71%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
No	28 (29%)	25 (33%)	3 (23%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Data stored in multiple sources					0.11
Yes	45 (47%)	37 (49%)	4 (31%)	4 (57%)	
No	23 (24%)	20 (27%)	2 (15%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Inconsistent data collection or data entry					0.074*
Yes	35 (37%)	27 (36%)	4 (31%)	4 (57%)	
No	33 (35%)	30 (40%)	2 (15%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Difficulty revising current systems to track measures					0.029**
Yes	35 (37%)	26 (35%)	5 (38%)	4 (57%)	
No	33 (35%)	31 (41%)	1 (8%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Difficulty distinguishing between BE/BEI services and non-BE/BEI services					0.10*
Yes	30 (32%)	26 (35%)	2 (15%)	2 (29%)	
No	38 (40%)	31 (41%)	4 (31%)	3 (43%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	
Other, please specify:					0.2
Yes	16 (17%)	15 (20%)	1 (8%)	0 (0%)	
No	18 (19%)	15 (20%)	2 (15%)	1 (14%)	
Respondent skip	34 (36%)	27 (36%)	3 (23%)	4 (57%)	
Not asked	27 (28%)	18 (24%)	7 (54%)	2 (29%)	

12. What challenges does your DCE anticipate in implementing the NP Services BE? *(Asked of those who said "Planning to implement in PY2023" for "Nurse practitioner services benefit enhancement" on Q10)*

Complexity of NP BE policy					0.5
Yes	19 (20%)	18 (24%)	1 (8%)	0 (0%)	
No	26 (27%)	17 (23%)	3 (23%)	6 (86%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	40 (53%)	9 (69%)	1 (14%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Currently do not utilize NPs					0.7
Yes	4 (4%)	3 (4%)	0 (0%)	1 (14%)	
No	41 (43%)	32 (43%)	4 (31%)	5 (71%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	40 (53%)	9 (69%)	1 (14%)	
Need to hire or train NPs					0.5
Yes	15 (16%)	11 (15%)	2 (15%)	2 (29%)	
No	30 (32%)	24 (32%)	2 (15%)	4 (57%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	40 (53%)	9 (69%)	1 (14%)	
Not offering the same benefit to all patients					0.7
Yes	22 (23%)	18 (24%)	2 (15%)	2 (29%)	
No	23 (24%)	17 (23%)	2 (15%)	4 (57%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	40 (53%)	9 (69%)	1 (14%)	
Competing priorities					0.7
Yes	21 (22%)	16 (21%)	2 (15%)	3 (43%)	
No	24 (25%)	19 (25%)	2 (15%)	3 (43%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	40 (53%)	9 (69%)	1 (14%)	
Do not need BE					0.4
Yes	13 (14%)	12 (16%)	0 (0%)	1 (14%)	
No	31 (33%)	22 (29%)	4 (31%)	5 (71%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	40 (53%)	9 (69%)	1 (14%)	
Other, please specify:					0.3
Yes	2 (2%)	1 (1%)	1 (8%)	0 (0%)	
No	14 (15%)	12 (16%)	1 (8%)	1 (14%)	
Respondent skip	29 (31%)	22 (29%)	2 (15%)	5 (71%)	
Not asked	50 (53%)	40 (53%)	9 (69%)	1 (14%)	
13a. As part of the DCE's efforts to engage Participant Providers, how important is each of the following practice support and improvement activities?					
DCE provides or arranges for centralized population health support staff (e.g., care managers, pharmacist, schedulers/administrative support)					0.002***
Very important	77 (81%)	66 (88%)	6 (46%)	5 (71%)	
Somewhat important	4 (4%)	2 (3%)	2 (15%)	0 (0%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Not important	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
DCE does not offer this activity	12 (13%)	5 (7%)	5 (38%)	2 (29%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE provides or arranges for staff embedded in practices (e.g., administrative, care manager, health educator/coach, social worker)					0.064*
Very important	51 (54%)	43 (57%)	5 (38%)	3 (43%)	
Somewhat important	13 (14%)	11 (15%)	0 (0%)	2 (29%)	
Not important	4 (4%)	2 (3%)	2 (15%)	0 (0%)	
DCE does not offer this activity	26 (27%)	18 (24%)	6 (46%)	2 (29%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE provides or arranges for investments in infrastructure at the practice level (Tooltip: Infrastructure refers to Electronic Health Record software, hardware, data analytic support, care delivery tools [e.g., shared decision-making aids, patient survey instruments], and licenses to access tools.)					0.12
Very important	61 (64%)	50 (67%)	6 (46%)	5 (71%)	
Somewhat important	19 (20%)	15 (20%)	3 (23%)	1 (14%)	
Not important	5 (5%)	4 (5%)	0 (0%)	1 (14%)	
DCE does not offer this activity	9 (9%)	5 (7%)	4 (31%)	0 (0%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Coaching or one-on-one review of performance, quality, and/or cost data					0.2
Very important	69 (73%)	54 (72%)	10 (77%)	5 (71%)	
Somewhat important	15 (16%)	13 (17%)	0 (0%)	2 (29%)	
Not important	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE does not offer this activity	10 (11%)	7 (9%)	3 (23%)	0 (0%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Data analysis support other than feedback reports on quality, utilization, or cost					0.9
Very important	76 (80%)	60 (80%)	10 (77%)	6 (86%)	
Somewhat important	7 (7%)	5 (7%)	1 (8%)	1 (14%)	
Not important	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE does not offer this activity	10 (11%)	8 (11%)	2 (15%)	0 (0%)	
Respondent skip	2 (2%)	2 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Regular meetings between DCE and individual practice leaders					0.070*

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Very important	83 (87%)	65 (87%)	11 (85%)	7 (100%)	
Somewhat important	6 (6%)	6 (8%)	0 (0%)	0 (0%)	
Not important	3 (3%)	3 (4%)	0 (0%)	0 (0%)	
DCE does not offer this activity	2 (2%)	0 (0%)	2 (15%)	0 (0%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Action-oriented initiatives focusing on small-scale, discrete areas for improvement (e.g., improving completion rates for flu vaccine, increasing number of annual wellness visits)					0.007***
Very important	74 (78%)	61 (81%)	6 (46%)	7 (100%)	
Somewhat important	10 (11%)	8 (11%)	2 (15%)	0 (0%)	
Not important	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
DCE does not offer this activity	9 (9%)	4 (5%)	5 (38%)	0 (0%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Training and education sessions					>0.9
Very important	74 (78%)	57 (76%)	11 (85%)	6 (86%)	
Somewhat important	16 (17%)	13 (17%)	2 (15%)	1 (14%)	
Not important	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
DCE does not offer this activity	3 (3%)	3 (4%)	0 (0%)	0 (0%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Workflow redesign or optimization support					0.4
Very important	51 (54%)	41 (55%)	5 (38%)	5 (71%)	
Somewhat important	26 (27%)	21 (28%)	4 (31%)	1 (14%)	
Not important	5 (5%)	4 (5%)	0 (0%)	1 (14%)	
DCE does not offer this activity	12 (13%)	8 (11%)	4 (31%)	0 (0%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other practice support and improvement activities, please specify:					0.5
Very important	11 (12%)	8 (11%)	1 (8%)	2 (29%)	
Somewhat important	5 (5%)	5 (7%)	0 (0%)	0 (0%)	
Not important	5 (5%)	3 (4%)	2 (15%)	0 (0%)	
DCE does not offer this activity	21 (22%)	16 (21%)	3 (23%)	2 (29%)	
Respondent skip	53 (56%)	43 (57%)	7 (54%)	3 (43%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
13b. Please estimate the portion of Participant Providers that use the DCE's practice support and improvement activities listed below. Your best estimate is fine. *(Asked of those who said "Very important" to Q13a)*					
DCE-provided centralized population health support staff (e.g., care managers, pharmacist, schedulers/administrative support)					0.006***
All	27 (28%)	24 (32%)	1 (8%)	2 (29%)	
Most	38 (40%)	33 (44%)	3 (23%)	2 (29%)	
Some	11 (12%)	8 (11%)	2 (15%)	1 (14%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	18 (19%)	9 (12%)	7 (54%)	2 (29%)	
DCE-provided staff embedded in practices (e.g., administrative, care manager, health educator/coach, social worker)					0.3
All	22 (23%)	21 (28%)	1 (8%)	0 (0%)	
Most	13 (14%)	9 (12%)	3 (23%)	1 (14%)	
Some	13 (14%)	12 (16%)	1 (8%)	0 (0%)	
None	3 (3%)	1 (1%)	0 (0%)	2 (29%)	
Don't know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	44 (46%)	32 (43%)	8 (62%)	4 (57%)	
DCE-provided investments in infrastructure at the practice level					0.6
All	17 (18%)	15 (20%)	1 (8%)	1 (14%)	
Most	36 (38%)	28 (37%)	4 (31%)	4 (57%)	
Some	7 (7%)	6 (8%)	1 (8%)	0 (0%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	34 (36%)	25 (33%)	7 (54%)	2 (29%)	
Coaching or one-on-one review of performance, quality, and/or cost data					0.004***
All	32 (34%)	30 (40%)	0 (0%)	2 (29%)	
Most	25 (26%)	14 (19%)	8 (62%)	3 (43%)	
Some	9 (9%)	7 (9%)	2 (15%)	0 (0%)	
None	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Don't know	2 (2%)	2 (3%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	26 (27%)	21 (28%)	3 (23%)	2 (29%)	
Data analysis support other than feedback reports on quality, utilization, or cost					0.002***

Question	Overall, N=95[1]	DCE Type			p-value (Standards and New Entrants only)[2]
		Standard, N=75[1]	New Entrant, N=13[1]	High Needs, N=7[1]	
All	32 (34%)	30 (40%)	0 (0%)	2 (29%)	
Most	24 (25%)	13 (17%)	8 (62%)	3 (43%)	
Some	19 (20%)	16 (21%)	2 (15%)	1 (14%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	19 (20%)	15 (20%)	3 (23%)	1 (14%)	
Regular meetings between DCE and individual practice leaders					0.2
All	42 (44%)	36 (48%)	4 (31%)	2 (29%)	
Most	34 (36%)	25 (33%)	4 (31%)	5 (71%)	
Some	6 (6%)	3 (4%)	3 (23%)	0 (0%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	12 (13%)	10 (13%)	2 (15%)	0 (0%)	
Action-oriented initiatives focusing on small-scale, discrete areas for improvement (e.g., improving completion rates for flu vaccine, increasing number of annual wellness visits)					0.046**
All	30 (32%)	29 (39%)	1 (8%)	0 (0%)	
Most	31 (33%)	21 (28%)	4 (31%)	6 (86%)	
Some	12 (13%)	10 (13%)	1 (8%)	1 (14%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	21 (22%)	14 (19%)	7 (54%)	0 (0%)	
Training and education sessions					0.5
All	39 (41%)	33 (44%)	4 (31%)	2 (29%)	
Most	25 (26%)	16 (21%)	5 (38%)	4 (57%)	
Some	9 (9%)	7 (9%)	2 (15%)	0 (0%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	21 (22%)	18 (24%)	2 (15%)	1 (14%)	
Workflow redesign or optimization support					0.7
All	21 (22%)	19 (25%)	1 (8%)	1 (14%)	
Most	15 (16%)	10 (13%)	2 (15%)	3 (43%)	
Some	13 (14%)	10 (13%)	2 (15%)	1 (14%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
None	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Don't know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	44 (46%)	34 (45%)	8 (62%)	2 (29%)	
Other practice support and improvement activity specified in 13a					0.8
All	5 (5%)	4 (5%)	1 (8%)	0 (0%)	
Most	2 (2%)	1 (1%)	0 (0%)	1 (14%)	
Some	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
None	1 (1%)	0 (0%)	0 (0%)	1 (14%)	
Don't know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	3 (3%)	3 (4%)	0 (0%)	0 (0%)	
Not asked	84 (88%)	67 (89%)	12 (92%)	5 (71%)	
14a. How important are each of the following information sharing activities for engaging your DCE's Participant Providers?					
Feedback reports on quality, utilization, or cost with comparisons at the practice level					0.7
Very important	86 (91%)	66 (88%)	13 (100%)	7 (100%)	
Somewhat important	6 (6%)	6 (8%)	0 (0%)	0 (0%)	
Not important	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE does not offer this activity	2 (2%)	2 (3%)	0 (0%)	0 (0%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Feedback reports on quality, utilization, or cost with comparisons at the individual clinician level					0.066*
Very important	75 (79%)	62 (83%)	7 (54%)	6 (86%)	
Somewhat important	13 (14%)	9 (12%)	4 (31%)	0 (0%)	
Not important	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE does not offer this activity	6 (6%)	3 (4%)	2 (15%)	1 (14%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other information to help providers manage care (e.g., specialty and other service use)					0.5
Very important	65 (68%)	53 (71%)	7 (54%)	5 (71%)	
Somewhat important	21 (22%)	14 (19%)	5 (38%)	2 (29%)	
Not important	2 (2%)	2 (3%)	0 (0%)	0 (0%)	
DCE does not offer this activity	6 (6%)	5 (7%)	1 (8%)	0 (0%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Real time data on emergency department (ED) and inpatient admissions, discharges, and transfers (ADTs)					0.4
Very important	83 (87%)	66 (88%)	11 (85%)	6 (86%)	
Somewhat important	4 (4%)	4 (5%)	0 (0%)	0 (0%)	
Not important	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE does not offer this activity	7 (7%)	4 (5%)	2 (15%)	1 (14%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other information sharing activities, please specify:					>0.9
Very important	12 (13%)	9 (12%)	1 (8%)	2 (29%)	
Somewhat important	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not important	7 (7%)	6 (8%)	1 (8%)	0 (0%)	
DCE does not offer this activity	18 (19%)	14 (19%)	3 (23%)	1 (14%)	
Respondent skip	57 (60%)	45 (60%)	8 (62%)	4 (57%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
14b. Please estimate the portion of Participant Providers that use the DCE's information sharing activities listed below. Your best estimate is fine. *(Asked of those who said "Very important" to Q14a)*					
Feedback reports on quality, utilization, or cost with comparisons at the practice level					0.13
All	29 (31%)	25 (33%)	2 (15%)	2 (29%)	
Most	40 (42%)	30 (40%)	7 (54%)	3 (43%)	
Some	14 (15%)	10 (13%)	3 (23%)	1 (14%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Respondent skip	2 (2%)	0 (0%)	1 (8%)	1 (14%)	
Not asked	9 (9%)	9 (12%)	0 (0%)	0 (0%)	
Feedback reports on quality, utilization, or cost with comparisons at the individual clinician level					0.029**
All	25 (26%)	23 (31%)	0 (0%)	2 (29%)	
Most	34 (36%)	27 (36%)	4 (31%)	3 (43%)	
Some	15 (16%)	11 (15%)	3 (23%)	1 (14%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	20 (21%)	13 (17%)	6 (46%)	1 (14%)	
Other information to help providers manage care (e.g., specialty and other service use)					0.010**
All	19 (20%)	17 (23%)	0 (0%)	2 (29%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Most	22 (23%)	19 (25%)	1 (8%)	2 (29%)	
Some	7 (7%)	4 (5%)	2 (15%)	1 (14%)	
None	2 (2%)	1 (1%)	1 (8%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	1 (8%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	44 (46%)	34 (45%)	8 (62%)	2 (29%)	
Real time data on emergency department (ED) and inpatient admissions, discharges, and transfers (ADTs)					0.6
All	29 (31%)	23 (31%)	3 (23%)	3 (43%)	
Most	36 (38%)	29 (39%)	4 (31%)	3 (43%)	
Some	14 (15%)	11 (15%)	3 (23%)	0 (0%)	
None	2 (2%)	1 (1%)	1 (8%)	0 (0%)	
Don't know	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	12 (13%)	9 (12%)	2 (15%)	1 (14%)	
Other information sharing activity specified in 14a					0.5
All	8 (8%)	6 (8%)	0 (0%)	2 (29%)	
Most	3 (3%)	2 (3%)	1 (8%)	0 (0%)	
Some	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	83 (87%)	66 (88%)	12 (92%)	5 (71%)	
15a. How important are each of the following incentives for engaging your DCE's Participant Providers?					
Financial bonuses tied to performance					0.004***
Very important	77 (81%)	65 (87%)	7 (54%)	5 (71%)	
Somewhat important	8 (8%)	5 (7%)	2 (15%)	1 (14%)	
Not important	3 (3%)	3 (4%)	0 (0%)	0 (0%)	
DCE does not offer this activity	7 (7%)	2 (3%)	4 (31%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Financial penalties tied to performance					0.057*
Very important	24 (25%)	20 (27%)	2 (15%)	2 (29%)	
Somewhat important	31 (33%)	28 (37%)	2 (15%)	1 (14%)	
Not important	8 (8%)	6 (8%)	0 (0%)	2 (29%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
DCE does not offer this activity	32 (34%)	21 (28%)	9 (69%)	2 (29%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Non-financial awards or recognition tied to performance					0.020**
Very important	21 (22%)	16 (21%)	3 (23%)	2 (29%)	
Somewhat important	47 (49%)	41 (55%)	3 (23%)	3 (43%)	
Not important	7 (7%)	6 (8%)	0 (0%)	1 (14%)	
DCE does not offer this activity	20 (21%)	12 (16%)	7 (54%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE provides upfront payments					>0.9
Very important	37 (39%)	30 (40%)	5 (38%)	2 (29%)	
Somewhat important	19 (20%)	13 (17%)	3 (23%)	3 (43%)	
Not important	8 (8%)	5 (7%)	1 (8%)	2 (29%)	
DCE does not offer this activity	31 (33%)	27 (36%)	4 (31%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other incentives, please specify:					0.8
Very important	11 (12%)	9 (12%)	2 (15%)	0 (0%)	
Somewhat important	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not important	4 (4%)	3 (4%)	1 (8%)	0 (0%)	
DCE does not offer this activity	22 (23%)	18 (24%)	3 (23%)	1 (14%)	
Respondent skip	57 (60%)	44 (59%)	7 (54%)	6 (86%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

15b. Please estimate the portion of Participant Providers that receive the DCE's incentives listed below. Your best estimate is fine. *(Asked of those who said "Very important" to Q15a)*

Financial bonuses tied to performance					0.3
All	36 (38%)	32 (43%)	2 (15%)	2 (29%)	
Most	19 (20%)	14 (19%)	3 (23%)	2 (29%)	
Some	12 (13%)	10 (13%)	2 (15%)	0 (0%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't Know	2 (2%)	1 (1%)	0 (0%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	26 (27%)	18 (24%)	6 (46%)	2 (29%)	
Financial penalties tied to performance					>0.9

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
All	8 (8%)	6 (8%)	1 (8%)	1 (14%)	
Most	4 (4%)	3 (4%)	1 (8%)	0 (0%)	
Some	4 (4%)	4 (5%)	0 (0%)	0 (0%)	
None	5 (5%)	5 (7%)	0 (0%)	0 (0%)	
Don't Know	3 (3%)	2 (3%)	0 (0%)	1 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	71 (75%)	55 (73%)	11 (85%)	5 (71%)	
Non-financial awards or recognition tied to performance					0.5
All	5 (5%)	5 (7%)	0 (0%)	0 (0%)	
Most	9 (9%)	5 (7%)	3 (23%)	1 (14%)	
Some	5 (5%)	4 (5%)	0 (0%)	1 (14%)	
None	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Don't Know	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	74 (78%)	59 (79%)	10 (77%)	5 (71%)	
DCE provides upfront payments					0.8
All	21 (22%)	17 (23%)	2 (15%)	2 (29%)	
Most	13 (14%)	10 (13%)	3 (23%)	0 (0%)	
Some	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
None	2 (2%)	2 (3%)	0 (0%)	0 (0%)	
Don't Know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	58 (61%)	45 (60%)	8 (62%)	5 (71%)	
Other incentive specified in 15a					0.7
All	6 (6%)	5 (7%)	1 (8%)	0 (0%)	
Most	4 (4%)	3 (4%)	1 (8%)	0 (0%)	
Some	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't Know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	84 (88%)	66 (88%)	11 (85%)	7 (100%)	

16. Which of the following methods does your DCE use to pay Participant Providers? Please select all that apply.					
Partial fee-for-service					0.7
DCE uses this method	34 (36%)	25 (33%)	5 (38%)	4 (57%)	
DCE does not use this method	45 (47%)	35 (47%)	7 (54%)	3 (43%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Respondent skip	16 (17%)	15 (20%)	1 (8%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Fee-for-service					0.6
DCE uses this method	44 (46%)	34 (45%)	6 (46%)	4 (57%)	
DCE does not use this method	35 (37%)	26 (35%)	6 (46%)	3 (43%)	
Respondent skip	16 (17%)	15 (20%)	1 (8%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Partial capitation					0.6
DCE uses this method	39 (41%)	30 (40%)	7 (54%)	2 (29%)	
DCE does not use this method	41 (43%)	31 (41%)	5 (38%)	5 (71%)	
Respondent skip	15 (16%)	14 (19%)	1 (8%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Total capitation					0.8
DCE uses this method	25 (26%)	18 (24%)	4 (31%)	3 (43%)	
DCE does not use this method	52 (55%)	42 (56%)	7 (54%)	3 (43%)	
Respondent skip	18 (19%)	15 (20%)	2 (15%)	1 (14%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Payments tied to quality thresholds					0.2
DCE uses this method	51 (54%)	42 (56%)	5 (38%)	4 (57%)	
DCE does not use this method	28 (29%)	19 (25%)	7 (54%)	2 (29%)	
Respondent skip	16 (17%)	14 (19%)	1 (8%)	1 (14%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other, please specify:					>0.9
DCE uses this method	20 (21%)	16 (21%)	3 (23%)	1 (14%)	
DCE does not use this method	21 (22%)	17 (23%)	3 (23%)	1 (14%)	
Respondent skip	54 (57%)	42 (56%)	7 (54%)	5 (71%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
17. Not including any capitated payments the DCE may make to providers, does your DCE use financial rewards and/or penalties with its Participant Providers?					
DCE uses financial rewards					0.037**
Yes	84 (88%)	69 (92%)	9 (69%)	6 (86%)	
No	10 (11%)	5 (7%)	4 (31%)	1 (14%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE uses financial penalties					0.6

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Yes	25 (26%)	21 (28%)	2 (15%)	2 (29%)	
No	69 (73%)	53 (71%)	11 (85%)	5 (71%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
18a. How many of your DCE's Participant Providers are employed directly by a health system or practice participating in the model?					0.5
All	38 (40%)	33 (44%)	3 (23%)	2 (29%)	
Most	25 (26%)	17 (23%)	5 (38%)	3 (43%)	
Some	11 (12%)	10 (13%)	1 (8%)	0 (0%)	
Very Few	8 (8%)	6 (8%)	1 (8%)	1 (14%)	
None	12 (13%)	8 (11%)	3 (23%)	1 (14%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
19. Does your DCE use financial rewards and/or penalties with its Preferred Providers?					
DCE uses financial rewards					0.5
Yes	40 (42%)	34 (45%)	4 (31%)	2 (29%)	
No	54 (57%)	40 (53%)	9 (69%)	5 (71%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE uses financial penalties					0.12
Yes	28 (29%)	26 (35%)	1 (8%)	1 (14%)	
No	66 (69%)	48 (64%)	12 (92%)	6 (86%)	
Respondent skip	1 (1%)	1 (1%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
20a. Does the DCE share upside financial risk (savings) directly with Participant Providers? *(Note: This is an aggregated version of question 20a)*					
Yes, DCE shares total savings with practitioners[3]	73 (77%)	58 (77%)	9 (69%)	6 (86%)	0.5
Yes, DCE shares service-specific savings with practitioners[3]	19 (20%)	14 (19%)	3 (23%)	2 (29%)	0.7
20c. Does the DCE share downside financial risk (losses) directly with Participant Providers? *(Note: This is an aggregated version of question 20c)*					

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Yes, DCE shares total losses with practitioners[3]	16 (17%)	13 (17%)	1 (8%)	2 (29%)	0.7
Yes, DCE shares service-specific losses with practitioners[3]	6 (6%)	4 (5%)	2 (15%)	0 (0%)	0.2
20a. Does the DCE share upside financial risk (savings) directly with Participant Facilities? *(Note: This is an aggregated version of question 20a)*					
Yes, DCE shares total savings with facilities[4]	9 (9%)	8 (11%)	0 (0%)	1 (14%)	0.6
Yes, DCE shares service-specific savings with facilities[4]	21 (22%)	19 (25%)	1 (8%)	1 (14%)	0.3
20c. Does the DCE share downside financial risk (losses) directly with Participant Facilities? *(Note: This is an aggregated version of question 20c)*					
Yes, DCE shares total losses with facilities[4]	6 (6%)	5 (7%)	0 (0%)	1 (14%)	>0.9
Yes, DCE shares service-specific losses with facilities[4]	0 (0%)	0 (0%)	0 (0%)	0 (0%)	No test
20a. Does your DCE share upside financial risk (savings) directly with the Participant Provider types listed below?					
Individual practitioners who may be employed directly by a health system or practice participating in the model					
Total DCE savings	48 (51%)	44 (59%)	3 (23%)	1 (14%)	0.018**
Service-specific savings	14 (15%)	10 (13%)	3 (23%)	1 (14%)	0.4
Provider type does not participate in DCE	7 (7%)	5 (7%)	1 (8%)	1 (14%)	>0.9
Does not share savings with this type of provider	26 (27%)	15 (20%)	7 (54%)	4 (57%)	0.016**
Physician groups/practices					
Total DCE savings	69 (73%)	55 (73%)	9 (69%)	5 (71%)	0.7
Service-specific savings	15 (16%)	11 (15%)	3 (23%)	1 (14%)	0.4
Provider type does not participate in DCE	4 (4%)	3 (4%)	1 (8%)	0 (0%)	0.5
Does not share savings with this type of provider	7 (7%)	5 (7%)	1 (8%)	1 (14%)	>0.9

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Networks of individual physician practices or other practitioners					
Total DCE savings	48 (51%)	41 (55%)	4 (31%)	3 (43%)	0.11
Service-specific savings	14 (15%)	10 (13%)	3 (23%)	1 (14%)	0.4
Provider type does not participate in DCE	19 (20%)	14 (19%)	4 (31%)	1 (14%)	0.5
Does not share savings with this type of provider	14 (15%)	9 (12%)	3 (23%)	2 (29%)	0.4
Independent or solo practitioners					
Total DCE savings	44 (46%)	35 (47%)	5 (38%)	4 (57%)	0.6
Service-specific savings	11 (12%)	8 (11%)	3 (23%)	0 (0%)	0.2
Provider type does not participate in DCE	22 (23%)	18 (24%)	3 (23%)	1 (14%)	>0.9
Does not share savings with this type of provider	18 (19%)	13 (17%)	3 (23%)	2 (29%)	0.7
Acute care hospitals					
Total DCE savings	7 (7%)	7 (9%)	0 (0%)	0 (0%)	0.6
Service-specific savings	6 (6%)	6 (8%)	0 (0%)	0 (0%)	0.6
Provider type does not participate in DCE	39 (41%)	33 (44%)	5 (38%)	1 (14%)	0.7
Does not share savings with this type of provider	42 (44%)	28 (37%)	8 (62%)	6 (86%)	0.10
Skilled nursing facilities (SNFs)					
Total DCE savings	4 (4%)	4 (5%)	0 (0%)	0 (0%)	>0.9
Service-specific savings	14 (15%)	13 (17%)	0 (0%)	1 (14%)	0.2
Provider type does not participate in DCE	26 (27%)	22 (29%)	3 (23%)	1 (14%)	0.8
Does not share savings with this type of provider	50 (53%)	35 (47%)	10 (77%)	5 (71%)	0.044**
Home health agencies (HHAs)					
Total DCE savings	3 (3%)	2 (3%)	0 (0%)	1 (14%)	>0.9
Service-specific savings	17 (18%)	16 (21%)	1 (8%)	0 (0%)	0.4
Provider type does not participate in DCE	23 (24%)	20 (27%)	2 (15%)	1 (14%)	0.5
Does not share savings with this type of provider	51 (54%)	36 (48%)	10 (77%)	5 (71%)	0.054*
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)					
Total DCE savings	1 (1%)	1 (1%)	0 (0%)	0 (0%)	>0.9
Service-specific savings	2 (2%)	2 (3%)	0 (0%)	0 (0%)	>0.9
Provider type does not participate in DCE	37 (39%)	33 (44%)	3 (23%)	1 (14%)	0.2
Does not share savings with this type of provider	54 (57%)	38 (51%)	10 (77%)	6 (86%)	0.079*
Other provider type, please specify:					

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Total DCE savings	2 (2%)	2 (3%)	0 (0%)	0 (0%)	>0.9
Service-specific savings	3 (3%)	3 (4%)	0 (0%)	0 (0%)	>0.9
Provider type does not participate in DCE	7 (7%)	7 (9%)	0 (0%)	0 (0%)	0.6
Does not share savings with this type of provider	26 (27%)	20 (27%)	5 (38%)	1 (14%)	0.5
20b. For upside risk (savings), what portion is shared with each provider type? *(Asked of those who shared any savings with each provider type)*					
Individual practitioners who may be employed directly by a health system or practice participating in the model					0.2
1-5%	4 (8%)	4 (9%)	0 (0%)	0 (0%)	
6-10%	1 (2%)	0 (0%)	0 (0%)	1 (50%)	
11-30%	11 (22%)	8 (18%)	2 (50%)	1 (50%)	
31-50%	15 (29%)	13 (29%)	2 (50%)	0 (0%)	
More than 50%	20 (39%)	20 (44%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Physician groups / practices					0.8
1-5%	4 (6%)	4 (8%)	0 (0%)	0 (0%)	
6-10%	2 (3%)	1 (2%)	0 (0%)	1 (17%)	
11-30%	14 (21%)	11 (21%)	2 (22%)	1 (17%)	
31-50%	19 (28%)	14 (27%)	4 (44%)	1 (17%)	
More than 50%	28 (42%)	22 (42%)	3 (33%)	3 (50%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Networks of individual physician practices or other practitioners					0.9
1-5%	3 (6%)	3 (7%)	0 (0%)	0 (0%)	
6-10%	2 (4%)	0 (0%)	0 (0%)	2 (50%)	
11-30%	12 (24%)	10 (24%)	1 (20%)	1 (25%)	
31-50%	12 (24%)	10 (24%)	2 (40%)	0 (0%)	
More than 50%	21 (42%)	18 (44%)	2 (40%)	1 (25%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Independent or solo practitioners					>0.9

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
1-5%	2 (5%)	2 (6%)	0 (0%)	0 (0%)	
6-10%	1 (2%)	0 (0%)	0 (0%)	1 (25%)	
11-30%	15 (37%)	11 (34%)	2 (40%)	2 (50%)	
31-50%	13 (32%)	11 (34%)	2 (40%)	0 (0%)	
More than 50%	10 (24%)	8 (25%)	1 (20%)	1 (25%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Acute care hospitals					>0.9
1-5%	3 (30%)	3 (30%)	0 (NA%)	0 (NA%)	
6-10%	2 (20%)	2 (20%)	0 (NA%)	0 (NA%)	
11-30%	4 (40%)	4 (40%)	0 (NA%)	0 (NA%)	
31-50%	0 (0%)	0 (0%)	0 (NA%)	0 (NA%)	
More than 50%	1 (10%)	1 (10%)	0 (NA%)	0 (NA%)	
Respondent skip	0 (0%)	0 (0%)	0 (NA%)	0 (NA%)	
Not asked	0 (0%)	0 (0%)	0 (NA%)	0 (NA%)	
Skilled nursing facilities (SNFs)					>0.9
1-5%	13 (81%)	13 (87%)	0 (NA%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (NA%)	0 (0%)	
11-30%	3 (19%)	2 (13%)	0 (NA%)	1 (100%)	
31-50%	0 (0%)	0 (0%)	0 (NA%)	0 (0%)	
More than 50%	0 (0%)	0 (0%)	0 (NA%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (NA%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (NA%)	0 (0%)	
Home health agencies (HHAs)					>0.9
1-5%	14 (78%)	14 (82%)	0 (NA%)	0 (0%)	
6-10%	2 (11%)	1 (6%)	0 (NA%)	1 (100%)	
11-30%	2 (11%)	2 (12%)	0 (NA%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (NA%)	0 (0%)	
More than 50%	0 (0%)	0 (0%)	0 (NA%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (NA%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (NA%)	0 (0%)	
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)					>0.9

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
1-5%	2 (67%)	2 (67%)	0 (NA%)	0 (NA%)	
6-10%	0 (0%)	0 (0%)	0 (NA%)	0 (NA%)	
11-30%	1 (33%)	1 (33%)	0 (NA%)	0 (NA%)	
31-50%	0 (0%)	0 (0%)	0 (NA%)	0 (NA%)	
More than 50%	0 (0%)	0 (0%)	0 (NA%)	0 (NA%)	
Respondent skip	0 (0%)	0 (0%)	0 (NA%)	0 (NA%)	
Not asked	0 (0%)	0 (0%)	0 (NA%)	0 (NA%)	
Other provider type specified in 20a					>0.9
1-5%	3 (60%)	3 (60%)	0 (NA%)	0 (NA%)	
6-10%	0 (0%)	0 (0%)	0 (NA%)	0 (NA%)	
11-30%	1 (20%)	1 (20%)	0 (NA%)	0 (NA%)	
31-50%	0 (0%)	0 (0%)	0 (NA%)	0 (NA%)	
More than 50%	1 (20%)	1 (20%)	0 (NA%)	0 (NA%)	
Respondent skip	0 (0%)	0 (0%)	0 (NA%)	0 (NA%)	
Not asked	0 (0%)	0 (0%)	0 (NA%)	0 (NA%)	
20c. Does your DCE share downside financial risk (losses) directly with the Participant Provider types listed below?					
Individual practitioners who may be employed directly by a health system or practice participating in the model					
Total DCE losses	9 (10%)	9 (13%)	0 (0%)	0 (0%)	0.3
Service-specific losses	3 (3%)	2 (3%)	1 (8%)	0 (0%)	0.4
Does not share losses with this type of provider	74 (84%)	58 (83%)	11 (92%)	5 (83%)	0.7
Physician groups/practices					
Total DCE losses	10 (11%)	7 (10%)	1 (8%)	2 (29%)	>0.9
Service-specific losses	6 (7%)	4 (6%)	2 (17%)	0 (0%)	0.2
Does not share losses with this type of provider	74 (81%)	60 (83%)	9 (75%)	5 (71%)	0.4
Networks of individual physician practices or other practitioners					
Total DCE losses	8 (11%)	6 (10%)	1 (11%)	1 (17%)	>0.9
Service-specific losses	2 (3%)	1 (2%)	1 (11%)	0 (0%)	0.2
Does not share losses with this type of provider	64 (84%)	53 (87%)	7 (78%)	4 (67%)	0.6

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Independent or solo practitioners					
Total DCE losses	5 (7%)	4 (7%)	0 (0%)	1 (17%)	>0.9
Service-specific losses	4 (5%)	2 (4%)	2 (20%)	0 (0%)	0.10
Does not share losses with this type of provider	62 (85%)	50 (88%)	8 (80%)	4 (67%)	0.6
Acute care hospitals					
Total DCE losses	4 (7%)	4 (10%)	0 (0%)	0 (0%)	>0.9
Service-specific losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Does not share losses with this type of provider	50 (89%)	37 (88%)	8 (100%)	5 (83%)	0.6
Skilled nursing facilities (SNFs)					
Total DCE losses	2 (3%)	2 (4%)	0 (0%)	0 (0%)	>0.9
Service-specific losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Does not share losses with this type of provider	65 (94%)	50 (94%)	10 (100%)	5 (83%)	>0.9
Home health agencies (HHAs)					
Total DCE losses	2 (3%)	1 (2%)	0 (0%)	1 (17%)	>0.9
Service-specific losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Does not share losses with this type of provider	68 (94%)	53 (96%)	11 (100%)	4 (67%)	>0.9
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)					
Total DCE losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Service-specific losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Does not share losses with this type of provider	56 (97%)	41 (98%)	10 (100%)	5 (83%)	>0.9
Other provider type, please specify:					
Total DCE losses	1 (1%)	1 (1%)	0 (0%)	0 (0%)	>0.9
Service-specific losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Does not share losses with this type of provider	40 (45%)	33 (49%)	5 (38%)	2 (29%)	0.5

20d. For downside risk (losses), what percentage is shared with each provider type?

(Asked of those who shared any losses with each provider type)

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Individual practitioners who may be employed directly by a health system or practice participating in the model					>0.9
1-5%	1 (11%)	1 (13%)	0 (0%)	0 (NA%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (NA%)	
11-30%	2 (22%)	2 (25%)	0 (0%)	0 (NA%)	
31-50%	1 (11%)	1 (13%)	0 (0%)	0 (NA%)	
More than 50%	5 (56%)	4 (50%)	1 (100%)	0 (NA%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (NA%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (NA%)	
Physician groups/practices					>0.9
1-5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	3 (27%)	2 (29%)	0 (0%)	1 (50%)	
31-50%	1 (9%)	1 (14%)	0 (0%)	0 (0%)	
More than 50%	7 (64%)	4 (57%)	2 (100%)	1 (50%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Networks of individual physician practices or other practitioners					0.4
1-5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	3 (50%)	2 (67%)	0 (0%)	1 (100%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	3 (50%)	1 (33%)	2 (100%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Independent or solo practitioners					0.5
1-5%	1 (20%)	1 (33%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	3 (60%)	2 (67%)	0 (0%)	1 (100%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	1 (20%)	0 (0%)	1 (100%)	0 (0%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Acute care hospitals					>0.9
1-5%	1 (33%)	1 (33%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	1 (33%)	1 (33%)	0 (0%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	1 (33%)	1 (33%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Skilled nursing facilities (SNFs)					
1-5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (NA%)	0 (NA%)	0 (NA%)	0 (NA%)	
Home health agencies (HHAs)					>0.9
1-5%	1 (50%)	1 (100%)	0 (0%)	0 (0%)	
6-10%	1 (50%)	0 (0%)	0 (0%)	1 (100%)	
11-30%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)					
1-5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	DCE Type: Standard, N=75[1]	DCE Type: New Entrant, N=13[1]	DCE Type: High Needs, N=7[1]	p-value (Standards and New Entrants only)[2]
More than 50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other provider type specified in 20c					>0.9
1-5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	1 (100%)	1 (100%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

NOTE: DCE: Direct Contracting Entity, NP = Nurse Practitioner, BE=Benefit Enhancements, BEI=Beneficiary Engagement Incentives.

[1] n (%)

[2] *p<0.10; **p<0.05; ***p<0.01.

[3] Practitioners include: Individual practitioners who may be employed directly by a health system or practice participating in the model, physician groups/practices, networks of individual physician practices or other practitioners, and independent or solo practitioners.

[4] Facilities include: acute care hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs).

Appendix D.2.2. Selected 2022 Pulse Check Survey Results by Organizational Structure

Question	**Overall**, N=95[1]	**Organizational Structure: Network of Individual Practices**, N=40[1]	**Medical Group Practice**, N=33[1]	**Integrated Delivery/ Hospital System**, N=22[1]	**p-value**[2]
3. Now we would like to know about different strategies that your DCE may or may not be focused on. For each of the items listed below, please select the response option that most accurately reflects the perspective of your DCE.					
Investments in primary care capacity such as non-physician providers, after-hours care					0.13
High priority	52 (55%)	22 (55%)	23 (70%)	7 (32%)	
Medium priority	27 (28%)	12 (30%)	7 (21%)	8 (36%)	
Low priority	12 (13%)	5 (13%)	2 (6%)	5 (23%)	
Not a priority / Not applicable	4 (4%)	1 (3%)	1 (3%)	2 (9%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Organizational Structure			p-value[2]
		Network of Individual Practices, N=40[1]	Medical Group Practice, N=33[1]	Integrated Delivery/ Hospital System, N=22[1]	
Investments in behavioral health capacity such as behavioral health professionals, telehealth appointments					0.5
High priority	31 (33%)	13 (33%)	8 (24%)	10 (45%)	
Medium priority	24 (25%)	9 (23%)	10 (30%)	5 (23%)	
Low priority	33 (35%)	14 (35%)	14 (42%)	5 (23%)	
Not a priority / Not applicable	7 (7%)	4 (10%)	1 (3%)	2 (9%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Initiatives to encourage referrals to high-quality or Preferred Providers					0.3
High priority	35 (37%)	17 (43%)	10 (30%)	8 (36%)	
Medium priority	48 (51%)	20 (50%)	19 (58%)	9 (41%)	
Low priority	7 (7%)	3 (8%)	2 (6%)	2 (9%)	
Not a priority / Not applicable	5 (5%)	0 (0%)	2 (6%)	3 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Complex care management or population-specific care management programs					0.4
High priority	84 (88%)	35 (88%)	29 (88%)	20 (91%)	
Medium priority	10 (11%)	5 (13%)	4 (12%)	1 (5%)	
Low priority	1 (1%)	0 (0%)	0 (0%)	1 (5%)	
Not a priority / Not applicable	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Initiatives to reduce low value care					0.2
High priority	44 (46%)	21 (53%)	16 (48%)	7 (32%)	
Medium priority	37 (39%)	14 (35%)	15 (45%)	8 (36%)	
Low priority	10 (11%)	4 (10%)	2 (6%)	4 (18%)	
Not a priority / Not applicable	4 (4%)	1 (3%)	0 (0%)	3 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Initiatives to reduce avoidable inpatient, emergency department, or post-acute care utilization					0.4
High priority	90 (95%)	38 (95%)	31 (94%)	21 (95%)	
Medium priority	4 (4%)	2 (5%)	2 (6%)	0 (0%)	
Low priority	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not a priority / Not applicable	1 (1%)	0 (0%)	0 (0%)	1 (5%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Initiatives to address beneficiaries' social needs, such as food insecurity, housing, and transportation					0.017**
High priority	47 (49%)	19 (48%)	13 (39%)	15 (68%)	
Medium priority	37 (39%)	16 (40%)	18 (55%)	3 (14%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Low priority	9 (9%)	5 (13%)	2 (6%)	2 (9%)	
Not a priority / Not applicable	2 (2%)	0 (0%)	0 (0%)	2 (9%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Emphasis on primary care touchpoints (e.g., annual wellness visits)					0.5
High priority	81 (85%)	33 (83%)	29 (88%)	19 (86%)	
Medium priority	13 (14%)	7 (18%)	4 (12%)	2 (9%)	
Low priority	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not a priority / Not applicable	1 (1%)	0 (0%)	0 (0%)	1 (5%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other, please specify:					0.11
High priority	14 (15%)	10 (25%)	2 (6%)	2 (9%)	
Medium priority	3 (3%)	2 (5%)	1 (3%)	0 (0%)	
Low priority	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Not a priority / Not applicable	19 (20%)	9 (23%)	4 (12%)	6 (27%)	
Respondent skip	58 (61%)	19 (48%)	25 (76%)	14 (64%)	
7. How does your DCE support Participant and Preferred Provider practices to offer expanded access to care? Select all that apply.					
DCE offers, funds, or supports centralized population health support staff (e.g., care managers, pharmacist, schedulers/administrative support)					
Participant Providers	83 (87%)	35 (88%)	30 (91%)	18 (82%)	0.6
Preferred Providers	28 (29%)	15 (38%)	6 (18%)	7 (32%)	0.2
DCE does not provide this type of support	10 (11%)	5 (13%)	3 (9%)	2 (9%)	>0.9
DCE directly provides or funds the provision of telehealth					
Participant Providers	47 (49%)	20 (50%)	21 (64%)	6 (27%)	0.030**
Preferred Providers	7 (7%)	6 (15%)	1 (3%)	0 (0%)	0.055*
DCE does not provide this type of support	48 (51%)	20 (50%)	12 (36%)	16 (73%)	0.030**
DCE offers, funds, or supports extended or weekend hours for practices					
Participant Providers	48 (51%)	20 (50%)	21 (64%)	7 (32%)	0.069*
Preferred Providers	6 (6%)	5 (13%)	1 (3%)	0 (0%)	0.2
DCE does not provide this type of support	47 (49%)	20 (50%)	12 (36%)	15 (68%)	0.069*
DCE offers, funds, or supports urgent or extended care (Tooltip: Extended care refers to services offered by the DCE (not just select practices in the DCE) beyond those offered in a typical primary care practice. Examples include IV fluids, ultrasound, and x-rays.)					
Participant Providers	48 (51%)	20 (50%)	19 (58%)	9 (41%)	0.5
Preferred Providers	10 (11%)	7 (18%)	1 (3%)	2 (9%)	0.13

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
DCE does not provide this type of support	46 (48%)	20 (50%)	14 (42%)	12 (55%)	0.7
DCE offers, funds, or provides other support for expanded access to care (please specify):					
Participant Providers	36 (38%)	19 (48%)	11 (33%)	6 (27%)	0.2
Preferred Providers	6 (6%)	2 (5%)	2 (6%)	2 (9%)	0.9
DCE does not provide this type of support	34 (36%)	16 (40%)	7 (21%)	11 (50%)	0.071*
9a. Does your DCE currently conduct activities to increase voluntary alignment?					
Yes	70 (74%)	32 (80%)	25 (76%)	13 (59%)	0.2
9b. Below is a list of different approaches that your DCE may use to increase voluntary alignment. For each one, please indicate whether your DCE uses this approach. *(Asked of those who said "Yes" to Q9a)*					
Communicates to beneficiaries through the DCE portal or email					0.11
Yes	48 (51%)	19 (48%)	21 (64%)	8 (36%)	
No	22 (23%)	13 (33%)	4 (12%)	5 (23%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	8 (20%)	8 (24%)	9 (41%)	
Communicates to beneficiaries via mail					0.2
Yes	56 (59%)	23 (58%)	21 (64%)	12 (55%)	
No	14 (15%)	9 (23%)	4 (12%)	1 (5%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	8 (20%)	8 (24%)	9 (41%)	
Communicates to beneficiaries via voice or text messages					0.034**
Yes	14 (15%)	10 (25%)	1 (3%)	3 (14%)	
No	56 (59%)	22 (55%)	24 (73%)	10 (45%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	8 (20%)	8 (24%)	9 (41%)	
Training for care managers, other care team members (e.g., social workers), or DCE providers to conduct outreach or educate beneficiaries about voluntary alignment					0.2
Yes	61 (64%)	30 (75%)	20 (61%)	11 (50%)	
No	9 (9%)	2 (5%)	5 (15%)	2 (9%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	8 (20%)	8 (24%)	9 (41%)	
Training for office or front desk staff to respond to beneficiary questions about voluntary alignment					0.3
Yes	63 (66%)	29 (73%)	22 (67%)	12 (55%)	
No	2 (2%)	0 (0%)	1 (3%)	1 (5%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Respondent skip	5 (5%)	3 (8%)	2 (6%)	0 (0%)	
Not asked	25 (26%)	8 (20%)	8 (24%)	9 (41%)	
Presentations for beneficiaries (e.g., via webinar, town hall, information sessions)					0.081*
Yes	16 (17%)	10 (25%)	2 (6%)	4 (18%)	
No	54 (57%)	22 (55%)	23 (70%)	9 (41%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	8 (20%)	8 (24%)	9 (41%)	
Partner/collaborate with potential referral sources (e.g., community-based organizations such as Area Agencies on Aging)					0.019**
Yes	14 (15%)	11 (28%)	1 (3%)	2 (9%)	
No	56 (59%)	21 (53%)	24 (73%)	11 (50%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	8 (20%)	8 (24%)	9 (41%)	
Other strategy, please specify:					0.5
Yes	12 (13%)	7 (18%)	3 (9%)	2 (9%)	
No	21 (22%)	10 (25%)	6 (18%)	5 (23%)	
Respondent skip	37 (39%)	15 (38%)	16 (48%)	6 (27%)	
Not asked	25 (26%)	8 (20%)	8 (24%)	9 (41%)	
10. Select the option that best reflects your DCE's implementation status for each BE or BEI. (Tooltip: DCEs may choose benefit enhancements (BEs) and beneficiary engagement incentives (BEIs) to implement and support their ability to manage the care of beneficiaries. BEs are conditional waivers of certain Medicare payment rules. BEIs permit DCE providers to give in-kind items or services to beneficiaries if certain conditions are satisfied.)					
Telehealth expansion waiver					0.3
Fully implemented and operational in PY2021	18 (19%)	11 (28%)	5 (15%)	2 (9%)	
Fully implemented and operational in PY2022	7 (7%)	4 (10%)	2 (6%)	1 (5%)	
Planning to implement in PY2023	23 (24%)	11 (28%)	6 (18%)	6 (27%)	
Decided not to implement	47 (49%)	14 (35%)	20 (61%)	13 (59%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Three-day skilled nursing facility (SNF) rule waiver					0.2
Fully implemented and operational in PY2021	31 (33%)	12 (30%)	13 (39%)	6 (27%)	
Fully implemented and operational in PY2022	19 (20%)	8 (20%)	3 (9%)	8 (36%)	
Planning to implement in PY2023	26 (27%)	14 (35%)	7 (21%)	5 (23%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Decided not to implement	19 (20%)	6 (15%)	10 (30%)	3 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Post-discharge home visit waiver					0.023**
Fully implemented and operational in PY2021	11 (12%)	7 (18%)	3 (9%)	1 (5%)	
Fully implemented and operational in PY2022	10 (11%)	7 (18%)	0 (0%)	3 (14%)	
Planning to implement in PY2023	35 (37%)	15 (38%)	10 (30%)	10 (45%)	
Decided not to implement	39 (41%)	11 (28%)	20 (61%)	8 (36%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Care management home visit waiver					0.2
Fully implemented and operational in PY2021	3 (3%)	2 (5%)	1 (3%)	0 (0%)	
Fully implemented and operational in PY2022	7 (7%)	5 (13%)	0 (0%)	2 (9%)	
Planning to implement in PY2023	39 (41%)	18 (45%)	12 (36%)	9 (41%)	
Decided not to implement	46 (48%)	15 (38%)	20 (61%)	11 (50%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Home health homebound waiver					0.020**
Fully implemented and operational in PY2021	8 (8%)	5 (13%)	3 (9%)	0 (0%)	
Fully implemented and operational in PY2022	10 (11%)	7 (18%)	0 (0%)	3 (14%)	
Planning to implement in PY2023	39 (41%)	16 (40%)	11 (33%)	12 (55%)	
Decided not to implement	38 (40%)	12 (30%)	19 (58%)	7 (32%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Concurrent care for beneficiaries that elect Medicare hospice benefit					0.6
Fully implemented and operational in PY2021	2 (2%)	1 (3%)	1 (3%)	0 (0%)	
Fully implemented and operational in PY2022	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Planning to implement in PY2023	37 (39%)	19 (48%)	11 (33%)	7 (32%)	
Decided not to implement	54 (57%)	18 (45%)	21 (64%)	15 (68%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Part B cost sharing support (cost sharing)					0.4
Fully implemented and operational in PY2021	6 (6%)	2 (5%)	1 (3%)	3 (14%)	
Fully implemented and operational in PY2022	16 (17%)	9 (23%)	5 (15%)	2 (9%)	
Planning to implement in PY2023	35 (37%)	16 (40%)	10 (30%)	9 (41%)	
Decided not to implement	37 (39%)	12 (30%)	17 (52%)	8 (36%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Chronic disease management reward (gift card)					0.2
Fully implemented and operational in PY2021	6 (6%)	2 (5%)	2 (6%)	2 (9%)	
Fully implemented and operational in PY2022	14 (15%)	9 (23%)	4 (12%)	1 (5%)	
Planning to implement in PY2023	34 (36%)	17 (43%)	9 (27%)	8 (36%)	
Decided not to implement	40 (42%)	11 (28%)	18 (55%)	11 (50%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Nurse practitioner services benefit enhancement					0.5
Fully implemented and operational in PY2021	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Fully implemented and operational in PY2022	6 (6%)	4 (10%)	2 (6%)	0 (0%)	
Planning to implement in PY2023	36 (38%)	17 (43%)	10 (30%)	9 (41%)	
Decided not to implement	51 (54%)	18 (45%)	20 (61%)	13 (59%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11a. Does your DCE track BE/BEI utilization, performance, or outcomes?					
Yes	68 (72%)	27 (68%)	24 (73%)	17 (77%)	0.7
11b. What measures does your DCE use to track BE/BEI utilization, performance, and outcomes? *(Asked of those who said "Yes" to Q11a)*					
Number of BE/BEI visits or services					0.8
Yes	65 (68%)	25 (63%)	23 (70%)	17 (77%)	
No	3 (3%)	2 (5%)	1 (3%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	

Question	Overall, N=95[1]	Organizational Structure			p-value[2]
		Network of Individual Practices, N=40[1]	Medical Group Practice, N=33[1]	Integrated Delivery/ Hospital System, N=22[1]	
Nature of BE/BEI visit or service					0.057*
Yes	49 (52%)	23 (58%)	12 (36%)	14 (64%)	
No	19 (20%)	4 (10%)	12 (36%)	3 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Cost of BE/BEI care					>0.9
Yes	50 (53%)	19 (48%)	18 (55%)	13 (59%)	
No	18 (19%)	8 (20%)	6 (18%)	4 (18%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Total cost of care					0.7
Yes	56 (59%)	24 (60%)	19 (58%)	13 (59%)	
No	12 (13%)	3 (8%)	5 (15%)	4 (18%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Demographics of beneficiaries receiving the BE/BEI					0.6
Yes	33 (35%)	14 (35%)	9 (27%)	10 (45%)	
No	34 (36%)	12 (30%)	15 (45%)	7 (32%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Hospital admissions/readmissions					0.7
Yes	56 (59%)	24 (60%)	18 (55%)	14 (64%)	
No	12 (13%)	3 (8%)	6 (18%)	3 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Emergency department (ED) utilization					0.6
Yes	55 (58%)	24 (60%)	18 (55%)	13 (59%)	
No	13 (14%)	3 (8%)	6 (18%)	4 (18%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Disease-specific outcome measures					0.071*
Yes	29 (31%)	17 (43%)	6 (18%)	6 (27%)	
No	39 (41%)	10 (25%)	18 (55%)	11 (50%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Medication adherence					0.13
Yes	27 (28%)	15 (38%)	5 (15%)	7 (32%)	
No	41 (43%)	12 (30%)	19 (58%)	10 (45%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Patient/caregiver satisfaction					0.10*
Yes	23 (24%)	14 (35%)	4 (12%)	5 (23%)	
No	45 (47%)	13 (33%)	20 (61%)	12 (55%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Barriers to care					0.079*
Yes	21 (22%)	13 (33%)	3 (9%)	5 (23%)	
No	47 (49%)	14 (35%)	21 (64%)	12 (55%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Other, please specify:					0.4
Yes	11 (12%)	6 (15%)	3 (9%)	2 (9%)	
No	20 (21%)	8 (20%)	4 (12%)	8 (36%)	
Respondent skip	37 (39%)	13 (33%)	17 (52%)	7 (32%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	

11c. For each item listed below, indicate which, if any, challenges your DCE experiences when implementing BE/BEI. *(Asked of those who said "Yes" to Q11a)*

Insufficient staff					0.003***
Yes	37 (39%)	17 (43%)	7 (21%)	13 (59%)	
No	23 (24%)	10 (25%)	9 (27%)	4 (18%)	
Respondent skip	8 (8%)	0 (0%)	8 (24%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Complexity of requirements					0.010***
Yes	43 (45%)	20 (50%)	10 (30%)	13 (59%)	
No	17 (18%)	7 (18%)	6 (18%)	4 (18%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Respondent skip	8 (8%)	0 (0%)	8 (24%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Lack of clarity about requirements					0.002***
Yes	24 (25%)	12 (30%)	3 (9%)	9 (41%)	
No	36 (38%)	15 (38%)	13 (39%)	8 (36%)	
Respondent skip	8 (8%)	0 (0%)	8 (24%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Not offering the same benefit to all patients					0.013**
Yes	38 (40%)	17 (43%)	11 (33%)	10 (45%)	
No	22 (23%)	10 (25%)	5 (15%)	7 (32%)	
Respondent skip	8 (8%)	0 (0%)	8 (24%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Other, please specify:					0.4
Yes	11 (12%)	5 (13%)	3 (9%)	3 (14%)	
No	15 (16%)	8 (20%)	2 (6%)	5 (23%)	
Respondent skip	42 (44%)	14 (35%)	19 (58%)	9 (41%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
11d. What does your DCE find challenging about tracking these BE/BEI utilization, performance, and outcome measures? *(Asked of those who said "Yes" to Q11a)*					
Time consuming to enter data					0.075*
Yes	42 (44%)	22 (55%)	11 (33%)	9 (41%)	
No	26 (27%)	5 (13%)	13 (39%)	8 (36%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Time consuming to pull data					0.052*
Yes	41 (43%)	21 (53%)	9 (27%)	11 (50%)	
No	27 (28%)	6 (15%)	15 (45%)	6 (27%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Lack of staff to track and manage data					0.094*
Yes	40 (42%)	20 (50%)	9 (27%)	11 (50%)	
No	28 (29%)	7 (18%)	15 (45%)	6 (27%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Data stored in multiple sources					0.5
Yes	45 (47%)	19 (48%)	13 (39%)	13 (59%)	
No	23 (24%)	8 (20%)	11 (33%)	4 (18%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Inconsistent data collection or data entry					0.7
Yes	35 (37%)	15 (38%)	10 (30%)	10 (45%)	
No	33 (35%)	12 (30%)	14 (42%)	7 (32%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Difficulty revising current systems to track measures					0.4
Yes	35 (37%)	17 (43%)	9 (27%)	9 (41%)	
No	33 (35%)	10 (25%)	15 (45%)	8 (36%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Difficulty distinguishing between BE/BEI services and non-BE/BEI services					0.6
Yes	30 (32%)	14 (35%)	8 (24%)	8 (36%)	
No	38 (40%)	13 (33%)	16 (48%)	9 (41%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	
Other, please specify:					0.2
Yes	16 (17%)	5 (13%)	10 (30%)	1 (5%)	
No	18 (19%)	7 (18%)	4 (12%)	7 (32%)	
Respondent skip	34 (36%)	15 (38%)	10 (30%)	9 (41%)	
Not asked	27 (28%)	13 (33%)	9 (27%)	5 (23%)	

12. What challenges does your DCE anticipate in implementing the NP Services BE? *(Asked of those who said "Planning to implement in PY2023" for "Nurse practitioner services benefit enhancement" on Q10)*

Complexity of NP BE policy					0.5
Yes	19 (20%)	6 (15%)	10 (30%)	3 (14%)	
No	26 (27%)	11 (28%)	8 (24%)	7 (32%)	

Question	Overall, N=95[1]	Organizational Structure			p-value[2]
		Network of Individual Practices, N=40[1]	Medical Group Practice, N=33[1]	Integrated Delivery/ Hospital System, N=22[1]	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	23 (58%)	15 (45%)	12 (55%)	
Currently do not utilize NPs					0.6
Yes	4 (4%)	1 (3%)	1 (3%)	2 (9%)	
No	41 (43%)	16 (40%)	17 (52%)	8 (36%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	23 (58%)	15 (45%)	12 (55%)	
Need to hire or train NPs					0.8
Yes	15 (16%)	5 (13%)	6 (18%)	4 (18%)	
No	30 (32%)	12 (30%)	12 (36%)	6 (27%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	23 (58%)	15 (45%)	12 (55%)	
Not offering the same benefit to all patients					0.037**
Yes	22 (23%)	7 (18%)	6 (18%)	9 (41%)	
No	23 (24%)	10 (25%)	12 (36%)	1 (5%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	23 (58%)	15 (45%)	12 (55%)	
Competing priorities					0.3
Yes	21 (22%)	8 (20%)	6 (18%)	7 (32%)	
No	24 (25%)	9 (23%)	12 (36%)	3 (14%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	23 (58%)	15 (45%)	12 (55%)	
Do not need BE					0.3
Yes	13 (14%)	2 (5%)	8 (24%)	3 (14%)	
No	31 (33%)	14 (35%)	10 (30%)	7 (32%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	23 (58%)	15 (45%)	12 (55%)	
Other, please specify:					0.15
Yes	2 (2%)	0 (0%)	1 (3%)	1 (5%)	
No	14 (15%)	8 (20%)	2 (6%)	4 (18%)	
Respondent skip	29 (31%)	9 (23%)	15 (45%)	5 (23%)	
Not asked	50 (53%)	23 (58%)	15 (45%)	12 (55%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
13a. As part of the DCE's efforts to engage Participant Providers, how important is each of the following practice support and improvement activities?					
DCE provides or arranges for centralized population health support staff (e.g., care managers, pharmacist, schedulers/administrative support)					0.8
Very important	77 (81%)	31 (78%)	28 (85%)	18 (82%)	
Somewhat important	4 (4%)	3 (8%)	1 (3%)	0 (0%)	
Not important	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
DCE does not offer this activity	12 (13%)	5 (13%)	3 (9%)	4 (18%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE provides or arranges for staff embedded in practices (e.g., administrative, care manager, health educator/coach, social worker)					0.8
Very important	51 (54%)	18 (45%)	19 (58%)	14 (64%)	
Somewhat important	13 (14%)	6 (15%)	5 (15%)	2 (9%)	
Not important	4 (4%)	2 (5%)	2 (6%)	0 (0%)	
DCE does not offer this activity	26 (27%)	13 (33%)	7 (21%)	6 (27%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE provides or arranges for investments in infrastructure at the practice level (Tooltip: Infrastructure refers to Electronic Health Record software, hardware, data analytic support, care delivery tools [e.g., shared decision-making aids, patient survey instruments], and licenses to access tools.)					>0.9
Very important	61 (64%)	25 (63%)	23 (70%)	13 (59%)	
Somewhat important	19 (20%)	8 (20%)	6 (18%)	5 (23%)	
Not important	5 (5%)	2 (5%)	2 (6%)	1 (5%)	
DCE does not offer this activity	9 (9%)	4 (10%)	2 (6%)	3 (14%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Coaching or one-on-one review of performance, quality, and/or cost data					0.3
Very important	69 (73%)	31 (78%)	26 (79%)	12 (55%)	
Somewhat important	15 (16%)	5 (13%)	4 (12%)	6 (27%)	
Not important	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE does not offer this activity	10 (11%)	3 (8%)	3 (9%)	4 (18%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Organizational Structure			p-value[2]
		Network of Individual Practices, N=40[1]	Medical Group Practice, N=33[1]	Integrated Delivery/ Hospital System, N=22[1]	
Data analysis support other than feedback reports on quality, utilization, or cost					0.3
Very important	76 (80%)	32 (80%)	29 (88%)	15 (68%)	
Somewhat important	7 (7%)	3 (8%)	2 (6%)	2 (9%)	
Not important	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE does not offer this activity	10 (11%)	3 (8%)	2 (6%)	5 (23%)	
Respondent skip	2 (2%)	2 (5%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Regular meetings between DCE and individual practice leaders					0.076*
Very important	83 (87%)	34 (85%)	31 (94%)	18 (82%)	
Somewhat important	6 (6%)	2 (5%)	0 (0%)	4 (18%)	
Not important	3 (3%)	1 (3%)	2 (6%)	0 (0%)	
DCE does not offer this activity	2 (2%)	2 (5%)	0 (0%)	0 (0%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Action-oriented initiatives focusing on small-scale, discrete areas for improvement (e.g., improving completion rates for flu vaccine, increasing number of annual wellness visits)					0.7
Very important	74 (78%)	31 (78%)	28 (85%)	15 (68%)	
Somewhat important	10 (11%)	3 (8%)	3 (9%)	4 (18%)	
Not important	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
DCE does not offer this activity	9 (9%)	4 (10%)	2 (6%)	3 (14%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Training and education sessions					0.002***
Very important	74 (78%)	33 (83%)	30 (91%)	11 (50%)	
Somewhat important	16 (17%)	5 (13%)	3 (9%)	8 (36%)	
Not important	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
DCE does not offer this activity	3 (3%)	0 (0%)	0 (0%)	3 (14%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Workflow redesign or optimization support					0.2
Very important	51 (54%)	21 (53%)	17 (52%)	13 (59%)	
Somewhat important	26 (27%)	10 (25%)	12 (36%)	4 (18%)	
Not important	5 (5%)	2 (5%)	3 (9%)	0 (0%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
DCE does not offer this activity	12 (13%)	6 (15%)	1 (3%)	5 (23%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other practice support and improvement activities, please specify:					0.11
Very important	11 (12%)	3 (8%)	3 (9%)	5 (23%)	
Somewhat important	5 (5%)	3 (8%)	1 (3%)	1 (5%)	
Not important	5 (5%)	3 (8%)	1 (3%)	1 (5%)	
DCE does not offer this activity	21 (22%)	12 (30%)	3 (9%)	6 (27%)	
Respondent skip	53 (56%)	19 (48%)	25 (76%)	9 (41%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
13b. Please estimate the portion of Participant Providers that use the DCE's practice support and improvement activities listed below. Your best estimate is fine. *(Asked of those who said "Very important" to Q13a)*					
DCE-provided centralized population health support staff (e.g., care managers, pharmacist, schedulers/administrative support)					0.8
All	27 (28%)	12 (30%)	7 (21%)	8 (36%)	
Most	38 (40%)	15 (38%)	16 (48%)	7 (32%)	
Some	11 (12%)	4 (10%)	4 (12%)	3 (14%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	18 (19%)	9 (23%)	5 (15%)	4 (18%)	
DCE-provided staff embedded in practices (e.g., administrative, care manager, health educator/coach, social worker)					0.10*
All	22 (23%)	6 (15%)	13 (39%)	3 (14%)	
Most	13 (14%)	6 (15%)	2 (6%)	5 (23%)	
Some	13 (14%)	4 (10%)	4 (12%)	5 (23%)	
None	3 (3%)	2 (5%)	0 (0%)	1 (5%)	
Don't know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	44 (46%)	22 (55%)	14 (42%)	8 (36%)	
DCE-provided investments in infrastructure at the practice level					0.5
All	17 (18%)	6 (15%)	5 (15%)	6 (27%)	
Most	36 (38%)	15 (38%)	16 (48%)	5 (23%)	

Question	Overall, N=95[1]	Organizational Structure			p-value[2]
		Network of Individual Practices, N=40[1]	Medical Group Practice, N=33[1]	Integrated Delivery/ Hospital System, N=22[1]	
Some	7 (7%)	4 (10%)	1 (3%)	2 (9%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	34 (36%)	15 (38%)	10 (30%)	9 (41%)	
Coaching or one-on-one review of performance, quality, and/or cost data					0.3
All	32 (34%)	16 (40%)	13 (39%)	3 (14%)	
Most	25 (26%)	10 (25%)	9 (27%)	6 (27%)	
Some	9 (9%)	4 (10%)	3 (9%)	2 (9%)	
None	1 (1%)	0 (0%)	0 (0%)	1 (5%)	
Don't know	2 (2%)	1 (3%)	1 (3%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	26 (27%)	9 (23%)	7 (21%)	10 (45%)	
Data analysis support other than feedback reports on quality, utilization, or cost					0.4
All	32 (34%)	17 (43%)	10 (30%)	5 (23%)	
Most	24 (25%)	10 (25%)	9 (27%)	5 (23%)	
Some	19 (20%)	5 (13%)	9 (27%)	5 (23%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	19 (20%)	8 (20%)	4 (12%)	7 (32%)	
Regular meetings between DCE and individual practice leaders					0.2
All	42 (44%)	18 (45%)	12 (36%)	12 (55%)	
Most	34 (36%)	12 (30%)	17 (52%)	5 (23%)	
Some	6 (6%)	4 (10%)	1 (3%)	1 (5%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	12 (13%)	6 (15%)	2 (6%)	4 (18%)	
Action-oriented initiatives focusing on small-scale, discrete areas for improvement (e.g., improving completion rates for flu vaccine, increasing number of annual wellness visits)					0.6
All	30 (32%)	13 (33%)	13 (39%)	4 (18%)	
Most	31 (33%)	13 (33%)	11 (33%)	7 (32%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Some	12 (13%)	5 (13%)	3 (9%)	4 (18%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	21 (22%)	9 (23%)	5 (15%)	7 (32%)	
Training and education sessions					0.007***
All	39 (41%)	16 (40%)	16 (48%)	7 (32%)	
Most	25 (26%)	14 (35%)	10 (30%)	1 (5%)	
Some	9 (9%)	3 (8%)	3 (9%)	3 (14%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	21 (22%)	7 (18%)	3 (9%)	11 (50%)	
Workflow redesign or optimization support					0.7
All	21 (22%)	9 (23%)	8 (24%)	4 (18%)	
Most	15 (16%)	6 (15%)	6 (18%)	3 (14%)	
Some	13 (14%)	5 (13%)	2 (6%)	6 (27%)	
None	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Don't know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	44 (46%)	19 (48%)	16 (48%)	9 (41%)	
Other practice support and improvement activity specified in 13a					0.080*
All	5 (5%)	2 (5%)	2 (6%)	1 (5%)	
Most	2 (2%)	1 (3%)	0 (0%)	1 (5%)	
Some	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
None	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Don't know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	3 (3%)	0 (0%)	0 (0%)	3 (14%)	
Not asked	84 (88%)	37 (93%)	30 (91%)	17 (77%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
14a. How important are each of the following information sharing activities for engaging your DCE's Participant Providers?					
Feedback reports on quality, utilization, or cost with comparisons at the practice level					0.12
Very important	86 (91%)	38 (95%)	30 (91%)	18 (82%)	
Somewhat important	6 (6%)	1 (3%)	3 (9%)	2 (9%)	
Not important	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE does not offer this activity	2 (2%)	0 (0%)	0 (0%)	2 (9%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Feedback reports on quality, utilization, or cost with comparisons at the individual clinician level					0.037**
Very important	75 (79%)	36 (90%)	25 (76%)	14 (64%)	
Somewhat important	13 (14%)	1 (3%)	6 (18%)	6 (27%)	
Not important	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE does not offer this activity	6 (6%)	2 (5%)	2 (6%)	2 (9%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other information to help providers manage care (e.g., specialty and other service use)					0.008***
Very important	65 (68%)	29 (73%)	26 (79%)	10 (45%)	
Somewhat important	21 (22%)	9 (23%)	3 (9%)	9 (41%)	
Not important	2 (2%)	1 (3%)	0 (0%)	1 (5%)	
DCE does not offer this activity	6 (6%)	0 (0%)	4 (12%)	2 (9%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Real time data on emergency department (ED) and inpatient admissions, discharges, and transfers (ADTs)					0.079*
Very important	83 (87%)	35 (88%)	32 (97%)	16 (73%)	
Somewhat important	4 (4%)	1 (3%)	0 (0%)	3 (14%)	
Not important	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE does not offer this activity	7 (7%)	3 (8%)	1 (3%)	3 (14%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other information sharing activities, please specify:					0.072*
Very important	12 (13%)	8 (20%)	2 (6%)	2 (9%)	
Somewhat important	1 (1%)	1 (3%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Not important	7 (7%)	3 (8%)	1 (3%)	3 (14%)	
DCE does not offer this activity	18 (19%)	9 (23%)	3 (9%)	6 (27%)	
Respondent skip	57 (60%)	19 (48%)	27 (82%)	11 (50%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
14b. Please estimate the portion of Participant Providers that use the DCE's information sharing activities listed below. Your best estimate is fine. *(Asked of those who said "Very important" to Q14a)*					
Feedback reports on quality, utilization, or cost with comparisons at the practice level					0.11
All	29 (31%)	17 (43%)	7 (21%)	5 (23%)	
Most	40 (42%)	13 (33%)	19 (58%)	8 (36%)	
Some	14 (15%)	7 (18%)	2 (6%)	5 (23%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Respondent skip	2 (2%)	1 (3%)	1 (3%)	0 (0%)	
Not asked	9 (9%)	2 (5%)	3 (9%)	4 (18%)	
Feedback reports on quality, utilization, or cost with comparisons at the individual clinician level					0.037**
All	25 (26%)	16 (40%)	5 (15%)	4 (18%)	
Most	34 (36%)	12 (30%)	16 (48%)	6 (27%)	
Some	15 (16%)	8 (20%)	3 (9%)	4 (18%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	20 (21%)	4 (10%)	8 (24%)	8 (36%)	
Other information to help providers manage care (e.g., specialty and other service use)					0.023**
All	19 (20%)	14 (35%)	3 (9%)	2 (9%)	
Most	22 (23%)	7 (18%)	11 (33%)	4 (18%)	
Some	7 (7%)	3 (8%)	4 (12%)	0 (0%)	
None	2 (2%)	1 (3%)	0 (0%)	1 (5%)	
Don't know	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	44 (46%)	14 (35%)	15 (45%)	15 (68%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Real time data on emergency department (ED) and inpatient admissions, discharges, and transfers (ADTs)					0.037**
All	29 (31%)	17 (43%)	9 (27%)	3 (14%)	
Most	36 (38%)	11 (28%)	16 (48%)	9 (41%)	
Some	14 (15%)	6 (15%)	6 (18%)	2 (9%)	
None	2 (2%)	1 (3%)	0 (0%)	1 (5%)	
Don't know	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (5%)	
Not asked	12 (13%)	5 (13%)	1 (3%)	6 (27%)	
Other information sharing activity specified in 14a					0.5
All	8 (8%)	4 (10%)	2 (6%)	2 (9%)	
Most	3 (3%)	3 (8%)	0 (0%)	0 (0%)	
Some	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	83 (87%)	32 (80%)	31 (94%)	20 (91%)	
15a. How important are each of the following incentives for engaging your DCE's Participant Providers?					
Financial bonuses tied to performance					0.8
Very important	77 (81%)	32 (80%)	29 (88%)	16 (73%)	
Somewhat important	8 (8%)	4 (10%)	1 (3%)	3 (14%)	
Not important	3 (3%)	1 (3%)	1 (3%)	1 (5%)	
DCE does not offer this activity	7 (7%)	3 (8%)	2 (6%)	2 (9%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Financial penalties tied to performance					0.008***
Very important	24 (25%)	13 (33%)	6 (18%)	5 (23%)	
Somewhat important	31 (33%)	9 (23%)	19 (58%)	3 (14%)	
Not important	8 (8%)	3 (8%)	1 (3%)	4 (18%)	
DCE does not offer this activity	32 (34%)	15 (38%)	7 (21%)	10 (45%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Non-financial awards or recognition tied to performance					0.5
Very important	21 (22%)	8 (20%)	8 (24%)	5 (23%)	
Somewhat important	47 (49%)	18 (45%)	19 (58%)	10 (45%)	
Not important	7 (7%)	4 (10%)	0 (0%)	3 (14%)	
DCE does not offer this activity	20 (21%)	10 (25%)	6 (18%)	4 (18%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE provides upfront payments					0.2
Very important	37 (39%)	15 (38%)	13 (39%)	9 (41%)	
Somewhat important	19 (20%)	13 (33%)	5 (15%)	1 (5%)	
Not important	8 (8%)	2 (5%)	3 (9%)	3 (14%)	
DCE does not offer this activity	31 (33%)	10 (25%)	12 (36%)	9 (41%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other incentives, please specify:					0.12
Very important	11 (12%)	5 (13%)	3 (9%)	3 (14%)	
Somewhat important	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not important	4 (4%)	1 (3%)	1 (3%)	2 (9%)	
DCE does not offer this activity	22 (23%)	12 (30%)	3 (9%)	7 (32%)	
Respondent skip	57 (60%)	21 (53%)	26 (79%)	10 (45%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

15b. Please estimate the portion of Participant Providers that receive the DCE's incentives listed below. Your best estimate is fine. *(Asked of those who said "Very important" to Q15a)*

Financial bonuses tied to performance					0.5
All	36 (38%)	15 (38%)	13 (39%)	8 (36%)	
Most	19 (20%)	12 (30%)	3 (9%)	4 (18%)	
Some	12 (13%)	4 (10%)	4 (12%)	4 (18%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't Know	2 (2%)	1 (3%)	1 (3%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	26 (27%)	8 (20%)	12 (36%)	6 (27%)	

Question	Overall, N=95[1]	Organizational Structure			p-value[2]
		Network of Individual Practices, N=40[1]	Medical Group Practice, N=33[1]	Integrated Delivery/ Hospital System, N=22[1]	
Financial penalties tied to performance					0.4
All	8 (8%)	3 (8%)	4 (12%)	1 (5%)	
Most	4 (4%)	4 (10%)	0 (0%)	0 (0%)	
Some	4 (4%)	2 (5%)	1 (3%)	1 (5%)	
None	5 (5%)	3 (8%)	1 (3%)	1 (5%)	
Don't Know	3 (3%)	1 (3%)	0 (0%)	2 (9%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	71 (75%)	27 (68%)	27 (82%)	17 (77%)	
Non-financial awards or recognition tied to performance					0.2
All	5 (5%)	1 (3%)	2 (6%)	2 (9%)	
Most	9 (9%)	6 (15%)	3 (9%)	0 (0%)	
Some	5 (5%)	1 (3%)	3 (9%)	1 (5%)	
None	1 (1%)	0 (0%)	0 (0%)	1 (5%)	
Don't Know	1 (1%)	0 (0%)	0 (0%)	1 (5%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	74 (78%)	32 (80%)	25 (76%)	17 (77%)	
DCE provides upfront payments					>0.9
All	21 (22%)	9 (23%)	8 (24%)	4 (18%)	
Most	13 (14%)	5 (13%)	4 (12%)	4 (18%)	
Some	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
None	2 (2%)	0 (0%)	1 (3%)	1 (5%)	
Don't Know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	58 (61%)	25 (63%)	20 (61%)	13 (59%)	
Other incentive specified in 15a					0.10
All	6 (6%)	1 (3%)	2 (6%)	3 (14%)	
Most	4 (4%)	4 (10%)	0 (0%)	0 (0%)	
Some	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't Know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Not asked	84 (88%)	35 (88%)	30 (91%)	19 (86%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
16. Which of the following methods does your DCE use to pay Participant Providers?					
Partial fee-for-service					0.093*
DCE uses this method	34 (36%)	18 (45%)	10 (30%)	6 (27%)	
DCE does not use this method	45 (47%)	18 (45%)	13 (39%)	14 (64%)	
Respondent skip	16 (17%)	4 (10%)	10 (30%)	2 (9%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Fee-for-service					0.013**
DCE uses this method	44 (46%)	26 (65%)	10 (30%)	8 (36%)	
DCE does not use this method	35 (37%)	11 (28%)	13 (39%)	11 (50%)	
Respondent skip	16 (17%)	3 (8%)	10 (30%)	3 (14%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Partial capitation					0.082*
DCE uses this method	39 (41%)	16 (40%)	13 (39%)	10 (45%)	
DCE does not use this method	41 (43%)	21 (53%)	10 (30%)	10 (45%)	
Respondent skip	15 (16%)	3 (8%)	10 (30%)	2 (9%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Total capitation					0.009***
DCE uses this method	25 (26%)	15 (38%)	7 (21%)	3 (14%)	
DCE does not use this method	52 (55%)	22 (55%)	14 (42%)	16 (73%)	
Respondent skip	18 (19%)	3 (8%)	12 (36%)	3 (14%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Payments tied to quality thresholds					0.028**
DCE uses this method	51 (54%)	24 (60%)	12 (36%)	15 (68%)	
DCE does not use this method	28 (29%)	13 (33%)	10 (30%)	5 (23%)	
Respondent skip	16 (17%)	3 (8%)	11 (33%)	2 (9%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other, please specify:					0.3
DCE uses this method	20 (21%)	7 (18%)	7 (21%)	6 (27%)	
DCE does not use this method	21 (22%)	10 (25%)	4 (12%)	7 (32%)	
Respondent skip	54 (57%)	23 (58%)	22 (67%)	9 (41%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
17. Not including any capitated payments the DCE may make to providers, does your DCE use financial rewards and/or penalties with its Participant Providers?					
DCE uses financial rewards					>0.9
Yes	84 (88%)	35 (88%)	30 (91%)	19 (86%)	
No	10 (11%)	4 (10%)	3 (9%)	3 (14%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE uses financial penalties					0.9
Yes	25 (26%)	12 (30%)	8 (24%)	5 (23%)	
No	69 (73%)	27 (68%)	25 (76%)	17 (77%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
18a. How many of your DCE's Participant Providers are employed directly by a health system or practice participating in the model?					No test
All	38 (40%)	9 (23%)	19 (58%)	10 (45%)	
Most	25 (26%)	10 (25%)	9 (27%)	6 (27%)	
Some	11 (12%)	3 (8%)	4 (12%)	4 (18%)	
Very Few	8 (8%)	8 (20%)	0 (0%)	0 (0%)	
None	12 (13%)	9 (23%)	1 (3%)	2 (9%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
19. Does your DCE use financial rewards and/or penalties with its Preferred Providers?					
DCE uses financial rewards					0.9
Yes	40 (42%)	18 (45%)	14 (42%)	8 (36%)	
No	54 (57%)	21 (53%)	19 (58%)	14 (64%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE uses financial penalties					0.4
Yes	28 (29%)	10 (25%)	13 (39%)	5 (23%)	
No	66 (69%)	29 (73%)	20 (61%)	17 (77%)	
Respondent skip	1 (1%)	1 (3%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Does the DCE share upside financial risk (savings) directly with Participant Providers?					
Yes, DCE shares total savings with practitioners[3]	73 (77%)	31 (78%)	26 (79%)	16 (73%)	0.9
Yes, DCE shares service-specific savings with practitioners[3]	19 (20%)	8 (20%)	5 (15%)	6 (27%)	0.5
Does the DCE share downside financial risk (losses) directly with Participant Providers?					
Yes, DCE shares total losses with practitioners[3]	16 (17%)	6 (15%)	6 (18%)	4 (18%)	0.9
Yes, DCE shares service-specific losses with practitioners[3]	6 (6%)	1 (3%)	4 (12%)	1 (5%)	0.3
Does the DCE share upside financial risk (savings) directly with Participant Facilities?					
Yes, DCE shares total savings with facilities[4]	9 (9%)	3 (8%)	1 (3%)	5 (23%)	0.047**
Yes, DCE shares service-specific savings with facilities[4]	21 (22%)	6 (15%)	10 (30%)	5 (23%)	0.3
Does the DCE share downside financial risk (losses) directly with Participant Facilities?					
Yes, DCE shares total losses with facilities[4]	6 (6%)	1 (3%)	0 (0%)	5 (23%)	0.002***
Yes, DCE shares service-specific losses with facilities[4]	0 (0%)	0 (0%)	0 (0%)	0 (0%)	No test
20a. Does your DCE share upside financial risk (savings) directly with the Participant Provider types listed below?					
Individual practitioners who may be employed directly by a health system or practice participating in the model					
Total DCE savings	48 (51%)	11 (50%)	21 (64%)	16 (40%)	0.13
Service-specific savings	14 (15%)	2 (9%)	5 (15%)	7 (18%)	0.7
Provider type does not participate in DCE	7 (7%)	2 (9%)	1 (3%)	4 (10%)	0.5
Does not share savings with this type of provider	26 (27%)	7 (32%)	6 (18%)	13 (33%)	0.3
Physician groups/practices					
Total DCE savings	69 (73%)	15 (68%)	25 (76%)	29 (73%)	0.8
Service-specific savings	15 (16%)	3 (14%)	4 (12%)	8 (20%)	0.7
Provider type does not participate in DCE	4 (4%)	0 (0%)	3 (9%)	1 (3%)	0.3
Does not share savings with this type of provider	7 (7%)	4 (18%)	1 (3%)	2 (5%)	0.13
Networks of individual physician practices or other practitioners					
Total DCE savings	48 (51%)	7 (32%)	18 (55%)	23 (58%)	0.13
Service-specific savings	14 (15%)	3 (14%)	3 (9%)	8 (20%)	0.4
Provider type does not participate in DCE	19 (20%)	4 (18%)	10 (30%)	5 (13%)	0.2

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Does not share savings with this type of provider	14 (15%)	8 (36%)	2 (6%)	4 (10%)	0.008***
Independent or solo practitioners					
Total DCE savings	44 (46%)	7 (32%)	12 (36%)	25 (63%)	0.025**
Service-specific savings	11 (12%)	3 (14%)	2 (6%)	6 (15%)	0.5
Provider type does not participate in DCE	22 (23%)	2 (9%)	15 (45%)	5 (13%)	<0.001***
Does not share savings with this type of provider	18 (19%)	10 (45%)	4 (12%)	4 (10%)	0.003***
Acute care hospitals					
Total DCE savings	7 (7%)	4 (18%)	1 (3%)	2 (5%)	0.13
Service-specific savings	6 (6%)	3 (14%)	0 (0%)	3 (8%)	0.10
Provider type does not participate in DCE	39 (41%)	3 (14%)	21 (64%)	15 (38%)	<0.001***
Does not share savings with this type of provider	42 (44%)	12 (55%)	11 (33%)	19 (48%)	0.3
Skilled nursing facilities (SNFs)					
Total DCE savings	4 (4%)	3 (14%)	0 (0%)	1 (3%)	0.050*
Service-specific savings	14 (15%)	3 (14%)	8 (24%)	3 (8%)	0.12
Provider type does not participate in DCE	26 (27%)	3 (14%)	12 (36%)	11 (28%)	0.2
Does not share savings with this type of provider	50 (53%)	13 (59%)	13 (39%)	24 (60%)	0.2
Home health agencies (HHAs)					
Total DCE savings	3 (3%)	1 (5%)	0 (0%)	2 (5%)	0.5
Service-specific savings	17 (18%)	3 (14%)	10 (30%)	4 (10%)	0.082*
Provider type does not participate in DCE	23 (24%)	3 (14%)	10 (30%)	10 (25%)	0.4
Does not share savings with this type of provider	51 (54%)	15 (68%)	13 (39%)	23 (58%)	0.091*
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)					
Total DCE savings	1 (1%)	0 (0%)	0 (0%)	1 (3%)	>0.9
Service-specific savings	2 (2%)	1 (5%)	0 (0%)	1 (3%)	0.7
Provider type does not participate in DCE	37 (39%)	4 (18%)	20 (61%)	13 (33%)	0.004***
Does not share savings with this type of provider	54 (57%)	17 (77%)	13 (39%)	24 (60%)	0.018**
Other provider type, please specify:					
Total DCE savings	2 (2%)	1 (5%)	0 (0%)	1 (3%)	0.7
Service-specific savings	3 (3%)	1 (5%)	0 (0%)	2 (5%)	0.5
Provider type does not participate in DCE	7 (7%)	2 (9%)	2 (6%)	3 (8%)	>0.9

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Does not share savings with this type of provider	26 (27%)	8 (36%)	6 (18%)	12 (30%)	0.3
20b. For upside risk (savings), what portion is shared with each provider type? *(Asked of those who shared any savings with each provider type)*					
Individual practitioners who may be employed directly by a health system or practice participating in the model					0.018**
1-5%	4 (8%)	3 (25%)	0 (0%)	1 (5%)	
6-10%	1 (2%)	0 (0%)	0 (0%)	1 (5%)	
11-30%	11 (22%)	0 (0%)	5 (26%)	6 (30%)	
31-50%	15 (29%)	4 (33%)	3 (16%)	8 (40%)	
More than 50%	20 (39%)	5 (42%)	11 (58%)	4 (20%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Physician groups / practices					0.002***
1-5%	4 (6%)	4 (27%)	0 (0%)	0 (0%)	
6-10%	2 (3%)	1 (7%)	0 (0%)	1 (3%)	
11-30%	14 (21%)	1 (7%)	3 (15%)	10 (31%)	
31-50%	19 (28%)	4 (27%)	3 (15%)	12 (38%)	
More than 50%	28 (42%)	5 (33%)	14 (70%)	9 (28%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Networks of individual physician practices or other practitioners					0.014**
1-5%	3 (6%)	3 (33%)	0 (0%)	0 (0%)	
6-10%	2 (4%)	0 (0%)	0 (0%)	2 (7%)	
11-30%	12 (24%)	1 (11%)	3 (21%)	8 (30%)	
31-50%	12 (24%)	2 (22%)	1 (7%)	9 (33%)	
More than 50%	21 (42%)	3 (33%)	10 (71%)	8 (30%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Independent or solo practitioners					0.14
1-5%	2 (5%)	2 (25%)	0 (0%)	0 (0%)	
6-10%	1 (2%)	0 (0%)	0 (0%)	1 (4%)	
11-30%	15 (37%)	1 (13%)	4 (67%)	10 (37%)	
31-50%	13 (32%)	2 (25%)	2 (33%)	9 (33%)	
More than 50%	10 (24%)	3 (38%)	0 (0%)	7 (26%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Acute care hospitals					0.8
1-5%	3 (30%)	1 (17%)	0 (0%)	2 (50%)	
6-10%	2 (20%)	1 (17%)	0 (0%)	1 (25%)	
11-30%	4 (40%)	3 (50%)	0 (0%)	1 (25%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	1 (10%)	1 (17%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Skilled nursing facilities (SNFs)					0.10
1-5%	13 (81%)	3 (75%)	8 (100%)	2 (50%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	3 (19%)	1 (25%)	0 (0%)	2 (50%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Home health agencies (HHAs)					0.078*
1-5%	14 (78%)	3 (75%)	8 (100%)	3 (50%)	
6-10%	2 (11%)	0 (0%)	0 (0%)	2 (33%)	
11-30%	2 (11%)	1 (25%)	0 (0%)	1 (17%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)					>0.9
1-5%	2 (67%)	1 (100%)	0 (0%)	1 (50%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	1 (33%)	0 (0%)	0 (0%)	1 (50%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other provider type specified in 20a					>0.9
1-5%	3 (60%)	2 (100%)	0 (0%)	1 (33%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	1 (20%)	0 (0%)	0 (0%)	1 (33%)	

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	1 (20%)	0 (0%)	0 (0%)	1 (33%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
20c. Does your DCE share downside financial risk (losses) directly with the Participant Provider types listed below?					
Individual practitioners who may be employed directly by a health system or practice participating in the model					
Total DCE losses	9 (10%)	3 (15%)	3 (9%)	3 (8%)	0.7
Service-specific losses	3 (3%)	1 (5%)	1 (3%)	1 (3%)	>0.9
Does not share losses with this type of provider	74 (84%)	16 (80%)	28 (88%)	30 (83%)	0.8
Physician groups/practices					
Total DCE losses	10 (11%)	3 (14%)	3 (10%)	4 (10%)	0.8
Service-specific losses	6 (7%)	1 (5%)	4 (13%)	1 (3%)	0.2
Does not share losses with this type of provider	74 (81%)	18 (82%)	23 (77%)	33 (85%)	0.7
Networks of individual physician practices or other practitioners					
Total DCE losses	8 (11%)	0 (0%)	4 (17%)	4 (11%)	0.2
Service-specific losses	2 (3%)	1 (6%)	0 (0%)	1 (3%)	0.7
Does not share losses with this type of provider	64 (84%)	17 (94%)	19 (83%)	28 (80%)	0.4
Independent or solo practitioners					
Total DCE losses	5 (7%)	1 (5%)	1 (6%)	3 (9%)	>0.9
Service-specific losses	4 (5%)	1 (5%)	2 (11%)	1 (3%)	0.4
Does not share losses with this type of provider	62 (85%)	18 (90%)	15 (83%)	29 (83%)	0.8
Acute care hospitals					
Total DCE losses	4 (7%)	4 (21%)	0 (0%)	0 (0%)	0.012**
Service-specific losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Does not share losses with this type of provider	50 (89%)	15 (79%)	12 (100%)	23 (92%)	0.2
Skilled nursing facilities (SNFs)					
Total DCE losses	2 (3%)	2 (11%)	0 (0%)	0 (0%)	0.073*
Service-specific losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Does not share losses with this type of provider	65 (94%)	17 (89%)	21 (100%)	27 (93%)	0.4

Question	Overall, N=95[1]	Organizational Structure: Network of Individual Practices, N=40[1]	Organizational Structure: Medical Group Practice, N=33[1]	Organizational Structure: Integrated Delivery/ Hospital System, N=22[1]	p-value[2]
Home health agencies (HHAs)					
Total DCE losses	2 (3%)	1 (5%)	0 (0%)	1 (3%)	0.7
Service-specific losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Does not share losses with this type of provider	68 (94%)	18 (95%)	23 (100%)	27 (90%)	0.4
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)					
Total DCE losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Service-specific losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Does not share losses with this type of provider	56 (97%)	18 (100%)	13 (100%)	25 (93%)	0.7
Other provider type, please specify:					
Total DCE losses	1 (1%)	0 (0%)	0 (0%)	1 (3%)	>0.9
Service-specific losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Does not share losses with this type of provider	40 (45%)	10 (50%)	14 (45%)	16 (43%)	0.9
20d. For downside risk (losses), what percentage is shared with each provider type? *(Asked of those who shared any losses with each provider type)*					
Individual practitioners who may be employed directly by a health system or practice participating in the model					0.5
1-5%	1 (11%)	0 (0%)	0 (0%)	1 (33%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	2 (22%)	1 (33%)	0 (0%)	1 (33%)	
31-50%	1 (11%)	1 (33%)	0 (0%)	0 (0%)	
More than 50%	5 (56%)	1 (33%)	3 (100%)	1 (33%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Physician groups/practices					0.2
1-5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	3 (27%)	1 (33%)	0 (0%)	2 (50%)	
31-50%	1 (9%)	1 (33%)	0 (0%)	0 (0%)	
More than 50%	7 (64%)	1 (33%)	4 (100%)	2 (50%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Organizational Structure			p-value[2]
		Network of Individual Practices, N=40[1]	Medical Group Practice, N=33[1]	Integrated Delivery/ Hospital System, N=22[1]	
Networks of individual physician practices or other practitioners					>0.9
1-5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	3 (50%)	1 (100%)	0 (0%)	2 (50%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	3 (50%)	0 (0%)	1 (100%)	2 (50%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Independent or solo practitioners					>0.9
1-5%	1 (20%)	1 (50%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	3 (60%)	1 (50%)	0 (0%)	2 (67%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	1 (20%)	0 (0%)	0 (0%)	1 (33%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Acute care hospitals					>0.9
1-5%	1 (33%)	1 (33%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	1 (33%)	1 (33%)	0 (0%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	1 (33%)	1 (33%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Skilled nursing facilities (SNFs)					-
1-5%	0 (NA%)	0 (NA%)	0 (0%)	0 (0%)	
6-10%	0 (NA%)	0 (NA%)	0 (0%)	0 (0%)	
11-30%	0 (NA%)	0 (NA%)	0 (0%)	0 (0%)	
31-50%	0 (NA%)	0 (NA%)	0 (0%)	0 (0%)	
More than 50%	0 (NA%)	0 (NA%)	0 (0%)	0 (0%)	
Respondent skip	0 (NA%)	0 (NA%)	0 (0%)	0 (0%)	
Not asked	0 (NA%)	0 (NA%)	0 (0%)	0 (0%)	
Home health agencies (HHAs)					>0.9
1-5%	1 (50%)	1 (100%)	0 (0%)	0 (0%)	
6-10%	1 (50%)	0 (0%)	0 (0%)	1 (100%)	
11-30%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Organizational Structure			p-value[2]
		Network of Individual Practices, N=40[1]	Medical Group Practice, N=33[1]	Integrated Delivery/ Hospital System, N=22[1]	
More than 50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)					-
1-5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other provider type specified in 20c					>0.9
1-5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	1 (100%)	0 (0%)	0 (0%)	1 (100%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

NOTE: DCE: Direct Contracting Entity; NP=Nurse Practitioner; BE=Benefit Enhancements; BEI=Beneficiary Engagement Incentives.
[1] n (%)
[2] *p<0.10; **p<0.05; ***p<0.01.
[3] Practitioners include: Individual practitioners who may be employed directly by a health system or practice participating in the model, physician groups/practices, networks of individual physician practices or other practitioners, and independent or solo practitioners.
[4] Facilities include: acute care hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs).

Appendix D.2.3. Selected 2022 Pulse Check Survey Results by Functional Role

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
3. Now we would like to know about different strategies that your DCE may or may not be focused on. For each of the items listed below, please select the response option that most accurately reflects the perspective of your DCE.					
Investments in primary care capacity such as non-physician providers, after-hours care					0.3
High priority	52 (55%)	6 (33%)	23 (59%)	23 (61%)	
Medium priority	27 (28%)	6 (33%)	12 (31%)	9 (24%)	
Low priority	12 (13%)	4 (22%)	3 (8%)	5 (13%)	
Not a priority / Not applicable	4 (4%)	2 (11%)	1 (3%)	1 (3%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Investments in behavioral health capacity such as behavioral health professionals, telehealth appointments					0.079*
High priority	31 (33%)	4 (22%)	14 (36%)	13 (34%)	
Medium priority	24 (25%)	3 (17%)	15 (38%)	6 (16%)	
Low priority	33 (35%)	8 (44%)	9 (23%)	16 (42%)	
Not a priority / Not applicable	7 (7%)	3 (17%)	1 (3%)	3 (8%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Initiatives to encourage referrals to high-quality or Preferred Providers					0.2
High priority	35 (37%)	3 (17%)	17 (44%)	15 (39%)	
Medium priority	48 (51%)	12 (67%)	15 (38%)	21 (55%)	
Low priority	7 (7%)	2 (11%)	4 (10%)	1 (3%)	
Not a priority / Not applicable	5 (5%)	1 (6%)	3 (8%)	1 (3%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Complex care management or population-specific care management programs					0.5
High priority	84 (88%)	15 (83%)	34 (87%)	35 (92%)	
Medium priority	10 (11%)	3 (17%)	5 (13%)	2 (5%)	
Low priority	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not a priority / Not applicable	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Initiatives to reduce low value care					0.6
High priority	44 (46%)	8 (44%)	20 (51%)	16 (42%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Medium priority	37 (39%)	7 (39%)	12 (31%)	18 (47%)	
Low priority	10 (11%)	3 (17%)	5 (13%)	2 (5%)	
Not a priority / Not applicable	4 (4%)	0 (0%)	2 (5%)	2 (5%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Initiatives to reduce avoidable inpatient, emergency department, or post-acute care utilization					0.2
High priority	90 (95%)	16 (89%)	36 (92%)	38 (100%)	
Medium priority	4 (4%)	2 (11%)	2 (5%)	0 (0%)	
Low priority	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not a priority / Not applicable	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Initiatives to address beneficiaries' social needs, such as food insecurity, housing, and transportation					0.040**
High priority	47 (49%)	7 (39%)	23 (59%)	17 (45%)	
Medium priority	37 (39%)	7 (39%)	10 (26%)	20 (53%)	
Low priority	9 (9%)	4 (22%)	4 (10%)	1 (3%)	
Not a priority / Not applicable	2 (2%)	0 (0%)	2 (5%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Emphasis on primary care touchpoints (e.g., annual wellness visits)					0.2
High priority	81 (85%)	13 (72%)	35 (90%)	33 (87%)	
Medium priority	13 (14%)	5 (28%)	3 (8%)	5 (13%)	
Low priority	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not a priority / Not applicable	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other, please specify:					0.2
High priority	14 (15%)	4 (22%)	3 (8%)	7 (18%)	
Medium priority	3 (3%)	1 (6%)	0 (0%)	2 (5%)	
Low priority	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not a priority / Not applicable	19 (20%)	5 (28%)	9 (23%)	5 (13%)	
Respondent skip	58 (61%)	8 (44%)	27 (69%)	23 (61%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Direct Care Provider, N=39[1]	Enabler, N=38[1]	p-value[2]
7. How does your DCE support Participant and Preferred Provider practices to offer expanded access to care? Select all that apply.					
DCE offers, funds, or supports centralized population health support staff (e.g., care managers, pharmacist, schedulers/administrative support)					
Participant Providers	83 (87%)	14 (78%)	34 (87%)	35 (92%)	0.3
Preferred Providers	28 (29%)	4 (22%)	11 (28%)	13 (34%)	0.6
DCE does not provide this type of support	10 (11%)	4 (22%)	3 (8%)	3 (8%)	0.2
DCE directly provides or funds the provision of telehealth					
Participant Providers	47 (49%)	12 (67%)	11 (28%)	24 (63%)	0.002***
Preferred Providers	7 (7%)	4 (22%)	0 (0%)	3 (8%)	0.007***
DCE does not provide this type of support	48 (51%)	6 (33%)	28 (72%)	14 (37%)	0.002***
DCE offers, funds, or supports extended or weekend hours for practices					
Participant Providers	48 (51%)	7 (39%)	16 (41%)	25 (66%)	0.052*
Preferred Providers	6 (6%)	1 (6%)	1 (3%)	4 (11%)	0.3
DCE does not provide this type of support	47 (49%)	11 (61%)	23 (59%)	13 (34%)	0.052*
DCE offers, funds, or supports urgent or extended care (Tooltip: Extended care refers to services offered by the DCE (not just select practices in the DCE) beyond those offered in a typical primary care practice. Examples include IV fluids, ultrasound, and x-rays.)					
Participant Providers	48 (51%)	10 (56%)	16 (41%)	22 (58%)	0.3
Preferred Providers	10 (11%)	3 (17%)	3 (8%)	4 (11%)	0.6
DCE does not provide this type of support	46 (48%)	8 (44%)	22 (56%)	16 (42%)	0.4
DCE offers, funds, or provides other support for expanded access to care (please specify):					
Participant Providers	36 (38%)	8 (44%)	11 (28%)	17 (45%)	0.3
Preferred Providers	6 (6%)	1 (6%)	3 (8%)	2 (5%)	>0.9
DCE does not provide this type of support	34 (36%)	8 (44%)	18 (46%)	8 (21%)	0.050**
9a. Does your DCE currently conduct activities to increase voluntary alignment?					
Yes	70 (74%)	12 (67%)	25 (64%)	33 (87%)	0.050*
9b. Below is a list of different approaches that your DCE may use to increase voluntary alignment. For each one, please indicate whether your DCE uses this approach. *(Asked of those who said "Yes" to Q9a)*					
Communicates to beneficiaries through the DCE portal or email					0.15
Yes	48 (51%)	7 (39%)	18 (46%)	23 (61%)	
No	22 (23%)	5 (28%)	7 (18%)	10 (26%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	6 (33%)	14 (36%)	5 (13%)	
Communicates to beneficiaries via mail					0.014**
Yes	56 (59%)	10 (56%)	16 (41%)	30 (79%)	
No	14 (15%)	2 (11%)	9 (23%)	3 (8%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	6 (33%)	14 (36%)	5 (13%)	
Communicates to beneficiaries via voice or text messages					0.036**
Yes	14 (15%)	4 (22%)	2 (5%)	8 (21%)	
No	56 (59%)	8 (44%)	23 (59%)	25 (66%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	6 (33%)	14 (36%)	5 (13%)	
Training for care managers, other care team members (e.g., social workers), or DCE providers to conduct outreach or educate beneficiaries about voluntary alignment					0.10*
Yes	61 (64%)	11 (61%)	20 (51%)	30 (79%)	
No	9 (9%)	1 (6%)	5 (13%)	3 (8%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	6 (33%)	14 (36%)	5 (13%)	
Training for office or front desk staff to respond to beneficiary questions about voluntary alignment					0.002***
Yes	63 (66%)	12 (67%)	18 (46%)	33 (87%)	
No	2 (2%)	0 (0%)	2 (5%)	0 (0%)	
Respondent skip	5 (5%)	0 (0%)	5 (13%)	0 (0%)	
Not asked	25 (26%)	6 (33%)	14 (36%)	5 (13%)	
Presentations for beneficiaries (e.g., via webinar, town hall, information sessions)					0.2
Yes	16 (17%)	3 (17%)	5 (13%)	8 (21%)	
No	54 (57%)	9 (50%)	20 (51%)	25 (66%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	6 (33%)	14 (36%)	5 (13%)	
Partner/collaborate with potential referral sources (e.g., community-based organizations such as Area Agencies on Aging)					0.036**

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Yes	14 (15%)	4 (22%)	2 (5%)	8 (21%)	
No	56 (59%)	8 (44%)	23 (59%)	25 (66%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	25 (26%)	6 (33%)	14 (36%)	5 (13%)	
Other strategy, please specify:					0.2
Yes	12 (13%)	2 (11%)	3 (8%)	7 (18%)	
No	21 (22%)	4 (22%)	6 (15%)	11 (29%)	
Respondent skip	37 (39%)	6 (33%)	16 (41%)	15 (39%)	
Not asked	25 (26%)	6 (33%)	14 (36%)	5 (13%)	
10. Select the option that best reflects your DCE's implementation status for each BE or BEI. (Tooltip: DCEs may choose benefit enhancements (BEs) and beneficiary engagement incentives (BEIs) to implement and support their ability to manage the care of beneficiaries. BEs are conditional waivers of certain Medicare payment rules. BEIs permit DCE providers to give in-kind items or services to beneficiaries if certain conditions are satisfied.)					
Telehealth expansion waiver					0.2
Fully implemented and operational in PY2021	18 (19%)	5 (28%)	8 (21%)	5 (13%)	
Fully implemented and operational in PY2022	7 (7%)	3 (17%)	1 (3%)	3 (8%)	
Planning to implement in PY2023	23 (24%)	4 (22%)	7 (18%)	12 (32%)	
Decided not to implement	47 (49%)	6 (33%)	23 (59%)	18 (47%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Three-day skilled nursing facility (SNF) rule waiver					0.3
Fully implemented and operational in PY2021	31 (33%)	5 (28%)	13 (33%)	13 (34%)	
Fully implemented and operational in PY2022	19 (20%)	5 (28%)	9 (23%)	5 (13%)	
Planning to implement in PY2023	26 (27%)	4 (22%)	7 (18%)	15 (39%)	
Decided not to implement	19 (20%)	4 (22%)	10 (26%)	5 (13%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Post-discharge home visit waiver					0.047**
Fully implemented and operational in PY2021	11 (12%)	0 (0%)	6 (15%)	5 (13%)	
Fully implemented and operational in PY2022	10 (11%)	6 (33%)	1 (3%)	3 (8%)	
Planning to implement in PY2023	35 (37%)	6 (33%)	14 (36%)	15 (39%)	
Decided not to implement	39 (41%)	6 (33%)	18 (46%)	15 (39%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Care management home visit waiver					0.018**
Fully implemented and operational in PY2021	3 (3%)	0 (0%)	0 (0%)	3 (8%)	
Fully implemented and operational in PY2022	7 (7%)	4 (22%)	0 (0%)	3 (8%)	
Planning to implement in PY2023	39 (41%)	8 (44%)	15 (38%)	16 (42%)	
Decided not to implement	46 (48%)	6 (33%)	24 (62%)	16 (42%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Home health homebound waiver					0.8
Fully implemented and operational in PY2021	8 (8%)	0 (0%)	5 (13%)	3 (8%)	
Fully implemented and operational in PY2022	10 (11%)	3 (17%)	4 (10%)	3 (8%)	
Planning to implement in PY2023	39 (41%)	7 (39%)	15 (38%)	17 (45%)	
Decided not to implement	38 (40%)	8 (44%)	15 (38%)	15 (39%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Concurrent care for beneficiaries that elect Medicare hospice benefit					0.2
Fully implemented and operational in PY2021	2 (2%)	0 (0%)	0 (0%)	2 (5%)	
Fully implemented and operational in PY2022	1 (1%)	1 (6%)	0 (0%)	0 (0%)	
Planning to implement in PY2023	37 (39%)	5 (28%)	18 (46%)	14 (37%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Decided not to implement	54 (57%)	11 (61%)	21 (54%)	22 (58%)	
Respondent skip	1 (1%)	1 (6%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Part B cost sharing support (cost sharing)					0.012**
Fully implemented and operational in PY2021	6 (6%)	0 (0%)	2 (5%)	4 (11%)	
Fully implemented and operational in PY2022	16 (17%)	3 (17%)	12 (31%)	1 (3%)	
Planning to implement in PY2023	35 (37%)	7 (39%)	10 (26%)	18 (47%)	
Decided not to implement	37 (39%)	7 (39%)	15 (38%)	15 (39%)	
Respondent skip	1 (1%)	1 (6%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Chronic disease management reward (gift card)					0.3
Fully implemented and operational in PY2021	6 (6%)	1 (6%)	2 (5%)	3 (8%)	
Fully implemented and operational in PY2022	14 (15%)	3 (17%)	8 (21%)	3 (8%)	
Planning to implement in PY2023	34 (36%)	7 (39%)	10 (26%)	17 (45%)	
Decided not to implement	40 (42%)	6 (33%)	19 (49%)	15 (39%)	
Respondent skip	1 (1%)	1 (6%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Nurse practitioner services benefit enhancement					0.059*
Fully implemented and operational in PY2021	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Fully implemented and operational in PY2022	6 (6%)	0 (0%)	6 (15%)	0 (0%)	
Planning to implement in PY2023	36 (38%)	8 (44%)	13 (33%)	15 (39%)	
Decided not to implement	51 (54%)	9 (50%)	20 (51%)	22 (58%)	
Respondent skip	1 (1%)	1 (6%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

11a. Does your DCE track BE/BEI utilization, performance, or outcomes?

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Yes	68 (72%)	10 (56%)	29 (74%)	29 (76%)	0.2
11b. What measures does your DCE use to track BE/BEI utilization, performance, and outcomes? *(Asked of those who said "Yes" to Q11a)*					
Number of BE/BEI visits or services					0.2
Yes	65 (68%)	9 (50%)	29 (74%)	27 (71%)	
No	3 (3%)	1 (6%)	0 (0%)	2 (5%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Nature of BE/BEI visit or service					0.044**
Yes	49 (52%)	8 (44%)	25 (64%)	16 (42%)	
No	19 (20%)	2 (11%)	4 (10%)	13 (34%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Cost of BE/BEI care					0.6
Yes	50 (53%)	7 (39%)	21 (54%)	22 (58%)	
No	18 (19%)	3 (17%)	8 (21%)	7 (18%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Total cost of care					0.4
Yes	56 (59%)	9 (50%)	22 (56%)	25 (66%)	
No	12 (13%)	1 (6%)	7 (18%)	4 (11%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Demographics of beneficiaries receiving the BE/BEI					0.14
Yes	33 (35%)	5 (28%)	11 (28%)	17 (45%)	
No	34 (36%)	4 (22%)	18 (46%)	12 (32%)	
Respondent skip	1 (1%)	1 (6%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Hospital admissions/readmissions					0.4

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Yes	56 (59%)	9 (50%)	22 (56%)	25 (66%)	
No	12 (13%)	1 (6%)	7 (18%)	4 (11%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Emergency department (ED) utilization					0.3
Yes	55 (58%)	9 (50%)	21 (54%)	25 (66%)	
No	13 (14%)	1 (6%)	8 (21%)	4 (11%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Disease-specific outcome measures					0.069*
Yes	29 (31%)	7 (39%)	8 (21%)	14 (37%)	
No	39 (41%)	3 (17%)	21 (54%)	15 (39%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Medication adherence					0.088*
Yes	27 (28%)	7 (39%)	8 (21%)	12 (32%)	
No	41 (43%)	3 (17%)	21 (54%)	17 (45%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Patient/caregiver satisfaction					0.016**
Yes	23 (24%)	7 (39%)	5 (13%)	11 (29%)	
No	45 (47%)	3 (17%)	24 (62%)	18 (47%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Barriers to care					0.10
Yes	21 (22%)	6 (33%)	6 (15%)	9 (24%)	
No	47 (49%)	4 (22%)	23 (59%)	20 (53%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Other, please specify:					0.4
Yes	11 (12%)	3 (17%)	3 (8%)	5 (13%)	
No	20 (21%)	4 (22%)	9 (23%)	7 (18%)	
Respondent skip	37 (39%)	3 (17%)	17 (44%)	17 (45%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
11c. For each item listed below, indicate which, if any, challenges your DCE experiences when implementing BE/BEI. *(Asked of those who said "Yes" to Q11a)*					
Insufficient staff					0.005***
Yes	37 (39%)	9 (50%)	16 (41%)	12 (32%)	
No	23 (24%)	1 (6%)	13 (33%)	9 (24%)	
Respondent skip	8 (8%)	0 (0%)	0 (0%)	8 (21%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Complexity of requirements					0.005***
Yes	43 (45%)	9 (50%)	22 (56%)	12 (32%)	
No	17 (18%)	1 (6%)	7 (18%)	9 (24%)	
Respondent skip	8 (8%)	0 (0%)	0 (0%)	8 (21%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Lack of clarity about requirements					<0.001***
Yes	24 (25%)	8 (44%)	9 (23%)	7 (18%)	
No	36 (38%)	2 (11%)	20 (51%)	14 (37%)	
Respondent skip	8 (8%)	0 (0%)	0 (0%)	8 (21%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Not offering the same benefit to all patients					0.006***
Yes	38 (40%)	8 (44%)	20 (51%)	10 (26%)	
No	22 (23%)	2 (11%)	9 (23%)	11 (29%)	
Respondent skip	8 (8%)	0 (0%)	0 (0%)	8 (21%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Other, please specify:					0.086*
Yes	11 (12%)	2 (11%)	3 (8%)	6 (16%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
No	15 (16%)	5 (28%)	7 (18%)	3 (8%)	
Respondent skip	42 (44%)	3 (17%)	19 (49%)	20 (53%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
11d. What does your DCE find challenging about tracking these BE/BEI utilization, performance, and outcome measures? *(Asked of those who said "Yes" to Q11a)*					
Time consuming to enter data					0.079*
Yes	42 (44%)	9 (50%)	19 (49%)	14 (37%)	
No	26 (27%)	1 (6%)	10 (26%)	15 (39%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Time consuming to pull data					0.011**
Yes	41 (43%)	10 (56%)	18 (46%)	13 (34%)	
No	27 (28%)	0 (0%)	11 (28%)	16 (42%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Lack of staff to track and manage data					0.057*
Yes	40 (42%)	8 (44%)	20 (51%)	12 (32%)	
No	28 (29%)	2 (11%)	9 (23%)	17 (45%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Data stored in multiple sources					0.002***
Yes	45 (47%)	9 (50%)	24 (62%)	12 (32%)	
No	23 (24%)	1 (6%)	5 (13%)	17 (45%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Inconsistent data collection or data entry					0.043**
Yes	35 (37%)	9 (50%)	13 (33%)	13 (34%)	
No	33 (35%)	1 (6%)	16 (41%)	16 (42%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Difficulty revising current systems to track measures					0.039**
Yes	35 (37%)	9 (50%)	12 (31%)	14 (37%)	
No	33 (35%)	1 (6%)	17 (44%)	15 (39%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Difficulty distinguishing between BE/BEI services and non-BE/BEI services					0.044**
Yes	30 (32%)	8 (44%)	13 (33%)	9 (24%)	
No	38 (40%)	2 (11%)	16 (41%)	20 (53%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
Other, please specify:					0.006***
Yes	16 (17%)	3 (17%)	1 (3%)	12 (32%)	
No	18 (19%)	4 (22%)	8 (21%)	6 (16%)	
Respondent skip	34 (36%)	3 (17%)	20 (51%)	11 (29%)	
Not asked	27 (28%)	8 (44%)	10 (26%)	9 (24%)	
12. What challenges does your DCE anticipate in implementing the NP Services BE? *(Asked of those who said "Planning to implement in PY2023" for "Nurse practitioner services benefit enhancement" on Q10)*					
Complexity of NP BE policy					0.056*
Yes	19 (20%)	3 (17%)	3 (8%)	13 (34%)	
No	26 (27%)	5 (28%)	11 (28%)	10 (26%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	10 (56%)	25 (64%)	15 (39%)	
Currently do not utilize NPs					0.2
Yes	4 (4%)	0 (0%)	2 (5%)	2 (5%)	
No	41 (43%)	8 (44%)	12 (31%)	21 (55%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	10 (56%)	25 (64%)	15 (39%)	
Need to hire or train NPs					0.091*

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Yes	15 (16%)	3 (17%)	7 (18%)	5 (13%)	
No	30 (32%)	5 (28%)	7 (18%)	18 (47%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	10 (56%)	25 (64%)	15 (39%)	
Not offering the same benefit to all patients					0.077*
Yes	22 (23%)	5 (28%)	9 (23%)	8 (21%)	
No	23 (24%)	3 (17%)	5 (13%)	15 (39%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	10 (56%)	25 (64%)	15 (39%)	
Competing priorities					0.10*
Yes	21 (22%)	4 (22%)	9 (23%)	8 (21%)	
No	24 (25%)	4 (22%)	5 (13%)	15 (39%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	50 (53%)	10 (56%)	25 (64%)	15 (39%)	
Do not need BE					0.3
Yes	13 (14%)	2 (11%)	3 (8%)	8 (21%)	
No	31 (33%)	6 (33%)	11 (28%)	14 (37%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	50 (53%)	10 (56%)	25 (64%)	15 (39%)	
Other, please specify:					0.3
Yes	2 (2%)	0 (0%)	1 (3%)	1 (3%)	
No	14 (15%)	4 (22%)	4 (10%)	6 (16%)	
Respondent skip	29 (31%)	4 (22%)	9 (23%)	16 (42%)	
Not asked	50 (53%)	10 (56%)	25 (64%)	15 (39%)	
13a. As part of the DCE's efforts to engage Participant Providers, how important is each of the following practice support and improvement activities?					
DCE provides or arranges for centralized population health support staff (e.g., care managers, pharmacist, schedulers/administrative support)					0.080*
Very important	77 (81%)	11 (61%)	32 (82%)	34 (89%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Somewhat important	4 (4%)	2 (11%)	1 (3%)	1 (3%)	
Not important	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
DCE does not offer this activity	12 (13%)	5 (28%)	5 (13%)	2 (5%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE provides or arranges for staff embedded in practices (e.g., administrative, care manager, health educator/coach, social worker)					0.026**
Very important	51 (54%)	6 (33%)	21 (54%)	24 (63%)	
Somewhat important	13 (14%)	4 (22%)	3 (8%)	6 (16%)	
Not important	4 (4%)	0 (0%)	1 (3%)	3 (8%)	
DCE does not offer this activity	26 (27%)	8 (44%)	14 (36%)	4 (11%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE provides or arranges for investments in infrastructure at the practice level (Tooltip: Infrastructure refers to Electronic Health Record software, hardware, data analytic support, care delivery tools [e.g., shared decision-making aids, patient survey instruments], and licenses to access tools.)					0.2
Very important	61 (64%)	9 (50%)	24 (62%)	28 (74%)	
Somewhat important	19 (20%)	3 (17%)	10 (26%)	6 (16%)	
Not important	5 (5%)	2 (11%)	1 (3%)	2 (5%)	
DCE does not offer this activity	9 (9%)	4 (22%)	4 (10%)	1 (3%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Coaching or one-on-one review of performance, quality, and/or cost data					0.2
Very important	69 (73%)	13 (72%)	25 (64%)	31 (82%)	
Somewhat important	15 (16%)	2 (11%)	8 (21%)	5 (13%)	
Not important	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE does not offer this activity	10 (11%)	3 (17%)	6 (15%)	1 (3%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Data analysis support other than feedback reports on quality, utilization, or cost					0.2
Very important	76 (80%)	12 (67%)	31 (79%)	33 (87%)	
Somewhat important	7 (7%)	1 (6%)	3 (8%)	3 (8%)	
Not important	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE does not offer this activity	10 (11%)	4 (22%)	5 (13%)	1 (3%)	
Respondent skip	2 (2%)	1 (6%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Regular meetings between DCE and individual practice leaders					0.041**
Very important	83 (87%)	14 (78%)	36 (92%)	33 (87%)	
Somewhat important	6 (6%)	2 (11%)	3 (8%)	1 (3%)	
Not important	3 (3%)	0 (0%)	0 (0%)	3 (8%)	
DCE does not offer this activity	2 (2%)	2 (11%)	0 (0%)	0 (0%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Action-oriented initiatives focusing on small-scale, discrete areas for improvement (e.g., improving completion rates for flu vaccine, increasing number of annual wellness visits)					0.007***
Very important	74 (78%)	10 (56%)	30 (77%)	34 (89%)	
Somewhat important	10 (11%)	3 (17%)	5 (13%)	2 (5%)	
Not important	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
DCE does not offer this activity	9 (9%)	5 (28%)	4 (10%)	0 (0%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Training and education sessions					0.3
Very important	74 (78%)	15 (83%)	27 (69%)	32 (84%)	
Somewhat important	16 (17%)	3 (17%)	9 (23%)	4 (11%)	
Not important	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
DCE does not offer this activity	3 (3%)	0 (0%)	3 (8%)	0 (0%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Workflow redesign or optimization support					0.004***
Very important	51 (54%)	6 (33%)	27 (69%)	18 (47%)	
Somewhat important	26 (27%)	6 (33%)	6 (15%)	14 (37%)	
Not important	5 (5%)	0 (0%)	1 (3%)	4 (11%)	
DCE does not offer this activity	12 (13%)	6 (33%)	5 (13%)	1 (3%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other practice support and improvement activities, please specify:					0.13
Very important	11 (12%)	1 (6%)	8 (21%)	2 (5%)	
Somewhat important	5 (5%)	1 (6%)	2 (5%)	2 (5%)	
Not important	5 (5%)	1 (6%)	1 (3%)	3 (8%)	
DCE does not offer this activity	21 (22%)	8 (44%)	5 (13%)	8 (21%)	
Respondent skip	53 (56%)	7 (39%)	23 (59%)	23 (61%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

13b. Please estimate the portion of Participant Providers that use the DCE's practice support and improvement activities listed below. Your best estimate is fine. *(Asked of those who said "Very important" to Q13a)*

DCE-provided centralized population health support staff (e.g., care managers, pharmacist, schedulers/administrative support)					0.028**
All	27 (28%)	5 (28%)	16 (41%)	6 (16%)	
Most	38 (40%)	4 (22%)	13 (33%)	21 (55%)	
Some	11 (12%)	2 (11%)	3 (8%)	6 (16%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	18 (19%)	7 (39%)	7 (18%)	4 (11%)	
DCE-provided staff embedded in practices (e.g., administrative, care manager, health educator/coach, social worker)					0.12
All	22 (23%)	1 (6%)	8 (21%)	13 (34%)	
Most	13 (14%)	2 (11%)	6 (15%)	5 (13%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Some	13 (14%)	3 (17%)	7 (18%)	3 (8%)	
None	3 (3%)	0 (0%)	0 (0%)	3 (8%)	
Don't know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	44 (46%)	12 (67%)	18 (46%)	14 (37%)	
DCE-provided investments in infrastructure at the practice level					0.3
All	17 (18%)	2 (11%)	10 (26%)	5 (13%)	
Most	36 (38%)	5 (28%)	13 (33%)	18 (47%)	
Some	7 (7%)	2 (11%)	1 (3%)	4 (11%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	34 (36%)	9 (50%)	15 (38%)	10 (26%)	
Coaching or one-on-one review of performance, quality, and/or cost data					0.029**
All	32 (34%)	2 (11%)	10 (26%)	20 (53%)	
Most	25 (26%)	8 (44%)	11 (28%)	6 (16%)	
Some	9 (9%)	2 (11%)	3 (8%)	4 (11%)	
None	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Don't know	2 (2%)	1 (6%)	0 (0%)	1 (3%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	26 (27%)	5 (28%)	14 (36%)	7 (18%)	
Data analysis support other than feedback reports on quality, utilization, or cost					0.083*
All	32 (34%)	3 (17%)	18 (46%)	11 (29%)	
Most	24 (25%)	7 (39%)	8 (21%)	9 (24%)	
Some	19 (20%)	2 (11%)	5 (13%)	12 (32%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	19 (20%)	6 (33%)	8 (21%)	5 (13%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Regular meetings between DCE and individual practice leaders					0.008***
All	42 (44%)	4 (22%)	26 (67%)	12 (32%)	
Most	34 (36%)	7 (39%)	9 (23%)	18 (47%)	
Some	6 (6%)	3 (17%)	1 (3%)	2 (5%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	12 (13%)	4 (22%)	3 (8%)	5 (13%)	
Action-oriented initiatives focusing on small-scale, discrete areas for improvement (e.g., improving completion rates for flu vaccine, increasing number of annual wellness visits)					0.030**
All	30 (32%)	1 (6%)	13 (33%)	16 (42%)	
Most	31 (33%)	6 (33%)	14 (36%)	11 (29%)	
Some	12 (13%)	3 (17%)	3 (8%)	6 (16%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	21 (22%)	8 (44%)	9 (23%)	4 (11%)	
Training and education sessions					0.2
All	39 (41%)	5 (28%)	19 (49%)	15 (39%)	
Most	25 (26%)	7 (39%)	7 (18%)	11 (29%)	
Some	9 (9%)	3 (17%)	1 (3%)	5 (13%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	21 (22%)	3 (17%)	12 (31%)	6 (16%)	
Workflow redesign or optimization support					0.032**
All	21 (22%)	1 (6%)	15 (38%)	5 (13%)	
Most	15 (16%)	3 (17%)	8 (21%)	4 (11%)	
Some	13 (14%)	2 (11%)	4 (10%)	7 (18%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
None	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Don't know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	44 (46%)	12 (67%)	12 (31%)	20 (53%)	
Other practice support and improvement activity specified in 13a					0.5
All	5 (5%)	1 (6%)	3 (8%)	1 (3%)	
Most	2 (2%)	0 (0%)	1 (3%)	1 (3%)	
Some	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
None	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Don't know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	3 (3%)	0 (0%)	3 (8%)	0 (0%)	
Not asked	84 (88%)	17 (94%)	31 (79%)	36 (95%)	
14a. How important are each of the following information sharing activities for engaging your DCE's Participant Providers?					
Feedback reports on quality, utilization, or cost with comparisons at the practice level					0.2
Very important	86 (91%)	15 (83%)	36 (92%)	35 (92%)	
Somewhat important	6 (6%)	3 (17%)	1 (3%)	2 (5%)	
Not important	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE does not offer this activity	2 (2%)	0 (0%)	2 (5%)	0 (0%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Feedback reports on quality, utilization, or cost with comparisons at the individual clinician level					0.3
Very important	75 (79%)	13 (72%)	30 (77%)	32 (84%)	
Somewhat important	13 (14%)	3 (17%)	5 (13%)	5 (13%)	
Not important	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE does not offer this activity	6 (6%)	2 (11%)	4 (10%)	0 (0%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Other information to help providers manage care (e.g., specialty and other service use)					0.011**
Very important	65 (68%)	11 (61%)	22 (56%)	32 (84%)	
Somewhat important	21 (22%)	6 (33%)	10 (26%)	5 (13%)	
Not important	2 (2%)	1 (6%)	1 (3%)	0 (0%)	
DCE does not offer this activity	6 (6%)	0 (0%)	6 (15%)	0 (0%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Real time data on emergency department (ED) and inpatient admissions, discharges, and transfers (ADTs)					0.007***
Very important	83 (87%)	13 (72%)	33 (85%)	37 (97%)	
Somewhat important	4 (4%)	1 (6%)	3 (8%)	0 (0%)	
Not important	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE does not offer this activity	7 (7%)	4 (22%)	3 (8%)	0 (0%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other information sharing activities, please specify:					0.6
Very important	12 (13%)	4 (22%)	3 (8%)	5 (13%)	
Somewhat important	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not important	7 (7%)	1 (6%)	4 (10%)	2 (5%)	
DCE does not offer this activity	18 (19%)	5 (28%)	6 (15%)	7 (18%)	
Respondent skip	57 (60%)	8 (44%)	26 (67%)	23 (61%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

14b. Please estimate the portion of Participant Providers that use the DCE's information sharing activities listed below. Your best estimate is fine. *(Asked of those who said "Very important" to Q14a)*

Feedback reports on quality, utilization, or cost with comparisons at the practice level					0.7
All	29 (31%)	3 (17%)	14 (36%)	12 (32%)	
Most	40 (42%)	7 (39%)	16 (41%)	17 (45%)	
Some	14 (15%)	4 (22%)	5 (13%)	5 (13%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Don't know	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Respondent skip	2 (2%)	1 (6%)	1 (3%)	0 (0%)	
Not asked	9 (9%)	3 (17%)	3 (8%)	3 (8%)	
Feedback reports on quality, utilization, or cost with comparisons at the individual clinician level					0.9
All	25 (26%)	3 (17%)	12 (31%)	10 (26%)	
Most	34 (36%)	6 (33%)	13 (33%)	15 (39%)	
Some	15 (16%)	4 (22%)	5 (13%)	6 (16%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	20 (21%)	5 (28%)	9 (23%)	6 (16%)	
Other information to help providers manage care (e.g., specialty and other service use)					0.022**
All	19 (20%)	3 (17%)	9 (23%)	7 (18%)	
Most	22 (23%)	4 (22%)	4 (10%)	14 (37%)	
Some	7 (7%)	1 (6%)	1 (3%)	5 (13%)	
None	2 (2%)	1 (6%)	1 (3%)	0 (0%)	
Don't know	1 (1%)	1 (6%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	44 (46%)	8 (44%)	24 (62%)	12 (32%)	
Real time data on emergency department (ED) and inpatient admissions, discharges, and transfers (ADTs)					0.2
All	29 (31%)	4 (22%)	13 (33%)	12 (32%)	
Most	36 (38%)	6 (33%)	13 (33%)	17 (45%)	
Some	14 (15%)	2 (11%)	5 (13%)	7 (18%)	
None	2 (2%)	1 (6%)	1 (3%)	0 (0%)	
Don't know	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Respondent skip	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Not asked	12 (13%)	5 (28%)	6 (15%)	1 (3%)	
Other information sharing activity specified in 14a					0.3
All	8 (8%)	2 (11%)	3 (8%)	3 (8%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Most	3 (3%)	2 (11%)	0 (0%)	1 (3%)	
Some	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	83 (87%)	14 (78%)	36 (92%)	33 (87%)	
15a. How important are each of the following incentives for engaging your DCE's Participant Providers?					
Financial bonuses tied to performance					0.055*
Very important	77 (81%)	13 (72%)	29 (74%)	35 (92%)	
Somewhat important	8 (8%)	1 (6%)	5 (13%)	2 (5%)	
Not important	3 (3%)	0 (0%)	2 (5%)	1 (3%)	
DCE does not offer this activity	7 (7%)	4 (22%)	3 (8%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Financial penalties tied to performance					0.053*
Very important	24 (25%)	4 (22%)	9 (23%)	11 (29%)	
Somewhat important	31 (33%)	3 (17%)	11 (28%)	17 (45%)	
Not important	8 (8%)	0 (0%)	5 (13%)	3 (8%)	
DCE does not offer this activity	32 (34%)	11 (61%)	14 (36%)	7 (18%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Non-financial awards or recognition tied to performance					0.007***
Very important	21 (22%)	3 (17%)	10 (26%)	8 (21%)	
Somewhat important	47 (49%)	6 (33%)	16 (41%)	25 (66%)	
Not important	7 (7%)	0 (0%)	4 (10%)	3 (8%)	
DCE does not offer this activity	20 (21%)	9 (50%)	9 (23%)	2 (5%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
DCE provides upfront payments					0.4
Very important	37 (39%)	5 (28%)	13 (33%)	19 (50%)	
Somewhat important	19 (20%)	5 (28%)	8 (21%)	6 (16%)	
Not important	8 (8%)	0 (0%)	5 (13%)	3 (8%)	
DCE does not offer this activity	31 (33%)	8 (44%)	13 (33%)	10 (26%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other incentives, please specify:					0.7
Very important	11 (12%)	4 (22%)	4 (10%)	3 (8%)	
Somewhat important	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not important	4 (4%)	1 (6%)	2 (5%)	1 (3%)	
DCE does not offer this activity	22 (23%)	5 (28%)	8 (21%)	9 (24%)	
Respondent skip	57 (60%)	8 (44%)	25 (64%)	24 (63%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

15b. Please estimate the portion of Participant Providers that receive the DCE's incentives listed below. Your best estimate is fine. *(Asked of those who said "Very important" to Q15a)*

Financial bonuses tied to performance					0.2
All	36 (38%)	4 (22%)	16 (41%)	16 (42%)	
Most	19 (20%)	8 (44%)	7 (18%)	4 (11%)	
Some	12 (13%)	1 (6%)	6 (15%)	5 (13%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't Know	2 (2%)	0 (0%)	0 (0%)	2 (5%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	26 (27%)	5 (28%)	10 (26%)	11 (29%)	
Financial penalties tied to performance					0.8
All	8 (8%)	1 (6%)	4 (10%)	3 (8%)	
Most	4 (4%)	2 (11%)	0 (0%)	2 (5%)	
Some	4 (4%)	0 (0%)	1 (3%)	3 (8%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
None	5 (5%)	1 (6%)	2 (5%)	2 (5%)	
Don't Know	3 (3%)	0 (0%)	2 (5%)	1 (3%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	71 (75%)	14 (78%)	30 (77%)	27 (71%)	
Non-financial awards or recognition tied to performance					0.4
All	5 (5%)	1 (6%)	4 (10%)	0 (0%)	
Most	9 (9%)	2 (11%)	2 (5%)	5 (13%)	
Some	5 (5%)	0 (0%)	3 (8%)	2 (5%)	
None	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Don't Know	1 (1%)	0 (0%)	1 (3%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	74 (78%)	15 (83%)	29 (74%)	30 (79%)	
DCE provides upfront payments					0.4
All	21 (22%)	2 (11%)	8 (21%)	11 (29%)	
Most	13 (14%)	2 (11%)	4 (10%)	7 (18%)	
Some	1 (1%)	1 (6%)	0 (0%)	0 (0%)	
None	2 (2%)	0 (0%)	1 (3%)	1 (3%)	
Don't Know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	58 (61%)	13 (72%)	26 (67%)	19 (50%)	
Other incentive specified in 15a					0.038**
All	6 (6%)	2 (11%)	4 (10%)	0 (0%)	
Most	4 (4%)	2 (11%)	0 (0%)	2 (5%)	
Some	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Don't Know	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	84 (88%)	14 (78%)	35 (90%)	35 (92%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
16. Which of the following methods does your DCE use to pay Participant Providers? Please select all that apply.					
Partial fee-for-service					0.4
DCE uses this method	34 (36%)	6 (33%)	15 (38%)	13 (34%)	
DCE does not use this method	45 (47%)	10 (56%)	20 (51%)	15 (39%)	
Respondent skip	16 (17%)	2 (11%)	4 (10%)	10 (26%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Fee-for-service					0.2
DCE uses this method	44 (46%)	11 (61%)	16 (41%)	17 (45%)	
DCE does not use this method	35 (37%)	6 (33%)	18 (46%)	11 (29%)	
Respondent skip	16 (17%)	1 (6%)	5 (13%)	10 (26%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Partial capitation					0.2
DCE uses this method	39 (41%)	7 (39%)	18 (46%)	14 (37%)	
DCE does not use this method	41 (43%)	10 (56%)	17 (44%)	14 (37%)	
Respondent skip	15 (16%)	1 (6%)	4 (10%)	10 (26%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Total capitation					0.12
DCE uses this method	25 (26%)	8 (44%)	8 (21%)	9 (24%)	
DCE does not use this method	52 (55%)	9 (50%)	25 (64%)	18 (47%)	
Respondent skip	18 (19%)	1 (6%)	6 (15%)	11 (29%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Payments tied to quality thresholds					0.4
DCE uses this method	51 (54%)	11 (61%)	21 (54%)	19 (50%)	
DCE does not use this method	28 (29%)	6 (33%)	13 (33%)	9 (24%)	
Respondent skip	16 (17%)	1 (6%)	5 (13%)	10 (26%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other, please specify:					0.7
DCE uses this method	20 (21%)	3 (17%)	10 (26%)	7 (18%)	
DCE does not use this method	21 (22%)	6 (33%)	7 (18%)	8 (21%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Respondent skip	54 (57%)	9 (50%)	22 (56%)	23 (61%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
17. Not including any capitated payments the DCE may make to providers, does your DCE use financial rewards and/or penalties with its Participant Providers?					
DCE uses financial rewards					0.12
Yes	84 (88%)	15 (83%)	33 (85%)	36 (95%)	
No	10 (11%)	3 (17%)	6 (15%)	1 (3%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE uses financial penalties					0.8
Yes	25 (26%)	5 (28%)	9 (23%)	11 (29%)	
No	69 (73%)	13 (72%)	30 (77%)	26 (68%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
18a. How many of your DCE's Participant Providers are employed directly by a health system or practice participating in the model?					No test
All	38 (40%)	3 (17%)	25 (64%)	10 (26%)	
Most	25 (26%)	6 (33%)	9 (23%)	10 (26%)	
Some	11 (12%)	3 (17%)	3 (8%)	5 (13%)	
Very Few	8 (8%)	1 (6%)	0 (0%)	7 (18%)	
None	12 (13%)	5 (28%)	2 (5%)	5 (13%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
19. Does your DCE use financial rewards and/or penalties with its Preferred Providers?					
DCE uses financial rewards					0.4
Yes	40 (42%)	6 (33%)	15 (38%)	19 (50%)	
No	54 (57%)	12 (67%)	24 (62%)	18 (47%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
DCE uses financial penalties					0.3
Yes	28 (29%)	3 (17%)	11 (28%)	14 (37%)	
No	66 (69%)	15 (83%)	28 (72%)	23 (61%)	
Respondent skip	1 (1%)	0 (0%)	0 (0%)	1 (3%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Does the DCE share upside financial risk (savings) directly with Participant Providers?					
Yes, DCE shares total savings with practitioners[3]	73 (77%)	14 (78%)	28 (72%)	31 (82%)	0.6
Yes, DCE shares service-specific savings with practitioners[3]	19 (20%)	5 (28%)	9 (23%)	5 (13%)	0.4
Does the DCE share downside financial risk (losses) directly with Participant Providers?					
Yes, DCE shares total losses with practitioners[3]	16 (17%)	2 (11%)	8 (21%)	6 (16%)	0.8
Yes, DCE shares service-specific losses with practitioners[3]	6 (6%)	1 (6%)	4 (10%)	1 (3%)	0.5
Does the DCE share upside financial risk (savings) directly with Participant Facilities?					
Yes, DCE shares total savings with facilities[4]	9 (9%)	2 (11%)	6 (15%)	1 (3%)	0.14
Yes, DCE shares service-specific savings with facilities[4]	21 (22%)	3 (17%)	6 (15%)	12 (32%)	0.2
Does the DCE share downside financial risk (losses) directly with Participant Facilities?					
Yes, DCE shares total losses with facilities[4]	6 (6%)	1 (6%)	4 (10%)	1 (3%)	0.5
Yes, DCE shares service-specific losses with facilities[4]	0 (0%)	0 (0%)	0 (0%)	0 (0%)	No test

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
20a. Does your DCE share upside financial risk (savings) directly with the Participant Provider types listed below?					
Individual practitioners who may be employed directly by a health system or practice participating in the model					
Total DCE savings	48 (51%)	5 (28%)	20 (51%)	23 (61%)	0.072*
Service-specific savings	14 (15%)	4 (22%)	6 (15%)	4 (11%)	0.5
Provider type does not participate in DCE	7 (7%)	2 (11%)	2 (5%)	3 (8%)	0.6
Does not share savings with this type of provider	26 (27%)	8 (44%)	11 (28%)	7 (18%)	0.12
Physician groups/practices					
Respondent skip	26 (27%)	5 (28%)	13 (33%)	8 (21%)	
Total DCE savings	69 (73%)	13 (72%)	26 (67%)	30 (79%)	0.5
Service-specific savings	15 (16%)	5 (28%)	5 (13%)	5 (13%)	0.3
Provider type does not participate in DCE	4 (4%)	0 (0%)	3 (8%)	1 (3%)	0.5
Does not share savings with this type of provider	7 (7%)	1 (6%)	5 (13%)	1 (3%)	0.2
Networks of individual physician practices or other practitioners					
Total DCE savings	48 (51%)	9 (50%)	14 (36%)	25 (66%)	0.032**
Service-specific savings	14 (15%)	5 (28%)	4 (10%)	5 (13%)	0.2
Provider type does not participate in DCE	19 (20%)	2 (11%)	12 (31%)	5 (13%)	0.11
Does not share savings with this type of provider	14 (15%)	3 (17%)	9 (23%)	2 (5%)	0.087*
Independent or solo practitioners					
Total DCE savings	44 (46%)	10 (56%)	12 (31%)	22 (58%)	0.040**
Service-specific savings	11 (12%)	3 (17%)	4 (10%)	4 (11%)	0.8
Provider type does not participate in DCE	22 (23%)	3 (17%)	10 (26%)	9 (24%)	0.8
Does not share savings with this type of provider	18 (19%)	3 (17%)	13 (33%)	2 (5%)	0.005***
Acute care hospitals					
Total DCE savings	7 (7%)	2 (11%)	5 (13%)	0 (0%)	0.061*
Service-specific savings	6 (6%)	1 (6%)	3 (8%)	2 (5%)	>0.9
Provider type does not participate in DCE	39 (41%)	4 (22%)	16 (41%)	19 (50%)	0.14
Does not share savings with this type of provider	42 (44%)	11 (61%)	15 (38%)	16 (42%)	0.3
Skilled nursing facilities (SNFs)					
Total DCE savings	4 (4%)	2 (11%)	2 (5%)	0 (0%)	0.14

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Service-specific savings	14 (15%)	0 (0%)	2 (5%)	12 (32%)	0.001***
Provider type does not participate in DCE	26 (27%)	1 (6%)	16 (41%)	9 (24%)	0.015**
Does not share savings with this type of provider	50 (53%)	15 (83%)	19 (49%)	16 (42%)	0.013**
Home health agencies (HHAs)					
Total DCE savings	3 (3%)	2 (11%)	0 (0%)	1 (3%)	0.048**
Service-specific savings	17 (18%)	2 (11%)	4 (10%)	11 (29%)	0.10*
Provider type does not participate in DCE	23 (24%)	2 (11%)	14 (36%)	7 (18%)	0.090*
Does not share savings with this type of provider	51 (54%)	12 (67%)	21 (54%)	18 (47%)	0.4
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)					
Total DCE savings	1 (1%)	1 (6%)	0 (0%)	0 (0%)	0.2
Service-specific savings	2 (2%)	0 (0%)	1 (3%)	1 (3%)	>0.9
Provider type does not participate in DCE	37 (39%)	3 (17%)	16 (41%)	18 (47%)	0.084*
Does not share savings with this type of provider	54 (57%)	14 (78%)	22 (56%)	18 (47%)	0.10*
Other provider type, please specify:					
Total DCE savings	2 (2%)	0 (0%)	1 (3%)	1 (3%)	>0.9
Service-specific savings	3 (3%)	1 (6%)	1 (3%)	1 (3%)	0.6
Provider type does not participate in DCE	7 (7%)	2 (11%)	4 (10%)	1 (3%)	0.4
Does not share savings with this type of provider	26 (27%)	8 (44%)	9 (23%)	9 (24%)	0.2
20b. For upside risk (savings), what portion is shared with each provider type? *(Asked of those who shared any savings with each provider type)*					
Individual practitioners who may be employed directly by a health system or practice participating in the model					0.2
1-5%	4 (8%)	0 (0%)	3 (14%)	1 (4%)	
6-10%	1 (2%)	0 (0%)	0 (0%)	1 (4%)	
11-30%	11 (22%)	0 (0%)	7 (33%)	4 (17%)	
31-50%	15 (29%)	5 (71%)	3 (14%)	7 (30%)	
More than 50%	20 (39%)	2 (29%)	8 (38%)	10 (43%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Physician groups / practices					0.12
1-5%	4 (6%)	1 (7%)	3 (12%)	0 (0%)	
6-10%	2 (3%)	0 (0%)	1 (4%)	1 (4%)	
11-30%	14 (21%)	2 (13%)	7 (28%)	5 (19%)	
31-50%	19 (28%)	8 (53%)	3 (12%)	8 (30%)	
More than 50%	28 (42%)	4 (27%)	11 (44%)	13 (48%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Networks of individual physician practices or other practitioners					0.008***
1-5%	3 (6%)	1 (9%)	2 (14%)	0 (0%)	
6-10%	2 (4%)	1 (9%)	0 (0%)	1 (4%)	
11-30%	12 (24%)	1 (9%)	7 (50%)	4 (16%)	
31-50%	12 (24%)	5 (45%)	0 (0%)	7 (28%)	
More than 50%	21 (42%)	3 (27%)	5 (36%)	13 (52%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Independent or solo practitioners					0.025**
1-5%	2 (5%)	2 (18%)	0 (0%)	0 (0%)	
6-10%	1 (2%)	0 (0%)	0 (0%)	1 (5%)	
11-30%	15 (37%)	2 (18%)	7 (64%)	6 (32%)	
31-50%	13 (32%)	5 (45%)	0 (0%)	8 (42%)	
More than 50%	10 (24%)	2 (18%)	4 (36%)	4 (21%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Acute care hospitals					>0.9
1-5%	3 (30%)	1 (33%)	1 (20%)	1 (50%)	
6-10%	2 (20%)	0 (0%)	1 (20%)	1 (50%)	
11-30%	4 (40%)	2 (67%)	2 (40%)	0 (0%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	1 (10%)	0 (0%)	1 (20%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Skilled nursing facilities (SNFs)					0.14
1-5%	13 (81%)	1 (50%)	1 (50%)	11 (92%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	3 (19%)	1 (50%)	1 (50%)	1 (8%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Home health agencies (HHAs)					0.10
1-5%	14 (78%)	2 (50%)	1 (50%)	11 (92%)	
6-10%	2 (11%)	1 (25%)	0 (0%)	1 (8%)	
11-30%	2 (11%)	1 (25%)	1 (50%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)					>0.9
1-5%	2 (67%)	0 (0%)	1 (100%)	1 (100%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	1 (33%)	1 (100%)	0 (0%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other provider type specified in 20a					0.6

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
1-5%	3 (60%)	0 (0%)	2 (100%)	1 (50%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	1 (20%)	1 (100%)	0 (0%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	1 (20%)	0 (0%)	0 (0%)	1 (50%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
20c. Does your DCE share downside financial risk (losses) directly with the Participant Provider types listed below?					
Individual practitioners who may be employed directly by a health system or practice participating in the model					
Total DCE losses	9 (10%)	1 (6%)	6 (16%)	2 (6%)	0.4
Service-specific losses	3 (3%)	1 (6%)	2 (5%)	0 (0%)	0.4
Does not share losses with this type of provider	74 (84%)	13 (81%)	29 (78%)	32 (91%)	0.3
Physician groups/practices					
Total DCE losses	10 (11%)	2 (11%)	6 (17%)	2 (5%)	0.3
Service-specific losses	6 (7%)	1 (6%)	4 (11%)	1 (3%)	0.3
Does not share losses with this type of provider	74 (81%)	15 (83%)	26 (72%)	33 (89%)	0.2
Networks of individual physician practices or other practitioners					
Total DCE losses	8 (11%)	0 (0%)	3 (11%)	5 (15%)	0.3
Service-specific losses	2 (3%)	1 (6%)	1 (4%)	0 (0%)	0.3
Does not share losses with this type of provider	64 (84%)	14 (88%)	23 (85%)	27 (82%)	>0.9
Independent or solo practitioners					
Total DCE losses	5 (7%)	1 (7%)	2 (7%)	2 (7%)	>0.9
Service-specific losses	4 (5%)	1 (7%)	3 (10%)	0 (0%)	0.2
Does not share losses with this type of provider	62 (85%)	12 (80%)	24 (83%)	26 (90%)	0.7
Acute care hospitals					
Total DCE losses	4 (7%)	1 (7%)	3 (13%)	0 (0%)	0.3
Service-specific losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Does not share losses with this type of provider	50 (89%)	12 (86%)	20 (87%)	18 (95%)	0.6
Skilled nursing facilities (SNFs)					
Total DCE losses	2 (3%)	1 (6%)	1 (4%)	0 (0%)	0.3
Service-specific losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Does not share losses with this type of provider	65 (94%)	15 (88%)	22 (96%)	28 (97%)	0.6
Home health agencies (HHAs)					
Total DCE losses	2 (3%)	1 (6%)	0 (0%)	1 (3%)	0.7
Service-specific losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Does not share losses with this type of provider	68 (94%)	14 (88%)	25 (100%)	29 (94%)	0.2
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)					
Total DCE losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Service-specific losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Does not share losses with this type of provider	56 (97%)	14 (93%)	23 (100%)	19 (95%)	0.5
Other provider type, please specify:					
Total DCE losses	1 (1%)	0 (0%)	0 (0%)	1 (3%)	>0.9
Service-specific losses	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
Does not share losses with this type of provider	40 (45%)	9 (56%)	11 (31%)	20 (54%)	0.10*
20d. For downside risk (losses), what percentage is shared with each provider type? *(Asked of those who shared any losses with each provider type)*					
Individual practitioners who may be employed directly by a health system or practice participating in the model					0.2
1-5%	1 (11%)	0 (0%)	0 (0%)	1 (50%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	2 (22%)	0 (0%)	1 (20%)	1 (50%)	
31-50%	1 (11%)	1 (50%)	0 (0%)	0 (0%)	
More than 50%	5 (56%)	1 (50%)	4 (80%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Physician groups/practices					0.3
1-5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	3 (27%)	0 (0%)	1 (20%)	2 (67%)	
31-50%	1 (9%)	1 (33%)	0 (0%)	0 (0%)	
More than 50%	7 (64%)	2 (67%)	4 (80%)	1 (33%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Networks of individual physician practices or other practitioners					>0.9
1-5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	3 (50%)	0 (0%)	1 (50%)	2 (67%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	3 (50%)	1 (100%)	1 (50%)	1 (33%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Independent or solo practitioners					0.6
1-5%	1 (20%)	1 (50%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	3 (60%)	0 (0%)	1 (100%)	2 (100%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	1 (20%)	1 (50%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Acute care hospitals					>0.9
1-5%	1 (33%)	0 (0%)	1 (50%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	1 (33%)	1 (100%)	0 (0%)	0 (0%)	

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	1 (33%)	0 (0%)	1 (50%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Skilled nursing facilities (SNFs)					-
1-5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Home health agencies (HHAs)					>0.9
1-5%	1 (50%)	1 (100%)	0 (0%)	0 (0%)	
6-10%	1 (50%)	0 (0%)	0 (0%)	1 (100%)	
11-30%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs)					-
1-5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Other provider type specified in 20c					>0.9

Question	Overall, N=95[1]	Functional Role: Convener, N=18[1]	Functional Role: Direct Care Provider, N=39[1]	Functional Role: Enabler, N=38[1]	p-value[2]
1-5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
6-10%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
11-30%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
31-50%	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
More than 50%	1 (100%)	0 (0%)	0 (0%)	1 (100%)	
Respondent skip	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Not asked	0 (0%)	0 (0%)	0 (0%)	0 (0%)	

NOTE: DCE: Direct Contracting Entity; NP=Nurse Practitioner; BE=Benefit Enhancements; BEI=Beneficiary Engagement Incentives.
[1] n (%)
[2] *p<0.10; **p<0.05; ***p<0.01.
[3] Practitioners include: Individual practitioners who may be employed directly by a health system or practice participating in the model, physician groups/practices, networks of individual physician practices or other practitioners, and independent or solo practitioners.
[4] Facilities include: acute care hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), long-term care hospitals (LTCHs) or inpatient rehabilitation facilities (IRFs).

Appendix E: Exhibits to Support Chapter 2

This appendix presents detailed DCE characteristics descriptives along with the p-values from Fisher's exact tests of independence to examine the significance of the association between and among DCE characteristics and other DCE-level implementation variables. Significance is indicated by asterisks in Appendices E.1.2 through E.1.5. Methods for these analyses can be found in **Appendix C**.

For additional information and findings on the 2022 Pulse Check Survey results presented in Chapter 2, please refer to **Appendix D.2.**

E.1: DCE Characteristics Results

Appendix E.1.1. DCE Type and Model Elections Across Performance Years

Exhibits E.1 through **E.3** present a summary of DCE type and model elections across both PY2021 and 2022 for both starter cohorts (2021 Starters and 2022 Starters).

Exhibit E.1. DCE Type Across Performance Years and Cohorts, PY2021–PY2022

		DCE Types over PYs					
		Standard		New Entrant		High Needs	
Cohorts	**Overall**	**n**	**%**	**n**	**%**	**n**	**%**
PY2021							
2021 Starters	53	29	55%	18	34%	6	11%
PY2022							
2021 Starters	50	37	74%	9	18%	4	8%
2022 Starters	49	41	84%	4	8%	4	8%
All DCEs	**99**	**78**	**79%**	**13**	**13%**	**8**	**8%**

SOURCE: GPDC PY2022 Financial Results (n=99 DCEs).
NOTE: DCE=Direct Contracting Entity.
The PY2021 counts include two New Entrant and one High Needs DCEs that exited at the end of PY2021. The PY2022 counts include 15 DCEs that exited the model in PY2022.
The 2021 Starters counts also include seven New Entrant DCEs and one High Needs DCE that entered the model in PY2021 and transitioned to Standard DCEs in PY2022.

Exhibit E.2. Payment Elections Across Performance Years and Cohorts, PY2021–PY2022

		Payment Elections over PYs					
		TCC		PCC (overall)		PCC + APO	
Cohorts	**Overall**	**n**	**%**	**n**	**%**	**n**	**%**
PY2021							
2021 Starters	53	11	21%	21	40%	21	40%
PY2022							
2021 Starters	50	26%	13	26%	24	48%	26%
2022 Starters	49	29%	17	35%	18	38%	29%
All DCEs	**99**	**27%**	**30**	**30%**	**42**	**42%**	**27%**

SOURCE: GPDC PY2022 Financial Results (n=99 DCEs)
NOTE: DCE=Direct Contracting Entity, TCC=Total Care Capitation, PCC=Primary Care Capitation; APO=Advanced Payment Option.
These counts also include 15 DCEs (3 DCEs that elected PCC, 5 DCEs that elected PCC+APO, and 7 DCEs that elected TCC) that exited the model in PY2022.
The 2021 Starters counts also include the following DCEs that entered into the model in PY2021 and then changed their payment election in PY2022: five DCEs that transitioned from PCC to PCC with APO; three DCEs that transitioned from PCC with APO to TCC, and one DCE that transitioned from TCC to PCC with APO.

Exhibit E.3. Risk-Sharing Elections Across Performance Years and Cohorts, PY2021–PY2022

		Risk-Sharing Elections over PYs			
		Global		Professional	
Cohorts	**Overall**	**n**	**%**	**n**	**%**
PY2021					
2021 Starters	53	39	74%	14	26%
PY2022					
2021 Starters	50	40	80%	10	20%
2022 Starters	49	32	67%	17	35%
All DCEs	**99**	**72**	**73%**	**27**	**27%**

NOTE: DCE=Direct Contracting Entity
These counts also include 15 DCEs (4 Professional DCEs and 11 Global DCEs) that exited the model in PY2022.
The 2021 Starters counts also include four DCEs that entered into the model in PY2021 and transitioned from Professional risk to Global risk in PY2022.

Appendix E.1.2. Organizational Characteristics and Model Elections by DCE Type

Exhibits E.4 and **E.5** presents a summary of organizational characteristics and model elections by DCE type in PY2022. They also include associated p-values from Fisher's exact tests of independence to examine the significance of the association across DCE types.

Exhibit E.4. Organizational Characteristics Across DCE Type in PY2022

Variables	Overall N=99[1]	DCE Type: Standard N=78[1]	DCE Type: New Entrant N=13[1]	DCE Type: High Needs N=8[1]	p-value (Standard and New Entrant only)[2]
Organizational Characteristics					
Organizational Structure					0.065*
Network of individual practices	44 (44%)	30 (38%)	7 (54%)	7 (88%)	
Medical group practice	33 (33%)	26 (33%)	6 (46%)	1 (13%)	
IDS/Hospital System	22 (22%)	22 (28%)	0 (0%)	0 (0%)	
Lead Organization Type					0.052*
Insurer	16 (16%)	12 (15%)	3 (23%)	1 (13%)	
MSO	24 (24%)	23 (29%)	2 (15%)	4 (50%)	
Primary Care Company	25 (25%)	12 (15%)	4 (31%)	0 (0%)	
Physician Practice	19 (19%)	11 (14%)	4 (31%)	3 (38%)	
Health System	15 (15%)	20 (26%)	0 (0%)	0 (0%)	
Functional Role					0. 034**
Convener	21 (21%)	12 (15%)	6 (46%)	3 (38%)	
Enabler	39 (39%)	33 (42%)	2 (15%)	4 (50%)	
Direct Care Provider	39 (39%)	33 (42%)	5 (38%)	1 (13%)	

NOTE: DCE=Direct Contracting Entity, MSO=Managed Services Organization, IDS=Integrated Delivery System.
[1] n (%)
[2] *p<0.10; **p<0.05; ***p<0.01.

Exhibit E.5. Risk-Sharing and Payment Elections Across DCE Type in PY2022

Variables	Overall N=99[1]	DCE Type: Standard N=78[1]	DCE Type: New Entrant N=13[1]	DCE Type: High Needs N=8[1]	p-value (Standard and New Entrant only)[2]
Risk-Sharing and Payment Elections					
Risk					0.316
Professional	27 (27%)	19 (24%)	5 (38%)	3 (38%)	
Global	72 (73%)	59 (76%)	8 (62%)	5 (63%)	
Capitation Type					0.503
PCC (overall)	72 (73%)	55 (71%)	11 (85%)	6 (75%)	
PCC+APO	42 (42%)	31 (40%)	6 (46%)	5 (63%)	
TCC	27 (27%)	23 (29%)	2 (15%)	2 (25%)	

NOTE: DCE=Direct Contracting Entity, TCC=Total Care Capitation, PCC=Primary Care Capitation; APO=Advanced Payment Option.
[1] n (%)
[2] *p<0.10; **p<0.05; ***p<0.01.

Appendix E.1.3. Risk-Sharing and Payment Elections by Organizational Characteristics

Exhibits E.6 through **E.8** present a summary of model elections by organizational characteristics in PY2022. They also include associated p-values from Fisher's exact tests of independence to examine the significance of the association between organizational characteristics and model elections.

Exhibit E.6. Risk-Sharing and Payment Elections Across DCE Organizational Structure in PY2022

		Organizational Structure			
Variables	**Overall** N=99[1]	**Network of Individual Practices** N=44[1]	**Medical Group Practice** N=33[1]	**IDS/Hospital System** N=22[1]	**p-value**[2]
Risk-Sharing and Payment Elections					
Risk					0.001***
Professional	27 (27%)	9 (20%)	5 (15%)	13 (59%)	
Global	72 (73%)	35 (80%)	28 (85%)	9 (41%)	
Capitation Type					0.094*
PCC (overall)	72 (73%)	27 (61%)	27 (82%)	18 (82%)	
PCC+APO	42 (42%)	19 (43%)	14 (42%)	9 (41%)	
TCC	27 (27%)	17 (39%)	6 (18%)	4 (18%)	

NOTES: TCC=Total Care Capitation, PCC=Primary Care Capitation; APO=Advanced Payment Option, IDS=Integrated Delivery System.
[1] n (%)
[2] *p<0.10; **p<0.05; ***p<0.01.

Exhibit E.7. Risk-Sharing and Payment Elections Across Lead Organization Type in PY2022

		Lead Organization Type					
Variables	**Overall** N=99[1]	**Insurer** N=16	**MSO** N=29[1]	**Primary Care Company** N=16	**Physician Practice** N=18[1]	**Health System** N=20[1]	**p-value**[2]
Risk-Sharing and Payment Elections							
Risk							0.014**
Global	72 (73%)	12 (75%)	24 (83%)	13 (81%)	15 (83%)	8 (40%)	
Professional	27 (27%)	4 (25%)	5 (17%)	3 (19%)	3 (17%)	12 (60%)	
Capitation Type							0.371
PCC (overall)	72 (73%)	11 (69%)	19 (66%)	10 (63%)	15 (83%)	17 (85%)	
PCC+APO	42 (42%)	7 (44%)	15 (52%)	5 (31%)	8 (44%	7 (35%)	
TCC	27 (27%)	5 (31%)	10 (34%)	6 (38%)	3 (17%)	3 (15%)	

NOTE: TCC=Total Care Capitation, PCC=Primary Care Capitation; APO=Advanced Payment Option, MSO=Managed Services Organization.
[1] n (%)
[2] *p<0.10; **p<0.05; ***p<0.01.

Exhibit E.8. Risk-Sharing and Payment Elections Across Functional Role in PY2022

Variables	Overall N=99[1]	Functional Role: Convener N=21[1]	Functional Role: Enabler N=39[1]	Functional Role: Direct Care Provider N=39[1]	p-value[2]
Risk-Sharing and Payment Elections					
Risk					0.030**
Professional	27 (27%)	7 (33%)	5 (13%)	15 (38%)	
Global	72 (73%)	14 (67%)	34 (87%)	24 (62%)	
Capitation Type					0.457
PCC (overall)	72 (73%)	13 (62%)	30 (77%)	29 (74%)	
PCC+APO	42 (42%)	10 (48%)	22 (56%)	10 (26%)	
TCC	27 (27%)	8 (38%)	9 (23%)	10 (26%)	

NOTE: TCC=Total Care Capitation, PCC=Primary Care Capitation; APO=Advanced Payment Option.
[1] n (%)
[2] *p<0.10; **p<0.05; ***p<0.01.

Appendix E.1.4. Value-Based Care Experience and Resources at Baseline, by DCE Type, Risk-Sharing and Payment Elections

Exhibits E.9 and **E.10** present a summary of value-based care and estimates of baseline (fiscal year 2019) revenue composition by DCE type and model elections. They also include associated p-values from Fisher's exact tests of independence, which are measures of the significance of the association between DCE type or model elections and baseline experience and revenue composition.

Exhibit E.9. Value-Based Care Experience and Baseline Resources Across DCE Type

Variables	Overall N=92[1]	DCE Type: Standard N=71[1]	DCE Type: New Entrant N=13[1]	DCE Type: High Needs N=8[1]	p-value (Standard and New Entrant only)[2]
Value-Based Care Experience and Resources at Baseline					
Prior APM Experience					
CEC	2 (2%)	2 (3%)	0 (0%)	0 (0%)	1.000
CPC or CPC+	15 (16%)	14 (19%)	0 (0%)	1 (13%)	0.300
Shared Savings Program	61 (66%)	53 (75%)	4 (31%)	4 (50%)	0.003***
NGACO	28 (30%)	25 (35%)	2 (15%)	1 (13%)	0.208
PCF	14 (15%)	10 (14%)	0 (0%)	4 (50%)	0.349
Other	13 (14%)	9 (13%)	2 (15%)	2 (25%)	0.677
Any APM	78 (85%)	64 (90%)	8 (62%)	6 (75%)	0.018**

Variables	Overall N=92[1]	DCE Type: Standard N=71[1]	DCE Type: New Entrant N=13[1]	DCE Type: High Needs N=8[1]	p-value (Standard and New Entrant only)[2]
None Reported	13 (14%)	6 (8%)	5 (38%)	2 (25%)	0.011**
Mean FY 2019 Revenue Composition					
FFS	22%	20%	19%	43%	0.417
MA	28%	25%	44%	27%	0.554
Other Medicare	1%	1%	1%	1%	0.278
Shared Savings Program	2%	3%	1%	2%	0.596
Commercial	32%	37%	11%	15%	0.738
Medicaid	9%	10%	7%	11%	0.951
Other	1%	1%	1%	1%	0.371

NOTE: CEC=Comprehensive End-Stage Renal Disease (ESRD) Care Model, CPC=Comprehensive Primary Care, CPC+=Comprehensive Primary Care Plus, NGACO=Next Generation Accountable Care Organization Model, PCF=Primary Care First, APM=Alternative Payment Model, FFS=fee-for-service, MA=Medicare Advantage.
[1] n (%)
[2] *p<0.10; **p<0.05; ***p<0.01.

Exhibit E.10. Value-Based Care Experience and Baseline Resources Across Risk and Payment Elections

Variables	Overall N=99[1]	Risk and Capitation: Global N=69[1]	Risk and Capitation: Professional N=23[1]	p-value[2]	Risk and Capitation: TCC N=25	Risk and Capitation: PCC N=67[1]	p-value[2]
Value-Based Care Experience and Resources at Baseline							
Prior APM Experience							
CEC	2 (2%)	1 (1%)	1 (4%)	0.4396	0 (0%)	2 (3%)	1.000
CPC or CPC+	15 (16%)	13 (19%)	2 (9%)	0.6619	1 (8%)	13 (19%)	0.272
Shared Savings Program	61 (66%)	51 (74%)	10 (43%)	0.01089	21 (84%)	40 (60%)	0.046**
NGACO	28 (30%)	18 (26%)	10 (44%)	0.1262	8 (32%)	20 (30%)	1.000
PCF	14 (15%)	13 (19%)	1 (5%)	0.1763	2 (8%)	12 (18%)	0.336
Other	13 (14%)	8 (12%)	5 (22%)	0.2989	2 (8%)	11 (16%)	0.502
Any APM	78 (85%)	61 (88%)	17 (74%)	0.1057	22 (88%)	56 (84%)	0.751

Variables	Overall N=99[1]	Risk and Capitation: Global N=69[1]	Professional N=23[1]	p-value[2]	TCC N=25	PCC N=67[1]	p-value[2]
None Reported	13 (14%)	7 (10%)	6 (26%)	0.0821*	2 (8%)	11 (16%)	0.502
Mean FY 2019 Revenue Composition							
FFS	22%	22%	21%	0.077*	26%	20%	0.054*
MA	28%	28%	26%	0.438	22%	30%	0.602
Other Medicare	1%	1%	1%	0.556	1%	1%	0.530
Shared Savings Program	2%	3%	1%	0.718	4%	2%	0.000***
Commercial	32%	32%	29%	0.026**	35%	30%	0.043**
Medicaid	9%	8%	13%	0.087*	10%	9%	0.105
Other	1%	1%	1%	0.413	1%	1%	0.636

NOTE: TCC=Total Care Capitation, PCC=Primary Care Capitation; APO=Advanced Payment Option, CEC=Comprehensive End-Stage Renal Disease (ESRD) Care Model, CPC=Comprehensive Primary Care, CPC+=Comprehensive Primary Care Plus, NGACO=Next Generation Accountable Care Organization Model, PCF=Primary Care First, APM=Alternative Payment Model, FFS=fee-for-service, MA=Medicare Advantage.

[1] n (%)

[2] *p<0.10; **p<0.05; ***p<0.01.

Appendix E.1.5. Cross-tabulations of Organizational Characteristics

Exhibits E.11 through **E.13** present a summary of how each organizational characteristic (organizational structure, lead organization type, and functional role) overlap and align with each other. They also include associated p-values from Fisher's exact tests of independence, which are measures of the significance of the association between different DCE organizational characteristics. Organizational structure, lead organization type, and functional role are strongly associated with one another.

Exhibit E.11. Lead Organization Type and Functional Role Across Organizational Structure

		Organizational Structure			
Variables	**Overall** N=99[1]	**Network of Individual Practices** N=44[1]	**Medical Group Practice** N=33[1]	**IDS/Hospital System** N=22[1]	**p-value**[2]
Organizational Characteristics					
Lead Organization Type					<0.0001***
Insurer	16 (16%)	8 (19%)	6 (19%)	2 (10%)	
MSO	24 (24%)	17 (39%)	11 (34%)	1 (5%)	
Primary Care Company	25 (25%)	6 (14%)	9 (28%)	1 (5%)	
Physician Practice	19 (19%)	12 (28%)	6 (19%)	0 (0%)	
Health System	15 (15%)	1 (3%)	1 (4%)	18 (82%)	
Functional Role					<0.0001***
Convener	21 (21%)	18 (41%)	0 (0%)	3 (14%)	
Enabler	39 (39%)	19 (44%)	18 (55%)	2 (10%)	
Direct Care Provider	39 (39%)	7 (16%)	15 (46%)	17 (78%)	

NOTE: MSO=management services organization, IDS=integrated delivery system.
[1] n (%)
[2] *p<0.10; **p<0.05; ***p<0.01.

Exhibit E.12. Organizational Structure and Functional Role Across Lead Organization Type

		Lead Organization Type					
Variables	**Overall** N=99[1]	**Insurer** N=16	**MSO** N=29[1]	**Primary Care Company** N=16[1]	**Physician Practice** N=18[1]	**Health System** N=20[1]	**p-value**[2]
Organizational Characteristics							
Organizational Structure							<0.0001***
IDS/Hospital System	44 (44%)	2 (13%)	1 (4%)	1 (7%)	0 (0%)	18 (90%)	
Medical Group Practice	33 (33%)	6 (38%)	11 (38%)	9 (57%)	6 (34%)	1 (5%)	
Network of Individual Practices	22 (22%)	8 (50%)	17 (59%)	6 (38%)	12 (67%)	1 (5%)	
Functional Role							<0.0001***
Convener	21 (21%)	5 (32%)	8 (28%)	2 (13%)	5 (28%)	1 (5%)	
Enabler	39 (39%)	9 (57%)	21 (73%)	3 (19%)	5 (28%)	1 (5%)	
Direct Care Provider	39 (39%)	2 (13%)	0 (0%)	11 (69%)	8 (45%)	18 (90%)	

NOTE: MSO=management services organization, IDS=integrated delivery system.
[1] n (%)
[2] *p<0.10; **p<0.05; ***p<0.01.

Exhibit E.13. Organizational Structure and Lead Organization Type Across Functional Role

Variables	Overall N=99[1]	Functional Role: Convener N=21[1]	Functional Role: Enabler N=39[1]	Functional Role: Direct Care Provider N=39[1]	p-value[2]
Organizational Characteristics					
Organizational Structure					<0.0001***
IDS/Hospital System	44 (44%)	3 (15%)	2 (6%)	17 (44%)	
Medical Group Practice	33 (33%)	0 (0%)	18 (47%)	15 (39%)	
Network of Individual Practices	22 (22%)	18 (86%)	19 (49%)	7 (18%)	
Lead Organization Type					<0.0001***
Insurer	16 (16%)	5 (24%)	9 (24%)	2 (6%)	
MSO	24 (24%)	8 (39%)	21 (54%)	0 (0%)	
Primary Care Company	25 (25%)	2 (10%)	3 (8%)	11 (29%)	
Physician Practice	19 (19%)	5 (24%)	5 (13%)	8 (21%)	
Health System	15 (15%)	1 (5%)	1 (3%)	18 (47%)	

[1] n (%)
[2] *p<0.10; **p<0.05; ***p<0.01

Appendix F: Data Sources for Quantitative Analyses

Exhibit F.1 describes the data files used for the construction of the GPDC intervention and comparison groups and the evaluation's quantitative analyses.

Exhibit F.1. Data Sources for Claims-Based Analyses

Data File	File Description, Source, and Evaluation Uses
Central Repository of Alignment Files	These files include the CY2021–2022 DCE Participant Provider list, DCE Preferred Provider list, DCE trigger file, payment reductions on the claims (capitation or the advanced payment option [APO] percentage reduction), and benefit enhancements elected by DCE Participant and Preferred Providers. They were created by the Innovation Center's GPDC payment analysis and operational support contractor. These lists were used to align beneficiaries prospectively to DCE Participant Providers in each performance year and select comparison groups (i.e., beneficiaries prospectively aligned to eligible non-DCE Participant/Preferred Providers). Some of the data also were used to create measures included in the descriptive analyses.
CM/CMMI Central Repository Payment Files	These files include capitated payment amounts for beneficiaries in each DCE in CY2021–2022. They were created by the model's payment analysis and operational support contractor. They were used to apportion capitated payments for care furnished to GPDC beneficiaries in CY2021–2022 to calculate total gross Medicare Parts A & B spending, which included capitation.
Medicare FFS Claims	These files contain carrier claims, durable medical equipment claims, home health agency claims, hospice claims, inpatient claims, outpatient claims, SNF claims for CY2017–2022. They were obtained from the Chronic Condition Warehouse (CCW). These files were used to create claims-based outcomes for GPDC and comparison group beneficiaries.
Master Beneficiary Summary Files	These files contain coverage, demographic, and chronic/potentially disabling condition flags for Medicare beneficiaries for CY2017–2022. They were obtained from the CCW. These files were used to identify beneficiaries enrolled in FFS each year to perform claim-based alignment and to create measures included in the descriptive and impacts analyses.
Master Data Management Files	These files contain beneficiary- and provider-level information for CY2018-CY2022 pertaining to alignment to GPDC and other APMs. They were obtained from the CCW.
Medicare Data on Physician Practice and Specialty (MD-PPAS)	These files contain data on provider-level information such as specialty, TIN practice assignment, etc. They were obtained from the CCW for CY2018-CY2021. These files were used to create market-level physician practice characteristics.
National Plan and Provider Enumeration System (NPPES)	These files contain provider specialties for CY2018-CY2022, which are used to determine the subset of providers who are eligible for alignment. They were obtained from the CCW.[5]

[5] National Plan and Provider Enumeration System (NPPES). Also available at: https://download.cms.gov/nppes/NPI_Files.html

Data File	File Description, Source, and Evaluation Uses
Medicare FFS Public Provider Enrollment File	These files are populated from Medicare Provider Enrollment, Chain, and Ownership System (PECOS) and contain provider specialties, which are used to determine the subset of providers who are eligible for alignment. They were obtained from the CMS website as of Q1 CY2023.[6]
Provider of Services (POS) File	These files contain bed counts and number of Medicare discharges from acute care hospitals, SNFs, and other LTC facilities for CY2017–CY2022. They were obtained from the CCW.[7]
American Hospital Association (AHA) Annual Surveys	These files contain health system information for acute care hospitals that were used in creating market-level variables. They were obtained from the AHA for CY2017–CY2021.
Area Health Resources File	These files contain the Health Professional Shortage Area variables for the lagged year (CY2017–CY2021) used in risk adjustment. They were obtained from the Health Resources & Services Administration (HRSA).[8]
Rural-Urban Commuting Area (RUCA) Code	These files contain the 2010 ZIP-based rural-urban commuting area codes used in comparison group construction (make the comparison group similar to the treatment group regarding rurality of beneficiary residence) and regression models. They were obtained from the United States Department of Agriculture, Economic Research Service (USDA ERS).[9]
Population Estimates Program (PEP)	These files contain estimates of U.S. population. The 2019 data were used to calculate COVID-19 county-level infection rate and mortality rate for CY2020–CY2022. They were obtained from the Census Bureau.[10]
COVID-19 data in the United States	These files contain daily CY2020-CY2022 COVID-19 cases and deaths number reported by each U.S. county. They were used to derive county-level COVID-19 measures including 7-day moving average infection rate, 7-day moving average mortality rate, and case-fatality rate. They were obtained from The New York Times coronavirus data repository.[11]
COVID-19 Pandemic Vulnerability Index	These files contain county-level CY2021–CY2022 COVID-19 measures for vaccination rate collected by HHS COVID-19 Community Profile Report. They were obtained from the National Institute of Environmental Health Sciences.[12]
COVID-19 Community Vulnerability Index	These files contain county-level community vulnerability index data used for the descriptive analyses. They were obtained from Surgo Ventures.[13]
Area Deprivation Index	These files contain 2019–2021 rankings of neighborhood socioeconomic disadvantage used for the descriptive analyses. They were obtained from the CCW from the Geographic Based Indices of Health.

[6] Medicare Fee-For-Service Public Provider Enrollment File (PPEF). Available at: https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/medicare-fee-for-service-public-provider-enrollment

[7] Provider of Services File (POS) – Hospital & Non-hospital Facilities. Also available at: https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/provider-of-services-file-hospital-non-hospital-facilities

[8] Area Health Resources Files (AHRF). Available at: https://data.hrsa.gov/data/download

[9] Rural-Urban Commuting Area Codes (RUCA). Available at: https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/

[10] Census Bureau Population Estimates Program. Available at: https://www2.census.gov/programs-surveys/popest/datasets/2010-2019/

[11] Coronavirus (COVID-19) data in the United States. Available at: https://github.com/nytimes/covid-19-data

[12] COVID-19 Pandemic Vulnerability Index (PVI). Information available at: https://www.niehs.nih.gov/research/resources/databases/covid19pvi/index.cfm and data available at: https://github.com/COVID19PVI/data

[13] COVID-19 Community Vulnerability Index (CCVI). Information available at: https://precisionforcovid.org/ccvi and data available at: https://covid-static-assets.s3.amazonaws.com/US-CCVI/surgo_ccvi.zip

Data File	File Description, Source, and Evaluation Uses
HRR-ZIP Code Crosswalk	These files contain a crosswalk for ZIP codes to Hospital Referral Regions (HRR) used for determining markets for GPDC and comparison groups. They were obtained from the Dartmouth Atlas Data website.[14]
Direct Contracting/Kidney Care Choices Rate Book	These files contain PY2022 county-level payment rates that are used to balance county-level differences in the entropy balancing. They were obtained from the Innovation Center website.[15]
5-year American Community Survey (ACS) Estimates	These files contain the five-year ZIP code tabulation area (ZCTA) level estimates from the ACS for the lagged year (CY2017–2021). The following tables were downloaded: B03002, B19013, C27006, S1501, S1701, S1703, S2701, B01001, B11003, B15003, B23001, B25003, B25004, B25044, and S2301. They were obtained from the U.S. Census Bureau website.[16]
Participation in the Comprehensive Care for Joint Replacement (CJR) Model	These files contain beneficiary-level flags for participation in the CJR Model for CY2018-CY2022. They were obtained from the CMS CJR Contractor.
Participation in the Bundled Payments for Care Improvement Advanced (BPCI-A) Model	These files contain beneficiary-level flags for participation in the BPCI-A Model for CY 2018–CY2022. They were obtained from the CMS BPCI-A Contractor.
Participation in the Oncology Care Model (OCM)	These files contain beneficiary-level flags for participation in the OCM Model for CY2018–CY2022. They were obtained from the CMS OCM Contractor.
ACO Model beneficiary and provider files	These files contain a list of beneficiaries and providers participating in NGACO and Shared Savings Program during CY2018–CY2022. They were used to describe beneficiary and provider's experience in Medicare ACO program.
Central Repository of High Needs Files	These files contain detailed information for high needs eligibility including concurrent and prospective Hierarchical Condition Category (HCC) Scores among all FFS beneficiaries for CY2018–CY2022. They were obtained from program contractor.
PY2021 and PY2022 GPDC Financial Results	This file contains financial results for PY2021-2022 DCEs and was used to calculate the net impact of Medicare spending. It was obtained from the Innovation Center website.[17]

NOTES: CM/CMMI=Center for Medicare/Center for Medicare and Medicaid Innovation (Innovation Center); CCW=Chronic Conditions Data Warehouse; SNF=skilled nursing facility; LTC=long-term care.

[14] HRR-ZIP Code Crosswalk. Available at: https://data.dartmouthatlas.org/supplemental/

[15] Direct Contracting/Kidney Care Choices (DC/KCC) Rate Book. Available at: https://www.cms.gov/priorities/innovation/media/document/dckcc-rate-book-dec2020

[16] 5-year American Community Survey (ACS) Estimates. Available at: https://data.census.gov/

[17] PY2021 GPDC Financial Results. Available at: https://www.cms.gov/priorities/innovation/media/document/gpdc-py2021-financial-results

Appendix G: Measure Specifications

This appendix:

- Specifies the variables used in the descriptive tables, entropy balancing, and regression adjustment for impact analyses.
- Describes the claims-based outcome measures used to evaluate the GPDC Model's impact.

G.1: Variables for Descriptive Analysis, Entropy Balancing, and Regression Adjustment

Here we describe and specify the variables used for the descriptive analysis, entropy balancing, and regression adjustment. **Exhibit G.1** lists each variable used, data source, level of measurement, a description of the variable, and the use of the variable in analyses.

Exhibit G.1. Variables for Descriptives, Weighting, and Risk Adjustment

Variable	Source	Level	Variable Description	Descriptive Tables	Entropy Balancing	Regression Adjustment
Domain: Demographics						
Age	MBSF	Beneficiary	Beneficiary age at end of the reference year. Continuous age is used for regression adjustment and reported in the descriptive tables, while age categories (under 65, 65-69, 70-74, 75-79, 80-84, 85 and over) are used for entropy balancing	X	X	X
Sex	MBSF	Beneficiary	Indicator for male	X	X	X
Dual eligibility	MBSF	Beneficiary	Indicator for dual eligibility in any month during the calendar year (that is, calendar year for the performance or baseline years)	X	X	X
Race	MBSF	Beneficiary	Beneficiary race as per the RTI International race code algorithm[18]; combining American Indian/Alaska Native, other, and unknown categories due to small sample size for some DCEs	X	X	X
Months of alignment	MBSF	Beneficiary	Number of beneficiary months of alignment in during the calendar year	X	X	X

[18] Beneficiary race code modified using RTI algorithm. https://resdac.org/cms-data/variables/research-triangle-institute-rti-race-code.

Variable	Source	Level	Variable Description	Descriptive Tables	Entropy Balancing	Regression Adjustment
Year	MBSF	Beneficiary	Calendar year 2021 cohort: 2018-2020 for the baseline years and 2021–2022 for the performance years (2021 for PY1 and 2022 for PY2) 2022 cohort: 2019–2021 for the baseline years and 2022 for PY2	X	X	X
GPDC status	Alignment file	Beneficiary	Indicator for whether a beneficiary is aligned to GPDC or comparison group in a year	X	X	X
State	MBSF	Beneficiary	State of residence; state is used to create Census Region (Northeast, Midwest, South, West) for descriptive tables	X		
Domain: Clinical[a]						
End-stage renal disease (ESRD)	MBSF	Beneficiary	Indicator for Medicare coverage based on ESRD diagnosis during the year		X	X
Disability	MSBF	Beneficiary	Indicator for Medicare coverage based on disability status during the year	X	X	X
Cancer	MBSF	Beneficiary	Indicator for cancer, including colorectal cancer, endometrial cancer, breast cancer, lung cancer, prostate cancer, urologic cancers (kidney, renal pelvis, and ureter), and leukemias & lymphomas, based on meeting CCW criteria[19] in the prior year		X	X
Cardiac conditions	MBSF	Beneficiary	Indicator for cardiac conditions, including acute myocardial infarction, heart failure, atrial fibrillation, and ischemic heart disease, based on meeting CCW criteria in the prior year	X	X	X
Vascular conditions	MBSF	Beneficiary	Indicator for vascular disease including hypertension and peripheral vascular disease, based on meeting CCW criteria in the prior year	X	X	X

[19] To be specific, we used MBSF 30 CCW Chronic Condition Segment and MBSF Other Chronic or Potentially Disabling Conditions Segment end of year indicator variables, and flag the beneficiary with the specific condition if the CCW chronic condition variables indicated as "beneficiary met claims criteria" (i.e., a minimum number/type of Medicare claims that have the proper diagnosis codes and occurred within a specified time period).

Variable	Source	Level	Variable Description	Descriptive Tables	Entropy Balancing	Regression Adjustment
Cognitive disorders	MBSF	Beneficiary	Indicator for cognitive disorders, including Alzheimer's disease and non-Alzheimer's dementia, based on meeting CCW criteria in the prior year		X	X
Stroke	MBSF	Beneficiary	Indicator for stroke, including stroke/transient ischemic attack, based on meeting CCW criteria in the prior year		X	X
Endocrine	MBSF	Beneficiary	Indicator for endocrine conditions, including diabetes, hyperlipidemia, anemia, hypothyroidism, and benign prostatic hyperplasia, based on meeting CCW criteria in the prior year	X	X	X
Eye	MBSF	Beneficiary	Indicator for eye disorders, including glaucoma and cataract, based on meeting CCW criteria in the prior year	X	X	X
Rheumatoid conditions	MBSF	Beneficiary	Indicator for rheumatoid conditions, including osteoporosis with or without pathological fracture and rheumatoid arthritis/osteoarthritis, based on meeting CCW criteria in the prior year	X	X	X
Respiratory conditions	MBSF	Beneficiary	Indicator for respiratory conditions, including asthma, chronic obstructive pulmonary disease, and all-cause pneumonia, based on meeting CCW criteria in the prior year	X	X	X
Chronic kidney disease	MBSF	Beneficiary	Indicator for chronic kidney disease, based on meeting CCW criteria in the prior year	X	X	X
Hip fracture	MBSF	Beneficiary	Indicator for hip fracture, including hip and pelvic fracture, based on meeting CCW criteria in the prior year		X	X
Infections	MBSF	Beneficiary	Indicator for infections, including human immunodeficiency virus and/or acquired immunodeficiency syndrome and viral hepatitis (general), based on meeting CCW criteria in the prior year		X	X

Variable	Source	Level	Variable Description	Descriptive Tables	Entropy Balancing	Regression Adjustment
Metabolic developmental disorders	MBSF	Beneficiary	Indicator for metabolic developmental disorders, including cystic fibrosis and other metabolic developmental disorders, based on meeting CCW criteria in the prior year		X	X
Mental health conditions	MBSF	Beneficiary	Indicator for behavioral health conditions, including schizophrenia; schizophrenia and other psychotic disorders; personality disorders; anxiety disorders; post-traumatic stress disorder; bipolar disorder; depression, bipolar, or other depressive mood disorders; or depressive disorders, based on meeting CCW criteria in the prior year	X	X	X
Developmental disorders	MBSF	Beneficiary	Indicator for developmental disorders, including attention deficit hyperactivity disorder (ADHD), conduct disorders, and hyperkinetic syndrome, autism spectrum disorders, intellectual disabilities and related conditions, other developmental delays, and learning disabilities, based on meeting CCW criteria in the prior year		X	X
Skin conditions	MBSF	Beneficiary	Indicator for skin conditions, including pressure and chronic ulcers, based on meeting CCW criteria in the prior year		X	X
Substance use disorders	MBSF	Beneficiary	Indicator for substance use disorders, including alcohol use disorders, drug use disorders, opioid use disorder, and tobacco use, based on meeting CCW criteria in the prior year		X	X
Chronic pain disorders	MBSF	Beneficiary	Indicator for chronic pain disorders, including fibromyalgia, chronic pain, and fatigue, based on meeting CCW criteria in the prior year	X	X	X
Spinal cord disorders/ injuries	MBSF	Beneficiary	Indicator for spinal cord disorders/injuries, including spinal cord injury and spina bifida and other congenital anomalies of the nervous system, based on meeting CCW criteria in the prior year		X	X

Variable	Source	Level	Variable Description	Descriptive Tables	Entropy Balancing	Regression Adjustment
Obesity	MBSF	Beneficiary	Indicator for obesity, based on meeting CCW criteria in the prior year	X	X	X
Traumatic brain injury	MBSF	Beneficiary	Indicator for traumatic brain injury, including traumatic brain injury and nonpsychotic mental disorders due to brain damage, based on meeting CCW criteria in the prior year		X	X
Sensory impairments	MBSF	Beneficiary	Indicator for sensory impairments, including blindness and visual impairment and sensory – deafness and hearing impairment, based on meeting CCW criteria in the prior year		X	X
Mobility impairments	MBSF	Beneficiary	Indicator for mobility impairments, based on meeting CCW criteria in the prior year		X	X
Liver conditions	MBSF	Beneficiary	Indicator for liver conditions, including liver disease, cirrhosis, and other liver conditions, based on meeting CCW criteria in the prior year		X	X
Neurological disorders and conditions	MBSF	Beneficiary	Indicator for neurological disorders and conditions, including Parkinson's Disease and Secondary Parkinsonism, cerebral palsy, epilepsy, muscular dystrophy, migraine and chronic headache, multiple sclerosis and transverse myelitis, based on meeting CCW criteria in the prior year		X	X
Total number of chronic conditions	MBSF	Beneficiary	Count of major chronic conditions in the prior year; capped at 10 when used in entropy balancing.	X	X	
Long-term care flag	Medicare claims	Beneficiary	Indicator for long-term care nursing home stay in the prior year	X	X	X
Prior Medicare Advantage (MA) enrollment	MBSF	Beneficiary	Indicator for whether a beneficiary was enrolled in a MA plan in the prior year	X	X	X
High Needs flag	Central Repository of High Needs Files	Beneficiary	Indicator for beneficiaries considered High Needs using the model's High Needs eligibility criteria. For more details the High Needs eligibility criteria, see the Global and Professional Direct Contracting Model Financial Operating Guide: Overview.	X		
Part D coverage	MBSF	Beneficiary	Indicator for Part D coverage in any month during the year	X		X

Variable	Source	Level	Variable Description	Descriptive Tables	Entropy Balancing	Regression Adjustment
Part D low-income drug subsidy	MBSF	Beneficiary	Indicator for received Part D Low-Income Drug Subsidy during the year	X		
Prospective CMS-HCC Risk Score	RTI High Needs File	Beneficiary	HCC score in the prior year	X		
Claims-Based Frailty Index	Medicare claims	Beneficiary	Frailty Index categories (0-≤0.15, >0.15-≤0.25, >0.25-≤0.35, >0.35-≤0.45, >0.45)	X		
Domain: Market or Neighborhood						
Rural-Urban Commuting Area (RUCA) Code	USDA ERS	ZIP	Rural-Urban Commuting Areas (RUCA) codes based on a beneficiary's ZIP code. For descriptive tables, we define rural area as having RUCA code 7-10.	X	X	X
Health professional shortage area (HPSA) primary care	AHRF	County	HPSA category for primary care based on a beneficiary's county			X
HPSA mental health	AHRF	County	HPSA category for mental health care based on a beneficiary's county			X
GPDC benchmark rate	GPDC Rate Book	County	County-level benchmark rate for GPDC-aged/disabled beneficiaries in 2022, based on beneficiary's county		X	
Providers per 1,000 FFS population within 10 miles	Medicare claims; MBSF	ZIP	Percentile of ZIP code-level number of Medicare FFS alignment-eligible providers within 10 miles per 1,000 Medicare FFS population. Based on provider location in outpatient/carrier claims and beneficiary residence in the MBSF	X	X	X
Percent below poverty line	5-year ACS Estimates	ZCTA	Percent population below federal poverty line in a beneficiary's ZCTA. The continuous version is used for descriptive tables; the percentile version is used for regression adjustment	X		X
Bachelor's degree or higher	5-year ACS Estimates	ZCTA	Percent population aged 25 and older holding a bachelor's degree in a beneficiary's ZCTA. The continuous version is used for descriptive tables; the percentile version is used for entropy balancing and regression adjustment	X	X	X
Median income	5-year ACS Estimates	ZCTA	Median household income in a beneficiary's ZCTA. The percentile version is used for entropy balancing and regression adjustment		X	X

Variable	Source	Level	Variable Description	Descriptive Tables	Entropy Balancing	Regression Adjustment
Area Deprivation Index	CMS and GBIH	Census Block Group	National percentile rank for Area Deprivation Index based on beneficiary's Census block group; ADI categories (1–25, 26–50, 51–75, 76–100)	X		
Hospital referral region (HRR)	Dartmouth Atlas ZIP code to HRR crosswalk	HRR	Indicator for HRR based on beneficiary's ZIP code			X
Domain: COVID-19						
ICU admission for COVID-19 diagnosis	Medicare claims	Beneficiary	Indicator for severity of COVID-19 based on principal diagnoses on acute care hospital claims with ICU use during the year	X		
Acute care hospital admission for COVID-19 diagnosis	Medicare claims	Beneficiary	Indicator for severity of COVID-19 based on principal diagnoses on acute care hospital claims (without ICU use) during the year	X		
Outpatient COVID-19 diagnosis	Medicare claims	Beneficiary	Indicator for severity of COVID-19 based on principal diagnoses on professional services, SNF, or outpatient claims only (without hospitalization) during the year	X		
COVID-19 case rate	NYT, PEP	County	County-level rates of COVID-19 infection in the year (seven-day average across the year)	X		
COVID-19 mortality rate	NYT, PEP	County	County-level COVID-19 mortality rates in the year (seven-day average across the year)	X		
COVID-19 case-fatality rate	NYT	County	County-level COVID-19 case-fatality rates in the year (seven-day average across the year)	X		
COVID-19 vaccination rate	PVI	County	County-level percent of population that are vaccinated in the year (average across the year)	X		
COVID-19 Community Vulnerability Index	Surgo Ventures	County	County-level COVID-19 Community Vulnerability Index (CCVI) incorporates evidence on COVID-19 risk factors measures how much a community is vulnerable to the impacts of COVID-19 through a simple composite score (index)	X		
Domain: Other Alternative Payment Models						
CPC+ or PCF Model	MDM	Beneficiary	Indicator for whether a beneficiary was aligned to CPC+ or PCF anytime in the year	X		

Variable	Source	Level	Variable Description	Descriptive Tables	Entropy Balancing	Regression Adjustment
FAI	MDM	Beneficiary	Indicator for whether a beneficiary was aligned to FAI anytime in the year	X		
IAH Demonstration	MDM	Beneficiary	Indicator for whether a beneficiary was aligned to the IAH Demonstration anytime in the year	X		
NGACO Model	MDM	Beneficiary	Indicator for whether a beneficiary was aligned to the NGACO Model anytime in the year	X		
CEC Model	MDM	Beneficiary	Indicator for whether a beneficiary was aligned to the CEC Model anytime in the year	X		
Shared Savings Program	MDM	Beneficiary	Indicator for whether a beneficiary was aligned to the Medicare Shared Savings Program anytime in the year	X		
ETC Model	MDM	Beneficiary	Indicator for whether a beneficiary was aligned to the ETC Model any time in the year	X		
KCC Model	MDM	Beneficiary	Indicator for whether a beneficiary was aligned to the KCC Model any time in the year	X		
VIT Demonstration	MDM	Beneficiary	Indicator for whether a beneficiary was aligned to the VIT Demonstration any time in the year	X		
CJR Model	CMS CJR Contractor	Beneficiary	Indicator for whether a beneficiary was in CJR Model anytime in the year	X		
BPCI or BPCI Advanced Initiatives	CMS BPCI-A Contractor	Beneficiary	Indicator for whether a beneficiary was in the BPCI or BPCI Advanced Models any time in the year	X		
OCM	CMS OCM Contractor	Beneficiary	Indicator for whether a beneficiary was in OCM anytime in the year	X		

NOTE: MBSF=Medicare Beneficiary Summary File; USDA ERS=US Department of Agriculture Economic Research Service; AHRF=Area Health Resource File; GBIH=Geographic Based Indices of Health; ACS=American Community Survey; NYT=New York Times Coronavirus Data in the U.S.; PEP=Census Bureau Population Estimates Program; PVI=Pandemic Vulnerability Index dataset; MDM=Master Data Management Files; ADHD=attention deficit hyperactivity disorder; FFS=fee-for-service; MA=Medicare Advantage; CPC+=Comprehensive Primary Care Plus; PCF=Primary Care First; FAI=Financial Alignment Initiative; IAH=Independence at Home; CEC=Comprehensive End-Stage Renal Disease (ESRD) Care; Shared Savings Program=Medicare Shared Savings Program; ETC=ESRD Treatment Choices; KCC=Kidney Care Choices; VIT=Value in Opioid Use Disorder Treatment; CJR=Comprehensive Care for Joint Replacement; BPCI=Bundled Payments for Care Improvement; OCM=Oncology Care Model; NGACO=Next Generation ACO; HCC=Hierarchical Condition Categories; ACS=American Community Survey; ZCTA=ZIP Code Tabulation Areas. Refer to **Appendix F, Exhibit F.1** for more details on each data source. [a] Clinical indicators are coded as "1" if beneficiary has one or more of the conditions in the indicator and "0" if otherwise/unknown. CCW indicators are based on the end-of-year flags in the prior year.

G.2: Measures of Spending, Utilization, and Quality

The following sections describe the claims-based spending, utilization, and quality measures used to evaluate the GPDC Model's impact, using difference-in-differences (DID) methods. Measures include gross and net total Medicare spending, eight categories of Medicare spending by care setting and service type, seven utilization measures, and six quality of care measures that were created for the treatment group and comparison group in performance and baseline years. Spending measure specifications in the performance and baseline years for the GPDC treatment and non-GPDC comparison group account for model-specific payments made to GPDC, NGACO, Comprehensive Primary Care Plus (CPC+), and Primary Care First (PCF) model participants that are captured in the Medicare claims.[20] In contrast, the utilization and quality measure specifications were consistent for the treatment and comparison groups in the performance and baseline years. Additionally, for six claims-based outcome measures, we descriptively assessed trends over time for the intervention group but did not include these measures in the impact analyses owing to their expected violations of the parallel trends test. These measures include: 1) primary care practitioner services, 2) primary care visits spending, 3) annual wellness visits, 4) chronic disease management for patients with multiple chronic conditions, 5) advance care planning, and 6) mortality. Since we balanced the DCE and comparison groups on beneficiary characteristics but not provider characteristics, we expected the two groups— for many DCEs and comparators—to differ in their baseline trends for the first five outcomes that are related to care processes. With regard to mortality, owing to the primary care focus of the GPDC Model, this outcome may be less under the control of DCEs and their providers. The trend graphs are presented in **Appendices J, K, and L.**

GPDC Model Payment Adjustments

Total Care Capitation (TCC). Capitated payment that applies to all services covered by Medicare Parts A and B that are provided to aligned beneficiaries by Participant and Preferred Providers participating in this option.

Primary Care Capitation (PCC). Capitated payment that applies to certain primary care services provided to aligned beneficiaries by Participant and Preferred Providers who are primary care practitioners participating in this option.

Advance Payment Option (APO). Reduced FFS payments for services not covered under PCC. Only DCEs that elect PCC can also choose this option.

G.2.1. Medicare Spending Outcomes

We created three kinds of outcome measures to capture DCE-level Medicare spending in the baseline years and PY2022: 1) total Medicare gross spending, 2) total Medicare net spending, and 3) Medicare spending in care settings. It is important to note that there are substantive differences in how the total spending and spending category measures are calculated. The total spending measure represents what Medicare actually paid by including beneficiary-level capitated payments under the GPDC Model, whereas the spending category measures represent what Medicare would have paid DCEs absent capitation, across a variety of care settings.

[20] Model-specific payment adjustments on claims included capitation for GPDC, population-based payments for NGACO, and flat fees or reduced visit fees for PCF/CPC+.

Direct comparisons between total spending and spending categories are not feasible, given differences in how these measures were constructed and analyzed.

Total Medicare Gross Spending

Total Medicare gross spending included Medicare Parts A and B spending, capturing GPDC's TCC/PCC and APO payments.[21] This measure distinguished between amounts paid on population-based payment (PBP) claims,[22] non-PBP claims,[23] and other model-specific payments reconciled through the claims system for APMs.

Exhibits G.2 and **G.3** detail the process for determining treatment and comparison group beneficiary gross Medicare spending during the baseline years prior to model onset and the performance years, respectively. The processes to calculate gross Medicare spending are described separately for baseline years prior to model onset and performance years below.

Baseline years prior to GPDC Model (2018–2020). We identified claims with claim admission date (for facility claims) or claim from date (for physician/supplier claims) during the baseline years prior to the GPDC Model (**Exhibit G.2**). The baseline years are 2018–2020 for the 2021 cohort and 2019-2021 for the 2022 cohort (of which 2019–2020 were prior to the GPDC Model).[24] We processed claims differently depending on whether they were facility claims[25] or physician/supplier claims.[26]

We then used the program identifier on the claim to distinguish between NGACO claims (to account for PBPs in this overlapping model) and non-NGACO claims, as well as between claims for treatment group and comparison group beneficiaries.

- For facility claims that were NGACO instances, gross Medicare spending was calculated as the claim value amount from claims with PBP adjustments for NGACO minus the uncompensated care payment amount.

[21] For more information on how TCC, PCC, and APO payments are defined by the model, refer to the PY2022 Financial Operating Policies: Capitation and Advanced Payment Mechanisms document, available at: https://www.cms.gov/priorities/innovation/media/document/gpdc-py2022-cap-adv-pay-mech.

[22] PBP claims are reduced based on the respective model's financial strategy that typically pays model participants outside of the claims system. To capture spending accurately, we removed those adjustments, available through the CCW, to allow for the claims to represent what Medicare would have paid, absent the GPDC Model.

[23] Although PBPs are a feature of several models, for PY2021 and its baseline years, we only adjust for PBP claims that are a feature of the NGACO Model. Although PBP claims are not a feature of the GPDC Model, beneficiaries aligned to the NGACO Model may be included in the treatment group in baseline years and for the comparison group in baseline and performance years. Thus, we account for PBP costs on claims for NGACO beneficiaries to accurately capture gross Medicare spending for this evaluation.

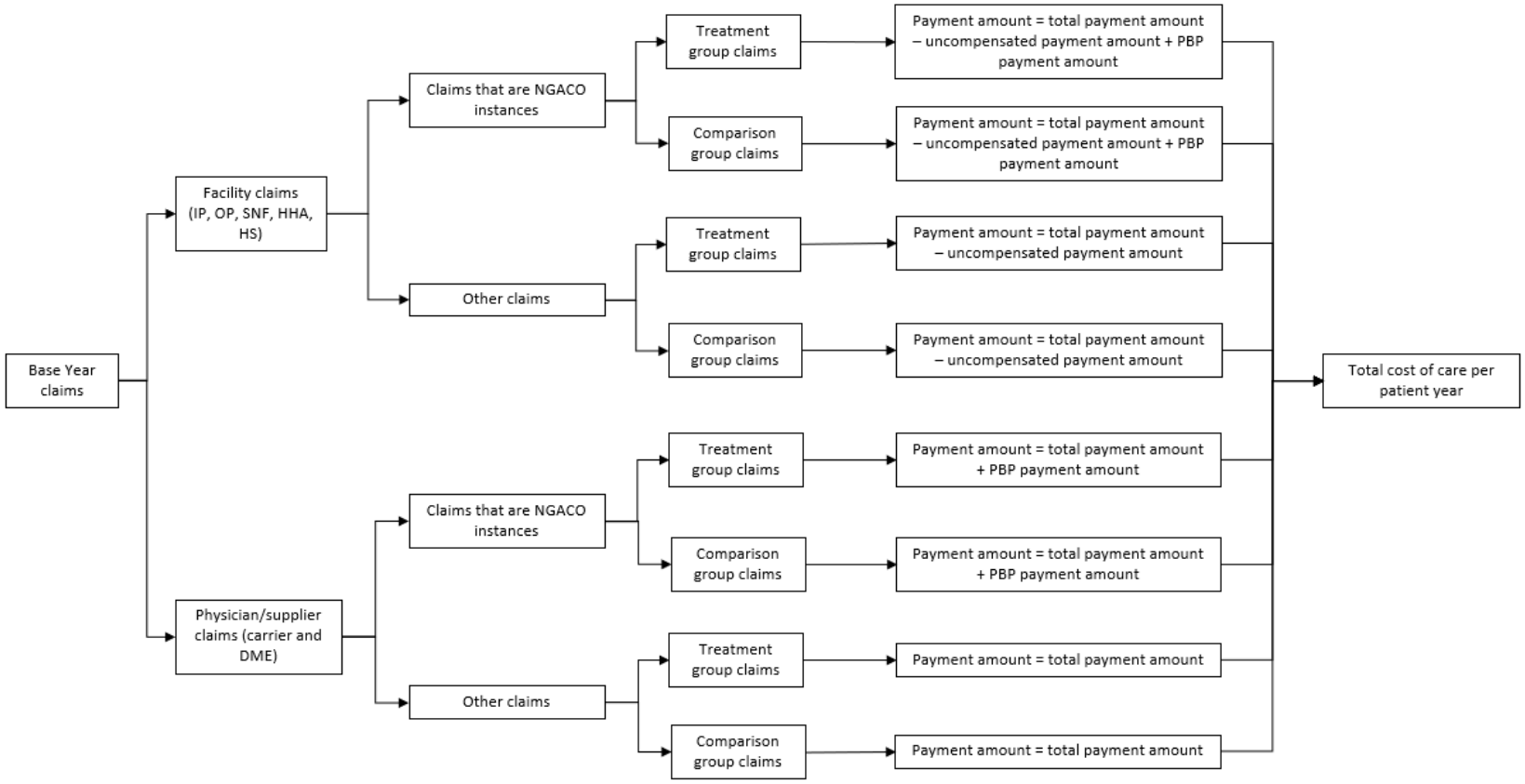
[24] For the 2022 cohort, claims in its baseline year 2021 were processed using the approach described for GPDC model's performance years (2021-2022) in Exhibit G.3.

[25] Facility claims include claim types 10 (Home Health Agency), 20 (non-swing bed skilled nursing facility), 30 (swing bed skilled nursing facility), 40 (hospital outpatient), 50 (hospice), and 60 (inpatient).

[26] Physician/supplier claims include claim types 71 (local carrier non-durable medical equipment, prosthetics, orthotics, and supplies), 72 (local carrier durable medical equipment, prosthetics, orthotics, and supplies), 81 (durable medical equipment regional carrier; non-durable medical equipment, prosthetics, orthotics, and supplies), and 82 (durable medical equipment regional carrier; durable medical equipment, prosthetics, orthotics, and supplies).

- For facility claims that were not NGACO instances, gross Medicare spending was calculated as the claim payment amount minus the uncompensated care payment amount.
- For physician/supplier claims that were NGACO instances, gross Medicare spending was calculated as the claim payment amount plus the claim PBP reduction amount.
- For physician/supplier claims that were not NGACO instances, we further distinguished between CPC+ and PCF claims and claims that were not associated with either of these primary care models. We used the program identifier on the claim to distinguish between CPC+/PCF claims and non-CPC+/PCF claims. For physician/supplier claims that were CPC+/PCF instances for beneficiaries in the treatment group or comparison group, gross Medicare spending was calculated as the claim payment amount adjusted for the corresponding line other applied amount, representing CPC+ Payment Adjustment Amounts, PCF Flat Visit Reduction Amounts, or PCF Flat Visit Fee Increased Amounts. For physician/supplier claims that were not CPC+/PCF instances for beneficiaries in the treatment group or comparison group, gross Medicare spending was calculated as the claim payment amount.

Exhibit G.2. Total Gross Medicare Spending in BYs prior to the GPDC Model (2018–2020)



NOTES: IP=Inpatient; OP=Outpatient; SNF=Skilled Nursing Facility; HHA=Home Health Agency; HS=Hospice; DME=Durable Medical Equipment; NGACO=Next Generation Accountable Care Organization; PBP=Population-Based Payment. The total payment amount for facility claims that are NGACO instances is the claim value amount from claims with value code Q0; the total payment amount for facility claims that are not NGACO instances (that is, "Other" claims) is the claim payment amount. The uncompensated care payment amount is subtracted from all payment amounts for facility claims. The total payment amount for physician/supplier claims that are NGACO instances is the claim payment amount plus the PBP reduction amount; the total payment amount for physician/supplier claims that are not NGACO instances and are either treatment group or comparison group claims could be from Comprehensive Primary Care Plus (CPC+); Primary Care First (PCF) instances or non-CPC+/PCF instances. The total payment amount for CPC+/PCF instances is the claim payment amount adjusted for the line other applied amount for claims with the line other applied indicator code T, A2, or A3. The total payment amount for non-CPC+/PCF instances is the claim payment amount.

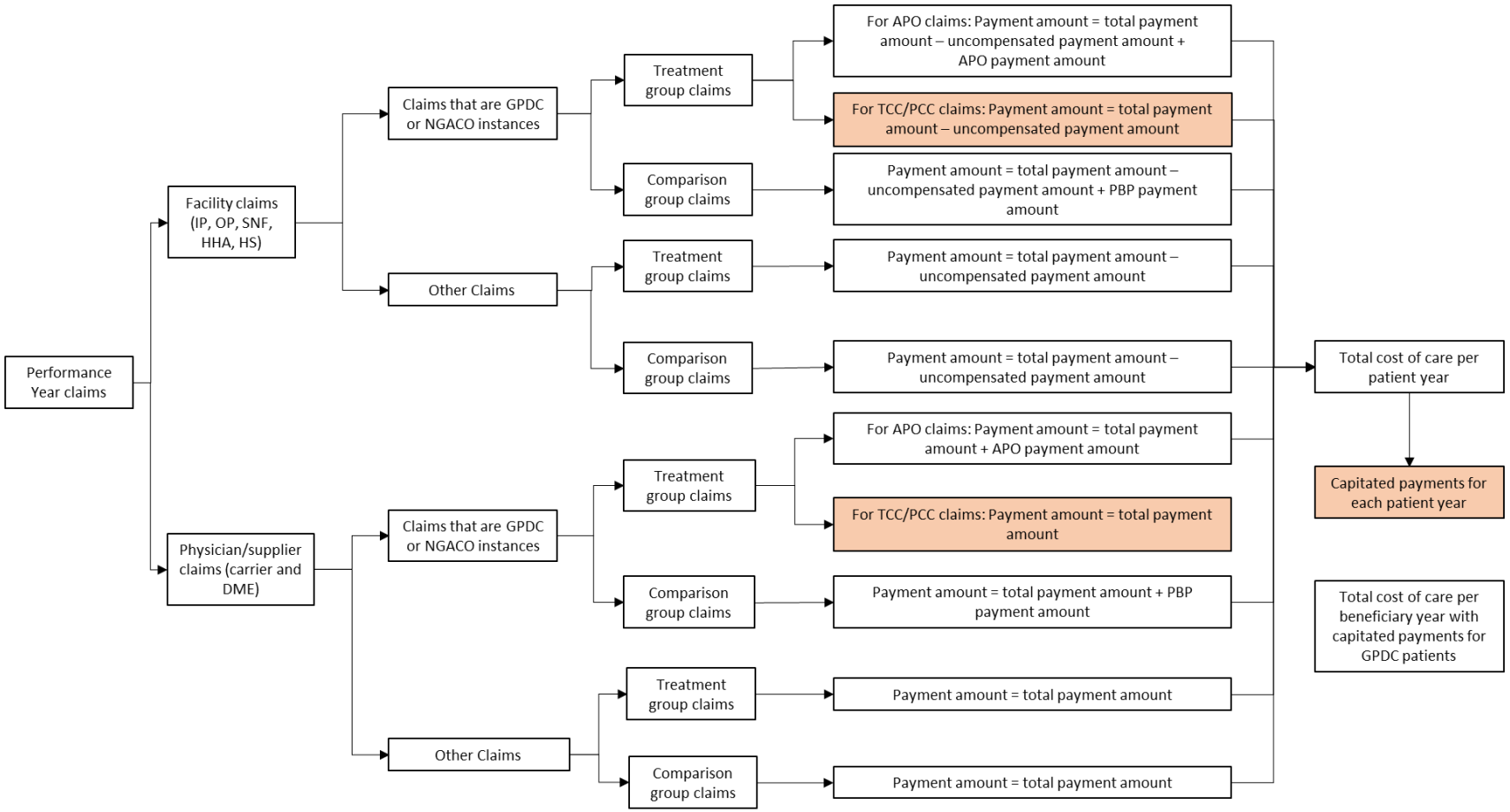
Performance Years (2021–2022). We identified PY claims in the same manner as we did for the BYs preceding the model's onset(**Exhibit G.3**). In addition, we distinguished GPDC claims (to account for capitation and APO payments; treatment group only) from non-NGACO/GPDC claims (treatment group and comparison group).

- For facility claims that were GPDC instances, gross Medicare spending for PCC+APO claims was calculated as the claim payment amount minus the uncompensated care amount plus the claim APO reduction amount; gross Medicare spending for TCC/PCC-only claims was calculated as the claim payment amount minus the uncompensated care payment amount. We linked Medicare claims to the GPDC provider election files, provided by the Innovation Center's GPDC payment analysis and operational support contractor,[27] to distinguish between APO and TCC/PCC claims.[28] We obtained PBP/APO reduction amounts from the CCW and aggregated monthly beneficiary-level TCC/PCC amounts, provided by the Innovation Center's GPDC Model payment analysis and operational support contractor, to the year-level for the purpose of calculating the gross Medicare spending measure. When spending was aggregated to the beneficiary-year level, capitated payments for each beneficiary-year were added to the gross Medicare spending amount.
- Facility claims that were not GPDC instances were processed the same way as claims that were either NGACO or other instances in the baseline years. In PY2022 there were no NGACO or CPC+ claims.
- For physician/supplier claims that were GPDC instances, gross Medicare spending for PCC+APO claims was calculated as the claim payment amount plus the claim APO reduction amount; gross Medicare spending for TCC/PCC only claims was calculated as the claim payment amount. As above, we aggregated spending to the beneficiary-year level and added the appropriate capitated payment for each beneficiary-year to the gross Medicare spending amount.
- For physician/supplier claims that were not GPDC instances for beneficiaries in the treatment group, gross Medicare spending was calculated as the claim payment amount.
- Physician/supplier claims that were not GPDC instances for beneficiaries in the comparison group were processed the same way as claims that were either NGACO instances or other instances in the baseline years. In PY2022 there were no NGACO or CPC+ claims.

[27] These data are available in the CM/CMMI Central Repository Payment File.

[28] To distinguish between TCC, PCC, and PCC+APO claims, we followed guidance provided by the Innovation Center's GPDC payment analysis and operational support contractor in "Constructing MER [Monthly Expenditure Report]/QBR [Quarterly Benchmark Report] Data from the Claim & Claim Line Feed Data Files" (January 16, 2022; Revision: 2022.01.02).

Exhibit G.3. Total Gross Medicare Spending in GPDC Model PYs (2021–2022)



NOTES: IP=Inpatient; OP=Outpatient; SNF=Skilled Nursing Facility; HHA=Home Health Agency; HS=Hospice; DME=Durable Medical Equipment; GPDC=Global and Professional Direct Contracting; APO=Advance Payment Option; PCC=Primary Care Capitation; TCC=Total Care Capitation; PBP=Population-Based Payment. The total payment amount for facility claims that are APO GPDC instances is the claim payment amount plus the APO PBP reduction amount. The total payment amount for facility claims that are TCC/PCC GPDC instances is the claim payment amount plus the beneficiary-year capitation amounts for TCC/PCC claims. The total payment amount for facility claims that are Next Generation Accountable Care Organization (NGACO) instances is the claim amount plus the NGACO PBP reduction amount. The total payment amount for facility claims that are non- GPDC/NGACO instances (that is, "Other" claims) is the claim payment amount. The uncompensated care payment amount is subtracted from all payment amounts for facility claims. The total payment amount for physician/supplier claims that are GPDC instances is the claim payment amount plus the PBP reduction amount. The total payment amount for physician/supplier claims that are APO GPDC instances is the claim payment amount plus the PBP reduction amount. The total payment amount for physician/supplier claims that are TCC/PCC GPDC instances is the claim payment amount plus the beneficiary-year capitation amount for TCC/PCC claims. The total payment amount for physician/supplier claims that are non- GPDC instances and are treatment group claims is the claim payment amount. The total payment amount for physician/supplier claims that are non- GPDC instances and are comparison group claims could be, NGACO, Comprehensive Primary Care

Plus (CPC+)/Primary Care First (PCF) instances or non-NGACO/CPC+/PCF instances. The total payment amount for NGACO instances is the claim payment amount plus the NGACO PBP reduction amount. The total payment amount for CPC+/PCF instances is the claim payment amount adjusted for the line other applied amount for claims with the line other applied indicator code T, A2, or A3. The total payment amount for non-NGACO/CPC+/PCF instances is the claim payment amount.

In computing total Medicare gross spending, we include the APO claims reduction amounts that are advanced to DCEs electing PCC plus APO (PCC+APO) option. Under the APO, DCEs receive advance monthly payments that are reduced on FFS claims for their providers participating in the APO. APO payments are reconciled against the amount of reduction made in FFS payments using the following formula:

$$\sum \text{APO Claims Reduction Amount} = \text{APO}\left(\sum \text{Monthly Advance Payment Amount} - \text{Reconciliation Amount}\right)$$

Total Medicare Net Spending

Total Medicare net spending is defined as total Medicare gross spending *less* the shared savings payments CMS made to GPDC DCEs (and more the shared losses GPDC DCEs made to CMS) in the respective PY under the Professional or Global option, representing the cost to CMS of incentive payments to DCEs to participate in the model. We obtained the shared savings amount from the public financial results from the Provisional Settlement[29] in November 2023.[30] We adjusted the shared savings/losses amount based on the difference in total aligned beneficiary-months between the model's population and the evaluation's population.[31] Shared savings applied to calculate the net spending totaled $578,803,708 for Standard DCEs, $32,005,895 for New Entrant DCEs (not including the shared savings amounts from the one New Entrant DCE excluded from our analysis due to inadequate sample, as noted below), and $21,421,718 for High Needs DCEs.

Medicare Spending in Care Settings

We constructed nine setting-specific outcomes for Medicare spending to reflect intensity of resource use (**Exhibit G.4**). These measures capture what Medicare would have paid absent GPDC's TCC/PCC payments and include amounts on non-APO claims plus the amount that Medicare would have paid absent APO reduction for APO claims for treatment group beneficiaries. They are adjusted for PBPs and other model-specific payments reconciled through the claims system for other APMs (NGACO, CPC+, and PCF) that overlapped with GPDC baseline years or treatment years (comparison group only) in PYs. Each measure reflects the paid amount on specific claims per beneficiary per year (PBPY), calculated as the paid amount in a year (through alignment end date) for beneficiaries aligned to either the DCE or comparison group.[32] Spending can accrue from beneficiaries with an admission date or visit encounter start date from the beginning of the PY (January 1) through the end of

[29] Per the GPDC FAQs, under the Provisional Settlement, "CMS will distribute interim-shared savings and collect interim-shared losses shortly after the end of the PY reflecting cost experience through the first six months of the PY, with a final settlement taking place once complete data are available for the full PY (approximately seven months after the PY ends)."

[30] PY2022 GPDC Financial Results. Available at: https://www.cms.gov/files/document/gpdc-py2022-financial-results.xlsx.

[31] The difference is about 7% (i.e., evaluation's beneficiary-month was 93% of model's beneficiary-month on average and overall, varied by DCE). Majority of the difference in total aligned beneficiary-month between the model's population and the evaluation's population is due to exclusion of prospectively plus aligned beneficiaries in the evaluation's sample.

[32] Direct comparisons between total spending and spending categories are not feasible given differences in how these measures were constructed and analyzed.

the PY (December 31) or until the last day the beneficiary remained aligned with the treatment or comparison group.

Exhibit G.4. Claims-Based Setting-Specific Medicare Spending Measures

Setting	Specification
Acute care	Paid amounts on FFS IP claims for short-term (general and specialty) hospitals or CAHs, excluding federal and non-federal emergency hospitals
Outpatient facility	Paid amounts on FFS OP claims for hospital outpatient care
SNF	Paid amounts on FFS non-swing bed SNF and swing bed SNF claims
IRF and LTCH	Paid amount on FFS inpatient claims for IRF and LTCH providers
Professional services	Paid amounts on FFS non-DME Carrier claims, excluding claim lines with one of the 76 E&M HCPCS codes used to determine GPDC Model alignment
*Primary care visits**	*Paid amounts on FFS outpatient and non-DME Carrier claims for primary care practitioners using the union of the E&M HCPCS codes used for GPDC Model alignment and the RBCS E&M services HCPCS codes*
Specialty care visits	Paid amounts on FFS outpatient and non-DME Carrier claims for specialty care practitioners, using the same HCPCS code list described for the primary care visits measure
Home health	Paid amounts on FFS home health claims
Hospice	Paid amounts on FFS hospice claims

NOTES: FFS=fee-for-service; IP=inpatient; CAH=critical access hospital; OP=outpatient; SNF=skilled nursing facility; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital; DME=Durable Medical Equipment; HCPCS=Healthcare Common Procedure Coding System; RBCS=Restructured BETOS Classification System; E&M=evaluation and management.
*Not included in the impact estimation; trend tracked for intervention group.

We constructed three measures used to capture spending in professional settings (professional services spending, primary care visits spending, and specialty care visits spending). The professional services spending measure captures the paid amounts on FFS non-DME (Durable Medical Equipment) Carrier claims and excludes Healthcare Common Procedure Coding System (HCPCS) codes for evaluation and management (E&M) services used for GPDC Model alignment that are captured in the primary care visit and specialty care visit spending measures. The primary care visit spending measure includes paid amounts on FFS Outpatient and non-DME Carrier claims with the union of HCPCS codes (total: 522 codes) for E&M services from the Restructured BETOS Classification System (RBCS; 514 codes) and E&M services used to determine GPDC Model alignment (76 codes) for outpatient services provided by primary care providers (that is, providers with a specialty code that indicates general practice, family medicine, internal medicine, pediatric medicine, geriatric medicine, nurse practitioner, clinical nurse specialist, or physician assistant). The primary care visit spending measure is not included in the impact estimation; we descriptively track trends in this measure for the intervention group. The specialty care visit spending measure includes paid amounts on the same claim types with the same HCPCS code list as used in the primary care visit spending measure, but limits claims to specialty care providers (that is, providers with a specialty code that indicates cardiology, gastroenterology, osteopathic manipulative medicine, neurology, obstetrics/gynecology, hospice and palliative care, sports medicine, physical medicine and rehabilitation, psychiatry, geriatric psychiatry, pulmonology, nephrology, infectious disease, endocrinology, rheumatology,

multispecialty clinic or group practice, addiction medicine, hematology, hematology/oncology, preventive medicine, medical oncology, gynecological/oncology, or neuropsychiatry). **Exhibit G.5** provides a high-level summary of the differences between the three spending measures in the professional settings.

Exhibit G.5. Summary of Setting-Specific Measures for Professional Services

	Claim Type(s) Include…		HCPCS/CPT Include…		Provider Type(s) Include…	
	Outpatient Claims	Non-DME Carrier Claims	GPDC Model Alignment E&M	RBCS E&M	Primary Care Provider	Specialty Care Providers
Professional services spending		✓		✓	✓	✓
Primary care visits spending	✓	✓	✓	✓	✓	
Specialty care visits spending	✓	✓	✓	✓		✓

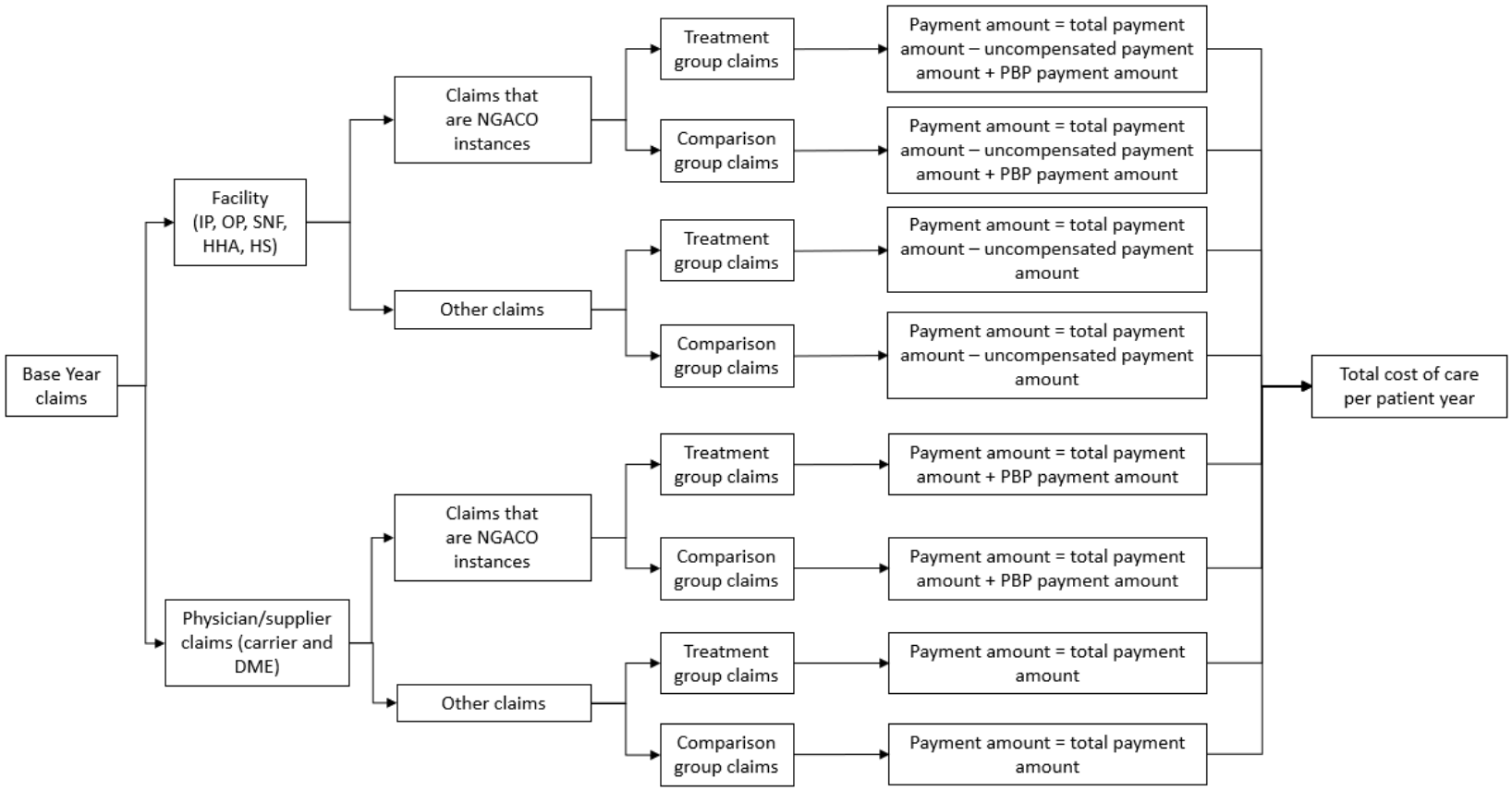
NOTES: DME=Durable Medical Equipment; HCPCS=Healthcare Common Procedure Coding System; RBCS=Restructured BETOS Classification System; E&M=evaluation and management.

Creating Setting-Specific Medicare Spending Measures. We adopted a different approach than is described above for gross Medicare spending to create measures in the BYs and PYs that captured Medicare spending for different settings and service types. Instead of calculating what Medicare actually paid (as was done for gross Medicare spending), we calculated what Medicare would have paid because we are unable to cleanly parse out capitated payments across different care settings, because capitated amounts are calculated at the beneficiary-year level. However, this approach enables understanding of how DCEs influenced intensity of resource use in care settings. Therefore, the gross Medicare spending measure and the measures of Medicare spending in separate care settings cannot be directly compared.

Exhibits G.6 and **G.7** detail the process for determining treatment and comparison group beneficiary gross Medicare spending in care setting and service type categories during the baseline years prior to model's onset and performance years, respectively. The processes use to calculate the separate Medicare spending category measures are described below separately for baseline years prior to model's onset and performance years.

Baseline years prior to the model's onset (2018–2020). Claims identification and processing for these baseline year spending category measures is the same as the process for their baseline year total Medicare spending measure (**Exhibit G.6**).

Exhibit G.6. Medicare Spending in Care Setting and Service Type Categories in Baseline Years Prior to Model Onset (2018–2020)

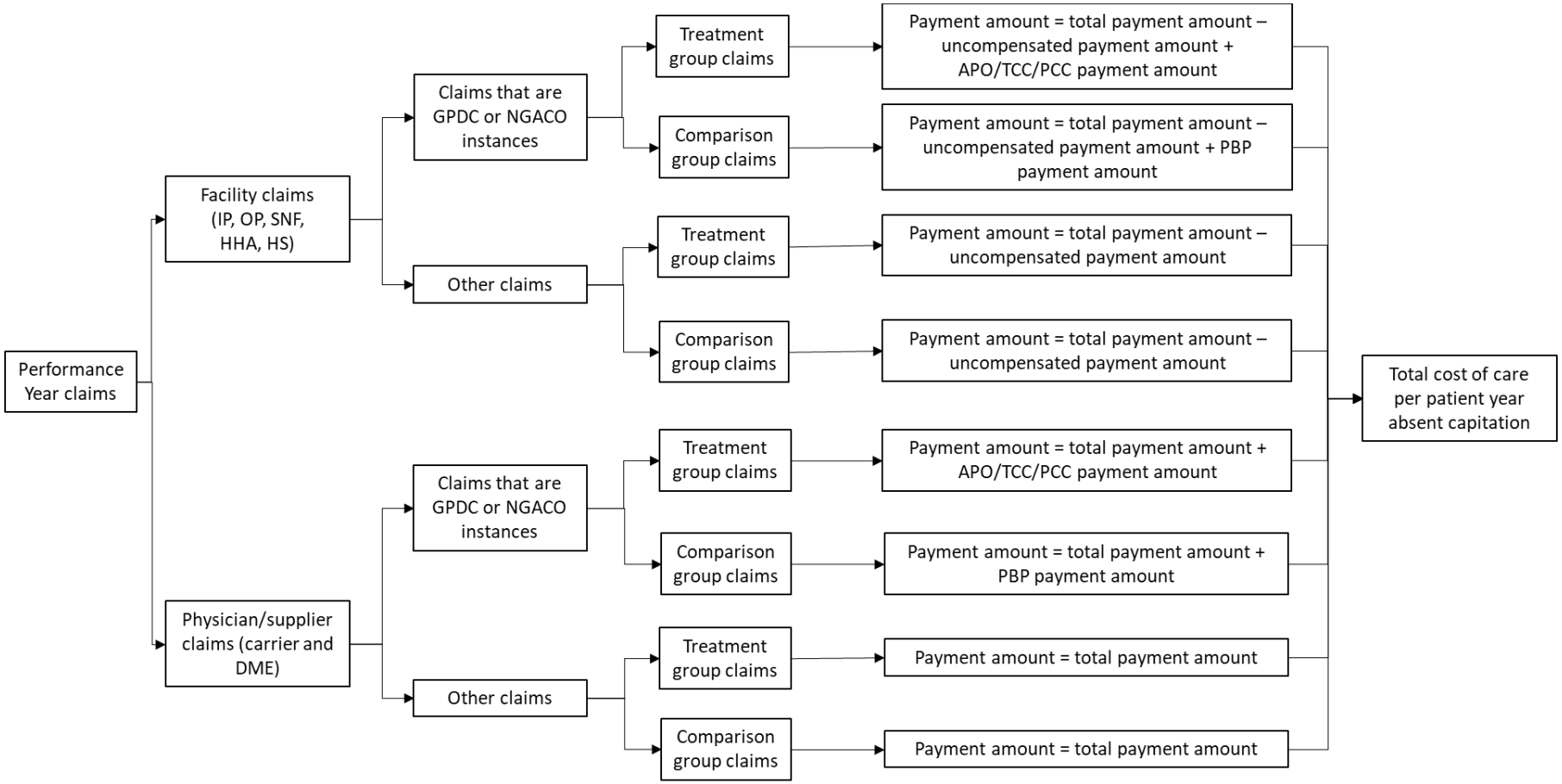


NOTES: IP=Inpatient; OP=Outpatient; SNF=Skilled Nursing Facility; HHA=Home Health Agency; HS=Hospice; DME=Durable Medical Equipment; NGACO=Next Generation Accountable Care Organization; PBP=Population-Based Payment. The total payment amount for facility claims that are NGACO instances is the claim value amount from claims with value code Q0; the total payment amount for facility claims that are not NGACO instances (that is, "Other" claims) is the claim payment amount. The uncompensated care payment amount is subtracted from all payment amounts for facility claims. The total payment amount for physician/supplier claims that are NGACO instances is the claim payment amount plus the PBP reduction amount; the total payment amount for physician/supplier claims that are not NGACO instances and are either treatment group or comparison group claims could be from Comprehensive Primary Care Plus (CPC+)/Primary Care First (PCF) instances or non-CPC+/PCF instances. The total payment amount for CPC+/PCF instances is the claim payment amount adjusted for the line other applied amount for claims with the line other applied indicator code T, A2, or A3. The total payment amount for non-CPC+/PCF instances is the claim payment amount.

Performance Years (2021–2022). We identified claims for Medicare spending in care setting and service type categories in the same manner for PYs (**Exhibit G.7**) as we did for the baseline years prior to model onset. Similar to the PYs' total Medicare spending measure, we then used the program identifier on the claim to distinguish between GPDC and non-GPDC claims. However, unlike the total spending measure, we only distinguish GPDC to account for APO payments (treatment group only).

- Facility claims that were GPDC instances were processed the same way as in the PYs total Medicare spending measure, except that beneficiary-year level capitated payments were not added to the spending amounts.
- Facility claims that were not GPDC instances were processed the same way as in the PYs total Medicare spending measure. In PY2021 these included NGACO and CPC+ claims.
- Physician/supplier claims that were GPDC instances were processed the same way as in the PYs total Medicare spending measure, except that beneficiary-year level capitated payments were not added to the spending amounts.
- Physician/supplier claims that were not GPDC instances were processed the same way as in the PYs total Medicare spending measure. In PY2021 these included NGACO and CPC+ claims.

Exhibit G.7. Medicare Spending in Care Setting and Service Type Categories in PYs (2021–2022).



NOTES: IP=Inpatient; OP=Outpatient; SNF=Skilled Nursing Facility; HHA=Home Health Agency; HS=Hospice; DME=Durable Medical Equipment; GPDC=Global and Professional Direct Contracting; APO=Advance Payment Option; PCC=Primary Care Capitation; TCC=Total Care Capitation; PBP=Population-Based Payment. The total payment amount for facility claims that are GPDC instances is the claim payment amount plus the APO/TCC/PCC PBP reduction amount; the total payment amount for facility claims that are NGACO instances is the claim payment amount plus the NGACO PBP reduction amount; the total payment amount for facility claims that are non- GPDC/NGACO instances (that is, "Other" claims) is the claim payment amount. The uncompensated care payment amount is subtracted from all payment amounts for facility claims. The total payment amount for physician/supplier claims that are GPDC instances is the claim payment amount plus the PBP reduction amount; the total payment amount for physician/supplier claims that are non- GPDC instances and are treatment group claims is the claim payment amount. The total payment amount for physician/supplier claims that are non- GPDC instances and are comparison group claims could be from NGACO, Comprehensive Primary Care Plus (CPC+)/Primary Care First (PCF) instances or non-CPC+/PCF instances. The total payment amount for NGACO instances is the claim payment amount plus

NGACO PBP reduction amount. The total payment amount for CPC+/PCF instances is the claim payment amount adjusted for the line other applied amount for claims with the line other applied indicator code T, A2, or A3. The total payment amount for non-CPC+/PCF instances is the claim payment amount.

Accounting for APO Claims in Gross Total and Setting-Specific Medicare Spending

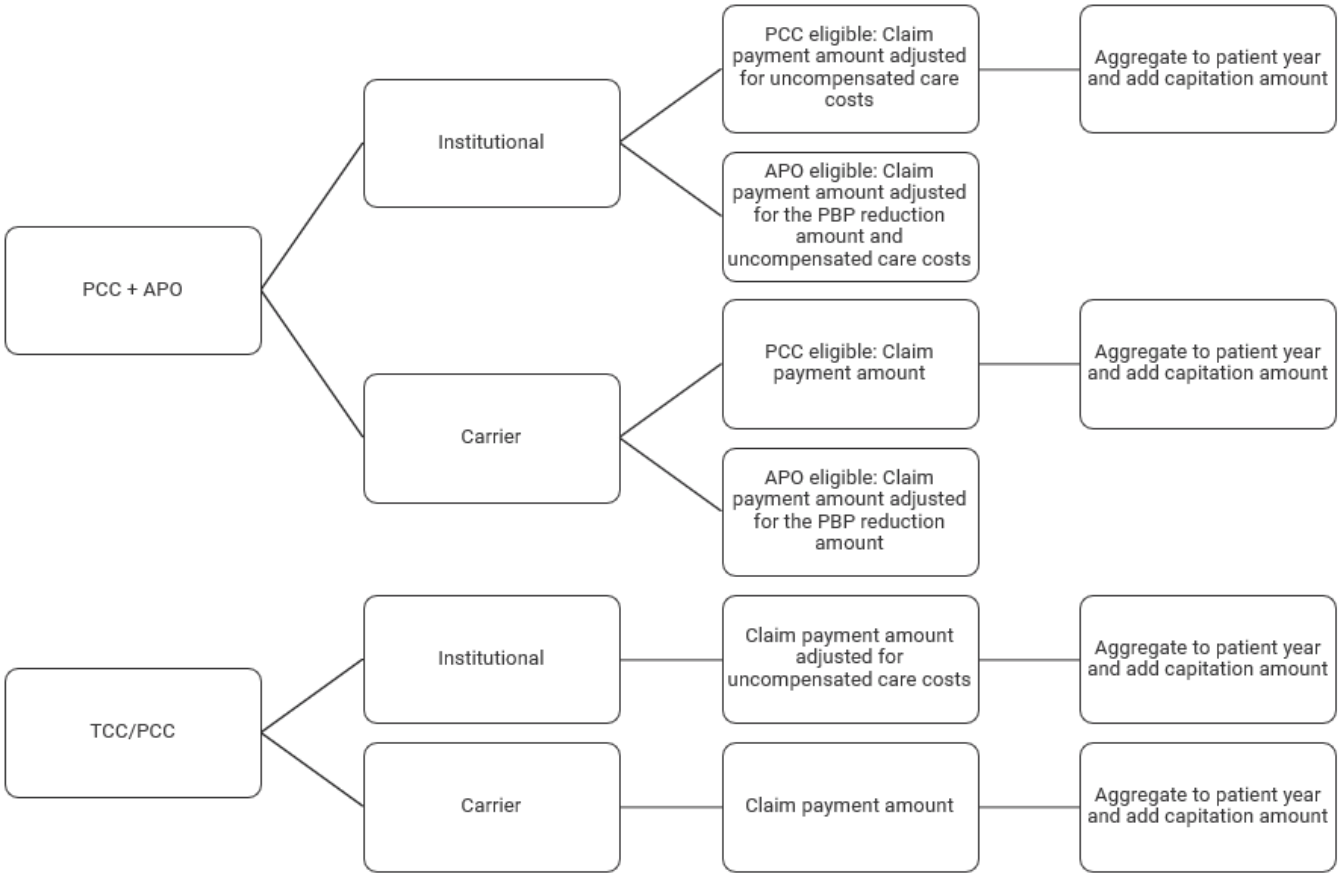
Exhibit G.8 shows the high-level process for accounting for APO claims in gross total Medicare spending and setting-specific Medicare spending measures in performance years. We determined whether claims were TCC, PCC only, or PCC+APO using guidance provided by the Innovation Center's GPDC payment analysis and operational support contractor. Irrespective of claim type, PCC+APO claims may have a component that is PCC-eligible and a component that is APO-eligible.

PCC+APO. For facility claims, the payment amount from the PCC-eligible component is the claim payment amount minus the uncompensated care payment amount. When we aggregate Medicare spending to the beneficiary-year, for gross Medicare spending, we add in the appropriate beneficiary-year capitation amount. For facility claims, the payment amount from the APO-eligible component is the claim payment amount plus the APO reduction amount minus the uncompensated care payment amount.

For physician/supplier claims, the payment amount from the PCC-eligible component is the claim payment amount. As above, when we aggregate gross Medicare spending to the beneficiary-year, we add in the appropriate beneficiary-year capitation amount. For physician/supplier claims, the payment amount from the APO-eligible component is the claim payment amount plus the APO reduction amount.

TCC/PCC only. For facility claims, the payment amount is the claim payment amount minus the uncompensated care payment amount. For physician/supplier claims, the payment amount is the claim payment amount. As described above, when we aggregate Medicare spending to the beneficiary-year, for gross Medicare spending, we add in the appropriate beneficiary-year capitation amount.

Exhibit G.8. Process to Account for APO Claims in Medicare Spending Measures for the GPDC Group in PYs (2021–2022)



NOTES: PCC=Primary Care Capitation; APO=Advance Payment Option; TCC=Total Care Capitation; PBP=Population-Based Payment.

G.2.2. Medicare Utilization Outcomes

Seven utilization measures (**Exhibit G.9**) were created for the treatment group and comparison group in performance and baseline years. These measures were selected to assess the GPDC Model's impact on utilization across different types of health care providers and settings. Unlike the total Medicare gross spending and spending category measures, the utilization measures are calculated the same way for the treatment and comparison group and in all baseline and performance years. As previously noted, the PCP services measure is not included in the impact estimation; we descriptively track trends in this measure for the intervention group.

Exhibit G.9. Claims-Based Utilization Measures

Main Outcome	Specification
Acute care hospitalizations	Number of all-cause acute care inpatient hospital stays per 1,000 beneficiaries per year (BPY) during the reference year (through alignment end date) for beneficiaries aligned to either the DCE or comparison group. Stays that included transfers between facilities are counted as one stay. All stays with admission date occurring between the start and the end of the reference year, or the end date of the beneficiary's alignment to the treatment or comparison group during the reference year, are included in the measure.
Acute care length of stay (days)	Number of days between acute care inpatient hospital admission and discharge per 1,000 BPY during the reference year (through alignment end date) for beneficiaries aligned to either the DCE or comparison group. Stays that included transfers between facilities are counted as one stay. Acute care inpatient hospital days from the start to the end of the reference year, or the end date of the beneficiary's alignment to the treatment or comparison group during the reference year, are included in the measure.
ED visits and observation stays	Number of ED visits, including observation stays, per 1,000 BPY during the reference year (through alignment end date) for beneficiaries aligned to either the DCE or comparison group. Visits that included transfers between facilities are counted as one visit. ED visits resulting in inpatient hospital stays are excluded. All ED visits, including observation stays, occurring between the start and the end of the reference year, or the end date of a beneficiary's alignment to the treatment or comparison group during the reference year, are included in the measure.
IRF and LTCH days	Number of institutional PAC (IRF and LTCH) days per 1,000 BPY during the reference year (through alignment end date) for beneficiaries aligned to either the DCE or comparison group. All institutional PAC days from the start to the end of the reference year, or the end date of the beneficiary's alignment to the treatment or comparison group during the reference year, are counted toward the measure.
SNF days	Number of SNF days (in either a swing bed or non-swing bed SNF) per 1,000 BPY[33] during the reference year (through alignment end date) for beneficiaries aligned to either the DCE or comparison group. All SNF days from the start to the end of the reference year, or the end date of the beneficiary's alignment to the treatment or comparison group during the reference year, are counted toward the measure.
Home health episodes	Number of 30-day home health episodes per 1,000 BPY during the reference year (through alignment end date) for beneficiaries aligned to either the DCE or comparison group. Prior to 1/1/2020, episodes include sum of 60-day home health episodes, as well as home health episodes with low-utilization payment adjustments and partial episode payment adjustments. After 1/1/2020, episodes include sum of 30-day home health episodes, as well as home health episodes with low-utilization payment adjustments and partial episode payment adjustments. Episodes were standardized to 30 days to allow for comparison over time. All episodes that began between the start and the end of the reference year, or the end date of a beneficiary's alignment to the treatment or comparison group during the year, are included in the measure.
Continuous hospice days prior to death	Number of continuous hospice service days between hospice election and death per 1,000 BPY during the reference year (through alignment end date) for beneficiaries aligned to either the DCE or comparison group who die while electing the Medicare hospice benefit, calculated using the claim from and claim through dates on hospice claims. Beneficiaries who disenroll from hospice alive and return would have their (measure) day count "restarted" at live discharge. Hospice stay days from the start to the end of the reference year, or the end date of a beneficiary's alignment to the treatment or comparison group during the year, are included in the measure.

[33] Although SNF days can only accumulate among SNF users, the measure rate per 1,000 BPY includes both SNF users and non-users.

Main Outcome	Specification
Professional services provided by primary care specialists (PCP services)*	Number of claims with E&M services that are "Primary Care Capitation (PCC)-eligible" provided by primary care providers (including FQHCs and RHCs) per 1,000 BPY for beneficiaries aligned to either the DCE or comparison group, calculated as the count of claims with "PCC-eligible" services in a year (through alignment end date). All "PCC-eligible" services that began between the start and the end of the reference year, or the end date of a beneficiary's alignment to the treatment or comparison group during the year, are included in the measure.

NOTES: PBPY=per beneficiary per year, ED=emergency department, PAC=post-acute care; SNF=skilled nursing facility; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital; DCE=Direct Contracting Entity; E&M=evaluation and management.
* Not included in the impact estimation; trend tracked for intervention group.

For measures that count days of utilization (for example, acute care length of stay in days): 1) stays beginning on or before the alignment end date and ending on or after the alignment end date or the end of the reference year will contribute all days in the length of stay to the measure (for example, for reference year 2022 and alignment end date December 31, 2022, a stay beginning on December 15, 2022, and ending January 4, 2023, contributes 20 days to the measure for 2022); and 2) stays beginning after the alignment end date do not contribute any days to the measure for that reference year (for example, for reference year 2022 and alignment end date December 15, 2022, a stay beginning on December 16, 2022 and ending on December 31, 2022, does not contribute any days to the measure for 2022).

For measures that count stays or visits (for example, number of acute care hospitalizations): 1) stays/visits beginning before January 1 of the reference year are not included in the measure (for example, for reference year 2022, a stay beginning on December 31, 2021, and ending on February 1, 2022, is not included in the measure); 2) stays/visits beginning on or before the alignment end date and ending on or after the alignment end date or the end of the reference year are included in the measure (for example, for reference year 2022 and alignment end date December 31, 2022, a stay beginning on December 31, 2022, and ending on January 1, 2023 is included in the measure for 2022); and 3) stays/visits beginning after the alignment end date are not included in the measure (for example, for reference year 2022 and alignment end date December 15, 2022, a stay beginning on December 16, 2022, and ending on December 31, 2022, is not included in the measure for 2022). Examples of qualifying stays for measures for reference year 2022 are provided in **Exhibit G.10.**

Exhibit G.10. Measure Eligible Stay Start and End Dates, Reference Year 2022

Reference Year Start Date	Alignment End Date	Stay Start Date	Stay End Date	Stay Included in Measure for Reference Year 2022	Days Included in Measure for Reference Year 2022
January 1, 2022	December 31, 2022	December 15, 2022	January 4, 2023	Yes	20
January 1, 2022	December 15, 2022	December 16, 2022	December 31, 2022	No	0
January 1, 2022	December 1, 2022	December 2, 2022	December 4, 2022	No	0

G.2.3. Medicare Quality of Care Outcomes

Six quality of care outcomes (**Exhibit G.11**) were created for the treatment group and comparison group in PY2022 and its baseline years. These measures were selected to assess the GPDC Model's impact on quality of care across different types of health care providers and settings, and for beneficiaries with varying levels of risk (for example, beneficiaries with multiple chronic conditions). Similar to the utilization measures, the quality measures are calculated the same way in the treatment and comparison group and in baseline and performance years. Additionally, as previously noted, four quality of care measures—mortality, advance care plan, annual wellness visits, and chronic care management for beneficiaries with multiple chronic conditions (MCC)—are not included in the impact estimation; we descriptively track trends in these measures for the intervention group.

Exhibit G.11. Claims-Based Quality of Care Measures, PY2022

Main Outcome	Specification
All-condition readmission [34]	Rate of beneficiaries who were readmitted to a hospital within 30 days following discharge from the index hospitalization per 1,000 BPY during the reference year (through alignment end date) for beneficiaries aligned to either the DCE or comparison group who had an eligible index hospitalization. The denominator excludes beneficiaries who did not experience a hospitalization in a given year. This measure reflects the share of beneficiaries who had one or more unplanned readmissions in the reference year, among those who had an eligible hospitalization. We use CMS' risk standardized all-condition readmission measure for GPDCs to identify eligible hospitalizations and unplanned readmissions. Beneficiaries eligible for the measure denominator are DCE- or comparison group-aligned beneficiaries with one or more eligible index hospitalizations between the start and the end of the reference year, or the end date of a beneficiary's alignment to the treatment or comparison group during the reference year, who do not meet denominator exclusion criteria; beneficiaries eligible for the measure numerator are those with one or more unplanned readmissions within 30 days of discharge from their index hospitalization who do not meet numerator exclusion criteria.
Mortality*	Rate of beneficiaries who died during the reference year per 1,000 BPY during the reference year (through alignment end date) for beneficiaries aligned to either the DCE or comparison group. Beneficiaries eligible for the measure denominator are DCE- or comparison group-aligned beneficiaries during the reference year; beneficiaries eligible for the measure numerator are those with date of death between the start and the end of the reference year, or the end date of the beneficiary's alignment to the treatment or comparison group during the reference year.

[34] Global and Professional Direct Contracting Model: Quality Measurement Methodology (for PY2022 only—1/1/2022-12/31/2022) (CMS)

Main Outcome	Specification
ACSC hospitalizations[35]	Rate of beneficiaries with one or more ACSC acute care hospitalizations in the performance year per 1,000 BPY during the reference year (through alignment end date) for beneficiaries aligned to either the DCE or comparison group. This measure reflects the risk of beneficiaries being hospitalized for ACSCs during the year. ACSCs include chronic conditions (diabetes with short-term complications, diabetes with long-term complications, chronic obstructive pulmonary disease or asthma in older adults, heart failure, uncontrolled diabetes, asthma in younger adults, and lower extremity amputation among beneficiaries with diabetes) and acute conditions (community-acquired pneumonia and urinary tract infection). Beneficiaries eligible for the measure denominator are DCE- or comparison group-aligned beneficiaries who do not meet denominator exclusion criteria; beneficiaries eligible for the measure numerator are those with at least one inpatient hospital discharge with a primary diagnosis code indicating select chronic (diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes, lower extremity amputation among beneficiaries with diabetes, COPD/asthma, or heart failure) and acute (community-acquired pneumonia or urinary tract infection) conditions between the start and the end of the reference year, or the end date of a beneficiary's alignment to the treatment or comparison group during the reference year, who do not meet numerator exclusion criteria.
Timely follow-up after acute exacerbations of chronic conditions[36]	Rate of beneficiaries who received follow-up care within the timeframe recommended by clinical practice guidelines in a non-emergency outpatient setting per 1,000 BPY during the reference year for beneficiaries aligned to either the DCE or comparison group with one or more acute events related to one of six chronic conditions (that is, hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, and Type I/II diabetes). Acute events are those that required either an ED visit, observation stay, or hospitalization. Beneficiaries eligible for the measure denominator are those with one of six chronic conditions who have an acute event during the reference year where the end of the follow-up period occurs between the start and the end of the reference year, or the end date of the beneficiary's alignment to the treatment or comparison group during the reference year, who do not meet denominator exclusion criteria; beneficiaries eligible for the measure numerator are those who receive timely follow-up following their acute event. Acute events where the beneficiary enters a SNF, non-acute care, or hospice care within the follow-up interval are not included in the measure. The model launched this measure in 2022 for Standard and New Entrant DCEs. The measure was a pay-for-reporting measure in 2022 and transitioned to a pay-for-performance measure in 2023.

[35] 2016 Measure Information About the Hospital Admissions for Acute and Chronic Ambulatory Care-Sensitive Condition (ACSC) Composite Measures (CMS)

[36] Global and Professional Direct Contracting Model: Quality Measurement Methodology (for PY2022 only—1/1/2022-12/31/2022) (CMS)

Main Outcome	Specification
Unplanned admissions for beneficiaries with multiple chronic conditions[37]	Rate of beneficiaries who had at least one acute, unplanned admission per 1,000 BPY during the reference year (through alignment end date) for beneficiaries aligned to either the DCE or the comparison group who have multiple chronic conditions. The denominator excludes beneficiaries who did not have at least two of eight chronic conditions, as defined in the MBSF 30 CCW Chronic Conditions Segment[38] (acute myocardial infarction, Alzheimer's disease and related disorders or senile dementia, atrial fibrillation, chronic kidney disease, chronic obstructive pulmonary disease or asthma, depression, heart failure, and stroke or transient ischemic attack [TIA]). This measure reflects the share of beneficiaries who had one or more unplanned admissions to an acute care hospital in the reference year, among those who had two or more chronic conditions. Beneficiaries eligible for the measure denominator are DCE- or comparison group-aligned beneficiaries with two or more chronic conditions in the year prior to the reference year who do not meet denominator exclusion criteria; beneficiaries eligible for the measure numerator are those with one or more unplanned hospitalizations.
Days at home[39]	Percent of days at home during the reference year (through alignment end date) for beneficiaries aligned to either the DCE or comparison group with complex, chronic conditions. Calculated as a proportion of days aligned to either the DCE or comparison group during the reference year (through alignment end date) per beneficiary rather than the count of days at home. The denominator excludes beneficiaries who do not have a prospective HCC score greater than or equal to 2.0 in the year prior to the reference year. This measure reflects the proportion of days aligned to the DCE or comparison group when the beneficiary is not "in care" (that is, eligible beneficiary days on which a beneficiary receives care in one of more of the following specified care settings: inpatient acute and post-acute facilities, comprising short-term acute care hospitals, critical access hospitals [CAHs], IRFs, inpatient psychiatric facilities [IPFs], LTCHs, and SNFs; ED visits; and observation stays). Beneficiaries are considered "at home" if they are enrolled in hospice, and hospital admissions for childbirth, miscarriage, or termination are not counted as "days in care." Days eligible for the denominator are days during the reference year when the beneficiary is alive and aligned to the DCE or comparison group. Days eligible for the numerator are days during the reference year when the beneficiary is alive, aligned to the DCE or comparison group, and not "in care."

[37] ACO #38 Risk-Standardized Acute Admission Rates for Beneficiaries with Multiple Chronic Conditions

[38] Additional information on the 30 CCW Chronic Conditions Algorithms is available at https://www2.ccwdata.org/documents/10280/19139421/chr-chronic-condition-algorithms.pdf.

[39] Global and Professional Direct Contracting Model: Quality Measurement Methodology (for PY2022 only—1/1/2022-12/31/2022) (CMS). Although the measure under the model is specified for use only in High Needs beneficiaries, we apply it in the evaluation to beneficiaries aligned to all DCE types and their comparison groups as a measure of population health.

Main Outcome	Specification
Recommended diabetes care[40]	Rate of beneficiaries who received the recommended diabetes care per 1,000 BPY during the reference year (through alignment end date) for beneficiaries aligned to either the DCE or the comparison group with a diagnosis of diabetes. The measure includes four submeasures: Hemoglobin A1c (A1C) testing,[41] eye exam,[42] LDL-C screening,[43] and medical attention for nephropathy.[44] This measure reflects the share of beneficiaries who received recommended diabetes care, indicating that they may have had effective care coordination. Beneficiaries eligible for the measure denominator are those with a documented diagnosis of diabetes (from the MBSF) in the reference year or the prior year. Beneficiaries eligible for the measure numerator are those received recommended care (that is, triggered the numerator for all four submeasures). This measure has currently only been calculated for beneficiaries aligned to Standard and New Entrant DCEs, as described above. Reporting of this measure for beneficiaries aligned to High Needs DCEs will commence from the next report onwards and be refined to HEDIS specifications that appropriately reflect care for special populations. The refined measure will also be adapted to high needs beneficiaries aligned to Standard and New Entrant DCEs, from the next report onwards.
Advance care plan[45]*	Rate of beneficiaries who have an advance care plan or surrogate decision maker documented in the medical record, or documentation in the medical record that an advance care plan was discussed but the beneficiary did not wish or was not able to name a surrogate decision maker or provide an advance care plan, per 1,000 BPY during the reference year (through alignment end date) for beneficiaries aligned to DCE comparison group. Advance care plans occur on eligible physician encounters, which are identified on claims using HCPCS codes. This measure reflects the share of beneficiaries who have an advance care plan or surrogate decision maker documented in the medical record, or documentation in the medical record that an advance care plan was discussed but the beneficiary did not wish or was not able to name a surrogate decision maker or provide an advance care plan, during the reference year. Beneficiaries eligible for the denominator are those with an eligible physician encounter (for example, not encounters that take place in an ED) during the reference year who are not enrolled in hospice during the reference year. Beneficiaries eligible for the numerator are those with a documented advance care plan or documentation in the medical record that an advance care plan was discussed but the beneficiary did not wish or was not able to name a surrogate decision maker or provide an advance care plan.
Annual wellness visit[46]*	Rate of beneficiaries who received an annual wellness visit per 1,000 BPY during the reference year (through alignment end date) for beneficiaries aligned the DCE group. Annual wellness visits occur on Outpatient and Carrier claims. This measure reflects the share of beneficiaries who received an annual wellness visit during the reference year. Beneficiaries eligible for the denominator are those aligned to either the DCE or comparison group during the reference year. Beneficiaries eligible for the numerator are those who received an annual wellness visit on an Outpatient or Carrier claim with TOB 12x, 13X, 22X, 23X, 71X, 77X, or 85X.

[40] Comprehensive Diabetes Care (CDC), available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/

[41] Comprehensive Diabetes Care: Hemoglobin A1c (A1C) Testing

[42] Comprehensive Diabetes Care: Eye Exam (retinal) performed

[43] Comprehensive Diabetes Care: LDL-C Screening

[44] Comprehensive Diabetes Care: Medical Attention for Nephropathy

[45] Quality ID #47: Advance Care Plan

[46] MLN: Medicare Preventive Services: Annual Wellness Visit (AWV)

Main Outcome	Specification
Chronic disease management for beneficiaries with multiple chronic conditions*	Rate of beneficiaries with at least one Chronic Care Management (CCM) service per 1,000 BPY during the reference year (through alignment end date) among beneficiaries aligned to the DCE group who have multiple chronic conditions. The denominator excludes beneficiaries who did not have at least two of eight chronic conditions, as defined in the MBSF 30 CCW Chronic Conditions Segment (acute myocardial infarction, Alzheimer's disease and related disorders or senile dementia, atrial fibrillation, chronic kidney disease, chronic obstructive pulmonary disease or asthma, depression, heart failure, and stroke or transient ischemic attack [TIA]). CCM services are identified on claims (professional; FQHC and RHC without a primary diagnosis code for mental health services) using HCPCS codes. This measure reflects the share of beneficiaries who received one or more CCM services in the reference year, among those who had two or more chronic conditions. Beneficiaries eligible for the measure denominator are DCE- or comparison group-aligned beneficiaries with two or more chronic conditions in the year prior to the reference year who do not meet denominator exclusion criteria; beneficiaries eligible for the measure numerator are those with one or more CCM services.

NOTES: BPY=beneficiaries per year; DCE=Direct Contracting Entity; ACSC=ambulatory care sensitive condition; ED=emergency department; SNF=skilled nursing facility.
* Not included in the impact estimation; trend tracked for intervention group.

Appendix H: Quantitative Methods

This appendix:

- Explains the process for creating GPDC Model treatment and comparison groups for the evaluation
- Describes the descriptive analyses conducted on the treatment and comparison groups for the Standard, New Entrant, and High Needs DCEs
- Describes the difference-in-differences (DID) design and analytic methodology used to assess the GPDC Model's impacts on key outcomes for Standard, New Entrant, and High Needs DCEs in PY2022 and cumulatively as of PY2022

H.1: Defining GPDC Model Treatment and Comparison Groups for the Evaluation

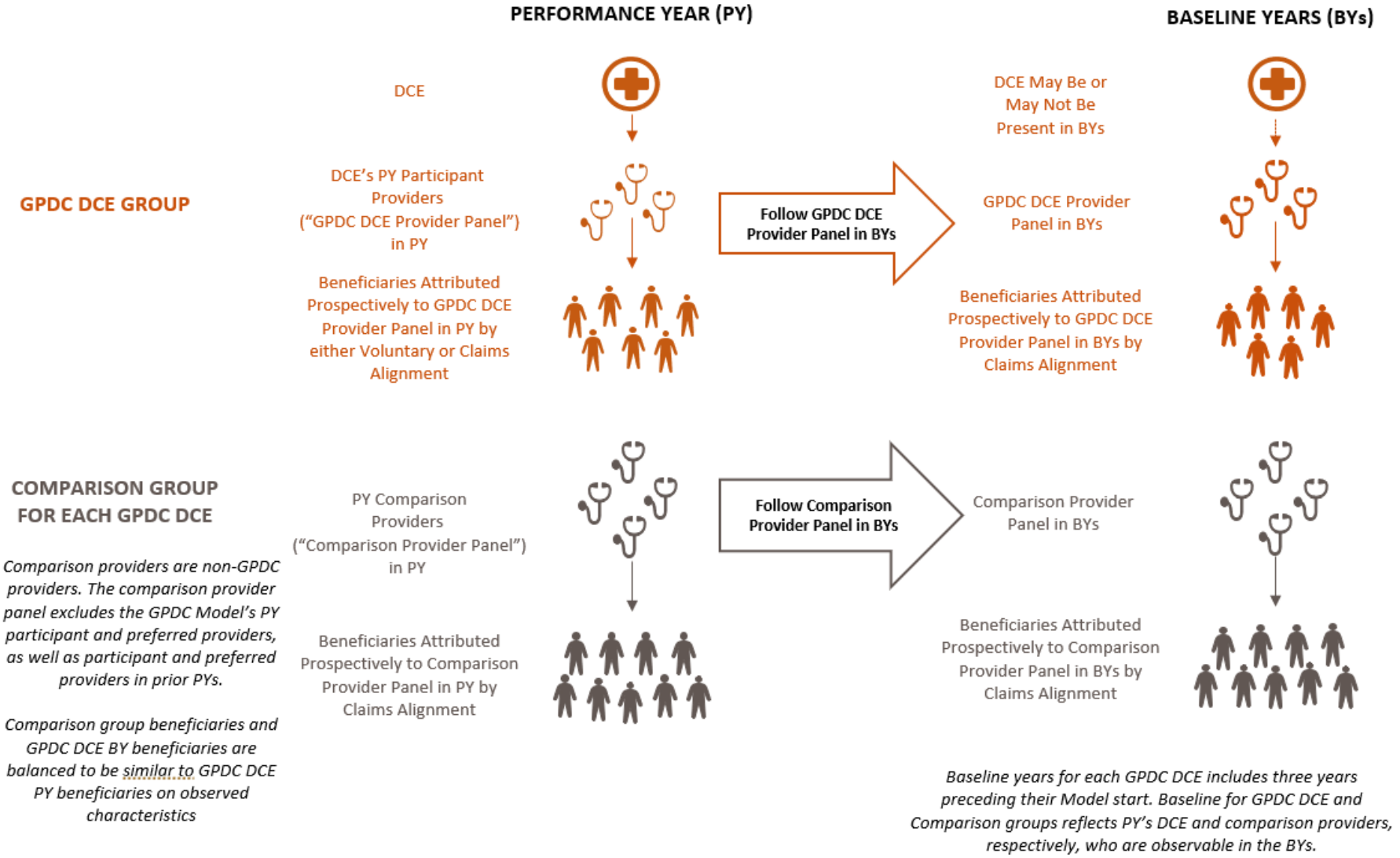
Our approach to defining the treatment and comparison groups for the evaluation is summarized in **Exhibit H.1**. Using the GPDC Model's alignment rules, we defined the GPDC DCE group in the evaluation as FFS Medicare beneficiaries prospectively aligned to the GPDC DCE Participant Providers in the performance year (intervention period treatment group) and baseline years (pre-intervention period treatment group). Specifically, for a given PY, we used the GPDC DCEs' Participant Provider panel in that year to identify treatment group beneficiaries prospectively aligned to these providers in the respective PY and in the corresponding baseline years, using the model's alignment rules. **For each cohort, we defined baseline years as the three years prior to the onset of participation in the model.** Accordingly, the 2021 cohort's baseline years comprised 2018–2020, while the 2022 cohort's baseline years comprised 2019–2021.

Using the same alignment rules, we defined the evaluation's comparison group as FFS Medicare beneficiaries in GPDC DCE market areas who could be prospectively aligned to non-GPDC providers[47] in the performance year (intervention period comparison group) and baseline years (pre-intervention period comparison group).[48] Specifically, we identified comparison group beneficiaries as those eligible to be prospectively aligned to the PY non-GPDC provider panel in PY and baseline years. See previous paragraph for how baseline years are defined to be cohort specific.

[47] Non-GPDC DCE providers are unaffiliated with GPDC DCEs (that is, not a GPDC DCE Participant or Preferred Provider).

[48] Our evaluation approach aligns with the model's rules for alignment, where beneficiaries are aligned to the model through Primary Care Qualified Evaluation and Management (PQEM) visits to Participant Providers. Preferred Providers are an extension of the Participant Providers' networks and provide necessary services to model beneficiaries but are *unable to align beneficiaries to the model.* Thus, services from Preferred Providers are not captured when we constructed the treatment and comparison beneficiary populations; however, these services will be captured in claims-based measures (for example, acute care stays, SNF stays, IRF/LTCH days, home health episodes).

Exhibit H.1. GPDC DCE and Comparison Groups to Evaluate Impact in a Performance Year



This section briefly describes the claims-based alignment process before describing in more detail how the treatment and comparison groups were derived. See **Exhibit H.2** for summary definitions.

Exhibit H.2. Definition of GPDC DCE Treatment and Comparison Groups in Performance and Baseline Years

	Baseline Years	Performance Year
Treatment Group		
Standard and New Entrant DCEs	Alignment-eligible beneficiaries residing in DCE market areas in the baseline years who are prospectively aligned to providers in the GPDC DCE's Participant Provider panel from a given performance year using the model's alignment rules and aligned for at least 30 days in the year.	Alignment-eligible beneficiaries prospectively aligned to GPDC DCE Participant Providers in a given PY using the model's alignment rules, situated in DCE market areas, and aligned for at least 30 days in the year. Following the model's rules, we included all prospective VA beneficiaries in this group but excluded Prospective Plus VA beneficiaries.
High Needs DCEs	Alignment-eligible beneficiaries **with high needs**[49] residing in DCE market areas in the baseline years who are prospectively aligned to providers in the GPDC DCE's Participant Provider panel from a given performance year using the model's alignment rules and aligned for at least 30 days in the year.	Alignment-eligible beneficiaries **with high needs** prospectively aligned to GPDC DCE Participant Providers in a given PY using the model's alignment rules, situated in DCE market areas, and aligned for at least 30 days in the year. Following the model's rules, we included all prospective VA beneficiaries in this group but excluded Prospective Plus VA beneficiaries.
Comparison Group		
Standard and New Entrant DCEs	Alignment-eligible beneficiaries residing in DCE market areas in the baseline years who are prospectively aligned to providers from the non-GPDC provider panel during the given performance year using the model's alignment rules. Beneficiaries must be aligned for at least 30 days in the year.	Beneficiaries residing in DCE market areas prospectively aligned to non-GPDC providers during the PY using model's alignment rules and aligned for at least 30 days in the year.
High Needs DCEs	Alignment-eligible beneficiaries with high needs residing in DCE market areas in the baseline years who are prospectively aligned to providers from the non-GPDC provider panel during the given performance year using the model's alignment rules. Beneficiaries must be aligned for at least 30 days in the year.	Beneficiaries with high needs[49] residing in DCE market areas prospectively aligned to non-GPDC providers during the PY using model's alignment rules and aligned for at least 30 days in the year.

NOTES: Non-GPDC providers exclude GPDC DCE Participant Providers and GPDC DCE Preferred Providers in the PY. We used a provider panel design to construct a non-GPDC provider list for the performance year (similar to the DCE Participant Provider list) by also requiring the non-GPDC providers to furnish at least one Primary Care Qualified Evaluation and Management (PQEM)[50] claim to the comparison group beneficiaries during the PY. We excluded Prospective Plus VA beneficiaries from the GPDC group because these beneficiaries started their alignment to the model not from the beginning of PY and may potentially exacerbate imbalance with the comparison group,

[49] High needs beneficiaries were identified using the model eligibility rules for PY2022 in the Global and Professional Direct Contracting Model Financial Operating Guide: Overview; this definition will be reviewed and updated each year as needed to ensure agreement with the model's operating procedures.

[50] A PQEM claim was defined as a claim for a primary care service furnished by a primary care specialist or a selected non-primary care specialist. A primary care service was identified by the Healthcare Common Procedure Coding System (HCPCS) code appearing on the claim line. In the case of claims submitted by a federally qualified health center (FQHC) or rural health clinic (RHC), all services were considered as primary care services. HCPCS codes for primary care services and provider specialty type codes for primary care specialists and selected non-primary care specialists can be found in Appendix Tables B.6.3, B.6.4, and B.6.5, respectively, from the PY2022 GPDC financial operating guide: https://www.cms.gov/priorities/innovation/media/document/gpdc-py2022-fin-op-guide-ovw.

who started their alignment to the comparison group from the beginning of PY. See "Voluntary Alignment" section in Section H.1.1. A representative sample of non-GPDC DCE beneficiaries in DCE markets was drawn to create the comparison group and maintain computationally feasible sample sizes. GPDC=Global and Professional Direct Contracting; DCE=Direct Contracting Entity; DID=difference-in-differences; VA=voluntary alignment; BY=baseline year; PY=performance year.

Additionally, DCEs may change type (Standard, New Entrant, High Needs) from year to year, for example, if the size or characteristics of their beneficiary population change. For DCEs that changed type from PY2021 to PY2022, they were assigned to the DCE type they were in the respective PY for the purpose of analysis. We continued to define the baseline period for these DCEs as the three years prior to starting the model (that is, DCEs in the 2021 cohort that changed type in PY2022 will continue to have 2018–2020 as their BYs). The DCEs that changed type from PY2021 to PY2022 are shown in **Exhibit H.3**. One DCE changed from High Needs to Standard, and seven DCEs changed from New Entrant to Standard. All eight DCEs changed their type on account of an increase in the size of their respective beneficiary population.

Exhibit H.3. Eight DCEs Changed Type from PY2021 to PY2022

DCE ID	Type in PY2021	Type in PY2022
D0005	New Entrant	Standard
D0011	High Needs	Standard
D0021	New Entrant	Standard
D0027	New Entrant	Standard
D0063	New Entrant	Standard
D0078	New Entrant	Standard
D0099	New Entrant	Standard
D0141	New Entrant	Standard

NOTES: DCE=direct contracting entity; PY=performance year.

H.1.1 Alignment Approach

The alignment approach used for the evaluation captures both prospectively claims-aligned and prospectively voluntarily aligned beneficiaries for the GPDC and comparison groups through the process detailed below.

Because such an alignment process does not exist for the comparison group, successful replication of the claims-based alignment process is essential in constructing a comparison group. We describe our process below to operationalize the claims-alignment algorithm in the evaluation for the comparison group, which involves aligning eligible beneficiaries to non-DCE alignment-eligible providers using the same alignment algorithm as the GPDC treatment group.

Claims-based alignment. We used final action claims on the Chronic Conditions Data Warehouse (CCW) and followed the GPDC Model's alignment algorithm to prospectively align eligible beneficiaries to treatment and comparison groups. In accordance with the model's rules, beneficiary alignment for a given baseline or performance year was based on Medicare claims from a preceding 24-month alignment period ending June 30th prior to the start of the year. The alignment algorithm was used to align beneficiaries to a DCE's Participant

Providers or to comparison providers in each BY or PY based on providers that rendered the largest share of dollars for beneficiaries' primary care qualified evaluation and management (PQEM) visits in the alignment period. The following steps detail the beneficiary alignment process used by the Innovation Center's GPDC payment analysis and operational support contractor.[51]

Step 1: Identify GPDC DCE Participant Providers and alignment-eligible providers

For each PY, we obtained the list of GPDC DCE Participant Providers in the first quarter after the PY ended, including taxpayer identification numbers (TINs), CMS certification numbers (CCNs), and national provider identifiers (NPIs) of GPDC DCE practices, facilities, and practitioners, from the Innovation Center's GPDC payment analysis and operational support contractor. Alignment-eligible providers include primary care specialists[52] or selected non-primary care specialists.[53]

Step 2: Identify alignment-eligible beneficiaries

For all three DCE types, several beneficiary alignment requirements were applied for both the GPDC and comparison groups. For our analyses, alignment-eligible beneficiaries must be living, be enrolled in both Medicare Parts A and B, not be enrolled in Medicare Advantage (MA) or another managed care plan, have Medicare as the primary payer, and be a U.S. resident, measured as of January 1st in the baseline year or performance year. An aligned beneficiary ended alignment and could not be aligned again during the BY/PY once they failed to meet all of the above conditions, and only the aligned period contributed to the analysis. We defined the GPDC and the comparison beneficiaries in the evaluation to be residing at the beginning of the year in the DCEs' market area, defined as Hospital Referral Regions (HRRs) with a threshold (that is, >=1 percent) of a DCE's aligned beneficiaries.[54]

In addition to meeting the above requirements, alignment-eligible beneficiaries for High Needs DCEs also had to meet *at least one* of the following conditions, per the model's definition of High Needs beneficiaries: 1) had conditions that impaired their mobility based on ICD-10 codes;[55] 2) had a CMS-Hierarchical Condition Categories (HCC) risk score of 3.0 or greater for beneficiaries eligible for Medicare due to age or disability (0.35 or greater for beneficiaries eligible due to end-stage renal disease [ESRD]); 3) had a CMS-HCC risk score greater than 2.0 and less than 3.0 for beneficiaries eligible due to age or disability (0.24 to 0.35 for beneficiaries eligible due to

[51] For more details on the beneficiary alignment procedures, see Appendix B in the Global and Professional Direct Contracting Model Financial Operating Guide: Overview.

[52] Global and Professional Direct Contracting Model Financial Operating Guide: Overview. Appendix B. Table B.6.4 "Specialty Codes Used to Identify Primary Care Specialists."

[53] Global and Professional Direct Contracting Model Financial Operating Guide: Overview. Appendix B. Table B.6.5 "Specialty Codes Used to Identify Selected Non-Primary Care Specialists."

[54] We did not use the model's eligibility criteria of "reside in a county that is included in the DCE service areas" because we defined the DCE market area for the evaluation as a collection of HRRs, which are based on ZIP code, rather than using a county-based definition. We used HRR because HRR is a larger geographic area than county, which allows us to minimize the thread of spillover, which might mitigate any impacts of the GPDC Model.

[55] Global and Professional Direct Contracting Model Financial Operating Guide: Overview. Appendix B. Table B.6.1 "Mobility Impairment ICD-10 Codes for High Needs Population DCEs".

ESRD) *and* two or more unplanned hospital admissions in the previous 12 months; or 4) demonstrated signs of frailty based on claims.[56] Once a beneficiary met the High Needs eligibility criteria and was aligned to a DCE, that beneficiary was considered High Needs eligible for the remaining performance years as long as the beneficiary was alignment-eligible for the GPDC Model in general. We used this same logic to determine our analytic sample of beneficiaries for High Needs DCEs.

Step 3: Pull primary care qualified evaluation and management (PQEM) claims furnished by alignment-eligible providers during the alignment period and calculate weighted charges

We pulled all carrier and outpatient claims with PQEM services (identified by HCPCS codes)[57] provided by alignment-eligible providers for the two-year alignment period (**Exhibit H.4**).[58] Provider specialty was determined by line specialty codes for carrier claims and Medicare Provider Enrollment, Chain, and Ownership System (PECOS) or National Plan and Provider Enumeration System (NPPES) database for outpatient claims based on the provider NPI. In the case of claims furnished by FQHCs or RHCs, all services were considered as primary care services (that is, not restricted to those furnished by alignment-eligible providers). We linked the DCE Participant Provider file and flagged claims furnished by DCE and non-DCE alignment-eligible providers (**Exhibit H.5**). Beneficiaries with no paid claims for PQEM services during the two-year alignment period were eliminated from further consideration for claims-based alignment. Weighted allowable charges on paid PQEM services were calculated for each beneficiary during the alignment period.[59]

Exhibit H.4. Alignment Period for Performance Years (PYs) and Baseline Years (BYs)

Cohort	BY/PY	Period	Alignment Year One	Alignment Year Two
2021	BY	CY 2018	7/1/2015–6/30/2016	7/1/2016–6/30/2017
2021	BY	CY 2019	7/1/2016–6/30/2017	7/1/2017–6/30/2018
2021	BY	CY 2020	7/1/2017–6/30/2018	7/1/2018–6/30/2019
2021	PY2021	CY 2021	7/1/2018–6/30/2019	7/1/2019–6/30/2020
2021	PY2022	CY 2022	7/1/2019–6/30/2020	7/1/2020–6/30/2021
2022	BY	CY 2019	7/1/2016–6/30/2017	7/1/2017–6/30/2018
2022	BY	CY 2020	7/1/2017–6/30/2018	7/1/2018–6/30/2019

[56] Global and Professional Direct Contracting Model Financial Operating Guide: Overview. Appendix B. Table B.6.2 "Frailty codes used to Determine Eligibility for Alignment to a High Needs Population DCE."

[57] Global and Professional Direct Contracting Model Financial Operating Guide: Overview. Appendix B. Table B.6.3 "Evaluation & Management Services."

[58] Global and Professional Direct Contracting Model Financial Operating Guide: Overview. Appendix B. Table B.2.1 "Alignment Years for Each Performance Year and Base Year."

[59] Weighted Allowable Charges: Global and Professional Direct Contracting Model Financial Operating Guide: Overview. Appendix B.2.2 Claim-Based Alignment Process. The allowable charge for PQEM Services provided during the first (earlier) alignment year will be weighted by a factor of one-third. The allowable charge for PQEM Services provided during the second (later, or more recent) alignment year will be weighted by a factor of two-thirds.

Cohort	BY/PY	Period	Alignment Year One	Alignment Year Two
2022	BY	CY 2021	7/1/2018–6/30/2019	7/1/2019–6/30/2020
2022	PY2022	CY 2022	7/1/2019–6/30/2020	7/1/2020–6/30/2021

NOTES: BY=baseline year; PY=performance year; CY=calendar year.

Step 4: Align eligible beneficiaries based on plurality of PQEM services

Alignment-eligible beneficiaries were aligned to a DCE or comparison group based on which entity provided the plurality of the PQEM services to the beneficiary over the two-year alignment period (**Exhibit H.5**). We summed the weighted allowable charges of PQEM services for each beneficiary at each DCE and non-DCE practice/facility (that is, TIN/CCNs that were not GPDC DCE Participant or Preferred Providers) provided by primary care providers or by selected non-primary care specialists over the two-year alignment period and determined the percent of the charges for PQEM services provided by primary care providers. Beneficiaries were aligned to the DCE or non-DCE practice/facility based on the two-track algorithm[60] and tie-breaker rules[61] of the Innovation Center's GPDC payment analysis and operational support contractor's alignment algorithm.

We aligned beneficiaries either to a DCE through their participant NPIs or CCNs (for FQHCs and RHCs), or to a non-DCE TIN/CCN, to determine the DCE and comparison groups, respectively. This approach allowed us to align an adequate number of beneficiaries in baseline years while not aligning many additional beneficiaries in the performance year beyond the model's list of prospectively aligned beneficiaries.

Exhibit H.5. Identification and Aggregation of PQEM Claims in Evaluation's Alignment Approach

	Identification of PQEM claims (Step 3)		Aggregation of PQEM claims (Step 4)	
	DCE group	Comparison group	DCE group	Comparison group
Evaluation's Alignment Approach	DCE participant NPIs/participant CCN for FQHCs/RHCs	Non-participant alignment-eligible NPIs/non-participant CCN for FQHCs/RHCs	Each DCE as one group	Non-DCE TIN/CCN

NOTES: DCE=Direct Contracting Entity; PQEM=primary care qualified evaluation and management; NPI=national provider identifier; CCN=CMS certification number; TIN=taxpayer identification number; FQHC=federally qualified health center; RHC=rural health clinic.

Step 5: Add prospective voluntarily aligned beneficiaries and drop Prospective Plus voluntarily aligned beneficiaries (GPDC group in PY only)

We included all prospective voluntarily aligned beneficiaries to DCEs in our analysis. Voluntary alignment (VA) was given precedence over claims-based alignment. For instance, if a beneficiary was claims-aligned to a non-

[60] Two-Track Algorithm: Global and Professional Direct Contracting Model Financial Operating Guide: Overview. Appendix B.2.2 Claim-Based Alignment Process. If 10% or more of the charges were provided by primary care providers, then beneficiaries were aligned to the DCE or non-DCE practice/facility based on which entity was responsible for the most weighted allowable charges of PQEM services provided by primary care providers; otherwise beneficiaries were aligned based on who was responsible for the most weighted allowable charges of PQEM services provided by selected non-primary care specialists.

[61] Tie-Breaker Rules: Global and Professional Direct Contracting Model Financial Operating Guide: Overview. Appendix B.2.2 Claim-Based Alignment Process. If there was a tie, then alignment was based on who provided the most recent PQEM service to the beneficiary during the two-year alignment period. A beneficiary was considered unaligned if there was still a tie when using the most recent PQEM service date.

DCE provider (defined as a primary care specialist or selected non-primary care specialist who was not a Participant or Preferred Provider for any GPDC DCE in the PY), but was voluntarily aligned to a DCE, then this beneficiary was added to the DCE voluntarily selected by the beneficiary and removed from the comparison group. We excluded Prospective Plus voluntarily aligned beneficiaries within a given PY from the GPDC group because their alignment process was not replicable either in the comparison group or in the GPDC group for the baseline period. We discuss this further in the subsection below titled "Voluntary alignment (VA)."

Step 6: Check the evaluation's alignment match rate with the model's operational list of prospectively aligned beneficiaries (GPDC group in PY only)

We checked the match rate between the evaluation's list of aligned GPDC beneficiaries (claims-aligned and prospective voluntarily aligned beneficiaries) and the list of aligned beneficiaries used for model operations by calculating the percentage of beneficiaries who appeared on both files out of those who appeared on each file individually. The match rate for each DCE type is shown in **Exhibit H.6**.[62] For all three DCEs types the evaluation captured 99.6% of the beneficiaries determined by model operations as prospectively aligned in PY2022; **Exhibit H.6 Column A**. This was akin to the match rate in PY2021 of 99.4%. The exclusion of Prospective Plus voluntarily aligned beneficiaries influenced High Needs and New Entrant DCEs who had larger proportions of such beneficiaries as determined by model operations, to a greater degree than Standard DCEs; **Exhibit H.6 Column B**. Only one New Entrant DCE lacked an adequate baseline because there were not enough beneficiaries aligned to the Participant Provider NPIs during the base year alignment period. There were no Standard or High Needs DCEs that lacked an adequate baseline.

Exhibit H.6. PY2022 Match Rate with Model Operations and Baseline Assessment, by DCE Type

	Column A % of evaluation's aligned beneficiaries matched against the model's operational list of prospectively aligned beneficiaries	Column B % of model's aligned beneficiaries (both prospective and Prospective Plus) matched against the evaluation's list of aligned beneficiaries
Standard DCEs	99.6%	90.5%
New Entrant DCEs	99.6%	86.2%
High Needs DCEs	98.6%	70.5%

NOTES: DCE=Direct Contracting Entity.

Step 7: Exclude beneficiaries and determine the ending date for alignment

We ended the alignment of an aligned DCE or comparison group beneficiary once they were not alignment-eligible based on the model exclusion criteria. A beneficiary was aligned to a DCE or comparison group for all months of the reference year until they met any of the following criteria: death, loss of Medicare Part A or Part B coverage, transition to MA or other managed care, residence in non-U.S. locations, or having Medicare as a

[62] We observed a lower match rate among our list of aligned beneficiaries because we used NPI alignment, which aligned more beneficiaries to the model and allowed us to capture beneficiaries in baseline years.

secondary payer.[63] For the PY DCE group only, a beneficiary also lost alignment eligibility and was excluded from the analytic sample if enrolled in other APMs that took precedence over GPDC for beneficiary alignment per the GPDC Financial Operating Guide.[64] We used both claims and model operational data (for the GPDC group in the PY only) to determine the date of alignment ending based on the earliest date of exclusions due to the above reasons or the last day of the year if a beneficiary was not excluded for any reason. For each BY/PY, a beneficiary was aligned to the DCE or comparison group from the first day of the year to the alignment end date. We specifically excluded beneficiaries in statewide health care transformation models (Vermont All-Payer ACO Model, Maryland Total Cost of Care Model) from all groups to remove any effects these regional models would have on mitigating estimated impacts of the GPDC Model.

Modifications to the Model's Alignment Logic. In addition, to replicate the alignment process using the model's logic, we also made three modifications, to define the GPDC group for the evaluation, as follows.

Identification and aggregation of PQEM claims. As mentioned in earlier steps, we used Participant Provider/non-Participant Provider alignment-eligible NPIs to identify PQEM claims furnished by GPDC or non-GPDC providers. This approach allowed us to establish an adequate baseline for all but two Standard and New Entrant DCEs. After identifying PQEM claims through NPIs, we aggregated total allowable PQEM charges to each DCE[65] or each non-GPDC practice[66] to align beneficiaries to GPDC and comparison group, respectively. We discuss this further in the following section "GPDC and Comparison Group Providers Used to Determine Beneficiary Alignment."

Identification of alignment-eligible beneficiaries. Several exclusions on eligibility were applied to beneficiary alignment for both the treatment and comparison groups. For our analyses, alignment-eligible beneficiaries at the beginning of a PY or BY must be living; be enrolled in both Medicare Parts A and B, without MA or other managed care; have Medicare as the primary payer; and be a U.S. resident. As described above, alignment-eligible beneficiaries for High Needs DCEs also had to meet at least one of four additional criteria indicating need based on mobility, risk score, utilization, and frailty. We did not apply the model's logic to require beneficiaries to reside in a county included in the DCE's service area because a small geographic area may pose larger spillover effect (that is, comparison beneficiaries receiving care from GPDC providers). Instead, we defined a DCE's market area as the collection of HRRs in which the majority of aligned DCE beneficiaries reside. We limited our analytic sample for both GPDC and comparison groups in the baseline and performance years to the identified market area for each DCE, to eliminate the risk of exogenous time-varying differences that cannot be

[63] We did not include the criteria for "reside in a county that is included in the DCE service areas" and defined DCE market area as a collection of HRRs because choosing a large geographic area to define the market would allow us to minimize the thread of spillover, which might downward bias results.

[64] Global and Professional Direct Contracting Model Financial Operating Guide: Overview. Appendix B. Table B.6.6 "Initiatives for Which Beneficiary Overlap with GPDC Is Prohibited."

[65] As each DCE includes a range of practices or sets of providers, this set pools all PQEM charges across Participating Providers affiliated within each DCE.

[66] Non-GPDC practices were defined as TINs and CCNs because an alternative organization of NPIs was unknown. Charges were pooled across all providers that contributed towards alignment for each comparison group practice TIN or CCN.

captured by the DID model. Although our definition of DCE market area comprises a larger geographic area than that used in the model's logic, it would cover the model's DCE service area identified by counties because each DCE's market area was assessed using the matched sample between the model's operational list and our list of aligned beneficiaries. We discuss this further in the subsection below titled "GPDC Market Areas for Evaluation of the GPDC Model."

Voluntary alignment (VA). VA is an intervention feature only available in the performance year for GPDC DCEs and indicates beneficiaries who designate a qualifying DCE Participant Provider as their primary source of care. We identified prospective VA beneficiaries from the model's operational list, using this list as a reference for comparing with claims-aligned beneficiaries. Because VA strategies will vary by individual DCEs, the process cannot be replicated on claims, which is not a problem for prospective VA beneficiaries who are also claims-aligned. To accommodate beneficiaries who are not claims-aligned, we allowed prospective VA to take precedence over claims alignment for GPDC DCEs, consistent with the model's alignment rules. In future reports, we will descriptively examine how VA-only beneficiaries' demographic characteristics, overall health status (for example, prevalence of chronic conditions), and health care utilization differ from claims-aligned beneficiaries in the performance year.

For the evaluation, we included GPDC DCE beneficiaries prospectively aligned to DCE providers by either claims alignment or VA at the start of PY, but excluded Prospective Plus VA beneficiaries[67] from the GPDC group because Prospective Plus VA beneficiaries may substantively differ from other prospectively aligned beneficiaries (either through claims alignment or VA) in the type of partial years they contribute to the study. First, Prospective Plus VA beneficiaries could never be aligned for the entire performance year because their alignment did not start at the beginning of the PY. Second, the year-end partial years for the Prospective Plus VA beneficiaries would systematically differ from the early-year partial years for claims-aligned and prospective VA beneficiaries, even if they aligned to the GPDC group for the same length of time (for example, Prospective Plus VA beneficiaries aligned between 7/1/2022 and 12/31/2022 versus prospective VA beneficiaries aligned between 1/1/2022 and 6/30/2022). Therefore, inclusion of Prospective Plus VA beneficiaries would potentially exacerbate imbalance between the GPDC and comparison groups, as well as the imbalance between the GPDC PY and the GPDC BY groups, because comparison beneficiaries and GPDC beneficiaries in the baseline were only claims-aligned effective at the beginning of BY or PY.

This approach allowed us to assess the impact of the GPDC DCEs on their prospectively claims- and voluntarily-aligned populations, relative to the comparison group's prospectively claims-aligned population, although it excludes the small proportion of Prospective Plus VA beneficiaries (3.3% in PY2022, 3.8% in PY2021: across all DCEs) and does not capture the full scale of impacts from Prospective Plus VA for GPDC DCEs. Consistent with the model's financial methodology and with our approach to identifying the comparison group, we limited the baseline treatment group to only claims-aligned beneficiaries. To ensure comparability in key covariates among

[67] Prospective Plus VA beneficiaries are prospectively aligned to a DCE Participant Provider in the second, third, and fourth calendar quarters of the performance year, either electronically or via the paper-based VA form. This differs from prospective VA beneficiaries who are aligned *prior to the performance year* and are aligned for the entire performance year.

these groups, we weighted the comparison group in baseline and performance years and the GPDC group in the baseline years (claims-aligned only) to resemble the GPDC performance year (claims-aligned and prospective VA beneficiaries) using entropy balancing, as detailed below. We used this approach to weighting groups because prospective VA beneficiaries were included in the GPDC group in the performance years, while VA was not an option either for the GPDC group in the baseline years or for the comparison group.

GPDC and Comparison Group Providers Used to Determine Beneficiary Alignment

Our primary approach for identifying GPDC DCE beneficiaries in the performance year was via claims-based and prospective VA to DCE Participant Providers in the performance year. We employed the same strategy to construct treatment and comparison groups across all GPDC DCE types using a claims-based approach. We expect DCEs to change their mix of Participant Providers across performance years by adding and dropping providers. Therefore, we created a unique baseline corresponding to the PY to ensure the baseline and performance years consist of beneficiaries aligned to the same panel of Participant Providers that participated in the respective performance year. Specifically, we identified PY Participant Providers in the corresponding baseline years. Beneficiaries aligned to these providers in the baseline years comprised the baseline treatment group.

We aligned eligible Medicare beneficiaries to a DCE through either claims-based alignment (described above) or VA (aligned beneficiaries designating a qualifying DCE Participant Provider as their primary source of care), with preference for VA, as applicable. Beneficiaries were aligned to DCEs until the end of the year or until they became ineligible based on the alignment eligibility rules described above (see "**Step 2: Identify alignment-eligible beneficiaries**" above).

Different from the model's alignment logic of identifying Participant Providers via TIN-NPI combination and aligning beneficiaries based on DCE TINs or CCNs (see **Exhibit H.5** and **Exhibit H.6**), we defined Participant Providers as NPIs and aligned beneficiaries to each DCE as one group (that is, group of Participant Providers) for two reasons. First, it may comprehensively capture their baseline, wherein some TIN-NPI combinations from the PY may not be present in baseline years. Second, it approximates the model's alignment approach in the PY where GPDC Participant Providers collaborate collectively.[68] A limitation of aligning beneficiaries to the group of GPDC DCE NPIs in the baseline years is that they could also bill visits to non-GPDC TINs, and this approach would consider those claims as furnished by GPDC providers. [69] The upside of this approach is that it gives us a more comprehensive pool of beneficiaries in the baseline years who were prospectively claims-aligned to the group of GPDC DCE NPIs. Thereby we reasonably assess the incremental effect of the GPDC model on total spending and other outcomes for its participant providers' aligned beneficiary populations, relative to a comparison group.

[68] When defining GPDC Participant Providers by NPIs and then aligning beneficiaries based on DCE TINs, we would still need to use TIN-NPI combinations. This may cause issues in the baseline years (see **Exhibits H.5** and **H.6**) and the alignment would be either through individual NPI or individual DCE as one group. Between these two options, aligning beneficiaries to an individual DCE as one group better reflects that GPDC participant providers collaborate collectively.

[69] This limitation only applies to the baseline years because our evaluation sample in the performance years included evaluation's aligned beneficiaries who were also model-aligned.

Comparison beneficiaries were aligned to non-GPDC practices (defined as TINs and CCNs because an alternative organization of NPIs was unknown) through their alignment-eligible practitioners (defined by NPIs; see **Exhibit H.5**). As mentioned earlier, because a NPI can bill under both GPDC TIN/CCN and non-GPDC TIN/CCN, we further removed comparison beneficiaries aligned to GPDC Participant or Preferred Provider TINs/CCNs after alignment and comparison beneficiaries aligned to NPIs who participated in a DCE that left the program in 2021. We considered comparison providers as a pool of alignment-eligible non-GPDC NPIs billed under non-GPDC TINs/CCNs who furnished at least one PQEM claim to aligned comparison beneficiaries in the PY and used this group of providers to align comparison beneficiaries in the baseline years. Comparison group providers could have been in FFS alone or in Medicare ACO initiatives like Next Generation ACO (NGACO) or the Shared Savings Program; ESRD-focused ACO initiatives like Comprehensive ESRD Care (CEC) or Kidney Care Choices (KCC); or primary care initiatives like Comprehensive Primary Care Plus (CPC+) or Primary Care First (PCF). Beneficiaries aligned to comparison providers were further limited to GPDC DCE market areas (see subsection below titled "GPDC Market Areas for Evaluation of the GPDC Model") and sampled within the HRR for each BY or PY (see subsection below titled "Sampling Comparison Beneficiaries from GPDC Markets").

We recognize that GPDC DCE and non-GPDC providers may differ on observed or unobserved characteristics that motivate the former group to organize into DCEs. Accordingly, in future reports, we will characterize providers based on several variables, including Medicare FFS, MA, and ACO experience; health system affiliation; and participation in other Innovation Center initiatives. We did not control for differences in provider characteristics in our estimation of the GPDC Model's impact, because these characteristics could potentially be mediators, or moderators, or even time-varying confounders. We account for time-invariant differences between DCE and comparison providers though the DCE fixed effect in our DID regression models.

GPDC Market Areas for Evaluation of the GPDC Model

Our approach of drawing DCEs and comparison groups from the same market areas recognizes the dynamic nature of these entities, with changes possible in their markets from one PY to the next. It is important that DCE and comparison groups be drawn from the same markets so that they are exposed in similar ways to key time-varying market factors that influence outcomes, such as provider supply and competition, overlapping area-level Innovation Center initiatives, and widespread shocks to the market, such as the COVID-19 public health emergency (PHE).

We examined the geographic distribution of providers and beneficiaries for each DCE and across DCE type, cohort, and model, to identify the markets in which DCEs operate and determine if comparison groups can be drawn from the same markets. We defined a DCE's market area as the HRR(s) in which a meaningful percentage (1% or more) of its aligned beneficiaries reside.[70] We chose this threshold as it allowed us to capture the majority of a DCE's aligned beneficiaries while offering a sizable comparison group. This method allowed us to

[70] We extended the market area to HRRs with at least 0.5% of DCE's aligned beneficiaries for six DCEs and use 1% criteria for all other DCEs.

capture more than 90% of each DCE's aligned beneficiaries (average 97% for each DCE, ranging from 91% to 99%).

Comparison group beneficiaries in the same HRRs as DCEs may receive care from DCE providers (direct spillover) or may become GPDC beneficiaries in future years. Recognizing this, we quantified the extent of direct spillover from the comparison group for each DCE in both the performance and baseline years (for example, proportions of comparison beneficiaries' Medicare spending or PQEM visits from GPDC providers) in **Appendix K**. We will conduct sensitivity analyses in future reports to assess how spillover affects our impact estimates.[71]

Sampling Comparison Beneficiaries from GPDC Markets

Due to the large geographic areas that HRRs cover, including *all* non-GPDC DCE beneficiaries in each DCE's comparison group was computationally challenging due to large file sizes. To ensure computational feasibility, we reduced the size of the final comparison group prior to conducting entropy balancing by choosing a random sample of comparison beneficiaries aligned to non-DCE providers in the DCE HRRs. We randomly selected 10 comparison beneficiaries for each GPDC DCE-aligned beneficiary in the HRR in order to have enough beneficiaries to balance the groups while maintaining computationally feasible for our complex analysis. In HRRs where the ratio of comparison beneficiaries to GPDC DCE-aligned beneficiaries was less than 10:1, all comparison beneficiaries in the HRR were included in the comparison group.[72]

We used simple random sampling with replacement to ensure that each beneficiary had equal probability to be selected in the sample.[73] Each HRR-DCE-reference year combination was sampled separately to keep these strata mutually exclusive. Because we conducted DCE-level analyses and estimated impacts for each DCE separately, sampling the comparison group in each market reflected the markets in which the DCEs were operating. Thus, selecting the comparison beneficiaries independently (without removing overlapping beneficiaries) for each DCE is an appropriate theoretical approach. In PY2022, when sampling the comparison group with replacement for each DCE, we observed approximately 29% to 32% of comparison beneficiaries overlapping across DCEs in each baseline or performance year. The corresponding share in PY2021 was 6% to 7%. However, each DCE-level impact estimate is independent in the pooled analyses because the comparison group is sampled independently for each DCE from all available comparison beneficiaries in its markets.

Outcomes for GPDC and comparison group-aligned beneficiaries in a given year reflect the performance of GPDC DCE and comparison providers in that specific year, respectively. Beneficiaries in our study can be aligned to GPDC providers in a year, and to comparison providers in the following year, and vice versa. We expect

[71] In this sensitivity check, we will estimate the GPDC Model's impact on Medicare spending after excluding beneficiaries from the comparison group receiving the majority of their care from GPDC providers in the performance year. If there are favorable effects from direct spillover of the GPDC Model, the model's impacts would become larger after excluding beneficiaries experiencing direct spillovers from the comparison group.

[72] This occurred in 186 HRRs across all PY2022 Standard and New Entrant DCEs.

[73] We successfully used a similar sampling approach in the Vermont All-Payer ACO Model evaluation to create a comparison group of manageable size. See the VT All-Payer ACO Model – Second Evaluation Report Appendices for more details on that approach.

beneficiaries to switch groups during the model, or between the baseline and performance years, based on how they seek care from providers, as well as providers entering and exiting the model. Our evaluation design accommodates this common occurrence in FFS Medicare where beneficiaries have freedom to seek care without restrictions among Medicare FFS providers. It is also consistent with how DCEs have financial responsibility to manage their prospectively aligned populations based on the set of providers participating in a given performance year.[74]

H.1.2. Entropy Balancing

The following sections describe how entropy balancing (EB) was used in the evaluation, including our rationale for using EB, our approach to EB, variables used in EB, and the results from EB for Standard, New Entrant, and High Needs DCEs.

Rationale. Beneficiaries in the GPDC Model may be systematically different from those in comparison groups due to observed and unobserved differences in characteristics of beneficiaries or of providers to whom they are aligned. Our DID evaluation design accounts for time-invariant differences between the two groups (that is, characteristics that do not change over time, such as location, whether observable or unobservable). However, DID does not account for differences that may be time-varying (for example, if the composition of the treatment and comparison groups differentially change over time).

We conducted EB to ensure the comparability of baseline and comparison beneficiaries in our analytic sample with PY GPDC beneficiaries. We ruled out more traditional propensity score (PS) approaches for balancing covariates (for example, regression, generalized boosted models, covariate balancing propensity methods) because slight misspecifications of the PS model can bias treatment effects. Instead, we used EB because it bypasses the propensity score estimation by using a maximum entropy reweighting scheme that directly incorporates covariate balance into the weight function. Thus, EB avoids both the iterative process of testing the PS model and the potential for misspecification.

The greatest advantage in using EB is that, unlike other weighting methods including covariate balancing propensity scores, ensuring balance between groups is the primary objective of the model. Researchers can specify the desired balance on first, second, or third moments (that is, mean, variance, or skewness) for each covariate between treatment and comparison groups. The EB method also reweights units smoothly to achieve balance so that the weights will be as close as possible to the base weights (one for every unit in unweighted sample), so that as much information as possible can be retained.

[74] Additionally, DCEs may change type (Standard, New Entrant, High Needs) from PY to PY, for example, as the size and characteristics of their beneficiary population change. For DCEs that changed type from PY2021 to PY2022, they were assigned to the DCE type they were in for the respective PY for the purpose of analysis. We continued to define the baseline period for these DCEs as the three years prior to starting the model (that is, DCEs in the 2021 cohort that switched type in PY2022 will continue to have 2018-2020 as their BYs).

Approach. We used the Stata package *ebalance* to employ the entropy balancing method.[75] For the DID design there are **four** groups to consider:

1) GPDC beneficiaries in the performance year (includes voluntarily aligned and claims-aligned beneficiaries; reference group)
2) GPDC beneficiaries in the baseline years (includes claims-aligned beneficiaries only)
3) Comparison beneficiaries in the performance year (claims-aligned beneficiaries only)
4) Comparison beneficiaries in the baseline years (claims-aligned beneficiaries only)

Because voluntarily aligned beneficiaries exist only in the PY GPDC group, we used that group as a reference and weighted beneficiaries in each year and treatment/comparison group combination to be similar to those beneficiaries. As the beneficiary populations served by GPDC and non-GPDC providers may change over time, this approach helps to ensure balance or comparability across all four groups and performance years. We used this approach for Standard and New Entrant DCEs; however, due to the small sample size of High Needs DCEs, we instead pooled each DCE's treatment group across the three baseline years and weighted the pooled baseline to be similar to the PY GPDC group.

We checked the balance between the treatment group in the baseline and performance years to subsequently weight the baseline treatment group to be balanced with the performance year treatment group, recognizing that there might be differences because VA is allowed in the performance year but not in the baseline. The comparison group in the baseline and performance years was also balanced with the treatment group in the performance year. We internally examined whether weighting the groups similarly in the baseline and performance periods after dropping VA beneficiaries made a difference—results were largely similar for Standard DCEs, while differences in results for New Entrant DCEs stemmed from the exclusion of VA beneficiaries.

Exhibit H.7 provides the total number of unweighted beneficiaries included in our entropy balancing models for Standard, New Entrant, and High Needs DCEs by GPDC or comparison group in the performance and baseline years, as well as the distribution of voluntarily aligned beneficiaries in the performance year GPDC group. The comparison group includes Medicare FFS beneficiaries who were aligned to comparison providers using the GPDC alignment algorithm and resided in the same market as the DCE (that is, a collection of HRRs that comprises at least 1% of aligned GPDC beneficiaries). Because we aimed to sample 10 comparison beneficiaries for each GPDC beneficiary, the size of the comparison group is about 10 times that of the GPDC group.

[75] Hainmueller J, Xu Y. "ebalance: A Stata package for entropy balancing," *Journal of Statistical Software* 2013;1(54):7.

Exhibit H.7. Distribution of Beneficiaries in Standard, New Entrant, and High Needs DCEs

	PY2022				BYs for 2021 Cohort: 2018–2020 2022 Cohort: 2019–2021	
	GPDC Group			Comparison Group	GPDC Group	Comparison Group
	Total	% of Voluntarily Aligned Beneficiaries	% of Beneficiaries Aligned through VA Only	Total	Total	Total
Standard DCEs	1,630,368	3.62%	0.70%	11,359,553	5,588,703	39,327,159
2021 Cohort	595,328	6.86%	1.53%	5,208,732	2,072,977	18,397,953
2022 Cohort	1,035,040	1.75%	0.22%	6,150,821	3,515,726	20,929,206
New Entrant DCEs	34,597	50.82%	21.45%	320,290	99,340	984,357
2021 Cohort	24,319	45.51%	22.08%	242,946	65,250	650,919
2022 Cohort	10,278	63.39%	19.96%	77,344	34,090	333,438
High Needs DCEs	5,775	5.56%	2.34%	58,195	15,328	153,097
2021 Cohort	3,475	7.11%	2.99%	34,785	9,718	97,057
2022 Cohort	2,300	3.22%	1.35%	23,410	5,610	56,040

NOTES: One New Entrant DCE (D0013) was excluded from analysis due to having insufficient data in the BYs. BYs comprised 2018–2020 for the 2021 Cohort and 2019–2021 for the 2022 Cohort. GPDC=Global and Professional Direct Contracting. DCE=Direct Contracting Entity; VA=voluntary alignment.

Variables Selected for Entropy Balancing. We created variables for each baseline year and performance year. The variables we used in our EB models fell into the following domains (**Appendix G** gives a complete list of all variables included in EB models):

- **Demographics** (beneficiary-level). Beneficiaries' health care needs may vary by demographic characteristics. Depending on the outcome measured, demographic characteristics may reflect determinants of health (factors that drive the outcome), confounders (factors that affect both the exposure and outcome, thereby causing a spurious association), or effect modifiers (factors that change the association between the exposure and outcome).
- **Clinical** (beneficiary-level). Beneficiaries' clinical characteristics and number of chronic conditions will drive cost and utilization patterns. A beneficiary's chronic conditions and disease burden will typically be associated with their level and intensity of health care spending and utilization during the year.
- **Market** (ZIP code tabulation area-/ZIP code-/county-level). Access to health care services and providers, as well as social determinants of health (SDOH), vary across regions, affecting beneficiary access to care and, potentially, health outcomes.

Results. In all cases for all DCE types, EB brought imbalanced variables closer to the PY2022 GPDC group and achieved <0.015 standardized differences between the treatment and weighted comparison group for all variables, representing little to no differences between the groups after balancing. This was akin to the excellent

balance between the groups noted in PY2021 after EB.[76] The following exhibits show the covariate balance before and after EB for Standard (**Exhibit H.8**), New Entrant (**Exhibit H.9**), and High Needs (**Exhibit H.10**) DCEs. In each exhibit, three comparisons are shown, with PY2022 GPDC group as the comparator in each:

- PY2022 GPDC group vs. PY2022 comparison group
- PY2022 GPDC group vs. Baseline GPDC group
- PY2022 GPDC group vs. Baseline comparison group

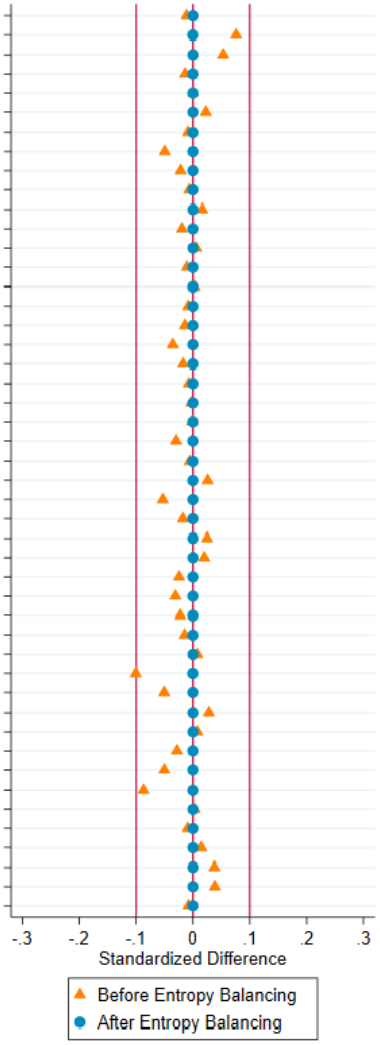
The exhibits show the standardized difference in covariates between the comparator (PY2022 GPDC group) and other group before EB (orange triangle) and after EB (blue dot). The red lines present cut-off values for ±0.1 standardized differences, a threshold that is commonly used in assessing variable balance. If the dots fall within two red lines, it indicates well-balanced covariates between two groups.

[76] NORC at the University of Chicago "Annual Report 1: Appendices. Evaluation of the Global and Professional Direct Contracting Model"

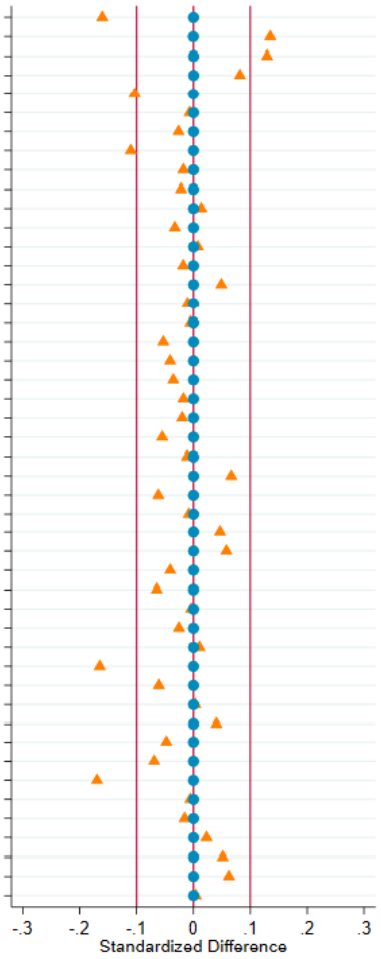
Exhibit H.8. Standard DCEs—Covariate Balance Before and After Entropy Balancing

PY2022 GPDC vs PY2022 Comparison

PY2022 GPDC vs Baseline GPDC



PY2022 GPDC vs Baseline Comparison



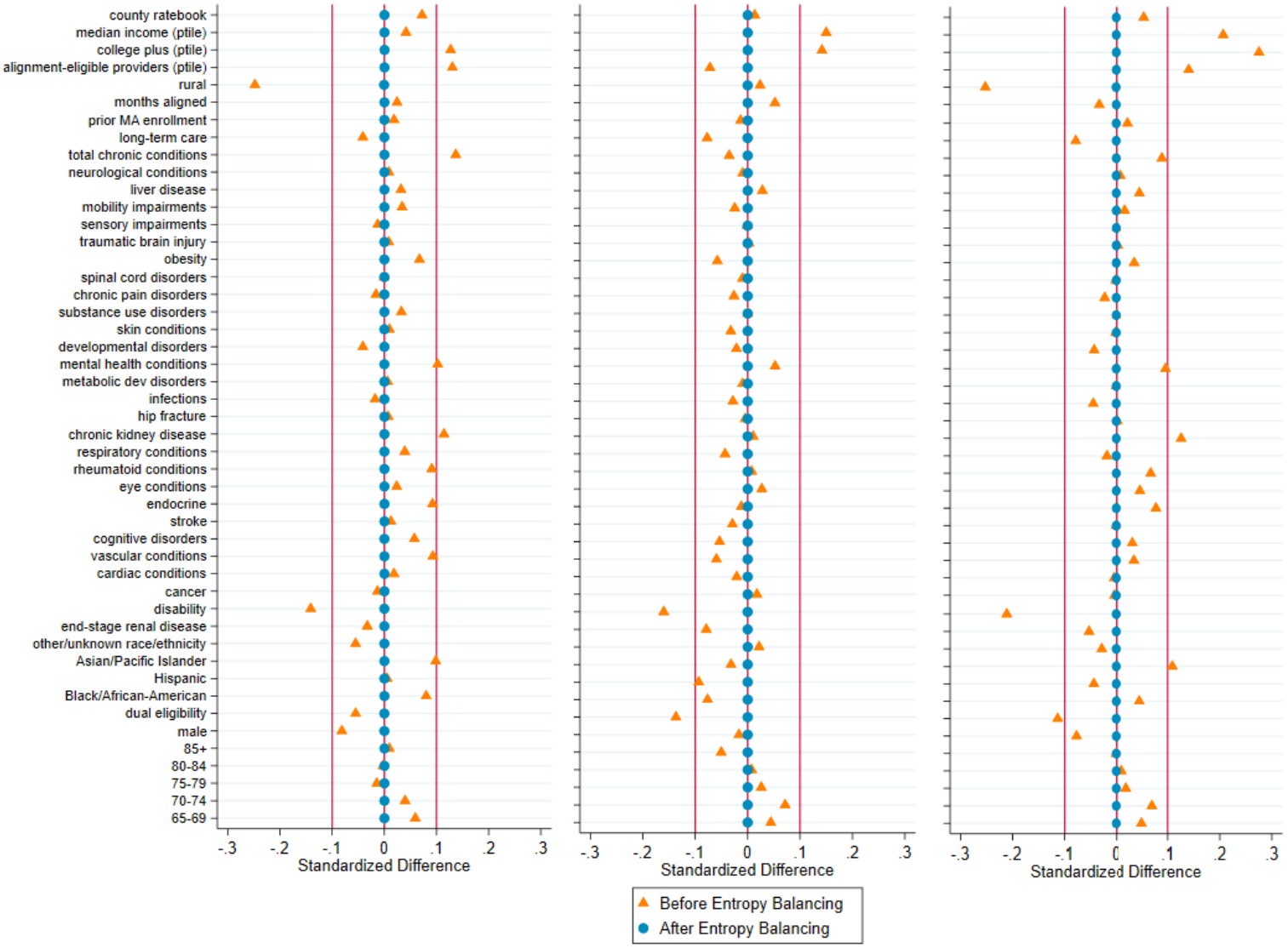
SOURCE: NORC analysis of Medicare demographic, clinical, and market data.

Exhibit H.9. New Entrant DCEs—Covariate Balance Before and After Entropy Balancing

PY2022 GPDC vs PY2022 Comparison

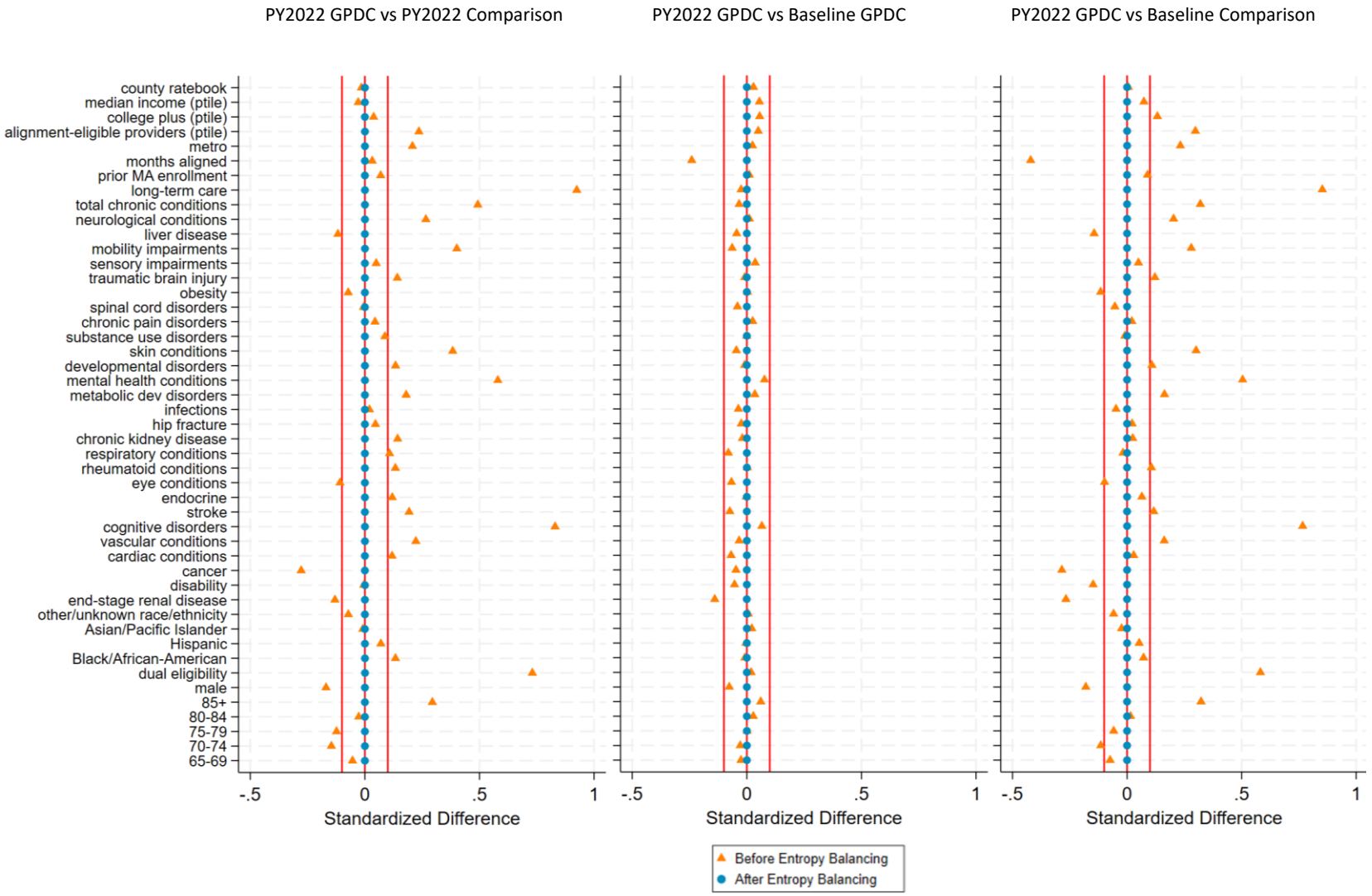
PY2022 GPDC vs Baseline GPDC

PY2022 GPDC vs Baseline Comparison



SOURCE: NORC analysis of Medicare demographic, clinical, and market data.

Exhibit H.10. High Needs DCEs—Covariate Balancing



SOURCE: NORC analysis of Medicare demographic, clinical, and market data.

H.2: Analytic Approach for Descriptive Analyses

For all three DCE types, we assessed descriptive characteristics of beneficiaries aligned to DCEs in PY2021–2022 and as of PY2022 (**Exhibits H.11** through **H.13**), including beneficiaries' demographic characteristics, enrollment/coverage information, clinical characteristics, and community characteristics. We used percentages to describe categorial and dichotomous variables and used means and standard deviations to describe continuous variables. Additionally, we assessed overlap with other alternative payment models, receipt of beneficiary care for COVID-19, and county-level COVID-19 infection rates, fatality rates, and vaccination status. For High Needs DCEs, we provide additional characteristics relevant to their status as High Needs beneficiaries in PY2021–2022 and as of PY2022, including common clinical conditions and criteria used to determine High Needs eligibility (for full eligibility criteria, see "Step 2: Identify alignment-eligible beneficiaries" in **Section H.1.1**),[77,78] including a claim-based index measuring beneficiary frailty.[79]

We also assessed descriptive characteristics for beneficiaries in the baseline period (2018–2020 for the 2021 Cohort and 2019–2021 for the 2022 Cohort) and comparison group (**Exhibits H.14** through **H.16**) to better understand the analytic populations used in our impact analyses. Differential change with significance level was also reported for each characteristic; differential change was calculated as the difference between GPDC and comparison groups from baseline years to performance year; significance level was based on the comparison between the differential changes and zero. As expected, after entropy balancing, beneficiary composition was very similar between the DCE and comparison groups (**Section H.1.2**).

We also descriptively assessed outcomes before regression adjustment for Standard, New Entrant, and High Needs DCEs (**Exhibits H.17** through **H.19**). Because these are descriptive analyses and do not account for differences between the GPDC and comparison groups on key sociodemographic, clinical, and market-level factors, we do not conduct statistical testing on differences between groups. Unadjusted estimates should not be interpreted as causal for the GPDC Model. Medicare spending categories do not sum to total Medicare spending due to differences in how the measures are defined; spending categories reflect what Medicare would have paid absent capitation, while total Medicare spending includes capitation.

Finally, as was noted in **Appendix G**, we did not include six measures in the impact estimation: primary care visits spending, PCP services, annual wellness visits, advance care planning, chronic care management for beneficiaries with multiple chronic conditions (MCC), and mortality. We descriptively assessed trends over time for the intervention group but did not include these measures in the impact analyses owing to their expected violations of the parallel trends test. Since we balanced the DCE and comparison groups on beneficiary characteristics but not provider characteristics, we expected the two groups—for many DCEs and comparators—to differ in their baseline trends for the first five outcomes

[77] Global and Professional Direct Contracting (GPDC) and Kidney Care Choices Models Risk Adjustment. Available at: https://innovation.cms.gov/media/document/gpdc-kcc-risk-adjustment.

[78] Global and Professional Direct Contracting Model Financial Operating Guide: Overview. Available at: https://www.cms.gov/priorities/innovation/media/document/gpdc-py2022-fin-op-guide-ovw.

[79] Kim DH, Schneeweiss S, Glynn RJ, Lipsitz LA, Rockwood K, Avorn J. Measuring frailty in Medicare data: development and validation of a claims-based frailty index. The Journals of Gerontology: Series A. 2018 Jun 14;73(7):980-7.

that are related to care processes. With regard to mortality, owing to the primary care focus of the GPDC Model, this outcome may be less under the control of DCEs and their providers. The trend graphs are presented in **Appendices J, K, and L**.

Exhibit H.11. Standard DCEs—Descriptive Characteristics of Beneficiaries Aligned in PY2021, PY2022, and as of PY2022

	GPDC (PY2021)	GPDC (PY2022)	GPDC (as of PY2022)
Number of beneficiaries	281,589	1,630,368	1,911,957
Total person-months	3,320,884	18,886,368	22,207,252
Months of alignment (mean ± SD)	11.8 ± 1.7	11.6 ± 1.1	11.6 ± 1.7
Demographics			
Age (mean ± SD)	74.5 ± 9.8	74.7 ± 10.0	74.7 ± 10.0
Sex (%)			
Female	56.9	57.0	57.0
Male	43.1	43.0	43.0
Race/Ethnicity (%)			
White	81.7	81.0	81.1
Black/African American	6.3	5.2	5.4
Hispanic	6.5	5.6	5.7
Asian/Pacific Islander	2.2	4.6	4.3
Other/Unknown	3.3	3.5	3.5
Health Care Coverage (%)			
Disabled with or without ESRD	7.8	7.9	7.8
Any dual eligibility	12.4	14.2	13.9
Any Part D coverage	76.2	77.1	77.0
Previously enrolled in MA	0.6	0.8	0.8
Clinical Characteristics			
Number of chronic conditions (mean ± SD)	6.1 ± 3.6	5.9 ± 3.6	5.9 ± 3.6
Endocrine conditions (%)	85.4	83.1	83.4
Vascular disease (%)	75.0	72.6	73.0
Rheumatoid conditions (%)	44.6	43.0	43.3
Eye conditions (%)	37.1	39.2	38.9
Cardiac conditions (%)	32.1	31.2	31.4
Behavioral health conditions (%)	29.7	29.0	29.1
Obesity (%)	25.5	22.8	23.2
Chronic pain disorders (%)	22.9	23.7	23.6
Respiratory conditions (%)	21.2	19.9	20.0
Had long-term care stay in prior year (%)	1.7	1.7	1.7
Prospective CMS-HCC Risk Score (mean ± SD)	1.2 ± 1.1	1.2 ± 1.1	1.2 ± 1.1
Community Characteristics			
Census Region (%)			
Northeast	21.1	15.3	16.2
Midwest	28.2	25.0	25.5

	GPDC (PY2021)	GPDC (PY2022)	GPDC (as of PY2022)
South	36.1	29.6	30.6
West	14.5	30.0	27.7
Rurality (%)			
Rural ZIP Code	3.5	6.3	5.9
Urban ZIP Code	96.5	93.7	94.1
Area Deprivation Index (ADI; %)			
Percent of aligned beneficiaries with ADI score of 1–25 (lowest socioeconomic disadvantage)	29.8	33.0	32.6
Percent of aligned beneficiaries with ADI score of 26–50	33.6	33.1	33.1
Percent of aligned beneficiaries with ADI score of 51–75	22.6	21.5	21.7
Percent of aligned beneficiaries with ADI score of 76–100 (highest socioeconomic disadvantage)	14.0	12.4	12.6
Percent of population living below the poverty line at ZCTA level (mean ± SD)	11.0 ± 6.8	10.7 ± 6.6	10.7 ± 6.6
Percent of population ages 25+ with a college degree at ZCTA level (mean ± SD)	35.7 ± 16.4	36.7 ± 17.1	36.6 ± 17.0
COVID-19 Beneficiary Care (%)			
Outpatient COVID-19 diagnosis	5.8	16.1	14.6
Acute care hospital admission for COVID-19 diagnosis	0.7	0.9	0.9
ICU admission for COVID-19 diagnosis	0.7	0.7	0.7
COVID-19 Community Characteristics			
COVID-19 case rate (mean ± SD)	29.5 ± 6.6	37.8 ± 8.3	36.6 ± 8.6
COVID-19 mortality rate (mean ± SD)	0.4 ± 0.2	0.2 ± 0.1	0.2 ± 0.1
COVID-19 case-fatality rate (mean ± SD)	1.7 ± 0.7	1.1 ± 0.4	1.2 ± 0.5
COVID-19 vaccination rate (mean ± SD)	38.9 ± 7.5	64.6 ± 11.3	60.8 ± 14.1
COVID-19 Community Vulnerability Index (mean ± SD)	0.6 ± 0.2	0.6 ± 0.2	0.6 ± 0.2

SOURCE: NORC analysis of Medicare enrollment, demographic, clinical, and market data.
NOTES: SD=standard deviation; ESRD=end-stage renal disease; MA=Medicare Advantage; HCC=Hierarchical Condition Category; ZCTA=ZIP Code Tabulation Area.

Exhibit H.12. New Entrant DCEs—Descriptive Characteristics of Beneficiaries Aligned in PY2021, PY2022, and as of PY2022

	GPDC (PY2021)	GPDC (PY2022)	GPDC (as of PY2022)
Number of beneficiaries	42,196	34,597	76,793
Total person-months	494,769	399,957	894,727
Months of alignment (mean ± SD)	11.7 ± 1.2	11.6 ± 1.8	11.7 ± 1.5
Demographics			
Age (mean ± SD)	74.5 ± 9.7	74.9 ± 9.3	74.7 ± 9.6
Sex (%)			
Female	59.4	60.0	59.7
Male	40.5	40.0	40.3
Race/Ethnicity (%)			

	GPDC (PY2021)	GPDC (PY2022)	GPDC (as of PY2022)
White	74.0	76.4	75.1
Black/African American	10.6	6.2	8.6
Hispanic	7.8	7.5	7.7
Asian/Pacific Islander	4.7	6.6	5.6
Other/Unknown	2.9	3.3	3.1
Health Care Coverage (%)			
Disabled with or without ESRD	7.6	6.2	7.0
Any dual eligibility	16.8	16.6	16.7
Any Part D coverage	75.5	77.2	76.3
Previously enrolled in MA	1.5	1.2	1.3
Clinical Characteristics			
Number of chronic conditions (mean ± SD)	6.4 ± 3.8	6.3 ± 3.7	6.4 ± 3.8
Endocrine conditions (%)	84.5	84.3	84.4
Vascular disease (%)	75.3	73.4	74.4
Rheumatoid conditions (%)	46.7	46.7	46.7
Eye conditions (%)	35.2	39.1	37.0
Cardiac conditions (%)	32.5	31.1	31.9
Behavioral health conditions (%)	33.4	33.6	33.5
Obesity (%)	27.7	22.3	25.3
Chronic pain disorders (%)	23.7	23.0	23.4
Respiratory conditions (%)	23.9	21.8	23.0
Had long-term care stay in prior year (%)	3.2	1.7	2.5
Prospective CMS-HCC Risk Score (mean ± SD)	1.3 ± 1.1	1.3 ± 1.2	1.3 ± 1.2
Community Characteristics			
Census Region (%)			
Northeast	7.2	11.6	9.2
Midwest	11.1	4.4	8.1
South	26.4	19.6	23.6
West	55.3	64.0	59.2
Rurality (%)			
Rural ZIP Code	1.8	2.2	2.0
Urban ZIP Code	98.2	97.8	98.0
Area Deprivation Index (ADI; %)			
Percent of aligned beneficiaries with ADI score of 1–25 (lowest socioeconomic disadvantage)	29.4	39.0	33.8
Percent of aligned beneficiaries with ADI score of 26–50	37.8	36.8	37.4
Percent of aligned beneficiaries with ADI score of 51–75	20.0	17.3	18.8
Percent of aligned beneficiaries with ADI score of 76–100 (highest socioeconomic disadvantage)	12.7	6.9	10.1
Percent of population living below the poverty line at ZCTA level (mean ± SD)	11.9 ± 7.2	11.7 ± 7.0	11.8 ± 7.1
Percent of population ages 25+ with a college degree at ZCTA level (mean ± SD)	31.9 ± 14.7	36.9 ± 15.7	34.2 ± 15.4

	GPDC (PY2021)	GPDC (PY2022)	GPDC (as of PY2022)
COVID-19 Beneficiary Care (%)			
Outpatient COVID-19 diagnosis	6.4	13.9	9.8
Acute care hospital admission for COVID-19 diagnosis	0.7	0.9	0.8
ICU admission for COVID-19 diagnosis	1.0	0.8	0.9
COVID-19 Community Characteristics			
COVID-19 case rate (mean ± SD)	30.1 ± 6.7	37.6 ± 7.8	33.4 ± 8.1
COVID-19 mortality rate (mean ± SD)	0.4 ± 0.2	0.3 ± 0.1	0.3 ± 0.2
COVID-19 case-fatality rate (mean ± SD)	1.7 ± 0.5	1.2 ± 0.3	1.5 ± 0.5
COVID-19 vaccination rate (mean ± SD)	36.4 ± 6.9	64.6 ± 10.8	49.1 ± 16.6
COVID-19 Community Vulnerability Index (mean ± SD)	0.8 ± 0.2	0.7 ± 0.2	0.7 ± 0.2

SOURCE: NORC analysis of Medicare enrollment, demographic, clinical, and market data.
NOTES: SD=standard deviation; ESRD=end-stage renal disease; HCC=Hierarchical Condition Category; ZCTA=ZIP Code Tabulation Area.

Exhibit H.13. High Needs DCEs—Descriptive Characteristics of Beneficiaries Aligned in PY2021, PY2022, and as of PY2022

	GPDC (PY2021)	GPDC (PY2022)	GPDC (as of PY2022)
Number of beneficiaries	2,018	5,775	7,793
Total person-months	21,094	54,737	69,777
Months of alignment (mean ± SD)	10.4 ± 2.4	9.5 ± 3.6	9.7 ± 3.4
Demographics			
Age (mean ± SD)	72.3 ± 14.6	77.9 ± 13.5	76.4 ± 14.0
Sex (%)			
Female	54.6	62.9	60.7
Male	45.4	37.1	39.3
Race/Ethnicity (%)			
White	60.5	68.9	66.7
Black/African American	27.5	18.6	20.9
Hispanic	7.5	8.6	8.3
Asian/Pacific Islander	2.9	2.0	2.3
Other/Unknown	1.7	1.8	1.7
Health Care Coverage (%)			
Disabled without ESRD	25.4	13.7	16.7
Any dual eligibility	68.1	67.6	67.8
Any Part D coverage	87.8	86.1	86.5
Received Part D low-income drug subsidy	69.3	67.0	67.6
Clinical Characteristics			
Number of chronic conditions (mean ± SD)	12.6 ± 4.7	12.3 ± 4.2	12.3 ± 4.2
Vascular disease (%)	93.6	94.3	94.1
Endocrine conditions (%)	87.4	94.6	92.7
Behavioral health conditions (%)	74.1	75.4	75.1
Rheumatoid conditions (%)	63.0	64.6	64.2
Cardiac conditions (%)	62.9	65.1	64.5

	GPDC (PY2021)	GPDC (PY2022)	GPDC (as of PY2022)
Respiratory conditions (%)	56.4	48.7	50.7
Cognitive disorders (%)	44.7	56.3	53.3
Chronic kidney disease (%)	44.3	46.6	46.0
Chronic pain disorders (%)	41.4	39.6	40.1
Substance use disorders (%)	38.2	25.1	28.5
Had long-term care stay in prior year (%)	47.6	49.0	48.6
Prospective CMS-HCC Risk Score (mean ± SD)	3.3 ± 2.0	3.3 ± 1.8	3.3 ± 1.9
Community Characteristics			
Census Region (%)			
Northeast	0.1	21.5	15.9
Midwest	24.7	2.8	8.5
South	40.1	44.9	43.7
West	35.0	30.8	31.9
Rurality (%)			
Rural ZIP Code	1.4	4.6	3.8
Urban ZIP Code	98.6	95.4	96.2
Area Deprivation Index (ADI; %)			
Percent of aligned beneficiaries with ADI score of 1–25 (lowest socioeconomic disadvantage)	23.1	34.8	31.8
Percent of aligned beneficiaries with ADI score of 26–50	25.1	23.6	24.0
Percent of aligned beneficiaries with ADI score of 51–75	21.8	22.3	22.2
Percent of aligned beneficiaries with ADI score of 76–100 (highest socioeconomic disadvantage)	30.1	19.3	22.1
Percent of population living below the poverty line at ZCTA level (mean ± SD)	15.0 ± 9.1	14.7 ± 8.8	14.8 ± 8.8
Percent of population ages 25+ with a college degree at ZCTA level (mean ± SD)	30.8 ± 17.1	33.6 ± 17.4	32.9 ± 17.4
Claims-Based Frailty Index (%)[80]			
0-≤0.15 (Non-Frail)	3.5	2.6	2.8
>0.15-≤0.25 (Pre-Frail)	27.8	22.3	23.7
>0.25-≤0.35 (Mildly Frail)	42.6	48.4	46.9
>0.35-≤0.45 (Moderately Frail)	21.1	22.7	22.3
>0.45 (Severely Frail)	5.0	4.0	4.3
COVID-19 Beneficiary Care (%)			
Outpatient COVID-19 diagnosis	16.2	26.3	23.7
Acute care hospital admission for COVID-19 diagnosis	2.1	4.1	3.6
ICU admission for COVID-19 diagnosis	2.5	2.3	2.3
COVID-19 Community Characteristics			
COVID-19 case rate (mean ± SD)	27.3 ± 5.6	41.8 ± 8.2	38.1 ± 10.0

[80] Kim DH, Schneeweiss S, Glynn RJ, Lipsitz LA, Rockwood K, Avorn J. Measuring frailty in Medicare data: development and validation of a claims-based frailty index. The Journals of Gerontology: Series A. 2018 Jun 14;73(7):980-7.

	GPDC (PY2021)	GPDC (PY2022)	GPDC (as of PY2022)
COVID-19 mortality rate (mean ± SD)	0.4 ± 0.2	0.3 ± 0.1	0.3 ± 0.1
COVID-19 case-fatality rate (mean ± SD)	1.9 ± 0.7	1.3 ± 0.4	1.5 ± 0.6
COVID-19 vaccination rate (mean ± SD)	37.7 ± 4.6	62.9 ± 13.1	56.4 ± 15.9
COVID-19 Community Vulnerability Index (mean ± SD)	0.8 ± 0.2	0.7 ± 0.2	0.7 ± 0.2

SOURCE: NORC analysis of Medicare enrollment, demographic, clinical, and market data.

NOTES: SD=standard deviation; ESRD=end-stage renal disease; HCC=Hierarchical Condition Category; ZCTA=ZIP Code Tabulation Area.

Exhibit H.14. Standard DCEs—Descriptive Characteristics of Beneficiaries Aligned in PY2022 and Baseline Years

	Baseline Years		PY2022		Differential Change for GPDC Group vs. Comparison Group[a]
	GPDC	Comparison	GPDC	Comparison	
Number of beneficiaries	4,891,104	4,891,104	1,630,368	1,630,368	-
Total person-months	56,658,684	56,658,828	18,886,368	18,886,250	-
Months of alignment (mean ± SD)	11.6 ± 1.8	11.6 ± 1.8	11.6 ± 1.7	11.6 ± 1.7	-
Demographics					
Age (mean ± SD)	74.6 ± 10.0	74.6 ± 10.0	74.7 ± 10.0	74.7 ± 10.1	0.013
Sex (%)					
Female	57.0	57.0	57.0	57.0	0.000
Male	43.0	43.0	43.0	43.0	-0.000
Race/Ethnicity (%)					
White	81.0	81.0	81.0	81.0	0.000
Black/African American	5.2	5.2	5.2	5.2	-0.000
Hispanic	5.6	5.6	5.6	5.6	-0.001
Asian/Pacific Islander	4.6	4.6	4.6	4.6	0.000
Other/Unknown	3.5	3.5	3.5	3.5	0.000
Health Care Coverage (%)					
Disabled with or without ESRD	7.9	7.9	7.9	7.9	-0.003
Previously enrolled in MA	0.8	0.8	0.8	0.8	-0.000
Any dual eligibility	14.2	14.2	14.2	14.2	-0.002
Any Part D coverage	75.0	75.3	77.1	76.6	0.8***
Received Part D Low-Income Drug Subsidy during the year	15.8	16.0	15.2	15.3	0.1*
Prospective HCC score	1.2 ± 1.1	1.2 ± 1.1	1.2 ± 1.1	1.2 ± 1.1	0.01***
Clinical Characteristics					
Number of chronic conditions (mean ± SD)	5.9 ± 3.6	5.9 ± 3.6	5.9 ± 3.6	5.9 ± 3.7	-0.003
Endocrine conditions (%)	83.1	83.1	83.1	83.1	0.001
Vascular disease (%)	72.6	72.6	72.6	72.6	-0.001
Rheumatoid conditions (%)	43.1	43.1	43.1	43.0	-0.001
Eye conditions (%)	39.2	39.2	39.2	39.2	0.002
Cardiac conditions (%)	31.2	31.2	31.2	31.2	-0.001
Behavioral health conditions (%)	29.0	29.0	29.0	29.0	-0.001
Obesity (%)	22.9	22.8	22.8	22.8	-0.001
Chronic pain disorders (%)	23.7	23.7	23.7	23.7	-0.001
Respiratory conditions (%)	19.9	19.9	19.9	19.9	-0.003
Chronic kidney disease (%)	20.2	20.2	20.2	20.2	-0.000
Had long-term care stay in prior year (%)	1.7	1.7	1.7	1.7	-0.001

	Baseline Years		PY2022		Differential Change for GPDC Group vs. Comparison Group[a]
	GPDC	Comparison	GPDC	Comparison	
Community Characteristics					
Percent below poverty line (mean ± SD)	11.4 ± 7.1	11.4 ± 7.2	10.7 ± 6.6	10.6 ± 6.6	0.02**
Percent population aged 25+ with college or higher degree (mean ± SD)	35.1 ± 16.9	35.6 ± 17.6	36.7 ± 17.1	37.2 ± 17.8	0.02
Census Region (%)					
Northeast	15.4	15.4	15.3	15.4	0.02
Midwest	24.9	24.6	25.0	24.5	0.2***
South	29.7	29.5	29.6	29.5	-0.1**
West	29.9	30.5	30.0	30.6	-0.08
Rurality (%)	6.3	6.3	6.3	6.3	-0.00
Area Deprivation Index (ADI; %)					
Percent of aligned beneficiaries with ADI score of 1–25 (lowest socioeconomic disadvantage)	32.9	34.1	33.1	34.1	0.1*
Percent of aligned beneficiaries with ADI score of 26–50	33.2	31.3	33.1	30.9	0.3***
Percent of aligned beneficiaries with ADI score of 51–75	21.5	21.3	21.5	21.6	-0.3***
Percent of aligned beneficiaries with ADI score of 76–100 (highest socioeconomic disadvantage)	12.4	13.3	12.4	13.4	-0.1***
Alignment-eligible providers per 1,000 FFS population in 10 miles	61.26 ± 24.48	61.26 ± 24.62	61.26 ± 24.26	61.26 ± 24.37	0.00
Health professional shortage area (HPSA) primary care score (% experiencing primary care shortage)	92.6	91.9	90.8	90.1	0.05
Participation in Other Alternative Payment Models (%)					
BPCI or BPCI Advanced Initiatives	1.5	2.0	0.01	1.3	-0.9***
CEC Model	0.09	0.1	0	0	0.01***
CJR Model	0.2	0.3	0.2	0.2	0.1***
CPC+ or PCF Model	9.9	7.6	0.001	8.7	-11.0***
ETC Model	0.05	0.05	0.2	0.2	-0.02***
FAI	0.2	0.1	0.1	0.09	-0.03***
IAH Demonstration	0.01	0.02	0	0.02	-0.01***
NGACO Model	25.9	2.7	0	0	-23.2***
KCC Model	0	0	0.0007	0.6	-0.6***
OCM	0.8	0.9	0.4	0.4	0.1***
Shared Savings Program	26.5	35.1	0	41.3	-32.8***
VIT Demonstration	0.0007	0.0008	0.01	0.01	0.001
COVID-19 Beneficiary Care					
Outpatient COVID-19 diagnosis (%)	2.2	2.3	16.1	16.0	0.2***
Acute care hospital admission for COVID-19 diagnosis (%)	0.4	0.4	0.9	1.0	-0.02**
ICU admission for COVID-19 diagnosis (%)	0.4	0.4	0.7	0.7	0.02*
COVID-19 Community Characteristics					
COVID-19 case rate (mean ± SD)	11.0 ± 11.6	10.9 ± 11.5	37.8 ± 8.3	38.0 ± 8.7	-0.3***
COVID-19 mortality rate (mean ± SD)	0.2 ± 0.2	0.2 ± 0.2	0.2 ± 0.1	0.2 ± 0.1	0.00***
COVID-19 case-fatality rate (mean ± SD)	1.3 ± 1.7	1.3 ± 1.8	1.1 ± 0.4	1.2 ± 0.5	0.02***
COVID-19 vaccination rate (mean ± SD)	8.3 ± 16.4	8.2 ± 16.3	64.6 ± 11.3	64.4 ± 11.9	0.1***
COVID-19 Community Vulnerability Index (mean ± SD)	0.3 ± 0.4	0.3 ± 0.4	0.6 ± 0.3	0.6 ± 0.3	0.00**

SOURCE: NORC analysis of Medicare enrollment, demographic, clinical, and market data.
NOTES: Estimates in this table are weighted using entropy balancing method. Baseline years are calendar years 2018–2020 for 2021 cohort and 2019–2021 for 2022 cohort. SD=standard deviation; ESRD=end-stage renal disease; ICU=intensive care unit; HPSA=health professional shortage area; MA=Medicare Advantage; BPCI=Bundled Payments for Care Improvement; CEC=Comprehensive ESRD Care; CJR=Comprehensive Care for Joint Replacement; CPC+=Comprehensive Primary Care Plus; PCF=Primary Care First; ETC=ESRD Treatment Choices; FAI=Financial Alignment Initiative; IAH=Independence at Home; NGACO=Next Generation ACO; KCC=Kidney Care Choices; OCM=Oncology Care Model; Shared Savings Program=Medicare Shared Saving Program; VIT=Value in Opioid Use Disorder Treatment.
[a] The change between GPDC and comparison groups and baseline to performance years. *p<0.10; **p<0.05; ***p<0.01.

Exhibit H.15. New Entrant DCEs—Descriptive Characteristics of Beneficiaries Aligned in PY2022 and Baseline Years

	Baseline Years		PY2022		Differential Change for GPDC Group vs. Comparison Group[a]
	GPDC	Comparison	GPDC	Comparison	
Number of beneficiaries	103,791	103,791	34,597	34,597	-
Total person-months	1,199,863	1,199,867	399,957	399,956	-
Months of alignment (mean ± SD)	11.6 ± 1.8	11.6 ± 1.8	11.6 ± 1.8	11.6 ± 1.8	-
Demographics					
Age (mean ± SD)	74.8 ± 9.4	74.8 ± 9.4	74.9 ± 9.4	74.8 ± 9.4	-0.01
Sex (%)					
Female	60.0	60.0	60.0	60.0	0.001
Male	40.0	40.0	40.0	40.0	-0.001
Race/Ethnicity (%)					
White	76.4	76.4	76.4	76.4	0.002
Black/African American	6.2	6.2	6.2	6.2	0.000
Hispanic	7.5	7.5	7.5	7.5	-0.002
Asian/Pacific Islander	6.6	6.6	6.6	6.6	-0.000
Other/Unknown	3.3	3.3	3.3	3.3	-0.001
Health Care Coverage and Case Mix (%)					
Disabled with or without ESRD	6.2	6.2	6.2	6.2	-0.01
Previously enrolled in MA	1.2	1.2	1.2	1.2	-0.000
Any dual eligibility	16.6	16.6	16.6	16.6	-0.01
Any Part D coverage	76.0	75.8	77.2	77.1	0.01
Received Part D Low-Income Drug Subsidy during the year	18.0	18.1	17.4	17.5	-0.001
Prospective HCC score	1.2 ± 1.1	1.2 ± 1.2	1.3 ± 1.2	1.3 ± 1.2	0.1***
Clinical Characteristics					
Number of chronic conditions (mean ± SD)	6.2 ± 3.7	6.3 ± 3.8	6.3 ± 3.7	6.3 ± 3.8	0.002
Endocrine conditions (%)	84.3	84.3	84.3	84.3	0.001
Vascular disease (%)	73.4	73.4	73.4	73.4	0.000
Rheumatoid conditions (%)	46.7	46.7	46.7	46.7	0.001
Eye conditions (%)	39.1	39.1	39.1	39.1	0.002
Cardiac conditions (%)	31.1	31.1	31.1	31.1	-0.000
Behavioral health conditions (%)	33.6	33.6	33.6	33.6	-0.001
Obesity (%)	22.3	22.3	22.3	22.3	-0.001
Chronic pain disorders (%)	23.0	23.0	23.0	23.0	-0.002
Respiratory conditions (%)	21.8	21.8	21.8	21.8	-0.002
Chronic kidney disease (%)	23.4	23.4	23.4	23.4	-0.001
Had long-term care stay in prior year (%)	1.7	1.7	1.7	1.7	-0.002
Community Characteristics					
Percent below poverty line (mean ± SD)	12.9 ± 7.8	12.8 ± 7.7	11.7 ± 7.0	11.8 ± 7.0	-0.2***

	Baseline Years		PY2022		Differential Change for GPDC Group vs. Comparison Group[a]
	GPDC	Comparison	GPDC	Comparison	
Percent population aged 25+ with college or higher degree (mean ± SD)	35.5 ± 16.1	35.9 ± 16.8	36.9 ± 15.7	37.7 ± 16.8	-0.3**
Census Region (%)					
Northeast	11.8	12.4	11.6	12.1	-0.01
Midwest	3.6	4.0	4.4	4.7	0.04
South	22.2	22.3	20.1	20.3	-0.09
West	62.4	61.4	64.0	62.9	0.06
Rurality (%)	2.2	2.2	2.2	2.2	-0.01
Area Deprivation Index (ADI; %)					
Percent of aligned beneficiaries with ADI score of 1–25 (lowest socioeconomic disadvantage)	41.1	42.3	39.0	41.6	-1.4***
Percent of aligned beneficiaries with ADI score of 26–50	35.2	33.4	36.8	33.5	1.5***
Percent of aligned beneficiaries with ADI score of 51–75	15.7	16.0	17.3	17.4	0.2
Percent of aligned beneficiaries with ADI score of 76–100 (highest socioeconomic disadvantage)	8.0	8.3	6.9	7.5	-0.3
Alignment-eligible providers per 1,000 FFS population in 10 miles	61.3 ± 22.5	61.3 ± 23.1	61.3 ± 22.4	61.3 ± 22.9	0.000
Health professional shortage area (HPSA) primary care score (% experiencing primary care shortage)	99.1	98.6	99.0	97.3	1.2***
Participation in Other Alternative Payment Models (%)					
BPCI or BPCI Advanced Initiative	1.7	1.8	0.01	1.4	-1.3***
CEC Model	0.1	0.1	0	0	0.01
CJR Model	0.2	0.2	0.2	0.1	0.1**
CPC+ or PCF Model	3.9	4.1	0	0	-0.3***
ETC Model	0.02	0.02	0.1	0.2	-0.02
FAI	0.08	0.04	0.01	0.02	-0.05***
IAH Demonstration	0.1	0.01	0	0.02	-0.2***
KCC Model	0	0	0	0.9	-0.9***
NGACO Model	8.2	3.0	0	0	-5.2***
OCM	0.9	1.0	0.4	0.4	0.06
Shared Savings Program	31.7	32.5	0	36.4	-35.6***
VIT Demonstration	0	0.00001	0.003	0.008	-0.005
COVID-19 Beneficiary Care (%)					
Outpatient COVID-19 diagnosis	1.6	1.6	13.9	15.2	-1.3***
Acute care hospital admission for COVID-19 diagnosis	0.2	0.3	0.9	1.0	0.003
ICU admission for COVID-19 diagnosis	0.3	0.3	0.8	0.9	-0.08
COVID-19 Community Characteristics					
COVID-19 case rate (mean ± SD)	7.4 ± 9.7	7.5 ± 9.9	37.6 ± 7.9	37.8 ± 8.1	-0.2**
COVID-19 mortality rate (mean ± SD)	0.1 ± 0.2	0.1 ± 0.2	0.3 ± 0.1	0.3 ± 0.1	-0.001
COVID-19 case-fatality rate (mean ± SD)	1.1 ± 1.7	1.1 ± 1.8	1.2 ± 0.3	1.2 ± 0.4	-0.002
COVID-19 vaccination rate (mean ± SD)	3.5 ± 10.6	3.5 ± 10.7	64.7 ± 10.9	64.2 ± 11.0	0.5***
COVID-19 Community Vulnerability Index (mean ± SD)	0.3 ± 0.4	0.3 ± 0.4	0.7 ± 0.2	0.7 ± 0.2	0.01*

SOURCE: NORC analysis of Medicare enrollment, demographic, clinical, and market data.

NOTES: Estimates in this table are weighted using entropy balancing method. Baseline years are calendar years 2018–2020 for 2021 cohort and 2019–2021 for 2022 cohort. SD=standard deviation; ESRD=end-stage renal disease; ICU=intensive care unit; HPSA=health professional shortage area; MA=Medicare Advantage; BPCI=Bundled Payments for Care Improvement; CEC=Comprehensive ESRD Care; CJR=Comprehensive Care for Joint Replacement; CPC+=Comprehensive Primary Care Plus; PCF=Primary Care First; ETC=ESRD Treatment Choices; FAI=Financial Alignment Initiative; IAH=Independence at Home; NGACO=Next Generation ACO; KCC=Kidney Care Choices; OCM=Oncology Care Model; Shared Savings Program=Medicare Shared Saving Program; VIT=Value in Opioid Use Disorder Treatment.

[a] The change between GPDC and comparison groups and baseline to performance years. *p<0.10; **p<0.05; ***p<0.01.

Exhibit H.16. High Needs DCEs—Descriptive Characteristics of Beneficiaries Aligned in PY2022 and Baseline Years

	Baseline Years		PY2022		Differential Change for GPDC Group vs. Comparison Group[a]
	GPDC	Comparison	GPDC	Comparison	
Number of beneficiaries	17,325	17,325	5,775	5,775	-
Total person-months	164,212	164,212	54,737	54,737	-
Months of alignment (mean ± SD)	9.5 ± 3.8	9.5 ± 3.8	9.5 ± 3.6	9.5 ± 3.6	-
Demographics					
Age (mean ± SD)	77.9 ± 13.2	77.5 ± 13.5	77.9 ± 13.5	77.5 ± 13.3	0.006
Sex (%)					
Female	62.9	62.9	62.9	62.9	0.002
Male	37.1	37.1	37.1	37.1	-0.002
Race/Ethnicity (%)					
White	68.9	68.9	68.9	68.9	-0.004
Black/African American	18.6	18.6	18.6	18.6	0.001
Hispanic	8.6	8.6	8.6	8.6	0.001
Asian/Pacific Islander	2.0	2.0	2.0	2.0	0.0004
Other/Unknown	1.8	1.8	1.8	1.8	0.0002
Health Care Coverage (%)					
Disabled without ESRD	14.0	13.9	13.7	13.9	-0.259
Any dual eligibility	67.6	67.6	67.6	67.6	0.016
Any Part D coverage	86.2	86.7	86.1	87.2	-0.683
Received Part D low-income drug subsidy	67.7	67.6	67.0	67.2	-0.319
Clinical Characteristics					
Number of chronic conditions (mean ± SD)	12.4 ± 4.2	12.4 ± 4.2	12.3 ± 4.2	12.3 ± 4.1	-0.013
Vascular disease (%)	94.3	94.3	94.3	94.3	0.001
Endocrine conditions (%)	94.6	94.6	94.6	94.6	0.001
Behavioral health conditions (%)	75.4	75.4	75.4	75.4	0.006
Rheumatoid conditions (%)	64.6	64.6	64.6	64.6	0.002
Cardiac conditions (%)	65.1	65.1	65.1	65.1	-0.0001
Respiratory conditions (%)	48.7	48.7	48.7	48.7	0.0005
Cognitive disorders (%)	56.3	56.3	56.3	56.3	0.006
Chronic kidney disease (%)	46.6	46.6	46.6	46.6	0.003
Chronic pain disorders (%)	39.6	39.6	39.6	39.6	0.001
Substance use disorders (%)	25.1	25.1	25.1	25.1	0.002
Prospective CMS-HCC Risk Score (mean ± SD)	3.2 ± 4.2	3.1 ± 2.0	3.3 ± 1.8	3.1 ± 1.9	0.142***
Had long-term care stay in prior year (%)	49.0	49.0	49.0	49.0	0.004
Community Characteristics					
Census Region (%)					

	Baseline Years		PY2022		Differential Change for GPDC Group vs. Comparison Group[a]
	GPDC	Comparison	GPDC	Comparison	
Northeast	21.5	21.1	21.5	20.8	0.293
Midwest	5.6	8.0	2.8	4.3	0.858*
South	42.8	42.3	44.9	46.3	-1.893*
West	30.0	28.6	30.8	28.6	0.742
Rurality (%)	3.4	4.1	4.6	4.2	1.065
Area Deprivation Index (ADI; %)					
Percent of aligned beneficiaries with ADI score of 1–25 (lowest socioeconomic disadvantage)	34.6	33.2	34.8	33.1	0.343
Percent of aligned beneficiaries with ADI score of 26–50	23.0	24.3	23.6	23.5	1.377
Percent of aligned beneficiaries with ADI score of 51–75	22.1	21.6	22.3	21.6	0.256
Percent of aligned beneficiaries with ADI score of 76–100 (highest socioeconomic disadvantage)	20.4	20.8	19.3	21.7	-1.975**
Percent below poverty line (mean ± SD)	15.7 ± 9.4	15.8 ± 9.6	14.8 ± 8.8	14.7 ± 8.5	0.148*
Percent population aged 25+ with college or higher degree (mean ± SD)	32.0 ± 17.2	32.4 ± 17.9	33.6 ± 17.4	33.8 ± 17.7	0.104
Claims-Based Frailty Index (%)[81]					
0-≤0.15 (Non-Frail)	3.8	6.1	2.6	4.6	0.280
>0.15-≤0.25 (Pre-Frail)	25.6	28.6	22.3	27.0	-1.816**
>0.25-≤0.35 (Mildly Frail)	45.1	41.7	48.4	43.4	1.647
>0.35-≤0.45 (Moderately Frail)	22.0	20.2	22.7	21.3	-0.294
>0.45 (Severely Frail)	3.5	3.3	4.0	3.7	0.183
Participation in Other Alternative Payment Models (%)					
BPCI or BPCI Advanced Initiative	5.6	5.3	0.8	5.1	-4.54***
CEC Model	0.5	0.4	0.0	0.0	-0.038
CJR Model	0.2	0.3	0.1	0.2	-0.02
CPC+ or PCF Model	11.0	7.8	0.0	7.9	-11.079
ETC Model	0.2	0.1	0.4	0.5	-0.140
FAI	0.0	0.2	0.0	0.4	-0.186
IAH Demonstration	1.1	0.2	0.0	0.1	-1.069
KCC Model	0.0	0.0	0.0	1.5	-1.487
NGACO Model	0.3	1.7	0.0	0.0	-1.350***
OCM	0.8	1.0	0.3	0.5	0.01
Shared Savings Program	13.3	19.6	0.0	25.7	-19.353
VIT Demonstration	0.0	0.0	0.0	0.0	-0.002
COVID-19 Beneficiary Care (%)					
Outpatient COVID-19 diagnosis	8.4	6.9	26.3	26.5	-1.656*
Acute care hospital admission for COVID-19 diagnosis	2.4	1.9	4.1	4.1	-0.416
ICU admission for COVID-19 diagnosis	1.9	1.6	2.3	2.5	-0.545*

[81] Kim DH, Schneeweiss S, Glynn RJ, Lipsitz LA, Rockwood K, Avorn J. Measuring frailty in Medicare data: development and validation of a claims-based frailty index. The Journals of Gerontology: Series A. 2018 Jun 14;73(7):980-7.

	Baseline Years		PY2022		Differential Change for GPDC Group vs. Comparison Group[a]
	GPDC	Comparison	GPDC	Comparison	
COVID-19 Community Characteristics					
COVID-19 case rate (mean ± SD)	11.0 ± 11.6	9.4 ± 11.4	41.8 ± 8.2	41.6 ± 8.4	-1.39***
COVID-19 mortality rate (mean ± SD)	0.2 ± 0.2	0.2 ± 0.2	0.3 ± 0.1	0.3 ± 0.1	-0.03***
COVID-19 case-fatality rate (mean ± SD)	3.5 ± 2.2	3.5 ± 2.2	1.3 ± 0.4	1.3 ± 0.4	0.05***
COVID-19 vaccination rate (mean ± SD)	11.0 ± 18.3	7.9 ± 16.2	62.9 ± 13.1	62.4 ± 13.1	-2.5***
COVID-19 Community Vulnerability Index (mean ± SD)	0.4 ± 0.4	0.3 ± 0.4	0.7 ± 0.2	0.7 ± 0.2	-0.05***

SOURCE: NORC analysis of Medicare enrollment, demographic, clinical, and market data.

NOTES: Estimates in this table are weighted using entropy balancing method. Baseline years are calendar years 2018–2020 for 2021 cohort and 2019–2021 for 2022 cohort. SD=standard deviation; ESRD=end-stage renal disease; ICU=intensive care unit; HPSA=health professional shortage area; MA=Medicare Advantage; BPCI=Bundled Payments for Care Improvement; CEC=Comprehensive ESRD Care; CJR=Comprehensive Care for Joint Replacement; CPC+=Comprehensive Primary Care Plus; PCF=Primary Care First; ETC=ESRD Treatment Choices; FAI=Financial Alignment Initiative; IAH=Independence at Home; NGACO=Next Generation ACO; KCC=Kidney Care Choices; OCM=Oncology Care Model; Shared Savings Program=Medicare Shared Saving Program; VIT=Value in Opioid Use Disorder Treatment.

[a] The change between GPDC and comparison groups and baseline to performance years. *p<0.10; **p<0.05; ***p<0.01.

Exhibit H.17. Standard DCEs—Unadjusted Spending, Utilization, and Quality of Care Outcomes in PY2022 and Baseline Years

	Baseline Years				PY2022			
	GPDC		Comparison		GPDC		Comparison	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Spending ($ PBPY)^								
Total Medicare spending (Parts A and B)	11,611.65	24,238.97	12,195.21	25,062.99	12,185.51	24,928.78	12,636.89	25,915.47
Acute care setting	3,186.25	12,273.80	3,409.93	12,884.92	3,171.77	12,752.52	3,290.55	13,113.07
OP facility	1,739.35	5,435.43	1,850.08	5,604.49	1,964.04	6,325.70	2,094.42	6,549.78
SNF	806.97	5,228.94	845.10	5,378.28	853.33	5,549.21	899.31	5,777.21
IRF and LTCH	359.31	4,141.26	378.33	4,215.53	371.84	4,216.72	381.23	4,198.96
Professional services	2,958.92	6,387.89	2,986.19	6,471.28	3,101.14	6,700.87	3,091.74	6,786.20
Primary care visits	*545.60*	*830.36*	*557.85*	*867.30*	*622.55*	*887.86*	*624.40*	*913.16*
Specialty care visits	189.01	359.51	200.08	382.48	195.05	356.61	204.77	378.81
Home health	589.47	2,399.50	617.25	2,481.07	570.77	2,394.76	612.64	2,525.53
Hospice	399.73	3,688.24	437.56	3,817.93	405.41	3,703.68	431.25	3,894.49
Utilization (per 1,000 BPY)								
Acute care hospitalizations	194.4	629.2	205.9	650.9	185.8	611.2	193.5	627.7
Acute care length of stay (days)	1209.5	4917.6	1298.5	5171.8	1209.3	5106.1	1263.3	5283.2
ED visits and observation stays	369.9	1058.1	391.4	1107.4	375.7	1042.2	399.5	1091.5
IRF and LTCH days	197.8	2301.6	210.6	2393.0	199.9	2305.9	206.6	2331.0
SNF days	1406.8	8977.4	1453.1	9129.2	1451.1	9135.9	1496.0	9410.4
Professional services by PCP	*5335.7*	*5718.3*	*5433.6*	*6065.9*	*5788.7*	*6201.6*	*5960.6*	*6756.3*
Home health episodes^	301.5	1239.3	321.2	1299.6	290.0	1210.4	316.6	1298.2
Continuous hospice days prior to death^	22.8	52.2	22.4	51.0	23.2	52.5	24.9	55.5
Quality of Care (per 1,000 BPY)								
All-condition readmissions^	162.5	368.9	165.5	371.6	165.8	371.9	165.9	372.0

	Baseline Years				PY2022			
	GPDC		Comparison		GPDC		Comparison	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Mortality	38.3	191.8	44.6	206.5	37.6	190.1	34.9	183.5
ACSC hospitalizations	21.6	145.5	21.3	144.5	18.5	134.8	18.1	133.5
Timely follow-up^	810.9	391.6	800.5	399.7	806.2	395.3	796.0	403.0
Unplanned admissions for beneficiaries with multiple chronic conditions^	228.0	419.5	232.0	422.1	216.9	412.1	225.4	417.8
Days at home	95.9	10.0	95.5	10.9	95.8	10.5	95.67	10.5
Recommended diabetes care^	392.6	488.3	356.4	478.9	410.5	491.9	371.2	483.1
*Advance care plan^*	*59.6*	*236.83*	*65.3*	*247.0*	*77.1*	*266.7*	*88.4*	*283.8*
Annual wellness visits	*429.9*	*495.1*	*354.0*	*478.2*	*506.6*	*500.0*	*405.9*	*491.1*
*Chronic disease management for beneficiaries with multiple chronic conditions^*	*74.0*	*261.8*	*71.0*	*256.9*	*85.3*	*279.4*	*85.6*	*279.7*

SOURCE: NORC analysis of Medicare claims and enrollment data.

NOTES: Estimates in this table are weighted using entropy balance weights but not regression-adjusted. Baseline years are calendar years 2018–2020 for 2021 cohort and 2019–2021 for 2022 cohort. ^Total spending and all spending categories are top coded at 99.9th percentile by DCE market and year. Home health episodes are top coded at 14. Eligible populations for continuous hospice days prior to death are decedents only. Eligible populations for all-condition readmissions are beneficiaries with index hospitalizations. Eligible populations for timely follow-up include beneficiaries with one or more acute events related to one of six chronic conditions (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, diabetes). Eligible populations for unplanned admissions and chronic disease management for beneficiaries with multiple chronic conditions are 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). Eligible populations for days at home are beneficiaries with multiple chronic conditions (prospective HCC score in the prior year >=2.0). Eligible populations for recommended diabetes care are beneficiaries with diabetes. Eligible populations for advance care plan include beneficiaries with eligible physician encounters in the year. Spending estimates are presented per beneficiary per year (PBPY). Utilization and quality estimates (except for "days at home" and "continuous hospice days prior to death") are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). SD=standard deviation; ED=emergency department; ACSC=ambulatory care sensitive condition; SNF=skilled nursing facility; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital; OP=outpatient. Measures in italics are secondary measures excluded from impact analyses; descriptive trends for the intervention group are shown for these measures in **Appendix J**.

Exhibit H.18. New Entrant DCEs—Unadjusted Spending, Utilization, and Quality of Care Outcomes in PY2022 and Baseline Years

	Baseline Years				PY2022			
	GPDC		Comparison		GPDC		Comparison	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Spending ($ PBPY)^								
Total Medicare spending (Parts A and B)	12,696.28	25,390.87	13,068.62	26,219.13	12,961.86	26,464.31	13,646.11	27,307.24
Acute care setting	3,592.38	13,129.08	3,869.16	13,901.65	3,514.67	14,232.99	3,762.18	14,569.73
OP facility	1,514.20	5,018.37	1,797.02	5,645.91	1,712.96	6,140.26	2,087.31	6,715.21
SNF	963.52	5,910.48	937.37	5,861.57	986.72	6,331.67	1,000.14	6,228.88
IRF and LTCH	361.68	4,329.48	379.79	4,276.82	361.74	4,087.11	371.31	4,192.28
Professional services	3,224.69	6,387.72	3,179.58	6,331.67	3,392.21	6,832.94	3,366.93	6,979.16
Primary care visits	*627.90*	*875.87*	*594.53*	*872.46*	*648.32*	*886.02*	*661.13*	*917.70*
Specialty care visits	197.19	355.43	218.59	381.51	195.90	344.67	226.74	386.15
Home health	704.51	2,624.06	671.99	2,587.38	619.45	2,439.76	661.02	2,590.87

	Baseline Years				PY2022			
	GPDC		Comparison		GPDC		Comparison	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Hospice	613.50	4,734.80	487.89	4,091.90	586.28	4,582.27	466.52	4,043.71
Utilization (per 1,000 BPY)								
Acute care hospitalizations	219.6	678.0	235.0	723.1	203.4	643.6	218.3	689.5
Acute care length of stay (days)	1366.3	5434.0	1473.4	5639.0	1334.5	6137.6	1418.7	5834.8
ED visits and observation stays	373.9	1075.6	405.2	1191.1	346.6	862.5	400.4	1118.9
IRF and LTCH days	187.8	2349.4	200.2	2363.3	200.4	2787.1	195.7	2267.3
SNF days	1629.1	9744.0	1554.7	9469.6	1612.2	9980.9	1612.7	9876.4
Professional services by PCP	*6300.1*	*6662.8*	*5779.9*	*6465.6*	*6378.0*	*7238.8*	*6280.1*	*7329.2*
Home health episodes^	340.7	1282.0	326.6	1260.3	292.8	1142.8	319.6	1246.9
Continuous hospice days prior to death^	28.3	60.6	22.8	51.3	28.1	59.3	25.5	55.1
Quality of Care (per 1,000 BPY)								
All-condition readmissions^	163.8	370.1	171.1	376.6	166.3	372.4	178.1	382.6
Mortality	42.2	201.0	47.4	212.6	40.6	197.4	38.1	191.5
ACSC hospitalizations	25.4	157.2	24.4	154.3	19.3	137.5	20.3	141.0
Timely follow-up^	820.2	384.1	801.3	399.0	819.2	385.0	793.9	404.5
Unplanned admissions for beneficiaries with multiple chronic conditions^	242.5	428.6	246.6	431.0	222.0	415.6	234.5	423.7
Days at home	95.8	10.0	95.3	11.1	96.1	10.2	95.5	10.9
Recommended diabetes care^	355.0	478.5	358.8	479.6	389.1	487.6	366.7	481.9
*Advance care plan^*	*69.7*	*254.6*	*62.2*	*241.4*	*66.3*	*248.9*	*92.0*	*289.1*
Annual wellness visits	*364.8*	*481.4*	*344.9*	*475.3*	*373.3*	*483.7*	*400.7*	*490.0*
*Chronic disease management for beneficiaries with multiple chronic conditions^*	*159.3*	*366.0*	*79.7*	*270.9*	*138.5*	*345.5*	*108.2*	*310.7*

SOURCE: NORC analysis of Medicare claims and enrollment data.

NOTES: Estimates in this table are weighted using entropy balance weights but not regression-adjusted. Baseline years are calendar years 2018–2020 for 2021 cohort and 2019–2021 for 2022 cohort. ^Total spending and all spending categories are top coded at 99.9th percentile by DCE market and year. Home health episodes are top coded at 14. Eligible populations for continuous hospice days prior to death are decedents only. Eligible populations for all-condition readmissions are beneficiaries with index hospitalizations. Eligible populations for timely follow-up are beneficiaries with one or more acute events related to one of six chronic conditions (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, diabetes). Eligible populations for unplanned admissions and chronic disease management for beneficiaries with multiple chronic conditions are 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). Eligible populations for days at home are beneficiaries with multiple chronic conditions (prospective HCC score in the prior year >=2.0). Eligible populations for recommended diabetes care are beneficiaries with diabetes. Eligible populations for advance care plan are beneficiaries with eligible physician encounters in the year. Spending estimates are presented per beneficiary per year (PBPY). Utilization and quality estimates (except for "days at home" and "continuous hospice days prior to death") are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). SD=standard deviation; ED=emergency department; ACSC=ambulatory care sensitive condition; SNF=skilled nursing facility; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital; OP=outpatient. Measures in italics are secondary measures excluded from impact analyses; descriptive trends for the intervention group are shown for these measures in **Appendix J**.

Exhibit H.19. High Needs DCEs—Unadjusted Spending, Utilization, and Quality of Care Outcomes in PY2022 and Baseline Years

	Baseline Years				Performance Year			
	GPDC		Comparison		GPDC		Comparison	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Spending ($ PBPY)^								
Total Medicare spending (Parts A and B)	35,786.09	43,247.46	34,645.96	44,221.27	39,614.69	45,333.46	40,781.22	47,884.36
Acute care setting	10,078.71	22,906.61	10,376.07	23,075.27	10,029.89	23,417.39	11,058.25	24,338.31
OP facility	3,002.66	6,065.71	3,338.57	7,555.71	2,986.68	6,151.48	3,750.39	7,710.19
SNF	6,223.87	14,632.96	5,437.74	13,832.75	8,058.23	16,705.65	8,393.68	17,242.89
IRF and LTCH	1,749.84	10,217.57	1,848.71	10,787.34	1,878.13	10,415.88	2,116.90	11,504.54
Professional services	4,620.15	7,865.18	4,959.87	8,797.68	5,244.43	10,468.29	5,972.55	11,413.43
Primary care visits	1,832.29	1,868.82	1,527.07	1,892.62	2,172.28	2,033.37	1,910.62	2,206.20
Specialty care visits	129.38	359.84	197.65	443.48	144.33	373.19	223.15	482.81
Home health	2,062.41	4,893.14	1,748.05	4,363.62	2,425.62	5,511.68	1,953.98	4,649.55
Hospice	3,958.79	10,966.49	3,143.52	9,611.83	4,454.82	12,077.12	3,123.54	9,892.46
Utilization (per 1,000 BPY)								
Acute care hospitalizations	721.1	1239.5	742.6	1240.0	680.3	1153.7	746.5	1208.5
Acute care length of stay (days)	5292.9	11004.5	5314.7	10779.7	5143.5	11408.7	5563.8	12317.2
ED visits and observation stays	680.6	1499.9	807.2	2361.0	712.0	1519.3	864.4	1906.0
IRF and LTCH days	1226.6	7642.3	1207.6	7138.9	1111.9	6933.9	1207.5	6856.0
SNF days	3266.0	13956.	3122.2	13305.5	2738.7	13035.1	2736.3	12981.4
Home health episodes^	1109.2	2511.1	970.4	2339.3	1219.0	2672.1	1019.6	2354.1
Continuous hospice days prior to death^	34.2	64.4	29.9	58.3	45.4	79.7	37.3	70.1
Professional services by PCP	*17458.4*	*15870.0*	*12752.5*	*13967.8*	*23365.0*	*19335.3*	*17667.7*	*18988.4*
Quality of Care (per 1,000 BPY)								
All-condition readmissions^	313.3	464.0	265.9	441.8	297.5	457.7	292.1	454.8
Mortality	307.6	461.5	280.5	449.2	227.9	419.5	184.3	387.8
ACSC hospitalizations	47.5	212.7	46.1	209.7	35.0	183.7	29.5	169.2
Timely follow-up^	650.1	477.1	711.9	452.9	658.8	474.9	706.1	455.6
Unplanned admissions for beneficiaries with multiple chronic conditions^	337.2	472.8	363.6	481.0	332.8	471.3	370.9	483.0
Days at home	73.6	31.6	75.2	31.5	79.7	26.9	81.3	26.4
Recommended diabetes care^	14.1	117.9	16.6	127.8	15.4	123.2	16.6	127.9
*Advance care plan^*	*297.0*	*457.0*	*215.5*	*411.2*	*371.4*	*483.2*	*235.2*	*424.1*

	Baseline Years				Performance Year			
	GPDC		Comparison		GPDC		Comparison	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Annual wellness visits	*234.7*	*423.8*	*141.6*	*348.6*	*292.1*	*454.8*	*201.7*	*401.3*
*Chronic disease management for beneficiaries with multiple chronic conditions^*	*6.8*	*82.2*	*2.7*	*52.0*	*16.6*	*127.6*	*3.0*	*54.7*

SOURCE: NORC team analysis of Medicare claims and enrollment data.

NOTES: Estimates in this table are weighted using entropy balance weights but not regression-adjusted. Baseline years are calendar years 2018–2020 for 2021 cohort and 2019–2021 for 2022 cohort. ^Total spending and all spending categories are top coded at 99.9th percentile by DCE market and year. Home health episodes are top coded at 14. Eligible populations for continuous hospice days prior to death are decedents only. Eligible populations for all-condition readmissions are beneficiaries with index hospitalizations. Eligible populations for timely follow-up are beneficiaries with one or more acute events related to one of six chronic conditions (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, diabetes). Eligible populations for unplanned admissions and chronic disease management for beneficiaries with multiple chronic conditions are 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). Eligible populations for days at home are beneficiaries with multiple chronic conditions (prospective HCC score in the prior year >=2.0). Eligible populations for recommended diabetes care are beneficiaries with diabetes. Eligible populations for advance care plan are beneficiaries with eligible physician encounters in the year. Spending estimates are presented per beneficiary per year (PBPY). Utilization and quality estimates (except for "days at home" and "continuous hospice days prior to death") are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). SD=standard deviation; ED=emergency department; ACSC=ambulatory care sensitive condition; SNF=skilled nursing facility; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital; OP=outpatient. Measures in italics are secondary measures excluded from impact analyses; descriptive trends for the intervention group are shown for these measures in **Appendix J**.

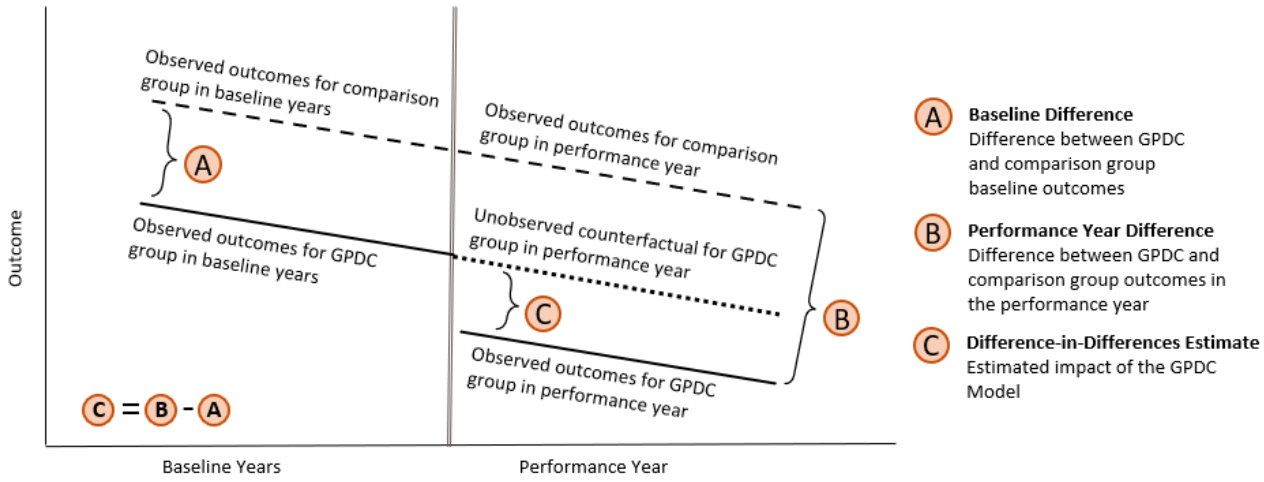
H.3: Analytic Approach to Estimate Impacts for Standard, New Entrant, and High Needs DCEs

For Standard, New Entrant, and High Needs DCEs in the GPDC Model's second performance year, we used a difference-in differences (DID) design to assess how the GPDC Model's providers in each DCE type impacted Medicare spending, utilization, and quality of care outcomes for their beneficiaries in each PY, relative to a comparison group and three preceding pre-intervention ("baseline") years (**Exhibit H.20**). By observing the outcomes among GPDC and comparison beneficiaries before model launch and in PYs, we can estimate the expected outcomes for GPDC beneficiaries in the absence of the GPDC Model (also known as the untreated counterfactual) by continuing baseline trends for GPDC beneficiaries into PY. The impact of the GPDC Model is the difference between the untreated counterfactual and the observed outcomes in PY. For Standard and New Entrant DCEs, DID regression models were run separately for each individual DCE. To aggregate DCE-specific impacts to obtain a model-level estimate (separately for Standard DCEs and New Entrant DCEs), we weighted each DCE impact by the proportion of total model-aligned beneficiaries who were aligned to the DCE. For High Needs DCEs, rather than DCE-specific models, we ran cohort-specific models (separate for 2021 Starters and 2022 Starters) by pooling each cohort's DCEs, because of the small sample sizes for each DCE. A model-level estimate was then calculated by weighting the impact for each cohort with the proportion of total model-aligned beneficiaries for that cohort.

The DID design requires the following key assumptions:

- **Unobserved factors affect the treatment and comparison groups similarly**. If observed characteristics between the GPDC and comparison group are correlated with unobserved characteristics between the two groups, using entropy balancing weights mitigate biases that may result from unobserved differences influencing outcomes between the two groups. For instance, we do not observe beneficiary-level income; however, by using ZIP Code Tabulation Area (ZCTA)-level median income in our entropy balancing weights, we aim to mitigate bias potentially arising from income differences between the GPDC and comparison groups.
- **The changes in outcomes over the baseline years are parallel between the treatment and comparison groups**. We tested this assumption by comparing trends for GPDC beneficiaries with trends for comparison beneficiaries in the baseline years.

Exhibit H.20. DID Design to Estimate the GPDC Model's Treatment Effect



NOTES: GPDC=Global and Professional Direct Contracting. The unobserved counterfactual is the expected outcomes for the GPDC group in the performance year absent the GPDC Model.

Performance and Baseline Years in DID Design

For PY2022 analyses, the baseline years were the three preceding calendar years before DCEs started the model (2019–2021 for 2022 cohort and 2018–2020 for 2021 cohort). The evaluation's three-year baseline is not the same baseline as the model's financial benchmarking methodology, which uses 2017–2019 as the baseline for all cohorts in PY2022[82] to limit direct effects of the COVID-19 pandemic in 2020.[83] We included 2020 in the baseline because:

- **We could capture a baseline for providers newer to serving FFS Medicare beneficiaries, particularly among New Entrant DCEs.**[84] We included DCEs with adequate data in all baseline years in our analyses. By using the most recent three years, we lose fewer providers from the GPDC and comparison performance year panels and can better capture providers who began to serve FFS beneficiaries more recently**.**

[82] For more details on the model's financial benchmarking methodology, see: https://www.cms.gov/priorities/innovation/media/document/gpdc-py2022-fin-op-guide-ovw.

[83] Including 2017 as a baseline year is also challenging for the evaluation from the update to the chronic conditions algorithms in the Chronic Conditions Data Warehouse (CCW) in 2017. Because of this change, the 2017 prospective chronic conditions flags (that is, flags using 2016 data) are not comparable to prospective chronic conditions flags in 2018 and beyond.

[84] "Not more than 50% of the DC Participant Providers in a New Entrant DCE may have prior experience in the Medicare Shared Savings Program, the Next Generation ACO Model, the Comprehensive ESRD Care Model, or the Pioneer ACO Model. Organizations found ineligible to participate as New Entrant DCEs on the basis of this criterion will have the opportunity to participate as a Standard DCE, provided all other model requirements are met. New Entrant DCEs may not have more than 3,000 beneficiaries that are "alignable" through claims-based alignment in any of the baseline years (CY2017, CY2018, and CY2019), as this suggests that the organization has significant experience serving Medicare FFS beneficiaries." Taken from: Direct Contracting Model: Global and Professional Options, Request for Applications; 11/25/19.

- **We observed no violation of parallel trends in the baseline years for total spending in the GPDC and comparison groups when including 2020 for New Entrant DCEs, while 9 Standard DCEs were found to have violations of parallel trends.**[85] Because baseline trends are parallel (similar between the two groups) for New Entrant DCEs, we would expect to observe very similar spending impacts if 2020 were excluded from the baseline years. However, for all DCE types, we conducted a sensitivity analysis that excluded 2020 from the baseline years (these results are shown in **Exhibit I.4** in Appendix I).
- **We believe that 2020 is an important data point** that may reflect changes in care seeking behaviors and practice patterns that are sustained into the model's performance years when COVID-19 is expected to be endemic and, thus, might be more comparable to the performance years than years before COVID-19.
- **We anticipated that community-level COVID-19 effects in 2020 should be similar between GPDC and comparison beneficiaries,** as our comparison beneficiaries are selected from the same geographic areas (that is, hospital referral regions [HRRs]) as GPDC beneficiaries. We also conducted sensitivity analyses to assess the extent to which the GPDC and comparison group beneficiaries were impacted by COVID-19, in two ways: 1) by dropping 2020 from the baseline period as noted above and 2) controlling for COVID-19 mortality in the regression models. The sensitivity checks indicated that our total spending impact estimates for Standard and New Entrant DCEs were robust to these sensitivity checks.

DID Model Specification and Key Covariates

For Standard and New Entrant DCEs, we estimated DID models separately for each DCE relative to its comparison group; for High Needs DCEs we estimated DID models separately for each cohort. We then pooled the DCE-level or cohort-level estimates as beneficiary-weighted averages to obtain the model's impact on spending, utilization, and quality of care outcomes in PY and as of PY separately for Standard, New Entrant, and High Needs DCEs, relative to their counterfactuals. We established the counterfactual by determining baseline years for all DCEs and a balanced beneficiary comparison group,[86] assuming parallel trends in the groups' outcomes within the DID estimation framework. Baseline years were cohort-specific and defined as the three years prior to a DCE beginning in the model, such that the baseline years for the 2021 cohort are 2018–2020, and the baseline years for the 2022 cohort are 2019–2021. The GPDC treatment effect for each DCE type reflects the marginal effect of the model over incentives that existed in the baseline period for its associated providers, relative to the comparison group. We estimated the treatment effect in our DID model as an interaction term

[85] To assess the assumption of parallel trends, we tested whether the differences in GPDC and comparison groups in 2021 (the baseline year prior to the performance year) versus the differences in first two baseline years (2019 and 2020) were jointly statistically indistinguishable from zero using a joint F-test; this test indicated that trends between the GPDC and comparison groups were parallel in the baseline years.

[86] Comparison group beneficiaries represent beneficiaries in the same markets as treatment group beneficiaries who mainly receive services from non-GPDC providers. Comparison group beneficiaries and DCE baseline beneficiaries were balanced to be like the DCE beneficiaries in the PY on observed characteristics, including beneficiary demographics and clinical characteristics and market characteristics. The EB process is described previously in Section H.1.2. In the PY, comparison group beneficiaries are prospectively claims-aligned to comparison providers, which are non-GPDC providers. PY comparison providers are then followed back to the BYs for prospective claims-alignment of comparison beneficiaries in the BYs. For additional detail on how beneficiaries were aligned to the BYs and PY2022 treatment and comparison groups, please see Section H.1.1.

capturing the relative change in average spending between treatment and comparison groups from the baseline years to PY. We included year fixed effects to account for observed trends in Medicare spending for beneficiaries in this evaluation.

Our model within the DID framework for estimating impact in a given performance year for given DCE (for Standard and New Entrant DCEs) or DCE cohort (for High Needs DCEs), adjusting for beneficiary and community (ZIP code-/ZCTA-/county-level) characteristics, with year and market (HRR) fixed effects (market fixed effects are at DCE level for High Needs), as well as a time-varying market effect, was specified as:

$$g\left[E\left(Y_{injkt}\right)\right] = \beta_0 + \beta_1 DCE_j + \theta_1 DCE_j * PY_t + \Upsilon Patient_{injkt} + \Lambda Community_{njkt} + \mathrm{T} Year_t + \Omega Market_k + \mathrm{K} Market_k * Year_t$$

Wherein:

- Y_{injkt} is the outcome for the beneficiary i in DCE or comparison group j, residing in community n, in market (HRR) k and year t. We modeled Y with appropriate distributional form and link function $g(.)$, for each spending, utilization, or quality of care outcome (**Exhibit H.21**).
- DCE_j is the binary indicator for being in the DCE group in either performance year or baseline years. It is set to the value of "1" if the beneficiary is aligned with a DCE Participant Provider (and "0" otherwise). The coefficient β_1 captures the mean of the difference between the DCE and comparison groups that is constant over time.
- Coefficient θ_1 is the DID estimate for $DCE_j * PY_t$, the indicator for being in the DCE group in a given performance year of the GPDC Model.
- $Patient$ and $Community$ are sets of beneficiary and community characteristics with coefficient sets Υ and Λ, respectively.
- $Year_t$, $Market_k$, $and\ Market_k * Year_t$ are yearly fixed effects, market fixed effect and time-varying market effects, with coefficient sets $\mathrm{T}, \Omega, \mathrm{and}\ \mathrm{K}$, respectively.

Impacts at the DCE-level were adjusted for the following characteristics:

- **Beneficiary-level covariates** included age (and the square of age), sex, race/ethnicity, disability, ESRD status, dual eligibility, Part D coverage, number of months of alignment in the year, disease burden at the end of the preceding year (using 25 clinical domain indicators representing for 66 chronic conditions), MA enrollment in the preceding year, and long-term care stay of >100 days in the preceding year.
- **Community-level covariates** included beneficiary residence in rural area, percentile of ZIP code-level Medicare primary care providers and alignment-eligible specialists per 1,000 Medicare FFS population in 10 miles, percentile of ZIP code-level population aged 25 years or older with a college or higher degree, percentile of ZIP code-level median household income, percentile of ZIP code-level poverty rate, HPSA category for primary care, and HPSA category for mental health care.

- **Market-level covariates** included indicators for each HRR and interactions for HRR and years to account for both time-invariant and time-varying market factors. All spending outcomes are top coded at 99.9th percentile to mitigate the issue of outliers in spending.

Statistical Model Specifications

Exhibit H.21 summarizes the distributional assumptions and link functions used for modeling the 21 claims-based outcome measures for the Standard, New Entrant, and High Needs DCEs in PY2022. **Appendix G** gives a complete description of how we defined, operationalized, and calculated all outcome measures. Outcome measures for spending and utilization were modeled as continuous variables, using generalized linear models (GLMs). For outcomes where more than 20% of the sample had zero values, we used two-part models (TPMs) with a probit or logit model to assess the likelihood of a non-zero outcome and GLM to assess levels of the outcome for those with non-zero outcomes. For spending outcome variables modeled with GLMs or non-zero part in the TPM, we determined the appropriate distributional form using a modified Park test.[87] This test examined the empirical relationship between the mean and the variance to ascertain the appropriate distribution. For utilization variables modeled with GLMs or non-zero part in the TPM, we chose between Poisson and negative binomial distribution based on the dispersion test. The quality of care measures were modeled as binary measures and therefore used logit models.

Exhibit H.21. PY2022 Statistical Model Specifications for Outcome Measures

Outcome Measure	Model Specification
Spending	
Total Medicare spending (Parts A and B)	Generalized linear model (GLM): Poisson distribution and log link
Acute care setting	Two-part model (TPM): first part probit; second part GLM with gamma distribution and log link
Professional services	GLM: Poisson distribution and log link
Outpatient facility	TPM: first part probit; second part GLM with gamma distribution and log link
SNF	TPM: first part probit; second part GLM with gamma distribution and log link
IRF and LTCH	TPM: first part probit; second part GLM with inverse Gaussian distribution and log link
E&M visits to specialty care	TPM: first part probit; second part GLM with gamma distribution and log link
Home health	TPM: first part probit; second part GLM with gamma distribution and log link
Hospice	TPM: first part probit; second part GLM with gamma distribution and log link
Utilization	
Acute care hospitalizations	TPM: first part probit; second part GLM with inverse Gaussian distribution and log link
Acute care length of stay (days)	TPM: first part probit; second part GLM with gamma distribution and log link
ED visits and observation stays	TPM: first part probit; second part GLM with inverse Gaussian distribution and log link
IRF and LTCH days	TPM: first part probit; second part GLM with inverse Gaussian distribution and log link
SNF days	TPM: first part probit; second part GLM with gamma distribution and log link

[87] Manning W, Mullahy J., "Estimating log models: To transform or not to transform?" *J Health Econ.* 2001;20:461–494.

Outcome Measure	Model Specification
Home health episodes	TPM: first part probit; second part GLM with gamma distribution and log link
Continuous hospice days prior to death	TPM: first part probit; second part GLM with gamma distribution and log link
Quality of Care	
All-condition readmissions	Logit
ACSC hospitalizations	Logit
Timely follow-up after acute exacerbation of chronic conditions	Logit
Unplanned admissions for beneficiaries with MCC	Logit
Days at home^	TPM: first part probit; second part GLM with gamma distribution and log link
Recommended diabetes care	Logit

NOTES: SNF=skilled nursing facility; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital; E&M=evaluation and management; ED=emergency department; ACSC=ambulatory care sensitive condition; MCC=multiple chronic conditions. ^For "days at home" measure, we modeled 100% of days at home in two-part probit model and converted the estimate back to the original scale.

Pooled Estimation

In our approach to estimating the GPDC Model's impacts, for Standard and New Entrant DCEs, we calculated the model-level impact employing a weighted average of impacts generated from DCE-specific regression models for each DCE type. For High Needs DCEs, we used the same approach using DCE cohort-specific regression models, rather than DCE-specific models. To aggregate individual DCE/Cohort impacts to obtain a model-level estimate, we weighted each DCE/Cohort's impact by the proportion of total model-aligned beneficiaries who are aligned to the DCE/Cohort:

$$Impact_{DCE1+\cdots+DCEn} = \frac{(Impact_{DCE1}) * \ldots\ldots + (Impact_{DCEn}) * (N_{DCEn})}{N_{D\ldots1+\ldots+DCEn}}$$

For example, if 5% of all aligned beneficiaries were aligned to a DCE with an impact estimate of $45 per beneficiary per year (PBPY) and the remaining beneficiaries were aligned to a DCE with an impact of $20 PBPY, the combined impact of the two DCEs would be ($45 * 0.05) + ($20 * 0.95) = $21.25 PBPY.

Standard errors for the model-level estimates were calculated as a weighted average of the standard errors associated with DCE-level impacts in the performance year included across each DCE type. Standard errors for individual DCE-level estimates were first converted to variances and weighted by the squared proportion of DCE beneficiaries in a given performance year, then converted back to standard error from the combined variance. This approach offered us the advantage of directly computing the model-level impacts from impacts of individual DCEs for their heterogenous beneficiary populations. We obtained similar model-level impacts from regression models that pooled all DCEs with DCE-level interactions to account for heterogeneity, and clustered standard errors at the DCE-market level.

The model-level cumulative estimate as of PY2022 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 similarly calculated as a weighted average, by squaring the weights used in calculating the model-level weighted averages.

Assessment of Parallel Baseline Trends

The DID design assumes that time-varying and time-invariant unobservable factors affect the treatment and comparison groups similarly. A key assumption of the DID design is that the baseline trends (that is, the change in outcomes within the baseline years) are parallel between treatment and comparison groups, which was verified prior to performing the DID analysis. For each level of analysis, we tested whether trends in total spending, utilization, and quality of care outcomes between DCE and comparison groups were parallel across the baseline years. We did not assess parallel trends for categories of Medicare spending in care settings because we evaluated their impacts to understand how total Medicare spending was impacted.

A DID approach attributes statistical evidence of divergence (or convergence) in outcomes between the treatment (GPDC DCE) and comparison groups (non-GPDC beneficiaries in GPDC DCE market areas) after the performance year began as model impacts. The DID estimation method has two main assumptions, detailed below.

The first assumption is often referred to as the *parallel trends* assumption, which states that the time trends in outcome variables would have been the same in the performance year in the absence of the model. The presence of parallel trends in the outcome variable(s) across the two groups in the baseline years serves as a justification for the assumption of parallel trends in the performance year.

The second assumption is one of *no anticipation* effect, which states that the model should not have had any effect on the DCEs in the baseline years. A violation of this assumption would be if the model is found to have a non-zero effect on the DCEs in the baseline years. Any presence of a divergence in the outcomes' trajectory across DCE and comparison groups during the baseline years could constitute a violation of both the *parallel trends* as well as the *no anticipation* assumption. Ignoring such a divergence in the baseline years could result in misattribution of the estimated effect to the model and result in biased estimates of the model's impact.

We assessed the assumption of parallel trends by verifying that there was no prior evidence of divergence/convergence in outcomes in the baseline years. Verifying that there is no empirical evidence of non-parallel trends in the baseline is an important step in supporting the validity of impacts calculated by DID. As both DID and parallel trend tests are intended to determine evidence of divergence/convergence, our approach to testing the parallel trends assumption mirrors the DID framework to calculate impacts. We verified the assumption of parallel trends for each DCE type by examining the significance of an interaction term between treatment (GPDC) and baseline year variables, for each outcome measure:

- **Estimating the GPDC Model's effect on outcomes for the baseline years**: We modified the model specification, shown in reduced form without covariates below, dropping performance year data and including treatment effects for the baseline years.

$$g[E(Y_{imnjkt})] = \beta_0 + \beta_1 DCE_j + \delta_1 BY2_t + \delta_2 BY1_t + \theta_{-2} DCE_j * BY2_t + \theta_{-1} DCE_j * BY1_t$$

After estimating this regression for each GPDC DCE type, we tested whether θ_{-2}, and θ_{-1} were jointly statistically different from zero. If yes, we rejected the null hypothesis of no divergence/convergence between the DCE and comparison groups during baseline years for that given outcome. When we found that θ_{-2}, and θ_{-1} are not jointly statistically distinguishable from zero, this combined F test gave us more confidence that any impacts we observe after the model start can be attributed to the GPDC Model.

Exhibits H.22 through **H.24** present parallel trends test results for selected outcomes from the pooled models for Standard, New Entrant, and High Needs DCEs. These results also point to the credibility of our pooled model-level impact estimates. As seen from **Exhibit H.22**, for most outcomes, the majority of Standard DCEs had parallel trends (such that the p-value of the joint F test on baseline trends was greater than 0.05). Evidence of parallel baseline trends was even stronger for New Entrant DCEs, wherein only a small handful to no DCEs, for each outcome, failed the parallel trends test (**Exhibit H.23**). For most outcomes, most New Entrant DCEs had parallel trends at 0.05 significance level, and all DCEs passed the parallel trends test for outcomes like total spending, acute care stays and acute care days. For High Needs DCEs, overall spending and most utilization measures have parallel trends at the 0.05 significance level. However, most quality of care measures do not have parallel trends at the 0.05 significance level. Adding a linear term generally decreased significance.

Exhibit H.22. Standard DCEs—Parallel Trends Test Results, PY2022

Setting	Outcome	Under parallel trends assumption		Under linear trends assumption	
		Number of DCEs failing parallel baseline trends test	% of Standard DCEs' aligned beneficiaries in these DCEs	Number of DCEs failing parallel baseline trends test with a significant linear trend	% of Standard DCEs' aligned beneficiaries in these DCEs
Total	Total Medicare spending (Part A and B)^	9	13.4%	8	12.2%
Ambulatory Care	ED visits including observation stays	15	31.3%	10	18.9%
	ACSC hospitalizations	11	9.4%	5	5.5%
	Unplanned admission^	7	8.7%	5	7.9%
	Recommended diabetes care^	13	25.8%	10	21.4%
Hospital-based Care	Acute care hospitalizations	9	19.1%	9	19.1%
	Acute care LOS	8	10.1%	8	10.1%
	All-condition readmissions^	2	5.1%	1	1.7%
	Timely follow-up^	7	3.9%	4	2.4%
Other Settings	SNF days	6	10.4%	6	10.4%
	IRF and LTCH days	4	2.5%	2	1.1%
	Home health episodes^	7	6.3%	6	6.2%
	Continuous hospice days prior to death^	10	6.8%	7	4.3%
	Days at home^	7	15.7%	5	8.6%

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTE: ED=emergency department; SNF=skilled nursing facility; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital; ACSC=ambulatory care sensitive condition; MCC=multiple chronic conditions. ^Total spending and all spending categories are top coded at 99.9th percentile by DCE market and year. Home health episodes are top coded at 14. Eligible population for unplanned admission is beneficiaries with multiple chronic conditions. Eligible population for recommended diabetes care are beneficiaries with diabetes. Eligible population for all-condition readmissions are beneficiaries with index hospitalizations. Eligible population for timely follow-up is beneficiaries with one or more acute events related to one of six chronic conditions (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disorder, diabetes). Eligible population for continuous hospice days prior to death are decedents in the year only. Eligible population for days at home are beneficiaries with chronic complex conditions.

Exhibit H.23. New Entrant DCEs—Parallel Trends Test Results, PY2022

Setting	Outcome	Under parallel trends assumption		Under linear trends assumption	
		Number of DCEs failing parallel baseline trends test	% of New Entrant DCEs' aligned beneficiaries in these DCEs	Number of DCEs failing parallel baseline trends test with a significant linear trend	% of New Entrant DCEs' aligned beneficiaries in these DCEs
Total	Total Medicare spending (Part A and B)^	0	N/A	N/A	N/A
Ambulatory Care	ED visits including observation stays	0	N/A	N/A	N/A
	ACSC hospitalizations	0	N/A	N/A	N/A
	Unplanned admission^	1	2.9%	0	0
	Recommended diabetes care^	0	N/A	N/A	N/A
Hospital-based Care	Acute care hospitalizations	0	N/A	N/A	N/A
	Acute care LOS	0	N/A	N/A	N/A
	All-condition readmissions^	1	2.4%	1	2.4%
	Timely follow-up^	2	8.0%	0	0
Other Settings	SNF days	3	15.4%	1	7.0%
	IRF and LTCH days	1	3.5%	0	0
	Home health episodes^	2	36.1%	0	0
	Continuous hospice days prior to death^	2	24.3%	1	18.4%
	Days at home^	4	31.7%	3	19.8%

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTE: ED=emergency department; SNF=skilled nursing facility; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital; ACSC=ambulatory care sensitive condition; MCC=multiple chronic conditions. ^Total spending and all spending categories are top coded at 99.9th percentile by DCE market and year. Home health episodes are top coded at 14. Eligible population for unplanned admission is beneficiaries with multiple chronic conditions. Eligible population for recommended diabetes care are beneficiaries with diabetes. Eligible population for all-condition readmissions are beneficiaries with index hospitalizations. Eligible population for timely follow-up is beneficiaries with one or more acute events related to one of six chronic conditions (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disorder, diabetes). Eligible population for continuous hospice days prior to death are decedents in the year only. Eligible population for days at home are beneficiaries with chronic complex conditions.

Exhibit H.24. High Needs DCEs—Parallel Trends Test Results, PY2022

Setting	Outcome	Overall	
		Parallel trends test p-value from pooled model	Linear trends test p-value from pooled model
Total	Total Medicare spending (Part A and B)^	0.341	N/A
Ambulatory Care	ED visits including observation stays	0.002	0.001
	ACSC hospitalizations	0.238	N/A
	Unplanned admission^	0.016	0.003
	Recommended diabetes care^	p<0.001	0.121
Hospital-based Care	Acute care hospitalizations	0.134	N/A
	Acute care LOS (days)	0.258	N/A
	All-condition readmissions^	p<0.001	p<0.001
	Timely follow-up^	p<0.001	0.422
Other Settings	SNF days	0.617	N/A
	IRF and LTCH days	0.150	N/A
	Home health episodes^	p<0.001	p<0.001
	Continuous hospice days prior to death^	0.503	N/A
	Days at home^	0.181	N/A

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: ED=emergency department; SNF=skilled nursing facility; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital; ACSC=ambulatory care sensitive condition; MCC=multiple chronic conditions. A parallel trends test p-value <0.05 means the outcome did not meet the parallel trends assumption; a linear trends test p-value <0.05 means the outcome showed significant difference in linear trends between GPDC and comparison group. ^Total spending and all spending categories are top coded at 99.9th percentile by DCE market and year. Home health episodes are top coded at 14. Eligible population for unplanned admission is beneficiaries with multiple chronic conditions. Eligible population for recommended diabetes care are beneficiaries with diabetes. Eligible population for all-condition readmissions are beneficiaries with index hospitalizations. Eligible population for timely follow-up is beneficiaries with one or more acute events related to one of six chronic conditions (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disorder, diabetes). Eligible population for continuous hospice days prior to death are decedents in the year only. Eligible population for days at home are beneficiaries with chronic complex conditions.

When a DCE failed the parallel trends test for a given outcome, the underlying assumption for the DID model is compromised, bringing into question the credibility of an impact estimate. **Exhibits H.25** and **H.26** compare pooled model-wide impact estimates from all DCEs and two sensitivity checks (only including DCEs with parallel baseline trends and adding a linear trend term for DCEs that failed the parallel trends test and that exhibited a linear trend), for Standard and New Entrant DCEs. These sensitivity checks were done for the impact estimates in PY2022. **Exhibit H.27** compares model-wide impact estimates from all High Needs DCEs to a sensitivity check that added a linear trend (the check of dropping DCEs failing the parallel trends test was not relevant for High Needs DCEs, because DCE-specific impact models were not estimated for this DCE type). Since for most outcomes, the number of DCEs (for Standard and New Entrant DCEs) that failed the parallel trends test was small, we relied on models without any adjustment for parallel trends as the main estimates (and these are reflected in the main report).

For Standard DCEs, as shown in **Exhibit H.25**, impact estimates were highly robust to re-estimating models on the subsample of DCEs with parallel baseline trends. Impact estimates for the majority of outcomes were also

robust to the second sensitivity check (that added a linear trend), with some exceptions noted in bold (for either a change in the sign or statistical significance relative to the main estimate). For New Entrant DCEs as well, as **Exhibit H.26** shows, the main estimates were largely robust in sensitivity checks (exceptions are bolded); NA values indicate when a sensitivity check was not applicable because all DCEs for that outcome passed the parallel trends test. For High Needs DCEs, only two of the seven outcomes where linear trend models were examined remained robust to the sensitivity check of adding a linear term.

Exhibit H.25. Standard DCEs—Sensitivity of Impacts on Spending, Utilization, and Quality of Care Outcomes in PY2022, Overall Sample Versus Excluding DCEs Failed Parallel Baseline Trends or Adding a Linear Trend Term

Setting	Outcome	Overall		Excluding DCEs that Failed Parallel Baseline Trends Test		Adding a Linear Trend to DCEs that Failed Parallel Baseline Trends Test	
		Impact Estimate	% Impact	Impact Estimate	% Impact	Impact Estimate	% Impact
Total	Total Medicare spending (Part A and B)^	121.57***	1.0	103.92***	0.9	139.09***	1.2
Ambulatory Care	ED visits including observation stays	-0.21	-0.05	-1.57	-0.4	**2.45****	**0.6**
	ACSC hospitalizations	-0.27	-1.5	-0.13	-0.7	-0.01	-0.07
	Unplanned admission^	-2.73***	-1.2	-2.66**	-1.2	**-0.74**	**-0.3**
	Recommended diabetes care^	2.00**	0.5	3.33***	0.8	3.08***	0.8
Hospital-based Care	Acute care hospitalizations	1.55***	0.8	1.13*	0.6	**1.01**	**0.5**
	Acute care LOS (days)	11.63**	0.9	11.02**	0.8	14.68***	1.1
	All-condition readmissions^	1.05	0.7	1.34	0.8	1.64	1.0
	Timely follow-up^	1.40	0.2	2.26	0.3	2.44	0.3
Other Settings	SNF days	-0.2	-0.01	15.39	0.9	17.64	1.1
	IRF and LTCH days	4.43*	2.1	4.79**	2.3	5.73**	2.8
	Home health episodes^	-14.47*	-0.5	-15.47*	-0.5	**-9.15**	**-0.3**
	Continuous hospice days prior to death^	-1.11***	-4.5	-1.15***	-4.7	-1.84***	-7.3
	Days at home^	0.02	0.02	0.04	0.05	0.02	0.03

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: ED=emergency department; ACSC=ambulatory care sensitive condition; LOS=length of stay; SNF=skilled nursing facility; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital. Estimates in this table are weighted and regression-adjusted. Spending estimates are presented per beneficiary per year (PBPY). Utilization and quality estimates (except for "days at home" and "continuous hospice days prior to death") are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). Estimates for "continuous hospice days prior to death" and "days at home" are presented per beneficiary per year (PBPY). Estimated percentage impact is the DID estimate relative to expected outcome for GPDC beneficiaries in PY2022 had the model not existed and had the beneficiaries' outcomes continued on the same trajectory since baseline. ^Total spending and all spending categories are top coded at 99.9th percentile by DCE market and year. Home health episodes are top coded at 14. Eligible population for unplanned admission is beneficiaries with multiple chronic conditions. Eligible population for recommended diabetes care are beneficiaries with diabetes. Eligible population for all-condition readmissions are beneficiaries with index hospitalizations. Eligible population for timely follow-up is beneficiaries with one or more acute events related to one of six chronic conditions (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disorder, diabetes). Eligible population for continuous hospice days prior to death are decedents in the year only. Eligible population for days at home are beneficiaries with chronic complex conditions. ***p<0.01, **p<0.05, *p<0.10. Bold values indicate outcomes that changed statistical significance in sensitivity analyses.

Exhibit H.26. New Entrant DCEs—Sensitivity of Impact on Spending, Utilization, and Quality of Care Outcomes in PY2022, Overall Sample Versus Excluding DCEs Failed Parallel Baseline Trends or Adding a Linear Trend Term

Setting	Outcome	Overall		Excluding DCEs that Failed Parallel Baseline Trends Test		Adding a Linear Trend to DCEs that Failed Parallel Baseline Trends Test	
		Impact Estimate	% Impact	Impact Estimate	% Impact	Impact Estimate	% Impact
Total	Total Medicare spending (Part A and B)^	-210.84	-1.59	NA	NA	NA	NA
Ambulatory Care	ED visits including observation stays	-12.28**	-3.16	NA	NA	NA	NA
	ACSC hospitalizations	-1.24	-6.10	NA	NA	NA	NA
	Unplanned admission^	3.86	1.72	4.96	2.20	3.86	1.72
	Recommended diabetes care^	19.79***	5.44	NA	NA	NA	NA
Hospital-based Care	Acute care hospitalizations	2.48	1.23	NA	NA	NA	NA
	Acute care LOS (days)	30.98	2.36	NA	NA	NA	NA
	All-condition readmissions^	-3.04	-1.80	-6.36	-3.73	-1.96	-1.16
	Timely follow-up^	10.69	1.31	0.20	0.02	10.69	1.31
Other Settings	Acute care hospitalizations	0.31	0.02	20.57	1.30	75.66	4.87
	Acute care LOS	17.96	9.18	22.87	11.91	17.96	9.18
	All-condition readmissions^	-61.91	-2.24	NA	NA	NA	NA
	Timely follow-up^	-2.92	-9.85	**-5.48****	**-17.70**	**-10.23***	**-27.70**
	SNF days	-0.04	-0.04	-0.05	-0.06	0.56	0.60

SOURCE: NORC analysis of Medicare claims and enrollment data.

NOTES: ED=emergency department; ACSC=ambulatory care sensitive condition; LOS=length of stay; SNF=skilled nursing facility; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital. Estimates in this table are weighted and regression-adjusted. Spending estimates are presented per beneficiary per year (PBPY). Utilization and quality estimates (except for "days at home" and "continuous hospice days prior to death") are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). Estimates for "continuous hospice days prior to death" and "days at home" are presented per beneficiary per year (PBPY). Estimated percentage impact is the DID estimate relative to expected outcome for GPDC beneficiaries in PY2022 had the model not existed and had the beneficiaries' outcomes continued on the same trajectory since baseline. ^Total spending and all spending categories are top coded at 99.9th percentile by DCE market and year. Home health episodes are top coded at 14. Eligible population for unplanned admission is beneficiaries with multiple chronic conditions. Eligible population for recommended diabetes care are beneficiaries with diabetes. Eligible population for all-condition readmissions are beneficiaries with index hospitalizations. Eligible population for timely follow-up is beneficiaries with one or more acute events related to one of six chronic conditions (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disorder, diabetes). Eligible population for continuous hospice days prior to death are decedents in the year only. Eligible population for days at home are beneficiaries with chronic complex conditions. ***p<0.01, **p<0.05, *p<0.10. Bold values indicate outcomes that changed statistical significance in sensitivity analyses. NA values indicate when a sensitivity check was not applicable since all DCEs for that outcome passed the parallel trends test.

Exhibit H.27. High Needs DCEs—Sensitivity of Impacts on Utilization, and Quality of Care Outcomes in PY2022, Overall Versus Adding a Linear Trend Term

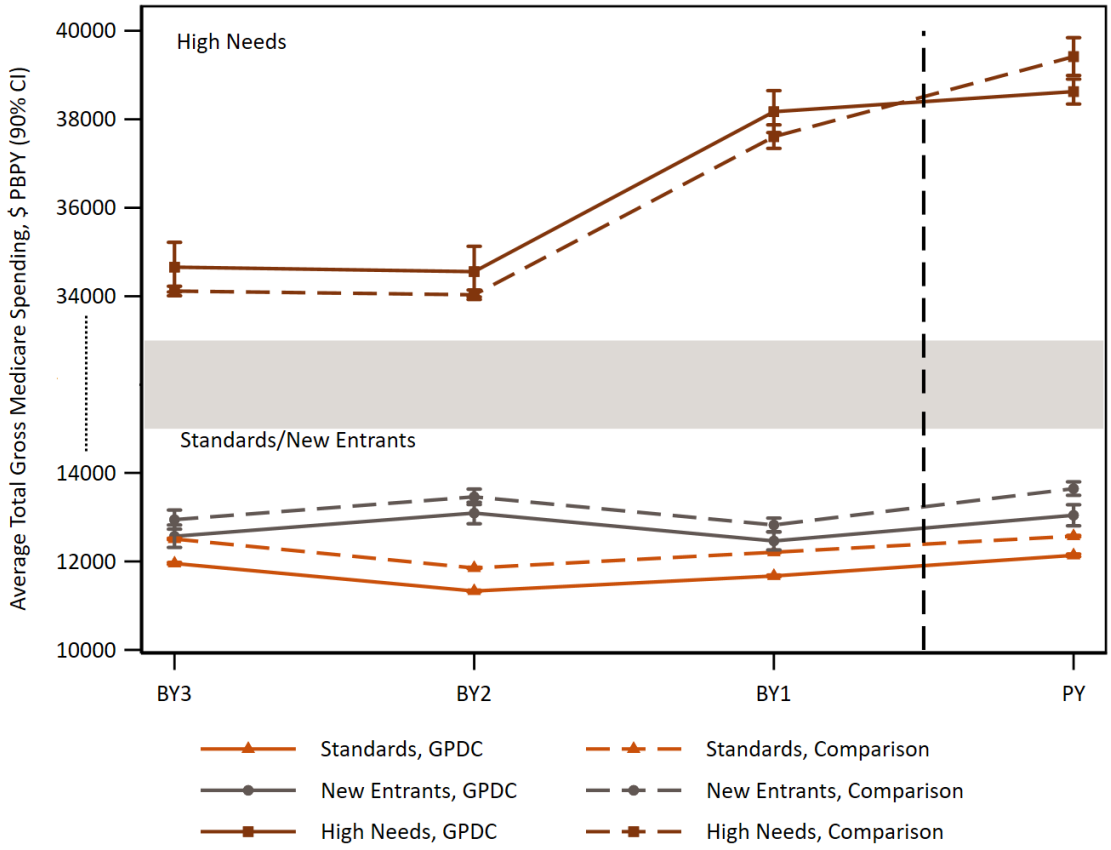
Setting	Outcome	Overall		Adding a Linear Trend to DCEs that Failed Parallel Baseline Trends Test	
		Impact Estimate	% Impact	Impact Estimate	% Impact
Total	Total Medicare spending (Part A and B)^	-1397.76***	-3.5	N/A	N/A
Ambulatory Care	ED visits including observation stays	-41.79**	-5.0	**-6.59**	**-7.6**
	ACSC hospitalizations	0.8*	-0.8	N/A	N/A
	Unplanned admission^	-4.59	-1.4	**1.76**	**5.9**
Hospital-based Care	Acute care hospitalizations	-43.70**	-6.1	N/A	N/A
	Acute care LOS	-404.32***	-7.7	N/A	N/A
	All-condition readmissions^	-11.7*	-5.0	**0.18**	**0.6**
	Timely follow-up^	19.57	3.0	2.60	4.1
Other Settings	SNF days	-1467.8	-12.3	N/A	N/A
	IRF and LTCH days	-108.87	-9.6	N/A	N/A
	Home health episodes^	-73.64	-5.1	-15.29	-10.0
	Continuous hospice days prior to death^	1546.30	4.6	N/A	N/A
	Days at home^	6.76**	0.7	N/A	N/A

SOURCE: NORC team analysis of Medicare claims and enrollment data.
NOTES: ED=emergency department; ACSC=ambulatory care sensitive condition; LOS=length of stay; SNF=skilled nursing facility; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital. Estimates in this table are weighted and regression-adjusted. Spending estimates are presented per beneficiary per year (PBPY). Utilization and quality estimates (except for "days at home" and "continuous hospice days prior to death") are presented as rate of the outcome per 1,000 beneficiaries per year (BPY). Estimates for "continuous hospice days prior to death" and "days at home" are presented per beneficiary per year (PBPY). Estimated percentage impact is the DID estimate relative to expected outcome for GPDC beneficiaries in PY2022 had the model not existed and had the beneficiaries' outcomes continued on the same trajectory since baseline. ^Total spending and all spending categories are top coded at 99.9th percentile by DCE market and year. Home health episodes are top coded at 14. Eligible population for unplanned admission is beneficiaries with multiple chronic conditions. Eligible population for recommended diabetes care are beneficiaries with diabetes. Eligible population for all-condition readmissions are beneficiaries with index hospitalizations. Eligible population for timely follow-up is beneficiaries with one or more acute events related to one of six chronic conditions (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disorder, diabetes). Eligible population for continuous hospice days prior to death are decedents in the year only. Eligible population for days at home are beneficiaries with chronic complex conditions. ***p<0.01, **p<0.05, *p<0.10. Bold values indicate outcomes that changed statistical significance in sensitivity analyses. NA values indicate when a sensitivity check was not applicable since all DCEs for that outcome passed the parallel trends test.

Appendix I: Exhibits to Support Chapter 3

Exhibit I.1 shows the average trends in gross Medicare spending from baseline years to the PY2022 for all three types of DCEs and their comparison groups. Compared to the first baseline year, all three types of DCEs and their relevant comparison groups increased their gross spending in PY2022, consistent with a broader post-pandemic trend. Both Standard and New Entrant DCEs had lower gross spending for all years compared with comparison groups, while High Needs DCEs had higher gross spending for base years and lower gross spending in PY2022 compared with their comparison group.

Exhibit I.1. In PY2022, Gross Medicare Spending Estimates by GPDC and Comparison Group Over Time[88]



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

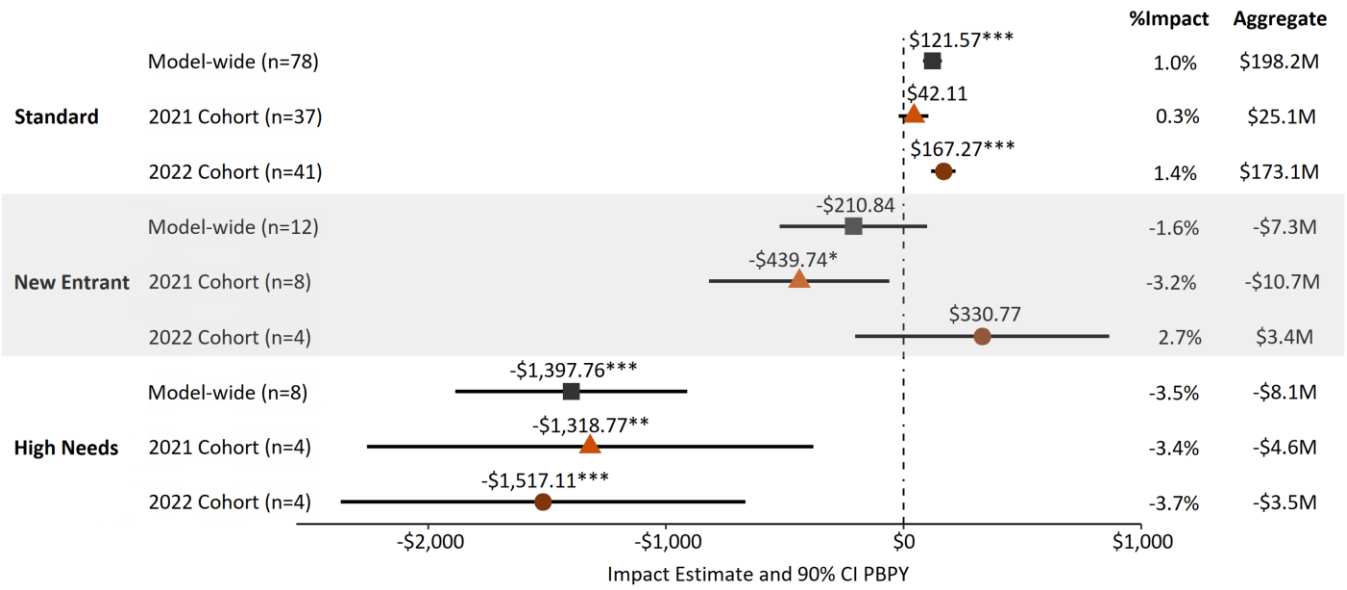
NOTES: Point estimates are the adjusted gross Medicare Parts A and B spending for GPDC or comparison beneficiaries in each year. Confidence intervals at the 90% level are displayed as bars around the point estimates. PBPY=per beneficiary per year. Performance year (PY) 2022 for Standard and New Entrant DCEs includes calendar year 2022 for the 2021 cohort and 2022 cohort DCEs. Baseline years (BY) BY 1–BY 3 span calendar years 2018–2020 for the 2021 cohort DCEs, and 2019–2021 for the 2022 cohort DCEs (i.e., BY1=CY2020 for 2021 cohort and CY2021 for 2022 cohort, BY2=CY2019 for 2021 cohort and CY2020 for 2022 cohort, BY3=CY2018 for 2021 cohort and CY2019 for 2022 cohort).

[88] We did not include PY2021 to this trend graph because 1) PY2021 only included 2021 cohort, and 2) within 2021 cohort, PY2021 BYs and PY2022 BYs are different because PY2021 and PY2022 participant providers are different.

Exhibit I.2 shows the gross spending impacts in PY2022 by cohort for the Standard, New Entrant, and High Needs DCEs, separately. Differences in impacts for cohorts in PY2022 reflect an additional year of experience in the model for 2021 cohort DCEs. Differences in impacts for cohorts may also reflect differences in their DCEs' organizations and markets.

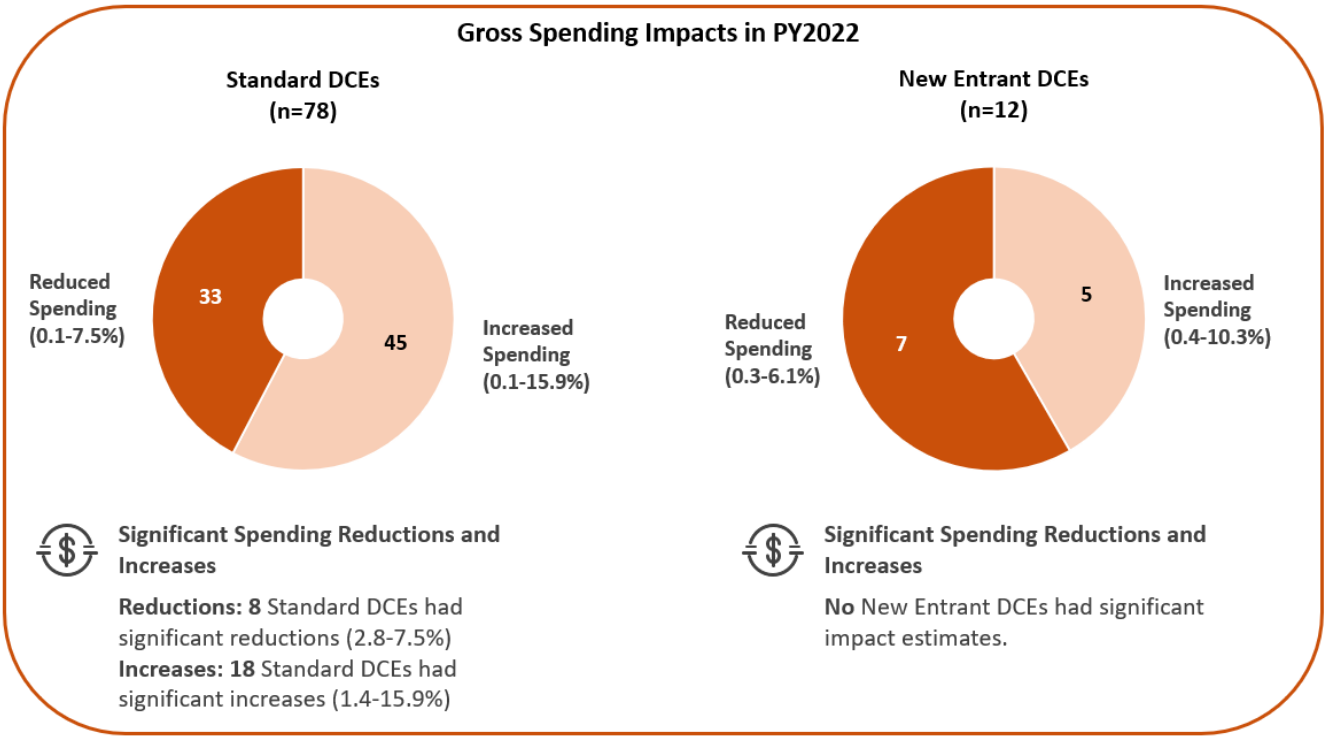
- Standard DCEs significantly increased gross Medicare spending in PY2022 by an estimated $198.2 million (1.0%) or $121.57 PBPY, with a non-significant increase of $25.1 million (0.3%) or $42.11 PBPY for the 2021 Cohort and a significant increase of $173.1 million (1.4%) or $167.27 PBPY for the 2022 Cohort.
- New Entrant DCEs decreased gross Medicare spending in PY2022 by an estimated $7.3 million (1.6%), or $210.84 PBPY, with a significant decrease of $10.7 million (3.2%) or $439.74 PBPY for the 2021 Cohort but a non-significant increase of 3.4 million (2.7%) or $330.77 PBPY for the 2022 Cohort.
- High Needs DCEs significantly decreased gross Medicare spending in PY2022 by an estimated $8.1 million (3.5%), or $1,397.76 PBPY. Both 2021 and 2022 Cohorts High Needs DCEs lowered gross Medicare spending significantly, with an estimate of $4.6 million or $1,318.77 PBPY for the 2021 Cohort and an estimate of 3.5 million or $1,517.11 PBPY for the 2022 Cohort.

Exhibit I.2. Gross Medicare Spending Impact Estimates in PY2022, by DCE Type and Cohort



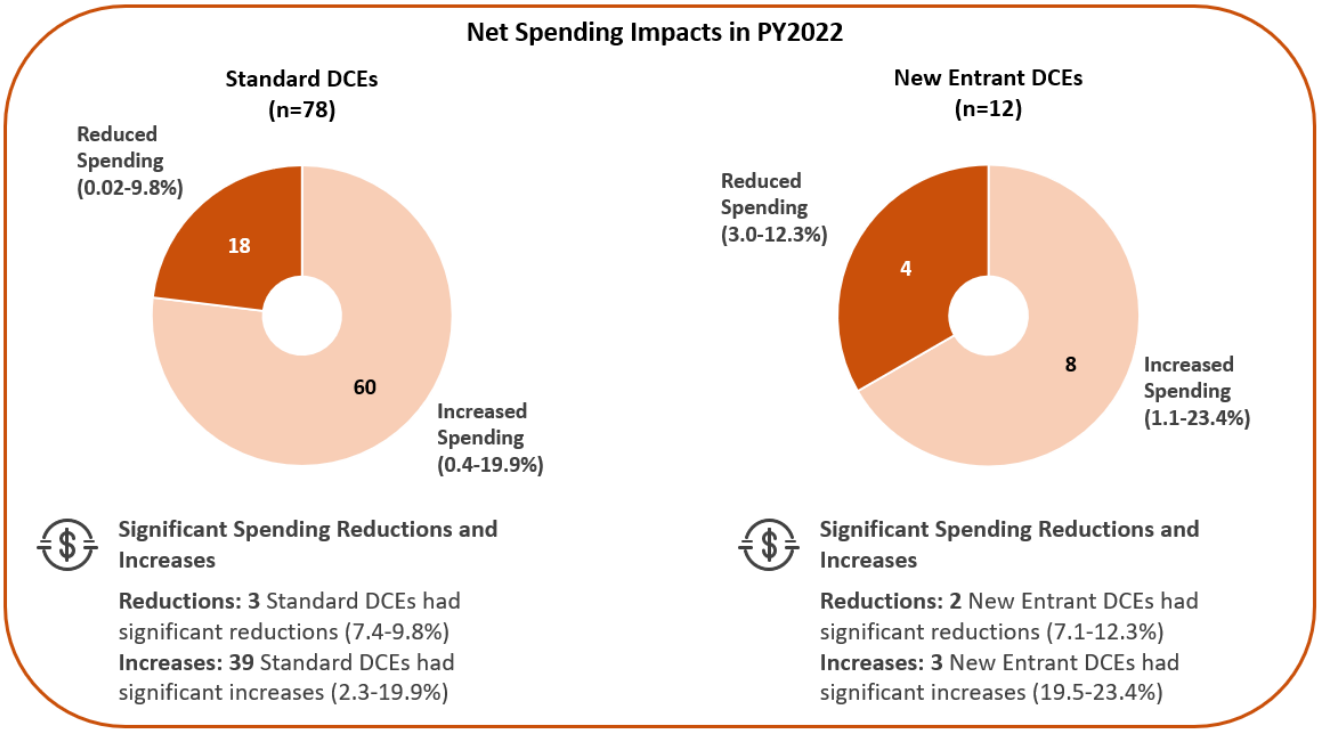
SOURCE: NORC analysis of Medicare claims, enrollment, and GPDC Model data.
NOTES: Model-wide impact in PY2022 includes impacts for the 2021 cohort and 2022 cohort of DCEs. In model-wide and cohorts' estimates, the n represents the number of DCEs. Estimated gross impact is the difference-in-differences (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. Aggregate estimate is the impact estimate for all aligned beneficiaries in PY. Estimated percentage impact is the DID estimate relative to expected outcome for GPDC beneficiaries in PY had the model not existed and had the beneficiaries' outcomes continued along the same trajectory since baseline. *p<0.10, **p<0.05, ***p<0.01.

Exhibit I.3. Standard DCE Gross Spending Impacts in PY2022



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

Exhibit I.4. Standard and New Entrant DCE Net Spending Impacts in PY2022

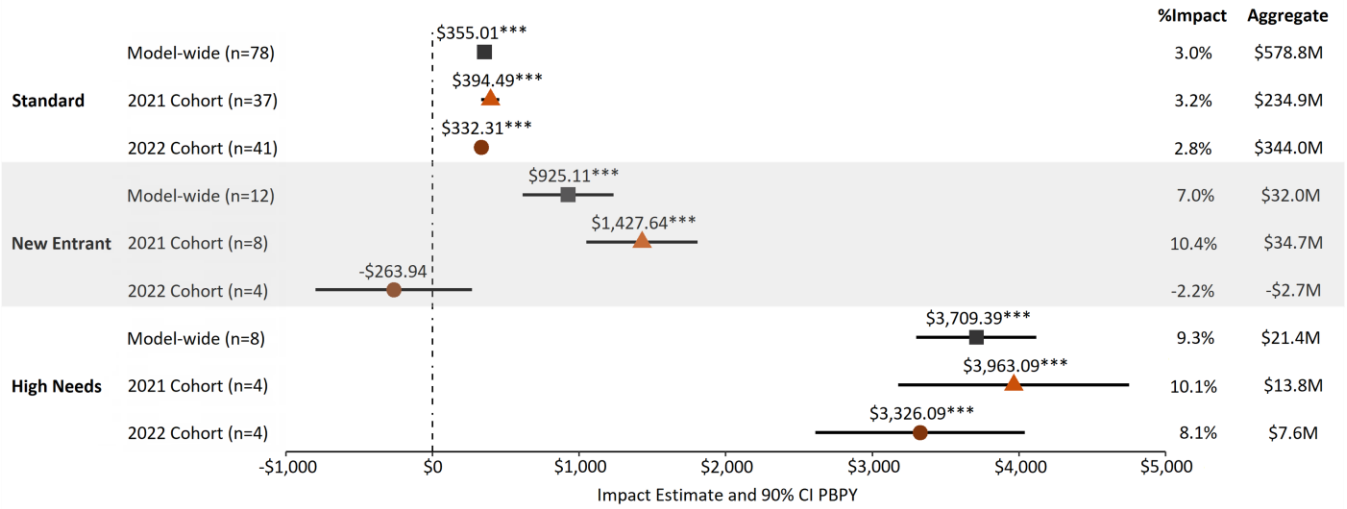


SOURCE: NORC analysis of Medicare claims, enrollment, and GPDC Model data.

Exhibit I.5 shows the net spending impacts in PY2022 by cohort for the three types. Net spending impacts in PY2022 differed for the 2021 and 2022 cohorts of DCEs.

- Standard DCEs significantly increased net Medicare spending in PY2022, with an estimate of $578.8 million (3.0%) or $355.01 PBPY. The significant increase was observed for both the 2021 and 2022 Cohorts.
- New Entrant DCEs significantly increased net Medicare spending in PY2022, with an estimate of $32.0 million (7.0%) or $925.11 PBPY. Despite a significant decrease in gross Medicare spending, the 2021 Cohort showed a significant increase of over 10% in net Medicare spending. In contrast, the 2022 Cohort showed a decline in net spending despite increasing gross spending due to recoupment of shared losses from its DCEs.
- High Needs DCEs also significantly increased net Medicare spending in PY2022, with an estimate of $21.4 million (9.3%) or $3,709.39 PBPY. Despite a significant decrease in gross Medicare spending, both the 2021 and 2022 cohorts of DCEs showed a significant increase in net Medicare spending.

Exhibit I.5. Net Medicare Spending Estimates in PY2022, by DCE Type and Cohort



SOURCE: NORC analysis of Medicare claims, enrollment, and GPDC Model data.
NOTES: Model-wide impact in PY2022 includes impacts for the 2021 cohort and 2022 cohort of DCEs. In model-wide and cohorts' estimates, the n represents the number of DCEs. Estimated net impact is the gross 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). Aggregate estimate is the net impact estimate for all aligned beneficiaries 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). *p<0.10, **p<0.05, ***p<0.01.

Exhibit I.6 presents the results of two sensitivity analyses to assess the extent to which the GPDC and comparison group beneficiaries were impacted by COVID-19: 1) by dropping 2020 from the baseline period and 2) controlling for county-level population's COVID-19 mortality in the regression models. We found no meaningful differences between the "main" model and these sensitivity tests. This is an expected result because our comparison group is drawn from the same geographic area as the treatment group; thus, we would not expect an adjustment for COVID-19 to meaningfully change our findings, or for 2020 to impact the two groups differently.

Exhibit I.6. Gross Medicare Spending Estimates in PY2022, by COVID-19-Related Sensitivity Checks

DCE Type	Model Specification	Number of GPDC Beneficiaries	Aggregate Impact Estimate $PBPY (90% CI)	% Impact
Standards	Main	1,630,368	121.57 (82.18, 160.96) ***	1.0
	Dropping 2020	1,630,368	100.11 (58.58, 141.64) ***	0.8
	Adding COVID-19 Mortality	1,630,368	120.63 (81.09, 160.17) ***	1.0
New Entrants	Main	34,597	-210.84 (-521.24, 99.56)	-1.6
	Dropping 2020	34,597	-223.68 (-562.94, 115.59)	-1.7
	Adding COVID-19 Mortality	34,597	-230.18 (-547.65, 87.28)	-1.7
High Needs	Main	5,775	-1,397.76 (-1,885.43, -910.09) ***	-3.5
	Dropping 2020	5,775	-1,305.24 (-2,540.70, -69.78) *	-3.3
	Adding COVID-19 Mortality	5,775	-1,348.80 (-1,846.51, -851.08) ***	-3.4

SOURCE: NORC analysis of Medicare claims, enrollment, and GPDC Model data.
NOTES: Model-wide impact in PY2022 includes impacts for the 2021 cohort and 2022 cohort 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. Aggregate estimate is the impact estimate for all aligned beneficiaries in PY. Estimated percentage impact is the DID estimate relative to expected outcome for GPDC beneficiaries in PY had the model not existed and had the beneficiaries' outcomes continued along the same trajectory since baseline. *p<0.10, **p<0.05, ***p<0.01.

Exhibits I.7 through **I.8** present detailed **DCE-level** impact results for spending for PY2022 Standard and New Entrant. We present mean outcomes in the baseline (2018–2020 for 2021 Cohort DCEs; 2019–2021 for 2022 Cohort DCEs) and performance (2022) years, and the change from **baseline** to **performance years** in the GPDC and comparison groups. The impact estimate, 90% confidence interval, and percent impact are estimated from the DID model. Impacts for High Needs DCEs are not presented at the DCE-level because these small DCEs were only evaluable at the cohort and DCE-type levels.

Our DID estimate is based on satisfying the parallel trends assumption, which allows us to establish the counterfactual when—absent the model—time trends in the outcome variable between the GPDC and comparison groups would be the same in the performance year. The presence of parallel trends in the outcome variable across the two groups in the BYs justifies the assumption of parallel trends in the performance year. As mentioned above, a few Standard DCEs were found to have violations of the parallel trends test for total spending, while all New Entrant DCEs passed the test. Failing the parallel trends test (that is, the p-value of the joint F test is less than 0.05) indicates that the DID estimate for the DCE needs to be interpreted with caution (affected entities are **bolded** to highlight these results).

Exhibit I.7. Standard DCEs—DCE-Level Gross Spending Impacts in PY2022

Standard DCE Name	DCE ID	Number of aligned beneficiaries	Comparison ($ PBPY)		GPDC ($ PBPY)		Difference-in-Difference				Parallel trends test p-value	Shared savings/ losses ($PBPY)
			Baseline	PY2022	Baseline	PY2022	Impact Estimate ($ PBPY)	90% CI ($ PBPY)		% Impact		
360 Health DCE Inc.	D0142	2,891	14,280.35	15,444.22	14,435.92	15,110.23	-502.24	-1,661.94	657.46	-3.22	0.55	744.34
ADVANCED VALUE CARE II	D0021	14,607	13,993.72	14,794.15	13,069.09	14,664.09	847.45***	404.6	1,290.30	6.13	0.17	-703.95
AKOS MD IPA, LLC	D0141	29,629	12,155.35	12,580.35	11,647.97	12,513.29	458.05***	187.06	729.05	3.80	0.53	-399.82
APA ACO Inc.	**D0215**	**19,380**	**15,339.37**	**17,030.71**	**13,448.08**	**15,170.44**	**239.56**	**-238.56**	**717.69**	**1.60**	**0.04**	**56.30**
Accountable Care Coalition of Direct Contracting, LLC	D0115	21,990	13,596.81	14,207.00	13,074.49	13,749.89	88.64	-257.49	434.77	0.65	0.70	-134.91
Accountable Care Coalition of Southeast Texas, Inc.	D0112	7,180	15,860.39	16,286.08	14,378.94	15,436.36	671.50*	5.90	1,337.10	4.55	0.20	672.55
AdventHealth Senior Care, Inc.	D0124	3,718	11,674.91	11,567.54	10,734.62	11,439.58	803.69*	110.65	1,496.72	7.56	0.70	121.26
Alignment Health ACO, LLC	D0178	4,858	9,514.38	9,856.95	9,208.08	8,968.66	-570.97*	-1,130.39	-11.54	-5.99	0.32	535.68
America's MDE, LLC	D0155	5,179	13,125.82	13,199.62	12,471.25	12,481.18	-60.18	-668.9	548.53	-0.48	0.37	588.92
American Choice Healthcare, LLC	D0086	37,962	15,088.36	15,923.50	14,261.20	14,626.83	-423.72**	-698.05	-149.39	-2.82	0.83	776.74
Arizona Care Network - Next, LLC	D0214	25,242	11,682.29	12,033.06	11,064.96	11,230.83	-166.37	-434.41	101.67	-1.46	0.10	216.68
Asaar Medical Inc.	D0071	56,319	11,785.25	11,915.72	11,033.03	11,189.19	34.02	-151.98	220.03	0.31	0.12	245.3
Auxilium Health Network	D0101	3,828	18,923.18	19,865.01	18,271.74	18,851.83	-329.32	-1,402.78	744.14	-1.72	0.06	-290.99
CareAllies Accountable Care Solutions, LLC	D0045	5,229	13,276.80	13,575.85	13,329.48	13,757.37	127.65	-532.45	787.76	0.94	0.96	529.55
CareMount Value Partners IPA	**D0019**	**26,300**	**13,117.37**	**14,059.26**	**12,591.21**	**13,699.79**	**204.48**	**-141.23**	**550.19**	**1.52**	**0.03**	**395.41**
Castell Accountable Care, LLC	D0136	47,745	11,156.11	11,269.10	10,473.40	10,723.21	143.73	-68.35	355.82	1.36	0.98	701.11
Castell Direct, LLC	D0153	5,811	13,403.68	13,651.53	11,728.92	12,326.81	381.01	-328.31	1,090.32	3.19	0.71	543.61
Central Utah Clinic, P.C.	D0042	14,866	11,481.56	11,449.81	10,924.53	11,201.48	307.14	-112.1	726.39	2.82	0.20	486.38

Standard DCE Name	DCE ID	Number of aligned beneficiaries	Comparison ($ PBPY)		GPDC ($ PBPY)		Difference-in-Difference				Parallel trends test p-value	Shared savings/ losses ($PBPY)
			Baseline	PY2022	Baseline	PY2022	Impact Estimate ($ PBPY)	90% CI ($ PBPY)		% Impact		
Central Valley Community Partners LLC	D0078	3,922	15,428.04	16,843.21	14,931.41	15,441.20	-859.83	-1,880.69	161.04	-5.27	0.79	-347.91
Cityblock Health DCE, LLC	D0120	3,579	12,676.13	13,885.14	12,422.29	13,014.11	-592.98	-2,023.94	837.99	-4.36	0.92	-394.64
Clover Health Partners LLC	D0132	155,813	13,054.86	13,665.18	12,781.19	13,615.43	236.71***	109.53	363.89	1.77	0.35	-294.71
Complete Health Accountable Care LLC	D0036	9,285	12,528.48	12,626.12	11,516.58	11,467.47	-138.86	-570.95	293.23	-1.20	0.61	1,093.88
Doctors Choice Medical Group	D0184	2,521	25,899.27	27,037.39	26,976.35	26,475.10	-1,686.69	-3,632.29	258.90	-5.99	0.32	-1,081.56
EXCELERA DCE	D0054	21,226	15,685.66	16,564.46	14,444.65	15,122.44	-131.48	-533.01	270.04	-0.86	0.55	287
Esse Health ACO, LLC	D0140	52,473	11,598.36	11,943.99	10,733.34	11,253.78	200.59*	9.73	391.45	1.81	0.68	327.78
FREEDOM PHYSICIANS CORPORATION	D0185	3,150	17,920.90	18,694.45	16,574.45	15,994.80	-1,295.09*	-2,466.32	-123.85	-7.49	0.17	-313.53
Fairview Health Services	D0147	23,580	11,776.07	11,773.00	11,500.78	11,620.57	122.78	-185.25	430.81	1.07	0.49	249.56
Genuine Health Direct, LLC	D0008	9,210	15,067.91	16,031.24	14,180.71	14,396.26	-691.07**	-1,228.78	-153.35	-4.58	0.65	1,330.02
Health Partners for the Elderly LLC	**D0084**	**5,133**	**13,901.82**	**13,719.06**	**13,138.66**	**15,025.62**	**2059.68*** **	**1,458.38**	**2,660.97**	**15.89**	**<0.001**	**-1,081.08**
Hudson Accountable Care, LLC	D0187	7,943	13,588.06	14,197.04	13,009.19	14,604.67	1,012.44**	242.55	1,782.33	7.45	0.40	-331.04
Humana Direct Contracting Entity, Inc.	D0203	51,881	10,866.36	11,184.22	10,294.18	10,581.94	-13.37	-211.18	184.45	-0.13	0.09	444.08
Indiana University Health ACO, Inc.	D0034	45,325	10,738.54	11,107.05	10,822.42	11,497.58	303.76**	73.73	533.8	2.71	0.64	60.69
Iowa Health Accountable Care, L.C.	D0007	99,483	10,545.73	10,745.58	10,330.20	10,674.01	148.05*	5.43	290.67	1.41	0.51	-150.48
NW Momentum Health Partners ACO	D0179	24,315	10,153.01	10,186.22	9,788.93	10,351.18	530.23***	204.49	855.98	5.40	0.07	102.70
NeueHealth Advantage ACO, LLC	D0151	30,650	14,067.62	14,970.81	13,429.75	14,251.10	-40.89	-351.7	269.92	-0.29	0.64	-73.02
NeueHealth Premier ACO, LLC	D0181	14,092	11,241.03	11,376.32	10,570.14	10,470.34	-227.01	-591.84	137.83	-2.12	0.57	1,077.78

Standard DCE Name	DCE ID	Number of aligned beneficiaries	Comparison ($ PBPY)		GPDC ($ PBPY)		Difference-in-Difference				Parallel trends test p-value	Shared savings/ losses ($PBPY)
			Baseline	PY2022	Baseline	PY2022	Impact Estimate ($ PBPY)	90% CI ($ PBPY)		% Impact		
Northern Michigan Health Network	D0067	7,907	9,791.26	9,802.07	9,260.62	9,400.45	129.61	-388.68	647.9	1.40	0.13	347.34
Oak Street Health Medicare Partners LLC	D0063	6,687	16,333.00	15,646.89	15,532.93	13,778.67	-1101.76**	-1,837.43	-366.1	-7.40	0.08	3,296.07
On Belay Health Solutions, LLC	D0027	6,019	11,835.31	12,412.63	11,236.03	11,393.19	-390.92	-995.65	213.82	-3.32	0.19	167.21
Park Nicollet Health Services ACO LLC	D0207	35,545	11,203.66	11,225.55	10,926.66	11,210.78	262.77*	6.92	518.62	2.40	0.83	-24.63
Pathways Accountable Care, LLC	D0048	11,601	14,638.25	14,809.42	13,998.50	14,229.65	67.47	-366.7	501.64	0.48	0.09	1,358.05
PeaceHealth Direct Contracting LLC	D0152	25,091	10,853.36	10,893.77	10,806.70	10,441.02	-405.92**	-668.55	-143.3	-3.74	0.42	261.11
Physician Leaders Direct Contracting Entity, LLC	**D0171**	**10,142**	**16,019.31**	**17,355.46**	**15,153.22**	**16,034.17**	**-382.96**	**-994.51**	**228.59**	**-2.33**	**0.02**	**986.12**
Physicians Healthcare Collaborative	D0068	11,405	9,932.93	9,882.17	9,678.10	9,652.55	23.91	-358.84	406.66	0.25	0.18	1,178.41
PraxisCare, Inc.	D0062	16,829	9,607.38	9,766.24	8,666.79	9,185.14	375.04**	83.8	666.27	4.26	0.37	148.35
Primary Care Alliance, LLC	D0010	11,661	12,362.30	12,443.46	11,139.40	11,558.98	346.45	-31.64	724.54	3.09	0.81	1,883.09
Q Point Health, LLC	D0127	8,979	11,355.12	11,540.70	11,085.89	11,925.62	658.56**	191.28	1,125.83	5.84	0.54	-483.97
Rancho Health Management, LLC	D0015	25,963	11,347.49	11,800.53	10,808.54	11,211.03	-29.03	-305.55	247.49	-0.26	0.57	112.13
Regal Medical Group	D0077	4,126	12,783.85	13,915.43	12,335.75	12,684.12	-743.55	-1,553.54	66.44	-5.54	0.17	338.29
Reliant Medical Group, Inc.	D0218	10,670	13,910.72	14,017.83	12,156.57	12,072.31	-177.87	-645.4	289.66	-1.45	0.85	1,538.82
Renovis Health LLC	D0011	2,485	20,348.49	19,745.80	20,661.52	19,660.92	-388.64	-2,336.62	1,559.35	-1.94	0.12	-34.78
Renown Direct Contracting Entity, LLC	D0133	11,533	10,899.79	10,971.22	10,081.12	10,537.02	389.83	-11.34	791.00	3.84	0.12	239.4
Saint Francis Hospital Medicare ACO, LLC	D0103	5,361	10,720.86	11,413.26	10,068.37	11,181.67	463.04	-102.17	1,028.24	4.32	0.41	101.69
St. Luke's Clinic Coordinated Care, Ltd	D0059	23,742	10,246.46	10,390.17	9,824.50	10,691.26	728.97***	410.13	1,047.81	7.32	0.38	346.33

Standard DCE Name	DCE ID	Number of aligned beneficiaries	Comparison ($ PBPY)		GPDC ($ PBPY)		Difference-in-Difference				Parallel trends test p-value	Shared savings/ losses ($PBPY)
			Baseline	PY2022	Baseline	PY2022	Impact Estimate ($ PBPY)	90% CI ($ PBPY)		% Impact		
Steward Integrated Care Network, Inc.	**D0130**	**8,614**	**13,277.82**	**13,487.57**	**12,022.03**	**11,954.19**	**-257.76**	**-712.93**	**197.42**	**-2.11**	**0.05**	**99.52**
Subsero Healthcare, LLC	D0172	7,324	13,707.67	13,983.41	12,672.01	12,339.51	-587.40*	-1,108.91	-65.9	-4.54	0.85	1,884.83
Sutter Preferred Direct Contracting Entity, LLC.	**D0163**	**111,166**	**12,619.39**	**13,511.57**	**12,239.82**	**13,314.62**	**209.46***	**25.61**	**393.3**	**1.60**	**0.02**	**-325.55**
SwingHealth Inc.	D0149	23,913	11,085.28	11,392.22	10,951.52	11,334.56	79.79	-197.29	356.88	0.71	0.08	-345.74
Temple Center For Population Health, Inc.	**D0012**	**6,647**	**12,472.42**	**12,785.01**	**11,857.92**	**12,528.44**	**373.33**	**-249.08**	**995.73**	**3.07**	**0.04**	**20.00**
The MetroHealth System	**D0020**	**8,071**	**10,773.68**	**10,753.62**	**10,429.20**	**11,288.89**	**879.11*****	**401.53**	**1,356.68**	**8.44**	**<0.001**	**197.27**
Triad HealthCare Network, LLC.	D0209	23,888	10,810.20	10,907.14	10,211.08	10,397.06	94.41	-313.47	502.28	0.92	0.45	342.28
UT Southwestern Accountable Care Network	D0211	106,681	12,861.03	12,892.11	12,357.97	12,577.08	189.25*	17.65	360.85	1.53	0.76	238.36
UW Health ACO, Inc.	**D0217**	**23,573**	**8,822.30**	**8,962.75**	**9,043.17**	**9,364.79**	**177.65**	**-132.42**	**487.72**	**1.93**	**0.04**	**90.76**
VillageMD New Hampshire ACO, LLC	D0106	6,574	12,415.89	13,067.71	11,998.53	12,108.66	-519.78	-1,156.02	116.47	-4.12	0.40	1,466.21
VillageMD Primary Providers ACO II, LLC	D0025	12,936	13,386.06	13,946.61	12,382.77	13,214.93	313.62	-142.28	769.51	2.43	0.54	815.9
VillageMD Primary Providers ACO III, LLC	D0099	14,038	13,123.24	12,733.15	12,482.04	12,082.73	-28.28	-421.28	364.72	-0.23	0.51	275.44
VillageMD Primary Providers ACO IV, LLC	D0100	15,296	10,682.76	11,136.43	10,178.86	10,717.34	106.21	-228.07	440.49	1.00	0.57	384.17
VillageMD Primary Providers ACO V, LLC	D0105	8,327	12,448.98	12,828.88	11,706.70	12,012.32	-51.62	-524.22	420.98	-0.43	0.29	515.28
VillageMD Primary Providers ACO, LLC	D0102	11,392	11,991.70	12,483.40	12,001.67	12,023.86	-469.90*	-884.93	-54.87	-3.76	0.83	298.59
agilon health Coastal DCE, Inc.	D0107	6,899	9,570.11	10,268.40	8,972.34	9,320.03	-306.99	-801.52	187.53	-3.19	0.36	772.33
agilon health Columbus Ohio DCE, Inc.	D0114	27,530	10,862.53	11,176.77	9,529.50	9,876.34	71.16	-199.9	342.23	0.73	0.50	1,036.99

Standard DCE Name	DCE ID	Number of aligned beneficiaries	Comparison ($ PBPY)		GPDC ($ PBPY)		Difference-in-Difference				Parallel trends test p-value	Shared savings/ losses ($PBPY)
			Baseline	PY2022	Baseline	PY2022	Impact Estimate ($ PBPY)	90% CI ($ PBPY)		% Impact		
agilon health Mid-Atlantic DCE, Inc.	D0156	10,297	10,881.44	10,731.31	10,361.14	10,441.67	223.48	-218.35	665.31	2.19	0.38	1,345.79
agilon health Northeast Ohio DCE, Inc.	D0056	9,654	10,773.86	10,896.28	9,752.72	9,870.50	6.95	-417.32	431.22	0.07	0.68	815.54
agilon health Northeastern DCE, Inc.	D0109	13,578	11,487.06	11,574.30	10,816.39	11,283.90	385.37	-11.53	782.26	3.54	0.52	604.64
agilon health Ohio DCE, Inc.	D0116	9,278	11,535.52	11,723.70	11,025.21	10,924.69	-280.37	-772.11	211.36	-2.50	0.17	1,311.01
agilon health Pennsylvania DCE, Inc.	D0113	5,179	10,147.45	10,503.99	9,511.40	9,728.72	-116.87	-672.96	439.22	-1.19	0.54	820.45
agilon health Texas DCE, Inc.	D0033	7,968	12,954.74	13,557.56	12,530.99	13,213.91	99.81	-410.98	610.6	0.76	0.10	86.87
ilumed, LLC	D0005	19,484	13,394.39	13,619.17	13,063.75	13,485.71	202.74	-140.83	546.3	1.53	0.45	1,047.34

SOURCE: NORC team analysis of Medicare claims and enrollment data.
NOTES: Estimates in this table are weighted and regression-adjusted. Total spending is top coded at 99.9th percentile by DCE market and year. Shared savings/losses for each DCE from financial settlement results were scaled to the number of beneficiary-months included in our analysis. Baseline years (BY) BY3–BY1 span calendar years 2018–2020 for the 2021 Cohort DCEs, and 2019–2022 for the 2022 Cohort DCEs. ***p<0.01, **p<0.05, *p<0.10. PBPY=per beneficiary per year; CI=confidence interval.

Exhibit I.8. New Entrant DCEs—DCE-Level Gross Spending Impacts in PY2022

New Entrant DCE Name	DCE ID	Number of aligned beneficiaries	Comparison ($ PBPY)		GPDC ($ PBPY)		Difference-in-Difference				Parallel trends test p-value	Shared savings/ losses ($ PBPY)
			Baseline	PY2022	Baseline	PY2022	Impact Estimate ($ PBPY)	90% CI ($ PBPY)		% Impact		
Arizona Health Advantage, Inc.	D0006	2,929	13,422.07	14,983.05	13,588.77	14,433.09	-736.04	-1,664.68	192.60	-4.85	0.67	106.97
Best Value Transportation, LLC	D0032	2,351	13,313.10	13,559.54	12,176.75	12,450.26	48.11	-905.95	1,002.17	0.39	0.63	741.70
Bluerock Care Community LLC	D0052	1,021	12,915.98	12,532.65	12,425.15	13,303.49	1,247.10	-245.02	2,739.22	10.34	0.19	-413.81
CenterWell Accountable Care LLC	D0201	964	15,542.43	16,125.74	14,787.36	15,580.21	237.88	-1,575.80	2,051.56	1.55	0.33	2,759.93

New Entrant DCE Name	DCE ID	Number of aligned beneficiaries	Comparison ($ PBPY)		GPDC ($ PBPY)		Difference-in-Difference				Parallel trends test p-value	Shared savings/ losses ($ PBPY)
			Baseline	PY2022	Baseline	PY2022	Impact Estimate ($ PBPY)	90% CI ($ PBPY)		% Impact		
CenterWell Care Solutions, Inc.	D0143	2,432	12,056.88	12,586.91	11,902.09	11,818.17	-607.15	-1,538.57	324.28	-4.89	0.09	749.24
Florence CIN II LLC	D0154	6,876	12,624.07	13,048.24	11,950.59	12,533.67	181.54	-509.29	872.37	1.47	0.75	-1,060.09
Giatros Health	D0104	1,186	12,548.42	12,285.33	12,062.38	11,694.45	-115.03	-1,471.49	1,241.44	-0.97	0.37	1,351.66
Iora Health NE DCE, LLC	D0004	11,056	11,048.12	11,567.61	11,042.27	11,109.61	-451.87	-972.61	68.87	-3.91	0.43	3,151.83
Midwest DCE, LLC	D0081	1,195	12,364.30	12,777.59	11,142.24	12,363.70	849.02	-505.46	2,203.49	7.37	0.13	-3.27
Nivano Physicians, Inc. IPA	D0160	1,269	18,247.36	19,788.78	15,163.38	15,946.56	-497.73	-2,470.86	1,475.41	-3.03	0.41	-1,524.42
Perfect Health DCE, LLC	D0098	1,435	25,027.61	24,667.04	27,781.16	27,292.38	-88.54	-2,838.40	2,661.32	-0.32	0.51	-746.30
United Physicians Association, Inc.	D0148	1,883	14,143.98	15,643.37	12,948.65	13,445.29	-876.02	-2,523.47	771.43	-6.12	0.28	3,734.36

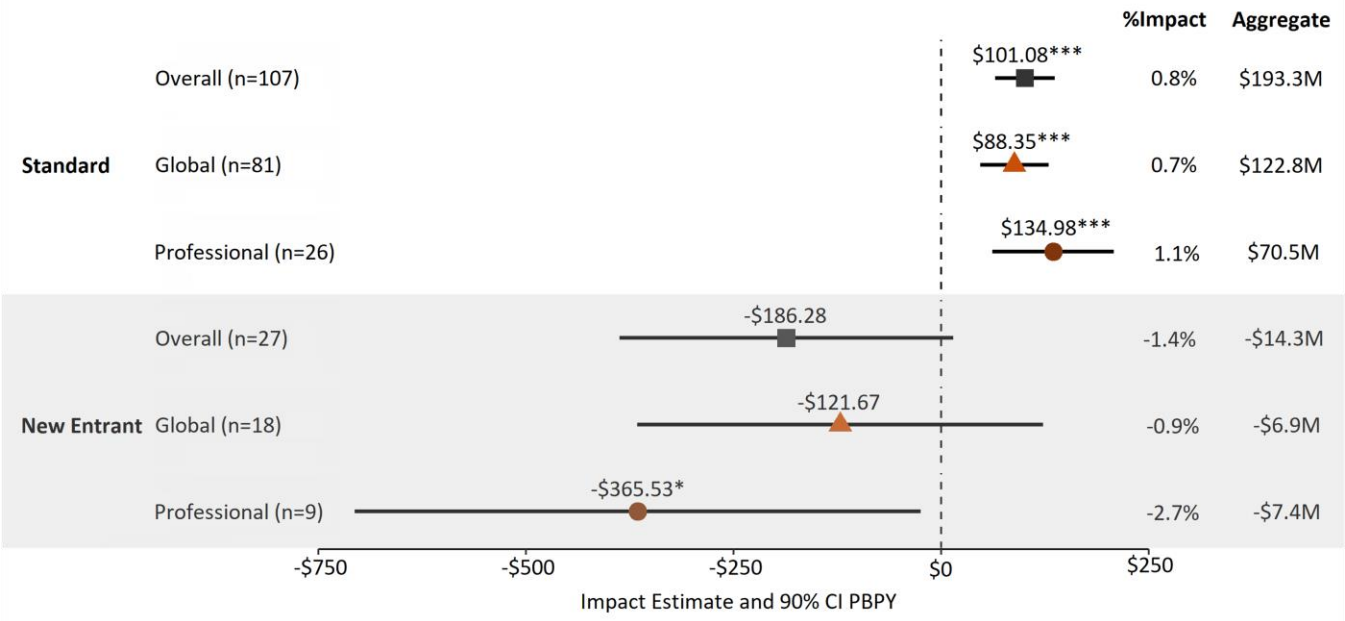
SOURCE: NORC team analysis of Medicare claims and enrollment data.

NOTES: Estimates in this table are weighted and regression-adjusted. Total spending is top coded at 99.9th percentile by DCE market and year. Shared savings/losses for each DCE from financial settlement results were scaled to the number of beneficiary-months included in our analysis. Baseline years (BY) BY3–BY1 span calendar years 2018–2020 for the 2021 Cohort DCEs, and 2019–2022 for the 2022 Cohort DCEs. Negative impact estimate values are spending decreases; positive impact estimate values are spending increases. Positive shared savings/losses values are shared savings; negative shared savings/losses values are shared losses. ***p<0.01, **p<0.05, *p<0.10. PBPY=per beneficiary per year; CI=confidence interval.

Exhibit I.9 shows the gross spending impacts by levels of risk for Standards and New Entrants as of PY2022. We examined gross Medicare spending impacts by two levels of risk, with higher risk for Global and lower risk for Professional. Higher level of risk was not associated with larger reduction in gross Medicare spending.

- For Standard DCEs, three quarters elected Global risk, and one quarter elected Professional risk. Standard DCEs were associated with significant increases in gross Medicare spending regardless of risk level and capitation election, with largest increase observed among DCEs electing Professional risk ($134.98, 1.1%), followed by those electing Global risk ($88.35, 0.7%)
- For New Entrant DCEs, two-thirds elected Global risk, and one third elected Professional risk. Gross Medicare spending decreased significantly among DCEs electing Professional risk ($365.53, 2.7%), while it decreased non-significantly among DCEs electing Global risk ($121.67, 0.9%).

Exhibit I.9. As of PY2022, Higher Level of Risk Was Not Associated with Larger Reductions in Gross Medicare Spending for Standard and New Entrant DCEs



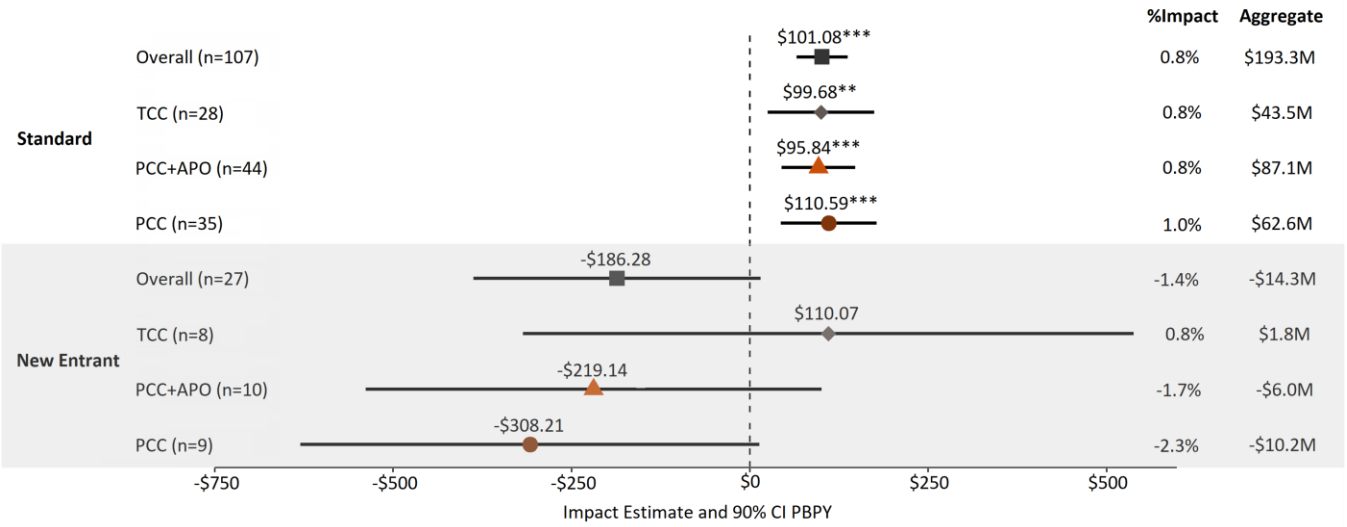
SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: Impacts on gross Medicare spending as of PY2022 shown for all Standard and New Entrant DCEs (Overall) and subgroups of DCEs based on their levels of risk: Global is the higher level, while Professional is the lower level. In overall and subgroups' cumulative estimates, the n represents the number of DCE-years. Estimated gross spending impact is the 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. Aggregate estimate is the impact estimate for all aligned beneficiaries in PYs. 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 on the same trajectory since baseline. *p<0.10, **p<0.05, ***p<0.01.

Exhibit I.10 shows the gross spending impacts by levels of capitation for Standard and New Entrant DCEs as of PY2022. We examined gross Medicare spending impacts by two levels of capitation, with higher capitation for Total Cost Capitation (TCC) and lower capitation for Primary Care Capitation (PCC) without or with Advanced

Payment Option (PCC+APO). A higher level of capitation was not associated with larger reductions in gross Medicare spending.

- For Standard DCEs, one quarter elected TCC, one third elected PCC, and the remaining elected PCC+APO. Standard DCEs were associated with significant increases in gross Medicare spending regardless of capitation level.
- For New Entrant DCEs, fewer elected TCC than PCC or PCC+APO. Gross spending increased non-significantly for those electing TCC (0.8%), and decreased non-significantly for those electing PCC or PCC+ APO (1.7%–2.3%)

Exhibit I.10. As of PY2022, Higher Level of Capitation Was Not Associated with Larger Reductions in Gross Medicare Spending for Standard and New Entrant DCEs



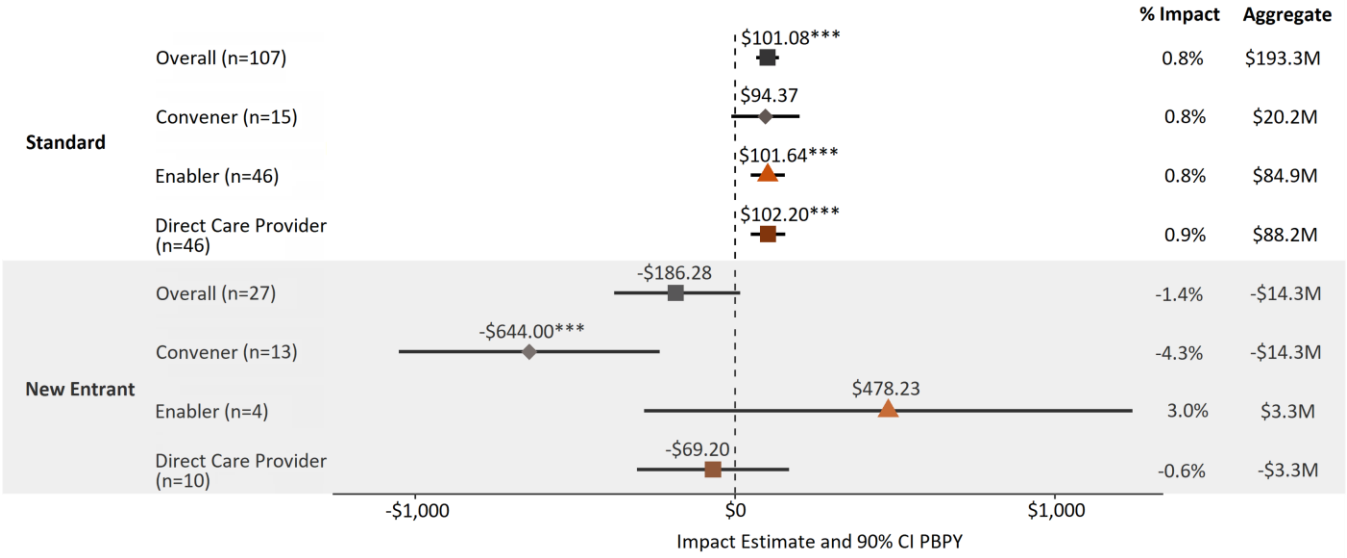
SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: Impacts on gross Medicare spending as of PY2022 shown for all Standard and New Entrant DCEs (Overall) and subgroups of DCEs based on their levels of risk and capitation: Total Care Capitation (TCC) is the higher, Primary Care Capitation (PCC) with or without Advanced Payment Option (APO) is lower level. In overall and subgroups' cumulative estimates, the n represents the number of DCE-years. Estimated gross spending impact is the 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. Aggregate estimate is the impact estimate for all aligned beneficiaries in PYs. 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 on the same trajectory since baseline. *p<0.10, **p<0.05, ***p<0.01.

Exhibit I.11 reflects how gross spending for Standard and New Entrant spending varied by the functional role (as a convener, direct care provider, or enabling organization) of the DCE as of PY2022.

- Standard DCEs across functional roles of convener, direct care provider, and enabler all had similar increases in gross Medicare spending. The increases were significant for direct care providers ($102.20, 0.9%) and enablers ($101.64, 0.8%) but were not significant for conveners.

- New Entrant DCEs that were conveners had a significant $644.00 (4.3%) decline in gross spending. Declines for New Entrant DCEs that were direct care providers were not statistically significant. New Entrant DCEs that were enablers were associated with non-significant increases in spending.

Exhibit I.11. As of PY2022, New Entrant DCEs That Were Conveners Were Associated with 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 functional role. In cumulative estimates overall and for subgroups, the 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. ***p<0.01.

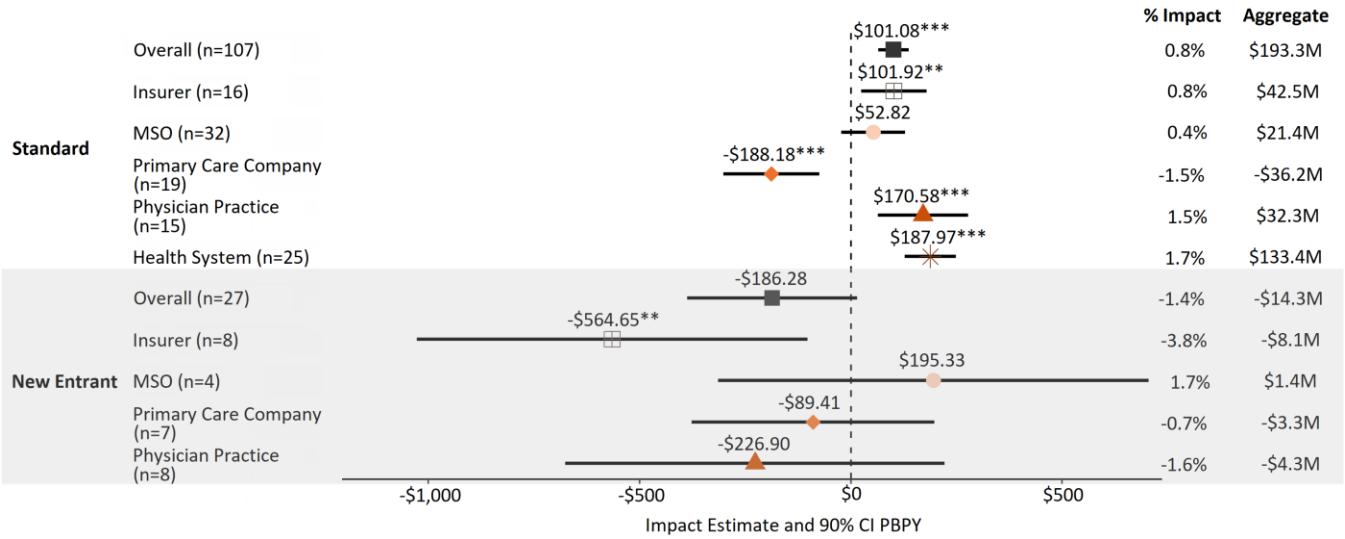
- **Exhibit I.12** shows the gross spending variation by **lead organization types** (Insurer, MSO, primary care company, physician practice, or health system) for Standard and New Entrant DCEs as of PY2022.[89] We hypothesized that health system-led DCEs may have fewer opportunities to reduce gross spending relative to DCEs led by other entities.
- For **Standard DCEs**, those led by primary care companies (18% as of PY2022) were associated with gross Medicare spending reductions of $188.18 PBPY (1.5%). Those led by health systems (23%) were associated with the largest increase in gross Medicare spending of $187.97 PBPY (1.7%); next were those led by physician practices (14%), with an estimate of $170.58 PBPY (1.5%); and then those led by insurers (15%),

[89] Leveraging application data (for example, DCE's descriptions of their organization and composition), additional documentation (such as an updated organization chart and ownership information), and publicly available information (that is, DCE websites and environmental scans for mergers and acquisitions), the NORC team first identified the organizations leading each DCE and then categorized them into types of organization using a typology of organization types informed by existing literature.

with an estimate of $101.92 PBPY (0.8%). Gross spending impacts for Standard DCEs led by MSOs (30%) were not statistically significant. Gross spending increases for health system-led Standard DCEs relative to their comparison groups accounted for over two-thirds of the aggregate spending increase for Standard DCEs in the model ($133.4M of $193.M). It is unclear why physician practices would have increased gross spending, counter to our hypotheses. Future reports will track whether these differences in gross spending by leadership are maintained over time and explore the factors that may be contributing to these differences (for example, differences in providers' experience, and beneficiary health-related factors).

- For **New Entrant DCEs**, those led by insurers (30% as of PY2022) were associated with gross Medicare spending declines of $564.65 PBPY (3.8%). DCEs led by other types of organizations (MSOs, physician practices, or primary care companies) were not associated with significant impacts on their gross Medicare spending. In future reports, our evaluation will continue to investigate the influences of market, provider, beneficiary, and implementation factors on gross spending impacts for subgroups of DCEs.

Exhibit I.12. As of PY2022, Standard DCEs Led by Primary Care Companies and New Entrant DCEs Led by Insurers Reduced Gross Spending



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 lead organization. In cumulative estimates overall and for subgroups, the n represents the number of DCE-years. MSO=management services organization. **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 the same trajectory since baseline. **Aggregate estimate** is the impact estimate for all aligned beneficiaries in PYs. **p<0.05, ***p<0.01.

Appendix J: Exhibits to Support Chapter 4

This appendix presents detailed impact results for spending, utilization, and quality of care outcomes by setting, for each PY, and cumulatively. The appendix also presents descriptive trend graphs for the secondary measures. For additional information and findings on the 2022 Pulse Check Survey results presented in Chapter 4, please refer to **Appendix D.2**.

J.1: Ambulatory Care Setting

Exhibits J.1 and **J.2** present detailed impact results for spending, utilization, and quality of care outcomes in the ambulatory care setting for PY2021, PY2022, and cumulatively (as of PY2022) for Standard and New Entrant DCEs, respectively. PY2021 (and therefore, cumulative) impact estimates, were not calculated for High Needs DCEs on account of small sample sizes in PY2021. The impact estimate, 90% confidence interval, and percent impact are estimated from the DID model.

Exhibit J.1. Standard DCEs—Spending, Utilization, and Quality Outcomes in Ambulatory Care for PY2021, PY2022, and as of PY2022

Measure (Hypothesized Direction of Impact)	Impact in PY2021				Impact in PY2022				Impact as of PY2022			
	% Impact	Impact Estimate	90% CI		% Impact	Impact Estimate	90% CI		% Impact	Impact Estimate	90% CI	
Professional Services, Primary and Specialty Care Visits												
Professional services spending (⬇)	0.5	-$15.66	-$8.93	$40.26	1.2	$35.81***	$24.73	$46.89	1.1	$32.85***	$22.73	$42.96
Specialty care visits spending (⬇)	1.3	$2.76	$1.41	$4.12	1.4	$2.65***	$2.11	$3.18	1.4	$2.66***	$2.16	$3.16
Outpatient Facility												
Outpatient facility spending (⬇)	-1.4	-$25.17	-$47.06	-$3.27	0.2	$4.37	-$6.6	$15.39	0.0008	0.02	-$9.92	$9.96
ED visits and observation stays (⬇)	-1.2	-4.6**	-8.1	-1.2	-0.05	-0.2	-1.7	1.3	-0.2	-0.9	-2.3	0.5
Quality of Care												
Hospitalizations for ACSCs (⬇)	-3.5	-0.6**	-1.1	-0.1	-1.5	-0.3**	-0.5	-0.05	-1.8	-0.3***	-0.5	-0.1
Recommended care for diabetes (⬆)	1.2	5.0**	1.50	8.50	0.6	2.3**	0.7	3.9	0.7	2.7***	1.3	4.1
Unplanned hospital admissions among beneficiaries with MCCs (⬇)	-1.5	-3.4	-6.9	0.2	-1.2	-2.7***	-4.4	-1.1	-1.3	-2.8***	-4.3	-1.3

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 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 professional services spending measure includes all physician, non-physician, and ancillary services (e.g., tests, imaging, ambulance services, Part B drugs administered in physician offices). The specialty care visits spending measure includes paid E&M services for specialty care practitioners. The Recommended Care for Diabetes measure is calculated for beneficiaries with diabetes. The unplanned hospitalization among beneficiaries with MCC measure is 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).
Impact estimates significant at p<0.1*, p<0.05**, p<0.01***.

Exhibit J.2. New Entrant DCEs—Spending, Utilization, and Quality Outcomes in Ambulatory Care for PY2021, PY2022, and as of PY2022

Measure (Hypothesized Direction of Impact)	Impact in PY2021				Impact in PY2022				Impact as of PY2022			
	% Impact	Impact Estimate	90% CI		% Impact	Impact Estimate	90% CI		% Impact	Impact Estimate	90% CI	
Professional Services, Primary and Specialty Care Visits												
Professional services spending (⬇)	-0.2	-$7.54	-$82.57	$67.49	-0.3	-$8.90	-$91.59	$73.80	-0.2	-$8.15	-$63.72	$47.41
Specialty care visits spending (⬇)	-0.2	-$0.51	-$4.18	$3.17	-3.4	-$6.74***	-$10.65	-$2.84	-1.6	-$3.32***	-$5.99	-$0.64
Outpatient Facility												
Outpatient facility spending (⬇)	-1.9	-$32.49	-$87.88	$22.90	-1.6	-$28.42	-$100.33	$43.48	-1.7	-$30.66	-$75.11	$13.79
ED visits and observation stays (⬇)	-2.8	10.6*	-20.8	-0.4	-3.2	-12.3**	-22.4	-2.1	-2.9	-11.4***	-18.6	-4.1
Quality of Care												
Hospitalizations for ACSCs (⬇)	4.4	0.8	-0.6	2.3	-6.1	-1.2	-2.9	0.4	-0.5	-0.07	-1.2	1.0
Recommended care for diabetes (⬆)	2.5	9.0	-0.3	18.2	5.2	19.0***	8.1	29.9	3.7	13.3***	6.3	20.4
Unplanned hospital admissions among beneficiaries with MCCs (⬇)	-7.0	-15.3***	-25.1	-5.6	1.7	3.9	-9.0	16.7	-2.8	-6.3	-14.2	1.7

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 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.

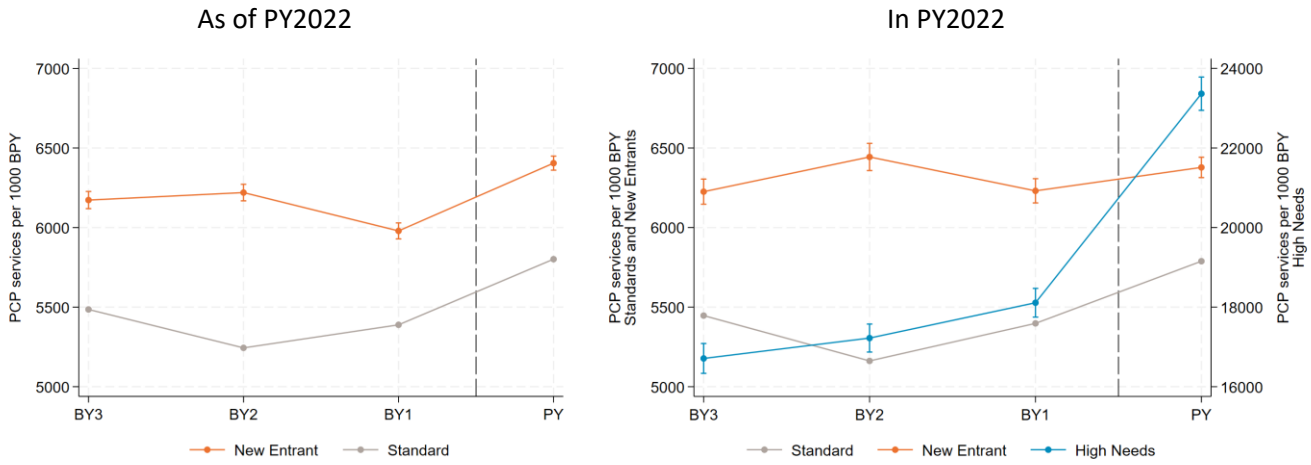
The professional services spending measure includes all physician, non-physician, and ancillary services (e.g., tests, imaging, ambulance services, Part B drugs administered in physician offices). The specialty care visits spending measure includes paid E&M services for specialty care practitioners. The Recommended Care for Diabetes measure is calculated for beneficiaries with diabetes. The unplanned hospitalization among beneficiaries with MCC measure is 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).

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

Exhibits J.3 through **J.7** present trends over time for the DCE group for the following ambulatory care measures which were not included in the impact analyses: primary care practitioner services (PCP services), Medicare spending for primary care visits, annual wellness visits, and chronic care management for patients with multiple chronic conditions (CCM services). See **Appendix G** for an explanation for why these measures were not included in the impact estimation. We show unadjusted trends for these measures for beneficiaries in the GPDC group from baseline to performance years, as of PY2022 (on the left-hand side) and in PY2022 (on the right-hand side). Because High Needs DCEs were not evaluable in PY2021, the cumulative (as of PY2022) graphs include only Standard and New Entrant DCEs. Similar to other trend graphs in this report, results for Standard and New

Entrant DCEs are presented using the left axis, while results from High Needs DCEs are presented using the right axis for all PY2022 graphs.

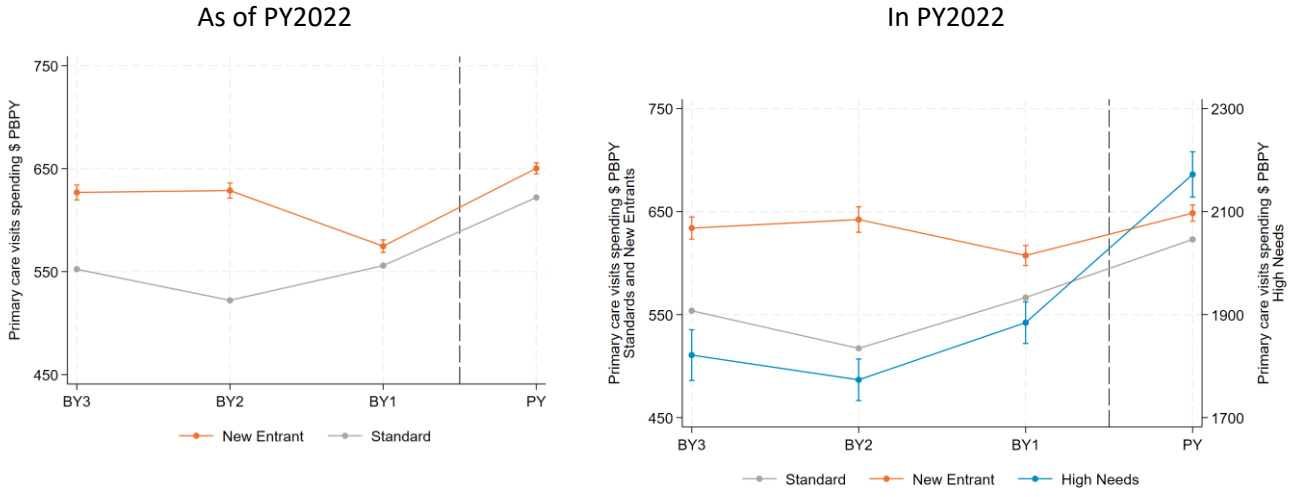
Exhibit J.3. GPDC Group Trends—Primary Care Practitioner Services from Baseline to Performance Years, as of PY2022 and in PY2022



SOURCE: NORC analysis of Medicare claims and enrollment data.

NOTE: PBY=beneficiary per year; PY=performance year; BY=baseline year; PCP=primary care practitioner. BY1 is the most recent BY prior to PY.

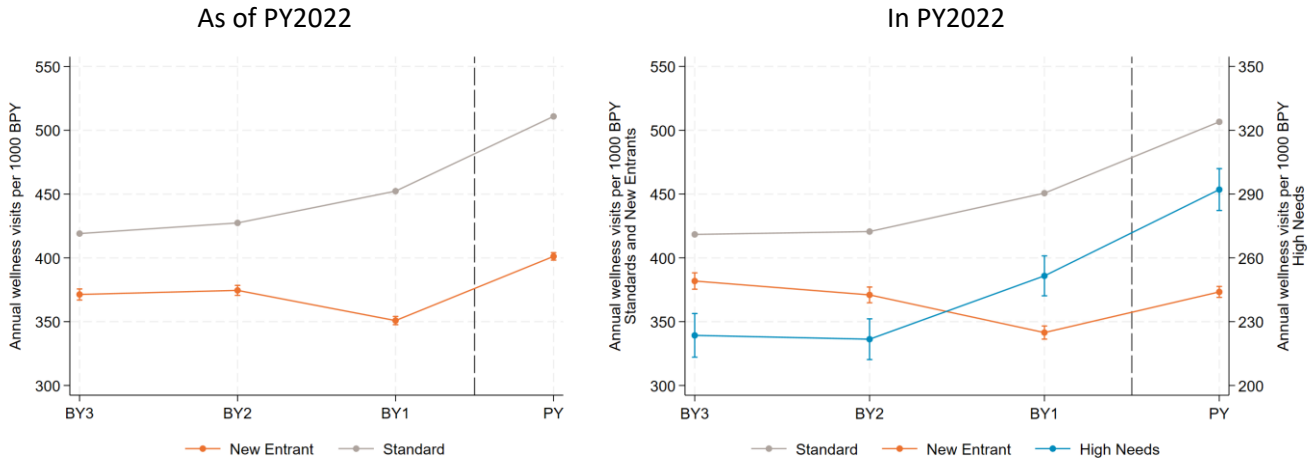
Exhibit J.4. GPDC Group Trends—Medicare Spending Primary Care Visits Spending from Baseline to Performance Years, as of PY2022 and in PY2022



SOURCE: NORC analysis of Medicare claims and enrollment data.

NOTE: PBY=beneficiary per year; PY=performance year; BY=baseline year. BY1 is the most recent BY prior to PY.

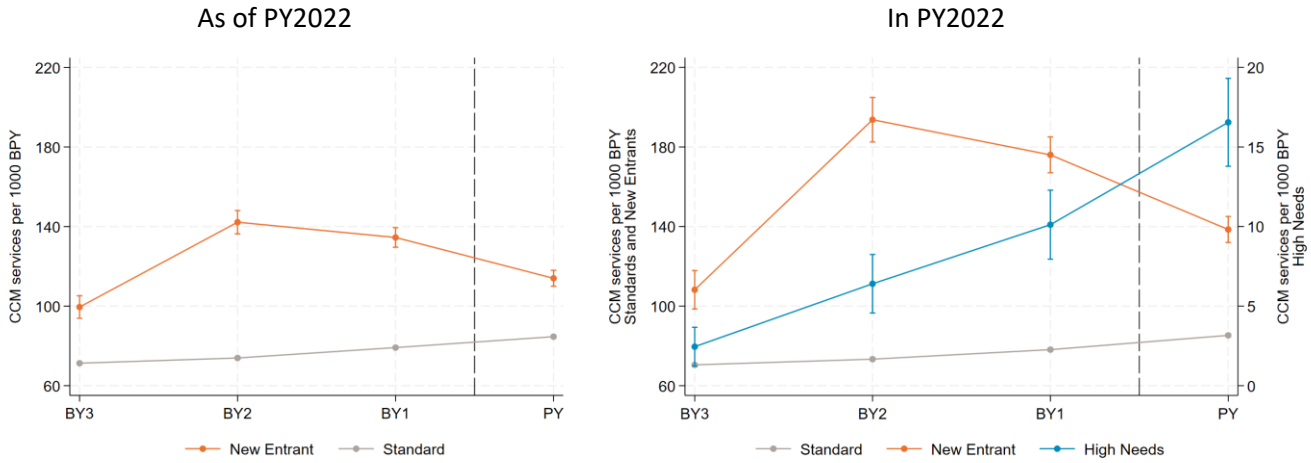
Exhibit J.5. GPDC Group Trends—Annual Wellness Visits from Baseline to Performance Years, as of PY2022 and in PY2022



SOURCE: NORC analysis of Medicare claims and enrollment data.

NOTE: PBY=beneficiary per year; PY=performance year; BY=baseline year. BY1 is the most recent BY prior to PY.

Exhibit J.6. GPDC Group Trends—Chronic Disease Management for Patients with Multiple Chronic Conditions from Baseline to Performance Years, as of PY2022 and in PY2022



SOURCE: NORC analysis of Medicare claims and enrollment data.

NOTE: PBY=beneficiary per year; PY=performance year; BY=baseline year; CCM=chronic care management for patients with multiple chronic conditions. BY1 is the most recent BY prior to PY.

J.2: Acute Care Setting

Exhibits J.7 and **J.8** presents detailed impact results for spending, utilization, and quality of care outcomes in the acute care setting for PY2021, PY2022, and cumulatively (as of PY2022) for Standard and New Entrant DCEs, respectively. PY2021 (and therefore, cumulative) impact estimates, were not calculated for High Needs DCEs on account of small sample sizes in PY2021. The impact estimate, 90% confidence interval, and percent impact were estimated from the DID model.

Exhibit J.7. Standard DCEs—Spending, Utilization, and Quality Outcomes in Acute Care for PY2021, PY2022, and as of PY2022 (Cumulatively)

Measure (Hypothesized Direction of Impact)	Impact in PY2021				Impact in PY2022				Impact as of PY2022			
	% Impact	Impact Estimate	90% CI		% Impact	Impact Estimate	90% CI		% Impact	Impact Estimate	90% CI	
Acute Care Hospital Spending and Utilization												
Acute care facility spending (⬇)	-$1.7	-$57.64**	-$102.50	-$12.80	1.7	$55.36***	$34.67	$76.05	1.2	$38.72***	$19.88	$57.56
Acute care hospitalizations (⬇)	-1.2	-2.5*	-4.7	-0.2	0.8	1.6***	0.6	2.5	0.5	1.0*	0.08	1.8
Acute care length of stay (days) (⬇)	-0.3	-4.1	-23.7	15.6	0.9	11.6**	3.4	19.8	0.7	9.3**	1.8	16.9
Acute Care Hospital Quality of Care												
All-condition readmissions (⬇)	-1.1	-1.80	-6.0	2.3	0.7	1.1	-0.8	2.9	0.4	0.6	-1.1	2.3
Timely follow-up after exacerbations of chronic conditions (⬆)	0.5	4.0	-3.6	11.6	0.2	1.4	-2.1	4.9	0.2	1.8	-1.4	5.0

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 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 is calculated for beneficiaries with at least one acute care hospitalization. The timely follow-up measure is 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.

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

Exhibit J.8. New Entrant DCEs—Spending, Utilization, and Quality Outcomes in Acute Care for PY2021, PY2022, and as of PY2022 (Cumulatively)

Measure (Hypothesized Direction of Impact)	Impact in PY2021				Impact in PY2022				Impact as of PY2022			
	% Impact	Impact Estimate	90% CI		% Impact	Impact Estimate	90% CI		% Impact	Impact Estimate	90% CI	
Acute Care Hospital Spending and Utilization												
Acute care facility spending (⬇)	-1.8	-$60.06	-$178.12	$58.01	0.6	$20.02	-$130.13	$170.16	-0.7	-$23.98	-$117.71	$69.74
Acute care hospitalizations (⬇)	-0.9	-1.8	-8.1	4.4	1.2	2.5	-4.2	9.1	0.05	0.1	-4.5	4.7
Acute care length of stay (days) (⬇)	0.4	5.6	-43.3	54.4	2.4	31.0	-25.1	87.1	1.3	17.0	-19.8	53.9
Acute Care Hospital Quality of Care												
All-condition readmissions (⬇)	0.7	1.1	-10.6	12.8	-1.8	-3.0	-16.3	10.2	-0.5	-0.8	-9.6	8.0
Timely follow-up after exacerbations of chronic conditions (⬆)	1.0	7.8	-12.8	28.4	1.3	10.7	-12.0	33.4	1.1	9.1	-6.2	24.3

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 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 is calculated for beneficiaries with at least one acute care hospitalization. The timely follow-up measure is 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.
Impact estimates significant at p<0.1*, p<0.05**, p<0.01***.

J.3: All Other Settings

Exhibits J.9 and **J.10** present detailed impact results for spending, utilization, and quality of care outcomes in all other settings for PY2021, PY2022, and cumulatively (as of PY2022) for Standard and New Entrant DCEs, respectively. PY2021 (and therefore, cumulative) impact estimates were not calculated for High Needs DCEs on account of small sample sizes in PY2021. The impact estimate, 90% confidence interval, and percent impact were estimated from the DID model.

Exhibit J.9. Standard DCEs—Spending, Utilization, and Quality Outcomes in Other Settings for PY2021, PY2022, and as of PY2022 (Cumulatively)

Measure (Hypothesized direction of change)	Impact in PY2021				Impact in PY2022				Impact as of PY2022			
	% Impact	Impact Estimate	90% CI		% Impact	Impact Estimate	90% CI		% Impact	Impact Estimate	90% CI	
Post-Acute Care												
SNF spending (⬇)	-2.3	$20.41*	-$39.8	-$1.03	0.02	$0.15	-$9.25	$9.55	-0.3	-$2.88	-$11.38	$5.63
SNF days (⬇)	-1.7	-27.0	-62.4	8.4	-0.01	-0.2	-15.9	15.5	-0.3	-4.1	-18.5	10.2
IRF and LTCH spending (⬇)	-3.3	-$13.80	-$29.80	$2.19	2.2	$8.62**	$1.63	$15.60	1.4	$5.31	-$1.09	$11.72
IRF and LTCH days (⬇)	-2.6	-5.9	-14.9	3.1	2.1	4.4*	0.6	8.2	1.4	2.9	-0.6	6.4
Home Health												
HH spending (⬇)	-2.5	$14.57***	-$22.31	-$6.84	-0.9	-$5.54**	-$9.21	-$1.86	-1.1	-$6.87***	-$10.20	-$3.53
HH episodes (⬇)	-2.7	-8.83***	-13.2	-4.5	-0.5	-14.5*	-26.9	-2.1	-0.9	-10.9***	-16.2	-5.6
Hospice												
Hospice spending (⬆)	2.2	$9.33	-$4.66	$23.32	1.8	$7.69**	$1.93	$13.45	1.9	$7.93**	$2.61	$13.26

Measure (Hypothesized direction of change)	Impact in PY2021				Impact in PY2022				Impact as of PY2022			
	% Impact	Impact Estimate	90% CI		% Impact	Impact Estimate	90% CI		% Impact	Impact Estimate	90% CI	
Continuous hospice days prior to death (⬆)	3.2	0.8	-0.4	1.9	-4.5	-1.1***	-1.5	-0.7	-3.7	-0.9***	-1.3	-0.5
Other Quality Measures												
Percent healthy days at home (⬆)	0.1	0.1	-0.01	0.2	0.02	0.02	-0.02	0.07	0.02	0.03	-0.01	0.07

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: DCE=Direct Contracting Entity. SNF=Skilled Nursing Facility. IRF=Inpatient Rehabilitation Facility. LTCH=Long Term Care Hospital. HH=Home health. 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 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.
Impact estimates significant at p<0.1*, p<0.05**, p<0.01***.

Exhibit J.10. New Entrant DCEs—Spending, Utilization, and Quality Outcomes in Other Settings for PY2021, PY2022, and as of PY2022 (Cumulatively)

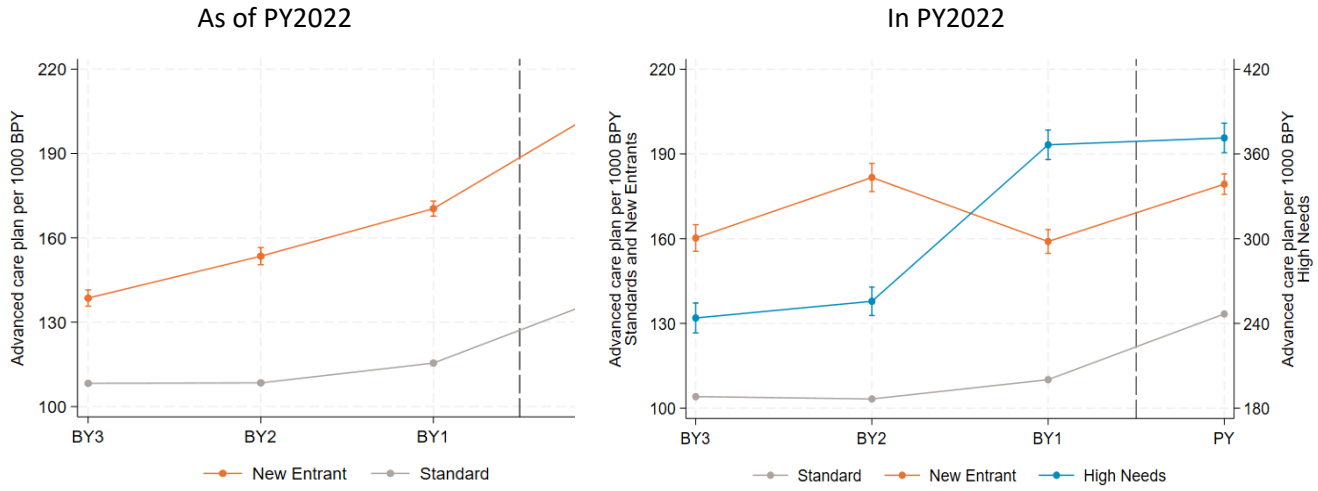
Measure (Hypothesized direction of change)	Impact in PY2021				Impact in PY2022				Impact as of PY2022			
	% Impact	Impact Estimate	90% CI		% Impact	Impact Estimate	90% CI		% Impact	Impact Estimate	90% CI	
Post-Acute Care												
SNF spending (⬇)	-4.6	-$39.02	-$92.93	$14.88	1.1	$11.12	-$59.47	$81.71	-1.8	-$16.43	-$59.89	$27.03
SNF days (⬇)	-3.3	-47.7	-141.8	46.4	0.02	0.3	-109.7	110.3	-1.7	-26.1	-97.7	45.6
IRF and LTCH spending (⬇)	12.0	$41.90	-$19.04	$102.83	13.2	$56.34	-$65.12	$177.81	12.6	$48.41	-$15.75	$112.56
IRF and LTCH days (⬇)	7.2	13.1	-8.0	34.1	9.2	18.0	-10.6	46.5	8.1	15.3	-2.0	32.6
Home Health												
HH spending (⬇)	3.8	$23.40*	$0.33	$46.47	-$5.77	-$36.69**	-$62.36	-$11.01	-$0.58	-$3.67	-$20.83	13.49
HH episodes (⬇)	4.5	14.3**	2.6	26.1	-2.2	-61.9	-139.6	15.8	1.5	8.0	-4.5	20.6
Hospice												
Hospice spending (⬆)	-3.1	-$17.14	-$63.39	$29.11	1.8	$8.95	-$38.15	$56.06	-1.0	-$5.38	-$38.49	$27.72
Continuous hospice days prior to death (⬆)	-13.5	-4.9	-10.0	0.3	-9.9	-2.9	-6.5	0.7	-11.9	-3.9**	-7.1	-0.7
Other Quality Measures												
Percent healthy days at home (⬆)	0.2	0.2	-0.1	0.4	-0.04	-0.04	-0.4	0.3	0.05	0.04	-0.2	0.3

SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTES: DCE=Direct Contracting Entity. SNF=Skilled Nursing Facility. IRF=Inpatient Rehabilitation Facility. LTCH=Long Term Care Hospital. HH=Home health. 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 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.
Impact estimates significant at p<0.1*, p<0.05**, p<0.01***.

Exhibits J.11 and **J.12** present trends over time for the GPDC group for the following measures that were not included in the impact analysis: Advance Care Planning, and Mortality. See **Appendix G** for an explanation for why these measures were not included in the impact estimation. We show unadjusted trends for beneficiaries in the GPDC group from baseline to performance years, as of PY2022 (on the left-hand side) and in PY2022 (on the right-hand side). Because High Needs DCEs were not evaluable in PY2021, the cumulative (as of PY2022) graph

includes only Standard and New Entrant DCEs. Similar to other trend graphs in this report, results for Standard and New Entrant DCEs are presented using the left axis, while results from High Needs DCEs are presented using the right axis for the PY2022 graph.

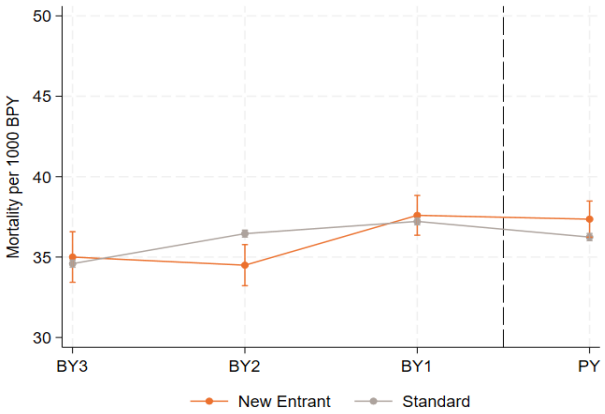
Exhibit J.11. GPDC Group Trends in Advance Care Planning from Baseline to Performance Years, as of PY2022 and in PY2022



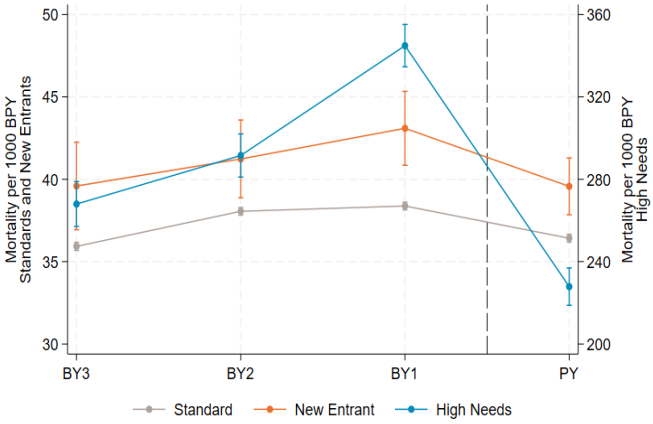
SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTE: PBY=beneficiary per year; PY=performance year; BY=baseline year. BY1 is the most recent BY prior to PY.

Exhibit J.12. GPDC Group Trends in Mortality from Baseline to Performance Years, as of PY2022 and in PY2022

As of PY2022



In PY2022



SOURCE: NORC analysis of Medicare claims and enrollment data.
NOTE: PBY=beneficiary per year; PY=performance year; BY=baseline year. BY1 is the most recent BY prior to PY.

Appendix K: Beneficiary Interviews - Methods and Detailed Findings

K.1: Methods

As part of the evaluation of the GPDC Model, the NORC team conducted semi-structured telephone interviews with 26 beneficiaries who were attributed to GPDC DCEs. Information collected from these interviews provides a broad perspective on beneficiaries' early experiences with care provided by all three DCE participant types.

We identified potential interview respondents using a list of all 344,521 beneficiaries attributed to a DCE in PY2021, the model's first performance year. We narrowed this list to a sample that included: non-decedent beneficiaries attributed to each of the three DCE types; beneficiaries with a chronic condition that would benefit from care management; and beneficiaries who had a sufficient number of physician visits (two to ten visits with an aligned provider) to be able to speak about their care experiences. We recruited beneficiaries who met these criteria by mail and telephone. During recruitment, we continuously monitored the characteristics and demographics of beneficiaries who completed interviews and adjusted our recruitment priorities to ensure that the interviews represented diverse perspectives. **Exhibit K.1** and **Exhibit K.2** provide a description of the recruitment characteristics and reported demographic characteristics of our sample, respectively.

Between October 2022 and January 2023, we conducted 30-minute, semi-structured interviews with 26 beneficiaries by phone and transcribed the recorded conversations.[90] **Exhibit K.3** provides the key domains covered in the interview guide and corresponding questions. We coded transcripts using Dedoose qualitative analysis software. To analyze the coded data, we ran queries on subcodes and combinations of subcodes relevant to each research question, then analyzed themes for common and divergent responses.

Exhibit K.1. Beneficiary Interviewee Characteristics

Group	Number of Interviewees
DCE Type	
Standard	13
New Entrant	7
High Needs	6
Alignment Status	
Claims-Aligned	13
Voluntary- and Claims-Aligned	13

[90] We aimed to speak with 30 beneficiaries and ultimately determined we had reached saturation having spoken with 26 beneficiaries.

Group	Number of Interviewees
Urban/Rural	
Urban	24
Rural	2
Medicare & Medicaid Dual Eligibility (in 2021)	
Ever dual	5
Not dual eligible	21
Spanish Speaker	
Spanish-preferred	1
English or no preference	25

SOURCE: 2021 Medicare Enrollment File.

Exhibit K.2. Beneficiary Interviewee Self-Reported Additional Characteristics

Group	Number of Interviewees
Self-reported Race	
White	19
Black	6
Prefer not to answer	1
Self-reported Ethnicity	
Non-Hispanic	24
Hispanic/Latino	1
Prefer not to answer	1
Self-reported Age	
<65 years old	4
65 to 74 years old	12
75 to 84 years old	9
≥85 years old	1
Self-reported Gender	
Male	8
Female	18
Self-reported Education	
High school degree or less	4
Some college	11
Bachelor's degree or higher	11

Group	Number of Interviewees
Self-reported Annual Income	
<$15,000	6
$15,000-$30,000	5
$30,000-$75,000	9
>$75,000	2
Prefer not to answer	4

SOURCE: Beneficiary self-report based on closed-ended questions asked at the end of the interview.

Exhibit K.3. Interview Domains and Questions

Domain	Questions
Access to care	• Is there a particular doctor or group of health care providers you usually see for health care? Has that changed since January 1, 2021? • How do you schedule appointments with [provider/provider group]? • Do any of your appointments happen by phone or video? • Have you ever needed care between appointments? Please describe what happened.
Care planning	• When you go to an appointment, do they seem to remember you and your situation, or do you have to re-explain things? • During your appointments, does anyone talk with you about how to manage your health and any chronic conditions? • Is there anything that you think your doctor or other health care provider does particularly well with respect to managing your health care? What could be better about the way your health care and any chronic conditions are managed?
Follow up after a health care visit	• Between visits, how do you communicate with your health care provider or provider group? Has that changed since January 1, 2021? • What do you like about the way your health care provider communicates with you? What could be better? • *If beneficiary sees specialists*: Is your usual doctor in touch with this other doctor or group of health care providers about your care?
Awareness of GPDC	• *For voluntarily aligned beneficiaries*: Medicare allows but does not require people to choose a "main doctor." The records we have show that you have selected a main Medicare doctor. Does that sound right to you? • *For claims-only aligned beneficiaries*: Medicare allows but does not require people to choose a "main doctor." Have any of your health care providers asked you to designate them as a "main doctor?" • Have you heard of a Medicare program called Global and Professional Direct Contracting?

There are several limitations to this analysis. First, the sample of beneficiaries interviewed was small (2.7% of the candidate sample) and was unlikely to be representative of all aligned beneficiaries. Participation was voluntary; roughly one-third of the interviewees volunteered to participate by calling a toll-free line upon receiving our recruitment letter. In addition, some recruitment was conducted concurrently with the fall 2022 Medicare open enrollment window, when beneficiaries were inundated with marketing calls, which may have diminished the number of beneficiaries willing to speak with us. Second, the changes to the health care system during the COVID-19 PHE made it impossible to disentangle practice changes from model implementation (such as use of telemedicine) from broader trends. Further, some beneficiaries interviewed had recently changed

physicians, so we could not conclude that changes in their care experience resulted from the model. Third, we knew only that beneficiaries were aligned to a DCE in PY2021; we did not know for how long they continued to be aligned (for example, whether they remained in the model continuously until they were interviewed in 2022). Finally, because none of our interviewees were familiar with the GPDC Model, we could not ask them directly whether they attributed any aspects of their care experiences to the model.

K.2: Detailed Findings

This section provides additional detail on the findings summarized in Chapter 5.

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

The detailed findings related to: 1) consistency of the beneficiary's care team; and 2) communication.

Consistency of Care Team

The Medicare beneficiaries interviewed—selected because they had a chronic condition and higher than average use of health care services—shared their experiences receiving care from their usual care providers. Overwhelmingly, they had regular PCPs who were familiar with them and their health situations. Such familiarity was largely established through many years of provider-patient relationships pre-dating the GPDC Model.

Nearly all interviewed beneficiaries had a practitioner whom they saw consistently for their regular care. All interviewees reported having a regular care practitioner who was a general practitioner, internist, family doctor, nurse practitioner, physician assistant, or in an unspecified area of practice. Most beneficiaries reported seeing the same practitioner regularly for their care and had received care from their PCP for two years or more. One beneficiary interviewed shared multiple frustrations with his practitioner, reportedly having decided to leave his PCP.

Beneficiaries were generally able to schedule PCP appointments at a time of their choosing. Roughly half of interviewees scheduled appointments in person, followed closely by scheduling by telephone. (Interviewees could report more than one mode of scheduling.) Of those we interviewed, only one used the patient portal, and it was for an urgent visit. Among the few beneficiaries who were most often unable to get appointments when they needed them, one reported often resorting to an urgent care clinic: "*The guy (PCP) is so overbooked... Sometimes two, three weeks. So I go to urgent care. I'm up there, an hour later, I have at least a doctor standing in front of me*."

Beneficiaries reported that their Medicare practitioners seemed to know them. For most beneficiaries, their practitioner's ability to remember them had not changed since the start of the GPDC Model. Interviewees stated that providers were very likely to remember them and their health situations. In these instances, the beneficiaries tended to describe the practitioner-patient relationship matter-of-factly: "*She knows me well*." Three beneficiaries cited PCPs' use of technology as aiding the providers' recall. One beneficiary described,

"Everything is on the computer, I go and that's how I imagine they remember…sometimes I have to see another doctor; therefore, as everything is written on the computer, he just asks me and I confirm." Another interviewee noted, *"Sometimes before he gets on his computer, he forgets what medications and all, but he sees a lot of people, so I'm good with that."* The few instances of PCPs not remembering a patient might have been from new patient-practitioner relationships. When medical care was sought out between PCP visits, beneficiaries interviewed noted that in two-thirds of those instances, the interim treatment team communicated with the beneficiaries' PCPs.

Communication

Most interviewees liked the way that their health care providers communicated with them. Three beneficiaries explained that they especially liked that their practitioner seemed concerned about them. Another two interviewees told us that their provider listened to them. One noted, "*He listens to everything I say, and he seems generally interested in what I'm saying."* Another two beneficiaries added that they appreciated that their health care providers got back to them quickly when they called with questions.

Two beneficiaries identified ways that their providers could improve communication. One beneficiary mentioned that she wished 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 her health care providers speak Spanish, so she relies on bilingual ancillary staff members or her grandson to translate.

Most beneficiaries we interviewed communicated with their health care providers between visits**.** Beneficiaries, not practitioners, typically initiated communication between visits. However, two interviewees described situations in which a practitioner had contacted them between visits. These between-visit communications took place primarily by telephone. One beneficiary described, *"I call the office and they will ask [the doctor], even though she's not at that branch. [Then] she will call me."* Two-thirds of those who communicated with their health care providers between visits used the telephone exclusively while the remaining one-third used a combination of telephone with email, text, patient portal, or video chat. All beneficiaries who contacted their health care providers between visits indicated that they received timely responses to their communication.

How Did Beneficiaries Respond to Changes in Care Delivery Stemming from the Model's Incentives?

We limited our interview questions to the two benefit enhancements—telehealth and home visits—that would have been most visible to beneficiaries. Most of the DCEs to which beneficiaries in our interview sample were

attributed offered both benefits.[91] Most beneficiaries who used telehealth benefits preferred in-person visits. Although few beneficiaries interviewed reported use of the home visit/remote patient monitoring, those who did use the benefit enhancement reported using it for wound care, annual checkups from a nurse, and hospital-at-home purposes.

Most beneficiaries who used telehealth preferred in-person visits. More than half of the beneficiaries interviewed reported having had a telehealth visit in the past two years. One beneficiary had no preference for either type of visit, another preferred telehealth for the convenience of not having to travel to appointment, but many who had used telehealth services expressed a preference for in-person visits. The most common reasons that beneficiaries gave related to communication in these visits included that they "liked to speak with people face-to-face" and were better able to read their practitioner's body language in person. One interviewee expressed a preference for in-person visits because unreliable internet connectivity made video calls challenging. A few beneficiaries preferred in-person visits because their practitioner could check their vital signs. Two noted that their preference depended on the distance they had to drive to the provider's office or the reason for the visit.

Few beneficiaries reported that their practitioners used home visits or remote patient monitoring. Few beneficiaries reported that their practitioners used home visits or remote patient monitoring**.** Several beneficiaries we interviewed mentioned that they monitored chronic conditions between visits and reported back to their physicians at their next appointment, through a patient portal, or (in one case) by asking a PCP to fax the data to a specialist. Two of these individuals had a device (for example, a defibrillator) at home that automatically transmitted data to their physician.

Twenty-one beneficiaries were asked specifically about home visits, and six recalled having had at least one home visit. Reasons for home visits included wound care, annual checkups from a nurse, and "*hospital at home."* One beneficiary explained that the home visit eliminated what could have been a challenging trip to the physician's office, *"Well, I just like the fact that I can have someone come to my home....I can get out. Sometimes I have to use a walker, sometimes I have to use a cane...the ride and the car can be uncomfortable due to one of my conditions that I have, just sitting comfortably...sometimes it takes a lot out of me to get in the car, or get there, get into the place. And then sometimes the seats in the waiting room are too small, so I either have to stand up or I'm sitting in a chair and I'm, it's like pinching my side or I'm uncomfortable. So it's like stressful."* One beneficiary described regular visits from a nurse practitioner at home. Another beneficiary, aligned to a High Needs DCE, reported that she received in-home visits from a podiatrist. The ongoing in-home visits began prior to the GPDC Model.

[91] High Needs DCEs did not offer telehealth or home visits, with one exception that offered home visits. One Standard DCE did not offer either benefit.

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

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

Subgroup Analyses

We assessed whether some beneficiary subgroups reported different care experiences, including patient communication with physicians, awareness of the GPDC Model, use of telehealth services, or overall satisfaction with care. We considered DCE type, type of alignment (voluntary or claims), Medicare-Medicaid dual eligibility, and patient demographics. These analyses found only very limited differences across subgroups among such a small sample of 26 beneficiaries.

DCE type. The Standard DCE beneficiaries that we interviewed had more complaints about communication challenges and lack of communication with their doctors than did the New Entrant DCE beneficiaries or the High Needs DCE beneficiaries. In contrast, the New Entrant and High Needs DCE beneficiaries who experienced communication challenges described unique situations. One New Entrant DCE beneficiary had difficulty tracking his medical record after changing his PCP. One High Needs DCE beneficiary reported a nurse who lacked knowledge about the beneficiary's medical history. We did not find differences across DCE types in beneficiary satisfaction with care received or communication between PCPs and specialists. Regarding wait times, few beneficiaries overall described long wait times to get appointments. However, of those beneficiaries who said they waited longer than they wished, two were in Standard DCEs and one was aligned with a New Entrant DCE. None of the six beneficiaries interviewed from High Needs DCEs said they waited longer than they wished to get appointments. The findings may not be generalizable due to the small sample size. However, it is also possible that High Needs DCEs, with their PACE-like delivery model, do a better job than Standard or New Entrant DCEs in providing timely appointments.

Alignment type. There were no differences in awareness of the GPDC Model between claims-aligned (n=13) and both voluntarily and claims-aligned (n=13) beneficiaries. None of the beneficiaries interviewed were aware of the model. Beneficiaries expressed similar attitudes toward ACOs in general, regardless of alignment mode: five claims-aligned beneficiaries and four voluntarily and claims-aligned beneficiaries expressed concerns about ACOs.

Dual eligibility status. We expected that dually eligible beneficiaries may be more likely to have a disability and thus more likely to use home visit services. Among the four dually eligible beneficiaries we asked about home visits, three reported ongoing home visits. In contrast, only 3 of 17 Medicare-only eligible beneficiaries we asked about home visits reported receiving any home visits. We found no difference in use of telehealth to monitor

ongoing conditions between Medicare-Medicaid dually eligible beneficiaries and Medicare-only eligible beneficiaries.

Demographic characteristics. A few patterns emerged among the small subset of beneficiaries who expressed dissatisfaction with certain aspects of their health care experience. Three-fourths of individuals who expressed dissatisfaction with any aspect of care were younger than age 65. The one rural beneficiary interviewed also shared a negative sentiment toward their care. The negative sentiments expressed by these individuals included their opinion not being considered in care planning, their provider not communicating well, not getting appointments as soon as wanted, and dissatisfaction with care management.

Appendix L: Exit Interviews – Methods and Detailed Findings

L.1: Methods

Between November 2022 and February 2023, the team conducted 11 one-hour individual or group interviews with 21 DCE or parent organization staff representing 12 separate DCEs that chose to exit GPDC in PY2021 or PY2022.[92] Interviewees included management staff who supported multiple activities, including implementation of the DCEs. We worked closely with CMS to develop a semi-structured interview guide to explore motivations for joining the GPDC Model, the focus of DCE initiatives, how expectations compared with experiences, reasons for exiting the model, challenges, and future plans. **Exhibit L.1** provides the key domains covered in the interview guide and corresponding questions.

A senior researcher led each interview, and a second researcher took transcript style notes. When possible, we conducted the interviews via videoconference and recorded for notetaking purposes with permission from the participants.[93] The NORC team debriefed after interviews and analyzed the interview notes by topic, recording findings in an Excel spreadsheet. Key themes were identified through iterative rounds of debriefing and discussion of findings.

L.2: Detailed Findings

Characteristics of DCEs that Exited the Model

The 12 DCEs that chose to exit the model reflected varied organization types and experience with accountable care (**Exhibit L.1**). Half were Standard DCEs, with almost as many New Entrant DCEs. Most had selected Global rather than Professional risk. The exiting DCEs included networks of individual practices, medical groups, and IDS/hospital systems. Half were led by health systems and another quarter by insurers. Considering functional roles of DCEs, no enablers exited, only conveners and direct care providers. All DCEs that exited had at least some prior APM experience.

[92] One of the group interviews included representatives from two DCEs owned by the same parent company that exited the GPDC Model for similar reasons. This interview included three executives from the parent company that could speak to the separate DCEs as well as the organization's overall corporate strategy related to ACOs.

[93] At the request of participants, two interviews were not recorded; one of the interviewees spoke with NORC only after being guaranteed anonymity because they and the other DCE employees had left the parent company under challenging circumstances.

Exhibit L.1 Characteristics of Exiting DCEs

Characteristics of Exiting DCEs	Number of Exiting DCEs (n=12)
DCE Type	
Standard	6
New Entrant	5
High Needs	1
Risk Level	
Global	9
Professional	3
Entry and Exit Date	
2021/2021	3
2021/2022	5
2022/2022	4
Organizational Structure	
Network of Individual Providers	5
Medical Group Practice	3
IDS/Hospital System	4
Lead Organization Type	
Health System	6
Insurer	3
MSO	2
Primary Care Company	1
Physician Practice	0
Functional Role	
Convener	7
Direct Care Provider	5
Enabler	0
Previous ACO Experience	
Previous Experience in any APM	12
Previous Experience in NGACO	6

SOURCE: PY2021/2022 Financial Results, model applications, interviews with DCEs.

NOTE: DCE type and risk level refers to the latest type and model elections of each DCE prior to exit (for example, a DCE that entered the model as a New Entrant DCE in PY2021 but exited as a Standard DCE in PY2022 is referred to as a Standard DCE). IDS=integrated delivery system; MSO=management service organization; APM=alternative payment model; NGACO=Next Generation ACO.

Primary Reasons for Exiting

The reasons interviewees reported for leaving the GPDC Model or consolidating ACOs were not always mutually exclusive and sometimes coincided with internal corporate reorganization.

Interviewees from four DCEs that left the GPDC Model (and that did not shift to other Innovation Center ACO models or Shared Savings Program) indicated that the primary reason for leaving was the unanticipated high financial loss, representing millions of dollars. Four other interviewees (from DCEs that chose to consolidate or shift ACO initiatives) indicated they may move some providers to what they considered the lower risk Shared Savings Program ACOs. Four interviewees, including several from DCEs where the parent company was shifting to other models or consolidating with other ACOs, indicated that enrollment challenges also contributed to their DCEs' exits, with three mentioning the 5,000 aligned beneficiary minimum threshold as one barrier to continued participation. The parent organizations choosing to consolidate into fewer ACOs anticipated benefiting from economies of scale by consolidating their providers' enrollees into fewer ACO entities.

Interviewees at two different DCEs—a national specialty care organization and a federal-qualified health center (FQHC)—noted that their experience confirmed that their organizations were not in the right model, despite already serving a Medicare FFS population. The FQHC DCE interviewees suggested that neither the GPDC nor ACO REACH Models considered challenges unique to FQHCs. For example, they highlighted the difficulty of meeting the minimum enrollment requirements. They also noted challenges related to their structure and operational experience. For example, FQHC staff members were not generally trained to focus on documentation of diagnoses to inform risk adjustment models. The FQHC also mentioned introducing AWVs as part of their DCE work to have staff better document or update diagnoses, identify patients' broader needs, and track specialty care.

Exiting DCEs Described Challenges in Model Operations

Multiple interviewees noted that the administrative hurdles in working with the GPDC Model, and the lack of transparency and clear documentation related to policies, were greater than expected and more than experienced with other Innovation Center ACO models. All described multiple administrative and operational challenges from participating in the model; however, none indicated that any one issue alone would have resulted in the decision to exit the GPDC Model.

More clarity and timely communications were required to fully understand model requirements. In general, DCE interviewees indicated that it was difficult to understand model requirements or to receive timely clarifications from CMS when needed.

Shifts in retrospective trend adjustments made financial planning difficult. Representatives of four of the DCEs were especially frustrated by what they considered to be large shifts in the retrospective trend adjustments, making financial planning difficult and resulting in substantial financial swings (by multiple millions of dollars) between quarters. Several interviewees from DCEs operating in the West also expressed strong objections to the

lack of consideration for regional differences in cost and utilization, which they believed resulted in them not being able to achieve savings.

Other factors such as lack of adjustments for areas with higher costs of living and higher utilization in services provided during the COVID-19 PHE were operational challenges flagged by exiting DCEs.

Changing alignment numbers proved difficult for population management. Several interviewees said the alignment processes were unclear and that not knowing which patients were part of the DCE early in the process made it difficult to effectively manage the population. The large monthly up-and-down swings in alignment numbers were especially challenging for DCEs where alignment hovered near the 5,000-beneficiary threshold. As one interviewee noted, reaching the minimum alignment requirement was *"more difficult than expected."* An interviewee from another DCE said that the DCE applied for and was accepted into the model but then no longer qualified because of the inevitable shifts—sometimes by several hundred patients in a given period—in claims-based alignment. Some DCEs tried voluntary alignment as a way to supplement claims-based alignment and to ensure that they met the minimum alignment requirements of the model: *"Since [we] had a group of providers that had been seeing those patients for a very long period of time, we thought voluntary alignment made sense … but at the end of the day, it didn't."*

Volume and accuracy of data and reports were difficult to navigate. Interviewees described challenges related to data access, data delays, and data inaccuracies. Many interviewees mentioned that their DCEs received data and reports that were either incorrect or incomplete, necessitating ongoing discussion with CMS. Others repeatedly emphasized how challenging it was to manage patients when they were unsure which patients were aligned to their DCE for months at a time.

One interviewee mentioned being surprised at the volume of data and reports they received related to the model and the amount of time it took to figure out how to interpret the reports, with understanding the benchmark reports being especially challenging.

Exiting DCEs' Expectations Versus Experiences

Most interviewees expressed surprise that their DCEs did not have financial success given their prior experience in managing or offering managed care products to MA, Special Needs Plans, and PACE programs. The greatest challenges included the significant financial losses that several DCEs experienced, unexpected volatility related to retrospective trend adjustments,[94] and experiences with alignment. Compared to their experience with MA, many interviewees reported that it was more difficult to identify who they were responsible for, and to manage

[94] Financial reconciliation compares a DCE's expenditures to its final benchmark. The final benchmark for the PY is based on final beneficiary alignment, risk score, full claims run-out, and other adjustments, including the retrospective trend adjustment. GPDC prospective benchmarks were based on the trend in the adjusted United States Per Capita Cost (USPCC). If the difference between the prospective adjusted USPCC trend and the observed expenditure trend exceeds +/-1%, the retrospective trend adjustment is applied to the benchmark to correct for this difference. For more information see: https://www.cms.gov/priorities/innovation/media/document/gpdc-py2022-fin-reconcil-ovw and https://www.cms.gov/priorities/innovation/media/document/dc-model-options-fnclmethrecon-slides.

care effectively. Several also mentioned that effectively controlling costs with Medicare FFS patients was more challenging in the absence of the ability to implement the utilization management protocols that MA organizations frequently use.[95]

Individual DCEs Conveyed Positive Lessons Learned

Most interviewees spoke about the administrative and operational challenges associated with the model; however, when asked about lessons learned from their experience, three interviewees mentioned the experience resulted in improvements that would or had outlasted their model participation:

- Preparing for their GPDC participation was an opportunity for a large health system DCE to bring together disparate medical groups and clinicians to set common goals and have productive discussions that led to improved communications.
- A DCE led by a large insurer began working more closely and consistently with clinic and practice managers.
- A DCE that was an FQHC set up a system to better track AWVs and enable a more systematic approach to understanding and documenting patients' interactions with specialists and specialty care received and to documenting all patient diagnoses.

Exiting DCEs' Plans After GPDC

Four of the larger parent organizations with exiting DCEs indicated they planned to shift to the Shared Savings Program, with some noting that if their applications were not accepted, they would shift their providers and aligned patients from the exiting DCEs to an existing ACO in their portfolio that would continue in the ACO REACH Model. Interviewees with five of the other DCEs said that, based on their experience, they would no longer pursue participation in any CMS ACO initiative. The remaining exiting DCEs planned to consolidate their providers with other REACH ACOs that continued to be part of their organization's value-based product line.

[95] Medicare Advantage plans frequently use prior authorization and referrals to manage patient utilization of services. Prior authorization is a process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Referral is a process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type. For more information, see the Medicare Managed Care Manual, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.