Direct Contracting (Professional and Global)

Frequently Asked Questions

Date: November 2019

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General Questions

Q: What is the Direct Contracting Model?

The Direct Contracting Model creates a new opportunity for the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) to test an array of financial risk-sharing arrangements to reduce Medicare expenditures while preserving or enhancing the quality of care furnished to beneficiaries. Direct Contracting leverages lessons learned from other Medicare Accountable Care Organization (ACO) initiatives, such as the Medicare Shared Savings Program and the Next Generation ACO (NGACO) Model, as well as innovative approaches from Medicare Advantage (MA) and private sector risk-sharing arrangements. This model is part of a strategy by the CMS Innovation Center to use the redesign of primary care as a platform to drive broader health care delivery system reform. The model creates a variety of pathways for health care providers and suppliers to take on financial risk supported by enhanced flexibilities. Because the model reduces burden, supports a focus on complex, chronically and seriously ill patients, and aims to encourage organizations to participate that have not typically participated in Medicare fee-for-service (FFS), Innovation Center models, or both, we anticipate that this model will appeal to a broad range of physician organizations and other types of health organizations.

Q: What are the model options under Direct Contracting?

The CMS Innovation Center will test up to three voluntary risk-sharing options: 1) Professional, a lower-risk option (50 percent Shared Savings/Shared Losses) and Primary Care Capitation (PCC) equal to seven percent of the total cost of care benchmark for enhanced primary care services; and 2) Global, a full risk option (100 percent Shared Savings/Shared Losses) and either PCC or Total Care Capitation (TCC). CMS has also sought comment on a potential third option, the Geographic Option, which is another full risk option (100 percent Shared Savings/Shared Losses) that will offer an opportunity to assume total cost of care risk for Medicare Parts A and B services for Medicare FFS beneficiaries in a defined target region. **Please note that the current Request for Applications (RFA) is for the Professional and Global Options of Direct Contracting. CMS anticipates issuing an RFA for the Geographic Option at a later date.**

Q: What are the benefits of participating in Direct Contracting?

Direct Contracting is intended to test whether the risk-based payment strategies available under the model align financial incentives and offer model participants (Direct Contracting Entities or DCEs) flexibility in engaging health care providers and patients in care delivery that results in preserving or enhancing quality of care while at the same time reducing the total cost of care. Specifically, Direct Contracting offers:

- Multiple risk-sharing arrangements,
- Flexible beneficiary alignment options, including enhancements to voluntary alignment,
- Capitation payment options that vary by risk-sharing arrangement,
- Benefit enhancements and payment rule waivers to improve care coordination and service delivery,
- A focus on complex chronic and seriously ill beneficiaries, and
- Options for organizations that have not participated in Medicare FFS previously

Q: How many years is Direct Contracting?

The model will be tested over six years, with an optional initial Implementation Period (IP), followed by five performance years (PY1-5). For purposes of this RFA, the IP will occur in calendar year 2020, and PY1, PY2, PY3, PY4 and PY5 will occur in calendar years 2021, 2022, 2023, 2024 and 2025 respectively.

Q: What is the purpose of the Implementation Period (IP) and when will it begin?

To help organizations new to Medicare FFS and/or Innovation Center models build an aligned Medicare FFS population, Direct Contracting provides enhanced opportunities for voluntary alignment. The optional IP provides DCEs with additional time to engage in beneficiary alignment activities and plan their care coordination and management strategies prior to the first performance year (PY1), which is Calendar Year (CY) 2021. We anticipate the optional IP will begin in May 2020.

Q: What is a DCE?

A DCE is a legal entity which participates in Direct Contracting pursuant to a Participation Agreement with CMS. Various types of organizations may apply to become a DCE including Accountable Care Organizations (ACOs). Under Direct Contracting, there will be three types of DCEs with different characteristics and operational parameters. These three types of DCEs are:

1. **Standard DCEs –** DCEs comprised of organizations that generally have experience serving Medicare FFS beneficiaries, including Medicare-only and dually eligible beneficiaries, who are aligned to a DCE through voluntary alignment or claims-based alignment. These organizations may have previously participated in section 1115A models involving shared savings (e.g., Next Generation ACO Model and Pioneer ACO Model) and/or the Shared Savings Program. Alternatively, new organizations, composed of existing Medicare FFS providers and suppliers, may be created in order to participate as this DCE type. In either case, providers and suppliers participating within these organizations would have substantial experience serving Medicare FFS beneficiaries.
2. **New Entrant DCEs –** DCEs comprised of organizations that have not traditionally provided services to a Medicare FFS population and that will primarily rely on voluntary alignment, at least in the first few performance years of the model. Claims-based alignment will also be utilized.
3. **High Needs Population DCEs –** DCEs that serve fee-for-service Medicare beneficiaries with complex needs, including dually eligible beneficiaries, who are aligned to the DCE through voluntary alignment or claims-based alignment. These DCEs are expected to use a model of care designed to serve individuals with complex needs, like the one employed by the Programs of All-Inclusive Care for the Elderly (PACE), to coordinate care for their aligned beneficiaries.

Q: Is Direct Contracting an Advanced Alternative Payment Model (APM)?

Direct Contracting will be an APM starting in performance year (PY) 2021.

Q: How does Direct Contracting differ from Medicare Advantage?

Unlike beneficiaries who enroll in an MA plan, beneficiaries aligned to organizations participating in the payment model options under Direct Contracting are not choosing to leave Medicare FFS. If a Medicare FFS beneficiary voluntarily aligns with a DCE, their health care coverage will not change and they retain the freedom to seek care from their Medicare provider or supplier of choice, unlike

enrolling in an MA plan with a network. However, DCEs are like MA plans in that they are risk-bearing entities managing the care of a panel of patients.

Q: How does Direct Contracting differ from the NGACO Model?

Direct Contracting builds on the experience of the NGACO Model and incorporates innovative approaches from MA and the private sector. Direct Contracting incorporates opportunities for greater financial risk than the NGACO Model supported by enhanced flexibilities and additional benefit enhancements. Direct Contracting builds on the cash flow mechanisms of the NGACO Model by introducing capitation, requiring DCEs to receive upfront, at-risk, capitated payments to pay their downstream providers and suppliers for services, allowing the DCE to better coordinate care delivery. Additionally, the Direct Contracting Model has a new financial methodology that features a benchmark developed based on the MA rate-book and a new risk adjustment strategy that mitigates coding intensity and improves the accuracy of risk adjustment for complex, high-risk patients. In order to support this new methodology, Direct Contracting also offers an enhanced voluntary alignment methodology, Prospective Plus Alignment, which allows DCEs to incorporate new beneficiaries into their aligned beneficiary population on a quarterly basis. Direct Contracting's benchmarking methodology and risk-sharing and beneficiary alignment options support the participation of organizations new to Medicare FFS and organizations focused on the provision of care to high needs beneficiaries.

Application Process

Q: When is the application period?

There are two application submission periods. CMS will stagger the deadlines for submitting applications so it can process applications from DCEs wanting to participate in the Implementation Period (IP) in 2020 before processing applications for those wanting to start the model in the first Performance Year (PY1), which is 2021. The application for organizations interested in the IP will be made available in early December. Please continue to check the website for application timeline updates. The application for organizations interested in starting in PY1 will open in Spring 2020.

Q: How does an organization apply to participate in the model?

The Request for Applications has been posted to the Direct Contracting website. Applicants may access the portal at: https://app1.innovation.cms.gov/dcrfa/dcrfaLogin.

Q: Is a Letter of Intent (LOI) required to apply to Direct Contracting?

Yes, a LOI is required to apply for Direct Contracting. CMS is reopening the LOI link for two weeks once the RFA is released, for interested organizations that did not previously submit an LOI. Please continue to check our website for updated timelines. The link to the LOI is https://app1.innovation.cms.gov/dc.

Q: When filling out the LOI, should an organization complete a separate LOI for each TIN of each provider?

The applicant should submit one single LOI. Applicants should apply under the TIN assigned to the entity that will serve as the DCE. If there are changes (such as a new TIN) between the submission of the LOI and application, be sure to note them in your application. CMS recognizes that details may change

following the submission of the LOI, however, the entity will be held to the information provided in its model application.

Q: If I have technical questions about the application tool, to whom should I send them?

Technical questions regarding the application should be sent to CMMIForceSupport@cms.hhs.gov. We will attempt to address all inquiries within three business days, however some questions may take longer to answer.

Q: How will CMS select participants for the model?

CMS will assess applications in accordance with specific criteria in five key domains: (1) organizational structure; (2) leadership and management; (3) financial plan and risk-sharing experience; (4) patient centeredness and beneficiary engagement; and (5) clinical care. These domains and associated point scores are detailed in Appendix D of the RFA. In addition, CMS will consider whether applicants have demonstrated that their organizational structure promotes the goals of the model by including a diverse set of providers and suppliers who demonstrate a commitment to high quality care. Lastly, applicants with prior participation in a CMS program, demonstration, or model will be asked to demonstrate routine compliance with the terms of such CMS programs, demonstrations, or models.

Q: When will CMS announce the model participants and when does the model start?

Model Timeline

Timeline	Implementation Period (PY0) DCE Applicants	Performance Period (PY1) DCE Applicants
Application Period	November 25, 2019 - February 25, 2020	March 2020 – May 2020
DCE Selection	April 2020	September 2020
Deadline for applicants to sign and return PA to the Innovation Center	Late April 2020 *(Implementation Period PA)* December 2020 *(Performance Period PA)*	December 2020
Initial Voluntary Alignment Outreach and start of IP or PY	May 2020	January 2021

Dates are subject to change

Q: If an applicant is accepted to participate as a DCE during the Implementation Period for the Professional or Global Option, can it also apply for the Geographic Option in PY1?

Yes, a DCE can apply to the Geographic Option after being accepted into the Implementation Period for the Professional or Global Option. If accepted into both model options, the DCE will need to decide which model option it wants to participate in before submitting a Participation Agreement for PY1 of either model option. The entity may only participate in one model option.

Eligibility

Q: What eligibility criteria do potential DCEs need to meet to be accepted into the model?

A DCE must be a legal entity identified by a Federal taxpayer identification number (TIN) formed

under applicable state, federal, or tribal law, and authorized to conduct business in each state in which it operates for purposes of the following:

- Receiving and distributing monies from CMS;
- Repaying monies determined to be owed to CMS;
- Establishing, reporting, and ensuring Direct Contracting Participant Provider compliance with health care quality criteria, including quality performance standards; and
- Fulfilling other DCE functions identified in the Participation Agreement.

A DCE formed by two or more Direct Contracting Participant Providers, each of which is identified by a unique TIN, must be a legal entity separate from the legal entity of any of its Direct Contracting Participant Providers or Preferred Providers. If the DCE is formed by a single Direct Contracting Participant Provider (such as a group practice), the DCE's legal entity and governing body may be the same as that of the Direct Contracting Participant Provider.

The DCE must also comply with all applicable laws and regulations, as well as all Direct Contracting participation requirements.

DCEs must have an identifiable governing body with sole and exclusive authority to execute the functions and make final decisions on behalf of the DCE. The DCE governing body must be separate and unique to the DCE and must not be the same as the governing body of an entity participating in the DCE (unless the DCE is formed by a single Direct Contracting Participant Provider, in which case the DCE's governing body may be the same as that of the Direct Contracting Participant Provider).

Q: Can an ACO apply to become a DCE if it is presently participating in the NGACO Model, Medicare Shared Savings Program, or another Innovation Center model?

Yes, participants in other shared savings initiatives – such as the Medicare Shared Savings Program or NGACO – can apply to participate in Direct Contracting. During the Implementation Period, the entities may participate in either of these initiatives and the Direct Contracting Model. However, during the Performance Years of the Direct Contracting Model, these entities must elect to participate in just one single initiative that involves shared savings.

Q: What eligibility criteria do providers need to meet to participate as part of a DCE?

Each DCE must contract with Direct Contracting Participant Providers. At least 25 percent control of the DCE's governing body shall be held by Direct Contracting Participant Providers or their designated representatives. DCEs may also elect to enter into arrangements with Preferred Providers. Direct Contracting Participant Providers may include, but are not limited to:

- Physicians or other practitioners in group practice arrangements
- Networks of individual practices of physicians or other practitioners
- Hospitals employing physicians or other practitioners
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Critical Access Hospitals (CAHs)

While a DCE will not be required to be a Medicare-enrolled provider or supplier in order to participate in

Direct Contracting, each Direct Contracting Participant Provider and Preferred Provider under the DCE must be a Medicare-enrolled provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202) by no later than June 30, 2020, in order to be eligible to participate in the model during PY1.

For subsequent performance years, DCEs will be able to update their list of Direct Contracting Participant Providers and Preferred Providers annually to add Medicare-enrolled Direct Contracting Participant Providers or Preferred Providers that satisfy the requirements of the model and are not Prohibited Participants.

Q: What is the difference between Direct Contracting Participant Providers and Preferred Providers?

Direct Contracting Participant Providers are the core providers and suppliers in the Professional and Global Options. Beneficiaries are aligned to the DCE through the Direct Contracting Participant Providers and these providers and suppliers are responsible for, among other things, reporting quality through the DCE and committing to beneficiary care improvement. Direct Contracting Participant Providers, unlike Preferred Providers, are subject to the Capitation Payment Mechanism selected by the DCE with Medicare Fee-For-Service claims reductions and a negotiated payment arrangement between the DCE and the Direct Contracting Participant Provider.

Preferred Providers contribute to DCE goals by extending and facilitating valuable care relationships beyond the DCE. For example, Preferred Providers may participate in benefit enhancements approved and available in PY1 and alternative payment arrangements with the DCE. Services furnished by Preferred Providers will not be considered in beneficiary alignment and Preferred Providers are not responsible for reporting quality through the DCE.

In addition to Direct Contracting Participant Providers and Preferred Providers, beneficiaries aligned to a DCE may also choose to receive services from Medicare FFS providers and suppliers that are not associated with the DCE.

Q: Can Direct Contracting Participant Providers and Preferred Providers also participate in the Medicare Shared Savings Program?

During the IP, DCEs and their Direct Contracting Participant Providers can participate in both Direct Contracting and the Medicare Shared Savings Program. During each performance year from PY1 (CY2021) through PY5 (CY2025), DCEs and their Direct Contracting Participant Providers may not simultaneously participate in the Shared Savings Program. The determination of whether such an overlap exists during PY1 – PY5 will be made at the TIN level. This requirement does not apply to Preferred Providers.

Q: Can Direct Contracting Participant Providers and Preferred Providers also participate in other Innovation Center models?

During the IP, DCEs and their Direct Contracting Participant Providers may participate in other Medicare demonstrations or models, if they meet all applicable eligibility criteria under the applicable demonstration or model.

During the model performance years (PY1 – PY5), Direct Contracting Participant Providers may not simultaneously participate in Direct Contracting and another model tested or expanded under section 1115A of the Act that involves shared savings, or any other Medicare initiative that involves shared

savings unless otherwise instructed by CMS. For example, Direct Contracting Participant Providers may not participate in the Maryland Total Cost of Care Model (all programs) and the Vermont All-Payer Accountable Care Organization Model. For the Comprehensive Primary Care Plus (CPC+) and Primary Care First Models, overlap is prohibited and determined based on the TIN/NPI combination of their clinicians. This restriction does not apply to Preferred Providers.

During the model performance years (PY1 – PY5), DCEs and their Direct Contracting Participant Providers may participate in other Medicare demonstrations or models that do not involve shared savings, if they meet all applicable eligibility criteria under the applicable demonstration or model.

Q: How many beneficiaries does each DCE need to begin in PY1?

DCEs are required to meet beneficiary alignment thresholds prior to the start of each performance year. The IP provides additional time for DCEs concerned about meeting the minimum beneficiary thresholds to align beneficiaries prior to PY1. In both the Professional and Global Options, DCEs will be expected to meet the minimum number of aligned beneficiaries outlined in the list below prior to PY1.

- **Standard DCE -** a minimum of 5,000 aligned Medicare FFS beneficiaries
- **New Entrant DCE -** a minimum of 1,000 aligned Medicare FFS beneficiaries with an increasing minimum beneficiary threshold each year to 5,000 in PY5
- **High Needs Population DCE -** a minimum of 250 aligned Medicare FFS beneficiaries with an increasing minimum beneficiary threshold each year to 1,400 in PY5

Beneficiary Alignment

Q: What eligibility criteria do beneficiaries need to meet to be aligned?

Beneficiaries will be considered alignment-eligible in a given month across all options for DCE alignment if they meet the following criteria:

- Are enrolled in both Medicare Parts A and B;
- Are not enrolled in an MA plan, Medicare Cost Plan under section 1876, Programs of All-Inclusive Care for the Elderly (PACE) organization, or other Medicare health plan;
- Have Medicare as the primary payer;
- Are a resident of the United States; and
- Reside in a county included in the DCE's service area (defined above).

For individuals to be eligible to be aligned to a High Needs Population DCE, they must also meet one or both of the following conditions: (1) have conditions that impair their mobility; and/or (2) meet the high needs special conditions for eligibility described in the RFA. Dually eligible beneficiaries and Medicare-only beneficiaries meeting one or both conditions are eligible for alignment to High Needs Population DCEs.

Q: How does CMS align beneficiaries to DCEs?

For the purpose of assigning accountability for risk sharing and the total cost of care, beneficiaries may be aligned to a DCE in two ways; however, the beneficiary alignment options available to a DCE will depend upon the DCE type. The two beneficiary alignment options are as follows:

1. Claims-based alignment where beneficiaries are aligned based on the plurality of primary care services, as evidenced in claims utilization data.
2. Voluntary alignment where beneficiaries communicate their desire to be aligned with a Direct Contracting Participant Provider.

In order to be aligned to a DCE, the beneficiary must also meet the beneficiary eligibility criteria (described above).

Q: What is voluntary alignment?

Voluntary alignment is a process whereby CMS aligns to a DCE those beneficiaries who have designated a Direct Contracting Participant Provider as their primary clinician or main source of care. A beneficiary who indicates that a Direct Contracting Participant Provider is his or her primary clinician or main source of care generally will be aligned to the DCE, even if the beneficiary would not otherwise be aligned to the DCE based on claims-based alignment. In most cases, voluntary alignment will override claims-based alignment to another organization, model, or program.

Q: How does voluntary alignment work?

CMS will permit DCEs to proactively communicate with beneficiaries regarding voluntary alignment, provided such communications comply with all applicable laws, regulations, guidance, and with the requirements of the Participation Agreement. Beneficiaries may voluntarily align with a DCE by designating a Direct Contracting Participant Provider as their primary clinician or main source of care by either selecting a "primary clinician" on MyMedicare.gov (referred to as electronic voluntary alignment) or completing a paper-based voluntary alignment form. In the event of a conflict, the electronic voluntary alignment will take precedence over paper-based voluntary alignment. The paper-based voluntary alignment would make use of a standardized template developed by CMS for Direct Contracting.

Beginning in the IP, DCEs may take steps, within certain parameters, to affirmatively ask beneficiaries to confirm their care relationships with the DCE. This outreach is limited to a DCE's service area, which consists of a Core Service Area and an Extended Service Area.

Q: What is the frequency of voluntary alignment?

DCEs will have two choices for the frequency of beneficiary voluntary alignment (1) Prospective Alignment, or (2) Prospective Plus Alignment. Both policies rely on establishing the DCE's aligned population prospectively to provide a stable prospectively set benchmark for DCEs. However, for those DCEs that select Prospective Plus Alignment, beneficiaries who voluntarily align to the DCE during the performance year will be added to the DCE's aligned beneficiary population on a quarterly basis prior to the end of the performance year to support more "real time" alignment for those beneficiaries who choose to voluntarily align.

Q: How will CMS determine a DCE's Core Service Area and Extended Service Areas?

CMS will identify a DCE's service area for purposes of beneficiary alignment based on the list of the Direct Contracting Participant Providers submitted by the DCE during the application process. A DCE's Core Service Area includes all counties in which the DCE's Direct Contracting Participant Providers have physical office locations. The Extended Service Area includes all counties contiguous to the Core

Service Area. The DCE's service area is distinct from the DCE's region, which includes all counties where DCE-aligned beneficiaries reside.

Q: Can a DCE operate in multiple regions that are geographically separate?

Yes, a DCE will be permitted to operate in multiple, non-contiguous regions.

Q: What is the difference between DCE service area and its region?

The service area is distinct from the DCE's region, which includes all counties where DCE-aligned beneficiaries reside. A DCE's region is used to determine which counties' regional expenditures should be incorporated into the Performance Year Benchmark for a DCE. More details on the benchmark methodology can be found in Section VI.G. in the RFA.

Q: Do beneficiaries retain freedom of choice in this model? Can beneficiaries switch primary care providers?

Beneficiaries will retain their choice of health care providers in this model and may switch health care providers at any time.

Q: What data will CMS share with DCEs during the Implementation Period and Performance Years?

CMS understands the importance of sharing timely, appropriate and useful data with DCEs participating under this model to support care coordination and quality improvement activities. During the IP and each performance year, DCEs will receive beneficiary level claims data for aligned and in the case of the IP, provisionally aligned beneficiaries. DCEs will regularly receive operational reports that may include Quarterly and Annual Utilization, Monthly Expenditures, Beneficiary Data Sharing Preferences, Monthly Claims Lag, and Beneficiary Alignment reports. During the performance years, CMS will also provide de-identified quarterly baseline benchmark reports (BBRs) to DCEs to enable them to monitor their financial performance throughout the performance year.

DCEs will only be permitted to use these data consistent with the terms of the applicable Participation Agreement.

Q: Can beneficiaries opt-out of CMS data sharing with DCEs?

Yes. Beneficiaries can opt out of data sharing at any time by contacting 1-800-MEDICARE and indicating their preference that CMS not share their data with DCEs or by submitting a request in writing to the DCE.

Benefit Enhancements and Patient Engagement Incentives

Q: What are some examples of benefit enhancements and patient engagement incentives that will be offered in Direct Contracting?

In order to emphasize high-value services and support the ability of DCEs to manage the care of beneficiaries, CMS has designed policies using the authority under section 1115A of the Social Security Act to conditionally waive certain Medicare payment requirements as part of testing Direct Contracting. Beneficiary engagement and coordination of care could be further enhanced by providing additional incentives to beneficiaries that would potentially motivate and encourage beneficiaries to become actively involved in their care. While we expect to include the benefit

enhancements and patient engagement incentives currently permitted in the NGACO Model, we are also proposing new ones in Direct Contracting subject to approval. The benefit enhancements and patient engagement incentives under consideration for Direct Contracting are highlighted in the table below:

Benefit Enhancements

Benefit Enhancements Anticipated for PY1	Proposed Benefit Enhancements and Patient Engagement Incentives for PY1	Potential Future Benefit Enhancements and Patient Engagement Incentives Under Consideration by CMS
• SNF 3-Day Rule Waiver • Asynchronous Telehealth • Post-discharge Home Visits • Care Management Home Visits	• Home Health Services Certified by Nurse Practitioners • Homebound Requirement Waiver for Home Health • Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit • Patient engagement incentives in the form of certain in-kind items and services • Cost-sharing Support for Part B Services • Chronic Disease Management Reward Program	• Tiered Cost Sharing Reduction • Alternative Sites of Care • Cost-sharing Support for SNF Services • Long-term Care Hospital 25-day average Length of Stay requirement and Other Site of Care Restrictions

Q: Are DCEs required to offer these benefit enhancements and patient engagement incentives?

A DCE may choose not to implement some or all benefit enhancements and patient engagement incentives offered under Direct Contracting. 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.

Financial Model

Q: What risk-sharing options are offered in the Direct Contracting Model?

CMS will test up to three voluntary risk-sharing options in the Direct Contracting Model. The current Request for Applications is seeking applicants for two risk-sharing options: 1) Professional, a lower-risk option (50% Shared Savings/Shared Losses (SS/SL)); and 2) Global, a full risk option (100% SS/SL). Additional information will be provided at a later date regarding a third option that CMS is considering offering, Geographic, which is a full risk option for all Medicare FFS beneficiaries in a defined target region.

Q. How will DCEs be paid in the Direct Contracting Model?

DCEs will be required to have a capitated payment arrangement whereby CMS makes a capitation payment to the DCE, which may be used by the DCE to support population health, for example by allowing the DCE to enter into value based payment arrangements with its downstream Direct Contracting Participant Providers, and if they elect it, Preferred Providers, or to invest in health care management tools, such as health care technologies. The type of risk-sharing arrangement the DCE enters will determine the type of capitation payments available to the DCE.

DCEs electing the Professional risk-sharing arrangement are required to receive PCC whereby CMS will pay 7% of the performance year benchmark (based on Part A and B services) to the DCE. This payment is intended to cover the Primary Care Based Services furnished to aligned beneficiaries by Direct Contracting Participant Providers and those Preferred Providers who have agreed to a claims reduction, along with an additional amount for enhanced primary care services, which can include infrastructure, technology, tools, and resources to support increased access to primary care, provision of care, and care coordination. Direct Contracting Participant Providers delivering primary care services will receive 100% of their payment from the DCE. Preferred Providers delivering primary care services who elect to receive payment through PCC will receive between 1-100% of their payment through the DCE; the remainder will be paid through the CMS payment systems. All Direct Contracting Participant Providers and Preferred Providers will continue to submit claims to the Medicare payment systems.

DCEs in the Global risk-sharing arrangement may either choose to receive the PCC described above or may select TCC, which encompasses all Medicare Part A and B services furnished to aligned beneficiaries by Direct Contracting Participant Providers and Preferred Providers, who have agreed to participate. Under TCC, CMS will pay the DCE 100% of the performance year benchmark (based on Part A and B services) minus a percentage for services expected to be billed by providers and suppliers not participating in TCC) for the care of the aligned beneficiaries based on historic experience. Monthly capitated payments will be paid to DCEs. Direct Contracting Participant Providers would receive 100% of their payments from the DCE. Preferred Providers who have elected to participate in TCC would receive between 1-100% of their payments through the DCE; the remainder would be paid through the CMS payment systems. All Direct Contracting Participant Providers and Preferred Providers will continue to submit claims to the Medicare payment systems.

Money paid to the DCE, either through the PCC or TCC, will be factored into shared savings/shared losses calculations.

Advanced Payment is an optional payment mechanism only available to DCEs that select PCC and functions like the population-based payments available in the NGACO Model. Advanced Payments are a cash flow mechanism under which CMS prospectively pays DCEs the estimated value of the reduction in Medicare payments for non-primary care claims submitted by Direct Contracting Participant Providers and Preferred Providers who have agreed to an FFS claims reduction. DCEs can negotiate with their Direct Contracting Participant Providers and Preferred Providers to enter into an arrangement under which they agree to an FFS Medicare claims reduction (between 1 – 100% of FFS claims). In exchange, CMS reduces FFS claims payments made to these providers and suppliers through the Medicare payment systems and pays the DCE a prospective per beneficiary per month (PBPM) payment representing the estimated value of the difference between the reduced FFS claims and the full FFS claims payment amount. Unlike the Capitated Payment Mechanisms, the value of Advanced Payments made to DCEs will be reconciled against

the actual value of the Medicare FFS claims for services furnished to aligned beneficiaries after the end of the Performance Year.

Q: Are DCEs required to participate in PCC, TCC, or Advanced Payments?

DCE are required to participate in PCC or TCC, depending on which risk-sharing option they select. DCEs selecting the Professional Option are required to be paid through PCC. DCEs selecting the Global Option can choose either PCC or TCC. DCEs selecting PCC in either risk option (Professional or Global) may also select Advanced Payments.

Q: Why is CMS requiring the Capitation Payment Mechanisms of PCC and TCC as part of this model?

CMS is requiring Capitation Payment Mechanisms in Direct Contracting to provide DCEs with an opportunity to administer the flow of funds while they manage total cost of care. By giving DCEs the funds to pay for services and increased flexibilities, DCEs will have greater leverage to enter into downstream payment arrangements that can incent providers to work together and coordinate care for a defined set of aligned beneficiaries, with the potential to generate better outcomes and lower costs.

Q: Are all Direct Contracting Participant Providers required to be paid through the PCC or TCC?

For DCEs that elect PCC, Direct Contracting Participant Providers delivering primary care services will be required to be paid through the PCC. For DCEs that elect TCC, all Direct Contracting Participant Providers will be required to be paid through the TCC. DCEs may choose to pay Preferred Providers through the applicable Capitation Payment Mechanism (PCC or TCC) if they consent to this type of payment arrangement.

Q: Are DCEs required to pay their Direct Contracting Participant Providers and/or Preferred Providers through their own FFS mechanisms?

No, DCEs may enter into their own downstream payment arrangement with their Direct Contracting Participant Providers and Preferred Providers and are not required to pay them FFS.

Q: What are the differences between the Global and Professional Options?

A DCE can choose either option when entering Direct Contracting. The table below highlights the differences between the options.

Comparison of the Professional and Global Options

	Policy	Professional	Global
1	Risk Arrangement	50% of savings/losses.	100% of savings/losses.
2	Capitation Option	PCC Only (set at 7% of the Total Cost of Care).	Both options available: PCC or TCC
3	Discount and Quality Withhold	5% Quality Withhold.	Fixed 5% Discount; 5% Quality Withhold.

Q: Why is the PCC set at 7% of the total cost of care?

Primary care expenditures are approximately 2-3% of the total cost of care in Medicare FFS. CMS has set the PCC at a higher value (7%) of the Performance Year benchmark for total cost of care to promote the delivery of enhanced and more comprehensive primary care services. The PCC includes two components, a base PCC amount and an enhanced PCC amount for providing enhanced primary care services. The base PCC amount is calculated based on the actual claim expenditures for primary care services provided to aligned beneficiaries during the baseline period by Direct Contracting Participant Providers and Preferred Providers. The enhanced PCC amount is calculated as the difference between 7% and the base primary capitation amount. DCEs that select the PCC option will still be subject to risk sharing against the Performance Year Benchmark, in which all performance year expenditures are collectively compared to the benchmark value to determine shared savings/shared losses. CMS will treat the base PCC amount as an expenditure against that benchmark. CMS will recoup the enhanced PCC amount prior to the calculation of shared savings/shared losses.

Q: How are the PCC, TCC and Advanced Payments considered in final shared savings/losses calculations?

The TCC and the base PCC portion of PCC will be treated as an expenditure in shared savings/shared losses calculations. That is, when CMS calculates the total cost of care at the end of the year, we will incorporate these payments, as well as additional Medicare expenditures made on behalf of aligned beneficiaries for claims and services not covered by the capitation payments, and determine whether together these expenditures exceed the performance year benchmark. If yes, the DCE must repay CMS for shared losses according to its risk sharing arrangement. If no, CMS will pay the DCE shared savings according to its risk sharing arrangement. CMS will not reconcile payments made through the PCC and TCC against actual services rendered to make DCEs whole—the DCE is at risk for expenditures that exceed what CMS pays through the PCC and TCC.

Advanced Payments, however, are treated differently than the PCC and TCC. The full amount of Advanced Payments will be reconciled against the actual claims submitted by providers and suppliers participating in this alternative funding flow. For example, if CMS underpaid the DCE based on the claims submitted, CMS would increase funds to equal the amount that would have been paid through the CMS payment systems. CMS will monitor claims submission and Advanced Payments to adjust payments as needed to protect against too much or too few funds being provided. A final reconciliation for Advanced Payments will be conducted as part of the calculations of Medicare expenditures for a performance year and shared savings/shared losses determination.

Q: How is the benchmark calculated?

The benchmark will be developed by: (1) calculating the DCE's historical baseline spending for its aligned beneficiary population; (2) trending the historical baseline expenditures forward based on the U.S. Per Capita Cost growth trend; (3) blending the historical baseline expenditures with regional expenditures using an adjusted Medicare Advantage Rate Book; (4) making adjustments to the blended expenditures to account for the risk of the aligned beneficiaries; and (5) applying a discount for DCEs that selected the Global Option and holding a portion of the benchmark "at risk" subject to the DCE's performance on quality measures. More details on the benchmarking methodology can be found in the RFA. Additional detail will also be provided in a Payment Methodology webinar later this year.

Q: Will the benchmark include Medicare Part D prescription drug spending?

The Direct Contracting benchmarks will not include Medicare Part D prescription drug spending. However, CMS remains interested in exploring ways in which DCEs can support beneficiaries in their management of and adherence to prescription drugs.

Q: How will risk adjustment be incorporated in Direct Contracting?

CMS will use risk adjustment to account for the underlying health status of the population of beneficiaries aligned to a DCE for the baseline period (i.e. a weighted average of 2017, 2018, and 2019) relative to the population of beneficiaries aligned to the DCE in each performance year. CMS will design a modified risk adjustment methodology to achieve two primary goals:

1. Mitigate the influence of coding intensity on risk adjustment, and
2. Improve accuracy of risk adjustment for organizations specializing in serving complex, high-risk patients.

Additional information regarding this modified risk adjustment methodology will be provided in subsequent financial methodology papers. CMS anticipates publishing a risk adjustment methodology paper at a later date. This paper will address various aspects of the risk adjustment methodology for Global and Professional under the Direct Contracting Model.

Q: Why is a discount applied to the benchmark for DCEs that select the Global Option? How is it calculated?

The discount is an adjustment that is incorporated into the benchmark for DCEs in the Global Option. As DCEs in the Global Option are eligible to retain up to 100% of savings, this discount will provide the primary mechanism for CMS to obtain savings from the DCEs participating in this option. CMS will apply the discount to the trended, regionally blended, risk adjusted benchmark. This discount will be set at two percent of the benchmark for PY1 and PY2 and increased by one percentage point during each subsequent year, requiring continuous improvement from DCEs in the Global Option. A discount is not applied for the Professional Option.

Q: Do all services count toward Shared Savings/Shared Losses?

Yes, all Parts A and B services for aligned beneficiaries will count toward shared savings/shared losses. Under the Direct Contracting Model, Professional DCEs will bear risk for 50% of shared savings/shared losses on the total cost of care (i.e. all Parts A and B services) for their aligned beneficiaries. Global DCEs will bear risk for 100% of shared savings/shared losses on the total cost of care for aligned beneficiaries.

Q: What risk mitigation strategies will be available in Direct Contracting?

Direct Contracting employs several risk mitigation strategies. Risk corridors are applied to all DCE types and vary based on risk option (Professional or Global). Risk corridors mitigate extreme shared savings or shared losses for DCEs if their actual performance year expenditures are far lower or higher than the benchmark. DCEs also have the option of electing a stop-loss arrangement prior to the start of each performance year. Stop loss is intended to reduce financial uncertainty associated with infrequent, but high-cost, expenditures for aligned DCE beneficiaries. It is calculated at the beneficiary level and the benchmark is adjusted to account for a DCE opting to have stop loss.

Q: When is final reconciliation conducted?

CMS will conduct final reconciliation approximately six months after the performance year ends. To provide more timely distribution of shared savings/shared losses, CMS will also provide the option for DCEs to select a provisional reconciliation option (selected at the start of the Performance Year). Under provisional reconciliation, CMS will distribute interim shared savings and collect interim shared losses shortly after the end of the performance year reflecting cost experience through the first six months of the performance year, with a final reconciliation taking place once complete data are available for the full performance year (approximately six months after the performance year ends).

Q: Are the capitation payments to DCEs subject to sequestration?

Yes. In accordance with the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA), CMS will reduce the payments made to DCEs by 2% for sequestration. The benchmark and performance year expenditures will be calculated on a pre-sequestration basis. TCC, PCC, and, if selected, Advanced Payments paid to DCEs will be calculated on a post-sequestration basis; where sequestration will result in a 2% reduction in any capitated payments and Advanced Payments paid by CMS to the DCE. At provisional and final financial reconciliation, any shared savings will be calculated on a post sequestration basis, where any shared savings earned by the DCE will also be reduced by 2%. Reductions for sequestration will not apply to the calculation of shared losses.

Q: Are DCEs required to secure a financial guarantee?

Each DCE must secure a financial guarantee for each Performance Year to ensure it can repay all Shared Losses and any other amounts owed under Direct Contracting. If CMS does not receive payment for Shared Losses and other amounts owed by the date the payment is due, CMS shall pursue payment under the financial guarantee and may withhold payments otherwise owed to the DCE under this model or any other CMS program or initiative.

Quality and Reporting

Q: How does quality reporting fit into the benchmark?

Similar to NGACO, CMS will use a quality "withhold," in which a portion of a DCE's performance year benchmark is held "at-risk," contingent upon the DCE's quality score. Five percent of the benchmark will be withheld each year for DCEs as the quality withhold amount. In Performance Year 1, DCEs will be able to receive all of this withhold back if they completely and accurately report the quality measures. Thus, Performance Year 1 will be a Pay-for-Reporting year. In Performance Year 2 and beyond, DCEs' performance on quality measures will determine how much of the quality withhold they will earn back. DCEs that improve their performance each year and/or are among the highest performing DCEs will earn back higher levels of the withhold, and potentially even more via a High Performers Pool (HPP). More details on this methodology is provided in the RFA and will be included in a future financial methodology paper.

Q: What is the High Performers Pool (HPP)?

Direct Contracting will test the use of an HPP to further incentivize high performance and continuous improvement on the model's quality measures. A DCE will qualify for a bonus from the HPP if in addition

to meeting the model's continuous improvement/sustained exceptional criteria, the DCE also demonstrates a high level of performance or meets improvement criteria on a pre-determined subset of the quality measures from the quality measure set. The HPP will be "funded" from quality withholds not earned back by the DCEs who met the continuous improvement/sustained exceptional criteria. Because the first performance year is pay for reporting, there will be no HPP in the first performance year.

Q: What quality measures will be included in the core set?

To ensure that DCEs meet the model goals of improved quality of care and health outcomes for Medicare beneficiaries, the Direct Contracting Model will include the assessment of quality performance during the performance years. The quality strategy is designed to provide achievable performance criteria that incentivize the practice transformations necessary to reduce utilization while maintaining care quality. The proposed quality measures for the PY 1 are as follows:

Core Set

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for Accountable Care Organizations (ACOs) surveys. Adaptation to include a measure of 24/7 access will be added later in the model.
2. Advanced Care Plan (the Innovation Center will determine Registry or Claims Reported before the first performance year)
3. All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (Claims Based)
4. Risk-Standardized All Condition Readmission (Claims Based)

Test Measures/Measures in Development

1. Gains in Patient Activation Measure (PAM) Scores at 12 months - This will be a test measure that will be required for DCEs who choose to implement the PAM. This will not be a Pay-for-Performance measure.
2. Days spent at home (Claims Based). This measure will be developed during the initial years of the model. The measure will be utilized by Global and Professional DCEs with overall organizational average HCC risk scores of 2 or greater.