Global and Professional Direct Contracting (GPDC) Model

Summary of Quality Performance, Financial Performance, and Model Payments

Updated 2/18/22

The Centers for Medicare and Medicaid Services (CMS) routinely conducts ongoing monitoring of the quality and financial performance of 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 Global and Professional Direct Contracting (GPDC) Model's impact on beneficiary quality and on the financial performance of participants.

1. Quality Performance

Summary: CMS is sharing performance data on All-Condition Readmission (ACR) and Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC) for the first quarter of the GPDC Model (April to June 2021). 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 Performance Year (PY) 2021 and PY2022, only the ACR and UAMCC measures are treated as pay-for-performance measures. The remaining measures are pay for reporting. Currently, only performance data from the first three months of PY2021 (April – June 2021) is available for ACR and UMCC due to the lag time required for data accuracy. CMS intends to share additional quality performance data on a quarterly basis as it becomes available. 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 2 of 2021 are therefore based on a performance period from July 1, 2020 through June 30, 2021.

ACR data should be read as the "percent of initial hospital admissions that resulted in an unplanned readmission." Because unplanned hospital readmissions are generally not desirable for Medicare beneficiaries, lower values for this quality measure are considered to indicate higher quality. For the 12-month period ending in June of 2021, the ACR score across all Standard and New Entrant GPDC Model participants (known as DCEs) was 13.42% (i.e., 13.42% 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 13.46%. 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." Because unplanned hospital admissions are generally not desirable for Medicare beneficiaries, lower values for this quality measure are considered to indicate

[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

higher quality. For the 12-month period ending in June of 2021, the UAMCC score across all Standard and New Entrant DCEs was 27.01 (i.e., for every 100 beneficiaries with multiple chronic conditions aligned to a participant in the GPDC Model there were 27.01 unplanned hospital admissions, adjusted for a 12-month period). 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 28.38. This difference is statistically significant.

CMS infers from this data that the GPDC model, to date, has not produced any early indications of reductions in quality or increases in Medicare costs. However, 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 based on performance data collected for purposes of quality measurement in the Model.

Table 1. GPDC Quality Data - April through June 2021

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	*Available in March 2022*				

(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, the Medicare Shared Savings Program, and the NGACO Model with at least 1,000 eligible beneficiaries.
(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).

2. Financial Performance

Summary: CMS is releasing summary statistics of PY2021 DCE financial performance. Across the 53 DCEs participating in the GPDC Model in PY2021, the total number of aligned beneficiaries remained roughly constant throughout PY2021 at approximately 344,000 beneficiaries. The total dollars under risk (also known as the sum of the Performance Year Benchmark across all 53 PY2021 DCEs), which is a cumulative year-to-date (YTD) figure from April 2021 through December 2021, increased in line with expectations and is consistent with an average per-beneficiary-per-month (PBPM) benchmark of approximately $1,160 (varying across quarters). Combined, all 53 DCEs that participated in the GPDC Model in PY2021 produced roughly 1.5% reduction in spending compared to their combined Performance Year benchmarks in PY2021 based on the latest data available. Combined with the capitation data (see below), this is analogous to a Medical Loss Ratio (MLR) of 98.25%[3].

[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 (1.5%) combined

Average reduction in spending fluctuated over the 9-month Performance Year 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 39 DCEs that are taking 100% risk (the 'Global' option) in PY2021, CMS applies a discount of 2% (in PY2021) to ensure savings for CMS; this adjustment has already been removed from the Performance Year Benchmarks in this data, so reductions in expenditures reported are in addition to the savings for CMS.[4] This data is not formal model evaluation data, but are collected for purposes of monitoring the Model's financial methodology and performance.

While PY2022 financial data is not yet available, we expect the average number of aligned beneficiaries across all participating DCEs during PY2022 to be approximately 1.8 million.

Table 2. GPDC Financial Performance Data - April through December 2021

Period covered	Data as of	DCE Count	Avg. aligned beneficiaries across all DCEs	Total dollars under risk across all DCEs (cumulative YTD)	Average reduction (increase) in spending compared to benchmark	Standard Deviation[1]
Apr-Jun 2021, YTD	July, 2021	53	344,390	$1,158,839,004	2.2%	10.6%
Apr-Sep 2021, YTD	October, 2021	53	343,495	$2,400,603,391	1.8%	9.9%
Apr-Dec 2021, YTD	January, 2022	53	343,423	$3,612,885,015	1.5%	9.6%

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

3. Capitation

PY2021 Summary: CMS is publishing available data on capitation in the GPDC Model. In 2021, only 2.5% of total services provided to aligned beneficiaries were impacted by capitation (i.e., 97.5% 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 healthcare contexts, for example in Medicare Advantage (MA). In Medicare Advantage, CMS pays MA plans capitation payments covering the total cost of care and MA plans take on responsibility for contracting a provider network and adjudicating and paying all claims that those providers send to the plan. In the GPDC Model, capitation

with the percent of the benchmark comprised of capitation payments that are not spent on FFS claims (2.5% * 10% = 0.25%): 100% - 1.5% - 0.25% = 98.25% MLR.

[4] These data include: the discount for Global DCEs, an incurred but not reported (IBNR) factor based on one month of claims-runout following the reporting period covered (i.e., through July for April-June data, through October for April-September data, etc.), an estimate for the retrospective trend factor and risk score normalization factor based on available data at the time, and the DCE-specific risk score cap. These data do not include stop-loss charges or payouts, the Coding Intensity Factor, the Retention Withhold, or the final retrospective trend update. For a full explanation of each benchmark component referenced here, please see the Financial Operating Guide: Overview paper available on our website: https://innovation.cms.gov/media/document/gpdc-py2022-fin-op-guide-ovw

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 and paying all claims and beneficiaries maintain the freedom of choice to see any Medicare-enrolled provider or supplier. Capitation in the GPDC Model enables participating healthcare providers to forgo a portion of their fee-for-service (FFS) claim payments in exchange for receiving compensation from the DCE, for example a greater share in 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 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 healthcare providers in the GPDC Model agree to forgo 100% of FFS claims payments for services rendered to aligned beneficiaries by participating providers.

Healthcare 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, healthcare 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.

Because capitation only affects participating providers, it generally impacts a small percentage of Medicare Covered Services provided to aligned beneficiaries. Healthcare providers participating in DCEs were not required to receive payment through capitation in PY2021 due to the Public Health Emergency. Despite capitation being optional during PY2021, 36 of 53 DCEs included healthcare providers that chose some form of capitation, with 25 opting for PCC and 11 for TCC. Across all 36 DCEs (i.e., excluding the 17 DCEs with no healthcare providers participating in capitation), capitation impacted on average 2.5% of total cost of care (i.e., 97.5% of all Medicare payments for services furnished to aligned beneficiaries were not impacted by capitation). Further, of the capitation payments made by CMS to DCEs for the purpose of delivering the small set of services impacted, preliminary data indicate that about 90% of those capitation payments directly translated into the provision of Medicare Covered Services (i.e., the dollar amount of Medicare FFS claim payments reduced in connection to capitation was approximately 90% of the dollar amount of the capitation payments made to DCEs).

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) - April through December 2021

Period	DCE count[1]	Average % of Performance Year Benchmark paid via capitation[2]	Preliminary % of capitation payments spent on Medicare Covered Services[3]
Apr-Jun 2021	36	2.5%	91.4%
Jul-Sep 2021	36		89.2%
Oct-Dec 2021	36		Available in May 2022

(1) PY2021 DCE count excludes 17 DCEs that had no participating healthcare providers that chose to participate in capitation.

(2) Average across all 36 DCEs of Base PCC % and [1 – TCC Withhold %], with each DCE weighted equally; because these values apply across all three quarters of PY2021, we have collapsed the data into one cell.

(3) These values are expected to trend closer to 100% once final calculations are made, for adjustments for healthcare providers who originally signed up for capitation, but terminated their participation in the Model during the Performance Year.

PY2022 Summary: Because the capitation payments are calculated prospectively, we are able to estimate that approximately 4% of total cost of care for all aligned beneficiaries will be impacted by capitation in PY2022. This represents a small but marked increase compared to the PY2021 data of approximately 2.5%, which is expected because (1) all healthcare providers participating in a DCE were required to participate in capitation in PY2022 and (2) a higher average claims reduction amount for PCC was required in PY2022 (1-100% permitted in PY2021 vs 5-100% in PY2022). We plan to publish that data once it becomes available for the percent of these payments 'spent' on Medicare Covered Services.

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 collected for the purposes of monitoring the Model's financial methodology and performance.

Table 4. GPDC PY2022 Capitation Data (PCC and TCC combined) – January through March 2022

Period	DCE count	Average % of Performance Year Benchmark paid via capitation[1]	% of capitation payments spent on Medicare Covered Services
Jan-Mar 2022	99	4.0%	Available in Fall 2022

(1) Average of all DCEs with each DCE weighted equally