



Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Seamless Care Models Group



Beneficiary Engagement and Incentives Models—Direct Decision Support  
(DDS Model)

Request for Application (RFA)

Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
Beneficiary Engagement and Incentives Models - Direct Decision Support (DDS)

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## I. Background

The Centers for Medicare & Medicaid Services (CMS) identifies strengthening beneficiary engagement as one of the agency’s goals to help achieve better care, smarter spending, and healthier people. Specifically, the “CMS Quality Strategy envisions health and care that is person-centered, provides incentives for the right outcomes, is sustainable, emphasizes coordinated care and shared decision making, and relies on transparency of quality and cost information.”<sup>1</sup>

Shared decision making (SDM) can ensure that treatment decisions better align with beneficiaries’ preferences and values for many preference-sensitive conditions, without one clearly superior course of treatment. Despite the inherent value of SDM, research studies in peer-reviewed scientific literature and experts in the field of SDM indicate that it has been difficult for practitioners to integrate SDM into routine care delivery. These difficulties are often because of overburdened staff, insufficient training, inadequate clinical information systems, lack of consistent methods to measure that SDM is taking place, and uncertainty as to whether, or how, to promote change and invest in the time, tools, and training required to achieve meaningful SDM.<sup>2,3,4</sup>

One facet of SDM is the use of patient decision aids (PDAs)—tools that present information about common medical choices. Although significant research has demonstrated the potential impact of decision aids, these tools do not supplant physician-patient conversations about treatment options; rather, they supplement and/or encourage it by better preparing patients to engage in that conversation. Providing information directly to patients about their health decisions acknowledges that patients formulate their decisions about their medical conditions outside of the clinical setting, as well as inside the practitioner’s office.

CMS is testing the direct decision support model (DDS Model), which aims to engage Medicare beneficiaries and provide them with information about their medical conditions through Decision Support Organizations (DSOs), by an organization that provides health management and decision support services. The DDS Model provides a population-based payment to participating

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<sup>1</sup> Centers for Medicare & Medicaid Services. Quality Strategy, pp. 2. (2016).

<sup>2</sup> Agency for Healthcare Research and Quality. (2015). Overcoming Barriers To Shared Decision Making [PowerPoint slides].

<sup>3</sup> Friedberg, M. W., Busum, K. V., Wexler, R., Bowen, M., & Schneider, E. C. (2013). A Demonstration Of Shared Decision Making In Primary Care Highlights Barriers To Adoption And Potential Remedies. *Health Affairs*, 32 (2), 268-275. doi: 10.1377/hlthaff.2012.1084 [doi]

<sup>4</sup> Légaré F, Ratté S, Gravel K, Graham ID. Barriers and facilitators to implementing shared decision-making in clinical practice: update of a systematic review of health professionals' perceptions. *Patient Educ Couns*. 2008 Dec; 73(3):526-35. PMID: 18752915.

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DSOs that are responsible for engaging an assigned population of Medicare FFS beneficiaries in ongoing communications and medical decision support on behalf of CMS. The participating DSOs may be commercial firms that already provide similar health information and decision support services to insured populations. Participating DSOs will have some discretion under the model in the methods they may use for engaging and supporting beneficiaries in their assigned population. To encourage beneficiary engagement, the model specifies that the DSO will provide a small incentive payment in the form of a store gift card to beneficiaries who complete the decision support process.

**For More Information please visit the Innovation Center webpage at <https://innovation.cms.gov/initiatives/Beneficiary-Engagement/>**

## **II. Statutory Authority**

### **A. General Authority to Test 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 Center for Medicare & Medicaid Innovation (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.

### **B. Financial and Payment Model Authorities**

Section 1115A(b)(2) of the Act requires the Secretary to select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The statute provides a non-exhaustive list of examples of models that the Secretary may select, which includes a model to assist individuals in making informed health care choices by using patient decision-support tools, including tools that meet the standards developed and identified under section 936(c)(2)(A) of the Public Health Service Act, that improve applicable individual and caregiver understanding of medical treatment options.

### **C. Fraud and Abuse Waiver Authority**

Under section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out section 1115A with

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respect to testing models described in section 1115A(b). For this model and consistent with this standard, the Secretary may consider issuing waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act. No fraud or abuse waivers are being issued in this document; fraud and abuse waivers for the DDS Model, if any, would be set forth in separately issued documentation. Notwithstanding any provision of this proposal, individuals and entities must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to section 1115A(d)(1) specifically for the DDS Model. Any such waiver issued in connection with the DDS Model would apply solely to that particular model and could differ in scope or design from waivers granted for other programs or models.

Additionally, CMS provides no opinion on the legality of any contractual or financial arrangement that the award recipients, sub-award recipients, practitioners, affiliated entities or any other relevant individuals or entities may propose, implement, or document. The receipt by CMS of any such documents in the course of the application process or otherwise shall not be construed as a waiver or modification of any applicable laws, rules or regulations, and will not preclude CMS, HHS or its Office of Inspector General, a law enforcement agency, or any other federal or state agency from enforcing any and all applicable laws, rules and regulations.

### **III. Model Design**

#### **A. Intervention**

The DDS Model seeks to engage Medicare beneficiaries outside of the traditional clinical care setting. The DDS Model will help beneficiaries identify their own personal values and priorities regarding their care. 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 health care 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.

CMS will determine whether this results in beneficiaries who feel they have made better decisions about their care while saving money for the Medicare Program or keeping expenditures neutral. The DDS Model will engage an assigned population of Medicare Fee-for-Service (FFS) beneficiaries through ongoing communications and medical decision support on behalf of CMS. Examples of methods are cited in Table 1 below.

DSOs will be required to guard all patient identifiable data using strict adherence to applicable privacy laws. They will be required to allow any beneficiary to opt out of the model, and in that

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case, the beneficiary will not be contacted again by the DSO. The beneficiary may opt out by either directly contacting the DSO, or by contacting 1-800-Medicare. Beneficiaries will also be able to confirm a DSO’s participation in the initiative by contacting 1-800 Medicare. DSOs will be monitored by CMS and its implementation contractor to assure that these requirements are strictly observed.

Organizations that participate in the DDS Model will advertise the model through direct mail to Medicare FFS beneficiaries who are assigned to the DSO by CMS. They may also use direct phone contact to introduce and explain the service. If the beneficiary would like to access the DDS services, they will reach out to the DSO by connecting to the website online, or through a phone call to the DSO. Please see section III D below for further details.

Although the DDS Model is designed to be sufficiently broad to allow various delivery mechanisms of decision support, it will require that all participating DSOs follow the complete DDS process, described in Table 1.

**Table 1. DDS Process**

<b>Step</b>	<b>Goals</b>	<b>Methods</b>	<b>Expectations of Participating Organizations</b>
Beneficiary Outreach	<ul style="list-style-type: none"> <li>● Establish contact with beneficiaries in assigned population</li> <li>● Market decision support services</li> <li>● Announce incentive to engage beneficiaries</li> <li>● Notify beneficiaries of option to opt-out and explain the opt-out process</li> </ul>	<ul style="list-style-type: none"> <li>● Postal mailings and telephone calls</li> </ul>	<ul style="list-style-type: none"> <li>● Prior experience with beneficiary recruitment using CMS and third party data</li> <li>● Experience with various communication models/methods</li> <li>● Strict adherence and documentation of beneficiary requests for opt-out</li> </ul>
Provide Decision Support	<ul style="list-style-type: none"> <li>● Provide condition-specific support for approved conditions/surgeries</li> <li>● Assess and/or collect beneficiary preferences, values, and health conditions to provide meaningful decision support</li> </ul>	<ul style="list-style-type: none"> <li>● Condition-specific decision support, evidence based decision support, that is web based, paper, a mobile application, or telephonic</li> <li>● Trained staff and/or certified tools to assess preferences, etc.</li> </ul>	<ul style="list-style-type: none"> <li>● Evidence-based decision support that has been vetted and previously deployed</li> </ul>

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Step	Goals	Methods	Expectations of Participating Organizations
Post-Decision Support	<ul style="list-style-type: none"> <li>• Assess quality of support and decision making process</li> <li>• Distribute beneficiary incentive to beneficiary</li> </ul>	<ul style="list-style-type: none"> <li>• Beneficiary questionnaire (paper, web-based, etc.)</li> <li>• Financial processing of beneficiary incentives/store gift cards</li> </ul>	<ul style="list-style-type: none"> <li>• DSO is required to report and transmit data to CMS for purposes of the evaluation and DSO payments/monitoring</li> </ul>

**B. Eligible Decision Support Organizations**

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 cost. CMS will seek established DSOs with a record of accomplishment working with adults, including Medicare-Medicaid enrollees and disabled populations. Each DSO selected will sign a Model Participation Agreement (MPA) with CMS establishing the necessary terms and conditions of participation in the model, including HIPAA business associate agreement provisions.

The focus of the DDS Model is to provide beneficiaries with evidence-based patient education material that educates them about their condition and encourages them to have a conversation with their practitioners about what care is best for them based on their values and preferences. CMS will not allow any interventions under this model that could be viewed as coercive or as a mechanism to ration care.

The DSOs will not include providers and suppliers. They will not diagnose, recommend or prescribe treatment in any way. DSOs will not take a position as to whether someone should or should not have a procedure or what treatment is best. They will provide information that encourages beneficiaries to take an active role in their own care and also improve the dialogue with their practitioner; the DSO will not interfere with the practitioner-patient relationship, but encourage it. Also, the DSOs may not make referrals or otherwise engage in actions that favor any particular provider or supplier. DSOs may provide this information using a variety of approaches, including web sites, information through direct mail, telephone advice lines, and instant messaging.

**C. Geographic Location**

DSOs will propose and apply for a geographically based-population (e.g., state and/or region). Only one DSO will be selected for a given geographic area. For the purposes of this model, a geographic area is defined as a metropolitan city, multiple cities or counties within a state, or

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multiple states with contiguous borders. CMS may give preference to applicants that apply for underserved areas or that prioritize vulnerable, high-cost, rural, or non-English speaking beneficiaries.

The DDS Model expects to reach 700,000 Medicare FFS beneficiaries annually, with no less than 100,000 Medicare FFS beneficiaries assigned to each DSO. CMS will have the right to approve or modify these areas based on demographics and other factors to ensure that they are balanced and representative of the Medicare FFS population. CMS plans to provide beneficiary names and addresses to the DSO for their geographic area. To the extent possible, DSOs will not be assigned to the same geographic areas as ACO participants in the SDM model. The evaluation will include a random sample of all beneficiaries assigned in the DSO's geographic area, not limited by health status, to assess the DDS Model's impact.

**D. Randomized Assignment of Beneficiaries**

CMS will use the Medicare FFS enrollment database to identify all beneficiaries in the assigned geographic area that are eligible to participate 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 assigned to its intervention group. Within the same assigned geographic area, a CMS evaluator will retain a control group sample equal in size. The use of randomized comparison groups will assist the evaluator to design a statistically strong research design to determine the impact of the model.

CMS will provide the minimum necessary data to DSOs (e.g., beneficiary name, address) for the purposes of targeted outreach in accordance with all applicable laws and regulations, including the Privacy Act, the Health Insurance Portability and Accountability Act (HIPAA) and Federal Information Security Management Act (FISMA) data regulations. The DSO will sign a HIPAA business associate agreement (as required by the Model Participant Agreement (MPA)) in order to receive and use these data. The MPA will set forth the approved uses of these data in detail. Monitoring DSO's use of these data will be carried out through the CMS data use tracking system.

**E. Beneficiary Eligibility, Assignment & Opting Out**

Decision support under the DDS Model will be offered to Medicare FFS beneficiaries in the predetermined geographic areas who are entitled to Part A and enrolled in Part B, and who are not enrolled in a Medicare Advantage plan. Medicare must be the beneficiary's primary payer, but the DDS Model will permit inclusion of people eligible for both Medicare and Medicaid. There will be no exclusions based on disability status. Beneficiaries will not enroll in the model, but will be randomly assigned to an intervention or comparison group. A beneficiary assigned to the intervention group may be contacted by the DSO, but this will not be the case for comparison group beneficiaries.

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The beneficiaries in the comparison group will only be known by CMS and the independent evaluation contractor, and their Medicare payment records will be available for evaluation purposes only (e.g., information on health care expenditures and utilization). These beneficiaries will not be aware that they are in the comparison group.

As described elsewhere, CMS will develop and monitor a process that will enable the beneficiaries who wish not to participate in the DDS Model to opt out. Assignment to an intervention or comparison group, or opt out from further contact by a DSO, will not impact the Medicare services that a beneficiary is otherwise eligible to receive. The intervention group beneficiary may simply ignore the DSO's mailing if they do not want to participate, and may contact the DSO or call 1-800-Medicare to opt out if they do not want to get any further contacts.

#### **F. Beneficiary Engagement Levels**

Beneficiary engagement is defined as a beneficiary participating in the model by completing the decision support process on the website (or phone) and offered a brief questionnaire. CMS expects that DSOs will achieve various levels of engagement depending on the population targeted, the impact of marketing materials, and the skill of the DSO in reaching out to the targeted population. Reported experience ranges from 3% to 11% engagement.<sup>5</sup> CMS has chosen a 7% target engagement to be attained by all DSOs in the second year of the model's operation. By the engagement rate, CMS means that 7% of the assigned beneficiary population will complete the DDS process on one or more conditions in a given year. CMS will hold the DSOs accountable for meeting this engagement rate, and the performance incentive payment to the DSOs will be partially based on the engagement rate of the assigned population (see Payment subsection below). For the first year, each DSO will be required to meet 50% of their engagement rate or 3.5%. Beginning in year two, DSOs will be held accountable for the entire 7% engagement rate (see Section IV, Payment).

#### **G. Beneficiary Incentives**

To reach desired levels of beneficiary engagement, the DSOs will utilize in-kind incentives and/or store gift cards. DSOs will not be allowed to offer cash or cash equivalents, such as VISA gift cards. DSOs will employ mechanisms that have shown promise in the disciplines of behavioral economics and psychology, such as education, defaults, and commitment devices, as well as non-monetary rewards. The mechanisms and plans for behavioral incentives must be approved by CMS prior to the start of the project. Modifications may be made during the project, but are subject to CMS review and approval before being made. CMS will develop criteria for appropriate use of these behavioral mechanisms to avoid arbitrary choices and to encourage

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<sup>5</sup> Evaluation of the Shared Decision Making (SDM) & Medication Management (MM) Health Care Innovation Awardees, Quarterly Report 6, June 16, 2015.

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mechanisms that assist beneficiaries in making health decisions that are aligned with their own values. DSOs will consider the strategic use of different kinds of in-kind incentives and/or store gift cards, the timing of these incentives, and the size of the incentives. DSOs will provide the approved forms of incentives up to \$25 per engagement, subject to a maximum of \$50 per year per beneficiary. Costs of any incentive programs need to be included in the DSO's per beneficiary per month (PBPM) proposed rate. Because the DSOs will distribute the in-kind incentives and/or store cards directly, CMS is not required to use a payment contractor for payments of these incentives to beneficiaries.

## **H. Targeted Conditions**

The intent of the DDS Model is for DSOs to address a broad range of acute and chronic conditions that affect a majority of the Medicare FFS population in its assigned geographic area.

CMS will require all DSOs, at the minimum, to target the following Preference-Sensitive Conditions (PSC):

- 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)
- Benign prostate hyperplasia

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. Examples of other conditions include other procedures plus chronic medical conditions such as cardiovascular conditions, diabetes, or chronic obstructive pulmonary disease (COPD).

## **IV. Payment**

### **A. Payments**

DSOs will receive a population-based payment for beneficiaries in the intervention group in the form of a fixed PBPM payment. CMS believes a capitated payment approach is appropriate because DSOs will be required to reach out to a large population in the assigned geographic region and provide decision support to all assigned beneficiaries who wish to participate. This PBPM payment will be made outside of the standard Medicare FFS claims system. The DSOs will propose the PBPM rate in their application. CMS may agree to different proposed rates from

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various applicants based on their applicants' proposed technical approach. As in all solicitations, the CMMI selection panel may negotiate regarding both price and technical approach on the entire proposal for any reason that it believes would improve the agreement for the Government. 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. 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 (see Section B below). The payment rate will not change during the operation of the model.

## **B. Performance Incentive Payments**

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. 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.

### **Beneficiary Engagement Rate**

CMS will require the DSOs to achieve a beneficiary engagement rate of 7%. A beneficiary will count toward the established engagement rate when the beneficiary completes the DDS process (see Table 1). For the first year, each DSO will be required to meet 50% of their engagement rate or 3.5%. Beginning in Year Two, DSOs will be held accountable for the entire 7% engagement rate. The beneficiary engagement rate metric will be determined as:

- Numerator: Engaged beneficiaries assigned to the DSO who complete the DDS process outlined in Table 1.
- Denominator: Total number of beneficiaries in the intervention group assigned to the DSO.

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## **Beneficiary Experience**

The DSO will be required to administer a CMS-designed questionnaire to beneficiaries that have completed the DDS process. This questionnaire may include, for example, the following three domains: beneficiary knowledge about treatment choices, beneficiary treatment choice concordance, and beneficiary satisfaction with the direct decision support process. The questionnaire may also include self-reported demographic information, such as education and socio-economic status. More information will be made available to selected DSOs in the MPA.

## **Data Reporting**

The DSOs must have capability to electronically transmit all required data to CMS and its contractors. The data to be sent to CMS by DSOs will be specified in the DDS MPA with CMS. The data required to be transmitted will be the minimum necessary to operate the model. Data will include, but will not be limited to:

- Beneficiary process information, such as whether or not the beneficiary engaged with the DSO and its health and medical treatment information. Any information regarding beneficiary process that is collected must be authorized by the beneficiary in accordance with HIPAA requirements specified in 45 C.F.R. § 164.508;
- Beneficiary identifiers such as Medicare ID;
- Beneficiary experience survey results; and
- Financial information on beneficiary incentives and PBPM payments.

Data provided to the DSO will be the minimum necessary to operate the project and will most likely include beneficiary name and address. The DSOs will be required to strictly adhere to all applicable laws and regulations, including the Privacy Act, HIPAA, and Federal Information Security Management Act regulations.

## **C. Beneficiary Incentive Payments**

To reach desired levels of beneficiary engagement, the DSOs will utilize in-kind incentives and/or store gift cards. DSOs will not be allowed to offer cash or cash equivalents, such as VISA gift cards. DSOs will employ mechanisms that have shown promise in the disciplines of behavioral economics and psychology, such as education, defaults, and commitment devices, as well as non-monetary rewards. The mechanisms and plans for behavioral incentives must be approved by CMS prior to the start of the project. Modifications may be made during the project, but are subject to CMS review and approval before being made. CMS will develop criteria for appropriate use of these behavioral mechanisms to avoid arbitrary choices and to encourage mechanisms that assist beneficiaries in making health decisions that are aligned with their own values. DSOs will consider the strategic use of different kinds of in-kind incentives and/or store gift cards, the timing of these incentives, and the size of the incentives. DSOs will provide the

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approved forms of incentives up to \$25 per engagement, subject to a maximum of \$50 per year per beneficiary. Costs of any incentive programs need to be included in the DSO's PBPM proposed rate. Because the DSOs will distribute the in-kind incentives and/or store cards directly, CMS is not required to use a payment contractor for payments of these incentives to beneficiaries.

## **V. Award Period**

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 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 total. The model will start approximately six months after all selected DSOs execute a MPA with CMS by a date specified by CMS. This six month pre-implementation period will allow time for planning, hiring staff at DSOs, setting up payment methods at CMS, and a myriad other development and preparation tasks at both CMS and the DSOs.

During the six-month pre-implementation period, DSOs will work with CMS and its contractors to establish data and payment transmission processes. In addition, this six-month period will allow DSOs and CMS time for planning, hiring staff at DSOs, and other development and preparation tasks.

CMS may, in its sole discretion, terminate the DDS MPA at any time and without prior notice if there are any fraud and abuse concerns with the DSO, sub-contractors, or any employee of the organization. If any problems are found with a DSO, sub-contractors, or its employees, CMS will first attempt to resolve the issue through remedial action, including discussions with the DSO. This remedial action may include requiring the submission and implementation of a corrective action plan (CAP) by the DSO. Details of this remediation process and related monitoring enforcement will be set forth in the MPA. In cases where a DSO is unable or unwilling to make corrections, has poor performance metrics and/or is not meeting other terms and conditions of the MPA, CMS may consider terminating the MPA or consider non-renewal of the DSO.

## **VI. Evaluation**

CMS, under contract with an independent evaluator, will conduct an independent evaluation of the DDS model. The goal of the evaluation is to determine whether the model improves the quality of care without increasing spending; reduces spending without reducing quality of care; or improves the quality of care and reduces spending. The evaluation should address what aspects of the model contribute most to success, how contextual factors influence this success, and what considerations should influence decision making on whether to modify, terminate, or

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expand the model. The evaluation results will be used to inform programmatic policy decisions. All DSOs in the DDS Model will be required to cooperate with the evaluation, which may include participation in questionnaires, interviews, site visits, and other activities that CMS determines necessary to conduct a comprehensive, formative, and summative evaluation. If a DSO does not meet the performance requirements or provide the data necessary to complete the evaluation of all outcome measures, CMS may terminate the agreement with the DSO.

## VII. Application Process

### A. Letter of Intent (LOI)

Interested organizations must submit a LOI no later than 5:00 PM EST March 5, 2017. Letters of Intent are required before an organization may submit an application. The LOI will not bind an interested organization to moving forward under the Model. Appendix B contains a LOI template. The LOI must be submitted online to be considered. To file an LOI, interested organizations may access an electronic portal at <https://app1.innovation.cms.gov/beidds/>.

### B. Application

CMS will only consider applications for the DDS Model from applicants that have submitted an LOI. Applications must be submitted by 11:59 PM EST March 5, 2017. The application must be completed online to be considered. Applicants may access the application portal at <https://app1.innovation.cms.gov/beidds/>. Appendix C contains an application template so that applicants can begin preparing their responses.

A panel of HHS experts will evaluate each complete and eligible DSO application. CMS will select DSOs from among the most highly qualified applicants. Selection is contingent on acceptance of the DSO Agreement (or MPA).

CMS may request interviews, site visits, or additional information related to application responses from applicants to assess their applications.

Any questions that arise during the application process may be directed to the Direct Decision Support mailbox, [DDSMModel@cms.hhs.gov](mailto:DDSMModel@cms.hhs.gov).

### C. Withdrawal of Application

Applicants seeking to withdraw a completed application must submit an electronic withdrawal request to CMS via the **Direct Decision Support** mailbox, [DDSMModel@cms.hhs.gov](mailto:DDSMModel@cms.hhs.gov). The request must be submitted as a PDF on the organization's letterhead and signed by an authorized corporate official. It should include the applicant organization's legal name, the organization's primary point of contact, and the full and correct address of the organization.

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## Appendix A: Preference-Sensitive Conditions

This model will require each DSO to provide decision support services for a set of six preference-sensitive conditions selected by the Centers for Medicare & Medicaid Services (CMS). Each DSO will be required to propose conditions in addition to the six required preference-sensitive conditions to target decision support in its assigned beneficiary population. The set of conditions were selected, with input from a group of clinicians at CMS, based on the following:

- a) The conditions are relatively high prevalence, high cost for Medicare FFS beneficiaries;
- b) There is a reasonable number of the conditions to allow their implementation in a reasonable time, starting at seven months;
- c) There are viable treatment options that exist for the conditions;
- d) The conditions meet the definition of preference-sensitive condition; and
- e) There are evidence-based, standardized Patient Decision Aids (PDA) for each condition that are publicly available.

**Table A-1. Preference-Sensitive Conditions**

Topic	Preference-Sensitive Conditions	Treatment/Decision Options	Specialty
Heart Disease	Stable Ischemic Heart Disease	Medical Management vs. Revascularization (e.g., angioplasty +/- stenting/bypass surgery)	Primary care Cardiology Surgery
Osteoarthritis	Hip	Non-surgical Management vs. surgery	Primary care Orthopedics
Osteoarthritis	Knee	Non-surgical Management vs. surgery	Primary care Orthopedics
Muscle/skeletal	Back Pain <ul style="list-style-type: none"> <li>• Herniated Disk</li> <li>• Spinal Stenosis</li> </ul>	Non-surgical Treatments, Injection Treatments, Surgical treatment	Primary care Orthopedics Neurosurgery Pain Medicine Neurology Rheumatology Radiology Physiatry

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Topic	Preference-Sensitive Conditions	Treatment/Decision Options	Specialty
Cancer	Clinically localized prostate cancer (cancer that is confined to the prostate gland)	Observation vs. treatment options	Urology Radiation Oncology
Urinary	Benign prostate hyperplasia (BPH)	Observation, Non-surgical Treatment, Surgery	Primary care Urology

The preference-sensitive conditions will be evaluated, at least annually, to ensure consistency with evidence based practice. CMS may consider modifications to the preference-sensitive conditions, however such changes would be applied across all model participants.

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## Appendix B: Letter of Intent

### Direct Decision Support (DDS) DDS applicant Letter of Intent (LOI)

#### Instructions

Thank you for your interest in participating in the CMS Innovation Center's Direct Decision Support (DDS) model. Applicants must complete a Letter of Intent (LOI) electronically by 5:00 PM EST March 5, 2017. To submit a LOI, interested organizations may access an electronic portal at <https://app1.innovation.cms.gov/beidds/>.

Only those applicants submitting a timely, completed LOI will be eligible to submit an application. Applications are due by 11:59 PM EST March 5, 2017.

For questions regarding the application process or DDS, please visit the Innovation Center's Beneficiary Engagement Model website <https://innovation.cms.gov/initiatives/Beneficiary-Engagement/> or email [DDSMModel@cms.hhs.gov](mailto:DDSMModel@cms.hhs.gov).

#### Contact Information

Participant/Organization Name:

Point of Contact (POC) Name:

POC Title:

POC Address:

POC City:

POC State:

POC Phone:

Extension:

POC Email:

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Applicant Information

1. Briefly describe the applicant's experience with providing direct decision support.
2. Briefly describe the applicant's experience providing direct decision support to populations similar to Medicare fee for service beneficiaries.
3. What is the geographic area where the applicant proposes to operate?
4. Is the applicant prepared to serve a population of 100,000 or more Medicare beneficiaries and what evidence can the applicant provide to support its position?

Request for Applications (RFA)

## Appendix C: Application Template

### General Information

Welcome to the Beneficiary Engagement and Incentives – Direct Decision support (DDS) Model online application.

Applications must be received 11:59 PM EST March 5, 2017.

The application must be completed online to be considered. The application can be found and completed at: <https://app1.innovation.cms.gov/beidds/>. Please follow the directions listed on the online application screen to complete the application.

Any questions about the application should be directed to [DDSMModel@cms.hhs.gov](mailto:DDSMModel@cms.hhs.gov).

Letter of Intent # \_\_\_\_\_

Please note; you must have a letter of intent # to continue.

### Applicant Information

1. Organization Name
2. Organization TIN/EIN
3. Contact person, phone, and email
4. Second contact person, phone and email
5. Street Address
6. City
7. State
8. Zip Code
9. Contact Information for the Project Officer:
10. Website, if applicable

### Evaluation Criteria

The following questions and scores will be used to determine the application selection process. There are a total of 100 points. To potentially earn the full amount of points for each section, the applicant must answer each question. The scoring panel evaluation will be reviewed with the proposed rate to determine the selected applicants.

### Organizational Structure and Capabilities {scoring for this section will be up to 30 points}

1. Submit a plan for your organizational structure and capabilities, including:
  - Describe staff, systems, and other resources in place to organize, plan, and implement the model.

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- Describe if any contractors will be used and, if so, in what capacity, if applicable.
- Describe how you meet the eligibility requirements, in section III- Eligible Decision Support Organizations. Include all necessary documentation including prior experience with this intervention on a similar population.
- To the best of your knowledge, has your organization, anyone employed in your organization, or any sub-contractors, or any contractors had a final adverse legal action, been the subject of an investigation by, prosecution by, or settlement with the Health and Human Services Office of the Inspector General, U.S. Department of Justice, or any other Federal or State enforcement agency in the last seven years relating to allegations of failure to comply with applicable Medicare or Medicaid billing rules, the Anti-Kickback Statute, or any other applicable fraud and abuse laws?
  - a. Yes
  - b. No

If yes, please describe any legal actions, investigations, prosecutions, and/or corrective action; the agency or agencies involved; and the resolution, if any (including any sanctions, probations and/or settlements). Failure to disclose could be grounds for application denial or immediate termination from the model.

- Describe whether you use decision support information that has been developed through a vetted, evidence-based method.
  - Describe whether you have mechanisms in place to handle beneficiary opt outs.
2. In the Excel spreadsheet provide a list of all procedures and conditions you will target in this model (insert Excel spreadsheet icon).



DDS Supplemental  
Application\_v6.xlsx

3. Include reference letters from at least three insurers, health systems, or other health care entities your organization has previously contracted with in providing direct decision support services. (Include in Appendix of the application.)

**Financial Plan {scoring for this section will be up to 30 points}**

1. Provide a description of a financial plan to support the implementation for the first two performance years of the DDS Model.

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- Describe how the PBPM payments will be used to support the intervention, including beneficiary engagement, DSO investments, risk mitigation, fraud and abuse prevention, and beneficiary incentives.
- Describe the likelihood that your plan will achieve savings for Medicare by providing decision support to Medicare FFS beneficiaries.

2. In the Excel spreadsheet:



DDS Supplemental  
Application\_v6.xlsx

- Include how you arrived at the PBPM rate, including projections related to:
  - ♦ Personnel expenses.
  - ♦ Beneficiary incentives.
  - ♦ Technological fees, enhancements, and licensures.
  - ♦ Decision aid fees.
  - ♦ Costs for beneficiary outreach (e.g., marketing materials).
  - ♦ Other expenses such as travel, construction, and fringe benefits.
  - ♦ Expected program income or in kind contributions.
- Include a high-level calculation for Medicare savings, including information on expected number of engaged beneficiaries for each performance year and impact on higher-cost procedures and overall healthcare utilization.

**Beneficiary Engagement Plan {scoring for this section will up to 20 points}**

1. If you have a proposed geographic location(s) to operate the model, please state the location(s) and the reasons why that location(s) was chosen.
2. Provide a description of your beneficiary engagement, including:
  - Describe what plans you have for engaging the maximum possible number of beneficiaries through the model period, including a representative mix of beneficiaries by range of conditions.
  - Describe whether you have mechanisms in place to educate beneficiaries on the use of the decision support process.

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- Describe how you would provide meaningful decision support and increase beneficiary satisfaction related to beneficiary preferences, values, and health conditions.
- Describe marketing materials for beneficiary recruitment.
- Describe and support the anticipated beneficiary engagement rate for all performance years. CMS expects DSOs to propose an aggressive and attainable beneficiary engagement target to meet the model's aim.
- Describe and provide supporting evidence on how to utilize behavioral and financial incentives to support beneficiary engagement.
- Describe and provide supporting evidence on how to engage diverse and/or underserved populations during the DDS Model, if applicable.
- Present the process for ensuring the distribution of the beneficiary incentives.

**Data Requirements {scoring for this section will be up to 20 points}**

1. Describe your ability to successfully implement and operate the data and reporting portion of the proposed project, including electronic capabilities to collect data from beneficiaries and report it to CMS and its contractors. The data must be transmitted in a form and manner that meet the model requirements and specifications as well as all applicable federal and state privacy and security requirements. Include in your description if you:
  - Have the ability to receive and use Medicare enrollment data.
  - Have the capacity to send data on a monthly basis to CMS including, but not limited to:
    - ◆ Beneficiary encounter information;
    - ◆ Beneficiary identifiers such as Medicare ID or unique record numbers;
    - ◆ Data that is condition and procedure-specific;
    - ◆ Data related to the beneficiary experience questionnaire; and
    - ◆ Financial information on beneficiary incentives and PBPM payments.