Direct Contracting (Professional and Global)

Frequently Asked Questions

Version 3

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Contents

General Questions

1. Q: What is the Direct Contracting Model?

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

2. Q: What are the model options under Direct Contracting?

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

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

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

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

4. Q: How many years is Direct Contracting? *(Updated, October 2020)*

The model will be implemented over six performance years (PY1-6), with an optional initial Implementation Period (IP). The IP will occur from October 2020 through March 2021, PY1 will occur from April 2021 through December 2021, and PY2, PY3, PY4, PY5 and PY6 will occur in calendar years 2022, 2023, 2024, 2025, and 2026 respectively. Note that the addition of PY6 is a policy change from the RFA due to the challenges posed by coronavirus disease 2019.

Since a number of model design features vary by year, we have summarized the changes here along with the original policy from the RFA for reference (note that the parameters listed in the table below apply both to DCEs that start in PY1/2021 and PY2/2022):

Revised model timeline and 'time-dependent model parameters':

Calendar year / PY	***Benchmark discount for Global DCEs***	***New Entrant / High Needs DCEs beneficiary minimum***	***New Entrant & High Needs DCEs Benchmarking***	***Earn back for 5% quality withhold***
2021*/PY1	*2%*	*1,000 / 250*	*Rate book-driven*	*1% performance, 4% reporting*
2022/PY2	*2%*	*1,000 / 250*	*Rate book-driven*	*1% performance, 4% reporting*
2023/PY3	*3%*	*2,000 / 500*	*Rate book-driven*	*5% performance*
2024/PY4	*4%*	*3,000 / 750*	*Rate book-driven*	*5% performance*
2025/PY5	*5%*	*5,000 / 1,200*	*Baseline-driven*	*5% performance*
2026/PY6	*5%*	*5,000 / 1,400*	*Baseline-driven*	*5% performance*

** April 1 – December 31, 2021*

Original model timeline and 'time-dependent model parameters' from the RFA:

Calendar year / PY	***Benchmark discount for Global DCEs***	***New Entrant / High Needs DCEs beneficiary minimum***	***New Entrant & High Needs DCEs Benchmarking***	***Earnback for 5% quality withhold***
2021/PY1	*2%*	*1,000 / 250*	*Rate book-driven*	*5% reporting*
2022/PY2	*2%*	*2,000 / 500*	*Rate book-driven*	*5% performance*
2023/PY3	*3%*	*3,000 / 750*	*Rate book-driven*	*5% performance*
2024/PY4	*4%*	*5,000 / 1,200*	*Baseline-driven*	*5% performance*
2025/PY5	*5%*	*5,000 / 1,400*	*Baseline-driven*	*5% performance*

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

To help organizations new to Medicare FFS and/or Innovation Center models build an aligned Medicare FFS population, Direct Contracting provides enhanced opportunities for voluntary alignment relative to existing Medicare initiatives. The optional IP provides DCEs with additional time to engage in beneficiary alignment activities and plan their care coordination and management strategies prior to the first performance year (PY2021), which begins April 1, 2021. The optional IP will begin in October 2020.

6. Q: What is a DCE?

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

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

7. Q: How can a DCE assess if they meet the requirements to be a Standard DCE, New Entrant DCE or High Needs Population DCE, for example, if they have sufficient level of experience with Medicare FFS to be a Standard DCE? ***(Updated, October 2020)***

Key criteria are outlined below. Complete details of each of the three DCE types are available in the RFA.

Standard DCEs

- Organizations with substantial experience serving Medicare FFS beneficiaries. These may be organizations that previously participated in section 1115A shared savings models (e.g., Next Generation ACO Model and Pioneer ACO Model) and/or the Shared Savings Program, or new organizations, composed of existing Medicare FFS providers and suppliers created in order to participate in Direct Contracting.
- Required to have a minimum of 5,000 aligned beneficiaries prior to the start of each Performance Year from PY1 through PY6.

New Entrant DCEs

- Organizations with less experience serving a Medicare FFS population and / or taking risk for FFS Medicare beneficiaries.
- May not have more than 50% of DC Participant Providers with prior experience in the Shared Savings Program, the Next Generation ACO Model, the Comprehensive ESRD Care Model, the Pioneer ACO Model or CPC+ Model*

- Must meet an increasing minimum number of aligned beneficiaries, with a minimum of at least 1,000 beneficiaries prior to the start of PY1 and PY2, 2,000 prior to the start of PY3, 3,000 prior to the start of PY4, and 5,000 prior to the start of PY5 and PY6.
- May not have more than 3,000 beneficiaries that are "alignable" through claims-based alignment in any base year (2017, 2018 and 2019) or in Performance Years 1-4. CMS will evaluate this by assessing the volume of services provided by the applicant's proposed DC Participant Providers to Medicare FFS beneficiaries. Any FFS beneficiaries with a plurality of Primary Care Qualified Evaluation & Management (PQEM) claims billed by a DCE's proposed DC Participant Providers in a given year will be considered "alignable" in that year*.

*Organizations found ineligible to participate on the basis of this criterion will have the opportunity to participate as a Standard DCE, provided all other model requirements are met.

<u>High Needs DCEs</u>

- Organizations with experience serving high cost, high acuity individuals.
- Where applicable, CMS will also assess an organization's experience providing a range of Medicaid-covered services and demonstrated ability to coordinate services across Medicare and Medicaid for dually eligible beneficiaries, and prevent unnecessary utilization of higher cost institutional care.
- Required to have demonstrated capabilities in coordination of services that emphasize person-centered care, such as an interdisciplinary care team that includes primary care, behavioral health, and Long-Term Services and Supports (LTSS) providers and that manages care across a range of settings.
- Must meet an increasing minimum number of aligned beneficiaries, with a minimum of at least 250 beneficiaries prior to the start of PY1 and PY2, 500 prior to the start of PY3, 750 prior to the start of PY4, 1,200 prior to the start of PY5, and 1,400 prior to the start of PY6. In addition to the beneficiary eligibility requirements that apply to all beneficiaries in Direct Contracting, beneficiaries must meet additional eligibility requirements to be aligned to a High Needs DCE – see page 54 of the RFA for details.

8. Q: Can a DCE move between the Global and Professional options?

Before signing the PY1 Participation Agreement, the DCE may switch from Global to Professional, and vice versa. The DCE cannot move from Global to Professional options once participation has begun. If the DCE wants to increase from Professional to Global, it can change only at the following times:

- Submit its change during the IP, to take effect PY1
- During PY2, to take effect PY3
- During PY3, to take effect PY4
- During PY4, to take effect PY5
- During PY5, to take effect PY6

Please note that this information was updated after the release of the RFA dated November 25, 2019.

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

Direct Contracting will be an Advanced APM starting in performance year (PY) 1 (April 1 – December 31, 2021).

10. Q: How does Direct Contracting differ from Medicare Advantage?

Unlike beneficiaries who enroll in an MA plan, beneficiaries aligned to organizations participating in the payment model options under Direct Contracting are not choosing to leave Medicare FFS. If a Medicare FFS beneficiary voluntarily aligns with a DCE, their health care coverage will not change and they retain the freedom to seek care from their Medicare provider or supplier of choice, unlike enrolling in an MA plan with a network. However, DCEs are like MA plans in that they are risk-bearing entities managing the care of a panel of patients.

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

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

Application Process

12. Q: What is the updated model timeline? ***(Updated, October 2020)***

The first performance year of the Direct Contracting Model was scheduled to begin January 1, 2021. However, in recognition of the impact of coronavirus disease 2019, CMS is delaying the start of the Performance Period of the Model by three months, such that the first performance year will begin April 1, 2021. The Implementation Period will begin in October 2020 for organizations that have already applied and are selected to begin participation during the IP. The application for participation beginning April 1, 2021 opened on June 4, 2020 and closed on July 6, 2020. Additionally, CMS plans to open a second application period in 2021 for organizations to enter the Direct Contracting Model on January 1, 2022. Note that participation in PY6 (2026) will be available to all DCEs, regardless of whether they begin the performance period in April 2021 or January 2022.

13. Q: If our organization already submitted an application, do we need to reapply? ***(Updated, October 2020)***

- If you applied to begin participation in the IP, were accepted, and sign the IP Participation Agreement (PA), you do not need to reapply to continue participating in PY1 (starting April 1,

2021).

- If you apply to begin participation in the IP and / or PY1 and were not accepted, you may reapply in the next application period to start January 2022.
- If you applied to begin participation in the IP or PY1 and are accepted, but wish to delay your start until January 2022, you do not need to reapply.

14. Q: Will there be additional opportunities to apply for Direct Contracting after Performance Year 1 begins in 2021?

CMS intends to have an additional application period in early 2021 for those interested in beginning participation in the model on January 1, 2022. A previously submitted Letter of Intent (LOI) **is not** required to apply for this application period.

15. Q: How does an organization apply to participate in the model? ***(Revised, October 2020)***

The application portal is currently closed. We will release information about applying to start in PY2/2022 in the future.

16. Q: Is a letter of intent (LOI) required to apply to Direct Contracting? ***(Updated, October 2020)***

While an LOI was required for the PY1 application, an LOI will not be required to access the PY2 application portal (i.e., to apply to begin the model in 2022).

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

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

18. Q: How will CMS select participants for the model?

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

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

The Geographic Option is still under development and the application for it will not be available during the Implementation Period for the Professional and Global Options.

20. Q: When are the DCE's arrangements with DC Participant Providers and Preferred Providers due to CMS and how are they submitted?

A sample arrangement between the DCE and the DC Participant Providers and Preferred Providers must be submitted with the application as well as a DC Participant Provider and Preferred Provider notification attestation signed by the DCE.

21. Q: How does the DC Participant Provider and Preferred Provider list submission process work? ***(New question, October 2020)***

Applicant DCEs that were awarded to participate beginning in the Implementation Period had an opportunity to update their DC Participant Provider List and Preferred Provider List for the IP provided with their application by August 14th. DCEs that begin participation during the IP will be required to submit a new DC Participant Provider List and a new Preferred Provider List for PY1 and each subsequent PY. DC Participant Providers and Preferred Providers do not carry over from year to year, though your prior year's list will be pre-populated in 4i as a starting point which DCEs will have the opportunity to adjust (i.e., add, remove, or edit providers). For PY1, this window to adjust provider lists is from September 15th through October 23rd (both for DCEs starting in the IP and for DCEs starting directly in PY1).

DC Participant Providers and Preferred Providers can be added mid-Performance Year as part of an ad-hoc process; however, DC Participant Providers that are added mid-Performance Year will not contribute to claims-based alignment for that PY and will not be eligible to participate in payment mechanisms (Total Care Capitation, Primary Care Capitation, and Advanced Payment). Further, DC Participant Providers can only be added if the provider in question (1) bills (at the time of the addition) for items and services he or she furnishes under a TIN that is used by a provider in the same DCE, and (2) did not bill under that TIN when the DCE submitted its provider list. Preferred Providers are not subject to the same restriction.

22. Q: What are the processes, deadlines and consequences for withdrawing early from Direct Contracting should a DCE choose to do so?

DCEs may participate in the IP and choose not to sign the PY1 Participation Agreement, which would signal a withdrawal from Direct Contracting, without any consequences.

To withdraw from Direct Contracting once a Performance Year begins, DCEs generally must terminate their Participation Agreement prior to February 28th of a Performance Year to avoid liability for shared losses (note: PY1 is the exception – since it starts on April 1, there will be no opportunity to terminate during the PY to avoid liability for shared losses for that PY). DCEs will face financial consequences for withdrawal prior to the final reconciliation for Performance Year 1 depending on the type of retention withhold a DCE chooses when it signs the PY1 Participation Agreement, from two options:

1) DCEs may choose a 2% "retention withhold," in the amount of an additional 2% discount applied to the DCE's Performance Year Benchmark. If the DCE's Participation Agreement remains in effect at the time of PY1 final reconciliation, the 2% retention withhold will be refunded to the DCE, as part of PY1 final reconciliation. If, on the other hand, the DCE terminates its Direct Contracting Participation Agreement before PY1 final reconciliation occurs, the DCE will not receive the 2%

withhold as part of PY1 reconciliation. CMS will conduct final reconciliation approximately six months after the performance year ends.

2) Alternatively, the DCE may choose to secure a "retention amount," calculated to be equivalent to the retention withhold (i.e., 2% of the DCE's Performance Year Benchmark), either with the same financial guarantee the DCE will be required to secure to ensure its ability to repay CMS Shared Losses or Other Monies Owed, or a separate financial guarantee. In the event that the DCE's Participation Agreement does not remain in effect at the time of PY1 final reconciliation, the DCE will be required to pay CMS the retention amount. If the DCE does not pay the retention amount to CMS, CMS would collect the retention amount under the terms of the DCE's financial guarantee. A DCE that selects to secure a retention amount would be required to continue its financial guarantee through the end of PY2 or until the retention amount is paid to CMS, whichever is later.

Eligibility

23. Q: What types of organizations can apply for the Direct Contracting model?

In addition to providing an option for NGACO participants who are seeking to continue their value based work with CMS, a key objective of Direct Contracting is to incent organizations that have not traditionally provided services to a Medicare FFS population or have not previously participated in Innovation Center models to join a risk-based total cost of care model for the Medicare FFS population. Therefore, a wide variety of organizations may be eligible to apply. The following are examples of organization types that may be eligible:

- ACOs or ACO-like organizations
- Network of individual practices (e.g., IPA)
- Hospital system(s)
- Integrated delivery system
- Partnership of hospital system(s) and medical practices
- Medicaid Managed Care Organizations (MCOs)
- Other payers
- Skilled Nursing Facilities (SNFs)
- Other

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

A DCE must be a legal entity identified by a Federal taxpayer identification number (TIN) formed under applicable state, federal, or tribal law, and authorized to conduct business in each state in which it operates for purposes of the following:

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

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

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

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

25. Q: How can health insurers participate in Direct Contracting? Can a health insurer apply as a DCE?

Health insurers are able to apply and participate as a DCE in either model option (Professional or Global). They may choose to apply as a Standard, New Entrant or High Needs DCE and are required to enter into arrangements with DC Participant Providers like all DCEs.

26. Q: Can an ACO become a DCE if it is presently participating in the NGACO Model, Medicare Shared Savings Program (Shared Savings Program), or another Innovation Center model? Can DCEs, DC Participant Providers and Preferred Providers also participate in the Medicare Shared Savings Program or other Innovation Center models? ***(Updated, October 2020)***

During the IP, DCEs and their DC Participant Providers and Preferred Providers can participate in both the Direct Contracting Model and the Shared Savings Program. During each performance year starting with 2021, DCEs and their DC Participant Providers may not simultaneously participate in the Shared Savings Program. The determination of whether such an overlap exists will be made at the TIN level prior to the start of each performance year. This requirement does not apply to Preferred Providers.

During the IP, DCEs and their DC Participant Providers and Preferred Providers may participate in other Innovation Center models if they meet all applicable eligibility criteria under the applicable demonstration or model. During each Performance Year, DCEs and their DC Participant Providers may only participate in other Innovation Center models that do not involve shared savings. They may not simultaneously participate in Direct Contracting and another model tested or expanded under section 1115A of the Act that involves shared savings, or any other Medicare initiative that involves shared savings, including the Maryland Total Cost of Care Model (all programs), the Vermont All-Payer ACO Model, the NGACO Model, the Kidney Care Choices models, CPC+ or Primary Care First, unless otherwise instructed by CMS. In addition, DC Participant Providers may not simultaneously participate in multiple DCEs in the Direct Contracting Model. These restrictions do not apply to Preferred Providers.

Related to overlaps, beneficiaries aligned to DCEs during the performance period will not be eligible to initiate episodes for the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model.

27. Q: If an organization is participating in another shared savings initiative and elects to participate as a DCE in Direct Contracting during the Performance Period, will CMS provide a pathway for organizations to transition from the existing shared savings initiative to Direct Contracting? Of particular interest is the ease with which CMS will allow organizations to exit existing shared savings agreements to participate in Direct Contracting. ***(Updated, October 2020)***

Per the previous question, while organizations generally cannot participate in two shared savings initiatives simultaneously, organizations currently in NGACO or the Shared Savings Program can apply to participate in the Direct Contracting Model during the IP and stay in their current model/program for some or all of the IP. Organizations may also choose to apply to begin participation in the Direct Contracting Model starting in PY1, which starts April 1, 2021, or PY2, which starts January 1, 2022. We have listed below information for transitioning to Direct Contracting in 2021 from three other initiatives:

Initiative transitioning from	Deadline to notify current initiative and Direct Contracting	Required effective date to drop from current initiative
Shared Savings Program	10/20/20	12/31/20 (PY2020)
NGACO	10/23/20	12/31/20 (PY2020)
CPC+	10/21/20	Prior to 4/1/21

28. Q: Does Direct Contracting have any regional eligibility requirements? How many DCEs are selected in each region?

No, there are no regional eligibility requirements. Participation in Direct Contracting is open to organizations across the country. CMS will select DCEs based on the quality of their application and the criteria listed in the RFA.

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

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

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

While a DCE will not be required to be a Medicare-enrolled provider or supplier in order to participate in the Direct Contracting Model, each DC Participant Provider and Preferred Provider under the DCE must be a Medicare-enrolled provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202) by no later than June 30, 2020, in order to be eligible to participate in the model during PY1.

For subsequent performance years, DCEs will be able to update their list of DC Participant Providers and

Preferred Providers annually to add Medicare-enrolled DC Participant Providers or Preferred Providers that satisfy the requirements of the model and are not Prohibited Participants.

30. Q: Must all downstream providers, including all DC Participant Providers and Preferred Providers, meet CEHRT Requirements?

DCEs are required to ensure that the percentage of DC Participant Providers that are eligible clinicians and that use certified electronic health record technology (CEHRT) to document and communicate clinical care to their patients or other health care providers meets or exceeds the CEHRT use criterion established under 42 C.F.R. 414.1415(a)(1)(i), currently 75%. If palliative care, hospice or home health providers are DC Participant Providers then they would be subject to this requirement and included in the denominator of the 75% requirement. Preferred Providers are not subject to this requirement.

31. Q: What is the difference between DC Participant Providers and Preferred Providers?

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

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

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

32. Q: If the DCE's TIN is associated with another program, for example a Shared Savings Program ACO, does it need to create a new TIN in order to apply to the Direct Contracting Model as a DCE?

During the IP, DCEs can participate in both Direct Contracting and the Shared Savings Program. During each performance year, however, DCEs and their DC Participant Providers may not simultaneously participate in another model tested or expanded under section 1115A of the Act that involves shared savings, or any other Medicare initiative that involves shared savings unless otherwise instructed by CMS. Direct Contracting uses a TIN-NPI combination to identify participating providers and suppliers, while the Shared Savings Program identifies ACO participants at the TIN level. The same TIN cannot be associated with a DCE or DC Participant Provider and a Shared Savings Program ACO or ACO Participant simultaneously during a performance year of the Direct Contracting Model.

33. Q: Can a DCE choose which of its associated NPIs participate in Direct Contracting and which do not? Can the DCE have some National Provider Identifiers (NPIs) in Shared Savings Program and some NPIs in Direct Contracting?

Direct Contracting is a split TIN model, meaning that all providers and suppliers billing under a TIN do not have to participate in Direct Contracting. Only providers and suppliers that are included on the DC Participant Provider List submitted by the DCE will be included in the DCE. DC Participant Providers and Preferred Providers are identified based on the TIN-NPI combination.

During the IP, DCEs and their DC Participant Providers and Preferred Providers can participate in both Direct Contracting and the Shared Savings Program. During each performance year of the Direct Contracting Model, however, they may not participate in the Shared Savings Program using the same TIN for the DCE or the DC Participant Providers. This restriction is not applicable to Preferred Providers.

34. Q: How many beneficiaries does each DCE need to begin in PY1? ***(Updated, October 2020)***

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

- **Standard DCE -** a minimum of 5,000 aligned Medicare FFS beneficiaries
- **New Entrant DCE -** a minimum of 1,000 aligned Medicare FFS beneficiaries with an increasing minimum beneficiary threshold each year to 5,000 prior to the start of PY5 and PY6
- **High Needs Population DCE -** a minimum of 250 aligned Medicare FFS beneficiaries with an increasing minimum beneficiary threshold each year to 1,400 prior to the start of PY6

New Entrant DCEs must not exceed 3,000 beneficiaries aligned via claims in any baseline year (2017, 2018, 2019) or any of the first four performance years (2021, 2022, 2023, and 2024). If the 3,000 threshold is exceeded, DCEs will have the opportunity to participate as a Standard DCE, provided the model requirements are met. Additionally, of the 5,000 aligned beneficiaries a New Entrant DCE is required to have by PY5, 3,000 or more must have been aligned via claims to show progress in establishing patient-provider relationships.

35. Q: Is a DCE still eligible to participate in PY 1 if it does not meet the beneficiary alignment requirements and thresholds during the IP?

In order to participate in the IP, the DCE does not need to meet the minimum beneficiary alignment thresholds. However, the DCE should use the Implementation Period to align beneficiaries prior to the start of PY1 and must meet the applicable minimum beneficiary threshold prior to the start of PY1. Organizations that fail to meet the applicable requirement regarding the minimum number of aligned beneficiaries prior to the start of each performance year will not be permitted to continue to participate in Direct Contracting.

36. Q: Can a Standard DCE split to form a separate High Needs DCE?

Standard DCEs are not allowed to split and form two separate DCEs – one High Needs DCE for their High Needs beneficiaries and one Standard DCE for their remaining beneficiaries.

37. Q: What happens if a High Needs Population DCE has high numbers of beneficiaries that can be used to construct a credible benchmark?

High Needs DCEs that reach 3,000 claim-based aligned beneficiaries will convert to a Standard DCE for purposes of their benchmark, similar to New Entrant DCEs. These High Needs DCEs will still have the flexibility to focus only on High Needs beneficiaries but their benchmark will incorporate a historical baseline component for claims-aligned beneficiaries.

Beneficiary Alignment

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

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

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

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

39. Q: How does CMS align beneficiaries to DCEs?

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

1. Claims-based alignment where beneficiaries are aligned based on the plurality of primary care services furnished by DC Participant Providers, as evidenced in claims utilization data.

2. Voluntary alignment where beneficiaries communicate their desire to be aligned with a DC Participant Provider.

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

40. Q: What is voluntary alignment?

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

41. Q: How does voluntary alignment work? ***(Updated, October 2020)***

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

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

42. Q: How will CMS identify and align beneficiaries to High Needs DCEs? ***(Updated, October 2020)***

CMS will align Medicare FFS beneficiaries to all DCE Types based on voluntary alignment and claims-based alignment. CMS will align individuals to a High Needs Population DCE if they meet the high needs criteria prior to initial alignment and are otherwise eligible for alignment to a DCE. For individuals to be eligible to be aligned to a High Needs Population DCE, they must meet at least one of the criteria listed at the bottom of page 26 in the Financial Operating Guide Overview. Medicare FFS beneficiaries, including dually eligible beneficiaries, meeting at least one of these conditions are eligible for alignment to a High Needs Population DCE.

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 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, dies, or is otherwise retrospectively removed from alignment). Starting in PY1, 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 as long as the beneficiary remains aligned to the same High Needs DCE. For example, if a beneficiary meets High Needs eligibility criteria and is aligned to DCE X in PY1, the beneficiary will not be de-aligned even if he / she ceases to meet High Needs eligibility in PY2, provided that he / she continues to be aligned to

DCE X in PY2 (through claims or voluntary alignment) and meets the general model eligibility requirements (enrolled in both Part A and B, Medicare primary payer, etc.)). This is to ensure continuity of care for High Needs beneficiaries and to avoid punishing High Needs DCEs for providing effective care.

43. Q: How will CMS determine a DCE's Core Service Area and Extended Service Areas? ***(Updated, October 2020)***

CMS will identify a DCE's service area for purposes of beneficiary alignment based on the list of the DC Participant Providers submitted by the DCE during the application process. A DCE's Core Service Area includes all counties in which the DCE's DC Participant Providers have physical office locations. The Extended Service Area includes all counties contiguous to the Core Service Area. The DCE's service area is distinct from the DCE's region, which includes all counties where DCE-aligned beneficiaries reside. For DCEs whose clinical model does not rely on a physical practice location (i.e. through delivery of services in locations other than a provider's office, such as beneficiaries' homes), DCEs may propose for CMS' consideration an alternative to the county-by-county physical practice location standard. To receive an exception, DCEs will be required to document their capability to operate in the proposed service area including the provision of face-to-face care and interaction with beneficiaries

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

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

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

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

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

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

47. Q: Will the beneficiary alignment processes differ for New Entrant DCEs given they may have no experience with FFS beneficiaries?

In an effort to encourage organizations new to Medicare FFS to participate in Direct Contracting, CMS will provide an alignment "glide path" to allow these New Entrant DCEs an adequate time to grow their population of aligned beneficiaries. Fundamentally, the mechanics of alignment will not change: voluntary alignment and claims-based alignment will serve as the sources of beneficiary alignment for these DCEs.

New Entrant DCEs may participate in Direct Contracting during the IP and engage in activities related to voluntary alignment to meet the minimum of 1,000 aligned beneficiaries prior to the start of PY1 (April 1, 2021). New Entrant DCEs will be required to increase the minimum number of aligned beneficiaries to

2,000, 3,000 and 5,000 prior to the start of PY3, PY4 and PY5 respectively. They will further be required to maintain a minimum of 5,000 aligned beneficiaries prior to the start of PY5. Further, prior to the start of both PY5 and PY6, the New Entrant DCE must have more than 3,000 beneficiaries aligned using claims-based alignment. If this is not the case, the DCE will not be permitted to continue participating in the model.

48. Q: What is the difference between Prospective Alignment and Prospective Plus Alignment? If a beneficiary voluntarily changes their alignment, does the selection of Prospective Alignment or Prospective Plus Alignment affect when the beneficiaries are voluntarily aligned to a DCE?

Both of these alignment options rely on establishing the DCE's aligned beneficiary population prospectively; however, they differ in the frequency with which CMS aligns beneficiaries through voluntary alignment.

- **Prospective Alignment** will function similarly to the prospective alignment methodology currently used in the NGACO Model. All claims-based alignment and voluntary alignment will be completed prior to the start of each performance year. If a DCE selects Prospective Alignment and a beneficiary who is not otherwise aligned to any model or entity voluntarily aligns to that DCE after the annual alignment process is run for a performance year, the beneficiary will not be aligned to the DCE until the following performance year.
- **Prospective Plus Alignment** will allow DCEs to have beneficiaries who have voluntarily aligned (through either electronic or paper-based) to the DCE since the annual prospective alignment process added to their aligned beneficiary population on a quarterly basis throughout the performance year. Only those beneficiaries who were not already aligned to another DCE or an organization participating in another initiative for the performance year will be aligned to the DCE mid-performance year under Prospective Plus Alignment.

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

Yes. Beneficiaries can opt out of data sharing at any time by contacting 1-800-MEDICARE and indicating their preference that CMS not share their data with the DCE.

Benefit Enhancements and Beneficiary Engagement Incentives

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

In order to emphasize high-value services and support the ability of DCEs to manage the care of beneficiaries, CMS has designed policies using the authority under section 1115A of the Social Security Act to conditionally waive certain Medicare payment requirements as part of testing Direct Contracting. Beneficiary engagement and coordination of care could be further enhanced by providing additional incentives to beneficiaries that would potentially motivate and encourage beneficiaries to become actively involved in their care. While we expect to include the benefit enhancements and beneficiary engagement incentives currently permitted in the NGACO Model, we are also considering including new ones in Direct Contracting. The benefit enhancements and beneficiary engagement incentives under consideration for Direct Contracting are highlighted in the table below:

Benefit Enhancements

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

51. Q: Can CMS provide a comprehensive list of benefit enhancements and beneficiary engagement incentives that are available in the NGACO model currently and expected to be available in Direct Contracting?

The NGACO model currently allows the following benefit enhancements and beneficiary engagement incentives, which CMS expects to include in the Direct Contracting Model beginning in PY1:

- 3-Day SNF rule waiver: Would conditionally waive the requirement for the three-day inpatient stay prior to the admission to a SNF.
- Telehealth expansion: Would conditionally waive the rural geographic requirement for an originating site and allow the beneficiary's place of residence to serve as an originating site when telehealth services are furnished by Preferred Providers, and also include coverage of certain teledermatology and teleophthalmology services furnished by DC Participants and Preferred Providers through asynchronous (i.e., store and forward) technologies.
- Post-discharge home visits: Would allow auxiliary personnel (e.g., licensed clinicians) to perform "incident to" post-discharge home visit services to non-homebound aligned beneficiaries under the general supervision of a DC Participant Provider or Preferred Provider for up to nine visits in a 90-day period.
- Care management home visits: Would allow auxiliary personnel (e.g., licensed clinicians) to perform "incident to" care-management home visit services to non-homebound aligned beneficiaries under the general supervision of a DC Participant Provider or Preferred Provider up to twelve times within a performance year.
- Cost Sharing Support for Medicare Part B Services: This beneficiary engagement incentive would allow DCEs to make payments to a DC Participant Provider or Preferred Provider to cover some or all of the amounts of beneficiary cost sharing not collected.
- Chronic Disease Management Reward Program: This beneficiary engagement incentive would allow DCEs to provide gift cards to eligible beneficiaries for the purpose of incentivizing

participation in a qualifying chronic disease management program. Among other requirements, the aggregate value of any and all gift cards provided to a beneficiary in a year cannot exceed $75, cannot be offered in the form of cash or monetary discounts or rebates, including reduced cost-sharing or reduced premiums, and cannot be redeemable for cash.

52. Q: Are DCEs required to offer these benefit enhancements and beneficiary engagement incentives?

A DCE may choose not to implement some or all benefit enhancements and beneficiary engagement incentives offered under Direct Contracting. Applicants will be asked to provide information regarding their proposed implementation of any benefit enhancements or beneficiary engagement incentives they select, but acceptance into Direct Contracting is not contingent upon the applicant agreeing to implement any particular benefit enhancement or beneficiary engagement incentive.

53. Q: Are benefit enhancements available to DCEs during the IP?

No, there will be no benefit enhancements allowed during the IP.

Financial Model

Note: Since the Direct Contracting team released financial specification papers, we have received additional stakeholder questions related to the financial methodology. For ease of reference, and since these questions are better organized in their own sub-categories, we have moved the financial-related FAQs to a separate finance-focused FAQ document to which we have added a number of questions related to the specification papers. The finance-focused FAQ document is available on our website under the Financial Methodology header.

Quality and Reporting

54. Q: What data will CMS provide, including benchmark and historical data, to organizations during the IP and PYs?

CMS plans to make several types of Medicare data available to DCEs participating in Direct Contracting. During the IP and the Performance Period, the DCE may request the minimum necessary data for their aligned beneficiaries to develop and implement care coordination and quality improvement activities. For both the IP and the Performance Period, the data may be used only consistent with the terms of the applicable CMS agreements, including the Participation Agreement, DC Participant Provider/Preferred Provider Certification forms and Data Use Agreements (DUAs).

During the IP and the Performance Period, CMS will provide those DCEs the opportunity to request detailed claims data. Such claims data will include individually identifiable Claim and Claim Line Feed (CCLF) reports for services furnished by Medicare-enrolled providers and suppliers to aligned beneficiaries during the IP or PY, respectively, as well as historical CCLF files. The historical CCLF files provided at the beginning of a performance year will capture a 36-month lookback of claims for newly aligned beneficiaries. Only 12 months of historical CCLF data will be made available during the IP.

During both the IP and the PYs, CMS will also provide DCEs, upon request, operational reports on a regular basis. These reports may include but will not be limited to: Quarterly and Annual Utilization; Monthly Expenditures; Beneficiary Data Sharing Preferences; Monthly Claims Lag; and Beneficiary Alignment reports.

During the PYs, CMS will also provide quarterly baseline benchmark reports (BBRs) to DCEs to enable them to monitor their financial performance throughout the performance year. The BBRs will not contain individually identifiable data. The same design and data source used to generate the BBRs will also be used for the interim and final reconciliation report. These reports will not be provided during the IP.

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

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

Core Set

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for Accountable Care Organizations (ACOs) surveys.[1] CAHPS is a program of the Agency for Healthcare Research and Quality, U. S. Department of Health and Human Services. Adaptation to include a measure of 24/7 access will be added later in the model.
2. All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (Claims Based)
3. Risk-Standardized All Condition Readmission (Claims Based)

Note that Advanced Care Plan (NQF 0326) has been removed from the proposed measure set.

Test Measures/Measures in Development

1. Days spent at home (Claims Based). This measure will be developed during the initial years of the model. The measure will be utilized by High Needs DCEs.
2. Care Coordination (Claims Based) is replacing Advanced Care Plan in the measure set. This measure will be developed during the initial years of the model. The measure will be utilized by all Global and Professional DCEs.

56. Q: How does quality reporting fit into the benchmark? ***(Updated, October 2020)***

Similar to NGACO, CMS will use a quality "withhold," in which a portion of a DCE's Performance Year Benchmark is held "at-risk," contingent upon the DCE's quality score. Five percent of the benchmark will be withheld during each performance year for DCEs as the quality withhold amount. The DCEs' performance on quality measures will determine how much of the quality withhold they will earn back.

[1] CAHPS® is a program of the Agency for Healthcare Research and Quality, U. S. Department of Health and Human Services.

In PY 1 and 2, DCEs are required to meet a pre-defined performance benchmark on one of two utilization measures (Risk-Standardized, All Condition Readmission or All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions) to earn back 1% of their quality withhold. All other measures are Pay-for-Reporting to earn back the remaining quality withhold. For PY 3-5, payment for quality will be tied to Continuous Improvement and Sustained Exceptional Performance (CI/SEP) criteria and overall quality performance. DCEs that improve their performance each year and/or are among the highest performing DCEs will earn back higher levels of the withhold, and potentially even more via the High Performers Pool (HPP). More details on this methodology will be included in a future financial methodology paper.

57. Q: What is the Continuous Improvement and Sustained Exceptional Performance (CI/SEP) criteria and how will it be applied? ***(Updated, October 2020)***

To encourage DCEs to deliver high quality, high value care, payment for improvement on quality will also be tied to demonstrable continuous improvement in reducing unnecessary or avoidable health care service utilization. Starting in PY 3, a pre-defined performance benchmark will serve as the CI/SEP criteria. Half (2.5%) of the quality withhold will be tied to demonstrable continuous improvement and sustained exceptional performance (CI/SEP) criteria. DCEs that exceed the CI/SEP benchmark will have their quality score applied to the entire 5% withhold (i.e., a quality score of 90% would result in a 4.5% earn back) whereas DCEs that do not meet or exceed the CI/SEP benchmark will have their quality score applied to half of the 5% withhold (i.e., a quality score of 90% would result in a 2.25% earn back). CMS recognizes that DCEs achieving high performance rates may have less room to show improvement. Accordingly, when establishing these continuous improvement targets, CMS will establish targets that still incentivize higher performing DCEs to continue to improve.

58. Q: What is the High Performers Pool (HPP)? ***(Updated, October 2020)***

Direct Contracting will test the use of an HPP to further incentivize high performance and continuous improvement on the model's quality measures. A DCE will qualify for a bonus from the HPP if in addition to meeting the model's continuous improvement/sustained exceptional criteria, the DCE also demonstrates a high level of performance or meets improvement criteria on a pre-determined subset of the quality measures from the quality measure set. The HPP will be "funded" from quality withholds not earned back by the DCEs who met the CI/SEP criteria. There will be no HPP in the first two performance years. Additional information on the HPP criteria will be shared prior to PY3.

59. Are DCE's DC Participant Providers and Preferred Providers eligible for Qualifying APM Participant (QP) status under the Quality Payment Program (QPP)?

DC Participant Providers who are on the DCE's provider list submitted to CMS are eligible to become a Qualifying APM Participant (QP) for a Performance Year. Beyond being on the provider list, these DC Participant Providers must meet the thresholds required by the QPP. If they meet one of the required thresholds, they will be entitled to an APM Incentive Payment and exempt from MIPS reporting requirements and payment adjustments. However, **Preferred Providers are not eligible for QP status under the Direct Contracting Model**. For additional questions related to MIPS and the APM Incentive

Payment, you can see the qpp.cms.gov website for more details or contact the Quality Payment Program help desk at qpp@cms.hhs.gov.

60. Q: Is the APM Incentive Payment considered an expenditure when calculating shared savings?

The APM Incentive Payment will not be included in the Benchmark or counted as part of the Total Cost of Care for a DCE aligned population.

Appendix

Appendix A:
The select non-primary care specialists that may bill Primary Care Qualified Evaluation and Management (PQEM) codes has been updated to include additional specialists as noted below.

Code[1]	**Specialty**
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

Appendix B:

The list of PQEM codes has been updated to include additional codes, as noted below.	
Administration of HRA	
96160	Administration of patient-focused health risk assessment instrument
96161	Administration of caregiver-focused health risk assessment instrument
Office or Other Outpatient Services	
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
Domiciliary, Rest Home, or Custodial Care Services	
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
Professional services provided in a non-skilled Nursing Facility *(note: per the proposed Medicare Shared Savings Program methodology, claims will be excluded from alignment if a beneficiary has a SNF stay with overlapping dates of service)*	
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
Domiciliary, Rest Home, or Home Care Plan Oversight Services	
99339	Brief
99340	Comprehensive
Home Services	
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
Prolonged care for outpatient visit	
99354	Prolonged visit, first hour

99355	Prolonged visit, add'l 30 mins
Telephone Visits – Online digital or Audio Only	
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 – *Note: for PHE only*
99442	Phone, Established Patient, 10–20 mins – *Note: for PHE only*
99443	Phone, Established Patient, 21+ mins – *Note: for PHE only*
Chronic Care Management (CCM) Services	
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
Behavioral Health Integration (BHI) Services	
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
Transitional Care Management Services	
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)
Advance Care Planning	
99497	ACP first 30 mins – *Note: subject to exclusion from alignment if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation*
99498	ACP add'l 30 mins – *Note: subject to exclusion from alignment if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation*
Wellness Visits	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit
Depression and alcohol misuse	
G0442	Annual alcohol misuse screening
G0443	Annual alcohol misuse counseling
G0444	Annual depression screening
Professional Services Provided in ETA Hospitals	
G0463	Professional Services Provided in ETA Hospitals
Virtual check-ins	
G2010 *PHE only*	Remote evaluation, Established Patient
G2012 *PHE only*	Brief communication technology-based service, 5-10 mins of medical discussion