

# Direct Contracting Model Global and Professional Options

## Financial Operating Guide: Overview

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## Reference Documents

Title
Direct Contracting Model Global and Professional Options: Financial Companion to Operating Guide Overview: Standard DCE
Direct Contracting Model Global and Professional Options: Financial Companion to Operating Guide Overview: New Entrant DCE
Direct Contracting Model Global and Professional Options: Financial Companion to Operating Guide Overview: High Needs Population DCE
Direct Contracting Model Global and Professional Options: Financial Operating Policies: Capitation and Advanced Payment Mechanisms
Direct Contracting Model Global and Professional Options: Financial Companion to Capitation and Advanced Payment Mechanisms
Direct Contracting Model Global and Professional Options and Kidney Care Choices Model: DC/KCC Rate Book Development
Direct Contracting Model Global and Professional Options and Kidney Care Choices Model: Risk Adjustment
Direct Contracting Model Global and Professional Options: Financial Reconciliation Companion
Direct Contracting Model Global and Professional Options: Beneficiary Alignment Document
KKCC Financial Operating Guide: Overview

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 Acronyms

A&D	Aged & Disabled
ACO	Accountable Care Organization
APO	Advanced Payment Option
BHI	Behavioral Health Integration
BY	Base Year
CAH2	Critical Access Hospital Method 2
CEC	Comprehensive ESRD Care
CCM	Chronic Care Management
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CPC+	Comprehensive Primary Care Plus
DC	Direct Contracting
DCE	Direct Contracting Entity
ESRD	End Stage Renal Disease
GAF	Geographic Adjustment Factor
HCC	Hierarchical Condition Category
HCPCS	Healthcare Common Procedure Coding System (HCPCS)
MA	Medicare Advantage
NGACO	Next Generation ACO
NPP	Non-Physician Practitioner
NPO	No Payment Option
OACT	Office of the Actuary
PBPM	Per-Beneficiary-Per-Month
PCC	Primary Care Capitation
PECOS	Provider Enrollment, Chain, and Ownership System
PQEM	Primary Care Qualified Evaluation and Management
PY	Performance Year
TCC	Total Care Capitation

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## Section 1: Introduction

This document is the first in a series of documents that provide Direct Contracting Entities (DCEs) with all the necessary details to understand the financial aspects of the Direct Contracting (DC) Model. It provides an overview of each component of the financial methodology but primarily focuses on the detailed calculation of the benchmark and relevant components. Additional policy documents will provide detail on other specific elements of financial operations, including the following:

- Use of risk adjustment models to set the benchmark,
- Development of the DC/KCC Rate Book,
- Total Care Capitation/Primary Care Capitation Payment Mechanisms, and
- Settlement and Financial Reconciliation, including stop-loss reinsurance and risk corridors.

[Section 2](#) provides a general overview of DC Model features relevant to financial operations, including a high-level description of the risk arrangements and payment mechanisms that are available to a DCE and the DC financial settlement and reconciliation process.

[Section 3](#) provides background on DC benchmarking components such as risk adjustment and the DC/KCC Rate Book, which will be used at multiple points in the calculation of the Benchmark. Separate policy documents will specify the detailed operational approach for the development of risk scores and DC/KCC Rate Book for the DC Model.

[Section 4](#) provides details for the calculation of the Performance Year (PY) Benchmark, including the development of the historical baseline expenditures, the prospective trend, the geographic adjustment factors, the regional rate, and the blended Benchmark calculation. This section focuses on the process for calculating the benchmark, aided by the referenced companion documents.

[Section 5](#) provides an overview of the operating policies for financial settlement and reconciliation, including the application of risk mitigation mechanisms and the timing of the preliminary and final Financial Reconciliation. Detailed settlement and risk mitigation policies will be further specified as part of a separate operating policy document.

[Section 6](#) provides an overview of the changes to the financial methodology for PY1 to account for the off-cycle performance period running from April through December 2021 (as opposed to the typical 12-month calendar year). Rather than changing the methodology for calculating the baseline, risk scores, and DC/KCC Rate Book, Centers for Medicare & Medicaid Services (CMS) will apply a seasonality adjustment factor to 2021 benchmarks to account for differences in expenditure patterns between April through December and January through December.

## Section 2: Overview of DC Model Financial Operations

DC creates a variety of pathways for taking on financial risk. As a result of this flexibility, the details related to many of the aspects of the financial methodology (benchmark calculation, capitation payment options, risk sharing and mitigation details, and reconciliation) are specific to DCE type and risk arrangement type. A summary of the different combinations of financial options available to DCEs is provided in **Figure 2.1**. The specific variations reflect (1) the basis for a beneficiary's alignment to the DCE, (2) the risk arrangement selected by the DCE, (3) the payment mechanism(s) selected by the DCE, (4) the risk mitigation mechanism(s) selected by the DCE, and (5) the reconciliation payment timeline selected by the DCE.

**Figure 2.1: Overview of DCE Financial Arrangement Options**

	Financial Arrangement Options		
<b>Beneficiary Alignment</b>	Voluntary and Claims-Based <sup>1</sup>		
<b>Risk Arrangement</b>	Global <sup>2</sup>		Professional <sup>3</sup>
<b>Capitation Arrangement</b>	Total Care	Primary Care	Primary Care
<b>Advanced Payment Option</b>	N/A	Optional <sup>4</sup>	
<b>Stop-Loss Reinsurance</b>	Optional		
<b>Provisional Reconciliation</b>	Optional		

<sup>1</sup> All DCE types use both voluntary and claims-based alignment.

<sup>2</sup> A DCE electing the Global risk arrangement can choose between Total Care Capitation and Primary Care Capitation.

<sup>3</sup> A DCE electing the Professional risk arrangement must participate in Primary Care Capitation.

<sup>4</sup> Advanced payment is not an option for a DCE that elects to participate in Total Care Capitation.

### 2.1 DCE Types

Under DC, there are three types of DCEs, defined based on the experience of DC Participant Providers with Medicare fee-for service (FFS) risk-based contracting and the populations the entities primarily serve:

- A **Standard DCE** is an organization with substantial experience with risk-based FFS contracts. Many of the Participant Providers in a Standard DCE will have participated in another CMS program or innovation model that involves risk sharing, such as the Medicare Shared Savings Program, Next Generation Accountable Care Organization (NGACO), Comprehensive Primary Care Plus (CPC+), or Comprehensive ESRD Care (CEC), among others. Some DCE organizations may have experience participating in section 1115A models involving Shared Savings whereas others may be newly formed to participate as a DCE.
- A **New Entrant DCE** is an organization with limited experience with risk-based FFS contracts. Most of the Participant Providers in a New Entrant DCE have not participated in another CMS program or innovation model that involves risk sharing in Medicare FFS.
- A **High Needs Population DCE** is an organization that serves Medicare FFS beneficiaries with complex needs, including dually eligible beneficiaries. These DCEs are expected to use a model of care designed to serve individuals with complex needs, similar to the Program of All-Inclusive Care for the Elderly model, to coordinate care for their aligned beneficiaries.

For each of the three DCE types, there are specific approaches to benchmark calculations. This paper elaborates on these approaches in each section, where applicable. Subsequent operating policy papers,

including three companion documents for Standard, New Entrant, and High Needs Population DCEs, will provide additional detail.

## 2.2 Alignment

A DCE is responsible for the cost and quality of the care received by beneficiaries who are aligned to it. A beneficiary is aligned to a DCE either because the beneficiary

- Has designated a qualifying DCE Participant Provider as their principal source of care (voluntary alignment); or
- Has historically received the plurality of primary care services from DCE Participant Providers (claims alignment).

The methods used to determine the voluntary and claims-aligned populations are described in detail in the *Operating Policies for Alignment in the Direct Contracting Model*.

Both voluntary and claims alignment are used for all three DCE types. Beneficiary alignment mechanism, DCE type, and performance year may determine the approach used for benchmark calculation. This is described later in Section 4.

## 2.3 DC Risk-Sharing Arrangements

The DC Model offers both risk-sharing arrangements and risk mitigation strategies. The two risk-sharing arrangements are the Global Option and the Professional Option.

- Under the Global Option risk arrangement (hereafter referred to as Global), the DCE assumes “full reward” for any savings and “full risk” for any losses. Under this arrangement, the benchmark is discounted (e.g., 2% in PY1) and the DCE is eligible for a “reward” of up to 100% of any savings but is also “at risk” for up to 100% of any losses.
- Under the Professional Option risk arrangement (hereafter referred to as Professional), the DCE assumes “partial reward” for any savings and “partial risk” for any losses. Under this arrangement, the benchmark is not discounted, but the DCE is eligible for a “reward” of up to only 50% of savings while being at risk for up to only 50% of any losses.

## 2.4 DC Risk Mitigation Strategies

The DC Model includes two risk mitigation strategies available for DCEs: risk corridors and stop-loss reinsurance. Risk corridors determine the percentage of the savings or losses that are retained by the DCE. Within both the Global and Professional risk arrangement options, each risk corridor is a range (or “band”) of savings/losses as a percent of a DCE’s Benchmark for a performance period. The savings or losses that fall within each specific band are associated with a specific level of responsibility for the DCE, with lower levels of responsibility as savings/losses increase. The size of the risk corridor bands and the percent of savings or losses that a DCE is responsible for vary based on the risk-sharing arrangement selected.

Another risk mitigation strategy is the optional stop-loss reinsurance. The purpose of the stop-loss arrangement is to reduce the financial uncertainty associated with infrequent but high-cost

expenditures for aligned beneficiaries. Stop-loss protects DCEs from financial liability for individual beneficiary expenditures above the stop-loss “attachment points” (i.e., dollar thresholds at which stop-loss protection begins). Stop-loss arrangements are an optional feature of both Global and Professional options.

## 2.5 DC Payment Mechanisms

The DC Model offers two payment mechanisms in which DCEs are paid a monthly capitated amount based on claims reductions made for Participant Providers and Preferred Providers. All DCEs must participate in one of the Capitation Payment Mechanisms:

1. Under Total Care Capitation (TCC) the capitated payment to the DCE applies to all services covered by Medicare Parts A and B that are provided to aligned beneficiaries by (a) Participant Providers and (b) Preferred Providers participating in TCC. Providers will receive FFS payments only for the portion of claims that are outside the scope of the TCC (which may include any unreduced portion of claims for Preferred Providers and any beneficiaries who had opted out of data sharing, or claims related to alcohol and substance use treatment).
2. Under Primary Care Capitation (PCC) the capitated payment to the DCE applies only to certain primary care services provided to aligned beneficiaries by (a) Participant Providers and (b) Preferred Providers participating in PCC. Those providers will continue to receive FFS payment for non-primary care services that are outside the scope of the PCC payment. A DCE electing PCC may also elect to receive reduced FFS payments for non-primary care services under the optional Advanced Payment Option (APO).

TCC is available only to a DCE that elects the Global (Full Risk) Option, but Global DCEs may choose to participate in PCC instead. However, a DCE that elects the Professional (Partial Risk) Option must participate in PCC, as summarized in **Figure 2.2**.

**Figure 2.2: Overview of DCE Capitation Mechanisms**

Payment Mechanism Elected by the DCE	Participant Providers	Preferred Providers
TCC	Must Participate 100% Claims Reduction, all PYs	Optional for all PY's If selected, 1%–100% Claims Reduction, all PYs
PCC	Must Participate starting PY2 PY1: Primary Care Claims Reduction 1%–100% (optional) PY2: Primary Care Claims Reduction 5%–100% PY3: Primary Care Claims Reduction 10%–100% PY4: Primary Care Claims Reduction 20%–100% PY5: Primary Care Claims Reduction 100% PY6: Primary Care Claims Reduction 100%	Optional for all PYs If selected, 1%–100% Claims Reduction for Primary Care Claims, all PYs
APO (only available if PCC is also elected)	Optional If selected, 1%–100% Non-Primary Care Claims Reduction, all PYs	Optional If selected, 1%–100% Non-Primary Care Claims Reduction, all PYs

For TCC, all Participant Providers must participate in the payment mechanism elected by the DCE and have relevant FFS claims reduced by 100%. Conversely, Preferred Providers may individually choose whether to participate in the payment mechanism and may choose the desired percent reduction for relevant FFS claims (1%–100%).

For PCC, all Participant Providers must participate in the payment mechanism elected by the DCE but will be able to choose the percentage by which relevant FFS claims are reduced (above an established floor). This floor will be set at a 0% reduction for the 2021 Calendar Year (CY) but will increase to 5% for the 2022 CY, 10% for the 2023 CY, 20% for the 2024 CY, and 100% for the 2025 CY and 2026 CY. Conversely, Preferred Providers may individually choose whether to participate in the payment mechanism and may choose the desired percent reduction for relevant FFS claims (1%–100%).

A DCE electing PCC may also elect to participate in the optional APO. The APO is available only to Preferred and Participant Providers of a DCE electing PCC. It is up to each individual provider to decide whether they want to pursue claims reduction via the APO, and each provider may choose the desired percent reduction for relevant FFS claims (1%–100%). Because APO applies to non-primary care services (i.e., services for which PCC does not apply), APO is complementary to PCC in that APO and PCC will never apply to the same service.

## Section 3: Background on Benchmark Components

The DC Model benchmarking approach relies on a number of components outside the scope of this paper, such as risk adjustment and the DC/KCC Rate Book. These features will be described in detail in future papers but are introduced below at a high level of detail with a focus on where they apply within the benchmarking methodology to provide context for when they are referenced in subsequent sections.

### 3.1 Risk Adjustment

Risk adjustment is a method for measuring population health risk and modifying payments to reflect the predicted expenditures of that population. Measurement of a population's health risks is achieved by designing and estimating models to predict expenditures based on demographic characteristics and medical conditions (Hierarchical Condition Categories [HCCs]). The risk score is the measurement of a beneficiary's risk status. Beneficiaries with risk scores greater than 1.0 are expected to incur higher medical costs than average, and beneficiaries with risk scores less than 1.0 are expected to incur lower medical costs than average.

The benchmark expenditure for the DC Model will be adjusted to reflect the risk, or expected cost, of DCE-aligned beneficiaries. DC risk adjustment will use two risk adjustment models: (1) the CMS-HCC risk adjustment model (Aged & Disabled [A&D] and End Stage Renal Disease [ESRD]) used in the MA program and (2) a new risk adjustment model (A&D) developed specifically for use in the DC Model.

The existing CMS-HCC A&D model will be used for risk adjustment in Standard DCEs and New Entrant DCEs. The existing CMS-HCC ESRD risk adjustment model will be used for risk adjustment in all models (Standard DCEs, New Entrant DCEs, and High Needs Population DCEs).

The new risk adjustment model, which is broadly based on the CMS-HCC A&D risk adjustment model, has been modified to improve payment accuracy for beneficiaries with serious or acute illness in the concurrent year. This new model will be used for risk adjustment of A&D beneficiaries in the High Needs Population DCEs.

The details of the DC risk adjustment methodology will be described in the *Direct Contracting Global and Professional Options: Risk Adjustment* paper.

### 3.2 DC/KCC Rate Book

The MA Rate Book establishes county-level rates for MA Plans for A&D beneficiaries and state-level rates for ESRD beneficiaries. The methodology for the most recently available MA Rate Book will be the starting point to develop an DC/KCC Rate Book specifically for the DC Model, for the purposes of incorporating regional expenditures into a DCE's financial benchmark. A DCE's region is defined as all counties in which one or more beneficiaries aligned to the DCE in the baseline period reside. The regional rate for each county is an eligible-month weighted average of the counties (A&D) or states (ESRD) based on where the DCE's aligned beneficiaries reside.

The DC/KCC Rate Book is based on the same methodology used for the MA Rate Book with adjustments to (1) remove factors applied to the MA Rate Book that are not relevant for DC (e.g., FFS spending

quartiles and quality bonus payment percentage for star ratings), (2) add components of Medicare FFS expenditures not included in the MA Rate Book (e.g., hospice services), and (3) include only the experience of FFS beneficiaries who are eligible to participate in the DC Model. As with the MA Rate Book, this DC/KCC Rate Book will establish a county rate for the A&D beneficiaries and a state-level rate for ESRD beneficiaries.

The role of the regional rate (from the DC/KCC Rate Book) in the benchmark will be described in Section 4 in greater detail but will generally vary based on the DCE type, beneficiary alignment method, and performance year. In some cases, it will be incorporated into DCEs' historical baseline expenditures to arrive at a blended benchmark (described in Sections 4.1.5 and 4.1.6). There are limits on the maximum upward (a ceiling of 5% of the FFS USPCC for the performance year) and downward (a floor of 2% of the FFS USPCC for the performance year) adjustment that can result from incorporating regional expenditures into the benchmark. In other instances, the regional rate will be used as the entirety of the baseline experience (Section 4.2).

The details of the DC/KCC Rate Book will be described in a separate methodological paper.

## Section 4: Benchmark Expenditure

The Performance Year Benchmark is the target amount for Medicare expenditures on covered items and services furnished to a DCE's aligned beneficiaries during a performance year. As shown in **Figure 4.1**, the Performance Year Benchmark is calculated differently across DCE types (Standard, New Entrant, High Needs Population), basis for beneficiary alignment (claims-aligned and voluntarily aligned), and performance year (PY1, PY2, PY3, PY4, PY5, and PY6).

**Figure 4.1: Calculation of Benchmark Expenditure by DCE Type and Basis for Beneficiary Alignment<sup>1</sup>**

	Standard DCE		New Entrant DCE <sup>2</sup>	High Needs Population DCE <sup>2</sup>
	Claims-Aligned Beneficiaries	Voluntarily Aligned Beneficiaries	All Beneficiaries	All Beneficiaries
PY1	Blend of historical baseline expenditure <sup>3</sup> and DC/KCC Rate Book	Driven primarily by the DC/KCC Rate Book		
PY2				
PY3				
PY4		Blend of historical baseline expenditure <sup>4</sup> and DC/KCC Rate Book		
PY5				
PY6				

<sup>1</sup> Beneficiaries who could be aligned to the same DCE via both voluntary and claims-based alignment when first aligned to a DCE will be treated as having claims-based alignment for benchmarking.

<sup>2</sup> If a New Entrant DCE or High Needs Population DCE has greater than 3,000 claims-based beneficiaries, their benchmark will be calculated using the Standard DCE methodology.

<sup>3</sup> The historical baseline period for claims-aligned beneficiaries in a Standard DCE is 2017, 2018, 2019.

<sup>4</sup> The historical baseline period for voluntarily aligned beneficiaries in PY5 is 2021, 2022, 2023 for all DCE types. The historical baseline period for voluntarily aligned beneficiaries in PY6 is 2022, 2023, 2024 for all DCE types. For claims-aligned beneficiaries to New Entrant and High Needs Population DCEs, in PY5 the historical baseline period is 2021, 2022, 2023 and in PY6 is 2022, 2023, 2024.

This section primarily focuses on the basic methodology for Standard DCEs with specific call outs to the unique features associated with New Entrant and High Needs Population DCEs, where applicable. The reason the paper focuses on the Standard DCE methodology is that, as **Figure 4.1** shows, the benchmarking methodology for New Entrant and High Needs Population DCEs parallels the Standard DCE methodology for voluntarily aligned beneficiaries and, therefore, is essentially contained within the Standard DCE methodology.

For all DCE types, a per-beneficiary per-month (PBPM) benchmark will be developed separately for both the A&D and ESRD beneficiary categories. This paper introduces all the steps and concepts applied in the calculation of the benchmark; the companion documents illustrate a complete benchmark calculation for each of the DCE types. We encourage you to reference the companion documents as you read this section, and we have called out where each step can be found in the corresponding Companion documents.

### 4.1 Benchmark Expenditure for Beneficiaries Aligned Based on Claims (Standard DCE)

#### 4.1.1 Historical Baseline Expenditure

For beneficiaries aligned via claims to a Standard DCE, the historical baseline is established based on aggregating all Medicare Parts A and B expenditures incurred by beneficiaries who would have been claims-aligned to the DCE in BYs 2017, 2018, and 2019. These historical expenditures from 2017, 2018, and 2019 are combined and weighted, giving more weight to the more recent historical year (10%, 30%,

and 60%, respectively). For every performance year of the model, the historical base years remain the same, although the expenditures themselves are recalculated each performance year to reflect any changes in the DC Participant Providers who are participating in the model, which correspond to changes in the beneficiaries who would have been claims-aligned to those providers in the same base years. Expenditures include the amounts paid on all claims for covered services provided to each beneficiary during months of eligible alignment and all associated claims, including any reductions or payment adjustments from other Medicare programs. For example, amounts paid on claims that were zeroed out or reduced because of participation in the NGACO program would be counted before any payment reductions.

➤ *Standard DCE Companion Document detail: See Section 2.1, Figure 2.2*

Beneficiaries attributed via voluntary alignment will not contribute any historical expenditures for the first 4 performance years of this model. Therefore, only regional expenditures via the DC/KCC Rate Book (described in Section 4.2) will be used to generate a benchmark for these beneficiaries in PY1–PY4. For PY5 and PY6, the recent historical expenditures for these beneficiaries will be used to calculate the historical baseline expenditures for the benchmark. The historical period for voluntarily aligned beneficiaries in PY5/2025 is 2021, 2022, 2023, and the historical baseline period for voluntarily aligned beneficiaries in PY6/2026 is 2022, 2023, 2024.

For the New Entrant DCE and High Needs Population DCE types, the benchmarking in PY1–PY4 will also be based entirely on regional expenditures, measured via the DC/KCC Rate Book, whether or not beneficiaries are aligned through voluntary alignment or claims-based alignment. For PY4 and PY5, the recent historical expenditures for these beneficiaries will also be used to calculate the historical baseline expenditures for the benchmark. The historical period for New Entrant DCE and High Needs Population DCE in PY5 is 2021, 2022, 2023, and the historical baseline period for New Entrant DCE and High Needs Population DCE types in PY6 is 2022, 2023, 2024. Note that for New Entrant DCEs and High Needs Population DCEs with greater than 3,000 claims-aligned beneficiaries, the benchmark will be calculated using the Standard DCE methodology.

#### **4.1.2 Application of prospective trend**

The USPCC growth trend is developed annually by the CMS Office of the Actuary (OACT) and announced in the annual Announcement of calendar year MA Capitation Rates and Part C and Part D Payment Policies released no later than the first Monday in April of the prior calendar year.<sup>1</sup> An adjusted version of the USPCC annual growth trend, which removes costs associated with uncompensated care and adds in hospice expenditures, will be applied to the DCE's historical baseline expenditures to trend them forward to be equivalent with performance year expenditures.

The prospective trend rate is calculated separately for each base year relative to the USPCC for the performance year. Each of the 3 base years is then independently trended forward to the performance year instead of applying the average trend across base years. The A&D and dialysis-only ESRD USPCC

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<sup>1</sup> More information is available at <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Trends> and <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents>

growth trends are applied separately to the historical baseline expenditures for the A&D and ESRD populations of aligned beneficiaries, respectively.

The trend derived from the USPCC figures will be determined in the April preceding each performance year and is not adjusted retrospectively to account for any changes to the USPCC that occur following the release of the relevant Rate Announcement. However, for each performance year, the trend is set using the most current USPCC for the April preceding that performance year. Thus, if the USPCC for a prior year has been altered it is used to set the trend for future performance years.

- *Standard DCE Companion Document detail: See Section 2.1, Figure 2.3*

#### **4.1.3 Risk Standardization**

Risk standardization is a method for standardizing expenditures for population health risks. Every beneficiary has a risk score that is a measure of their total risk status based upon demographic characteristics and medical conditions (HCCs). The DCE's risk score will be a weighted average of the risk of all aligned beneficiaries. To risk standardize expenditures, the DCE's trended baseline expenditure for each base year is divided by the DCE's risk score.

- *Standard DCE Companion Document detail: See Section 2.1, Figure 2.4*

#### **4.1.4 Geographic Adjustment Factors (GAFs) adjustment**

The DCE's trended, risk-standardized baseline expenditure for each base year is then adjusted to reflect the anticipated impact of changes in the regional GAFs applied to payment amounts under the Medicare FFS payment systems. Every county has its own GAF, determined by the regional differences in various factors such as area wage indices. The GAF Adjustment is applied by multiplying the Trended Risk-Standardized Baseline Expenditure by the DCE's regional GAF for each base year.

- *Standard DCE Companion Document detail: See Section 2.1, Figure 2.4*

#### **4.1.5 Historical baseline (3-year average)**

The DCE's trended, risk-standardized and GAF-adjusted baseline expenditures for each of the 3 base years are then combined but with more weight placed on the more recent base year. BY1 is weighted 10%, BY2 is weighted 30%, and BY3 is weighted 60%. The result is a weighted 3-year average that serves as the final historical baseline.

- *Standard DCE Companion Document detail: See Section 2.1, Figure 2.5*

#### **4.1.6 Regional rate for claims-aligned beneficiaries**

For claims-aligned beneficiaries, regional expenditures are also incorporated into the benchmark to account for the DCE's efficiency relative to its region. Separate from the historical baseline, the weighted average of the county rates (or state-level rates for ESRD beneficiaries) based on the DC/KCC Rate Book (see Section 3.2) will be calculated for each DCE in each base year. To incorporate regional expenditures

into a DCE's benchmark, the DCE's region will include all counties in which one or more beneficiaries aligned to the DCE in the baseline period reside, and the weighted average will depend on both the county rates and the number of aligned beneficiaries residing in each county in each of the base years.

➤ *Standard DCE Companion Document detail: See Section 2.1, Figure 2.6*

#### 4.1.7 Blended benchmark

CMS will blend the regional expenditures (Section 4.1.5) with the DCE's historical baseline expenditures (Section 4.1.4), to determine the blended Performance Year Benchmark. The proportion of the blended benchmark made up of historical baseline expenditures relative to regional expenditures changes over the model performance years with more weight shifting to regional expenditures, as summarized in **Figure 4.2**.

**Figure 4.2: Composition of the Performance Year Blended Benchmark**

Performance Year	% of Blended Benchmark Historical Expenditures	% of Blended Benchmark Regional Expenditures
PY1	65%	35%
PY2	65%	35%
PY3	65%	35%
PY4	60%	40%
PY5	55%	45%
PY6	50%	50%

In **Figure 4.3** below, blended benchmark historical expenditures are 65%, the DCE risk-standardized, GAF-adjusted baseline expenditure is \$831.12, and the DCE Regional Rate based on the DC/KCC Rate Book is \$858.58. Thus the blended benchmark (before applying ceiling/floor) is \$840.73.

Furthermore, there are limits on the maximum upward (ceiling) and downward (floor) adjustment that can result from incorporating regional expenditures into the benchmark. The ceiling for incorporating the regional expenditures is a flat dollar amount increase equal to 5% of the FFS USPPC for the performance year. The floor for incorporating the regional expenditures is a flat dollar amount decrease equal to 2% of the FFS USPPC for the performance year. These caps are achieved for the A&D and the ESRD Benchmarks separately; therefore, it is possible for blending to hit the cap for one category but not the other.

For example, **Figure 4.3** below illustrates that in a hypothetical performance year in which the Adjusted FFS USPPC (A&D) estimate is \$833.13 PBPM, the ceiling for adjustment to the historical benchmark (A&D) would be 5% of that \$833.13 or \$41.66 PBPM, and the maximum floor to the historical benchmark (A&D) would be -2% of that \$833.13 or -\$16.66 PBPM. Because the difference between the blended benchmark and DCE baseline falls between those two values, the floor/ceiling adjustment does not need to be applied in this example.

Finally, the DCE Regional Rate Baseline Adjustment factor is calculated as the ratio of the blended benchmark, divided by the weighted average DCE Regional Rate based on the DC/KCC Rate Book. In **Figure 4.3**, this is illustrated in the \$840.73 divided by \$858.58, arriving at a DCE Regional Rate Baseline Adjustment of 0.979. This factor is prospective and does not change during the performance year. It is

multiplied by the performance year DCE Regional Rate (based on the DC/KCC Rate Book), along with the performance year risk score and number of eligible months in the performance year, to arrive at the final Performance Year Benchmark.

In this example, the DCE Regional Rate Baseline Adjustment factor of 0.979 establishes that in the historical period, the blended benchmark is 97.9% of the Regional Rate; this same rate is then applied in the performance year. The Performance Year Benchmark is set at 97.9% of the performance year's Regional Rate. By directly incorporating the regional rate based upon performance year alignment, this approach accounts for any significant changes in the counties where the DCE's aligned population resides over time.

**Figure 4.3: Blended Benchmark Calculation**

	Three Year-Benchmark
17 EQUALS: DCE Risk-Standardized, GAF-Adjusted Baseline Expenditure	\$831.12
18 DCE Regional Rate based on DC/KCC Rate Book	\$858.58
19 Blend Percentage (% historical)	65%
20 Blended Benchmark (before applying ceiling/floor)	\$840.73
21 Difference between Blended Benchmark and DCE Baseline	\$9.61
22 Ceiling on Blended Benchmark Adjustment	\$41.66
23 Floor on Blended Benchmark Adjustment	(\$16.66)
24 Blended Benchmark	\$840.73
25 <b>DCE Regional Rate Baseline Adjustment</b>	<b>0.979</b>

\* The proportion of regional expenditures that will be blended with the historical baseline expenditures will increase incrementally over the course of the DC Performance Period, beginning with regional expenditures comprising 35% of the benchmark in PY1 and increasing to 50% of the benchmark by PY6.

➤ *Standard DCE Companion Document detail: See Section 2.1, Figure 2.7 and Figure 2.8*

#### 4.2 Benchmark Expenditure for Voluntarily Aligned Beneficiaries (Standard DCE)

In PY1 through PY4, the benchmark for beneficiaries aligned to a Standard DCE through voluntary alignment is the regional rate for those beneficiaries. Beginning in PY5, the benchmark for voluntarily aligned beneficiaries will begin to incorporate historical expenditures. This change in benchmarking approach and baseline period is summarized below in **Figure 4.4**.

**Figure 4.4: Benchmark for Voluntarily Aligned and Claims-Aligned Beneficiaries**

Performance Year	Benchmark for Claims-Aligned Beneficiaries	Benchmark for Voluntarily Aligned Beneficiaries
PY1/2021	Blend of Historical Baseline for CY2017, CY2018, CY2019 <sup>1</sup> and CY 2021 Regional Rate	2021 Regional Rate
PY2/2022 <sup>1</sup>	Blend of Historical Baseline for CY2017, CY2018, CY2019 <sup>1</sup> and CY2022 Regional Rate	2022 Regional Rate

Performance Year	Benchmark for Claims-Aligned Beneficiaries	Benchmark for Voluntarily Aligned Beneficiaries
PY3/2023	Blend of Historical Baseline for CY2017, CY2018, CY2019 <sup>1</sup> and CY2023 Regional Rate	2023 Regional Rate
PY4/2024	Blend of Historical Baseline for CY2017, CY2018, CY2019 <sup>1</sup> and CY2024 Regional Rate	2024 Regional Rate
PY5/2025	Blend of Historical Baseline for CY2017, CY2018, CY2019 <sup>1</sup> and CY2025 Regional Rate	Blend of Historical Baseline for CY2021, CY2022, CY2023 <sup>2</sup> and CY2025 Regional Rate
PY6/2026	Blend of Historical Baseline for CY2017, CY2018, CY2019 <sup>1</sup> and CY2026 Regional Rate	Blend of Historical Baseline for CY2022, CY2023, CY2024 <sup>3</sup> and CY2025 Regional Rate

<sup>1</sup> The historical baseline for claims-aligned beneficiaries is the blend of the baseline expenditure for beneficiaries aligned in CY2017, CY2018, and CY2019 based on the performance year Participant Provider list.

<sup>2</sup> The historical baseline for voluntarily aligned beneficiaries is the average of the baseline expenditure for beneficiaries who were voluntarily aligned in CY2021, CY2022, and CY2023.

<sup>3</sup> The historical baseline for voluntarily aligned beneficiaries is the average of the baseline expenditure for beneficiaries who were voluntarily aligned in CY2022, CY2023, and CY2024

- *Standard DCE Companion Document detail: See Section 2.1, Figure 2.9 and Section 3.0, Figure 3.1.*

#### 4.2.1 Benchmark during first 4 years of voluntary alignment

In the first 4 performance years, regional expenditures based upon the DC/KCC Rate Book serve as the source for the financial benchmark. The regional payment for voluntarily Aligned beneficiaries is a person-month weighted average of the county rates (or state rates for ESRD) for those voluntarily aligned beneficiaries. The payment for every county in which a voluntarily aligned beneficiary lives is based on the number of eligible beneficiary-months attributed to the DCE multiplied by the DC/KCC Rate Book value for that county. These county payments are then combined and divided by the total eligible months across all voluntarily aligned beneficiaries to arrive at the voluntarily aligned beneficiary standardized baseline.

- *Standard DCE Companion Document detail: See Section 2.1, Figure 2.9*
- *New Entrant DCE Companion Document detail: See Figure 2.2 and Figure 2.3*
- *High Needs Population DCE Companion Document detail: See Figure 2.2 and Figure 2.3*

#### 4.2.2 Benchmark during fifth and subsequent years of voluntary alignment

Beginning in PY5, the benchmark for voluntarily aligned beneficiaries will be calculated similarly to claims-aligned beneficiaries, as a blend between historical baseline and regional rate. However, the approach for voluntarily aligned beneficiaries will still differ slightly from the approach previously described for claims-aligned beneficiaries, in that there is a different baseline period for the voluntarily aligned beneficiaries, as summarized in **Table 4.2**. For claims-aligned beneficiaries, the baseline period for the historical expenditure component of the benchmark will continue to be 2017–2019. For voluntarily aligned beneficiaries, however, the baseline period for the historical expenditure component

of the benchmark in PY5 is 2021, 2022, 2023 (with BY1 weighted 10%, BY2 weighted 30%, and BY3 weighted 60%) and in PY6 is 2022, 2023, 2024 (with BY1 weighted 10%, BY2 weighted 30%, and BY3 weighted 60%). The claims used for each of the base years will come from the beneficiaries voluntarily aligned to that DCE during each of those prior performance years (2021–2023 for PY5 and 2022–2024 for PY6).

The historical baseline will be developed from the expenditure incurred in each base year by any beneficiary who was voluntarily aligned to the DCE in that year. For example, the historical voluntary alignment baseline expenditure for CY2021 is the expenditure incurred by beneficiaries who were voluntarily aligned in PY1/CY2021; the historical voluntary alignment baseline expenditure for CY2022 is the expenditure incurred by beneficiaries who were voluntarily aligned in PY2/CY2022.

- *Standard DCE Companion Document detail: See Section 3.0, Figure 3.1*
- *New Entrant DCE Companion Document detail: See Section 3, Figures 3.1–3.7*
- *High Needs Population DCE Companion Document detail: See Section 3, Figures 3.1–3.7*

### **4.3 Combined Benchmark (Standard DCE)**

As previously described, up until this point benchmarks have been calculated separately for A&D populations and ESRD populations, and within each of those populations have been calculated separately for claims-aligned and voluntarily aligned beneficiaries. These separate benchmarks are then combined to arrive at a single PBPM target benchmark.

#### **4.3.1 Combined claims-aligned and voluntarily aligned benchmarks**

First, the claims-aligned and voluntarily aligned benchmarks are combined based on a person-month weighted average of the two benchmarks. Note that claims-aligned and voluntarily aligned benchmarks are combined separately for A&D and for ESRD.

- *Standard DCE Companion Document detail: See Section 2.3, Figure 2.11*

#### **4.3.2 Combined A&D and ESRD Benchmark**

The aggregate A&D Benchmark and aggregate ESRD Benchmark are then combined to arrive at the total benchmark expenditure. This is calculated based upon a simple sum of the two benchmarks because both are in aggregate dollars.

- *Standard DCE Companion Document detail: See Section 2.3, Figure 2.11*
- *New Entrant DCE Companion Document detail: See Section 2.3, Figure 2.3*
- *High Needs Population DCE Companion Document detail: See Section 2.3, Figure 2.3*

### **4.4 Discount (Standard DCE)**

The discount applied to the total benchmark expenditure is determined by the risk arrangement selected by the DCE (see Section 2.4). For DCEs participating in the Global risk track there is a 2%

discount applied to the trended, regionally blended, risk-adjusted benchmark in PY1 (2%–5% in PY2–PY6). For Professional DCEs, the Performance Year Benchmark does not include this discount.

- *Standard DCE Companion Document detail: See Section 2.4, Figure 2.12*
- *New Entrant DCE Companion Document detail: See Section 2.4, Figure 2.4*
- *High Needs Population DCE Companion Document detail: See Section 2.4, Figure 2.4*

#### 4.5 Quality Withhold (Standard DCE)

For both Global and Professional DCEs, a 5% quality withhold is also applied to the total benchmark expenditure for all aligned beneficiaries. A portion of this is held at risk and can be earned back by the DCE's reporting of and performance on a pre-determined set of quality measures in the performance year.

- *Standard DCE Companion Document detail: See Section 2.4, Figure 2.12*
- *New Entrant DCE Companion Document detail: See Section 2.4, Figure 2.4*
- *High Needs Population DCE Companion Document detail: See Section 2.4, Figure 2.4*

The portion of the withhold tied to reporting versus performance and the set of quality metrics measured will vary based on the model performance year. The first 2 performance years will have 1% of the quality withhold tied to performance and 4% of the quality withhold tied to reporting, whereas subsequent performance years will have the full 5% quality withhold tied to performance, as shown in **Figure 4.5**.

**Figure 4.5: Application of Quality Withhold by Performance Year**

	<b>Pay-for-Performance</b>	<b>Pay-for-Reporting</b>
<b>PY1</b>	1%	4%
<b>PY2</b>	1%	4%
<b>PY3</b>	5%	0%
<b>PY4</b>	5%	0%
<b>PY5</b>	5%	0%
<b>PY6</b>	5%	0%

## Section 5: Financial Settlement and Reconciliation

Financial reconciliation is the process by which CMS determines Shared Savings or Shared Losses for a DCE by comparing actual Medicare expenditures in the performance year with the total benchmark expenditure after earned quality. Medicare expenditures are inclusive of TCC or PCC payments and the advanced payments (after they have been reconciled against actual reductions) paid by CMS to the DCE, as well as FFS claims paid by CMS directly to the Medicare providers and suppliers for Medicare Parts A and B items and services furnished to DC beneficiaries.

### 5.1 Risk Mitigation

As described in Section 2.4, there are two different risk-sharing arrangements that determine the portion of savings or losses for which a DCE is at risk.

- Under the Global risk arrangement, the DCE assumes full risk for any savings or loss.
- Under the Professional risk arrangement, the DCE assumes partial risk for any savings or loss.

In addition, there are risk mitigation strategies in the DC Model, including risk corridors and optional stop-loss reinsurance.

#### 5.1.1 Risk Corridors

Under both Global and Professional options, risk corridors (bands) determine the percentage of the savings retained by the DCE, as shown in **Figure 5.1**. For example, for all savings or losses up to 5% of the Performance Year Benchmark (risk band 1), the DCE in the Professional option is responsible for 50% of savings or losses and CMS is responsible for the remaining 50%. DCEs will be responsible for a progressively smaller portion of additional savings or losses as their savings or losses reach risk bands 2, 3, and 4.

**Figure 5.1: Direct Contracting Model Risk Corridors: Percentage of Savings/Losses Retained by DCE**

Risk Band	Risk Arrangement			
	Global Option (Full Risk)		Professional Option (Partial Risk)	
	% of Benchmark	Savings/Losses Rate <sup>1</sup>	% of Benchmark	Savings/Losses Rate <sup>1</sup>
Corridor 1	Less than 25%	100%	Less than 5%	50%
Corridor 2	25% to 35%	50%	5% to 10%	35%
Corridor 3	35% to 50%	25%	10% to 15%	15%
Corridor 4	More than 50%	10%	More than 15%	5%

<sup>1</sup> Percentage of savings or losses within the corridor retained by the DCE.

#### 5.1.2 Optional Stop-Loss Reinsurance

All DCEs will also have the option of participating in a stop-loss reinsurance arrangement, which is designed to reduce the financial uncertainty associated with infrequent but high-cost expenditures for aligned beneficiaries. Stop-loss protects DCEs from financial liability for individual beneficiary

expenditures that are above the stop-loss “attachment points” (i.e., dollar thresholds at which stop-loss protection begins).

The stop-loss attachment points are developed prospectively, before the start of each performance year, based on expenditure data derived from a national reference population of Medicare FFS beneficiaries and adjusted to reflect regional differences in Medicare payment rates for each DCE, using the same DCE-specific GAFs used in calculating the Performance Year Benchmark. The attachment point for a beneficiary will be equal to 12 times a PBPM attachment point that is prospectively established for the year based on the 99th percentile of the expenditure PBPM accruing to the A&D Benchmark by reference beneficiaries. An adjustment will be applied to a beneficiary’s attachment point for each month of experience that the beneficiary accrues to the ESRD Benchmark. The ESRD adjustment will be equal to the difference between the 99th percentile of the expenditure PBPM accruing to the A&D Benchmark and the 99th percentile of the expenditure PBPM accruing to the ESRD Benchmark by reference beneficiaries. The beneficiary’s attachment point will be adjusted to reflect the GAF of the county in which the beneficiary resides in January of the baseline or performance year.

The stop-loss payout rate is equal to a percentage of the expenditure incurred by an aligned beneficiary whose total expenditure exceeds the prospectively established attachment point. That percentage depends on the difference between the beneficiary’s incurred expenditure and the stop-loss attachment point. The amount that is paid out under the stop-loss arrangement will increase as the expenditure incurred by the beneficiary during alignment increases according to a schedule—referred to as stop-loss bands.

Under the stop-loss arrangement, DCEs will retain liability for a portion of expenditures above each attachment point if, selected. A PBPM stop-loss “charge” is applied to the DCE’s Performance Year Benchmark. This charge will be based on the percent of expenditures above each of the DCE’s attachment points in the baseline period. The net impact of stop-loss charges and payouts will impact the total expenditures incurred by the DCE in a performance year, as described in Section 5.5.3. The full details of the stop-loss attachment point calculations will be described in a separate operating policy document.

## **5.2 Timing of Financial Settlement and APO Reconciliation**

*Provisional Financial Reconciliation.* DCEs will have the option for a provisional Financial Reconciliation. The purpose of this option is to provide timely distribution of provisional Shared Savings or repayment of provisional Shared Losses following the end of the performance year. The target for this reconciliation is within a month after the performance year ends (January 31 target). The provisional reconciliation does not account for the full claims processing run-out.

*Final Financial Reconciliation.* Final Financial Reconciliation will be conducted approximately 6 months after the performance year ends for all DCEs. This reconciliation includes claims run-out through the end of the first quarter of the calendar year following the performance year for expenditures incurred in the performance year. Final Financial Reconciliation is based on risk, adjusting the Performance Year Benchmark using the final risk scores for the performance year and then comparing the Performance Year Benchmark with performance year expenditures for aligned beneficiaries to determine Shared Savings or Shared Losses.

**Figure 5.2: Provisional Financial Reconciliation and Final Financial Reconciliation**

	<b>Provisional Financial Reconciliation</b>	<b>Final Financial Reconciliation</b>
<b>Date for Reconciliation</b>	January 31 of the CY following the PY	July 31 of the CY following the PY
<b>Claims Included in Reconciliation</b>	PY expenditures incurred through June 30	PY expenditures incurred through December 31
<b>Claims Run-out</b>	Through December 31 of the PY	Through March 31 of the CY following the PY
<b>Risk Scores</b>	Initial risk scores	Final risk scores

### 5.3 Total Benchmark Expenditure

As described previously, reconciliation involves comparing the total benchmark expenditure amount for the DCE with the actual incurred expenditures in the performance year. Section 4 described in detail the methodology for determining the total benchmark expenditure. For DCEs participating in Global, there is a discount applied to the total benchmark expenditure, and for both Global and Professional DCEs, there is a quality withhold applied. See Section 4 for details.

### 5.4 Earned Quality Withhold

As described in Section 4, for both Global and Professional DCEs there is a 5% quality withhold held at risk, depending on the DCE's performance on a pre-determined set of quality measures. A DCE's quality score will be determined based on their performance and improvement in specified quality domains. This quality score is then multiplied by the amount withheld to determine the Earned Quality Withhold. In the example in **Figure 5.3**, the DCE had a 100% on the quality score and therefore received back the entire amount of the quality withhold through the Earned Quality Withhold.

**Figure 5.3: Calculation of Earned Quality Withhold PBPM Calculation**

Benchmark Expenditure for All Aligned Beneficiaries	\$142,421,941.83
LESS: Discount	(\$2,848,438.84)
EQUALS: Benchmark Expenditure after Discount	\$139,573,502.99
LESS: Quality Withhold	(\$7,121,097.09)
PLUS: Earned Quality Withhold	\$7,121,097.09
EQUALS: Benchmark Expenditure after Earned Quality	\$139,573,502.99

### 5.5 Performance Year Expenditure

The performance year expenditure is the total payment that has been made by Medicare for services provided to DCE-aligned beneficiaries during months in which they were alignment eligible and aligned to the DCE. It is equal to the payments made to the DCE for services within the scope of the capitation Payment (either TCC or PCC) plus the FFS payments made to providers by the Medicare Administrative Contractors, including any reduction in FFS payments made under the APO (after they have been reconciled against actual reductions). An example is provided in **Figure 5.4**.

**Figure 5.4: DCE Performance Period Expenditure**

<b>DCE Performance Period Expenditure</b>	
Capitation Payment	\$92,954,744
PLUS: Participant Provider Claim Payments	\$2,059
PLUS: Preferred Provider Claim Payments	\$19,118,181
PLUS: Non-DCE Provider Claims	\$23,374,678
EQUALS: Total Cost of Care before Stop-Loss	\$135,449,663

### 5.5.1 Capitation payments to DCE

The capitation payment amount is calculated for A&D and ESRD beneficiaries separately and then summed together. The capitation payment amount from the Shared Savings Calculations.

### 5.5.2 Claims Payments to Participant, Preferred, and non-DCE Providers

Beneficiaries aligned to a DCE will continue to accrue claims payments outside of the capitation arrangement, and these payments to Participant, Preferred, and non-DCE providers will also be included in the DCE Performance Period Expenditure. These claims can occur for a number of reasons.

*FFS payments to DCE providers participating in the capitation arrangement:* DCE providers may continue to receive FFS payments for select services in addition to the capitation payments, depending on the payment arrangement selected. If applicable, these FFS payments will be included in the total cost of care. The DCE in **Figure 5.4** is an example of TCC, so there is a very small amount of FFS claims for Participant Providers. These would be claims for beneficiaries who had opted out of data sharing or claims related to substance use treatment, for example. Because not all Preferred Providers are required to participate in the capitation arrangement, a larger portion of the expenditures was paid through FFS claims.

*FFS payments to DCE providers participating in the APO:* For DCE providers who elected to participate in the APO (PCC only), those payments must also be included into the total cost of care, after they have been reconciled against actual reductions. The provider claims amounts used to generate the performance period expenditures reflect this reconciliation of APO to actual reductions.

*FFS payments to other providers:* Payments that were made to other (DCE and non-DCE) providers not participating in the capitation payments or APO are also included in the total cost of care. This includes Preferred Providers who had opted out of the capitation arrangement or had less than a 100% fee reduction and non-DCE providers.

### 5.5.3 Net stop-loss payout under optional stop-loss arrangement

The total cost of care is summed together before any of the optional stop-loss thresholds are applied. In this example, the DCE's stop-loss payout and charge is based upon the blended Benchmark with quality withhold added back in, multiplied by the DCE's risk score, the beneficiary-months aligned to the DCE, and the agreed upon stop-loss payout rate. **Figure 5.5** illustrates an example of the stop-loss calculation.

The stop-loss reinsurance option is described in Section 5.1.2, and full details of the stop-loss attachment point calculations will be provided in separate operating policy documents.

**Figure 5.5: Stop-Loss Calculation**

EQUALS: Total Cost of Care before Stop-Loss	\$87,341,851.38	\$48,107,811.37	\$135,449,663
Less: Stop-Loss Payout			\$16,253,960
Plus: Stop-Loss Charge			(\$16,253,960)
Total Cost of Care After Stop Loss			\$135,449,663

## 5.6 Gross Savings (Loss) and Shared Savings After Application of Risk Corridors

Gross Savings (Loss) is calculated based on the difference between the total benchmark expenditure after Earned Quality and the total cost of care after Stop-Loss. As shown in **Figure 5.6**, it can be expressed as the Gross Savings PBPM or as a percent of the total benchmark expenditure after earned quality.

Each DCE will be participating in either full risk or partial risk arrangement. Each risk arrangement has unique risk corridors (described in **Figure 5.1**). The Shared Savings received by a DCEs, or the Shared Losses for which a DCE is liable, will depend on the risk arrangement and the application of the risk corridors. In the example in **Figure 5.6**, the DCE's gross savings is 2.90% of the total benchmark expenditure after earned quality, which is entirely within the first risk band. Thus, if that DCE were participating in a Global/full-risk option, the DCE would retain all of those savings; under a Professional/partial risk option, the DCE would retain 50% of those savings.

**Figure 5.6: Calculation and Expression of Savings (Loss)**

<b>Savings (Loss)</b>	
Gross Savings (Loss)	\$4,123,840
....Gross Savings PBPM	\$38.88
...% of Benchmark Expenditure	2.90%

## 5.7 APO Reconciliation

Under the APO, DCE providers may elect to receive reduced FFS payments for non-primary care services. In return, the DCE receives a monthly payment intended to be equal to the amount of the reduction in FFS payments made to providers participating in APO. As part of the annual Financial Reconciliation, the APO payments made to the DCE will be reconciled against the amount of the reduction that was made in FFS payments to the providers electing to participate in the APO. If the reduction in FFS payments to those providers is greater than the APO payment made to the DCE, the difference will be paid to the DCE; if the FFS payment reduction is less than the APO payment made to the DCE, then the difference will be returned to CMS.

Because it is directly reconciled to the actual observed claims reductions, the APO does not either decrease or increase the performance period expenditure and therefore has no impact on the calculation of Shared Savings (or Shared Losses). The APO merely affects the timing of cash flows.

## Section 6: Changes to Financial Methodology for PY1

The first performance year for DC begins in April 2021 and ends in December 2021, covering a 9-month period (instead of the typical 12-month January through December performance period for PY2–PY6). The DC financial methodology (including features such as the baseline expenditures, risk scores, and DC/KCC Rate Book) is designed around this 12-month performance period and needs to be adapted to account for the off-cycle performance period.

### 6.1 DC PY1 Financial Methodology

To maintain consistency with the financial methodology for the remainder of the DC Model, CMS will calculate the benchmark for the first PY using much the same 12-month methodology used for PY2 through PY6.

- The baseline period (2017–2019 for Standard DCEs) will continue to be based on 12-month calendar years.
- CMS will apply the CMS-HCC prospective risk adjustment model to the Standard and New Entrant DCEs and the Center for Medicare & Medicaid Innovation (CMMI)-HCC concurrent risk adjustment model to the High Needs Population DCEs; diagnoses will be captured from a full 12-month calendar year period to be consistent with the data months used to calibrate the models.
- The DC/KCC Rate Book for PY1 will continue to be calculated based on expenditures from historical 12-month calendar years.

Instead of changing these features, CMS will address the off-cycle performance year by applying a seasonality adjustment to the PY1 Benchmark that accounts for the difference in expenditures between a 12-month calendar year (January – December) and the 9-month performance period for PY1 (April – December).

### 6.2 Seasonality Adjustment

CMS will determine the seasonality adjustment to the PY1 Benchmark based on historical expenditures for a national reference population of Medicare FFS beneficiaries who are eligible for the DC Model. For each of the 3 baseline years (2017, 2018, and 2019), CMS will determine the percent difference between the PBPM expenditures for the 9-month period from April to December and the 12-month calendar year from January to December. The differences identified in each of the three baseline years will then be averaged to determine the seasonality factor for the performance year. This process will be conducted separately for the A&D and ESRD Benchmarks and is outlined in **Figure 6.1** below using illustrative data for A&D.

**Figure 6.1: Determination of Seasonality Factor for PY1 (Illustrative)**

	PBPM Expenditures (A&D)			3-Year Average
	2017	2018	2019	
January – December	\$922.45	\$950.56	\$986.21	
April – December	\$927.32	\$957.36	\$996.44	

	PBPM Expenditures (A&D)			
	2017	2018	2019	3-Year Average
<b>Seasonality Factor (April – December / January – December)</b>	100.53%	100.72%	101.04%	<b>100.76%</b>

The 3-year average seasonality factor (in this example, 100.76% for A&D and 100.07% for ESRD) would then be applied to the PY1 final Performance Year Benchmark (after applying discount and quality adjustments) for A&D and ESRD, calculated based on the 12-month methodology described above. This step is outlined below in **Figure 6.2**. The seasonality factor will impact the benchmark for all beneficiaries, both claims-aligned and voluntarily aligned.

**Figure 6.2: Application of Seasonality Factor to PY1 Benchmark**

	PY Benchmark (A&D)	PY Benchmark (ESRD)
<b>Calculated PY Benchmark (after Earned Quality)</b>	\$1,009.72	\$7,788.20
<b>Seasonality Factor</b>	100.76%	100.07%
<b>Seasonality-Adjusted Benchmark</b>	\$1,017.39	\$7,793.65

### 6.3 Timing of Financial Reconciliation

In addition, the timeline for Financial Reconciliation will be applied differently for PY1. Because the PY1 performance period only lasts 9 months (April to December of 2021) and because of limitations in prospectively determining quality benchmarks for 2021 because of COVID-19, PY1 will have a mandatory provisional reconciliation approximately 7 months after PY1 ends and a mandatory Final Reconciliation approximately 19 months after PY1 ends (at the same time as PY2 Final Reconciliation).

For PY1, there will not be an option to have a provisional reconciliation 1 month after the performance year ends. The mandatory provisional reconciliation 7 months after the end of the PY will include all final inputs (e.g., performance year expenditures and risk scores) with the exception of quality scores, which will be included in the Final Reconciliation 19 months after the end of PY1.

**Figure 6.3: Financial Reconciliation Timing for PY1**

	Provisional Financial Reconciliation	Final Financial Reconciliation
<b>Target Date for Reconciliation</b>	July 31 of calendar year following the PY (2022)	July 31 of CY 2 years following the PY (2023)
<b>Claims Included in Reconciliation</b>	PY expenditures incurred through December 31, 2021	PY expenditures incurred through December 31, 2021
<b>Claims Run-out</b>	Run-out through March 31, 2022	Run-out through March 31, 2022
<b>Risk Scores</b>	Final risk scores	Final risk scores
<b>Quality Scores</b>	Preliminary quality scores	Final quality scores

## Appendix A: Glossary of Terms

### **Adjusted FFS USPCC**

The adjusted fee-for service (FFS) US per capita cost (USPCC) removes uncompensated care and adds hospice back into FFS expenditures.

### **Adjusted FFS USPCC Trend**

The Adjusted FFS USPCC trend is the performance year adjusted FFS USPCC divided by the baseline year adjusted FFS USPCC, which is applied to express base year expenditures as performance year expenditures.

### **Benchmark Before Discount or Quality Withhold**

The calculated Performance Year Benchmark for a Direct Contracting Entity (DCE), with performance year risk scores and eligible months, before applying the discount or quality withhold.

### **Blend Percentage**

The blend percentage is the percentage of the blended benchmark that is the trended historical baseline expenditures. One minus the blend percentage is the percent that is the DCE Regional Rate based on the DC/KCC Rate Book.

### **Blended Benchmark (Before Applying Ceiling or Floor)**

The blend of trended historical baseline expenditures and the DCE Regional Rate (based on the DC/KCC Rate Book), before applying the ceiling or floor on the blend.

### **Blended Benchmark (After Applying Ceiling or Floor)**

The blend of trended historical baseline expenditures and the DCE Regional Rate (based on the DC/KCC Rate Book), after applying the ceiling or floor on the blend.

### **Blended Benchmark Ceiling**

The limit on the maximum upward adjustment that can result from incorporating regional expenditures into the benchmark, equaling 5% of the adjusted FFS USPCC for the performance year.

### **Blended Benchmark Floor**

The limit on the maximum downward adjustment that can result from incorporating regional expenditures into the benchmark, equaling 2% of the adjusted FFS USPCC for the performance year.

### **Combined Benchmark**

The combined benchmark created by adding the claims-aligned and voluntarily aligned benchmarks for Aged & Disabled (A&D) and End Stage Renal Disease (ESRD) separately and then combining the A&D and ESRD Benchmarks.

### **DCE Regional Rate**

The weighted average of all the county rates (or state-level rates for ESRD beneficiaries) in which one or more beneficiaries aligned to the DCE in the baseline period reside, based on the DC/KCC Rate Book.

### **DCE Regional Rate Baseline Adjustment**

The ratio of the blended benchmark divided by the weighted average performance year DCE Regional Rate based on the DC/KCC Rate Book, expressed as the benchmark as a percentage of DCE Regional Rate.

**Discount**

The discount that is applied to the benchmark expenditure before discount or withhold. It is determined by the risk arrangement selected by the DCE; applying only to DCEs that select the Global Option.

**FFS USPCC**

The FFS USPCC that is developed annually by the CMS Office of the Actuary (OACT).

**GAF Adjustment**

An adjustment made to the DCE's trended, risk-standardized baseline expenditure for the baseline years to reflect the anticipated impact on county expenditure of differences in the regional Geographic Adjustment Factors (GAFs).

**Historical Baseline**

The weighted average of the DCE's trended, risk-standardized, and GAF-adjusted baseline expenditure per-beneficiary-per-month (PBPM) for each of the 3 baseline years, with more weight placed on the more recent baseline year (BY1 is weighted 10%, BY2 is weighted 30%, and BY3 is weighted 60%).

**Historical Base Year Expenditure**

The total Medicare Parts A and B expenditure incurred by beneficiaries who would have been claims-aligned to the DCE in each base year.

**Prospective Trend**

A factor applied to each of the three base year DCE expenditures, independently trending the expenditure forward to be comparable with performance year expenditure. The trends are applied separately to the historical baseline expenditure for the A&D and ESRD populations.

**Quality Withhold**

A percentage withhold applied to the total benchmark expenditure for all aligned beneficiaries that is held "at risk" and can be earned back by the DCE's reporting of and performance on a pre-determined set of quality measures in the performance year.

**Total Benchmark Expenditure**

The total benchmark expenditure amount for which a DCE is at risk in a performance year, without consideration of risk mitigation, before application of the discount or quality withhold/earn back.

**Total Benchmark Expenditure after Discount**

The total benchmark expenditure amount for which a DCE is at risk in a performance year, without consideration of risk mitigation, after application of the discount but before application of the quality withhold/earn back.

**Total Benchmark Expenditure after Earned Quality**

The total benchmark expenditure amount for which a DCE is at risk in a performance year, without consideration of risk mitigation, after application of the discount and the quality withhold/earn back. This is the benchmark compared with expenditures to determine gross savings/losses.

## Appendix B: Beneficiary Alignment Procedures

### B.1 DC Beneficiary Alignment Procedures

A beneficiary is aligned to a DCE based on either claims-based alignment or voluntary alignment. CMS will automatically run claims-based alignment before each performance year for every DCE based on the final DC Participant Provider list submitted for that performance year. Voluntary alignment consists of electronic voluntary alignment and paper-based voluntary alignment. CMS will also automatically run electronic voluntary alignment for all DCEs for the purposes of beneficiary alignment before each performance year; paper-based voluntary alignment is optional, and a DCE must choose to participate in paper-based voluntary alignment.

The annual process in which CMS prospectively runs alignment for a given performance year prior to that performance year is called prospective alignment and applies to all DCEs automatically. DCEs will have the option to elect Prospective Plus Alignment, in which voluntary alignment is also performed prospectively before the start of the second through fourth calendar quarters of a performance year.

**Table B.1.1** shows the alignment process and choices available for DCEs.

**Table B.1.1 Alignment Options**

	Prospective Alignment	Prospective Plus – Q2	Prospective Plus – Q3	Prospective Plus – Q4
Claims-Based Alignment	Mandatory	N/A	N/A	N/A
Electronic Voluntary Alignment	Mandatory	Optional	Optional	Optional
Paper-Based Voluntary Alignment	Optional	Optional	Optional	Optional

### B.2 Claims-Based Alignment

#### B.2.1 Definitions

##### 1. Alignment Period

Each performance year and base year are associated with an alignment period that consists of 2 alignment years. The first alignment year for the first performance year is the 12-month period ending 21 months prior to the start of the first performance year. The second alignment year is the 12-month period ending 9 months before the start of the first performance year. The first alignment year for performance years 2–6 and each base year is the 12-month period ending 18 months prior to the start of the performance year or base year, as applicable. The second alignment year is the 12-month period ending 6 months prior to the start of the performance year or Base Year, as applicable.

**Table B.2.1** specifies the alignment years for the first performance year (April 1, 2021, to December 31, 2021) and, for a Standard DCE, each of the relevant base years.

**Table B.2.1 Alignment Years for each Performance Year and Base Year**

	<b>Period Covered</b>	<b>Alignment Year 1</b>	<b>Alignment Year 2</b>
<b>Base Year 1</b>	CY2017	7/1/2014 – 6/30/2015	7/1/2015 – 6/30/2016
<b>Base Year 2</b>	CY2018	7/1/2015 – 6/30/2016	7/1/2016 – 6/30/2017
<b>Base Year 3</b>	CY2019	7/1/2016 – 6/30/2017	7/1/2017 – 6/30/2018
<b>Performance Year 1</b>	April 1, 2021 – December 31, 2021	7/1/2018 – 6/30/2019	7/1/2019 – 6/30/2020
<b>Performance Year 2</b>	CY2022	7/1/2019 – 6/30/2020	7/1/2020 – 6/30/2021
<b>Performance Year 3</b>	CY2023	7/1/2020 – 6/30/2021	7/1/2021 – 6/30/2022
<b>Performance Year 4</b>	CY2024	7/1/2021 – 6/30/2022	7/1/2022 – 6/30/2023
<b>Performance Year 5</b>	CY2025	7/1/2022 – 6/30/2023	7/1/2023 – 6/30/2024
<b>Performance Year 6</b>	CY2026	7/1/2023 – 6/30/2024	7/1/2024 – 6/30/2025

## 2. Alignable Beneficiary

The population of “alignable beneficiaries” includes all beneficiaries who had at least one Primary Care Qualified Evaluation and Management (PQEM) service that was paid by Medicare FFS during the alignment period.

## 3. Alignment-Eligible Beneficiaries

The population of alignment-eligible beneficiaries includes all alignable beneficiaries who meet all of the following criteria:

- Enrolled in Medicare Parts A and B;
- Not enrolled in Medicare Advantage or other Medicare managed care plan;
- Do not have Medicare as a secondary payer;
- Resident of the United States; and
- Reside in a county that is included in the DCE service area.

For a High Needs Population DCE, a beneficiary must also meet one or more of the following conditions to be considered an alignment-eligible beneficiary (see Section B.5 for more details on eligibility checks for High Needs Population DCEs):

- Have one or more conditions that impair the beneficiary’s mobility listed in **Table B.6.1**;
- Have at least one significant chronic or other serious illness (defined as having a risk score of 3.0 or greater for A&D beneficiaries or a risk score of 0.35 or greater for ESRD beneficiaries using the CMS-HCC methodologies);

- Have a CMS-HCC risk score between 2.0 and 3.0 for A&D beneficiaries (or a risk score between 0.24 and 0.35 for ESRD beneficiaries) and two or more unplanned hospital admissions in the previous 12 months; or
- Exhibit signs of frailty, as evidenced by a claim submitted by a provider or supplier specifically for a hospital bed or transfer equipment for use in the home listed in **Table B.6.2**.

#### **4. Base Years**

Base year means “Base Year One,” which is the calendar year that is 4 years before the first performance year; “Base Year Two” is the calendar year that is 3 years before the first performance year; and “Base Year Three” is the calendar year that is 2 years before the first performance year. The 3 months immediately following each base year will be used for claims run-out for that base year.

#### **5. PQEM Services for Claims-Based Alignment**

PQEM Services means a Primary Care Service (furnished by a Primary Care Specialist or a Selected Non-Primary Care Specialist).

#### **6. Primary Care Services**

In the case of claims submitted by physicians and non-physician practitioners (NPPs), a Primary Care Service is identified by the Healthcare Common Procedure Coding System (HCPCS) code appearing on the claim line and identified by one of the HCPCS codes listed in **Table B.6.3**.

In the case of claims submitted by a Federally Qualified Health Center (type of bill = 77x) or Rural Health Clinic (type of bill = 71x), all services are considered primary care services.

In the case of claims submitted by a Critical Access Hospital Method 2 (CAH2) (type of bill = 85x), a Primary Care Service is identified by the HCPCS code appearing on the line item claim (for revenue centers 096x, 097x, or 098x) for the service.

#### **7. Primary Care Specialist**

A Primary Care Specialist is a physician or NPP whose principal specialty is included in **Table B.6.4**.

A physician or NPP’s specialty is determined based on the CMS Specialty Code recorded on the claim. In the case of a claim submitted by a CAH2, the specialty code is determined by the Center for Program Integrity based on the physician’s or NPP’s primary specialty as recorded in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).

#### **8. Selected Non-Primary Care Specialists**

A Selected Non-Primary Care Specialist is a physician or NPP whose principal specialty is included in **Table B.6.5**.

A physician or NPP's specialty is determined based on the CMS Specialty Code recorded on the claim. In the case of a claim submitted by a CAH2, the specialty code is determined by the Center for Program Integrity based on the physician's or NPP's primary specialty as recorded in PECOS.

## **B.2.2 Claims-Based Alignment Process**

### **1. General**

Claims-based alignment of a beneficiary is determined by comparing the following:

- a. The weighted allowable charges for all PQEM Services that the beneficiary received from DC Participant Providers in each DCE (separately) participating in DC, and
- b. The weighted allowable charges for all PQEM Services that the beneficiary received from each provider or supplier that is not a DC Participant Provider and identified by a Medicare-enrolled billing Taxpayer Identification Number.

### **2. Weighted Allowable Charges**

The allowable charge on paid claims for services received during the 2 alignment years associated with a performance year or base year will be used to determine the DCE or other provider or supplier Taxpayer Identification Number from which the beneficiary received the plurality of PQEM Services.

- a. The allowable charge for PQEM Services provided during the first (earlier) alignment year will be weighted by a factor of one-third.
- b. The allowable charge for PQEM Services provided during the second (later, or more recent) alignment year will be weighted by a factor of two-thirds.

The allowable charge that is used in alignment will be obtained from claims for PQEM Services that are

- a. Incurred in each alignment year as determined by the date-of-service on the claim line item; and
- b. Paid within 3 months following the end of the second alignment year as determined by the effective date of the claim.

### **3. The Two-Track Algorithm**

Alignment for a performance year or base year uses a two-track alignment algorithm.

- a. *Alignment based on PQEM Services provided by Primary Care Specialists.* If 10% or more of the allowable charges incurred on PQEM Services received by a beneficiary during the 2 alignment years are furnished by Primary Care Specialists, then beneficiary alignment is based on the allowable charges incurred on PQEM Services furnished by Primary Care Specialists.

- b. *Alignment based on Primary Care Services provided by Selected Non-Primary Care Specialists.* If less than 10% of the PQEM Services received by a beneficiary during the 2 alignment years are furnished by Primary Care Specialists, then beneficiary alignment is based on the PQEM Services furnished by Selected Non-Primary Care Specialists.

#### 4. Tie-Breaker Rules

In the case of a tie in the dollar amount of the weighted allowed charges for PQEM Services, the beneficiary will be aligned to the DCE if a DC Participant Provider has billed the most recent PQEM service for the beneficiary in the alignment period.

#### 5. Alignment to the DCE

Subject to the precedence rules described in 4.0, CMS will align a Beneficiary to the DCE based on claims alignment if CMS determines that (1) the beneficiary is an alignable beneficiary; (2) the beneficiary is an alignment-eligible beneficiary as of January 1 of the performance year; (3) the beneficiary received the plurality of his or her PQEM Services during the 2 Alignment Years from the DCE's DC Participant Providers; and (4) the beneficiary is not already aligned to a participant in the Medicare Shared Savings Program or other Medicare Shared Savings initiatives that takes precedence to the model for purposes of beneficiary alignment.

### B.3 Voluntary Alignment

#### B.3.1 Paper-Based Voluntary Alignment Definition

If the DCE selects to participate in paper-based voluntary alignment, subject to the precedence rules described in Section B.4, CMS will align a beneficiary to the DCE for the first performance year based on paper-based voluntary alignment if the beneficiary

1. Is an alignment-eligible beneficiary (as defined in Section B.2.1); and
2. Has completed a voluntary alignment form designating a DC Participant Provider as their main doctor, main provider, or the main place they receive care, provided that the designation is valid (see Section B.4.2) and more recent than any other designation made by the beneficiary.

**Note: although this alignment mechanism is historically referred to as paper-based voluntary alignment, electronic forms and signatures are also acceptable.**

CMS will align the beneficiary to the DCE through paper-based voluntary alignment regardless of whether the beneficiary would be aligned to the DCE based on claims alignment.

#### B.3.2 Electronic Voluntary Alignment Definition

Subject to the precedence rules (see Section B.4), CMS will align a beneficiary to a DCE based on electronic voluntary alignment if the beneficiary:

1. Is an alignment-eligible beneficiary (as defined in Section B.2.1); and

2. Has designated a DC Participant Provider as their primary clinician through MyMedicare.gov, provided that the designation is valid (determined in accordance with Section B.4.2) and more recent than any other designation made by the beneficiary.

CMS will align the beneficiary to the DCE through electronic voluntary alignment regardless of whether the beneficiary would be aligned to the DCE based on claims alignment.

### **B.3.3 Removal of Voluntarily Aligned Beneficiaries**

A beneficiary aligned to the DCE for a performance year via voluntary alignment will be removed from alignment to the DCE for purposes of financial settlement for the performance year if (1) none of the DCE's DC Participant Providers furnished any services to the beneficiary during the performance year and (2) a provider or supplier that is not a DC Participant Provider submitted a claim for services furnished to the beneficiary during the performance year.

## **B.4 Alignment Precedence Rules**

### **B.4.1 Alignment across models and programs**

CMS employs a formal, cross-agency governance structure to execute hierarchical decision making to prevent the alignment of beneficiaries to multiple models involving Shared Savings and resolve conflicts when they occur. There will be no changes made to this policy for DC (i.e., DC will be subject to the existing cross model structure).

In practice, this means the following:

- When deciding what model or program a beneficiary will be aligned to (e.g., the Medicare Shared Savings Program vs. DC), electronic voluntary alignment will take precedence over paper-based voluntary alignment, which takes precedence over claims-based alignment.
- No beneficiaries who are already prospectively aligned to another Shared Savings model for a given performance year will be aligned to a DCE.

See CMS-wide guidance on model overlaps for additional details.

### **B.4.2 Alignment within DC**

Once it is determined that a beneficiary will be aligned to the DC Model per the rules in Section B.4.1, a revised set of rules specific to the DC Model will apply.

First, a voluntary alignment attestation (i.e., designation of a DC Participant Provider as a beneficiary's primary clinician, main doctor, main provider, or the main place they receive care), whether through electronic voluntary alignment or paper-based voluntary alignment, is considered "valid" for a given performance year of the model performance period, if either

1. The designation was made no earlier than 2 years before the start of that performance year;  
or

2. The DC Participant Provider designated by the beneficiary has submitted a claim for a PQEM service furnished to the beneficiary in 24 months before the start of that performance year.

Within DC, the most recent valid voluntary alignment attestation (whether through electronic voluntary alignment or paper-based voluntary alignment) will take precedence over any prior or invalid designations, and voluntary alignment will take precedence over claims-based alignment. In addition, if the most recent valid voluntary alignment attestation is to a provider or supplier that is not a DC Participant Provider or participant in any other Shared Savings model (by definition, this would have to be electronic voluntary alignment), the beneficiary will not be aligned to a DCE, even if there is a less recent valid paper-based voluntary alignment attestation or the beneficiary would be claims-aligned to a DCE.

#### **B.4.3 Prospective Plus Alignment Process and Precedence**

Before the start of each quarter, CMS will compile a list of beneficiaries who have voluntarily aligned via electronic voluntary alignment or paper-based voluntary alignment since the previous lists were collected and who meet all other beneficiary eligibility criteria. DCEs will be responsible for submitting to CMS updated Paper-Based Voluntary Alignment information prior to the start of each quarter to allow for timely updates to these CMS lists (note: CMS will set a deadline prior to each quarter by which updated information is due in order for it to count in the next quarter. Although the deadline is not final, we expect it to be roughly 1 month prior to each quarter). Only those beneficiaries who were not already aligned to another DCE or an organization participating in another Shared Savings initiative or other model for which beneficiary overlap with DC is prohibited for the performance year will be aligned to the DCE mid-year under Prospective Plus Alignment.

#### **B.5 High Needs Eligibility**

In recognition of how the health of High Needs beneficiaries can deteriorate quickly and that eligibility determinations must be made in a timely manner to provide the necessary support to at-risk beneficiaries when they need it most, we will be checking High Needs eligibility quarterly. Beneficiaries who, barring eligibility, would otherwise be aligned to a High Needs Population DCE either through claims or voluntary alignment will essentially have up to four chances to become eligible each performance year. Once a beneficiary is determined to be eligible they will be aligned starting in the next quarter for the remaining months of the performance year, for example January 1, April 1, July 1, or October 1 as applicable (unless the beneficiary does not meet general eligibility requirements in Section B.2.1, dies, or is otherwise retrospectively removed from alignment). Once a beneficiary is determined to be High Needs eligible and is aligned to a DCE, that beneficiary will be considered High Needs eligible for the duration of the performance period, even if they cease to meet High Needs eligibility criteria (unless they cease to meet general eligibility requirements in Section B.2.1, dies, or is otherwise retrospectively removed from alignment). This is to ensure continuity of care for High Needs beneficiaries and to avoid punishing High Needs DCEs for providing effective care.

**Table B.5.1 Opportunities within a Performance Year to Meet High Needs Eligibility**

Effective date	January 1 of PY	April 1 of PY	July 1 of PY	October 1 of PY
<b>CA<sup>1</sup> prior to PY</b>	Check eligibility	If not eligible for Jan 1, re-check	If not eligible for Apr 1, re-check	If not eligible for July 1, re-check
<b>VA<sup>2</sup> prior to PY</b>	Check eligibility	If not eligible for Jan 1, re-check	If not eligible for Apr 1, re-check	If not eligible for July 1, re-check
<b>VA for April 1<sup>3</sup></b>		Check eligibility	If not eligible for Apr 1, re-check	If not eligible for July 1, re-check
<b>VA for July 1<sup>3</sup></b>			Check eligibility	If not eligible for July 1, re-check
<b>VA for October 1<sup>3</sup></b>				Check eligibility

<sup>1</sup> CA = Claims-Aligned<sup>2</sup> VA = Voluntarily Aligned<sup>3</sup> Prospective Plus Alignment

For each quarterly eligibility check, we will use the most recent 12-month period (updated quarterly) of claims history available at that time, limiting run-out to the extent possible. To generate risk scores for the eligibility criteria listed above, diagnoses from this 12-month period will be run through both the prospective CMS-HCC risk adjustment model and the concurrent CMMI-HCC risk adjustment model, and a beneficiary will be considered eligible if they meet the requirements with either risk score. This will allow us to identify High Needs beneficiaries who are both chronically ill and more acutely ill. This 12-month period will also be used to check for claims-based eligibility criteria like mobility, frailty, and unplanned hospitalizations.

**Table B.5.2 Proposed Clinical Measurement Periods to Determine High Needs Eligibility**

Effective date	Lookback Period for Data to Determine High Needs Eligibility			
	January 1 of PY	April 1 of PY	July 1 of PY	October 1 of PY
<b>PY1 (Apr–Dec 2021)</b>	N/A	12/1/19 – 11/30/20  OR 2/1/20 – 1/31/21	5/1/20 – 4/30/21	8/1/20 – 7/31/21
<b>PY2 (CY2022)</b>	12/1/20 – 11/30/21	2/1/21 – 1/31/22	5/1/21 – 4/30/22	8/1/22 – 7/31/22
<b>PY3 (CY2023)</b>	12/1/21 – 11/30/22	2/1/22 – 1/31/23	5/1/22 – 4/30/23	8/1/22 – 7/31/23
<b>PY4 (CY2024)</b>	12/1/22 – 11/30/23	2/1/23 – 1/31/24	5/1/23 – 4/30/24	8/1/23 – 7/31/24
<b>PY5 (CY2025)</b>	12/1/23 – 11/30/24	2/1/24 – 1/31/25	5/1/24 – 4/30/25	8/1/24 – 7/31/25
<b>PY6 (CY2026)</b>	12/1/24 – 11/30/25	2/1/25 – 1/31/26	5/1/25 – 4/30/26	8/1/25 – 7/31/26

Note: Because PY1 starts in April, either of the first two eligibility checks will apply for the performance year start. Clinical measurement periods are subject to change.

## B.6 Reference Tables

**Table B.6.1. Mobility Impairment Codes for High Needs Population DCEs**

The following diagnoses for mobility-related conditions are drawn from the list of Other Chronic or Potentially Disabling Conditions in the CMS Chronic Condition Data Warehouse. For a list of the ICD-10 codes associated with these diagnoses, please see the Condition Algorithms at <https://www.ccwdata.org/web/guest/condition-categories>. Per the Chronic Condition Data Warehouse guidelines, one inpatient claim (claim type 60) with a diagnosis from the list below will be sufficient for meeting High Needs Population DCE eligibility or two claims with a diagnosis from the list below with different dates of services for any other claim types.

### Cerebral Palsy

33371	Athetoid cerebral palsy
343	Infantile cerebral palsy
3430	Congenital diplegia
3431	Congenital hemiplegia
3432	Congenital quadriplegia
3433	Congenital monoplegia
3434	Infantile hemiplegia
3438	Other specified infantile cerebral palsy
3439	Infantile cerebral palsy unspecified

### Cystic Fibrosis and Other Metabolic Developmental Disorders

243	Congenital hypothyroidism
2552	Congenital adrenal hyperplasia
2692	Unspecified vitamin deficiency
2701	Phenylketonuria (pku)
2702	Disturbance of aromatic amino-acid metabolism
2703	Disturbances of branched chain amino-acid metabolism
2704	Disturbance of sulfur-bearing amino-acid metabolism
2706	Disorders of urea cycle metabolism
2707	Other disturbances of straight-chain amino-acid metabolism
2711	Galactosemia
2770	Cystic fibrosis
27700	Cystic fibrosis without mention of meconium ileus
27701	Cystic fibrosis with meconium ileus
27702	Cystic fibrosis with pulmonary manifestations
27703	Cystic fibrosis with gastrointestinal manifestations
27709	Cystic fibrosis with other manifestations
27781	Primary carnitine deficiency
27785	Disorders of fatty acid oxidation
2776	Other deficiencies of circulating enzymes (Biotinidase deficiency)

**Mobility Impairments**

3341	Hereditary spastic paraplegia
34200	Flaccid hemiplegia and hemiparesis affecting unspecified side
34201	Flaccid hemiplegia and hemiparesis affecting dominant side
34202	Flaccid hemiplegia and hemiparesis affecting non-dominant side
34210	Spastic hemiplegia and hemiparesis affecting unspecified side
34211	Spastic hemiplegia and hemiparesis affecting dominant side
34212	Spastic hemiplegia and hemiparesis affecting non-dominant side
34280	Other specified hemiplegia and hemiparesis affecting unspecified side
34281	Other specified hemiplegia and hemiparesis affecting dominant side
34282	Other specified hemiplegia and hemiparesis affecting non-dominant side
34290	Hemiplegia, unspecified, affecting unspecified side
34291	Hemiplegia, unspecified, affecting dominant side
34292	Hemiplegia, unspecified, affecting non-dominant side
344	Other paralytic syndromes
3440	Quadriplegia and quadraparesis
34400	Quadriplegia, unspecified
34401	Quadriplegia, C1-C4, complete
34402	Quadriplegia, C1-C4, incomplete
34403	Quadriplegia, C5-C7, complete
34404	Quadriplegia, C5-C7, incomplete
34409	Other quadriplegia
3441	Paraplegia
3442	Diplegia of upper limbs
3443	Monoplegia of lower limb
34430	Monoplegia of lower limb affecting unspecified side
34431	Monoplegia of lower limb affecting dominant side
34432	Monoplegia of lower limb affecting non-dominant side
3444	Monoplegia of upper limb
34440	Monoplegia of upper limb affecting unspecified side
34441	Monoplegia of upper limb affecting dominant side
34442	Monoplegia of upper limb affecting non-dominant side
3445	Unspecified monoplegia
3446	Cauda equina syndrome
34460	Cauda equina syndrome without mention of neurogenic bladder
34461	Cauda equina syndrome with neurogenic bladder
3448	Cauda equina syndrome with neurogenic bladder
34481	Locked-in state
34489	Other specified paralytic syndrome
3449	Paralysis, unspecified
43820	Late effects of cerebrovascular disease, hemiplegia affecting unspecified side
43821	Late effects of cerebrovascular disease, hemiplegia affecting dominant side
43822	Late effects of cerebrovascular disease, hemiplegia affecting non-dominant side
43830	Late effects of cerebrovascular disease, monoplegia of upper limb affecting unspecified side
43831	Late effects of cerebrovascular disease, monoplegia of upper limb affecting dominant side

43832	Late effects of cerebrovascular disease, monoplegia of upper limb affecting non-dominant side
43840	Late effects of cerebrovascular disease, monoplegia of lower limb affecting unspecified side
43841	Late effects of cerebrovascular disease, monoplegia of lower limb affecting dominant side
43842	Late effects of cerebrovascular disease, monoplegia of lower limb affecting non-dominant side
43850	Late effects of cerebrovascular disease, other paralytic syndrome affecting unspecified side
43851	Late effects of cerebrovascular disease, other paralytic syndrome affecting dominant side
43852	Late effects of cerebrovascular disease, other paralytic syndrome affecting non-dominant side
43853	Late effects of cerebrovascular disease, other paralytic syndrome, bilateral

### Multiple Sclerosis and Transverse Myelitis

340	Multiple sclerosis
341	Other demyelinating diseases of the central nervous system
3410	Neuromyelitis optica
3412	Acute (transverse) myelitis
34120	Acute (transverse) myelitis nos
34121	Acute (transverse) myelitis in conditions classified elsewhere
34122	Idiopathic transverse myelitis
3418	Other demyelinating diseases of the central nervous system
3419	Demyelinating diseases of central nervous system

### Muscular Dystrophy

359	Muscular dystrophies and other myopathies
3590	Congenital hereditary muscular dystrophy
3591	Hereditary progressive muscular dystrophy

### Spina Bifida and other Congenital Anomalies of the Nervous System

7400	Anencephalus
7401	Craniorachischisis
7402	Iniencephaly
741	Spina bifida
7410	Spina bifida with hydrocephalus
74100	Spina bifida unspecified region with hydrocephalus
74101	Spina bifida cervical region with hydrocephalus
74102	Spina bifida dorsal (thoracic) region with hydrocephalus
74103	Spina bifida lumbar region with hydrocephalus
7419	Spina bifida without mention of hydrocephalus
74190	Spina bifida unspecified region without hydrocephalus
74191	Spina bifida cervical region without hydrocephalus
74192	Spina bifida dorsal (thoracic) region without hydrocephalus
74193	Spina bifida lumbar region without hydrocephalus
7420	Encephalocele
7421	Microcephalus

7422	Congenital reduction deformities of brain
7423	Congenital hydrocephalus
7424	Other congenital anomalies of nervous system
7425	Other specified congenital anomalies of spinal cord
74251	Diastematomyelia
74253	Hydromyelia
74259	Other specified congenital anomalies of spinal cord
7428	Other specified congenital anomalies of nervous system
7429	Unspecified congenital anomaly of brain, spinal cord, and nervous system

### Spinal Cord Injury

9072	Late effect of spinal cord injury
95200	C1-C4 level with unspecified spinal cord injury
95201	C1-C4 level with complete lesion of spinal cord
95202	C1-C4 level with anterior cord syndrome
95203	C1-C4 level with central cord syndrome
95204	C1-C4 level with other specified spinal cord injury
95205	C5-C7 level with unspecified spinal cord injury
95206	C5-C7 level with complete lesion of spinal cord
95207	C5-C7 level with anterior cord syndrome
95208	C5-C7 level with central cord syndrome
95209	C5-C7 level with other specified spinal cord injury
95210	T1-T6 level with unspecified spinal cord injury
95211	T1-T6 level with complete lesion of spinal cord
95212	T1-T6 level with anterior cord syndrome
95213	T1-T6 level with central cord syndrome
95214	T1-T6 level with other specified spinal cord injury
95215	T7-T12 level with unspecified spinal cord injury
95216	T7-T12 level with complete lesion of spinal cord
95217	T7-T12 level with anterior cord syndrome
95218	T7-T12 level with central cord syndrome
95219	T7-T12 level with other specified spinal cord injury
9522	Lumbar spinal cord injury without evidence of spinal bone injury
9523	Sacral spinal cord injury without evidence of spinal bone injury
9524	Cauda equina spinal cord injury without evidence of spinal bone injury
9528	Multiple sites of spinal cord injury without evidence of spinal bone injury
9529	Unspecified site of spinal cord injury without evidence of spinal bone injury

**Table B.6.2. Frailty codes used to Determine Eligibility for Alignment to a High Needs Population DCE**

<b>Transfer equipment</b>	
E0172	Seat lift mechanism placed over or on top of toilet, any type
E0621	Slings or seats, patient lift, canvas or nylon
E0625	Patient lift, bathroom or toilet, not otherwise classified
E0627	Seat lift mechanism, electric, any type

E0628	Separate seat lift mechanism for use with patient owned furniture-electric
E0629	Seat lift mechanism, non-electric, any type
E0630	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s)
E0635	Patient lift, electric with seat or sling
E0636	Multi-positional patient support system, with integrated lift, patient accessible controls
E0637	Combination sit to stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels
E0638	Standing frame/table system, one position (e.g., upright, supine, or prone stander), any size including pediatric, with or without wheels
E0639	Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories
E0640	Patient lift, fixed system, includes all components/accessories
E0641	Standing frame/table system, multi-position (e.g., three-way stander), any size including pediatric, with or without wheels
E0642	Standing frame/table system, mobile (dynamic stander), any size including pediatric
E0700	Safety equipment, device or accessory, any type
E0705	Transfer device, any type, each
E0710	Restraints, any type (body, chest, wrist, or ankle)
E0910	Trapeze bars, aka patient helper, attached to bed, with grab bar
E0911	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar
E0912	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar
E0940	Trapeze bar, free standing, complete with grab bar
E1035	Multi-positional patient transfer system, with integrated seat, operated by care giver, patient weight capacity up to and including 300 lbs
E1036	Multi-positional patient transfer system, extra-wide, with integrated seat, operated by caregiver, patient weight capacity greater than 300 lbs
<b>Hospital Bed</b>	
E0250	Hospital bed, fixed height, with any type side rails, with mattress
E0251	Hospital bed, fixed height, with any type side rails, without mattress
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress
E0256	Hospital bed, variable height, hi-lo, with any type side rails, without mattress
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress
E0261	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress
E0265	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress
E0266	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress
E0270	Hospital bed, institutional type includes oscillating, circulating and stryker frame, with mattress
E0271	Mattress, innerspring
E0272	Mattress, foam rubber
E0273	Bed board

E0274	Over-bed table
E0277	Powered pressure-reducing air mattress
E0280	Bed cradle, any type
E0290	Hospital bed, fixed height, without side rails, with mattress
E0291	Hospital bed, fixed height, without side rails, without mattress
E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress
E0296	Hospital bed, total electric (head, foot and height adjustments), without side rails, with mattress
E0297	Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress
E0301	Hospital bed, heavy duty, extra-wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress
E0302	Hospital bed, extra heavy duty, extra-wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress
E0303	Hospital bed, heavy duty, extra-wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress
E0304	Hospital bed, extra heavy duty, extra-wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress
E0305	Bed side rails, half length
E0310	Bed side rails, full length
E0315	Bed accessory: board, table, or support device, any type
E0316	Safety enclosure frame/canopy for use with hospital bed, any type
E0370	Air pressure elevator for heel
E0371	Nonpowered advanced pressure-reducing overlay for mattress, standard mattress length and width
E0372	Powered air overlay for mattress, standard mattress length and width
E0373	Nonpowered advanced pressure-reducing mattress
E0462	Rocking bed with or without side rails

**Table B.6.3: Evaluation & Management Services**

<b>Administration of HRA</b>	
96160	Administration of patient-focused health risk assessment instrument
96161	Administration of caregiver-focused health risk assessment instrument
<b>Office or Other Outpatient Services</b>	
99201	New Patient, brief
99202	New Patient, limited
99203	New Patient, moderate
99204	New Patient, comprehensive
99205	New Patient, extensive
99211	Established Patient, brief

99212	Established Patient, limited
99213	Established Patient, moderate
99214	Established Patient, comprehensive
99215	Established Patient, extensive
<b>Domiciliary, Rest Home, or Custodial Care Services</b>	
99324	New Patient, brief
99325	New Patient, limited
99326	New Patient, moderate
99327	New Patient, comprehensive
99328	New Patient, extensive
99334	Established Patient, brief
99335	Established Patient, moderate
99336	Established Patient, comprehensive
99337	Established Patient, extensive
<b>Professional services provided in a non-skilled Nursing Facility<sup>1</sup></b>	
99304	Initial Nursing Facility Care
99305	Initial Nursing Facility Care
99306	Initial Nursing Facility Care
99307	Subsequent Nursing Facility Care
99308	Subsequent Nursing Facility Care
99309	Subsequent Nursing Facility Care
99310	Subsequent Nursing Facility Care
99311	Subsequent Nursing Facility Care
99312	Subsequent Nursing Facility Care
99313	Subsequent Nursing Facility Care
99314	Subsequent Nursing Facility Care
99315	Nursing Facility Discharge Services
99316	Nursing Facility Discharge Services
99317	Nursing Facility Discharge Services
99318	Other Nursing Facility Care
<b>Domiciliary, Rest Home, or Home Care Plan Oversight Services</b>	
99339	Brief
99340	Comprehensive
<b>Home Services</b>	
99341	New Patient, brief
99342	New Patient, limited
99343	New Patient, moderate
99344	New Patient, comprehensive
99345	New Patient, extensive
99347	Established Patient, brief
99348	Established Patient, moderate
99349	Established Patient, comprehensive
99350	Established Patient, extensive
<b>Prolonged care for outpatient visit</b>	
99354	Prolonged visit, first hour
99355	Prolonged visit, add'l 30 mins

<b>Telephone Visits – Online Digital or Audio Only</b>	
99421	Online digital, Established Patient, 5–10 mins
99422	Online digital, Established Patient, 10–20 mins
99423	Online digital, Established Patient, 21+ mins
99441	Phone, Established Patient, 5–10 mins— <i>Note: for PHE only</i>
99442	Phone, Established Patient, 10–20 mins— <i>Note: for PHE only</i>
99443	Phone, Established Patient, 21+ mins— <i>Note: for PHE only</i>
<b>Chronic Care Management (CCM) Services</b>	
99487	Extended care coordination time for especially complex patients (first 60 mins)
99489	Add'l care coordination time for especially complex patients (30 mins)
99490	Comprehensive care plan establishment/implementations/revision/monitoring
G0506	Add'l work for the billing provider in face-to-face assessment or CCM planning
<b>Behavioral Health Integration (BHI) Services</b>	
99484	Monthly services furnished using BHI models
99492	Initial psychiatric collaborative care management, first 70 mins
99493	Subsequent psychiatric collaborative care management, first 60 mins
99494	Initial or subsequent psychiatric collaborative care management, add'l 30 mins
<b>Transitional Care Management Services</b>	
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)
<b>Advance Care Planning</b>	
99497	ACP first 30 mins— <i>Note: subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation</i>
99498	ACP add'l 30 mins— <i>Note: subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation</i>
<b>Wellness Visits</b>	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit
<b>Depression and alcohol misuse</b>	
G0442	Annual alcohol misuse screening
G0443	Annual alcohol misuse counseling
G0444	Annual depression screening
<b>Professional Services Provided in ETA Hospitals</b>	
G0463	Professional Services Provided in ETA Hospitals
<b>Virtual check-ins</b>	
G2010	Remote evaluation, Established Patient— <i>Note: for PHE only</i>
G2012	Brief communication technology-based service, 5–10 mins of medical discussion— <i>Note: for PHE only</i>

<sup>1</sup> Note: per the proposed Medicare Shared Savings Program methodology, claims will be excluded from alignment if a beneficiary has a skilled nursing facility stay with overlapping dates of service.

**Table B.6.4. Specialty Codes Used to Identify Primary Care Specialists**

<b>Code<sup>1</sup></b>	<b>Specialty</b>
1	General Practice
8	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Clinical Nurse Specialist
97	Physician Assistant

<sup>1</sup> The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf>

**Table B.6.5. Specialty Codes Used to identify Selected Non-Primary Care Specialists**

<b>Code<sup>1</sup></b>	<b>Specialty</b>
6	Cardiology
10	Gastroenterology
12	Osteopathic manipulative medicine
13	Neurology
16	Obstetrics/gynecology
17	Hospice and palliative care
23	Sports medicine
25	Physical medicine and rehabilitation
26	Psychiatry
27	Geriatric psychiatry
29	Pulmonology
39	Nephrology
44	Infectious disease
46	Endocrinology
66	Rheumatology
70	Multispecialty clinic or group practice
79	Addiction medicine
82	Hematology
83	Hematology/oncology
84	Preventative medicine
90	Medical oncology
98	Gynecological/oncology
86	Neuropsychiatry

<sup>1</sup> The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf>