



Global and Professional Direct Contracting (GPDC) Model

Frequently Asked Questions

Version 4

Date: April 2021

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General Questions

1. Q: What is the Global and Professional Direct Contracting (GPDC) Model?

The Global and Professional Direct Contracting (GPDC) 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. GPDC 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 risk-sharing options under GPDC? *(Revised, April 2021)*

The CMS Innovation Center will test two voluntary risk-sharing options under GPDC: 1) Professional, a lower-risk option (50 percent Shared Savings/Shared Losses, subject to risk corridors) and Primary Care Capitation (PCC) for primary care services, generally equal to seven percent of the performance year benchmark in order to support enhanced primary care services; and 2) Global, a full risk option (100 percent Shared Savings/Shared Losses, subject to risk corridors) and either PCC or Total Care Capitation (TCC). Separately, CMS also announced the Geographic Direct Contracting Model (“Geo”), which also involves full risk (100 percent Shared Savings/Shared Losses). Geo 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 Geo model is currently under review. More information is available on the Geographic Direct Contracting Model website.**

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

GPDC 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, GPDC 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 GPDC?

The model will be implemented over six performance years (PY2021-2026), with an optional initial Implementation Period (IP). The IP started in October 2020 and continued through March 2021, PY2021 will occur from April 2021 through December 2021, and PY2022, PY2023, PY2024, PY2025 and PY2026 will occur in calendar years 2022, 2023, 2024, 2025, and 2026 respectively.

Since a number of model design features vary by year, we have summarized the policies here (note that the parameters listed in the table below apply both to DCEs that start in PY2021 and PY2022):

Revised model timeline and ‘time-dependent model parameters’:

<i>Calendar year / PY</i>	<i>Benchmark discount for Global DCEs</i>	<i>New Entrant / High Needs Population DCEs beneficiary minimum</i>	<i>New Entrant & High Needs Population DCEs Benchmarking</i>	<i>Earn back for 5% quality withhold</i>
<i>PY2021*</i>	2%	1,000 / 250	Rate book-driven	1% performance, 4% reporting
<i>PY2022</i>	2%	1,000 / 250	Rate book-driven	1% performance, 4% reporting
<i>PY2023</i>	3%	2,000 / 500	Rate book-driven	5% performance
<i>PY2024</i>	4%	3,000 / 750	Rate book-driven	5% performance
<i>PY2025</i>	5%	5,000 / 1,200	Baseline-driven	5% performance
<i>PY2026</i>	5%	5,000 / 1,400	Baseline-driven	5% performance

* April 1 – December 31, 2021

5. Q: What is the purpose of the Implementation Period (IP) and when will it begin? (Revised, April 2021)

To help organizations new to Medicare FFS and/or Innovation Center models build an aligned Medicare FFS population, GPDC provides enhanced opportunities for voluntary alignment relative to existing Medicare initiatives. The optional IP provided 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 began April 1, 2021. The optional IP began in October 2020. CMS is considering providing an optional Implementation Period for organizations that were accepted in the previous application cycles and have chosen to defer their start date to January 1, 2022. CMS will provide information regarding any additional Implementation Periods.

6. Q: What is a Direct Contracting Entity (DCE)? How can a DCE assess if it meets the requirements to be a Standard DCE, New Entrant DCE, or High Needs Population DCE, for example, if it has its sufficient level of experience with Medicare FFS to be a Standard DCE? (Revised, April 2021)

A DCE is a legal entity that participates in GPDC pursuant to a Participation Agreement with CMS. Various types of organizations may apply to become a DCE including Accountable Care Organizations (ACOs). Under GPDC, there are currently three types of participating DCEs with different characteristics and operational parameters.

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, including Medicare-only and dually eligible beneficiaries, who are aligned to a DCE through voluntary alignment or claims-based alignment. 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 GPDC. 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.
- Required to have a minimum of 5,000 aligned beneficiaries prior to the start of each Performance Year from PY2021 through PY2026.
- Required to have at least 3,000 beneficiaries that would have been aligned via claims in at least one base year (2017-2019).

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 (NGACO) Model, the Comprehensive ESRD Care (CEC) Model, the Pioneer ACO Model, the Vermont All Payer ACO Model, or Comprehensive Primary Care Plus (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 PY2021 and PY2022, 2,000 prior to the start of PY2023, 3,000 prior to the start of PY2024, and 5,000 prior to the start of PY2025 and PY2026.
- For PY2021 through PY2024, may not have more than 3,000 beneficiaries that are “alignable” through claims-based alignment in any base year (2017, 2018 and 2019). CMS will assess this by determining the volume of services provided by the DCE’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 who also meet beneficiary eligibility requirements as of January 1 in a given year will be considered “alignable” in that year.*

*Organizations found ineligible to participate as a New Entrant DCE based on this criterion will be offered the opportunity to participate as a Standard DCE, provided all other model requirements are met.

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. Entities applying as a Standard DCE or a New Entrant DCE will not be allowed to also apply as a High Needs Population DCEs in the same service area.

- 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 PY2021 and PY2022, 500 prior to the start of PY2023, 750 prior to the start of PY2024, 1,200 prior to the start of PY2025, and 1,400 prior to the start of PY2026. In addition to the beneficiary eligibility requirements that apply for purposes of aligning beneficiaries to other types of DCEs in GPDC, beneficiaries must meet additional eligibility requirements to be aligned to a High Needs Population DCE – see Appendix B of the [Financial Operating Guide Overview](#) paper available on our website for details.

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

By a date specified by CMS prior to signing the Performance Period Participation Agreement, a DCE may switch from Global to Professional, and vice versa. A DCE cannot move from Global to Professional once participation has begun. If the DCE wants to increase from Professional to Global, it can change only at the following times, which vary based on whether the DCE started participation in PY2021 or PY2022:

- During PY2022, to take effect PY2023 (*only if the DCE started participation in PY2021*)
- During PY2023, to take effect PY2024
- During PY2024, to take effect PY2025
- During PY2025, to take effect PY2026

8. Q: Is GPDC an Advanced Alternative Payment Model (APM)?

The model is an Advanced APM under the CMS Quality Payment Program (QPP) starting in PY2021 (April 1 – December 31, 2021).

9. Q: How does GPDC differ from Medicare Advantage (MA)?

Unlike beneficiaries who enroll in an MA plan, beneficiaries aligned to organizations participating in the payment model options under GPDC remain in Medicare FFS. If a Medicare FFS beneficiary is aligned to a DCE, their health care coverage will not change and they retain the freedom to seek care from their Medicare FFS 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.

10. Q: How does GPDC differ from the NGACO Model?

GPDC builds on the experience of the NGACO Model and incorporates innovative approaches from MA and the private sector. GPDC incorporates opportunities for greater financial risk than the NGACO Model supported by enhanced flexibilities and additional benefit enhancements. GPDC 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, GPDC has a new financial methodology that features a benchmark developed based on the DC/KCC 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, GPDC 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. GPDC'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

11. Q: What is the updated model timeline? *(Revised, April 2021)*

The first performance year of the GPDC Model year began on April 1, 2021. The Implementation Period began in October 2020. The application for participation beginning April 1, 2021 opened on June 4, 2020 and closed on July 6, 2020. The Innovation Center no longer intends to solicit applications from new organizations interested in participating in the GPDC Model beginning on January 1, 2022, including organizations interested in participating in the model as a MCO-based DCE type. Organizations that applied and were accepted in the previous application cycles have the option to defer their start date to January 1, 2022 as long as they continue to meet model requirements. Note that PY2026 will be the final performance year for all DCEs regardless of whether they begin the performance period in April 2021 or January 2022.

12. Q: If our organization already submitted an application, do we need to reapply? *(Revised, April 2021)*

- If you applied to begin participation in the IP and/or PY2021 and were not accepted, you may reapply in any subsequent application period (if offered at the sole discretion of CMS, though none are currently planned). The Innovation Center no longer intends to solicit applications from new organizations interested in participating in the GPDC Model beginning on January 1, 2022.
- If you applied to begin participation in the IP or PY2021 and were accepted, but notify CMS that you wish to delay your start until January 2022 by a deadline provided by CMS, you do not need to reapply.
- If you entered the IP, terminated your IP participation during the IP, and wish to participate in PY2022, you need to submit a modified application focused on updates to key information from your original application submitted for participation in the IP. CMS will provide additional information about the submission of a modified application in Spring 2021.

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

The application portal is currently closed. The Innovation Center no longer intends to solicit applications from new organizations interested in participating in the GPDC Model beginning on January 1, 2022, including organizations interested in participating in the model as a MCO-based DCE type.

14. Q: How did CMS select participants for the model?

CMS assessed 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 considered 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 were asked to demonstrate routine compliance with the terms of such CMS programs, demonstrations, or models.

15. Q: When are the DCE's arrangements with DC Participant Providers and Preferred Providers due to CMS and how are they submitted? *(Revised, April 2021)*

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

16. Q: How does the DC Participant Provider and Preferred Provider list submission process work? *(Revised, April 2021)*

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 update (i.e., add, remove, or edit providers and suppliers). PY2021 DCEs and deferred PY2022 DCEs will have the opportunity to update (i.e. add, remove, and edit providers and suppliers) their DC Participant Provider List and Preferred Provider List in 4i in late summer 2021.

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 neither DC Participant Providers nor Preferred Providers will be eligible to participate in the DCE's selected DC capitation payment mechanism (Total Care Capitation, Primary Care Capitation) or Advanced Payment. Further, DC Participant Providers can only be added if the provider in question (1) bills (at the time of the proposed addition) for items and services he or she furnishes under a TIN that is used by an entity that is a DC Participant Provider in the same DCE, and (2) did not bill under that TIN when the DCE submitted its Proposed DC Participant Provider list, unless the DC Participant Provider meets one of the following exceptions:

1. If the DC Participant Provider bills under a TIN that is now under the control of the DCE or a current DC Participant Provider as the result of a merger or acquisition by the DCE or DC Participant Provider, and the individual's billing number was not assigned to a TIN that was under the control of the DCE or DC Participant Provider when the DCE submitted its Proposed DC Participant Provider List, or
2. If the DC Participant Provider was dropped from the DCE's final DC Participant Provider List for the performance year due to overlaps with another Innovation Center model or a shared savings initiative (e.g., Medicare Shared Savings Program), and that overlap has since been resolved.

Preferred Providers are not subject to the same restriction.

17. Q: What are the processes, deadlines and consequences for withdrawing early from GPDC should a DCE choose to do so? *(Revised, April 2021)*

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

To withdraw from GPDC 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: for each DCE's first PY, regardless of start date, there will be no opportunity to terminate during the PY to avoid liability for shared losses for that PY). DCEs will also face financial consequences for not participating in at least two performance years and have two options for securing a Participation Commitment Mechanism:

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 remains a participant in the model at the time CMS completes the relevant financial settlement for the DCE's first performance year, the 2% retention withhold will be refunded to the DCE. If, on the other hand, the DCE voluntarily terminates its participation in the model prior to the completion of the relevant financial settlement for the DCE's first PY, the DCE will not receive the 2% withhold as part of financial settlement for its first PY.
2. Alternatively, the DCE may choose to secure a "Retention Guarantee Amount," calculated to be equivalent to the retention withhold (i.e., 2% of the DCE's Performance Year Benchmark), either by increasing the amount of the financial guarantee the DCE will be required to secure to ensure its ability to repay CMS Shared Losses and Other Monies Owed, or through a separate financial guarantee. In the event that the DCE is not still participating in the model at the time CMS completes the relevant financial settlement for the DCE's first performance year, 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.

Eligibility

18. Q: What types of organizations can apply for the GPDC model? *(Revised, April 2021)*

In addition to providing an option for NGACO participants who are seeking to continue their value based work with CMS, a key objective of GPDC 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

Note: The GPDC Model is not accepting new applications at this time.

19. 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.

Each DCE's TIN must be unique from all other TINs used by another DCE or Medicare ACO (i.e., two DCEs cannot share a TIN). 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.

All applicants must provide a copy of a certificate of incorporation or other documentation demonstrating that they are recognized as a legal entity in the state in which they are located prior to participating in the model.

If the entity has not yet been incorporated by the application submission deadline, the entity can either submit your application to incorporate or a statement identifying the proposed corporation. Please note when you are intending to incorporate in the application.

The DCE must also comply with all applicable laws and regulations, as well as all GPDC 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).

Note: The GPDC Model is not accepting new applications at this time.

20. Q: How can health insurers participate in GPDC? 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 Population DCE and are required to enter into arrangements with DC Participant Providers.

Note: The GPDC Model is not accepting new applications at this time.

21. Q: Can an ACO become a DCE if it is currently 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? *(Revised, April 2021)*

During each Performance Year, simultaneous participation by DCEs and their DC Participant Providers in GPDC and certain other risk-based initiatives is prohibited. Specifically, simultaneous participation in GPDC and the Medicare Shared Savings Program, the Next Generation ACO Model, the Comprehensive ESRD Care Model, the Maryland Total Cost of Care Model, the Vermont All-Payer ACO Model, the Kidney Care Choices Model, any other Medicare initiative that involves shared savings, the Primary Care First Model, the Comprehensive Primary Care Plus Model, or the Independence at Home Demonstration is prohibited unless otherwise instructed by CMS. Simultaneous participation in GPDC and the Maryland Total Cost of Care Model is also prohibited for 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.

22. Q: Does GPDC have any regional eligibility requirements? How many DCEs are selected in each region?

Generally, there are no regional eligibility requirements. Participation in GPDC 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.

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

Each Standard, New Entrant, or High Needs Population 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 is not be required to be a Medicare-enrolled provider or supplier in order to participate in the GPDC 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) at the time when they are added to the DC Participant Provider list or Preferred Provider list.

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.

24. 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.

25. Q: What is the difference between DC Participant Providers and Preferred Providers? *(Revised, April 2021)*

DC Participant Providers are the core providers and suppliers in the Professional and Global Risk-Sharing 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. Unlike Preferred Providers, beginning in PY2022, all DC Participant Providers are required to be subject to the DC 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 written 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 beginning in PY2021 and have the option to participate in the DCE's selected DC capitation payment mechanism. Services furnished by Preferred Providers will not be considered in beneficiary alignment and Preferred Providers are not responsible for reporting quality through the DCE. Preferred Providers are optional for all DCEs.

There are no restrictive provider networks in GPDC. Beneficiaries aligned to a DCE are not required to receive services from DC Participant Providers or Preferred Providers. Beneficiaries, including those aligned to a DCE, may choose to receive services from Medicare FFS providers and suppliers that are not associated with the DCE.

26. 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 GPDC as a DCE?

The same TIN cannot be associated with a DCE and a Shared Savings Program ACO simultaneously during a performance year of GPDC. DCEs would have to create a unique TIN to operate both (and would be subject to restrictions on provider and beneficiary overlaps as described in the RFA).

27. Q: Can a TIN choose which of its associated NPIs participate in GPDC and which do not? Can a TIN have some National Provider Identifiers (NPIs) in the Shared Savings Program and some NPIs in GPDC? *(Revised, April 2021)*

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

During each performance year of the GPDC Model, DCEs and their DC Participant Providers may not participate in the Shared Savings Program using the same TIN as providers and suppliers participating in the Shared Savings Program, since the Shared Savings Program defines its participants at the TIN level (i.e., it is not a split TIN initiative). This restriction is not applicable to Preferred Providers.

28. Q: How many beneficiaries does each DCE need to begin each PY? *(Revised, April 2021)*

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 PY2021. In both the Professional and Global Risk-Sharing Options, DCEs will be expected to meet the minimum number of aligned beneficiaries outlined in the list below prior to the start of the applicable Performance Year.

Performance Year	High-Needs-Population	New Entrant	Standard
PY2021	250	1,000	5,000
PY2022	250	1,000	5,000
PY2023	500	2,000	5,000
PY2024	750	3,000	5,000
PY2025	1,200	5,000	5,000
PY2026	1,400	5,000	5,000

New Entrant DCEs must not exceed 3,000 beneficiaries aligned via claims in any baseline year (2017, 2018 or 2019). If the 3,000 threshold is exceeded, the DCE will have the opportunity to participate as a Standard DCE, provided the applicable requirements are met. Additionally, of the 5,000 aligned beneficiaries a New Entrant DCE is required to have by PY2025, 3,000 or more must have been aligned via claims to show progress in establishing patient-provider relationships.

29. Q: Is a DCE still eligible to participate in PY2021 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 PY2021 and must meet the applicable minimum beneficiary threshold prior to the start of PY2021. 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 GPDC.

30. Q: Can a Standard DCE or New Entrant DCE split to form a separate High Needs Population DCE? *(Revised, April 2021)*

Standard DCEs or New Entrant DCEs are not allowed to split and form two separate DCEs – one High Needs Population DCE for their High Needs-eligible beneficiaries and one Standard DCE / New Entrant DCE for their remaining beneficiaries.

31. 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 Population DCEs that reach 3,000 claim-based aligned beneficiaries in at least one base year (2017, 2018 or 2019) will convert to a Standard DCE methodology for purposes of their benchmark, similar to New Entrant DCEs. These High Needs Population DCEs will still have the flexibility to focus only on High Needs-eligible beneficiaries and will still use the concurrent risk adjustment methodology, but their benchmark will incorporate a historical baseline component for claims-aligned beneficiaries.

Beneficiary Alignment

32. 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. Beneficiaries meeting one or both conditions are eligible for alignment to High Needs Population DCEs.

33. Q: How will GPDC alignment interact with Medicare managed care enrollment processes, including auto-assignment and D-SNP default enrollment for newly eligible Medicare beneficiaries? *(New Question, April 2021)*

There is no impact on Medicare managed care enrollment. Beneficiaries will be prospectively aligned to a DCE only if they are in Medicare FFS. If a beneficiary is aligned to a DCE and becomes ineligible for DCE alignment due to Medicare managed care enrollment, the beneficiary would become de-aligned from the DCE effective starting the first day of the month they lost eligibility (i.e. the date their Medicare managed care became effective).

DCEs will not be permitted to undertake communication or marketing activities directed at Medicare managed care enrollees.

34. Q: How does beneficiary alignment affect their Part D coverage?

Alignment has no effect on Part D enrollment or coverage. DCEs are expected to help with beneficiary medication management as part of effective care management plans.

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

For the purpose of assigning accountability for risk sharing and the total cost of care, the beneficiary alignment options available to a DCE will depend upon the DCE type. In order to be aligned to a DCE, the beneficiary must also meet the beneficiary eligibility criteria (described above).

Beneficiaries may be aligned to a Standard, New Entrant, or High Needs Population DCE in two ways:

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.

For more information on alignment, please refer to Appendix B of the [Financial Operating Guide Overview](#) paper available on our website.

36. Q: Will DCE applicants be permitted to serve only a subset of their alignment-eligible population, e.g. those with only certain diagnoses or living in certain regions of the state or service area?

No, DCEs must serve the entire alignment-eligible population.

37. 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 their 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.

38. Q: How does voluntary alignment work?

CMS will permit DCEs to proactively communicate with beneficiaries regarding voluntary alignment, provided such communications comply with all applicable laws, regulations, guidance, and with the requirements of the Participation Agreement. Beneficiaries may voluntarily align with a DCE by designating a DC Participant Provider as their primary clinician or main source of care by either selecting a “primary clinician” on [MyMedicare.gov](#) or [any successor site](#) (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 GPDC. Electronic platforms such as DocuSign or a patient portal may be used to accept "paper-based" voluntary alignment forms.

39. Q: How will CMS identify and align beneficiaries to High Needs Population DCEs?

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 via voluntary alignment or claims-based alignment. 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 PY2021, 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 Population DCE. For example, if a beneficiary meets High Needs eligibility criteria and is aligned to DCE X in PY2021, the beneficiary will not be de-aligned even if he/she ceases to meet High Needs eligibility in PY2022, provided that he/she continues to be aligned to DCE X in PY2022 (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 Population DCEs for providing effective care.

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

For Standard, New Entrant, and High Needs Population DCEs, 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.

41. 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.

42. 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 the Financial Operating Guide Overview document available on our website.

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

Beneficiaries will retain their choice of Medicare FFS providers and suppliers and may switch health care providers at any time.

44. 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 GPDC, 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 GPDC 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 PY2021 (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 PY2023, PY2024 and PY2025 respectively. They will further be required to maintain a minimum of 5,000 aligned beneficiaries prior to the start of PY2025. Further, prior to the start of both PY2025 and PY2026, 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.

45. 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 voluntary alignment) 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.

46. 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 does not share their data with the DCE.

Benefit Enhancements and Beneficiary Engagement Incentives

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

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 GPDC. 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 including new benefit enhancements in GPDC. The benefit enhancements and beneficiary engagement incentives for implementation in GPDC are highlighted in the following table.

Benefit Enhancements Available for PY2021 & PY2022 ¹	Potential Future Benefit Enhancements Under Consideration by CMS
<ul style="list-style-type: none"> • 3-Day Skilled Nursing Facility (SNF) Rule Waiver Benefit Enhancement • Telehealth Benefit Enhancement • Post-Discharge Home Visits Benefit Enhancement • Care Management Home Visits Benefit Enhancement • Home Health Homebound Waiver Benefit Enhancement • Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement 	<ul style="list-style-type: none"> • Alternative Sites of Care • Long-Term Care Hospital 25-day average Length of Stay requirement and Other Site of Care Restrictions • Nurse Practitioner Services Bundle³

(1) Please note, the previously proposed benefit enhancement “Home Health Services Certified by Nurse Practitioners” was made permanent as authorized by section 3708 of the CARES Act.

48. 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 GPDC? *(Revised, April 2021)*

The NGACO model currently allows the following benefit enhancements and beneficiary engagement incentives, which CMS will also offer under the GPDC model beginning in PY2021:

- 3-Day SNF rule waiver: Conditionally waives the requirement for the three-day inpatient stay prior to the admission to a SNF or Swing Bed Hospital that is a DC Participant Provider or Preferred Provider.
- Telehealth: Conditionally waives the rural geographic requirement for an originating site and allows the beneficiary’s place of residence to serve as an originating site when telehealth services are furnished by Preferred Providers, and also permits 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: Allows 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: Allows 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 twenty times within a performance year, unlike the NGACO Model, which allows only 2 visits per 90-day period.
- Part B Cost-Sharing Support: This beneficiary engagement incentive allows DCEs to enter into arrangements with DC Participant Providers and Preferred Providers, under which they will

reduce or eliminate beneficiary cost sharing for certain categories of Part B services and aligned beneficiaries identified by the DCE.

- Chronic Disease Management Reward Program: This beneficiary engagement incentive allows DCEs to provide a gift card reward 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.

49. Q: Are DCEs required to offer these benefit enhancements and beneficiary engagement incentives? *(Revised, April 2021)*

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

Financial Model

Note: Since the GPDC 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

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

CMS plans to make several types of Medicare data available to DCEs participating in GPDC. During the Performance Period, each DCE may request the minimum necessary data for their aligned beneficiaries to develop and implement care coordination and quality improvement activities. 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).

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 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.

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.

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

51. Q: What quality measures will be included in the proposed core set? *(Revised, April 2021)*

To ensure that DCEs meet the model goals of improved quality of care and health outcomes for Medicare beneficiaries, the GPDC 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 quality measures for PY2021 and PY2022 are as follows:

Measures for PY2021 and PY2022

1. All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (Claims Based)
2. Risk-Standardized All Condition Readmission (Claims Based)
3. Days spent at home (Claims Based). This measure will be developed during the initial years of the model. The measure will be utilized only by High Needs Population DCEs.

Additional Measures Beginning in PY2022

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for Accountable Care Organizations (ACOs) surveys.¹
2. Timely Follow-up After Acute Exacerbation of Chronic Conditions (Claims Based). This measure will be developed during the initial years of the model. The measure will be utilized only by Standard DCEs and New Entrant DCEs.

52. Q: How does quality reporting fit into the benchmark?

Similar to NGACO, CMS will use a quality “withhold,” in which a portion of a DCE’s Performance Year Benchmark is held “at-risk,” contingent upon the DCE’s quality score. Five percent of the benchmark will be withheld 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.

In PY2021 and PY2022, 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 PY2023-PY2026, 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

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

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 are included in the Quality Measurement Methodology paper available on our website.

53. Q: What are the Continuous Improvement and Sustained Exceptional Performance (CI/SEP) criteria and how will they be applied?

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 PY2023, 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.

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

GPDC 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 provided in Appendix C of the RFA. 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 PY2023.

55. Q. Are a 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 approved DC Participant Provider List for a given PY are eligible to become a Qualifying APM Participant (QP) for that 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 GPDC 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.

56. 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.