Global and Professional Direct Contracting (GPDC) Model
Summary of Quality Performance, Financial Performance, and Model Payments
Updated 03/28/23

The Centers for Medicare & Medicaid Services (CMS) conducts routine and ongoing monitoring of the quality and financial performance of innovative payment and care delivery reform models. Note that the data in this document are for model monitoring purposes, and are not evaluation results. This document will be updated regularly to provide information on the quality and financial performance of the Direct Contracting Entities (DCEs) participating in the Global and Professional Direct Contracting (GPDC) Model.

1. Quality Performance

Summary: CMS is sharing performance data on the All-Condition Readmission (ACR) and Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC) measures for the first performance year (PY) of the GPDC Model (April to December, 2021) and the first three quarters of the second PY (January through September 2022). The GPDC Model focuses quality measurement on a small set of critically important quality measures, including CAHPS® (beneficiary experience of care surveys),[1] ACR, UAMCC, Days at Home (High Needs Population DCEs only), and Timely Follow-Up After Acute Exacerbations of Chronic Conditions (Standard and New Entrant DCEs only).[2] However, in PY2021 and PY2022, only the ACR and UAMCC measures are treated as pay-for-performance measures. The remaining measures are pay-for-reporting. Because all claims-based measures have a 12-month performance period, CMS shares performance measure data based on 12-month rolling periods for quarterly reports. For example, performance data for quarter 3 of 2022 are based on a performance period from October 1, 2021 through September 30, 2022.

ACR data should be read as the "percent of initial hospital admissions that resulted in an unplanned readmission." Lower values for unplanned hospital readmissions indicate higher quality. For the 12-month period ending in September of 2022, the ACR score across all Standard and New Entrant GPDC Model participants (known as DCEs) was 15.21% (i.e., 15.21% of hospital admissions resulted in an unplanned readmission for beneficiaries aligned to a DCE). For reference, the ACR score across all non-DCE TINs (including TINs participating in traditional Medicare, the Medicare Shared Savings Program, and the Next Generation ACO (NGACO) Model) was 15.18%. This difference is not statistically significant.

UAMCC data should be read as the "number of unplanned hospital admissions per 100 beneficiaries with multiple chronic conditions per year." Lower values for unplanned hospital admissions indicate higher quality. For the 12-month period ending in September of 2022, the UAMCC score across all Standard and New Entrant DCEs was 30.65 (i.e., for every 100 beneficiaries with multiple chronic conditions aligned to a participant in the GPDC Model there were 30.65 unplanned hospital admissions). For reference, the ACR score across all non-DCE TINs (including TINs participating in traditional Medicare, the Medicare Shared Savings Program, and the NGACO Model) was 32.54. This difference is statistically significant (i.e., GPDC Model participants scored statistically better on the UAMCC measure).

[1] Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] For more information on the GPDC Model quality policy, please see the PY2022 Quality Measurement Methodology paper available on our website: https://innovation.cms.gov/media/document/gpdc-py2022-qual-meas-meth

Table 1. GPDC Quality Data - October 2021 through September 2022

12-Month Period Ending:	DCE[1] count	ACR[2]		UAMCC[3]	
		All DCE TINs	All Non-DCE TINs[4]	All DCE TINs	All Non-DCE TINs[4]
June 2021	47[5]	13.42%	13.46%	27.01	28.38
September 2021	47	14.27%	14.30%	29.29	30.63
December 2021	47	14.98%	14.96%	30.75	32.58
March 2022	91[6]	15.20%	15.17%	31.92	33.37
June 2022	91	15.17%	15.13%	31.32	32.81
September 2022	91	15.21%	15.18%	30.65	32.54

(1) DCE = Participants in GPDC Model, referred to as Direct Contracting Entities (DCEs).
(2) ACR = All-Condition Readmission; this data should be interpreted as "percent of initial hospital admissions that resulted in an unplanned readmission." Lower values are more favorable.
(3) UAMCC = Unplanned Admissions for Patients with Multiple Chronic Conditions; this data should be interpreted as "number of unplanned hospital admissions per 100 beneficiaries with multiple chronic conditions per year." Lower values are more favorable.
(4) All Non-DCE TINs = All non-DCE TINs participating in traditional Medicare and the Medicare Shared Savings Program with at least 1,000 eligible beneficiaries. Note, data from the NGACO Model was included for the 2021 performance year.
(5) Data excludes 6 High Needs Population DCEs given small sample size and lack of comparability to a general reference population (like all non-DCE TINs).
(6) Data excludes 8 High Needs Population DCEs given small sample size and lack of comparability to a general reference population (like all non-DCE TINs).

This data is based on performance data collected for purpose of quality measurement in the model and does not represent formal evaluation data. In general, the statistically significant findings on the UAMCC measure, while early, indicate that quality may be improving, and we look forward to evaluation findings.

2. Financial Performance

Summary: CMS is releasing summary statistics of DCEs' financial performance. Across the 99 DCEs participating in the GPDC Model in PY2022, the total number of aligned beneficiaries through the four quarters of PY2022 is approximately 1,735,000 beneficiaries. The total dollars under risk (i.e., the sum of the Performance Year Benchmark across all 99 PY2022 DCEs), which is a cumulative year-to-date (YTD) figure from January 2022 through December 2022, is consistent with an average per-beneficiary-per-month (PBPM) benchmark of approximately $1,117 (varying slightly throughout the PY). Based on the four quarters of 2022, all 99 DCEs that participated in the GPDC Model in PY2022 combined for a roughly 1.6% reduction in Medicare spending compared to their combined PY benchmarks in PY2022. Combined with the capitation data (see below), this is analogous to a Medical Loss Ratio (MLR) of 98.2%.[3]

Average reduction in Medicare spending has fluctuated over the four quarters of the PY in a pattern that is consistent with the results of other ACO-based initiatives. It is important to caveat that this data is not final and is subject to change. For the 72 DCEs that elected 100% risk, (the 'Global' option), in PY2022, CMS applies a discount of 2% to ensure savings for CMS; this adjustment has already been removed from the PY Benchmarks

[3] MLR generally refers to the percent of health care premiums spent on medical claims. Because the GPDC Model exists within traditional Medicare and model participants are not functioning as payers, this terminology is generally not used in the context of ACO-based models like the GPDC Model. However, for comparison purposes, MLR may be considered analogous to the reduction in spending compared to the benchmark (1.6% - see Table 2, most recent data for PY2022) combined with the percent of the benchmark comprised of capitation payments (2.8% - see Table 3, most recent data for PY2022) and the percentage of those payments that is not spent on Medicare Covered Services (1 – 92.6% = 7.4% - see Table 3, most recent data for PY2022). For PY2022, MLR could be estimated to be 100% - 1.6% - (2.8% * 7.4%) = 98.2%.

in this data; because of this, the reductions in expenditures that are reported are in addition to the savings for CMS.[4]

This data does not represent formal model evaluation data, but is collected for purposes of monitoring the Model's financial methodology and performance.

Table 2. GPDC Financial Performance Data

Period covered	Data as of	DCE Count	Avg. aligned beneficiaries across all DCEs	Total dollars under risk across all DCEs (cumulative YTD)	Aggregate reduction (increase) in spending compared to benchmark	Standard Deviation[1]
PY2021						
Apr–Jun 2021	July 2021	53	344,390	$1,158,839,004	2.2%	10.6%
Apr–Sep 2021	October 2021	53	343,495	$2,400,603,391	1.8%	9.9%
Apr–Dec 2021	January 2022	53	343,423	$3,612,885,015	1.5%	9.6%
Apr–Dec 2021	May 2022	53	338,938	$3,514,813,246	1.7%	10.1%
PY2022						
Jan–Mar 2022, YTD	May 2022	99	1,768,708	$5,749,697,246	4.5%	8.8%
Jan–Jun 2022, YTD	July 2022	99	1,748,470	$11,179,301,866	3.5%	7.7%
Jan–Sep 2022, YTD	October 2022	99	1,742,057	$17,259,574,662	2.0%	7.4%
Jan–Dec 2022, YTD	January 2023	99	1,735,112	$23,267,561,796	1.6%	7.1%

(1) Standard Deviation in average reduction (increase) in spending compared to benchmark across all 53 DCES participating in PY2021

[4] For a full explanation of the benchmark methodology, please see the Financial Operating Guide: Overview paper available on our website: https://innovation.cms.gov/media/document/gpdc-py2022-fin-op-guide-ovw

3. Capitation

CMS is publishing available data on capitation in the GPDC Model. From January to December of PY2022, only 2.8% of total services provided to aligned beneficiaries were impacted by capitation (i.e., 97.2% of all Medicare payments for services to aligned beneficiaries were not impacted by capitation). Capitation in the GPDC Model functions differently than capitation in other health care contexts, such as Medicare Advantage (MA). In Medicare Advantage, CMS pays MA plans capitation payments covering the total cost of care, and MA plans assume responsibility for contracting a provider network and adjudicating and paying all claims that those providers bill to the plan. In the GPDC Model, capitation payments cover only a portion of total cost of care: Medicare Part A and Part B services rendered by health care providers participating in the Model who agree to participate in capitation. CMS retains responsibility for adjudicating all claims, including those covered by capitation, and for paying approved claims, as appropriate and in accordance with accompanying claims reduction arrangements. Beneficiaries maintain the freedom of choice to see any Medicare-enrolled provider or supplier. Capitation in the GPDC Model enables participating health care providers to forgo a portion of their fee-for-service (FFS) claim payments in exchange for receiving compensation from the DCE (e.g., share of savings) with the goal of better aligning financial incentives at the point of care.

There are two capitation options (called 'capitation payment mechanisms') in the GPDC Model. Primary Care Capitation (PCC) is a payment mechanism in which participating primary care providers in the GPDC Model agree to forgo between 1-100% of FFS claims payments for a specific set of services rendered to aligned beneficiaries by participating health care providers (see Table B.6.3 in the Financial Operating Guide: Overview paper for a list of these services). Total Care Capitation (TCC) is a payment mechanism in which participating health care providers in a DCE agree to forgo 100% of FFS claims payments for services rendered to aligned beneficiaries.

Health care providers who are not participating in the GPDC Model do not have their claim payments adjusted in any way under the model, even when providing services to aligned beneficiaries. Further, health care providers who are participating in TCC or PCC do not have their claims payments adjusted in any way under the model when providing services to beneficiaries who are not aligned to their DCE.

Because capitation only affects participating health care providers, it generally impacts a small percentage of Medicare Covered Services provided to aligned beneficiaries. During PY2022, all Participant Providers were required to have some portion of their eligible claims reduced via capitation, while Preferred Providers could choose whether to participate in capitation. Of the 99 DCEs in the model for PY2022, 72 opted for PCC and 27 for TCC. Through the four quarters of PY2022, capitation impacted, on average, 2.8% of total cost of care (i.e., 97.2% of all Medicare payments for services furnished to aligned beneficiaries were not impacted by capitation). Further, the total amount of forgone FFS claim payment due to TCC and PCC through four quarters of PY2022 is equal to 92.6% of the total TCC and PCC payments made to DCEs. In other words, the amount of Medicare payments withheld (not paid out as they would have been outside of the model) was 92.6% of the capitation dollars paid, which can be interpreted as 92.6% of capitation dollars paid being spent on Medicare Covered Services. This is a decrease from PY2022 Q3, but is in line with the averages deduced through PY2021 (~91%). This figure tends to fluctuate during the Performance Year for a variety of reasons – i.e., change in capitation payment levels (due to alignment attrition, updated Withhold Percentage, and updated PBPM benchmark); seasonality-related considerations (e.g., services at beginning of PY contribute less to benchmark expenditures due to beneficiaries' Part B deductible); and updated incurred and paid expenditure totals with varying levels of claims run-out. In summary, we would expect the cumulative, YTD percent of capitation dollars spent on Medicare Covered Services to normalize at the historical average of ~90% by financial settlement.

Two policy changes from PY2021 to PY2022 that may change the proportion of payments impacted by capitation are (1) all Participant Providers participating in a DCE were required to participate in capitation in

PY2022 and (2) a higher minimum claims reduction amount for PCC was required in PY2022 (1–100% permitted in PY2021 vs. 5–100% in PY2022).

It is important to caveat that this data is not final and is subject to change. Further, this data is not formal model evaluation data, but data collected for the purposes of monitoring the Model's financial methodology and performance.

Table 3. GPDC PY2021 Capitation Data (PCC and TCC combined)

Period covered	Data as of	DCE Count[1]	Aggregate % of Performance Year Benchmark paid via capitation	Preliminary % of capitation payments spent on Medicare Covered Services[2]
PY2021				
Apr–Jun 2021	January 2022	36	2.5%	91.4%
Apr–Sep 2021	January 2022	36	2.5%	90.3%
Apr–Dec 2021	May 2022	36	2.5%	90.8%
PY2022				
Jan–Mar 2022, YTD	January 2023	99	3.5%	82.3%
Jan–Jun 2022, YTD	January 2023	99	3.5%	93.5%
Jan–Sep 2022, YTD	January 2023	99	2.7%[3]	96.1%
Jan–Dec 2022, YTD	January 2023	99	2.8%	92.6%

(1) PY2021 DCE count excludes 17 DCEs that had no participating health care providers that chose to participate in capitation.
(2) Reflects the total amount of forgone FFS claim payment due to TCC and PCC as a proportion of total TCC and PCC payments made to DCEs; driven by many factors, such as level of capitation payment, precision of expenditure estimation with varying levels of claims run-out, incidence of health care services furnished outside construct of Medicare fee schedule, and amount of savings that ACOs generate on capitation payments; prior quarters' data is updated to incorporate adjustments made to reflect most recent estimates of accurate capitation levels.
(3) Q1 and Q2 capitation payments were based on the preliminary benchmark, while Q3 and Q4 capitation payments were based on the Q1 and Q2 benchmark, respectively. The Q3 and Q4 payments also included the retrospective trend adjustment. It is expected to see a change in the % of performance year benchmark paid via capitation from Q1 and Q2 to Q3 and Q4.