Global and Professional Direct Contracting Model: Quality Measurement Methodology (for PY2022 only—1/1/2022–12/31/2022)

Revision: v 2.1

Prepared for:
Centers for Medicare & Medicaid Services (CMS)
Center for Medicare and Medicaid Innovation (The Innovation Center)
Seamless Care Models Group
7500 Security Boulevard, N2-13-16
Baltimore, MD 21244-1850

Prepared by:
RTI International
3040 East Cornwallis Road
Research Triangle Park, NC 27709

Revision history

Revision	Date	Revisions
2.1	November 30, 2021	(PY2022 Version) Updated to provide additional information
2.0	August 3, 2021	(PY2022 Version) Updated for PY2022
1.1	March 12, 2021	(PY2021 Version) Minor edits to standardize terminology

Reference documents

Title
Global and Professional Direct Contracting (GPDC) Model: Frequently Asked Questions, Version 4. April 2021
PY2022 Global and Professional Direct Contracting Model: Financial Operating Guide: Overview
Global and Professional Direct Contracting Model: Companion to Financial Operating Guide Overview: Standard DCE
Global and Professional Direct Contracting Model: Companion to Financial Operating Guide Overview: New Entrant DCE
Global and Professional Direct Contracting Model: Companion to Financial Operating Guide Overview: High Needs Population DCE
PY2022 Global and Professional Direct Contracting Model: Financial Reconciliation Overview

Contents

List of Acronyms

ACO	Accountable Care Organization
ACR	Risk-Standardized All-Condition Readmission
CAHPS®	Consumer Assessment of Healthcare Providers and Systems®
CI/SEP	Continuous Improvement/Sustained Exceptional Performance
CMS	Centers for Medicare & Medicaid Services
DAH	Days at Home for Patients with Complex, Chronic Conditions
DCE	Direct Contracting Entity
ED	emergency department
FFS	Medicare Fee-for-Service
FQHC	Federally Qualified Health Center
GPDC	Global and Professional Direct Contracting
HCC	Hierarchical Condition Category
HPP	High Performers Pool
IP	Implementation Period
P4P	Pay-for-Performance
P4R	Pay-for-Reporting
PY	Performance Year
RSAAR	A Risk-Standardized Acute Admission Rate
RSRR	Risk-Standardized Readmission Rate
SNF	Skilled Nursing Facility
Timely Follow-Up	Timely Follow-Up After Acute Exacerbations of Chronic Conditions
TIN	Tax Identification Number
The Innovation Center	Center for Medicare & Medicaid Innovation
UAMCC	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions

This document provides an overview of the quality measurement and performance evaluation methodology for Direct Contracting Entities (DCEs) participating in the Global and Professional Direct Contracting (GPDC) Model. The quality approach is discussed at a high level for the entire performance period, and Performance Year 2022 (PY2022) is discussed in additional detail. This document includes information on the GPDC Model focusing on the Standard, New Entrant, and High Needs Population DCE types. This document may be subject to periodic changes and will be updated to reflect policies applicable during the current PY.

Section 1 provides a brief overview of the GPDC Model with context relevant to the quality strategy. **Section 2** describes the quality performance assessment process in detail and provides an overview of how performance assessment will differ in subsequent PYs. **Section 3** provides a series of worked examples of the application of the quality strategy. **Section 4** provides additional details regarding the design of the Quality Measures in use during PY2022 of the GPDC Model.

1. Model Background: Context for Quality Approach

1.1 GPDC Model Overview

The Global and Professional Direct Contracting (GPDC) Model is part of a strategy by the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (the Innovation Center) to drive broader health care delivery system reform through the redesign of primary care. The GPDC Model builds on lessons learned from other Medicare Accountable Care Organization (ACO) initiatives, such as the Medicare Shared Savings Program (Shared Savings Program) and the Next Generation ACO Model, and innovative risk-sharing approaches from Medicare Advantage and the private sector. GPDC Model participants are referred to as Direct Contracting Entities (DCEs).

DCEs are expected to improve quality of care and health outcomes for Medicare beneficiaries. As such, the GPDC Model will include an assessment of quality during each performance year (PY) using several Quality Measures.

Before describing the quality approach, **Section 1** briefly reviews several features of the GPDC Model that have implications for the model's quality strategy. For more detail on these general model features, please see the financial specification papers and frequently asked questions available on the GPDC Model website.[1]

1.2 Types of DCEs

DCEs can participate as one of three DCE types in PY2022. The characteristics and criteria that define each type of DCE are as follows:

- **Standard DCEs**—Standard DCEs comprise organizations that generally have substantial experience serving Medicare fee-for-service (FFS) beneficiaries, including Medicare-only and dually eligible beneficiaries. These DCEs also may have prior experience participating in Medicare ACO initiatives.
- **New Entrant DCEs**—New Entrant DCEs consist of organizations that have limited experience serving the FFS Medicare population or participating in Medicare risk-based contracts. To qualify as a New Entrant DCE, no more than 50% of a DCE's DC Participant Providers may have prior experience in any of the ACO initiatives, the Comprehensive End-Stage Renal Disease (ESRD) Care Model, or the Comprehensive Primary Care Plus (CPC+) Model.
- **High Needs Population DCEs—**High Needs Population DCEs serve FFS Medicare beneficiaries with complex needs. Only beneficiaries who meet one or more of the High Needs eligibility criteria may be aligned to a High Needs Population DCE.[2] Additionally, High Needs Population DCEs are expected to coordinate care for their aligned beneficiaries using a model of care

[1] Financial specification papers, and FAQs are available at the bottom of the GPDC Model main page at https://innovation.cms.gov/innovation-models/direct-contracting-model-options.

[2] High Needs population eligibility criteria: (1) Hierarchical Condition Category (HCC) risk score ≥ 3.0 (for concurrent or prospective Aged and Disabled scores) or > 0.35 (for prospective ESRD scores); (2) HCC risk score ≥ 2.0 and < 3.0 (for concurrent or prospective Aged and Disabled scores) or ≥ 0.24 and < 0.35 (for prospective ESRD scores) with two or more unplanned admissions in the last year; (3) signs of frailty based on hospital bed or transfer equipment use; and (4) signs of mobility impairment based on International Classification of Diseases, Version 10, Clinical Modification (ICD-10-CM) diagnosis codes. More detailed information is available in the appendix of the *Direct Contracting Financial Operating Guide: Overview.*

designed for individuals with complex needs, like the one employed by the Programs of All-Inclusive Care for the Elderly.

The Quality Benchmark development approach used for the High Needs Population DCE varies slightly from the one used for Standard and New Entrant DCEs. Additional details are provided in **Section 2.3.2** of this document.

1.3 Beneficiary Alignment

Eligible beneficiaries will be aligned to DCEs via claims and voluntary alignment.[3] All DCEs are required to meet minimum beneficiary alignment thresholds prior to the start of each PY, as outlined in **Table 1-1**. These minimum aligned beneficiary requirements impact the construction of quality performance benchmarks that vary by DCE type and are discussed in **Section 2.3.2**.

Table 1-1. Minimum Counts of Aligned Medicare FFS Beneficiaries Required by Year

DCE Type	Minimum Aligned Medicare FFS Beneficiaries					
	PY2021*	PY2022	PY2023	PY2024	PY2025	PY2026
Standard	5,000	5,000	5,000	5,000	5,000	5,000
New Entrant	1,000	1,000	2,000	3,000	5,000	5,000
High Needs	250	250	500	750	1,200	1,400

* April–December 2021

[3] Please see *Appendix B: Beneficiary Alignment Procedures,* found on page 27 of the *Financial Operating Guide: Overview*, for more detailed information regarding beneficiary alignment. Available at https://innovation.cms.gov/media/document/gpdc-py2022-fin-op-guide-ovw.

2. Quality Overview

2.1 Quality Measures

The mission of Innovation Center models, including the GPDC Model, is to lower the cost of care for Medicare beneficiaries while maintaining or improving the quality of care provided. As such, DCEs are expected to meet goals of improved quality of care and health outcomes for the Medicare beneficiaries they serve. The GPDC Model quality strategy provides achievable performance criteria that aim to incentivize changes in care delivery that reduce unnecessary utilization while improving quality of care.

To accomplish these goals, the GPDC Model will include the assessment of quality performance during each PY using several Quality Measures. Performance on these measures will impact the PY Benchmark for Final Financial Reconciliation.[4]

In PY2022, DCEs will be assessed using the following five Quality Measures (see **Section 4** for more detailed information):

1. Risk-Standardized All-Condition Readmission (ACR) measures how many hospital stays result in a readmission within 30 days after patient discharge.
2. All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC) measures unplanned hospital admissions among Medicare FFS beneficiaries 65 years of age and older with multiple chronic conditions.
3. Days at Home for Patients with Complex, Chronic Conditions (DAH) measures the number of days that adults with complex, chronic disease spend at home or in community settings and out of acute and post-acute care settings (such as inpatient hospital or emergent care settings or post-acute skilled nursing). This measure will apply only to **High Needs Population DCEs.**
4. Timely Follow-Up After Acute Exacerbations of Chronic Conditions (Timely Follow-Up) is defined as the percentage of acute events related to one of six chronic conditions where follow-up care was received within the time frame recommended by clinical practice guidelines in a non-emergency outpatient setting. Acute events are those that required either an emergency department visit or hospitalization. The six chronic conditions include hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, and diabetes. This measure is will apply to **Standard and New Entrant DCEs** only and is new in PY2022.
5. Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Survey. The GPDC CAHPS Survey will use the ACO CAHPS Survey and derive CAHPS Summary Survey Measures for scoring. The GPDC CAHPS Survey will include additional content relevant to patient/caregiver experience with care delivered by a DCE and apply to all three DCE types, although a separate survey will be administered to High Needs Population DCEs than is administered to Standard and New Entrant DCEs. The GPDC CAHPS Measure is new in PY2022. DCEs must contract with a CMS-approved CAHPS Survey vendor for each reporting year to administer the CAHPS Survey.

[4] Materials providing details about the financial methodology used for the GPDC Model, including the Financial Operating Guide Overview and Financial Reconciliation Overview papers, are available at https://innovation.cms.gov/innovation-models/direct-contracting-model-options.

Table 2-1 shows the proposed Quality Measure set by PY. Please note that these Quality Measures and timing are proposed and are subject to change. Prior to each PY, additional quality guidance will be issued informing DCEs of adjustments to the quality approach, if any.

Table 2-1. Summary Table of Quality Measures Used by Year

Measure	PY2021	PY2022	PY2023	PY2024	PY2025	PY2026	Method of Data Submission
ACR	X	X	X	X	X	X	CMS calculates from claims
UAMCC	X	X	X	X	X	X	CMS calculates from claims
DAH	Y	Y	Y	Y	Y	Y	CMS calculates from claims
Timely Follow-Up	—	Z	Z	Z	Z	Z	CMS calculates from claims
CAHPS	—	X	X	X	X	X	DCE contracts with CMS-approved CAHPS vendor

— = not applicable
X = All DCE Types
Y = High Needs Population DCEs only
Z = Standard and New Entrant DCEs only

2.2 Quality Withhold

In each PY, 5% of a DCE's financial benchmark (the Quality Withhold) will be held "at risk" and can be earned back, in part or in full, subject to the DCE's quality performance on the Quality Measures. Some or all of the 5% Quality Withhold will be tied to quality reporting or quality performance in each PY, as **Table 2-2** displays.

Table 2-2. Portions of Quality Withhold Tied to Reporting and Performance by Year

PY	Quality Withhold	Portion Tied to Reporting	Portion Tied to Performance
PY2021*	5%	4%	1%
PY2022	5%	4%	1%
PY2023	5%	0%	5%
PY2024	5%	0%	5%
PY2025	5%	0%	5%
PY2026	5%	0%	5%

*= April–December 2021

2.3 Quality Score

CMS will use the Quality Measures (Table 2-1) to calculate a Total Quality Score with a value ranging from 0% to 100% for each DCE in each PY. This Total Quality Score will be applied to the 5% Quality Withhold to calculate the Quality Withhold earn-back. For example, a Total Quality Score of 100% would

allow a DCE to earn back the entire 5% withhold, whereas a Total Quality Score of 80% would allow a DCE to earn back 80% of the 5% withhold, or 4%. A DCE's Total Quality Score will be based on a Pay-for-Reporting (P4R) Component Quality Score and a Pay-for-Performance (P4P) Component Quality Score, weighted according to Table 2-2 in a given PY. **Tables 2-3** and **2-4** show how the measures in Table 2-1 map to the Quality Withhold breakdown in Table 2-2.

When a new measure is introduced, it will typically not be P4P for the first year; CMS will typically introduce it as either P4R or as Reporting-Only during the first year of implementation. A Reporting-Only measure does not factor into a DCE's Total Quality Score, although CMS will collect the data for informational purposes (e.g., to determine whether a measure is used in a future PY or to help set the measure's Quality Benchmark). Per Tables 2-3 and 2-4, no measures are currently planned as Reporting-Only, although if any measures beyond those listed in Table 2-1 are introduced, CMS expects that they will begin as Reporting-Only. Although measures are generally either P4R or P4P in a given PY, ACR and UAMCC are both P4R and P4P in PY2021 and PY2022.

Table 2-3. P4R and P4P Measures by PY: Standard and New Entrant DCEs

PY	P4R	P4P	Reporting-Only
PY2021	• 4% = claims-based measures (ACR, UAMCC)	• 1% = Meet benchmark with either ACR or UAMCC	—
PY2022	• 2% = claims-based measures (ACR, UAMCC, Timely Follow-Up) • 2% = CAHPS	• 1% = Meet benchmark with either ACR or UAMCC	—
PY2023–PY2026	—	• 1.25% = ACR • 1.25% = UAMCC • 1.25% = Timely Follow-Up • 1.25% = CAHPS	*Only if new measure introduced for first year of use*

— = not applicable.

Table 2-4. P4R and P4P Measures by PY: High Needs Population DCEs

PY	P4R	P4P	Reporting-Only
PY2021	• 4% = claims-based measures (ACR, UAMCC, DAH)	• 1% = Meet benchmark with either ACR or UAMCC	—
PY2022	• 2% = claims-based measures (ACR, UAMCC, DAH) • 2% = CAHPS	• 1% = Meet benchmark with either ACR or UAMCC	—
PY2023–PY2026	—	• 1.25% = ACR • 1.25% = UAMCC • 1.25% = DAH • 1.25% = CAHPS	*Only if new measure introduced for first year of use*

— = not applicable.

CMS maintains the authority to revert measures from P4P to P4R if the measure owner determines that an appropriate benchmark to evaluate performance cannot be established, the measure causes patient

harm, or the measure no longer aligns with clinical practice. CMS may also remove measures from use in the evaluation of quality performance.

2.3.1 Pay-for-Reporting

Performance on P4R components is binary: DCEs either get full credit for reporting (100% Component Quality Score) or no credit (0% Component Quality Score). As shown in Tables 2-3 and 2-4, claims-based measures (including ACR, UAMCC, DAH, and Timely Follow-Up) are assessed as one combined P4R component (4% in PY2021, 2% in PY2022). This is because reporting of claims-based measures is derived from data in the CMS Integrated Data Repository.[5] As such, no action is required by DCEs to satisfy the reporting requirement for claims-based measures (Table 2-1 documents which measures are claims-based).

In **PY2021**, ACR and UAMCC are P4R for Standard and New Entrant DCEs, and ACR, UAMCC, and DAH are P4R for High Needs Population DCEs. All three measures (ACR, UAMCC, and DAH) are claims-based, thus all DCEs (regardless of DCE type) will get credit for the 4% of the 5% Quality Withhold tied to reporting.

In **PY2022**, 4% of the Quality Withhold is again tied to reporting, although CAHPS is introduced and will determine 2% of that 4%. For the remaining 2% tied to reporting, all measures are claims-based (including Timely Follow-Up, which is introduced for Standard and New Entrant DCEs) and thus no action is required by DCEs to satisfy this component of the reporting requirement.

To satisfy the quality requirement for CAHPS, DCEs will be responsible for selecting a CMS-approved vendor to administer the CAHPS Survey. In fall 2021, CMS will publish information on DCEs' CAHPS-related responsibilities and timelines in **The Innovation Center's GPDC Knowledge Library**. (Please see Table 2-8 below for more information on resources that will be made available). DCEs will need to select their CAHPS vendor by July 2022. The **CMS GPDC Newsletter** will proactively notify DCEs of all CAHPS information.

Occasionally, CMS may exempt a DCE from CAHPS for a given PY if the DCE's number of survey-eligible aligned beneficiaries is below the minimum number typically required for conducting a reliable CAHPS Survey. These numbers are shown in **Table 2-5**. CMS will directly notify exempted DCEs in the Spring of 2022 that they will not need to hire a CAHPS survey vendor for PY2022. Exempted DCEs may conduct the CAHPS Survey electively but CMS will not collect their CAHPS scores. See **Section 2.5.2** for further details on the computation of Quality Component Scores for CAHPS-exempt DCEs.

[5] The Integrated Data Repository is a high-volume data warehouse that integrates Parts A, B, C, and D and DME claims; beneficiary and provider data sources; and ancillary data such as contract information, risk scores, and more.

Table 2-5. Survey-Eligible Aligned Beneficiaries in a DCE Required for Conducting the GPDC CAHPS Survey

Standard and New Entrant DCEs	
DCEs with 100 or more Participant Providers	• CMS will draw a random sample of 860 survey-eligible aligned beneficiaries. • If there are fewer than 860 survey-eligible aligned beneficiaries, but at least 416, all eligible beneficiaries will be surveyed. • If there are fewer than 416 survey-eligible aligned beneficiaries, the survey cannot be conducted.
DCEs with 25 to 99 Participant Providers	• CMS will draw a random sample of 860 survey-eligible aligned beneficiaries. • If there are fewer than 860 survey-eligible aligned beneficiaries, but at least 255, all eligible beneficiaries will be surveyed. • If there are fewer than 255 survey-eligible aligned beneficiaries, the survey cannot be conducted.
DCEs with two to 24 Participant Providers	• CMS will draw a random sample of 860 survey-eligible aligned beneficiaries. • If there are fewer than 860 survey-eligible aligned beneficiaries, but at least 125, all eligible beneficiaries will be surveyed. • If there are fewer than a minimum of 125 survey-eligible aligned beneficiaries, the survey cannot be conducted.
High Needs DCEs	
All DCEs	• All eligible beneficiaries will be surveyed.

In **PY2023–PY2026**, 0% of the Quality Withhold will be tied to reporting. Please note that this policy applies to all DCEs, even those that begin model participation in PY2022.

2.3.2 Pay-for-Performance

Unlike P4R measures, which are binary in the GPDC Model, P4P measures are assessed with Component Quality Scores between 0% and 100%, which are weighted using the component weights shown in Tables 2-3 and 2-4. To calculate a DCE's score on an individual Quality Measure, CMS will establish a Quality Benchmark using data from large individual physician practices, group practices, and other non-DCE organizations. Each Quality Measure will have its own set of benchmarks. Quality Measures for High Needs Population DCEs will have a separate set of benchmarks from Quality Measures for Standard and New Entrant DCEs.

For claims measure Quality Benchmarks, CMS will calculate Quality Measure scores using all available Medicare FFS data aggregated to the Tax Identification Number (TIN) level for non-GPDC participating physicians, group practices, hospitals, or similar entities (see TIN definition, Appendix B, Terminology List) by applying the same rules to align beneficiaries to TINs as are used to align beneficiaries to DCEs. Additionally, for High Needs Population DCEs, Quality Benchmarks will likewise be developed using non-GPDC participating TINs, but subset to claims only for those beneficiaries who meet the High Needs eligibility criteria.

To better ensure comparability with DCEs, TINs included in the Quality Benchmarking calculations must also meet minimum aligned beneficiary requirements. For example, in **PY2021 and PY2022,** for the Standard and New Entrant DCE Quality Benchmarks, TINs must have at least 1,000 aligned beneficiaries to be included in the Quality Benchmark distribution, whereas for the High Needs Population DCE

Quality Benchmarks, TINs must have at least 250 aligned beneficiaries who meet High Needs eligibility requirements. Applying these minimum aligned beneficiary counts addresses potential concerns about differences between smaller TIN-level entities and DCEs. These minimum aligned beneficiary counts for the Quality Benchmarks are analogous to minimum beneficiary thresholds for each DCE type as applied in PY2021 and PY2022 (1,000+ beneficiaries for New Entrant DCEs[6] and 250+ High Needs beneficiaries for High Needs Population DCEs).

In **PY2021 and PY2022**, for the 1% of the Quality Withhold tied to performance, separate performance benchmarks will be set for ACR and UAMCC (note: for High Needs Population DCEs, DAH is P4R only). DCEs that meet the performance benchmark for either ACR or UAMCC will earn back the full 1% of the Quality Withhold based on their performance. DCEs that do not meet either of the performance benchmarks will have their Component Quality Score determined by a sliding scale so they can earn back a portion of the performance-based 1% (see **Section 2.5** for a more-detailed description of the sliding scale proposed for PY2021).

In **PY2023–PY2026**, separate benchmarks will be released for all P4P measures, including ACR, UAMCC, DAH (High Needs Population DCEs only), Timely Follow-Up (Standard and New Entrant DCEs only), and CAHPS. More information will be released around these Quality Benchmarks prior to PY2023.

2.4 Continuous Improvement/Sustained Exceptional Performance (CI/SEP) and High Performers Pool (HPP)

In **PY2023–PY2026**, the CI/SEP criteria will determine whether the portion of the Quality Withhold eligible for earn-back is 5% or 2.5%. The CI/SEP criteria will also be used to determine if DCEs are eligible for any additional bonus payments as part of the HPP.

2.4.1 Continuous Improvement/Sustained Exceptional Performance

In PY2023–PY2026, a set of CI/SEP criteria will be used to determine the portion of the Quality Withhold that a DCE is eligible to earn back. Specifically, a DCE's Total Quality Score will be applied to the full 5% Quality Withhold if the DCE meets the CI/SEP criteria in the PY, whereas it will be applied to only half of the Quality Withhold (2.5%) if the DCE does not meet the CI/SEP criteria in the PY. In other words, if the DCE does not meet the CI/SEP criteria, the DCE will automatically lose half of the Quality Withhold, and the most that the DCE will be able to earn back is 2.5%. More information on the CI/SEP criteria will be provided prior to PY2023.

2.4.2 High Performers Pool

In PY2023–PY2026, DCEs that meet the CI/SEP criteria will be eligible for inclusion in the HPP. The HPP provides an opportunity for a bonus payment based on quality performance or improvement. The portion of the Quality Withhold that is not earned back by DCEs that meet the CI/SEP criteria will fund the HPP. For example, a DCE that meets CI/SEP criteria and achieves a Total Quality Score of 95% will earn back 4.75% of its 5% Quality Withhold. The remaining 0.25% of the DCE's PY Benchmark that is not earned back will fund the HPP. Funds in the HPP will be distributed to the highest performing DCEs. As a result, the highest performing DCEs may earn back more than the 5% Quality Withhold in total. Criteria

[6] Because the same quality benchmarks are being used for Standard and New Entrant DCEs, TINs must meet a minimum of 1,000 aligned beneficiaries to be included in the quality benchmark distribution, equivalent to the minimum for participation for New Entrant DCEs in PY2021 and PY2022.

for the HPP will be shared prior to PY2023. CMS will retain the entire forfeited portion of the Quality Withhold from DCEs that fail to meet the CI/SEP criteria.

2.5 Application of Quality Assessment to Final Financial Reconciliation

The process of determining the impact of quality measurement and performance on the PY Benchmark is summarized in this section using PY2022 as an example. The steps are as follows:

- CMS develops Quality Benchmarks for each P4P measure.
- Component Quality Scores are calculated: P4R Quality Measures are assessed, and P4P Quality Measures are compared against their Quality Benchmarks to determine performance levels.
- Component Quality Scores are weighted to calculate the Total Quality Score.
- *(PY2023–PY2026 only)* CI/SEP criteria are assessed to determine the amount of the Quality Withhold to which the Total Quality Score will be applied.
- *(PY2023–PY2026 only)* HPP funds are distributed.

2.5.1 Step 1. CMS Develops Quality Benchmarks for Each P4P Measure

In **PY2022**, ACR and UAMCC will have P4P components. These measures assess the occurrence of undesirable outcomes—thus, lower measure scores represent better performance. Performance levels for each DCE are determined by comparing their Quality Measure scores with the relevant Quality Benchmark. The DCE earns a performance level for each measure based on where the measure score falls in comparison to the benchmark threshold values.

Table 2-6 presents hypothetical Quality Benchmark distributions for Standard/New Entrant DCEs (using historical Medicare claims data) for both P4P measures. For example, a DCE with a measure score or risk-standardized readmission rate (RSRR) of 15.10% for ACR would be in the 50th percentile group for that measure (the score exceeds the threshold for the 60th percentile group but is less than the maximum threshold for the 50th percentile group). A DCE with a measure score or RSRR of 15.60% for ACR would be in the 20th percentile group for that measure (the score exceeds the threshold for the 25th percentile group but is less than the maximum threshold for the 20th percentile group). A DCE with a measure score of 74.89 admissions per 100 person-years for UAMCC would be in the 10th percentile group (the score exceeds the threshold for the 15th percentile group but is less than the maximum threshold for the 10th percentile group).

Table 2-6. Hypothetical Benchmark Distributions for ACR and UAMCC for Comparison with Standard and New Entrant DCE Measure Scores

Percentile	5	10	15	20	25	30	40	50	60	70	80	90
ACR	16.34	15.99	15.79	15.68	15.57	15.47	15.31	15.18	15.08	14.95	14.82	14.6
UAMCC	82.5	75.23	71.08	68.43	66.67	64.68	61.2	58.48	55.98	53.37	50.16	46.12

Please note that Table 2-6 presents an example only. These are not the final Quality Benchmarks and are not intended to provide an indication of the final Quality Benchmarks. Historically, Quality Benchmarks for other models have been released prior to the start of a given PY. However, observed and anticipated changes in utilization and outcomes resulting from coronavirus disease 2019 have made it inappropriate to use data from 2020 for Quality Benchmarking. Given the likelihood of ongoing impacts on current and future PYs, CMMI is taking a different approach for GPDC quality benchmarking.

For **PY2021**, GPDC Quality Benchmarks will not be released until June 2022 and will be based on a hybrid approach, combining historical and concurrent data from two discontinuous 12-month periods, the calendar years 2019 and 2021. A DCE's Final Earn-Back Rate for PY2021 will be determined during final reconciliation, which will occur in 2023.[7]

For PY2022, GPDC Quality Benchmarks will shift to being based only on data from the 12-month period concurrent with the performance year. Starting with the first quarterly quality report for PY2022, CMMI will provide provisional quality benchmarks to DCEs in their quarterly reports, which will be calculated based on data from the same reporting period (i.e., April 1, 2021-March 31, 2022 for PY2022 Q1). The provisional benchmarks will be updated in each subsequent quarterly report with data from the same period being used to calculate DCE's performance. Because the DCE performance and benchmarks will be based on the same time-period and have the same exact risk adjustment coefficients, DCEs will have a more accurate picture from quarter to quarter of their performance relative to the benchmark. A DCE's Final Earn-Back Rate for PY2022 will be based on quality benchmarks calculated using data from calendar year 2022 and will be determined during final reconciliation, which will occur in 2023. As with the hybrid approach for PY2021, the use of concurrent benchmarks for PY2022 will avoid potential coronavirus disease 2019 impacts.

2.5.2 Step 2. Component Quality Scores Are Calculated: P4R Quality Measures Are Assessed, and P4P Quality Measures Are Compared against Their Quality Benchmarks to Determine Performance Levels

P4R Component: For PY2022,[8] 4% of the 5% Quality Withhold is associated with P4R. The claims-based measures of ACR, UAMCC, and DAH (for High Needs Population DCEs only) comprise 2% of the Quality Withhold, and the CAHPS Measure comprises 2%. There are therefore two Component Quality Scores associated with P4R, one for the claims-based measures, and one for CAHPS.

- All DCEs will meet the requirement for the claims-based measures and automatically earn a Component Quality Score of 100% for the portion of the withhold tied to the P4R claims-based measures in Table 2-3.
- All DCEs that authorize a survey vendor to conduct the CAHPS Survey will receive a P4R Component Quality Score for CAHPS of 100%. DCEs that do not authorize a survey vendor to conduct the CAHPS Survey will receive a P4R Component Quality Score for CAHPS of 0%. DCEs that are exempt from CAHPS will have a single P4R Component Quality Score of 100%.

P4P Component: The PY2022 P4P component will be the same as PY2021, which combines the ACR and UAMCC measures. The highest performance level (i.e., percentile) achieved for either Quality Measure determines the P4P Component Quality Score. Furthermore, the P4P component is considered pass/fail—all DCEs with at least one measure at or exceeding the 30th percentile will pass and receive a 100% Component Quality Score.

As in PY2021, in PY2022, a **sliding scale approach** will be applied to DCEs that do not meet the 30th percentile threshold on at least one of the two measures. The sliding scale allows DCEs to earn back at

[7] For more detailed information regarding the reconciliation process, see the Financial Reconciliation Overview paper at https://innovation.cms.gov/media/document/gpdc-py2022-fin-reconcil-ovw.

[8] For PY2021, 4% of the 5% Quality Withhold will be determined solely by P4R of three Quality Measures, namely, ACR, UAMCC, and DAH (High Needs Population DCEs only). Because the Quality Measures used in PY2021 are claims-based measures, all DCEs will meet this requirement and will receive a P4R Component Quality Score of 100%.

least a portion of the 1% withhold, based on their highest measure performance. The details of the sliding scales are presented in **Table 2-7**. In the example in Step 1 above, where a DCE achieved the 20th percentile for ACR and the 10th percentile for UAMCC, the DCE would receive a P4P Component Quality Score of 80%.

Table 2-7. Sliding Scale Earn-Back for P4P Component Quality Score, PY2021 and PY2022

Percentile Met	P4P Component Quality Score
≥ 30th	100%
25th to < 30th	95%
20th to < 25th	80%
15th to < 20th	60%
10th to < 15th	40%
5th to < 10th	20%
< 5th	0%

2.5.3 Step 3. Component Quality Scores Are Weighted to Calculate the Total Quality Score

After assessing P4R measures and determining performance levels for each P4P measure, CMS calculates Component Quality Scores for each DCE. The component weight is the proportion of the overall Quality Withhold tied to that component. In PY2022, there are three Component Quality Scores. The first component is P4P, based on ACR and UAMCC. The P4P component has a weight of 1/5, contributing 1% out of the 5% Quality Withhold. The second component is P4R for claims-based measures and has a weight of 2/5, contributing 2% out of the 5% Quality Withhold. The third component is P4R for CAHPS and has a weight of 2/5, contributing 2% out of the 5% Quality Withhold. Note that additional P4P components (such as DAH) will be added in subsequent years.

The Total Quality Score is the percentage of the Quality Withhold eligible for earn-back that a DCE will actually earn back based on its quality performance and reporting. The Total Quality Score is calculated as the sum of the products of the Component Quality Scores and component weights, as shown in the equation below.

$$\text{Total Quality Score} = \sum \text{(Component Quality Scores * Component Weights)}$$

In our example above, the DCE receives a P4P Component Quality Score of 80% based on the sliding scale. The same DCE receives a P4R Component Quality Score for claims-based measures of 100%. This DCE also authorized a CAHPS Survey vendor, earning 100% of the P4R Component Quality Score for CAHPS. The P4P component has a weight of 1/5 and the P4R components each have a weight of 2/5. The Total Quality Score for this DCE is (80% * 1/5) + (100% * 2/5) + (100% * 2/5) = 96%.

2.5.4 Step 4. Total Quality Score Is Multiplied by the *Eligible* Earn-Back Rate to Determine a DCE's *Final* Earn-Back Rate

In **PY2022**, the Eligible Earn-Back Rate will be 5% for all DCEs. A DCE with a Total Quality Score of 96% will have a Final Earn-Back Rate of 4.8%. A DCE's Final Earn-Back Rate will be determined during final

reconciliation, which will occur in 2023 for PY2022.[9] The steps for the example described in this section, starting with **Section 2.5**, are summarized in Table 3-1.

For **PY2023–PY2026**, the CI/SEP criteria will determine how much of the Quality Withhold the DCE is eligible to earn back. For DCEs that meet the CI/SEP criteria, the Quality Score will be multiplied by the full 5% Quality Withhold. DCEs that do not meet the CI/SEP criteria will only be eligible to earn back half of the Quality Withhold. Their Quality Score will be multiplied by 2.5% to determine their final earn-back.

2.5.5 Step 5. *(PY2023–PY2026 only)* HPP Funds Are Distributed

In PY2023 and beyond, DCEs that meet the CI/SEP criteria will be eligible for a bonus payment from the HPP funds based on meeting additional HPP criteria. The bonus payment will be a dollar addition to the Final Earn-Back Rate. As a result, the highest performing DCEs may earn back more than the 5% Quality Withhold. Criteria to determine the HPP bonus payments will be shared prior to PY2023.

2.6 Quality Measure Resources

Additional measure documentation will be made available each PY to provide further guidance and technical information. **Table 2-8** displays the forthcoming resources for DCEs for PY2022.

Table 2-8. Quality Measure Resources

Document	Measure Type	Description	Location
Measure Information Forms (MIFs)	Claims-based measures	Detailed descriptive information on each measure.	• PY2021 MIFs available in 4i Knowledge Base • PY2022 MIFs Forthcoming in December 2021
Quality Benchmark Report	All P4P measures	Basis for determining DCE performance on P4P measures.	• PY2021 Benchmark Report will be released June 2022 • PY2022 provisional benchmarks will be included in each quarterly report starting with the Quarter 1 Quarterly Quality Report, which will be released in September 2022.[10] Final benchmarks will be made available in Summer 2023.

(continued)

[9] Preliminary reconciliation for PY2021 will occur in 2022 and will use a placeholder Total Quality Score of 100% for all DCEs. A DCE's Final Earn-Back Rate for PY2021 will be determined during final reconciliation, which will occur in 2023.

[10] See Section 2.5.1, as well as Appendix A, for additional discussion of PY2022 quality benchmarking.

Table 2-8. Quality Measure Resources (continued)

Document	Measure Type	Description	Location
Website: gpdccahps.org Email: gpdccahps@rti.org	CAHPS	• Official website and web portal for news and information about the GPDC CAHPS Survey, for both CAHPS Survey vendors and DCEs. Will contain information on DCE requirements, deadlines, information about survey schedules, and answering patients' survey-related questions with confidence. • Technical assistance to complement the GPDC Model Helpdesk	Forthcoming in January 2022

3. Worked Examples of Quality Score Calculations

In the following subsections we provide worked examples of selected scenarios for PY2021, PY2022, and PY2023.

3.1 Worked Examples of the Final Earn-Back Rate Calculation for PY2021

The following tables present two examples of the calculation of the Final Earn-Back Rate for a DCE in different scenarios in PY2021. The Component Quality Scores used in these examples are not based on historical data. The Component Quality Scores used are entirely fabricated elements that are needed to work through the examples. The scenarios include the following:

1. **Table 3-1**: A DCE that does NOT meet the 30th percentile benchmark threshold in PY2021.
2. **Table 3-2**: A DCE that does meet the 30th percentile benchmark threshold in PY2021.

Table 3-1. Final Earn-Back Rate Calculation, PY2021 Example

(DCE that does NOT meet 30th percentile benchmark threshold)

Component	Component Quality Score	Component Weight
1. P4P: ACR and UAMCC	80%	1/5
2. P4R: ACR and UAMCC (and DAH for High Needs Population DCEs only)	100%	4/5
Total Quality Score	96.0%	
Eligible Earn-Back Rate	5.0%	
Final Earn-Back Rate	4.8%	

Table 3-2. Final Earn-Back Rate Calculation, PY2021 Example

(DCE that meets 30th percentile benchmark threshold)

Component	Component Quality Score	Component Weight
1. P4P: ACR and UAMCC	100%	1/5
2. P4R: ACR and UAMCC (and DAH for High Needs Population DCEs only)	100%	4/5
Total Quality Score	100%	
Eligible Earn-Back Rate	5%	
Final Earn-Back Rate	5%	

3.2 Worked Examples of the Final Earn-Back Rate Calculation for PY2022

In PY2022, Timely Follow-Up will be included in P4R for Standard and New Entrant DCEs. For High Needs Population DCEs, in PY2022 DAH will continue to be P4R. Both Timely Follow-Up and DAH are claims-based, so P4R requirements will also be automatically fulfilled. CAHPS will also be added as a P4R measure—DCEs will be responsible for selecting and paying for CMS-approved vendors to administer the CAHPS Survey.

The P4P approach in PY2022 will be the same as PY2021 for all three DCE types, including the application of a sliding scale for DCEs not achieving the performance benchmark that determines earn-back of the 1% of the Quality Withhold tied to performance.

Table 3-3 shows calculations for a DCE that does NOT meet the 30th percentile benchmark threshold in PY2022 and **Table 3-4** shows a DCE that does meet the threshold. Note the addition of Timely Follow-Up in the P4R measures for New Entrant and Standard DCEs and CAHPS for all DCE types.

Table 3-3. Final Earn-Back Rate Calculation, PY2022 Example

(DCE that does NOT meet 30th percentile benchmark threshold)

Component	Component Quality Score	Component Weight
1. P4P: ACR and UAMCC	80%	1/5
2. P4R: ACR, UAMCC, Timely Follow-Up (for New Entrant and Standard DCEs), and DAH (for High Needs Population DCEs)	100%	2/5
3. P4R: CAHPS	100%	2/5
Total Quality Score	96.0%	
Eligible Earn-Back Rate	5%	
Final Earn-Back Rate	4.8%	

Table 3-4. Final Earn-Back Rate Calculation, PY2022 Example

(DCE that meets 30th percentile benchmark threshold)

Component	Component Quality Score	Component Weight
1. P4P: ACR and UAMCC	100%	1/5
2. P4R: ACR, UAMCC, Timely Follow-Up (for New Entrant and Standard DCEs), and DAH (for High Needs Population DCEs)	100%	2/5
3. P4R: CAHPS	100%	2/5
Total Quality Score	100%	
Eligible Earn-Back Rate	5%	
Final Earn-Back Rate	5%	

3.3 Worked Examples of the Final Earn-Back Rate Calculation for PY2023–PY2026

The performance assessment methodology for PY2023–PY2026 has not yet been finalized, but some elements have been established. Most notably, the CI/SEP criteria and HPP will be implemented for PY2023–PY2026. In these PYs, the Eligible Earn-Back Rate will be 2.5% for DCEs that do not to meet the CI/SEP Gateway criteria and 5% for those DCEs that do pass the gateway. DCEs that meet the CI/SEP criteria will also be eligible for bonus payments from the HPP. CMS will release additional details about this performance-based incentive bonus at a later date.

Tables 3-5 and **3-6** show calculations accounting for the CI/SEP Gateway criteria in PY2023 under two different scenarios. The scenarios assume that PY2023 has multiple P4P measure components and no P4R components.

Table 3-5. Final Earn-Back Rate Calculation, PY2023 Example

(High Needs Population DCE that does NOT meet CI/SEP Gateway criteria)

Component	Component Quality Score	Component Weight
1. P4P: ACR	96%	1/4
2. P4P: UAMCC	74%	1/4
3. P4P: DAH (High Needs Population DCEs Only)	60%	1/4
4. P4P: Timely Follow-Up for Exacerbation of Chronic Conditions (Standard/New Entrant Only)	N/A	N/A
5. P4P: CAHPS	94%	1/4
Total Quality Score	81.000%	
Eligible Earn-Back Rate (Either 2.5% or 5%, Based on CI/SEP Gateway)	2.500%	
Final Earn-Back Rate	2.025%	
HPP Incentive Bonus	N/A	

Table 3-6. Final Earn-Back Rate Calculation, PY2023 Example

(Standard DCE meets CI/SEP Gateway criteria)

Component	Component Quality Score	Component Weight
1. P4P: ACR	82%	1/4
2. P4P: UAMCC	98%	1/4
3. P4P: DAH (High Needs Population DCEs Only)	N/A	N/A
4. P4P: Timely Follow-Up for Exacerbation of Chronic Conditions (Standard/New Entrant Only)	94%	1/4
5. P4P: CAHPS	92%	1/4
Total Quality Score	91.500%	
Eligible Earn-Back Rate (Either 2.5% or 5%, Based on CI/SEP Gateway)	5.000%	
Final Earn-Back Rate	4.575%	
HPP Incentive Bonus	+ $ TBD	

4. Quality Measure Details for PY2022

For PY2022, CMS will measure quality of care for DCEs using five measures (see Table 2-1). The ACR and UAMCC measures will be used for all DCE types. DAH will be used only for High Needs Population DCEs. Timely Follow-Up will be used only for the Standard and New Entrant DCEs. PY2021 versions of Measure Information Forms contain more detailed information for three of the four claims-based measures, namely, ACR, UAMCC, and DAH, are currently available in the 4i Knowledge Library. PY2022 versions of these and the PY2022 Measure Information Form for Timely Follow-Up will be made available in December 2021.

4.1 Risk-Standardized All-Condition Readmission Measure

4.1.1 ACR Summary

Description: Risk-adjusted percentage of hospitalizations by DCE-assigned beneficiaries that result in an *unplanned* readmission to a hospital within 30 days following discharge from the index hospital admission.[11]

Measure Overview: ACR is an outcome measure calculated using 12 consecutive months[12] of Medicare FFS claims data. The measure is an RSRR that adjusts for stay-level factors and clinical and demographic characteristics. Lower RSRRs indicate better performance. This Quality Measure is adapted from the hospital risk-standardized ACR Quality Measure developed for CMS by Yale.[13]

Rationale: Hospital readmissions are costly and often preventable.[14] They are also disruptive to patients and caregivers and put patients at additional risk of hospital-acquired infections and complications.[15] Some readmissions are unavoidable, but studies have shown that readmissions also result from poor quality of care, inadequate coordination of care, or lack of effective discharge planning and transitional care. High readmission rates and institutional variations in readmission rates indicate an opportunity for improvement. Given that interventions have been able to reduce 30-day readmission rates for a variety of medical conditions, it is important to include an all-condition 30-day readmission rate as a Quality Measure.

4.1.2 ACR Denominator and Numerator Information

Denominator Statement: All relevant hospitalizations for DCE-aligned beneficiaries aged 65 or older at nonfederal, short-stay acute care, or critical access hospitals.

---

[11] Index hospital admission is any eligible admission to an acute care hospital assessed in the measure for the outcome (readmitted or not within 30 days).

[12] For PY2021, the full calendar year 2021, including January through March, will be used to calculate ACR and UAMCC.

[13] Horwitz, L., Partovian, C., Lin, Z., et al. (2011). *Hospital-wide all-cause risk-standardized readmission measure: Measure methodology report*. Prepared for the U.S. Centers for Medicare and Medicaid Services. New Haven, CT: Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation.

[14] Jencks, S., Williams, M., & Coleman, E. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine*, *360*(14), 1418-1428.

[15] Horwitz, L., Partovian, C., Lin, Z., et al. (2011). *Hospital-wide all-cause risk-standardized readmission measure: Measure methodology report*. Prepared for the U.S. Centers for Medicare and Medicaid Services. New Haven, CT: Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation.

Admissions are eligible for inclusion in the denominator if the following criteria are met:

1. Patient is enrolled in Medicare FFS.
2. Patient is actively aligned to a DCE.
3. Patient is age 65 or older.
4. Patient was discharged from a nonfederal acute care hospital.
5. Patient did not die in the hospital.
6. Patient is not transferred to another acute care facility upon discharge.
7. Patient is enrolled in Medicare Part A for the 12 months before and including the date of the index admission.

A hospital readmission within 30 days will also be eligible to be counted as an index admission included in the measure denominator calculation if the patient meets all other eligibility criteria. This allows the measure to capture repeated readmissions for the same patient, whether at the same hospital or another.

Denominator Exclusions:

1. Admissions for patients without 30 days of post-discharge data.
2. Admissions for patients lacking a complete enrollment history for the 12 months before admission.
3. Admissions for patients to a Prospective Payment System–exempt cancer hospital.
4. Admissions for patients with medical treatment of cancer.
5. Admissions for primary psychiatric disease.
6. Admissions for rehabilitation care.
7. Admissions for patients discharged against medical advice.

Numerator Statement: Risk-adjusted readmissions at a nonfederal, short-stay, acute care, or critical access hospital within 30 days of discharge from an index admission included in the denominator.

Numerator Exclusions: Planned readmissions are excluded—scheduled admissions are not considered signals of low care quality. Planned readmissions are identified using procedure and diagnosis codes.

4.2 All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC)

4.2.1 UAMCC Summary

Description: Rate of risk-standardized, acute, unplanned hospital admissions per 100 person-years among beneficiaries who are 66 years and older at the start of the measurement period, have multiple chronic conditions, and are aligned to the DCE.

Measure Overview: Like ACR, UAMCC is an outcome measure calculated using 12 consecutive months of Medicare FFS claims data. The measure is a risk-standardized acute admission rate (RSAAR) that adjusts for age, chronic disease categories, and other clinical risk factors present at the start of the 12-month measurement period. Lower RSAARs indicate better performance. This Quality Measure is adapted from the hospital RSAAR Quality Measure developed for CMS by Yale.

Rationale: Patients with multiple chronic conditions account for a significant proportion of Medicare beneficiaries; they experience high morbidity and costs associated with their disease or diseases, and they are more likely to have unplanned hospital admissions. Unplanned admissions are costly and potentially dangerous. However, research shows that effective health care can lower the risk of admission for patients with chronic disease.[16,17,18,19,20,21] DCE program goals are fully aligned with the objective of lower patient risk of admission—DCEs are expected to improve quality and outcomes by providing patient-centered care, engaging in effective chronic disease management, promoting care coordination, adopting evidence-based practices, and supporting clinical process improvement.

4.2.2 UAMCC Denominator and Numerator Information

Denominator Statement: All DCE-aligned beneficiaries aged 66 years and older at the start of the measurement period with ICD-10 codes that fall into two or more of nine chronic disease groups: (1) acute myocardial infarction, (2) Alzheimer's disease and related disorders of senile dementia, (3) atrial fibrillation, (4) chronic kidney disease, (5) chronic obstructive pulmonary disease and asthma, (6) depression, (7) heart failure, (8) stroke and transient ischemic attack, and (9) diabetes.

Denominator Exclusions:

1. Beneficiaries who do not have 12 months of continuous enrollment in Medicare Part A and Part B during the year prior to the measurement year (to ensure adequate claims data to identify beneficiaries).
2. Beneficiaries who do not have 12 months of continuous enrollment in Medicare Part A during the measurement year. Beneficiaries who die during the measurement period are excluded if they do not have continuous enrollment in Medicare Part A until death (i.e., the 12-month requirement is relaxed for these beneficiaries). Beneficiaries with continuous enrollment until death are excluded after the time of death.

Numerator Statement: Number of acute *unplanned* admissions per 100 person-years risk for admission. Persons are considered at risk for admission if they are included in the denominator (as described above), alive, enrolled in FFS Medicare, and not currently admitted to an acute care hospital. The outcome includes inpatient admissions to an acute care hospital for any cause during the measurement year unless an admission is identified as "planned."

Numerator Exclusions: N/A

---

[16] Brown, R.S., Peikes, D., Peterson, G., et al. (2012). Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high-risk patients. *Health Affairs, 31*(6), 1156–1166.
[17] Chen, J.Y., Tian, H., Taira Juarez, D., et al. (2010). The effect of a PPO pay-for-performance program on patients with diabetes. *The American Journal of Managed Care, 16*(1), e11–19.
[18] United States Congress: Patient Protection and Affordable Care Act, 42 U.S.C. United States Congress. Washington, DC, United States Government Printing Office. Public Law 111–148: 119–906, 2010.
[19] Leong, A., Dasgupta, K., Bernatsky, S., et al. (2013). Systematic review and meta-analysis of validation studies on a diabetes case definition from health administrative records. *PloS One, 8*(10), e75256.
[20] McCarthy, D., Cohen, A., & Johnson, M. (2013). *Gaining ground: Care management programs to reduce hospital admissions and readmissions among chronically ill and vulnerable patients*. New York, NY. The Commonwealth Fund.
[21] Sadur, C.N., Moline, N., Costa, M., et al. (1999). Diabetes management in a health maintenance organization. Efficacy of care management using cluster visits. *Diabetes Care, 22*(12), 2011–2017.

4.3 Days at Home for Patients with Complex, Chronic Conditions (DAH)

4.3.1 DAH Summary

Description: Risk factor-adjusted, mortality-adjusted, nursing home transition-adjusted days at home, averaged over all patients within a DCE.

Measure Overview: This is a DCE-level measure of days at home or in community settings (i.e., not in acute care, such as inpatient hospital or emergent care settings, or post-acute settings, such as Skilled Nursing Facilities [SNFs] among adult Medicare FFS beneficiaries with complex, chronic conditions who are aligned to participating DCEs). The measure includes risk adjustment for differences in patient mix across DCEs, with an additional adjustment based on patients' risk of death. An additional adjustment that accounts for patients' risk of transitioning to a long-term nursing home is also applied incentivize community-based care.in alignment with the Center for Medicare & Medicaid Services (CMS) policy goals. A higher risk-adjusted score indicates better performance.

Rationale: The primary goal of the DAH measure is to promote high-quality coordinated care to keep adults with complex, chronic conditions in home or community settings and out of select acute, post-acute, or long-term care settings.

Generally, patients prefer to remain at home and avoid unnecessary hospitalizations and time in institutional settings. Days at home are associated with other important outcomes, including social activity and avoiding depression.[22] Timely and appropriate primary care and end-of-life care services can increase the number of days patients spend at home.[23] Several studies demonstrate that time spent at home differs substantially among older patients, which suggests that there is potential for improving the quality of care and resulting days at home for the elderly population.[24,25]

4.3.2 DAH Denominator and Numerator Information

Denominator Statement: Eligible beneficiaries aligned to participating DCEs.

Eligible beneficiaries are:

- Adult (age 18 or older);
- Alive as of the first day of the PY;
- Continuously enrolled in Medicare FFS parts A and B during the full PY (up to date of death among patients who died) and one full year prior; and
- Have an average Hierarchical Condition Category (HCC) composite risk score ≥ 2.0 in the year prior to the PY.

The measure includes eligible beneficiaries who are aligned to a participating DCE as determined by the model.

---

[22] Lee, H., Shi, S. M., & Kim, D. H. (2019). Home Time as a Patient-Centered Outcome in Administrative Claims Data. *Journal of the American Geriatrics Society,* 67(2), 347–351. doi: 10.1111/jgs.15705

[23] Totten, A. M., White-Chu, E. F., Wasson, N., et al. (2016). *Home-Based Primary Care Interventions*. Rockville, MD.

[24] Burke, L. G., Orav, E. J., Zheng, J., & Jha, A. K. (2020). Healthy Days at home: A novel population-based outcome measure. *Healthcare (Amsterdam, Netherlands), 8*(1), 100378. doi: 10.1016/j.hjdsi.2019.100378

[25] Wallace, L., et al. (2019). *2019 Condition-Specific Excess Days in Acute Care Measures Updates and Specifications Report. Yale New Haven Health Services Corporation – Center for Outcomes Research & Evaluation*. YNHHSC/CORE.

Denominator Exclusions: There are currently no denominator exclusions or exceptions for the measure. All patients meeting the denominator inclusion criteria are included.

Numerator Statement: The outcome measured for each eligible beneficiary is days spent "at home," adjusted for clinical and social risk factors, risk of death, and risk of transitioning to a long-term nursing home. Days at home are defined as those days when a beneficiary is alive and not in care.

A "day in care" is defined as any eligible patient day on which a patient receives care in one (or more) of the following specified care settings: inpatient acute and post-acute facilities (short-term acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term care hospitals, and SNFs); emergency departments; and observation stays. There are two exceptions:

1. A patient is always considered "at home" if they are enrolled in hospice, even if they receive care in settings normally counted as "days in care" (i.e., a patient will have no measured days in care as long as they are in hospice).
    a. Rationale: to promote effective and appropriate care for terminally ill patients
2. Hospital admissions for childbirth, miscarriage, or termination are not counted as "days in care."
    a. Rationale: obstetric admissions may not indicate care quality; counting these admissions may create perverse incentives in the care of pregnant patients A "day at home" is defined as any eligible day that is not considered a "day in care" based on the above definition. "Eligible days" are all days in the measurement year that the beneficiary is alive.

Numerator Exclusions: Care in settings not listed above (including outpatient visits and procedures, hospice, residential psychiatric and substance abuse facilities, assisted living facilities and group homes, and home health and telehealth services) are not considered "days in care" in this measure; rather, they are treated as "days at home."

Finally, days spent in a long-term or residential nursing home (except for SNF care) are not counted as "days in care" by this definition. However, this measure includes an adjustment that accounts for patients' risk of transitioning to a long-term nursing home, to encourage home- and community-based care in alignment with CMS's policy goals.

4.4 Timely Follow-Up after Acute Exacerbations of Chronic Conditions (Timely Follow-Up)

4.4.1 Timely Follow-Up Summary

Description: DCE-level rate of follow-up for patients with chronic conditions who have experienced an acute exacerbation of one of six conditions of interest, which can be attributed to providers participating in the model.

Measure Overview: This is a measure of follow-up for patients with chronic conditions who have experienced an acute exacerbation hypertension, asthma, heart failure (HF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), or diabetes, which can be attributed to providers participating in the Innovation Center GPCD model. Results of the measure are aggregated on an DCE level. The Yale New Haven Health Services Corporation – Center for Outcomes Research & Evaluation

respecified the Timely Follow-up After Acute Exacerbations of Chronic Conditions Measure, which was originally specified by IMPAQ, NQF #3455.

Rationale: Patients hospitalized or seen acutely in the ED and hospital outpatient departments for exacerbations of chronic conditions are at high risk of readmission and poorly coordinated care, which may increase healthcare spending, worsen healthcare outcomes, and result in poor quality of life. Evidence has shown that delivering clinically appropriate follow-up care and improving care coordination can improve healthcare outcomes, reduce readmissions, and reduce healthcare costs. The intent of the Timely Follow-Up measure is to encourage appropriate follow-up care and improve care coordination at discharge. A systematic review has demonstrated that, when coupled with other types of discharge support, timely follow-up does positively contribute to health outcomes and is a key component of high-quality healthcare (2). We anticipate the Timely Follow-Up measure will encourage model participants to improve care coordination and produce long-term savings for a given healthcare system.

4.4.2 Timely Follow-Up Denominator and Numerator Information

Denominator Statement: The sum of the DCE-level acute exacerbations that require either an ED visit, observation stay, or inpatient stay (i.e., acute events) for hypertension, asthma, HF, CAD, COPD, or diabetes.

An acute event is assigned to [condition] if the primary diagnosis is a sufficient code for [condition] or if the primary diagnosis is a related code for [condition] AND at least one additional diagnosis is a sufficient code for [condition].

In cases where the event has two or more conditions with a related code as the primary diagnosis and a sufficient code in additional diagnosis positions, the event is assigned to the condition with a sufficient code appearing in the "highest" (closest to primary) diagnosis position.

If there is more than one visit that makes up an acute event, and they are assigned different conditions, the event is assigned the condition that occurs last in the sequence. Following this methodology, only one condition is recorded in the denominator per acute event.

Denominator Exclusions:
The measure excludes events with:

- Subsequent acute events that occur two days after the prior discharge but still during the follow-up interval of the prior event for the same reason. To prevent double counting, only the first acute event will be included in the denominator.
- Acute events after which the patient does not have continuous enrollment for 30 days.
- Acute events where the discharge status of the last claim is not "to community" ("Left against medical advice" is not a discharge to community.).
- Acute events for which the calendar year ends before the follow-up window ends (e.g., acute asthma events ending fewer than 14 days before December 31).
- Acute events where the patient enters a skilled nursing facility (SNF), non-acute care, or hospice care within the follow-up interval.

Numerator Statement: The sum of the DCE-level denominator events (Emergency Room [ED], observation hospital stay or inpatient hospital stay) for acute exacerbations of hypertension, asthma,

HF, CAD, COPD, or diabetes where follow-up was received within the time frame recommended by clinical practice guidelines, as detailed below:

- Hypertension: Follow up within 14 days for high-acuity patients, 30 days for medium-acuity patients and 6 months for low-acuity patients
- Asthma: Follow up within 14 days of the date of discharge
- HF: Follow up within 14 days of the date of discharge
- CAD: Follow up within 7 days for high-acuity patients or within 6 weeks for low-acuity patients
- COPD: Follow up within 30 days of the date of discharge
- Diabetes: Follow up within 14 days for high-acuity patients

This measure is defined at the DCE-level, meaning that results are aggregated for each participating entity in the GPDC Model. The follow-up visit must occur within the condition-specific timeframe to be considered timely and for the conditions of the numerator/measure to be met. A timely follow-up visit is defined as a claim for the same patient after the acute event discharge date that is a non-emergency outpatient visit and has a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code indicating a visit that constitutes appropriate follow-up.

Numerator Exclusions: There are currently no numerator exclusions or exceptions for the measure. All patients meeting the numerator inclusion criteria are included.

4.5 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

4.5.1 CAHPS Summary

Description: A DCE-level summary of patient experience of care from beneficiaries surveyed with the CAHPS Measure. The CAHPS Measure applies to Standard, New Entrant, and High Needs Population DCEs. Each DCE is required to collect and report this measure to CMS, which is done by contracting with and paying for a CAHPS Survey vendor. The vendor conducts the survey using mail and telephone follow-up, and reports results to CMS.

Measure Overview: The CAHPS questionnaire used in GPDC is the CAHPS for ACO Survey with modifications relevant to patient/caregiver experience with care delivered by a DCE. It is designed to ask patients about their experience with primary care services received from their provider during the past 6 months. Domains in the questionnaire include the extent to which patients could access care and information in a timely manner when needed, how well the patient's provider communicated with them, and whether the provider spoke with the patient about things they could do to promote their health.

Rationale: Person and family engagement in care is important to CMS and part of the agency's quality strategy. Research shows that patients and families who have positive experiences with providers are more likely to be engaged with their care and have better adherence to provider healthcare

guidelines.[26,27,28] Adherence to recommended guidelines such as weight and blood sugar control results in improved population health for all DCE-aligned beneficiaries. Additional research finds that positive patient of experience indicates high-quality care has been provided[29]and is associated with improved clinical outcomes[30,31] and reduced costs[32] in some setting. Thus, patient experience is a lever capable not only of providing our beneficiaries with a better experience—which itself is valuable—but also capable of spurring long-term benefits in clinical outcomes, population health, and costs within the GPDC Model.

CMS measures patient experience through the CAHPS measurement science. This methodology asks patients to what extent certain provider behaviors took place. All the behaviors posed in the surveys are desirable and are hallmarks of quality care. CAHPS surveys give a standardized and objective measure that allows for equitable comparisons between entities.

4.5.2 CAHPS Denominator and Numerator Information

Denominator Statement: The population of interest for the denominator is FFS beneficiaries of each DCE with recent visits for primary care services. We reach this population in several steps:

1. A sample of beneficiaries from claims for primary care services among DCE participating providers is created.
2. A survey is sent to all sampled beneficiaries. The mail with non-response telephone follow-up survey methodology ensures that enough responses will be received for the results to reach a high level of statistical precision and distinguish between DCEs with sufficient reliability.
3. The denominator becomes all beneficiaries who answered the survey questions.

Denominator Exclusions: A number of beneficiaries are excluded from the CAHPS Measure, including beneficiaries who received care in recent visits but are now deceased; beneficiaries who are less than 18 years old; institutionalized beneficiaries; beneficiaries receiving Hospice benefit; beneficiaries sampled for some other concurrent CAHPS Surveys; beneficiaries residing outside the United States, Puerto Rico, or the Virgin Islands, beneficiaries receiving less than two primary care service visits with a provider from the DCE during the lookup period; beneficiaries who have a language or disability barrier that prevents them from completing the survey and do not have a someone who can assist them or proxy for them.

---

[26] Zolnierek, K. B., & Dimatteo, M. R. (2009). Physician communication and patient adherence to treatment: a meta-analysis. *Med Care, 47*(8), 826-834. doi:10.1097/MLR.0b013e31819a5acc

[27] Ratanawongsa, N., Karter, A. J., Parker, M. M., Lyles, C. R., Heisler, M., Moffet, H. H., . . . Schillinger, D. (2013). Communication and medication refill adherence: The Diabetes Study of Northern California. *JAMA Intern Med, 173*(3), 210-218. doi:10.1001/jamainternmed.2013.1216

[28] Lee, Y. Y., & Lin, J. L. (2009). The effects of trust in physician on self-efficacy, adherence and diabetes outcomes. *Soc Sci Med, 68*(6), 1060-1068. doi:10.1016/j.socscimed.2008.12.033

[29] Cook, N., et al. (2015, December). Patient Experience in Health Center Medical Homes. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/26026275

[30] Meterko, M., Wright, S., Lin, H., Lowy, E., & Cleary, P. D. (2010). Mortality among patients with acute myocardial infarction: The influences of patient-centered care and evidence-based medicine. *Health Services Research, 45*(5pl), 1188-1204. doi: 10.1111/j.1475-6773.2010.01138.x

[31] Boulding, W., Glickman, S. W., Manary, M. P., Schulman, K. A., & Staelin, R. (2011). Relationship between patient satisfaction with inpatient care and hospital readmission within 30 days. *Am J Manag Care, 17*(1), 41-48.

[32] Anhang Price, R., Elliott, M. N., Zaslavsky, A. M., Hays, R. D., Lehrman, W. G., Rybowski, L., Cleary, P. D. (2014). Examining the role of patient experience surveys in measuring health care quality. *Med Care Res Rev, 71*(5), 522-554. doi:10.1177/1077558714541480

A DCE can be excluded from the CAHPS Measure for a particular PY if that DCE does not have a sufficient number of beneficiaries with recent primary care visits for a reliable CAHPS Survey to be conducted.

Numerator Statement: The CAHPS Measure uses the top box methodology, which will compute the percentage of most positive responses to all component questions in that survey domain, at the DCE level. The numerator is beneficiaries answering in the most positive way.

We illustrate this in **Table 4-1** with the survey domain "How Well Your Providers Communicate." This domain consists of five component questions each with the possible answers of "Never," "Sometimes," "Usually," and "Always." We recode the survey responses so the most positive response, "Always," is 1, and all other responses are 0. After recoding, we calculate the average proportion of responses that were a top box score across the questions that make up the domain to arrive at the final score for Communication for the DCE. ***Table 4-1*** shows a hypothetical example of a DCE with seven beneficiaries answering the questions in the "How Well Your Providers Communicate" domain.

Table 4-1. CAHPS Scoring Example for a Single DCE for the Survey Domain "How Well Your Providers Communicate"

Beneficiary	In the last 6 months, how often did this provider explain things in a way that was easy to understand? (Explain)	In the last 6 months, how often did this provider listen carefully to you? (Listen Carefully)	In the last 6 months, how often did this provider seem to know the important information about your medical history? (Medical History)	In the last 6 months, how often did this provider show respect for what you had to say? (Respect)	In the last 6 months, how often did this provider spend enough time with you? (Enough Time)
1	1	1	1	1	1
2	1	0	0	1	—
3	0	0	1	1	1
4	—	0	0	0	0
5	1	1	—	1	1
6	—	1	1	0	1
7	1	1	1	1	—

Explain is (1+1+0+1+1)/5 = 0.80
Listen Carefully is (1+0+0+0+1+1+1)/7 = 0.57
Medical History is (1+0+1+0+1+1)/6 = 0.67
Respect is (1+1+1+0+1+0+1)/7 = 0.71
Enough Time is (1+1+0+1+1)/5 = 0.80
We take the mean scores of all component question's top box score and conclude that the DCE's performance score for "How Well Your Providers Communicate" is 0.710 ((0.8 + 0.57 + 0.67 + 0.71 + 0.80)/5 = 0.71)

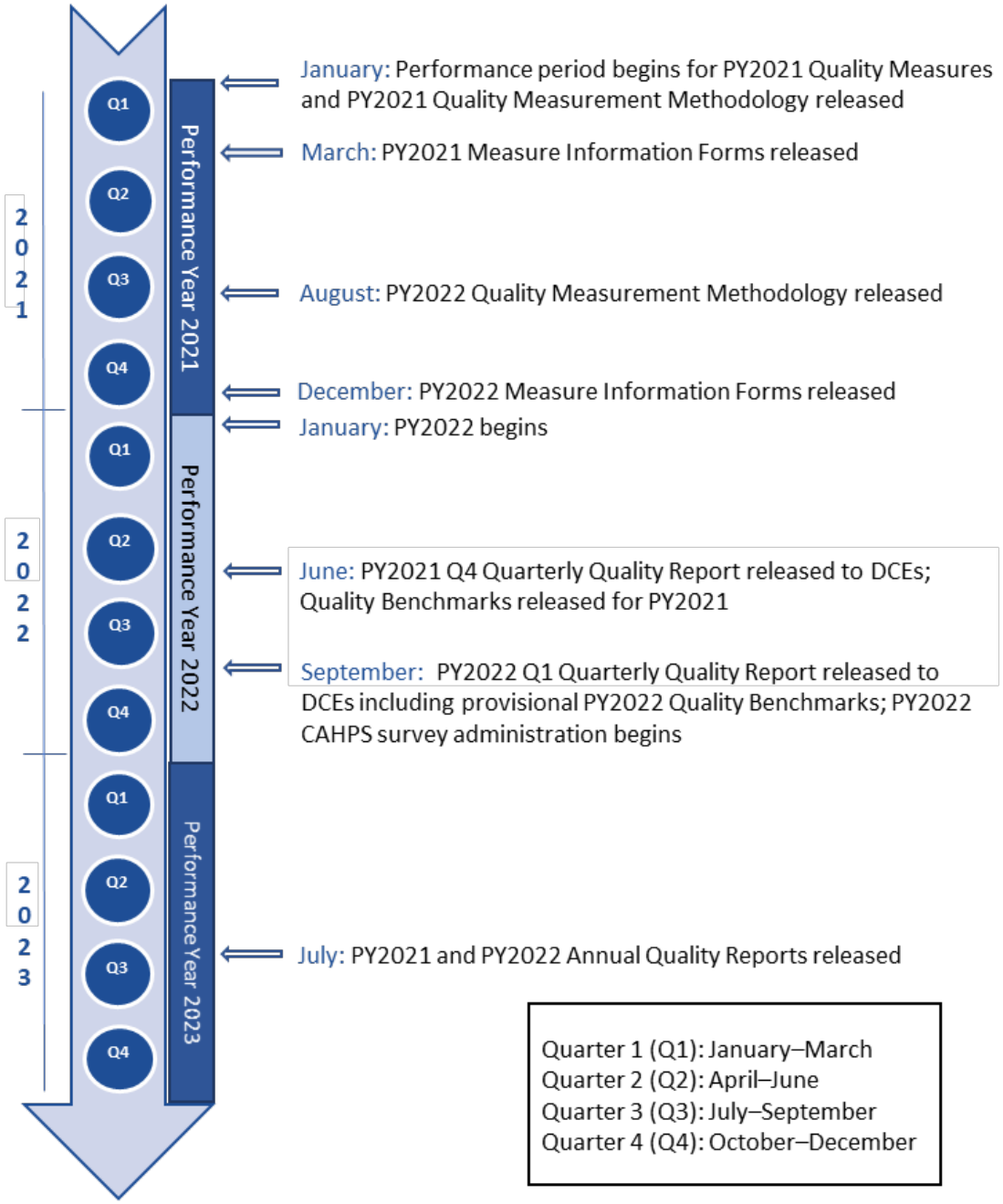
Numerator Exclusions: Beneficiaries who elect to not answer a question are excluded from calculation and do not impact the top box score. Similarly, beneficiaries who screen out of a question are excluded from the calculation and do not impact the top box score. An example screening question is whether the provider ordered a blood test, x-ray or other test in the last 6 months. If the beneficiary answered "no," to the screening question, the beneficiary would screen out of the measure question about whether someone followed up with them about the results of that test.

Appendices

Appendix A—Timeline for PY2021 and PY2022

The figure below shows key time points for the GPDC Quality Strategy for PY2021 and PY2022. For PY2021, CMS will establish benchmarks using all available and applicable Medicare FFS data from a time frame that includes two 12-month periods: January 1, 2019, to December 31, 2019, and January 1, 2021, to December 31, 2021. The time frame was split to reflect a pre–coronavirus disease 2019 period and a post–coronavirus disease 2019 "surge" period, respectively. This decision was made because of the observed and expected effects of coronavirus disease 2019 on utilization and outcomes. Changes caused by the coronavirus disease 2019 pandemic have made it inappropriate to use data from the first half of 2020 for benchmarking. For PY2022, CMS will move to concurrent benchmarks, using all available and applicable Medicare FFS data from the same 12-month period as the performance year (i.e., January 1, 2022, to December 31, 2022). The use of concurrent benchmarks will allow CMS to provide DCEs with provisional quality benchmarks in the PY2022 quarterly quality reports. The provisional quality benchmarks will be based on data from the reporting period for the respective quarter (e.g., for the Q1 Quarterly Quality Report, the provisional quality benchmark data provided will be based on data from April 1, 2021 through March 31, 2022).

Figure A-1. Timeline of Quality Reporting and Performance Assessment Activities



Appendix B—Terminology List (selected)

Beneficiary	A person who has health care insurance through the Medicare program.
Component Quality Score	The percentage of the Quality Withhold for a specific component that the Direct Contracting Entity (DCE) will earn back based on individual measures or components of the quality measurement approach that contribute to the Final Earn-Back Rate.
Continuous Improvement/ Sustained Exceptional Performance (CI/SEP)	To encourage DCEs to deliver high-quality, high-value care, payment for improvement on quality will also be tied to demonstrable continuous improvement in reducing unnecessary or avoidable health care service utilization from Performance Year (PY) 2023 through PY2026. Specifically, half of the Quality Withhold will be tied to a set of CI/SEP criteria. CMS recognizes that DCEs achieving high performance rates may have less room to show improvement. Accordingly, when establishing these continuous improvement targets, CMS will establish targets that still incentivize higher performing DCEs to continue to improve.
Direct Contracting Entity (DCE)	An organization participating in the Global and Professional Direct Contracting (GPDC) Model pursuant to a participation agreement with CMS.
Eligible Earn-Back Rate	In both the Global and Professional Options, a portion of the Performance Year Benchmark will be held at risk, dependent on the DCE's performance on a predetermined set of Quality Measures and CI/SEP. Specifically, this quality incentive will be structured as a quality "withhold," set at 5% of the value of the trended, regionally blended, risk-adjusted benchmark, and will be recalculated for each performance year. The DCE will have the opportunity to earn back some or all of the Quality Withhold, depending on the DCE's performance on the Quality Measure set and CI/SEP. In PY2021 and PY2022, the Eligible Earn-Back Rate will be 5% for all DCEs. From PY2023 through PY2026, the Eligible Earn-Back Rate will be 5% or 2.5% dependent on the DCE's performance on the CI/SEP criteria. If the DCE does not meet the CI/SEP criteria, the DCE's Eligible Earn-Back Rate will only be 2.5%.
Final Earn-Back Rate	Equals the Total Quality Score times the Eligible Earn-Back Rate.
Global Option	A full risk option with 100% Shared Savings/Shared Losses and either Primary Care Capitation or Total Care Capitation.
High Needs Population DCEs	DCEs that serve GPDC Model beneficiaries with complex, high needs including individuals dually eligible for Medicare and Medicaid and Medicare-only beneficiaries who are at risk of becoming dually eligible. These DCEs serve FFS Medicare beneficiaries with complex needs who are aligned to the DCE through voluntary alignment or claims-based alignment. Only beneficiaries who meet one or more of the High Needs eligibility criteria may be aligned to a High Needs Population DCE. Additionally, High Needs Population DCEs are expected to coordinate care for their aligned beneficiaries using a model of care designed for individuals with complex needs, like the one employed by the Programs of All-Inclusive Care for the Elderly. Like New Entrant DCEs, High Needs Population DCEs are required to meet a minimum number of aligned beneficiaries that increases over subsequent years of the program. High Needs Population DCEs must have at least 250 aligned High Needs beneficiaries prior to the start of PY2021 and PY2022, 500 prior to the start of PY2023, 750 prior to the start of PY2024, 1,200 prior to the start of PY2025, and 1,400 prior to the start of PY2026.

High Performers Pool (HPP)	DCEs in the Global and Professional Options will qualify for a bonus from the HPP if they meet the CI/SEP and also demonstrate a high level of performance or meet improvement criteria on a predetermined subset of the Quality Measures from the Quality Measure set. The HPP will be funded from quality withholds not earned back by the DCEs who met the CI/SEP. The funds in the HPP will be distributed to the highest performing DCEs through an HPP Bonus based on quality performance or improvement. The criteria for assessing quality performance or improvement may be based on an individual DCE's performance on the specified measures in the current performance year compared to the prior performance year, or may be based on performance against the Quality Measure benchmark, or a combination of both. The criteria for the HPP will be shared prior to PY2023.
New Entrant DCEs	DCEs with limited experience delivering care to Medicare FFS beneficiaries who meet eligibility criteria for New Entrant DCEs. Consists of organizations that have not traditionally provided services to a Medicare FFS population. New Entrant DCEs also use claims-based alignment, but they will likely rely primarily on voluntary alignment to attain the minimum number of aligned beneficiaries, at least in the first few PYs of the model. To qualify as a New Entrant DCE, no more than 50% of a DCE's GPDC Participant Providers may have prior experience in any of the ACO initiatives, the Comprehensive ESRD Care Model, or the Comprehensive Primary Care Plus (CPC+) Model.
Pay-for-Performance	Criteria for achieving payments are based on DCE performance relative to a quality benchmark or standard.
Pay-for-Reporting	Criteria for achieving payments are based on DCEs meeting the level of complete and accurate reporting.
Professional Option	A lower risk option with 50% Shared Savings/Shared Losses and Primary Care Capitation equal to 7% of the total cost of care benchmark for enhanced primary care services.
Quality Benchmark	Distribution of Quality Measure scores used to evaluate the performance of a DCE.
Quality Measure	A Quality Measure is a numeric quantification of health care quality for a designated accountable health care entity, such as hospital, health plan, nursing home, or clinician. Measures are based on scientific evidence about processes, outcomes, perceptions, or systems that relate to high-quality care.
Quality Withhold	A portion of a DCE's financial benchmark that will be held at risk each PY subject to the DCE's quality performance as reflected by the DCE's Quality Measure scores.
Reporting-Only	A Reporting-Only measure does not factor into a DCE's Total Quality Score in any way, although CMS will collect the data for informational purposes (e.g., to determine whether a measure is used in a future PY; to help set the measure's Quality Benchmark). No measures are currently planned as Reporting-Only.
RSAAR	A Risk-Standardized Acute Admission Rate. Lower RSAARs indicate better performance.
RSRR	Risk-Standardized Readmission Rate. Lower RSRRs indicate better performance.

Standard DCEs	DCEs with substantial experience serving the Medicare FFS beneficiaries, which are likely to have prior experience participating in Medicare ACO initiatives. Composed of organizations that generally have substantial experience serving Medicare FFS beneficiaries, including Medicare-only and dually eligible beneficiaries. These DCEs also most likely have prior experience participating in Medicare ACO initiatives. New organizations, composed of existing Medicare FFS providers and suppliers, may also participate as this DCE type. To qualify as a Standard DCE, the DCE must have a minimum of 5,000 aligned beneficiaries prior to the start of each PY (PY2021–PY2026). Standard DCEs will likely include beneficiaries aligned through both voluntary and claims-based processes.
Tax Identification Number (TIN)	A unique identifier assigned by the IRS. In a health care setting, a TIN could uniquely identify a physician, a group practice, a hospital, or similar entity.
Total Quality Score	The percentage of the earn-back-eligible portion of the Quality Withhold that a DCE will actually earn back based on its quality performance and reporting. Total Quality Score = ∑ (Component Quality Scores * Component Quality Withhold Weights).