

Direct Contracting Model: Professional and Global Options

Benefit Enhancements and Patient Engagement Incentives Webinar

December 18, 2019

Event Transcript

Thank you so much and thank you everyone for joining today as we go over the Benefit Enhancement and Patient Engagement Incentives for the direct contracting professional and global options.

As we go through the slides, please direct any questions regarding Benefit Enhancements or Patient Engagement Incentives to the Q&A box. We do ask that questions be limited to these topics as we go through the slides.

My name is Sarah Wheat [PH], and I am the Direct Contracting Model Benefit Enhancement's lead and will be taking you through your presentation today.

Again today, I'll be talking to you about Benefit Enhancements and Patient Engagement Incentives for the Direct Contracting model. Today, we will cover background and overview, current Benefit Enhancements tested under the Innovation Center, current Patient Engagement Incentives tested under the Innovation Center, newly proposed Benefit Enhancements for performance year one and possible future Benefit Enhancements and Patient Engagement Incentive.

Please note the Benefit Enhancements and Patient Engagement Incentive described in this webinar are proposed and subject to change. CMS will release more information as it becomes available.

Okay, so just before we get into the slides, we want to take an audience poll, we just want to get a feel for where our audience is, so we can level set for the webinar. Please take a few seconds and answer the poll. We got answers coming in; we'll give it a couple more seconds.

Okay, great. It looks like about half of the attendees today are eligible to participate in the Direct Contracting model. We have a pretty split between those who are unsure or now so that's helpful for our team to direct the webinar as we go forward.

Let's get into the background and overview. The Direct Contracting model built on experience with the Medicare Accountable Care Organizations, or ACOs, such as the Medicare Shared Savings Program and the Next Generation ACO model. The DC model also leverages innovative approaches from Medicare Advantage and private sector risk sharing arrangements. The Direct Contracting Entities or DCEs that would participate in this model are expected to use Redesigned Primary Care, Benefit Enhancements, and other model flexibilities to better manage costs and quality of care, while ensuring beneficiaries still retain their choice of providers.

The Direct Contracting model will focus on three main goals. The first transforming risk sharing arrangements; this will consist of flexible cash flow, predictable prospective spending targets and payments tailored to the beneficiary population you are serving, such as a complex chronically ill population.

The second is to empower and engage beneficiaries. This is achieved by using enhanced voluntary alignment and various Benefit Enhancement and Patient Engagement Incentives.

Lastly, reducing provider burden, we aim to meet this goal by reducing the number of quality measures to a small set of core quality measures focused on outcomes and patient experiences of

care by offering waivers to facilitate care delivery and opportunities for organizations new to Medicare fee-for-service to participate in the model. Today, we will focus on empowering and engaging beneficiaries through Benefit Enhancements and Patient Engagement Incentives.

CMS seeks to emphasize high value services and support DCEs in managing their aligned beneficiaries through these Benefit Enhancements and Patient Engagement Incentives. Please note a DCE may choose not to implement all or any of the Benefit Enhancements and Patient Engagement Incentives offered under the Direct Contracting model.

Applicants will be asked to provide information regarding their proposed implementation of any Benefit Enhancements or Patient Engagement Incentives they select, but acceptance into Direct Contracting is not contingent upon the applicant agreeing to implement any particular Benefit Enhancement or Patient Engagement Incentive.

The Direct Contracting model built off the Next Generation ACO model by proposing to offer the same Benefit Enhancements and Patient Engagement Incentives currently available in the Next Gen model.

Additionally, CMS will be hosting three new Benefit Enhancements. CMS will continue to focus on Benefit Enhancements that foster patient's engagement in their own care and enable provider flexibility to determine the most appropriate high value care.

Well, I will go into these in more detail at subsequent slides. You can see the Benefit Enhancements currently in the Next Generation model, as well as the newly proposed Benefit Enhancements for performance year one. They are telehealth expansion, post discharge home visits, care management home visits, 3-day SNF rule waiver, chronic disease management reward and cost sharing support for part B services.

Direct Contracting has also proposed three new Benefit Enhancements to begin in performance year one. They are home health services certified by nurse practitioners, homebound requirement for home health and concurrent care for beneficiaries that elect the Medicare hospice benefit.

We'll get started talking about the current Benefit Enhancements that are being tested on the Innovation Center right now. In order to emphasize these high value services and support the ability of DCEs to manage the care of beneficiaries, CMS has defined policies using the authority under Section 1115(a) of the Social Security Act to conditionally waive certain Medicare payment requirements as part of testing Direct Contracting. Let's get into it.

The telehealth expansion benefit will accomplish three things: the first, eliminate the world geographic component of originating site requirements; the second to allow the originating site to include a beneficiary's home; and the last to permit the use of asynchronous telehealth and the specialty of tele-ophthalmology and tele-dermatology.

In addition to the home and an aligned beneficiary, you may receive care at one of the CMS defined telehealth originating sites. Approved originating sites include the following: physician or practitioners offices; hospitals; clinics and federally qualified health centers; hospital based renal dialysis centers; skilled nursing facilities; and community mental health centers.

In addition to these flexibilities around originating sites, the proposed waiver would also include the use of asynchronous telehealth in the specialties of tele-ophthalmology and tele-dermatology.

Asynchronous telehealth includes the transmission of recorded health history, for example, a retinal scan or digital images through a secure electronic communication system to a practitioner, usually a

specialist, who uses the information to evaluate the case or render a service outside of a real time interaction. Both new and existing beneficiaries aligned to your DCE would be eligible for these services.

In addition, the distance site provider can be either a DCE participant provider or a DCE preferred provider that has elected to use the Benefit Enhancement. A DCE will use CMMI specific codes when billing for these services. CMS will provide more details on billing for telehealth and other Benefit Enhancements when the information becomes available.

Currently, a post discharge home visit service is a service a physician can provide to their patients in their home and bill through Medicare. This service is not a home health service for the homebound. The current post discharge home visit must be provided under the direct supervision of a physician or in other words, the physician is required to provide the service directly to the patient at their home. A clinician cannot provide this service in place of the physician today.

However, the Direct Contracting model will allow for us physician to contract with licensed clinicians to provide this service to patients in a patient's home. I would like to highlight that this proposed waiver allows incident two claims for home visits to non homebound aligned beneficiaries by licensed clinicians under the general supervision instead of direct supervision of a DCE participant provider or a preferred provider.

In our regulation at 42 CFR 410.26(a)(3). General supervision means that the service is furnished under the physician or other practitioner's overall direction and control with the physician or other practitioner's presence is not required during the performance of the service.

Eligibility for this waiver is determined if the beneficiary does not qualify for Medicare coverage of home health services. The beneficiary is an aligned beneficiary at the time the services are furnished or within the grace period. The services are furnished by auxiliary personnel under the general supervision of a DCE participant provider or preferred provider, who is identified by the DCE as participating in the post discharge home visits, Benefit Enhancement and who is a physician or other practitioner.

The services are furnished in the beneficiary's home, after the beneficiary has been discharged from an inpatient facility. Lastly, the services are furnished not more than nine times within 90 days following the discharge from an inpatient facility, which for example would include an acute inpatient hospital, inpatient psychiatric facility, skilled nursing facility, long-term care hospital or inpatient rehabilitation facility.

Please note for the purpose of this Benefit Enhancement, home can be defined as a beneficiary's home, rest home, assisted living and/or nursing facility.

As with the post discharge home visit waiver, the care management home visits allow incident two claims for home visits to non homebound aligned beneficiaries by licensed clinicians under the general supervision instead of direct supervision as a DCE participant provider or a preferred provider.

General supervision means that the services furnished under the physician or other practitioner's overall direction and control, but the physician or other practitioner's presence is not required during the performance of the service.

An aligned beneficiary will be eligible to receive up to 12 care management home visits within a performance year. Please note this is a change from the Next Generation ACO model, where visits were limited to two visits within a 90-day period.

A beneficiary is eligible for care management home visit if they meet the following criteria: the beneficiary is determined to be at risk of hospitalization; the beneficiary does not qualify for Medicare coverage of home health services; the services are furnished in the beneficiary's home after a DCE participant provider or preferred provider has initiated a care treatment plan; or the beneficiary is not receiving services under the post discharge home visits Benefit Enhancement.

Additionally, there are no specific model requirements that define the care treatment plan. Care management home visits can be incorporated into a broader care treatment plan for the beneficiary and not to be a standalone document.

We'll now discuss the 3-Day SNF Rule waiver. Currently and traditional fee-for-service Medicare beneficiaries are eligible for Medicare covered skilled nursing facility or SNF services, when a beneficiary is admitted within 30 days of an inpatient hospital stay of three consecutive days or more. This starts with the day the hospital admits the beneficiary as an inpatient. The 3-Day SNF waiver waves the required three-day inpatient hospital stay for a patient to go to a skilled nursing facility or a swing bed hospital. Just to note this is by far the most popular Benefit Enhancement currently in the Next Generation ACO model.

Generally, the eligibility requirements include that the beneficiary must be aligned to a DCE that has elected to participate in the waiver. The beneficiary must be medically stable with confirmed diagnosis and the DCE must have indicated the 3-Day SNF rule waiver as a Benefit Enhancement in their participant provider and preferred provider list. Participating DCEs will have the opportunity to add additional SNFs as preferred providers at designated points during the performance year.

In addition, please note that a SNF must have an overall quality rating of three or more stars and seven out at the past 12 months under the CMS Five-Star Quality Rating System. Star ratings are reviewed at the time of participant list submission. This will not be removed if their star ratings decline during the performance year once they have been approved for that performance year.

The beneficiary eligibility criteria will be carried over from the Next Generation model. A beneficiary is eligible if, first the beneficiary is not residing in a SNF or a long term care facility at the time of SNF admission under this waiver. For the purposes of this waiver, independent living facilities and assisted living facilities shall not be deemed long term care facilities. A beneficiary must also be medically stable with a confirmed diagnosis. Lastly, the beneficiary must have skilled nursing or rehabilitation need identified by a physician or other practitioner that cannot be provided on an outpatient basis. Additionally, a beneficiary can be admitted directly to the SNF and does not require an inpatient hospital evaluation or treatment.

Now we'll discuss the current Patient Engagement Incentives that are being tested under the Innovation Center. These incentives provide a waiver of certain fraud and abuse laws for DCEs to use in care management and to use for care flexibility.

First, we'll talk about the chronic disease management reward. Chronic disease management reward program has been used to improve care quality, promote self management and reduce costs. Beneficiaries may be eligible to receive this reward if, the beneficiary was an eligible beneficiary at the time enrolled in or began participating in the chronic disease management program. Beneficiary satisfied all the criteria for obtaining the gift card as set forth in the DCEs implementation plan. The

gift card is provided to the beneficiary directly by the DCE. The cost of the gift card is funded entirely by the DCE and the gift card is programmed to prevent the purchase of tobacco and/or alcohol products. Additionally, if the beneficiary was aligned to the DCE when he or she enrolled in the chronic disease management reward, then the beneficiary is eligible for the gift card even if he or she has left the DCE.

A chronic disease management program will be described under DCEs implementation plan and will focus on promoting improved health, preventing injuries and illness and promoting effective use of healthcare resources for individuals with the chronic diseases targeted by the program. A DCE may target specific sub populations, but that must be clearly articulated in their implementation plan. DCEs may not discriminate against populations that would otherwise be eligible.

The following are examples of chronic disease management program, utilizing particular services or preventative screening benefits, adhering to prescribed treatment regimens, attending education or self-care management lessons and meeting nutritional goals.

The next Patient Engagement Incentive we have is cost sharing support for Part C services. Cost sharing support, for example, reductions or subsidies generally describe a discount that lowers the amount a beneficiary has to pay for a deductible, copayments and coinsurance. Cost sharing support is designed to minimize beneficiaries out of pocket costs, when they go to the doctor or have a hospital stay. The goal of this Patient Engagement Incentive is to reduce financial barriers, so that aligned beneficiaries may obtain immediate care and better comply with the treatment plan, thereby improving their own health outcomes.

Under these incentives, DCEs will make payments to those DC participant providers and preferred providers to cover some or all of the amount of beneficiary cost sharing not collected.

While DCE may tailor this Patient Engagement Incentive to fit the needs of their population, there are some criteria DCs must follow when implementing this service. An eligible service may include any Part B service identified in the DCEs implementation plan, which does not include durable medical equipment or prescription drugs.

Eligible beneficiaries may include without limitation one or more of the following: aligned beneficiaries without Medicare supplemental insurance; aligned beneficiaries experience high health care costs; and/or aligned beneficiaries who require certain Part B services, their seat of which could reduce the individual's overall health care costs.

In addition, the cost sharing support must advance one or more of the following clinical goals, adherence to a treatment regimen, adherence to a drug regimen, adherence to follow up care or management of a chronic disease or condition.

A DCE must have an agreement with each DC participant provider and preferred provider who has agreed to provide cost sharing support for Part B services and must specify the following: categories of eligible beneficiaries and eligible services, where they may provide cost sharing support; requirement of the DC participant provider or preferred provider provide cost sharing support in accordance with the DCEs implementation plan; amount and frequency with which the DCE will reimburse the DC participant provider or preferred providers or the cost sharing amounts not collected; a DC is not required to submit their cost sharing support arrangement as part of the implementation plan or review process.

Okay, so let's take a little pause and do another audience poll. After going through that, we'd like to know how many of you are likely to apply to participate in the Direct Contracting model.

As the answers coming in, we'll give it a few more seconds. Okay, great. Well, thank you everyone for answering that. It looks like at least half of you are in the likely to very likely participation in the Direct Contracting model category. A good number are unsure, but we hope that these series of webinars we will be conducting will clarify that for you or change your mind. With that we can continue with the slides.

Now, we will discuss newly proposed Benefit Enhancements for performance year one, which will begin January 1st, 2021. The first of which is home health services certified by nurse practitioners. Under current Medicare rules, nurse practitioners can order home health services, but Medicare will not pay for those services unless a physician certified the beneficiary's eligibility for the home health benefit. As a result, nurse practitioners must locate a physician to document the nurse practitioner's assessment, even if the physician is not necessarily involved in the assessment.

In the Direct Contracting model, we are proposing to offer the home health services certification by nurse practitioners Benefit Enhancement as a waiver, a waiver currently planned for implementation under the Maryland Total Cost of Care Model. This Benefit Enhancement would offer DCEs the ability to improve quality of care by providing a streamlined approach to certifying home health patients, reduce Medicare expenditures by providing nurse practitioners with greater flexibility to coordinate patient care and avoid duplicative work, and promote greater use of non-physician practitioners and supporting existing patient provider relationships.

Under this waiver, a Direct Contracting Entity may allow nurse practitioners to certify that aligned beneficiaries are eligible to receive the home health benefits in accordance with Medicare law. However, this waiver would only apply for DCEs in those states that allow nurse practitioners to order home healthcare for beneficiaries within the scope of their practice.

Please note Medicare would continue to assume costs for these home health services as this waiver would only brought in the category of entities that can certify home healthcare services for Medicare beneficiaries.

The next proposed waiver is the homebound requirement waiver for home health. Currently, to receive Medicare reimbursement for home healthcare services, a Medicare beneficiary must meet the definition of homebound. This means a beneficiary may either (a) need the assistance of a supportive advice, special transportation or another person to leave their residence or (b) have a condition that makes leaving his or her home medically contraindicated. Two, there must be a normal inability to leave the home and leaving the home must require a considerable and taxing effort.

These eligible homebound beneficiaries are entitled to receive the following services: skilled nursing care; home health aides; physical therapy; occupational therapy; speech language pathology; medical social services; routine and non-routine medical supplies; durable medical equipment and osteoporosis drugs.

The current requirement focuses on a beneficiary's mobility limitation, or often neglecting the underlying health condition or comorbidities, often present in the population.

Unless homebound status is certified skilled nursing care services in the home are not reimbursable by Medicare or a beneficiary residing in their home. The proposed waiver would seek to waive the homebound requirement for the reimbursement of home health services for beneficiaries in specified diagnosis group.

We believe providing access to home health services is expected to reduce hospital readmissions, improve patient outcomes and reduce costs for the population. This additional flexibility also would aid DCEs in developing alternative payment arrangements with home health agencies promoting innovation.

This waiver would allow home health services to be provided in the absence of mobility limitations and allow DCEs to identify and provide services to those aligned beneficiaries who are most at-risk of an inpatient hospital admission. Eligibility for this waiver determined as an aligned beneficiary otherwise qualifies for home health services under current regulations, except that the beneficiary is not required to be confined to the home and have a combination of clinical risks which will be determined by CMS at a later date. Most importantly, this waiver would enhance patient's ability to return to, remain, and receive care in their home.

Lastly, just on implementation here, DCEs would identify home health providers that are DC participant providers or preferred providers to provide these services to eligible aligned beneficiaries. All other requirements regarding Medicare coverage and payment for home health services would continue to apply.

Our last of the newly proposed Benefit Enhancements is the concurrent care for beneficiaries that elect the Medicare hospice benefit. Under current Medicare rules, beneficiaries who elect hospice care generally waive their right to Medicare coverage for treatment of their terminal condition. That is by electing hospice beneficiaries waive Medicare coverage for services that are considered curative or sometimes referred to as conventional care in favor of receiving services that are more palliative in nature.

However, studies have shown that offering both palliative and curative care in hospice can result in better pain and symptom management, care coordination and shared decision making as well as the timely incorporation of patient centered goals into a plan of care.

The Direct Contracting model aims to waive the requirement that beneficiaries who let the Medicare hospice benefit give up their right to receive curative care as a condition of electing a hospice benefit.

With the goal of easing care transitions and ensure hospice eligible beneficiaries face a left star transition and choice between electing or foregoing cost of care.

With this waiver, DCEs would work with their hospice providers as well as non-hospice provider to define and provide a set of concurrent services related to a health system release terminal condition and related conditions that are appropriate to provide on a transitional basis and align with the enrollees wishes.

Currently, this benefit is limited to those DCEs participating in the global option of Direct Contracting. However, I will state that this is just a proposed Benefit Enhancement and requirements are subject to change.

In similar to the approach we use for the three-day, skilled nursing facility rule waiver, Benefit Enhancement or SNF waiver, DCEs would identify the hospices with which they would partner in this Benefit Enhancement. Likewise, DCEs will be able to identify non-hospice providers included under this Benefit Enhancement. These partner hospices and non-hospice providers could be either a DCE participant providers or preferred providers. These expenditures would be included as part of the total cost of care for the relevant performance year for the purposes of model financial calculations.

Just a little more into the implementation side, the Medicare claim system would continue claims based edits to prevent non-hospice claims from processing, while a beneficiary is under hospice election, except with respect to those hospice and non-hospice organizations identified as participating by the DCE.

The Medicare fee-for-service claims submitted by these organizations will be paid by Medicare, if they are otherwise appropriate for payment, absent the restriction for paying claims for beneficiaries that has elected hospice.

Those are the Proposed Benefit Enhancement Patient Engagement Incentives for performance year one. I will quickly go over some possible future Benefit Enhancements and Patient Engagement Incentives for future years in the model.

Some suggestions are tiered cost sharing reduction, alternative sites of care, cost sharing support for skilled nursing facility services, long term care hospital of 25-day length of stay or other type of care restrictions.

Okay, so that is what we wanted to cover today on Benefit Enhancements and Patient Engagement Incentives. Let me just go over the model timeline for everyone here. For the implementation period, we will have the application period open from November 25th of this year to February 25th of 2020.

The performance period application will open from March 2020 to May 2020. DC selection for implementation period will be in April of next year 2020, and DC selection for the performance year one will happen in September of 2020.

Lastly -- in addition, deadline for applicants to sign and return their participation agreement for the implementation period that will be in late April of 2020, for the performance year one that will be December 2020.

Lastly, just on initial voluntary alignment outreach. This will start for the implementation period in May of 2020 and for the performance year period PY1 January 2021.

I will just note that the subject maybe -- the timeline may be subject to change and please continue to correct -- check the Direct Contracting webpage for webinar and offers our dates and times.

Okay, so now we're going to take a few questions. I'm going to go on mute for a moment, while I go through some of the questions we've got in, but please continue to submit your questions regarding Benefit Enhancements and Patient Engagement Incentives to the chat box and we will be right back.

[Brief pause while questions are reviewed]

Okay, I'm going to go through some of these questions. Thank you everyone who submitted them. We have a question here. Does the DCE have to submit intend to participate and the Benefit Enhancement in their DCE application, or can they decide after they are approved as a DCE?

If you intend to use that Benefit Enhancement for that performance year, you would need to submit your intend in the implementation plan with your application. If does not then you have to implement that Benefit Enhancement, but it is required if you would like to implement it in the future.

Another question here, is the DCE applies to provide Benefit Enhancements, is it required to provide them throughout the performance year or can it discontinue or modify them?

Great question. They're not required to use the Benefit Enhancements throughout the performance year. That is up to the discussion of the DCE and their providers. As far as modifying them, you do have opportunities to add or drop Benefit Enhancements throughout the year, but that guidance regarding ad hoc additions or drops will be coming later closer to performance year one.

Another question here on care management home visits, what is the scope of time for the 12 care management home visits, 12 in one year? Yes, that's correct. It's 12 in one performance year.

Question, what is the monetary value of chronic disease management reward gift card or is that up to the DCEs discretion? This will be \$75. That's what it is in Next Gen ACO and that should be continued in the Direct Contracting model. Again, once that is short up, we will make sure to let all potential applicants know.

Here's a question, as the new home care waivers will involve potential billing discrepancies and how much of the same administered a burden that we will see with this SNF three-day waiver?

I would have to push to receive the details sooner, so we may begin to work on our home health partners as well as build our implementation plans to optimize these fees. That's a great point. We are working as much -- as quickly as possible to make sure that not only is the policy could be beneficial to the DCEs, but that we communicate the policy to our shared systems, so we don't have any issues in the claim system, but thank you for that and noted.

Okay, here's a question here. When do DCEs have to indicate their intent to participate in Benefit Enhancements? Do they have to submit their implementation plan in their DCE application?

Yes, you will have to submit your implementation plan in your application -- with your application for either the implementation period or performance year one.

What services do the post discharge home visit waiver allow? I didn't go into it in too much detail on the webinar, but CMMI has specific G-codes used to build for these services that will carry over into the Direct Contracting model. I will ensure to include the specific G-codes in a follow-up FAQ document. They are -- under the discretion of the DCE, but also ensure that you're working within the limits of your state's laws when providing those services.

The DCE that serves a high need population use this Benefit Enhancement to provide additional long term services and support, such as personal care aid services, to avoid long term nursing home placement.

As of right now, the Benefit Enhancements and Incentives, I went over today are what we have proposed for the first performance year; however, as the performance years go on, we will definitely be connecting with our DCEs to see what their needs are clinically and what would be best for their beneficiary population, so definitely potentially in the future, more to come with that.

If a Benefit Enhancement is implemented, is there a routine administrative overhead and reporting that the DCE must complete for CMS during the performance year? Great question.

DCE will have certain monitoring requirements; however, we are working to ensure those are streamlined and less burdensome as possible for the DCEs, so they can really get to the heart of just providing the services for the -- and not to provide them, because it's too burdensome.

Do Benefit Enhancements start in the implementation period or the performance period? Benefit Enhancements will start in the performance period, so that will be January 1, 2021.

Can you start in PY 2021, but not select all waivers until a subsequent year? Yes, you can, if you are applying for PY1, which is 2021, I would urge you to submit an implementation plan for NAB that you want to submit for that PY or else you will have to wait to a subsequent performance year to submit an implementation plan.

Is the DCE home visit benefit structure different than the post discharge home visit waiver? It appears the DCE model will permit the contract as home health agencies to provide and build to the service. PDHVW requires that bills are submitted to the general supervising physician who submits a bill. So yes, when submitting any claims for the care management or post discharge home visit Benefit Enhancement that will have to come -- be billed through the general supervising physician or other practitioner who must be a DCE participant provider or preferred provider.

This one -- did I hear correctly that beneficiary incentive can be unique to our population and they are social determinants of health, for example, transport or food? Not quite. We want that -- using the cost sharing or chronic disease management reward, we want DCEs to see what would be most beneficial for either a group of beneficiaries or a targeted group of clinical patients. However, that does not mean it can take shape of transportation or food. However, some of these more social determinants of health incentives we are you know, we'll be looking to in the future.

Could you clarify the cost sharing reduction option? Is this to reduce the patient's exposure to the Part B deductibles or coinsurance? If a deductible applies provider does not collect, but receives reimbursement from DCE, Medicare is billed as a member to pay for it, correct? Yes, they would bill the same way their -- they would bill the claim regularly. A beneficiary would not be responsible for whatever cost sharing service the DCE has established between its beneficiaries and their patients.

Will the DCE home visit permit the contracted home health agencies to provide a service and bill for these services? There is a list of auxiliary personnel who are allowed to bill for this. I will ensure that in a follow-up FAQ document, the correct legislation is outlined there, and DCEs will be able to use that to make their determinations on who they will contract with, if implementing this waiver.

I see some questions are slowing down a little bit. I'm going to just jump on mute for a bit, but please we have remaining time so please feel free to keep sending questions and we will be right back.

Hi, everyone, we've got a few more questions. One here is, do organizations who are applying for implementation period have to submit their Benefit Enhancements by February 25 or do they have until May 2020 to submit their Benefit Enhancement implementation plan?

I apologize if I misspoke earlier, because we're not implementing any Benefit Enhancements in the implementation period. Those DCEs that are applying for the implementation period are not required to submit an implementation plan, if they are intending even in the future to provide Benefit Enhancements.

Will a beneficiary receive an EOB from Medicare that shows cross sharing services that's supposed to be paid even though the provider waived? What we do when we implement any of these changes in the system is we'll make sure that Medicare summary notice correctly reflects the Benefit Enhancement that was used when billing for that service, so beneficiaries should be aware of them receiving those awards.

Do costs associated with providing some of the enhancements, for example, cost sharing factor into the DCEs performance against the PY benchmark? Great question. I'm just double checking with -- in the room. Let me circle back to that one.

Okay. Thanks everyone. Again, so do costs associated with providing some of the enhancements factored into the DCEs performance against the PY benchmark.

For Benefit Enhancements like the SNF waiver or has discharge home visits, yes, that will. The Patient Engagement Incentives those are coming out of the DCEs own funding. Those will not count against the benchmark.

We have received a couple questions regarding some language in the RFA regarding DCEs providing vouchers for medication, non-urgent transport -- vouchers for dental services. That is something I am going to take back to the team to clarify and will ensure is updated correctly in the subsequent FAQ document.

Okay, few more questions and just to clarify on the Patient Engagement Incentives, specifically regarding page 24 of the RFA. These are examples of Patient Engagement Incentives that DCE can provide to their beneficiaries that they will pay for. It's important to note that we say Benefit Enhancements for its Patient Engagement Incentives, because they work two different ways. Benefit Enhancements work through the Medicare fee-for-service system. While Patient Engagement Incentives are [inaudible 0:50:13] waivers that the Direct Contracting Entity can choose to participate in.

If we are currently using these waivers in another ACO model, do we need to complete an implementation plan for the same DC waivers? Yes, you would need to complete a new implementation plan for any waivers in DCE.

For cost sharing, if a patient has not gone to their cardiologist and have heart failure, because of a co-pay, would we be able to pay that co-pay? Yeah, that's sort of, that's what we're getting at with that flexibility for the DCEs. Again, it's going to be tailored to your beneficiary population and will need to be specified in your implementation plan, how you're going to use it, but generally that's what flexibilities we're getting at.

For those insured savings who are already approved for SNF waiver, will the SNF waiver be similar to ones like in SSPR and the ACO? Yes, it will flow very similarly. Again, before the performance year one starts in January 2021, we will ensure to provide guidance on billing for these services.

Will costs associated with addressing social determinants of health and barriers to care count towards the benchmark? These generally fall into the Patient Engagement Incentives, so no they would not count towards the benchmark.

I have a couple questions on when these will be finalized and when we'll release waiver guidance. I would say just stay tuned to these -- when using these in a system and proposing these we have to work with many different components of CMS, so there's a lot of coordination among different offices to get these in place. Come January 2021, you're ready to bill with no problems, so please just stay tuned.

Do we have to submit an implementation plan for Patient Engagement Incentives such as non-urgent transportation? Yes, you would have to submit an implementation plan for any Benefit Enhancements or Patient Engagement Incentives, your DCE plans to submit.

I'm going to go back on mute for a minute. Please feel free to keep sending in questions.

[Brief pause while questions are reviewed]

Okay. We've got a few more questions come in. One here we have is, will any data be made available to support providers in considering their options as a DCE prior to application?

We do urge potential DCEs to obviously read the RFA and base many decisions off that and use that as an example. However, Shared Savings Programs like the Medicare Shared Savings Program and the Next Generation ACO do have public resources on the CMMI or CMS website where you can get sort of a feel for how they're implementing these Benefit Enhancements.

Can a DCE offer patient incentives to only select patients or do they have to offer them to all aligned patients? No, DCE can specifically determine beneficiary eligibility to how they would like to provide this Benefit Enhancement. It would just need to be detailed in your implementation plan when submitted.

I see questions are slowing down a little bit. I'd go back on mute, please feel free to continue to submit them.

[Brief pause while questions are reviewed]

Okay. We have another question that came in. This is one, what impact will social determinants of health have on funding the model?

It's hard to say this is going to be specific to your DCE. This is something we urge potential DCEs to work with their financial people to see what sort of impact on cost benefit would be for their patients and for ultimately provider saving and DCE savings.

There are a few questions I would love -- I'm going to take back to the team. If I didn't get to your question, I apologize, but we will be following up with in FAQ document. Anything that wasn't answered I'll ensure it is answered for -- in FAQ at a later date.

Just quickly before we wrap up, I want to share the dates of our upcoming webinars. We will have an application overview on January 7. The office hour session for this along with applications for this webinar applications will be on January 8th, so please feel free to contact, bring your questions to that office hour as well.

January 15, we will start payment. Payment part two will be on January 22nd. Then we will have remaining office hour sessions for those third and fourth payment webinars as we continue to go through the months before applications are submitted. If you have a specific Benefit Enhancement question, please feel free to e-mail the Direct Contracting inbox at dpc@cms.hhs.gov. If it's specific to Benefit Enhancements and you'd like to see it in the office hours, please use the subject line office hours, we will ensure that it's addressed during that call.

In addition, we have a link here to our website, which will have a link to the application and if you need support with Salesforce, please e-mail CMMIForceSupport@cms.hhs.gov.

We stick with that, we are at the hour. I will conclude today's webinar. Again, please feel free to reach out to the help desk for any questions that I didn't get to or if you need clarification on and then please join us for office hours on January. Thank you so much.

[End of event].