Frequently Asked Questions Posted February 27, 2017

When preparing a budget for the application, what line item should be used for rent, utilities, security certification, insurance, audit, profits, etc.? If more rows are needed (e.g., if there are more than 6 decision aids per year) where should that information be captured in the budget?

The Direct Decision Support (DDS) Applicant Financial Workbook should be used to capture financial information for the life of the project. If more rows are needed to record information, applicants can enter any costs that do not fit in the main Financial Workbook tabs in the "Other Costs" tab of the workbook. The Financial Workbook is available on the DDS website at: Beneficiary Engagement and Incentives: Direct Decision Support (DDS) Model Main Page. Instructions for completing the file can be found on the first tab of the workbook. All proposed applicant costs will be evaluated for reasonableness and best-value determinations.

When preparing a budget for the application, will there be any required travel for model participants?

CMS is not requiring any travel for the DDS Model for learning collaboratives or meetings. Any travel costs must describe how the travel supports the model's goals.

How should we document or account for the costs incurred during the pre-implementation period?

Funding is not available for costs incurred during the pre-implementation period. Funding for selected applicants will be for the period of performance January 1, 2018 through the period of award and annual renewals within the DDS Model.

Is there a maximum for fringe?

While there is no set maximum for fringe, all proposed applicant costs will be evaluated for reasonableness and best-value determinations. Applicants must list and itemize all components of the fringe benefit rate and show how the fringe benefit amount is computed for all five years.

Is there a maximum for indirect or administrative overhead?

If an applicant wishes to propose indirect costs, the applicant must either a) provide a copy of their negotiated indirect cost rate agreement (NICRA), or b) propose no more than the *de minimis* indirect rate of 10%. As always, all proposed applicant costs will be evaluated for reasonableness and best-value determinations for the award period. Applicants should use the "Other Costs" tab for proposing any indirect costs.

Would an applicant be eligible for the DDS Model if the organization is made up of a newly formed joint venture or partnership where one member has previous DSO experience and one member does not, or could two separate entities submit a joint application?

Newly formed organizations may be eligible for this model if the organization can satisfy the requirements of the request for application (RFA). DSO applications will be reviewed to determine eligibility. The DDS Model will select DSOs that have documented experience in providing evidence based, beneficiary-focused clinical information. A successful applicant will have prior success engaging Medicare beneficiaries and impacting the utilization of health care services and costs. CMS will seek established DSOs with a record of accomplishment working with adults, including Medicare-Medicaid enrollees and disabled populations. Applicants should submit complete responses to the application questions, ensuring that responses clearly identify the nature of any partnerships or other relationships that are critical to the implementation of the DDS Model.

Can a health plan partner with a DSO? For example, can the health plan perform administrative services such as outreach, initial enrollment/engagement, and fulfilling incentives as part of the Direct Decision Support Model?

DSO applications will be reviewed individually to determine eligibility. However, no medical providers, suppliers, or government health agencies are eligible to apply and participate as a DSO in the DDS Model. A DSO may contract or subcontract tasks to another entity. The DSO should ensure all questions in the RFA are answered in detail as it relates to the contractor or subcontractor.

What Section 508 Compliance standards do the DSOs need to adhere to?

All entities doing business with the federal government must comply with federal regulations to include 508 compliance in the following areas:

- Ensure all documentation is created in a 508 friendly format (e.g., emails, documents created in Microsoft Office).
- All software and hardware purchased must be 508 compliant.
- All applications developed for CMS must be validated for 508 compliance.
- All websites developed for CMS purposes must be validated for 508 compliance.

Is there a list available of eligible entities, for example, DSOs and organizations that have developed Patient Decision Aids (PDAs) for some of the other conditions you have identified, that we might consider partnering with in order to cover all of the conditions you want included in the DSO model?

CMS does not have a list of DSOs for circulation. DSO selection will be publicly announced in June of 2017.

What data will be given to DSOs, and can the DSOs integrate with CMS data systems to access these data? Is the DSO allowed to link the data provided by CMS on assigned beneficiaries to existing databases such as phone numbers and comorbidity lists?

CMS will provide DSOs with beneficiary names and addresses only. CMS will not provide access to any other CMS beneficiary databases. Organizations may link beneficiary name and address to their own databases as long as this is done in a manner consistent with the terms and conditions that CMS will set forth in its Model Participation Agreement (MPA) with DSOs.

How often will the list of beneficiaries be updated and distributed? How will the list be replenished as beneficiaries fall off of the list? What is the format and file type of the list? Is there any additional information on the technical method DSOs will use to receive/send beneficiary activity data back to Medicare (e.g. via API)?

The Beneficiary File (TBF) of DSO beneficiaries will be distributed by the DDS Model Implementation and Monitoring Contractor under the direction of CMS. The processes for maintaining the TBF (i.e. the list of 100,000 beneficiaries assigned to the DSO) are currently under development. CMS is taking into account the need to replenish the TBF periodically due to expected changes to the assigned beneficiary population as the process is developed. Data will be delivered in accordance with all applicable laws and regulations, including the Privacy Act, the Health Insurance Portability and Accountability Act (HIPPA), and Federal Information Security Management Act (FISMA) data regulations. The DSO will sign a HIPAA business associate agreement as required by the MPA in order to receive and use the data. During the six-month pre-implementation period, DSOs will work with CMS and its contractors to establish data and payment transmission processes. CMS is currently considering the use of a secure Electronic File Transfer (EFT) process to transfer data to and from DSOs. The model implementation processes will be shared with the DSOs during the pre-implementation period (July 1 – December 31, 2017).

Will DSOs be permitted to reach beneficiaries via unsecured email or text messaging, with beneficiary consent, to provide information on decision topics?

Modes of communication with Medicare beneficiaries will be reviewed during the pre-implementation period. Beneficiary privacy and confidentiality measures/requirements will be specified in the MPA and reviewed during the pre-implementation period.

Is there an implementation and monitoring contractor (IMC) or other form of oversight for PDAs? Will there be a review of how PDAs are selected? Are PDAs expected to be updated and maintained when the evidence changes in the 2 years of this program?

The IMC will provide oversight and ensure PDAs proposed by the DSOs are acceptable to CMS. During the pre-implementation activities, the CMS contractor will review the DSO's formal set of PDAs to be used. It is expected that DSOs will update PDAs as needed through the life of the model.

How were the target engagement rates determined; specifically, 3.5% in year one and 7% in each following year?

Based on prior CMS experience, engagement rates in similar models range from 3% to 11%. CMS expects DSOs to engage approximately 7% of the target population. A 3.5% engagement rate during the first year allows for a ramp up period both for beneficiaries and for DSOs.

May the beneficiary questionnaire be administered telephonically?

The DSO is expected to administer the CMS questions as provided and will be required to report and transmit data to CMS for purposes of the evaluation. CMS will consider different modes of delivery for the questionnaire and will review this as part of the DSO's application during application review. More information about the administration and requirements of the questionnaire will be provided to DSOs during the pre-implementation period.

Please clarify how the 'evidence-based decision support' to be provided to beneficiaries (Step 2, DDS process) differs from patient decision aids as required by the ACO model program?

Decision support is a much broader statement relating to all of the activities a DSO will use to support beneficiary decision making with their provider, while a PDA is a specific tool that presents information about common medical choices.

What is the purpose of the beneficiary incentive in the DDS model? Who is providing the incentive, and what are the stipulations around how it should be administered? Can Prescription Drug Benefits Cards be used as the incentive payment?

To encourage beneficiary engagement, the model specifies that the DSO will provide a small incentive payment to beneficiaries who complete the decision support process in the form of a store gift card not to exceed $25.00 per occurrence or $50.00 per year. CMS will consider different incentives proposed by the DSOs as long as they are not cash or cash equivalents.

Would awarded DSOs be given the opportunity to modify organizational plans and outreach?

Applicants should submit a full and complete application to ensure it can be evaluated by CMS. Once submitted, no changes to the application can be made. CMS reserves the right to contact any applicant to clarify items within the application. During the period of model operations CMS will consider modifications to the organizational plans and outreach based on specific circumstances and information provided by the DSOs.

In the application, to whom should reference letters be addressed?

Reference letters may be addressed: To Whom It May Concern.

Where can I find the recording of the DDS Model Webinar: Overview and Letter of Intent Process?

The Direct Decision Support Model - Overview and Letter of Intent Process webinar recording is available on the DDS website: Beneficiary Engagement and Incentives: Direct Decision Support (DDS) Model Main Page

Where can I find the Direct Decision Support (DDS) Request for Application? Will DSOs be provided a form for the application? When will the Excel files in the RFA be made available?

The Direct Decision Support (DDS) Request for Application can be found at: https://app1.innovation.cms.gov/beidds or on the DDS website at: Beneficiary Engagement and Incentives: Direct Decision Support (DDS) Model Main Page

Where can I find the recording of the DDS Model: Application Process Webinar?

The Direct Decision Support Model - Application Process webinar recording is available on the DDS website at: Beneficiary Engagement and Incentives: Direct Decision Support (DDS) Model Main Page.

The following Frequently Asked Questions have been revised. Posted February 27, 2017.

Should additional Preference-Sensitive Conditions (other than the required 6) be proposed? If a DSO proposes a greater number of conditions to include in its outreach, does this immediately improve a DSO's chances of getting selected?

The intent of the DDS Model is for DSOs to address a broad range of acute and preference-sensitive conditions (PSCs) that affect a majority of the Medicare fee-for-service (FFS) population in its assigned geographic area. In addition to the required PSCs, DSOs will also propose to target a broader set of conditions or procedures for outreach to their awarded population. CMS may approve some, all, or none of the DSO's other proposed conditions/procedures. It is not a disadvantage to propose a long list of additional conditions. While it does not automatically increase an organization's chances of receiving an award, it will be taken into consideration along with their overall proposal for decision support.

Will CMS help DSOs identify existing decision aid libraries or decision aid developers to utilize/partner with in their pilots? Are DSOs expected to include all marketing materials and PDAs as part of the application packet?

It is the expectation that all DSOs will have experience with direct decision support and be able to implement the requirements of the model. CMS will review the proposed decision aids (PDAs) for approval, but will not provide assistance in developing the model. If actual PDAs or marketing materials are not already developed or available, applicants will need to describe their potential PDAs and any marketing materials for beneficiary recruitment as part of the DDS Model Request for Application, and make available the PDAs and marketing materials for approval by CMS during the implementation period starting in July.

Would the DSO receive notification from CMS on which condition(s) a beneficiary has in order to provide decision support? Is the 100,000 a general population of Medicare beneficiaries, regardless of condition?

DSOs will be provided a randomized general population of 100,000 Medicare beneficiaries that is not condition-specific and will likely include a variety of conditions. The DSO will receive a file of their assigned beneficiaries that will contain name and addresses only. No additional data from CMS will be provided.

What is the expected number of DDS awards, and could a DSO be awarded more than one market?

CMS will select 7 separate and distinct DSOs for 7 separate and distinct geographic areas. Each DSO will be randomly assigned a target population of 100,000 beneficiaries. Each DSO will be assigned to only one given geographic area by CMS.

Can you explain how the geographic regions are defined? Are they defined by CMS or by the applicant? If by the applicant, is there data we can access to use to propose the geographic area?

The geographic regions are defined by state and county. The applicant may propose the geographic region where they would prefer to operate. If they have no preference, applicants can state as such in the narrative portion of their application. CMS is not providing data for applicants to use to propose the geographic area.

Can medical providers, suppliers, or a Department of Health (Jurisdiction or State) serve as a DSO?

The DDS Model will select DSOs that have documented experience in providing evidence-based beneficiary-focused clinical information. Medical providers, suppliers, or government health agencies are not eligible to apply and participate as a DSO in the DDS Model.

Frequently Asked Questions Posted February 3, 2017

Who is eligible to apply for the Beneficiary Engagement Incentives (BEI) Direct Decision Support Model (DDS) Model?
CMS will consider Decision Support Organizations (DSOs) that have documented experience in providing evidence-based, beneficiary-focused clinical information and meet the criteria outlined in the RFA. This experience includes prior success engaging Medicare beneficiaries and impacting the utilization of health care services and cost. CMS will enter into participant agreements with DSOs that are selected.

In the DDS model, can an ACO be a DSO?
ACOs cannot participate in the DDS model.

How many LOIs can a DSO submit?
The online website will allow DSOs to create multiple LOIs; however, only one application per DSO may be submitted for CMS review.

Does the DSO need to be physically based in the geographic target area that the DSO serves?
No, the DSO does not need to be physically located in the geographic target area that the DSO serves.

One question on the LOI application asks what geographic boundary the DSO prefers to operate in. If the organization has no preference, is this a disadvantage or an advantage? Can the organization also request urban vs. rural or other characteristics rather than specific locations?
It is not a disadvantage to list several geographic areas. However, organizations listing several geographic areas may have a greater opportunity to contribute to portions of the country not listed by other applicants. Geographic locations are defined by county and state only.

Are applicants required to have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number in order to apply?
The D&B DUNS will be needed to conduct due diligence on the DSO. All organizations are required to register in the System for Award Management (SAM) which requires the organization to have a DUNS, however, it is not needed to submit the application.

What is the CMS helpdesk email to contact with log-in or other technical questions?
Applicants should contact: CMMIForceSuport@cms.hhs.gov or call 1-888-734-6433 and select “option 5” for log-in or other technical issues.

What is the deadline for LOI and applications?
The LOI deadline is 5:00 PM on March 5, 2017. The application deadline is 11:59 PM March 5, 2017.

When will awards be made and the DDS Model begin?
The Innovation Center anticipates that awards will be made in June with the pre-implementation period beginning in July 2017. The model will begin January 1, 2018. A public announcement of the awardees will be made in June.

What is CMS’s definition of beneficiary engagement for purposes of implementing the DDS Model?
For purposes of the DDS Model, beneficiary engagement is defined as a beneficiary participating in the model by completing the decision support process on the website (or phone) and being offered a brief questionnaire.

What engagement rate is required for the model?

DSOs will need to meet a minimum 3.5% target engagement rate in year one and 7% in year two of the DDS model's operation. By the engagement rate, CMS means that 3.5% and 7% of the assigned beneficiary population will complete the DDS process for one or more conditions in a given year.

How will data be reported to CMS?

DSOs will report data electronically each month to CMS, therefore DSOs must have the capability to electronically transmit all required data to CMS and its contractors. CMS will provide further guidance and detail on this process through its participant agreements with DSOs. CMS is currently considering transfer of files with DSOs via a CMS- approved electronic file transfer process but this approach has not been finalized.

What reporting is required of DSOs who receive the funding award?

The data required to be transmitted will be the minimum necessary to operate and evaluate the model, such as, but not limited to, beneficiary process information, beneficiary questionnaire results, and financial information on beneficiary incentives.

How will the payments be made and at what frequency?

DSOs will receive a fixed population-based payment in the form of a per beneficiary per month payment (PBPM) for beneficiaries in the geographic area assigned to them. DSOs will be provided a PBPM payment at 75% of the negotiated PBPM rate. The remaining 25% will be an annual holdback. CMS may pay the remaining 25% to DSOs on a semi-annual basis as a performance incentive payment based on beneficiary engagement rates and the quality of the direct decision support process.

Is the DDS paid the rate for all the beneficiaries in the region or just those who take advantage of the program?

CMS will pay the DSO a PBPM payment for all 100,000 beneficiaries assigned to them, which includes beneficiaries that take advantage of the program, as well as those beneficiaries that do not take advantage of the program.

Will the payment rate change during the course of the DDS Model?

No, CMS will specify the PBPM rate in its participant agreement with the DSO and this payment rate will not change during the model's operation.

Will CMMI set per member per month (PMPM) reimbursement for DSOs or will DSOs be expected to submit a proposed PMPM as part of their application? If the former, what is the PMPM set by CMMI?

DSO's will be expected to submit a proposed PBPM. PBPM rates in similar CMS projects have varied from $0.50 to $3.00 PBPM. CMS expects PBPM rates under the DDS Model to be comparable to CMS's prior experience.

Will organizations with telephonic support for SDM (either through live coaches and/or IVR) have preference in the selection process over organizations that support web/mobile and/or print but do not have telephonic delivery? If yes, is there a strong preference for live coaching over IVR support?

Since there are many different approaches to SDM we have no preference of one method over another. All approaches will be considered.

Is the incentive required? Meaning, if the DSO can get people to engage, must there be an incentive payment?

Yes, it is required.

What expectations are there for the DSO regarding distribution of incentives? May the DSO partner with a third party to manage the incentive payments?
Yes, DSOs may partner with third party vendors and should identify them and their role in the model within their application. DSOs will be required to report the number of beneficiaries receiving incentives. Incentives will be paid by the DSO, or its vendor, after completion of the questionnaire.

How long is and what are the questions in the post-decision support questionnaire? Does CMS expect that the questionnaire will be delivered immediately following the completion of the decision aid or at some later time? Will the questionnaire need to be completed in order for the organization to get engagement credit for that beneficiary, or is completion of the decision aid sufficient?
The questionnaire is a short, five minute, CMS-developed instrument that will contain demographic, process and outcome questions. The DSO will be required to offer the beneficiary the questionnaire once the beneficiary has completed the DSO's DDS process. The DSO must implement and integrate the questionnaire within its decision support process (i.e. CMS will provide the questions, but the DSO will carry out the administration). The beneficiary does not have to complete the questionnaire for the DSO to be given engagement credit, but must provide proof the questionnaire was offered to the beneficiary. This information will be reported on a monthly basis and audited by CMS.

There is a reference to 'Model Participant Agreement' under 'Payment'. Could we review a copy?
The Model Participation Agreement (MPA) will be shared once DSOs are selected.

When will further detail be available regarding the specifics of the measures?
More information will be forthcoming during the pre-implementation period.

There is no SDM training mentioned for SDM practitioners with DSOs like there is for ACOs. Is there an expectation that eligible DSOs seek such training as such scaled efforts have not been done before?
CMS will not provide shared decision making training to DSOs, as they are expected to be currently delivering these types of services.

Will the awards be all at once or on a rolling basis?
All awards will be announced at once.

How will beneficiaries be assigned to a DSO? How will randomization be done?
CMS will use the Medicare FFS enrollment database to identify all beneficiaries in the predetermined geographic area that are eligible to participate in the DDS Model and will randomly assign each selected beneficiary to either an intervention or comparison group. CMS will provide the DSO with enrollment information for at least 100,000 beneficiaries randomly assigned to the intervention group.

Is there a specific model that we need to use? Or are there recommended models? Or are we creating the model?
CMS provides requirements for the decision support to be tested in the DDS Model. However, additional details, such as how DSOs conduct outreach to engage beneficiaries, what protocols are used for providing decision support, what decision support materials are to be used, and the method of engagement (e.g., phone, web) should be proposed by the applicant and must be approved by CMS.

Frequently Asked Questions Posted December 8, 2017

What is the authority for the BEI Model?

Section 1115A of the Social Security Act (the Act) (42 U.S.C. 1315a) (as added by Section 3021 of the Patient Protection and Affordable Care Act of 2010 (hereinafter "ACA") authorizes the Innovation Center to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and Children's Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

How is the term beneficiary engagement used in the BEI model?

Beneficiary engagement broadly refers to the actions and choices of individuals with regard to their health and health care, and how CMS can facilitate these decisions to best improve quality, patient experience, and spending outcomes. The BEI Models focuses on shared decision making, including the use of patient decision aids (PDAs), tools that present information about common medical choices, and the provision of a variety of health care decision support services.

What is Shared Decision Making?

Shared Decision Making is a process of communication, deliberation, and decision making that includes sharing information with the beneficiary by outlining treatment options, including potential harms, benefits, and alternatives; eliciting and supporting the beneficiary's values and preferences; maintaining an interactive and meaningful dialogue based on the best medical evidence tailored to the beneficiary's condition; and making an optimal decision that takes into account the evidence on options, practitioner/care team expertise, and the beneficiary's values and preferences.[1,2]

What approaches will the BEI Model test?

The Model will test two approaches: The Shared Decision Making Model (SDM Model) will test an approach to supporting beneficiaries in shared decision making delivered by practitioners within the patient's usual site of care. In this model, the shared decision making process is a collaboration between the beneficiary and the practitioner.

The Direct Decision Support Model (DDS Model) will test an approach to shared decision making provided outside of the usual site of care by an organization that provides health management and decision support services that will contact beneficiaries directly.

What is the Direct Decision Support Model?

The Direct Decision Support (DDS) Model aims to engage beneficiaries and provide information about their medical conditions through a Decision Support Organization (DSO), an organization that does not furnish health care services. The DDS Model will test if this design results in beneficiaries' satisfaction with their care decisions while maintaining or improving quality and either reducing or keeping neutral Medicare spending.

What is the objective of the DDS Model?

This model is designed to test whether engaging beneficiaries about their overall health and specific clinical conditions outside the clinical care setting will enable beneficiaries to become more informed, empowered, and engaged healthcare consumers and have a positive impact on their health care decision making, utilization patterns, and cost of care. The model will not interfere with the physician-patient relationship.

The focus of the DDS Model is to provide beneficiaries with patient friendly material that educates them about their condition and encourages them to have a conversation with their practitioners about what care is best for them.

What are the steps in the DDS model?

Although the DDS Model is designed to be sufficiently broad to capture various delivery mechanisms of decision support, CMS will require that all DSOs follow a DDS process that includes: conducting beneficiary outreach, providing decision support and having the beneficiary complete a post-decision support survey.

What is the target population for the DDS Model?

Decision support under the DDS Model will be offered to Medicare FFS beneficiaries in a given DSO's assigned geographic areas who are entitled to Part A and enrolled in Part B, and who are not enrolled in a Medicare Advantage or PACE plans. The DDS Model will permit inclusion of people eligible for both Medicare and Medicaid, for whom Medicare is the primary payer.

What is a DSO?

DSOs do not provide medical advice and/or treatment, but assist beneficiaries by providing them with additional unbiased information about their medical condition(s). The participating DSOs may be commercial firms that already provide similar health information and decision support services to insured populations. DSOs will not include clinical providers or suppliers. CMS will select DSOs that have documented experience in providing evidence-based, beneficiary- focused clinical information. A successful applicant will have prior success engaging Medicare beneficiaries and impacting the utilization of health care services and cost. CMS will seek established DSOs with a record of accomplishment working with adults, including dually eligible and disabled populations.

Will DSOs be practicing medicine?

DSOs are not practicing medicine. They will not diagnose, recommend or prescribe treatment in any way. DSOs may not make referrals or otherwise engage in actions that favor any particular clinical practitioner or supplier. DSOs do not take a position as to whether someone should or should not have a procedure, or what treatment is best. This approach is necessary and intentional to ensure the interventions under this model are not misperceived as an attempt to coerce or ration care. DSOs will focus on providing information that encourages beneficiaries to take an active role in their care and improve the dialogue with their practitioner.

What is the purpose of the beneficiary incentive in the DDS model? Who is providing the incentive, and what are the stipulations around how it should be administered?

To encourage beneficiary engagement, the model specifies that the DSOs will provide a small incentive payment to beneficiaries who complete the decision support process in the form of a store gift card. Beneficiaries that have completed the DDS process will be administered a survey to capture their experience and earn the incentive.

What are the conditions that the DDS Model targets?

CMS will require all DSOs to target the same preference-sensitive conditions as in the SDM model: stable ischemic heart disease, hip osteoarthritis, knee osteoarthritis, herniated disk or spinal stenosis, clinically localized prostate cancer (cancer that is confined to the prostate gland) and benign prostate hyperplasia. In addition, the DSOs may propose and use a broader set of conditions for outreach to their awarded population, and CMS will require the DSOs to list these conditions in their application. Examples of other potential chronic conditions include cardiovascular conditions, diabetes, or chronic obstructive pulmonary disease (COPD).

What is a Preference-Sensitive Condition?

A Preference-Sensitive Condition is a medical condition for which the clinical evidence does not clearly support one treatment option, and the appropriate course of treatment depends on the values or preferences of the beneficiary regarding the benefits, harms, and scientific evidence for each treatment option.[3]

Will the DDS model affect a beneficiary's relationship with their physician?

The DDS Model uses DSOs to engage beneficiaries in decision-making regarding possible treatment options, an approach currently being used by many other payers, including managed care organizations and commercial insurers. It is not the intention of CMS to interfere with the practitioner-patient relationship. The focus of the DDS Model is to provide beneficiaries with evidence-based, patient-friendly material that educates them about their condition and encourages them to have a conversation with their practitioners about what care is best for them.

What is the period of performance for DSOs participating in the DDS Model?

CMS will initially award two year agreements for operations. During this initial two-year period, data will be collected from DSOs to determine monthly payments, track initial indicators of engagement performance, and operate an implementation and monitoring system. These operational tasks will be specified in the Model Participant Agreement (MPA). Up to three subsequent annual renewal agreements may be awarded and will be contingent on meeting the specified 7% engagement rate and other milestones contained in the MPA with DSOs. The model will operate for up to five performance years.

How will CMS monitor DSO performance and capture beneficiary experience in the DDS Model?

CMS will collect and review operational data and performance metric data submitted by the participating DSOs to assess DSO performance in the DDS Model. In addition, beneficiaries will be asked to complete a questionnaire that captures their experience. The questionnaire will contain both process and outcome questions.

What type of payment do the participating DSOs receive in the DDS model?

DSOs will be paid on a population-based payment structure for beneficiaries in the intervention group and will receive a fixed per beneficiary per month (PBPM) payment for each beneficiary in the geographic region assigned to them. DSOs will receive a semi-annual incentive payment if they meet specified performance metrics (i.e. organizations that achieve the required engagement rate and achieve a score of at least 50% on the quality score).

Is there an incentive for DSOs to perform requirements of the DDS Model?

CMS will operate a process to provide performance incentive payments to DSOs that are successfully engaging Medicare beneficiaries. The amount of the performance incentive payment will depend on the performance of each DSO. Performance metrics will be standardized across DSOs and be derived from self-reported DSO Medicare beneficiary and operational metrics.

Examples of potential categories for the DDS Model performance measures may be:

- Beneficiary Engagement Rate
- Feedback from the beneficiary about the quality of the direct decision support process

Final performance measures may be specified in the MPA. CMS will develop a process to measure and pay the 25% hold back incentive to the DSOs as explained below. Under the example, CMS would allocate 50% of the hold back amount (12.5% points) for organizations that successfully achieved the required engagement rate, and the remaining 12.5% points to organizations that achieved high quality based on data from the beneficiary questionnaire. Under the example, the DSO must achieve a score of at least 50% on the beneficiary feedback quality score in order to get any payment for quality.

How will the DDS model be characterized under the Quality Payment Program?

The DDS Model will be operated by non-providers/suppliers; therefore, the Quality Payment Program is not applicable to the DDS model.

How will beneficiaries know they are in the model?

Once a beneficiary makes contact with the DSO and gains access to the DSO's educational and informational items, the beneficiary is considered to be in the model.

Can beneficiaries opt out of the DDS Model?

Beneficiaries may opt out of the DDS model and never be contacted again by the DSO if they desire. They may opt out by either directly contacting the DSO, or by contacting 1-800-Medicare. All beneficiaries assigned to a DSO will receive a letter (on CMS letterhead) informing them of the DDS project and listing options for opting out of the project. CMS will monitor DSO's compliance with opt-out to ensure each beneficiary's choice to participate is respected.

How do DSOs apply to participate in the DDS Model?

DSOs who are interesting in participating in the DDS Model must submit an electronic, non-binding Letter of Intent (LOI). The LOI submission period begins on December 2, 2016 and closes on March 5, 2017.

Only DSOs that submit timely and completed LOIs will be eligible to submit an application. The application period begins on January 28, 2017 and closes on March 5, 2017. Applications must be completed online using an authenticated web link and password, which will be emailed to applicants upon submission of a complete LOI. Submission of PDF versions of the LOI or applications will not be accepted.

Where can interested parties access the LOI form?

The link to the DDS LOI form is available on the BEI website.

When can applications be submitted?

The application period begins on January 28, 2017 and ends on March 5, 2017.

Who do I contact if I have questions?

Questions about the model can be directed to: DDSmodel@cms.hhs.gov

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[1] Alston, C., Berger, Z. D., Brownlee, S., Elwyn, G., Fowler Jr., F. J., Hall, L. K., Montori, V. M., Moulton, B., Paget, L., Shebel, B. H., Singerman, R., Walker, J., Wynia, M. K., & Henderson, D. (2014). Shared Decision-Making Strategies for Best Care: Patient Decision Aids. Institute of Medicine.

[2] The SHARE Approach. (2015) AHRQ. < http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/>

[3] O'Connor AM, Llewellyn-Thomas HA, Flood AB. "Modifying Unwarranted Variations In Health Care: Shared Decision Making Using Patient Decision Aids." Health Aff (Millwood). 2004 Suppl. Web Exclusive: VAR63-72. October 7, 2004.