Global and Professional Direct Contracting (GPDC) Model

Finance-Focused

Frequently Asked Questions

Version 2

Date: April 2021

General Questions

1. Q: What risk-sharing options does the Global and Professional Direct Contracting (GPDC) Model offer?

CMS will test two voluntary risk-sharing options in the GPDC Model: 1) Professional, a lower-risk option (50% Shared Savings/Shared Losses (SS/SL)); 2) Global, a full risk option (100% SS/SL).

2. Q: Are Direct Contracting Entities (DCEs) required to participate in Primary Care Capitation (PCC), Total Care Capitation (TCC), or Advanced Payments?

Standard, New Entrant, and High Needs Population DCEs are required to participate in PCC or TCC, depending on which risk-sharing option they select. DCEs who select the Professional risk option must elect PCC. DCEs who select the Global risk option must choose either PCC or TCC. DCEs in either risk option (Professional or Global) that select PCC may also select the Advanced Payment Option.

3. Q: Why is CMS requiring the Capitation Payment Mechanisms of PCC and TCC for DCEs with DC Participant Providers or Preferred Providers as part of this model?

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

In recognition of the challenges posed by coronavirus disease 2019, PCC will be optional for Performance Year 1 (PY2021) for DC Participant Providers. For DC Participant Providers who elect the PCC payment mechanism in PY2021, they can individually choose the amount of claims reduction ranging from 1-100. Starting in PY2022, DC Participant Providers must have some portion of their eligible claims reduced via PCC, with a floor of at least 5 percent claims reduction. This floor will increase to 10 percent for PY2023, 20 percent for PY2024, and 100 percent for PY2025 and PY2026. Including Preferred Providers in PCC is optional for all performance years of the model. This policy applies to all DCEs regardless of start date.

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

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

Comparison of the Professional and Global Options

	Policy	Professional	Global
1	Risk Arrangement	50% of savings/losses.	100% of savings/losses.
2	Capitation Option	PCC only (generally set at 7% of the Performance Year Benchmark).	Both options available: PCC or TCC.

	Policy	Professional	Global
3	Discount and Quality Withhold	• No discount. • 5% Quality Withhold.	• Discount of 2% in PY2021/PY2022 (increasing to 3% in PY2023, 4% in PY2024, and 5% in PY2025/PY2026). • 5% Quality Withhold.

Benchmarking

5. Q: How is the Performance Year Benchmark calculated?

The benchmark will be developed by using all or the latter three of the following five steps: (1) calculating the DCE's historical baseline spending for its aligned beneficiary population; (2) trending the historical baseline expenditures forward based on an adjusted version of the U.S. Per Capita Cost (USPCC) growth trend; (3) blending the historical baseline expenditures with regional expenditures using an adjusted Medicare Advantage Rate Book (referred to as the DC/KCC Rate Book); (4) making adjustments to the blended expenditures to account for the risk of the aligned beneficiaries; and (5) applying a discount for DCEs that selected the Global Option and withholding a portion of the benchmark "at risk" subject to the DCE's performance on quality measures. Please consult the Financial Operating Guide Overview paper available on our website for more details. The Financial Operating Guide Overview applies to Standard, New Entrant, and High-Needs Population based DCEs.

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

The discount is an adjustment incorporated into the benchmark for DCEs in the Global Option. As DCEs in the Global Option are eligible to retain up to 100% of gross savings, this discount will provide the primary mechanism for CMS to obtain savings from the DCEs participating in this option. CMS will apply the discount to the trended, regionally blended, risk adjusted benchmark. This discount will be set at two percent of the benchmark for PY2021 and PY2022 and increased by one percentage point for each subsequent year until PY2026, requiring continuous improvement from DCEs in the Global Option. A discount is not applied for the Professional Option.

Performance year	Global discount	Professional discount
2021	2%	N/A
2022	2%	N/A
2023	3%	N/A
2024	4%	N/A
2025	5%	N/A
2026	5%	N/A

7. Q: What is included in the total cost of care calculation?

All expenditures incurred by Medicare, including capitation payments, non-claims-based payments, and FFS claims paid, on behalf of aligned beneficiaries would be included as part of total cost of care of the DCE for the relevant performance year. This includes all outpatient services, such as primary care and specialist services, skilled nursing facility (SNF) services, ER and hospital visits and in-patient services. For beneficiaries who have elected hospice, all care, whether for hospice or non-hospice services, will be included. The Advanced Alternative Payment Models (APM) 5% incentive payment (discussed at https://qpp.cms.gov/apms/advanced-apms) will not be included in the Benchmark or counted as part of the Total Cost of Care for a DCE aligned population.

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

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

9. Q: Will non-claims-based payments be included as expenditures?

Non-claims-based payments from CMS will be included in the Performance Year Benchmark (and performance year expenditures) when they take the place of claims that would have otherwise been paid through FFS. This will include Capitation Payments or Advanced Payments in GPDC. Non-claims-based payments that are independent of claims, such as the infrastructure payments offered in the Next Generation ACO (NGACO) model, will not be included in the benchmark or expenditures.

10. Q: What is the patient financial responsibility for cost sharing in GPDC? Do the capitation payment mechanisms or Advanced Payment change this?

GPDC does not change cost-sharing responsibility of beneficiaries or Supplemental Payers (regardless of the DCE type, how providers are paid or whether the provider is participating in capitation or Advanced Payment).

CMS is including an optional beneficiary engagement incentive under which a DCE may (but is not required to) enter into a cost sharing support arrangement with its DC Participant Providers and Preferred Providers, pursuant to which the DC Participant Providers and Preferred Providers would not collect beneficiary cost sharing amounts (in whole or in part) from categories of aligned beneficiaries and for categories of Part B services (excluding prescription drugs and durable medical equipment) identified by the DCE. For example, a High Needs DCE may decide to limit cost sharing responsibilities for certain high needs beneficiaries who need to visit providers on a monthly basis in order to decrease hospital utilization. This would be an optional arrangement that a DCE can pursue.

11. Q: How will CMS calculate the maximum upward and downward adjustment that occurs to the financial benchmark each year when combining baseline and regional expenditures?

CMS will calculate a maximum upward and downward adjustment in the benchmarking methodology that includes a historical baseline component (i.e., Standard DCEs in PY2022). When combining the baseline with the regional expenditures, we will limit the overall upward adjustment from incorporating the regional expenditures to a flat dollar amount equal to five percent of the adjusted FFS United States Per Capita Cost (USPCC) for the performance year, and the overall downward adjustment to a flat dollar amount equal to two percent of the adjusted FFS USPCC.

The weighting for the blending of the baseline and regional expenditures will function as follows:

	PY2021	PY2022	PY2023	PY2024	PY2025 & PY2026
Composition of the Performance Year Benchmark	65% Historical Baseline Expenditures	65% Historical Baseline Expenditures	60% Historical Baseline Expenditures	55% Historical Baseline Expenditures	50% Historical Baseline Expenditures
	35% Regional Expenditures	35% Regional Expenditures	40% Regional Expenditures	45% Regional Expenditures	50% Regional Expenditures

12. Q: Are there any methodological differences for DCEs that join the model in April 2021 vs. those that join the model in January 2022?

Regardless of the start date for a DCE (April 2021 or January 2022), the financial methodology will be the same within a given performance year. Features such as the baseline period, blend weighting, and DC/KCC Rate Book will be applied in the same manner for all DCEs in each performance year.

13. Q: How will the effects of coronavirus disease 2019 in calendar year 2020 impact benchmarking for 2021 and future performance years?

The 2020 calendar year is not included in the fixed baseline period used to develop benchmarks for Standard DCEs. It is also not included in the years used to develop the DC/KCC Rate Book for performance year 2021. In future performance years, CMS may avoid using 2020 as one of the years used in the DC/KCC Rate Book development, to limit direct impacts of coronavirus disease 2019. As the CMS- Hierarchical Condition Category (HCC) prospective risk adjustment model used for Standard and New Entrant DCE types is prospective, risk scores used for 2021 may be somewhat impacted by coronavirus disease 2019. CMS anticipates that the retrospective normalization factor should help account for changes in coding practices driven by coronavirus disease 2019, but we will continue to monitor the effects of the pandemic and consider methodological updates as new information becomes available.

14. Q: A number of benchmarking elements (such as beneficiary alignment, risk score normalization, the Coding Intensity Factor (CIF) and the DC/KCC Rate Book) make use of the DC National Reference Population. Which beneficiaries are included in this population and how is it different from the FFS population?

The DC National Reference Population consists of the subset of FFS beneficiaries that meet the eligibility criteria for the Model. The following criteria must be met for a beneficiary month to be eligible:

- The beneficiary is alive on the first day of the month.
- The beneficiary is enrolled in Part A.
- The beneficiary is enrolled in Part B.
- The beneficiary is enrolled in Traditional FFS Medicare (e.g., not enrolled in MA).
- The beneficiary has Medicare listed as the primary payer.
- The beneficiary is a U.S. resident.

Only beneficiaries that meet these criteria can be aligned to GPDC, so the same criteria are applied as part of benchmarking in order to generate consistent and accurate benchmarks.

15. Q: The first PY runs from April 1, 2021 through December 31, 2021, a period of 9 months. How will the shortened PY impact the benchmarking and reconciliation calculations?

To maintain consistency with the financial methodology for the remainder of GPDC, CMS will calculate the benchmark on a per-beneficiary-per-month (PBPM) basis for the first PY using the same 12-month methodology used for PY2022 through PY2026. CMS will address the shortened PY by applying a seasonality adjustment to the PY2021 PBPM Benchmark that accounts for the difference in monthly expenditures between a 12-month calendar year (January – December) and the 9-month performance period for PY2021 (April – December). This seasonality adjustment will apply to the benchmark after all other benchmarking calculations are complete. The seasonally adjusted benchmark will then be compared to the expenditures accrued during the 9-month performance year spanning April - December 2021.

DC/KCC Rate Book

16. Q: What years are used to construct the DC/KCC Rate Book? Is the Rate Book based on a fixed baseline period (2017 - 2019) or does that adjust with each performance year?

The DC/KCC Rate Book uses a three-year baseline period to construct the county relative cost indices. The third and most recent year from this baseline period is used to construct the historical National Conversion Factor, which is trended to the performance year using an adjusted version of the FFS USPCC trend published by the CMS Office of the Actuary (OACT). This baseline period is not fixed; it will roll forward based on the performance year. However, CMS is continuing to monitor the potential impact of coronavirus disease 2019 on potential base years (BYs) for use in the DC/KCC Rate Book and may revise BYs used in order to establish appropriate county rates for a given performance year (PY). For example, CMS may determine that 2020 is not appropriate as a BY and apply 2017, 2018, and 2019 as the 3 BYs for PY2022 instead of 2018, 2019, and 2020. Final decisions on BYs will be communicated prior to a given PY with the publication of the DC/KCC Rate Book. The proposed base years for the DC/KCC Rate Book construction are as follows:

Performance year	**Calendar year**	**DC/KCC Rate Book base years** Data used for DC/KCC Rate Book development
1	2021	2017, 2018, 2019
2	2022	2018, 2019, 2020
3	2023	2019, 2020, 2021
4	2024	2020, 2021, 2022
5	2025	2021, 2022, 2023
6	2026	2022, 2023, 2024

17. Q: How do the county rates distinguish between beneficiaries with different eligibility categories and/or different health risks?

The county rates in the DC/KCC Rate Book are calculated on a risk-standardized basis for the average beneficiary in each county. Separate county rates are provided for Aged & Disabled (A&D) and End-Stage Renal Disease (ESRD) eligibility categories based on precedents in Medicare Advantage and other CMS programs. Within the A&D and ESRD rates, any additional differences in beneficiary eligibility

categories or health risk are reflected in the application of risk adjustment to the county rates; beneficiaries will all have the same county rates, however, they will have different risk scores and thus will contribute different amounts to the benchmark and payment.

Capitation

18. Q: What does CMS mean when indicating that the DCE will be responsible for paying downstream providers? Will all providers and suppliers still bill Medicare and receive payment under current models?

CMS will be making capitated monthly payments directly to each DCE according to the DCE's PCC or TCC election. Each DCE will be required to have its own payment arrangements with its DC Participant Providers and Preferred Providers participating in capitation. DCEs must have payment arrangements with DC Participant Providers and Preferred Providers for any payments subject to capitation or advanced payment. All other claims submitted that are not subject to reductions for capitation or advanced payment will continue to be paid in full by CMS via the FFS claims processing system. Note that all providers (even those participating in the Capitation Payment Mechanism or Advanced Payment Option) are still required to submit claims to CMS for services provided to beneficiaries.

DC Participant Providers and Preferred Providers receive payments for Part A and Part B services from the DCE and/or CMS based on their contractual arrangement with the DCE. The payments from the DCE may include sub-capitation and other value-based payments. All DC Participant Providers must participate in the Capitation Payment Mechanism selected by the DCE. Preferred Providers have the option to participate in the Capitation Payment Mechanism. Both DC Participant and Preferred Providers also have the option to participate in the Advanced Payment Option if the DCE selects Primary Care Capitation.

19. Q: How will DCEs be paid in the GPDC Model?

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

DCEs electing the Professional risk-sharing arrangement are required to receive PCC (starting in PY2022 – it is optional in PY2021) whereby CMS will generally pay 7% of the Performance Year Benchmark (based on Part A and B services) to the DCE in monthly capitation payments. This payment is intended to cover the primary care based services furnished to aligned beneficiaries by DC Participant Providers and Preferred Providers participating in PCC with the DCE, along with an additional amount for enhanced primary care services, such as increased access to primary care, enhanced provision of care, and care coordination. DC Participant Providers and Preferred Providers delivering primary care services and participating in PCC will receive some or all of their payment for such primary care services from the DCE; the remainder, if any, will be paid through the FFS system. All DC Participant Providers and Preferred Providers will continue to submit claims to the Medicare payment systems.

Starting in PY2021, DCEs in the Global risk-sharing arrangement must choose to receive either PCC, described above, or TCC, which encompasses all Medicare Part A and B services furnished to aligned

beneficiaries by DC Participant Providers and Preferred Providers who have agreed to participate. Under TCC, CMS will pay the DCE 100% of the Performance Year Benchmark (based on Part A and B services) minus a percentage for services expected to be billed by providers and suppliers not participating in TCC for the care of the aligned beneficiaries based on historical experience. Monthly capitated payments will be paid to DCEs. DC Participant Providers would receive 100% of their Medicare payments from the DCE. Preferred Providers who have elected to participate in TCC would receive between 1-100% of their payments through the DCE; the remainder would be paid through the FFS claims processing system. All DC Participant Providers and Preferred Providers will continue to submit claims to the Medicare payment systems.

Payments made to each DCE, either through the PCC or TCC, will be factored into shared savings/shared losses calculations.

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

20. Q: Are DCEs required to pay their DC Participant Providers and/or Preferred Providers through their own FFS mechanisms?

No, DCEs may enter into their own downstream payment arrangement with their DC Participant Providers and Preferred Providers and are not required to pay them FFS. However, any such arrangements must comply with the applicable terms of the GPDC Participation Agreement.

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

Yes, in accordance with the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA), as amended, CMS will reduce the payments made to DCEs by 2% to account for sequestration. The benchmark and performance year expenditures will be calculated on a pre-sequestration basis. However, sequestration will be applied to TCC, PCC, and, if selected, Advanced Payments before they are paid to DCEs; where sequestration will result in a 2% reduction in any capitated payments and Advanced Payments paid by CMS to the DCE. In addition, at Provisional and Final Financial Reconciliation, calculations will be performed on a pre-sequestration basis, however any shared savings payments earned by the DCE will have sequestration applied and be reduced by 2%. Reductions for sequestration will not apply to the recoupment of any shared losses. **Please note, however, that the temporary suspension of sequestration due to the ongoing Public Health Emergency (PHE) also applies to GPDC.**

22. Q: Will CMS process claims for the capitated population-based payments?

DCEs are required to receive capitation payments from CMS for services provided by their DC Participant Providers and Preferred Providers participating in the capitation payment to aligned beneficiaries (note that PCC is optional for PY2021). While these providers and suppliers are expected to submit claims to CMS, the DCE (and CMS if claims are not fully zeroed out) will compensate these providers and suppliers for services provided. Depending on the type of capitation the DCE chooses, claims will be reduced or zeroed out either for primary care services for PCC or all services for TCC. Submitted claims that are subject to reduction will still be processed and adjudicated according to regular processes. The claims data, including allowed charges and paid amount, will be made available to DCEs. DCEs must work with their DC Participant Providers and Preferred Providers to determine and administer the appropriate payment that the providers and suppliers should receive based on their agreements with the DCE. In terms of the claims submission process, there is no difference between how claims are submitted to CMS under Original Medicare as compared to GPDC. No changes will be made to claims adjudication. The only difference is the allowed amount will be fully paid for FFS claims, whereas it will be reduced according to the provider's TCC, PCC, or Advanced Payment claims reduction election in GPDC.

23. Q: Why is the PCC set at 7% of the total cost of care? Is there any flexibility around the 7%?

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

While we expect PCC to function as described in the RFA and in the paragraph above in general, we acknowledge that there may be specific DCEs that would prefer flexibility in how they receive PCC payments. As such, we are allowing the following flexibilities:

- DCEs whose DC Participant Providers have historically provided primary care services that exceed 7% of total expenditures for their historically aligned population will be allowed to have their Base PCC amount match that historical amount (e.g., if Base PCC is calculated to be 8%, we will keep it at 8% rather than constrain it down to 7%). Note: we expect this to be rare.
- DCEs for whom Base PCC exceeds 5% will still be entitled to up to 2% Enhanced PCC. This means that total PCC payments can exceed 7% (this is rare). For example, if Base PCC is calculated to be 6% or 8%, in both cases the DCE would be allowed to receive up to 2% Enhanced PCC. The Enhanced PCC would be fully recouped separate to final reconciliation, just as described in the RFA.
- DCEs will be allowed to elect to receive lower Enhanced PCC payments than they are entitled to. For example, for a DCE whose Base PCC = 3%, Enhanced PCC would be 7% - 3% = 4%. The DCE in

this example could receive up to 4% Enhanced PCC but is able to elect a lower amount if they choose (e.g., 0%, 1%, 2% or 3%).

24. Q: How are the discount and quality withhold reflected in capitation payments?

The capitation payment is calculated as a percentage of the benchmark after the application of any discounts and the quality withhold (as well as a projected quality earn back). For example, if the DCE had a projected quality score of 90% based on historical quality scores, the benchmark would be reduced by 5% for the quality withhold, but 4.5% would be assumed to be earned back (90% * 5% = 4.5%) for the purposes of calculating the capitation payments, resulting in a benchmark equivalent to 99.5% of the pre-quality withhold benchmark. Only after applying the quality withhold / projected earn back is the capitation payment calculated. For PCC (under most scenarios), the payment is 7% of the benchmark, and would be calculated as 7% of the benchmark reflecting the quality withhold and expected earn back (which in the above example, was equal to 99.5% of the pre-quality withhold benchmark).

25. Q: What are the implications for DCEs when individual providers drop from the DCE within a given performance year? Can providers/NPIs be added mid-PY?

Our policy towards addressing provider drops is outlined in Section 4.2 of our Capitation and Advanced Payments Mechanisms paper. If an individual provider drops from the DCE within a given PY, their FFS reductions shall continue until the end of the month, at which point they will be fully FFS. At the end of the quarter, the DCE's monthly capitation payment may be updated to reflect this change. Individual or facility providers may be added during the PY and will be eligible for benefit enhancements. However, all providers added mid-PY are ineligible for payment mechanisms for the duration of that PY. In addition, CMS reserves the right to adjust capitation payments for provider drops, for example a major hospital system dropping from the model. Also, please note that for TCC, the withhold percentage will be updated quarterly. Please see the relevant section within our specification paper at this link: https://innovation.cms.gov/media/document/dc-cap-advpymntmech.

26. Q: Will a DCE's DC Participant Providers and those Preferred Providers who elect to participate in the DCE's selected capitation payment mechanism be required to sign and submit a fee reduction agreement with their DCE? What is the timeline for the DCE to submit the fee reduction agreement to CMMI? ***(Revised, April 2021)***

Yes, a fee reduction agreement will be required to be signed prior to the start of each PY. The FFS reduction agreement does not need to be submitted to CMS as a matter of course, but will be subject to audit and must be provided to CMS, upon request. This fee reduction agreement will serve as an attestation between the DCE and the entity under whose Tax Identification Number (TIN) the DC Participant Provider or Preferred Provider bills Medicare, that all providers and suppliers participating in the DCE's selected capitated payment mechanism that bill under that TIN have agreed to participate in the capitation payment mechanism and to the applicable fee reduction. More information about the timing and requirements related to this fee reduction agreement will be shared in the future.

Risk-Adjustment

27. Q: What is the purpose of the Coding Intensity Factor (CIF) and the DCE-level symmetric 3% cap risk adjustment components?

For GPDC, one of CMS' goals is to set fair and accurate benchmarks, and this goal extends to the application of risk adjustment given its effect on benchmarking. If left unchecked, coding intensity may lead to two different challenges: 1) overpayments resulting from differential coding patterns, and 2) excessive investment in coding intensity activities, where the resources may be better directed at health care services. Measures to limit risk score growth or changes in coding behavior include a program-level Coding Intensity Factor (CIF) and a DCE-level symmetric 3% cap.

- Coding Intensity Factor. The retrospective coding intensity factor will ensure that the change in normalized risk scores across all claims-aligned beneficiaries is zero between the baseline year (2019) and the performance year. It will be applied uniformly across DCEs for a given risk adjustment model.
- Symmetric 3% cap. A symmetric 3% cap will be applied to DCE-specific risk score growth only for Standard and New Entrant DCEs in PY2021 and onwards and beginning in PY2024 for High Needs Population DCEs if significant risk score growth is observed. Risk score growth will be determined at the DCE-level and the symmetric 3% cap applied for each performance year relative to an annual rolling risk score reference year.

28. Q: As a result of coronavirus disease 2019, some providers have experienced a reduction in wellness visits and in diagnosis reporting. Since this may impact risk scores, how will this be addressed?

We are continuing to monitor the impact of coronavirus disease 2019 on submissions that may affect risk scores calculated using the CMS-HCC prospective risk adjustment model. Diagnoses from 2020 dates of service continue to be submitted on FFS claims and the deadline for the final reconciliation risk score run using these diagnoses will not occur until 2022. In addition, CMS released information regarding the use of diagnoses from telehealth services for risk adjustment in MA and for ACOs. As referenced in the recent Medicare Shared Savings Program related communication, "Final CMS-HCC risk scores will include telehealth visits when those visits meet all criteria for risk adjustment eligibility, which include being from an allowable inpatient, outpatient, or professional service. Diagnoses resulting from telehealth services can meet the risk adjustment face-to-face requirement when the services are provided using an interactive audio and video telecommunications system that permits real-time interactive communication." For more information on risk adjustment for ACOs, including the GPDC Model, and diagnosis codes identified in a telehealth visit, please see "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing" which can be found at:

https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf, Section U - Pp. 93-94. Note that in GPDC, we will be calculating risk scores on a different schedule using both the CMS-HCC prospective risk adjustment model (v24) and the CMMI-HCC concurrent risk adjustment model.

29. Q: Will there be a seasonality adjustment made for the risk scores for PY2021? How will the model account for the abbreviated first performance year (April – December instead of January – December)?

Although there is a seasonality adjustment for the benchmark, there is no seasonality adjustment for risk scores. For the CMS-HCC prospective risk adjustment model, diagnoses will be collected for the full 12-months of calendar year 2020 (counting months in which the beneficiary was eligible for Medicare FFS). Similarly, for the CMMI-HCC concurrent risk adjustment model, diagnoses will be pulled for all Medicare FFS eligible months in 2021. Note that for Medicare new enrollees in the Standard and New Entrant DCEs, no diagnoses are used in risk score calculations.

30. Q: Why is the CMMI-HCC concurrent risk adjustment model not used for beneficiaries aligned to Standard and New Entrant DCEs that meet the High Needs Population eligibility criteria?

The CMS-HCC prospective risk adjustment model has been analyzed extensively, is well understood and performs well for large populations because it distributes the risk of both high and low expenditures across many more beneficiaries. It has been effectively used in MA, NGACO and the Medicare Shared Savings Program. As a result, the prospective model is being used for Standard and New Entrant DCEs. The CMMI-HCC concurrent risk adjustment model appears to be better suited to addressing the challenge of accurately risk adjusting payments for small populations of beneficiaries with complex illnesses and chronic conditions. High Needs Population DCEs have a minimum beneficiary alignment threshold of 250 for PY2021. In addition, these beneficiaries are subject to highly variable health statuses and highly variable costs (so High Needs Population DCEs are more likely to have small populations of aligned beneficiaries with high expenditure risks). Because of the concurrent nature of the model, acute conditions are weighted more heavily than chronic conditions, while demographic factors receive relatively less weight. Thus, the concurrent model can better capture a rapid deterioration in health in the current year through the occurrence of acute episodes that are difficult to predict or prevent.

31. Q: As a patient panel of beneficiaries from a specific performance year continues to be served, over time their risk scores are likely to increase. Will the symmetric 3% cap lead to underpayment as a result of constraining risk score growth?

A cohort or group of beneficiaries on a DCE's patient panel may have a worsening health status over time with increasing risk scores; however, over time the DCE will likely also be aligning new beneficiaries whose risk scores will also contribute to the average risk score for the DCE. In totality, the combined risk scores of the original beneficiary panel and the newer beneficiaries who are added to the patient panel will likely tend to reflect a random distribution of healthier to sicker beneficiaries. Without the introduction of coding intensity, this will have a tendency to stabilize the average population risk score over time from year and year. The application of the symmetric 3% cap and the CIF is based on a 'cross-sectional' reference population rather than a 'cohort' of beneficiaries. By 'cross-sectional,' we mean that the reference population and performance year population are intended to capture equivalent populations at different points in time, rather than to track the same group of aligned beneficiaries over time (which we would call a 'cohort' approach). I.e., while the 2021 aligned population and 2019 reference population may have some beneficiaries in common, it is not necessarily the same population. For example, in PY2021, the symmetric 3% cap reference year is 2019, which means the reference population for the symmetric 3% cap is the set of beneficiaries that would have been aligned via claims

in 2019 using the same DC Participant Providers used in PY2021. As such, while a given set of beneficiaries (or 'cohort') may have risk score increases over time as they age, the reference population should capture an equivalent mix of beneficiaries since it is cross-sectional in nature. For this reason, we do not believe that the tendency of a given cohort's risk scores to increase over time will unfairly penalize DCEs via the symmetric 3% cap, since the reference population is not based on a cohort.

32. Q: Will there be a Part D risk adjustment model?

There will not be a risk adjustment model to address Part D costs, since Part D costs are not included in GPDC benchmarks.

33. Q: Will there be a normalization factor for the High Needs Population DCEs?

If risk scores are calculated for beneficiaries and expenditures in years other than the denominator year or the year in which the risk adjustment model is set, the average population risk score can diverge from a 1.0. Normalization is a mechanism to calibrate the population-average risk score back to a 1.0 in any one given year. Since the CMMI-HCC concurrent risk adjustment model will be applied to the High Needs Population DCEs, we will be applying a normalization factor that is tailored to the CMMI-HCC concurrent risk adjustment model. The normalization factor is based on the average risk score for the DC National Reference Population. The CMMI-HCC concurrent model risk scores will be divided by this normalization factor.

34. Q: Will hospice members be risk adjusted?

Yes, beneficiaries receiving hospice services will be subject to risk adjustment.

35. Q: Why is the symmetric 3% cap applied before the CIF?

The symmetric 3% cap is applied at the DCE level relative to the DCE-specific reference risk score. This holds DCEs with higher coding pattern differentials accountable first at the DCE level by constraining their risk score growth with the symmetric 3% cap. Then, the CIF is applied at the program level to ensure a zero-sum impact of risk score growth across the program; it must be applied after risk scores have been set for each DCE via the symmetric 3% cap.

36. Q: Can you clarify how the normalization factor, the symmetric 3% cap and Coding Intensity Factor (CIF) will be applied in an example risk score calculation (including how the reference populations will be established)? ***(Revised, April 2021)***

CMMI has provided more details on how the normalization factor, the symmetric 3% cap and the CIF will be applied in Appendix C of the DC/KCC Risk Adjustment paper available on our website (https://innovation.cms.gov/media/document/dc-riskadjustment).

37. Q: What data source will be used by DCEs to submit diagnoses for risk score calculation in GPDC?

Medicare FFS claims data and Medicare Advantage Risk Adjustment Processing System (MA RAPS) data are the sources of diagnosis data for risk scores. We will be using diagnoses from allowable professional, inpatient and outpatient claims. Note that the professional, inpatient and outpatient claims will also be subject to diagnosis filtering (see next question).

38. Q: Are there plans to use different claims filters for the CMS-HCC prospective risk adjustment model and/or the CMMI-HCC concurrent risk adjustment model that will be used in GPDC vs the data filtering approach used MA?)

The same filtering approach which is used in MA for FFS claims data will be used for GPDC. Chapter 7 on Risk Adjustment from the Medicare Managed Care Manual provides details on the valid sources of risk adjustment diagnoses. The sources of data include hospital inpatient facilities, hospital outpatient facilities and physicians. Details on the filtering methodology applied to these sources of data are further clarified in this document, which can be found at the following link: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf

39. Q: Will CMMI provide SAS code to support the CMMI HCC model?

CMS-HCC prospective risk adjustment model software is available for everyone to use. The 2020 Model Software/ICD-10 Mappings can be found at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/Risk2020.
CMMI is looking into making the CMMI-HCC concurrent risk adjustment model software also available for stakeholders to use. We expect to have this software available in the future.

40. Q: How will the symmetric 3% cap and CIF be applied relative to voluntarily aligned beneficiaries? ***(Revised, April 2021)***

Risk scores for beneficiaries who are aligned solely on the basis of voluntary alignment (i.e., voluntarily aligned, and not eligible for claims-based alignment) to Standard and New Entrant DCEs will be excluded from the application of the symmetric 3% cap and CIF in their first Performance Year of alignment. However, voluntarily aligned beneficiaries in their second or later Performance Year of alignment will be included in the application of the symmetric 3% cap and retrospective CIF even if they have not yet been eligible for claims-based alignment. The reference populations for both the symmetric 3% cap and the CIF are based on the beneficiaries that would have been aligned to the DCE through claims-based alignment in the relevant reference year (as voluntary alignment for GPDC does not exist before the model starts). In a voluntarily aligned beneficiary's initial year of alignment, the DCE has not had a chance to engage with the beneficiary; however, once the beneficiary reaches their second year of voluntary alignment to the DCE, it is anticipated that the DCE will have engaged with the beneficiary, such that the beneficiary's risk scores can be compared to beneficiaries who would have been aligned to the DCE via claims-based alignment during the historical reference year.

41. Q: Will CMMI allow for the submission of diagnoses for risk adjustment pulled from retrospective medical record chart review linked to claims?

Diagnoses for risk adjustment will be collected directly from FFS claims data and MA RAPS data that meet the risk adjustment filtering requirements. A separate data stream of diagnoses pulled from medical record reviews will not be used for GPDC risk adjustment.

42. Q: How will risk score accruals and updates work under monthly payments? Will there be a true-up at the end of the performance years?

Beneficiary risk scores will be updated during the course of each performance year as diagnoses, which are submitted on beneficiaries' FFS claims, become available. Initial risk scores will be based on lagged

data to start with; however, this data will be replaced with diagnoses from the formal data collection period over the course of each performance year. As the performance year progresses, more current and more accurate beneficiary data will be submitted on FFS claims and the risk scores will be recalculated. DCEs will be provided with multiple risk score updates for each beneficiary throughout each performance year, and after the end of the performance year the risk, score for each beneficiary will be finalized. This final risk score will be used in the Final Reconciliation process for determining shared savings or losses.

Reconciliation

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

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

Advanced Payments, however, are treated differently than the PCC and TCC. The full amount of Advanced Payments will be reconciled against the actual amount of FFS claims dollars reduced under the Advanced Payment Option (APO). For example, if CMS paid the DCE fewer dollars than it reduced during the PY, CMS would make up the difference. CMS will monitor claims submission and Advanced Payments to adjust payments as needed to protect against significant over or under payments. A final reconciliation for Advanced Payments will be conducted as part of the calculations of Medicare expenditures for a performance year and shared savings/shared losses determination.

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

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

For both TCC and PCC, shared savings/losses are based off total cost of care and are calculated by comparing the DCE's benchmark with all Medicare expenditures for services delivered to aligned beneficiaries. Medicare expenditures are defined as capitation payments, Advanced Payments, and FFS claims billed for aligned beneficiaries. Under TCC, capitation includes payments made for claim reductions for all Participant Providers and Preferred Providers that opt into capitation; there is no Advanced Payment for TCC. Under PCC, capitation is the 'Base PCC amount,' defined as the percent of historical spending represented by primary care billing by all Participant Providers and Preferred Providers that opt into capitation; 'Enhanced PCC amount,' which is the difference between the Base PCC amount and 7% of the benchmark. The Enhanced PCC amount is recouped fully by CMS separately

from the reconciliation process, and so is not included in our definition of 'Medicare expenditures' in this context.

45. Q: How do the risk corridors apply when calculating shared savings? For example, if a Professional DCE achieved gross savings equal to 7.5% of the benchmark, how much would that DCE earn in shared savings?

The DCE would earn 3.375% of the benchmark as shared savings. For Professional DCEs, the following risk corridors apply:

Corridor	Savings in corridor	DCE responsibility	DCE savings
0-5%	5%	50%	2.500%
5-10%	2.5%	35%	0.875%
Total			**3.375%**

For the first 5% of gross savings achieved, a Professional DCE earns 50% shared savings. For the next 5% of gross savings (5-10%), a Professional DCE earns 35% shared savings. Thus, for a DCE that achieves 7.5% gross savings, of the first 5% the DCE earns 50% as shared savings (2.5%) plus 35% of the next 2.5% (0.875%), for a total of 3.375%.

46. Q: What risk mitigation strategies will be available in GPDC?

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

47. Q: When is final reconciliation conducted?

Starting in PY2022, CMS will conduct final reconciliation approximately six months after the PY ends. To provide more timely distribution of shared savings/shared losses, CMS will also provide the option for DCEs to select a provisional reconciliation option (this option must be selected at the start of the PY). Under provisional reconciliation, CMS will distribute interim-shared savings and collect interim-shared losses shortly after the end of the performance year reflecting cost experience through the first six months of the performance year, with a final reconciliation-taking place once complete data are available for the full PY (approximately seven months after the PY ends).

Since PY2021 lasts only 9 months, it will function differently. Provisional reconciliation will occur approximately six months after the PY ends, while final reconciliation will occur 12 months after provisional reconciliation (at the same time as final reconciliation for PY2022). While provisional reconciliation starting in PY2022 is optional, it will be required in PY2021. This change is a result of the shortened duration of PY2021 and more details is available in the financial specification papers.

48. Q: Will DCEs know the stop-loss attachment points specific to their DCE prior to their decision to purchase or not purchase stop-loss from CMS for any given performance year? *(Revised, April 2021)*

Yes, full details about stop loss attachments points and details about each DCE's stop-loss charge will be made available prior to the deadline to make stop-loss participation decisions for a given PY. The final details of the stop loss methodology are included in the Participation Agreement, while a summary is available in the Financial Reconciliation Overview paper.

49. Q: Are DCEs required to secure a financial guarantee?

Each DCE must secure a financial guarantee for each PY to ensure it can repay all shared losses and any other amounts owed under GPDC. If CMS does not receive payment for shared losses and other amounts owed by the date the payment is due, CMS will pursue payment under the financial guarantee and may withhold payments otherwise owed to the DCE under this model or any other CMS program or initiative.