Direct Contracting (Professional and Global)

Frequently Asked Questions from Benefit Enhancements Webinar

Date: November 2020

Contents

General Questions

1. Q: Will the slide deck and recording be available?

The slide deck was sent out with the November 20 edition of the Direct Contracting Model newsletter. The recording can be found here.

Benefit Enhancements (BEs) and Beneficiary Engagement Incentives (BEIs)

2. Q: Are these flexibilities only available to a DCE if they make the decision prior to the first performance year or can the DCE choose which BEs they will provide each performance year?

Direct Contracting Entities (DCEs) will choose which Benefit Enhancements (BEs) and Beneficiary Engagement Incentives (BEIs) they will offer prior to each performance year (PY), and their decision will apply for the duration of that performance year. DCEs will have the opportunity to re-submit and / or modify BE/BEI elections for each subsequent performance year.

3. Q: Are BEs and BEIs required? Can DCEs offer more than one BE and BEI?

No, BEs or BEIs are not required. Yes, your DCE may offer more than one BE or BEI, however the DCE must submit an Implementation Plan prior to the start of a PY for each BE and BEI they plan to offer Please note, only the Cost Sharing Support for Part B Services and the Chronic Disease Management Reward BEIs require the submission of implementation plans prior to the start of the PY.

4. Q: Can a DCE's Preferred Providers provide BEs and BEIs?

Yes, Preferred Providers can provide any of the BEs or BEIs that their DCE has elected as long as the DCE adds the Preferred Provider onto the DCE's provider list and elects the BE(s) for that provider within 4i. Please note, BEIs are not elected in the 4i because they are processed outside the claims system and will have separate monitoring requirements.

5. Q: Are there any restrictions in terms of which BEs are available according to the DCE Type (Standard, New Entrant, or High Needs) or Risk Sharing Option (Global or Professional)?

The Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit is currently limited to DCEs participating in the Global option. All other BEs are available for all DCE types and Risk Sharing Options.

6. Q: Are there any restrictions in terms of which BEIs are available according to the DCE Type (Standard, New Entrant, or High Needs) or Risk Sharing Option (Global or Professional)?

No, there are no restrictions on BEIs with regard to DCE type or Risk Sharing Options.

7. Q: Will CMS be providing an Implementation Plan Guidance document to ensure all CMS requirements are reflected in the plan that we submit?

Yes, guidance for Implementation Plans will be released in the next few weeks.

8. Q: Can a DCE select multiple BEs and BEIs but implement only the ones in which the DCE has developed current infrastructure?

Yes. To ensure you can implement a BE, you must submit a corresponding Implementation Plan prior to the start of that PY even if you do not elect to use that BE during the performance year.

9. **Q: How does CMS inform other vendors in the community (Skilled Nursing Facilities, Home Health care companies, etc.) of changes and waivers specific to the DCE?**

DCEs should develop a strategy for informing their DC Participant Providers and Preferred Providers about the availability and proposed operations of a BE.

10. **Q: Which waivers are financed by the DCE and which are financed by Medicare fee for service (FFS)?**

BEs are payment waivers designed to allow services that would not normally be paid under Traditional Medicare. As such, claims for BEs provided during the year will be reimbursed on a fee for service basis by Medicare, unless the claim is also subject to a reduction due to capitation or Advanced Payment. However, like all other covered services provided to aligned beneficiaries, use of these BEs will contribute to the DCE's performance year expenditures, which will count against the benchmark. BEIs are financed by the DCE or in coordination with their DC Participant Providers or Preferred Providers and do not impact financial reconciliation.

11. **Q: Is only the provider identified on the DCE's provider list by his/her unique TIN/NPI combination with the post-discharge / care management visit BE(s) elected in 4i able to be the general supervisor for the post-discharge/ care management visits?**

Yes. The DC Participant Provider or Preferred Provider must have elected the BE(s) in order to provide these services under their general supervision. CMS will use the unique TIN/NPI combination to identify the relevant provider(s).

12. **Q: Will additional BEs be considered, such as BEs related to permanent supporting housing, Non-Emergency Medical Transportation (NEMT), deductible forgiveness, food and prescription vouchers?**

The examples above such as support for housing, NEMT, deductible forgiveness, and food and prescription vouchers would be considered BEIs and not BEs. Beneficiary engagement incentives are used as additional incentives to beneficiaries that would potentially motivate and encourage beneficiaries to become actively involved in their care. In order for your DCE to provide waivers such as housing or prescription vouchers, the following conditions must be met:

1. There is a reasonable connection between the items or services and the medical care of the beneficiary;
2. The items or services are preventative care items and services or advance a clinical goal for the beneficiary, including adherence to a treatment regime, adherence to a drug regime, adherence to a follow-up care plan, or management of a chronic disease or condition; and
3. The in-kind item or service is not a Medicare-covered item or service for the beneficiary on the date the in-kind item or service is furnished to that beneficiary. For purposes of this exception, an item or service that could be covered pursuant to a benefit enhancement is considered a Medicare-covered 24 item or service, regardless of whether the DCE selects to participate in such Benefit Enhancement for a given performance year.

For more information on BEIs, please see The Direct Contracting Model: Global and Professional Options Request for Applications or refer to page 23 of the RFA in this link: https://innovation.cms.gov/files/x/dc-rfa.pdf.

13. Q: Is the Concurrent Care for Hospice waiver available to a High Needs DCE?

The Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit is available to only those DCEs participating in the Global option. DCEs of all DCE Types, including High Needs DCEs, which elect the Global Risk Sharing Option are able to offer the Concurrent Care for Beneficiaries that Elect the Medicare Hospice BE.

14. Q: Do you have to have a formal Chronic Disease Management program for the Chronic Disease Management Award?

No, your DCE can develop your own Chronic Disease Management Program, if desired. Please ensure you follow the criteria outlined in the forthcoming Implementation Plan guidance.

15. Q: Will CMS be providing a comprehensive list of Part B services that can be covered under the Cost Sharing for Part B services Beneficiary Engagement incentive?

No, CMS will not be providing a comprehensive list of services covered under the cost-sharing waiver. Details regarding the criteria for the waiver will be provided with the Implementation Plan guidance. Please consult with your own counsel to determine the scope of any waivers.

16. Q: If no DC Participant Providers or Preferred Providers are providing a BE, then how would a DCE's beneficiaries be eligible for BE related services?

In addition to a DCE electing to offer a BE at the DCE level, a DCE's DC Participant Provider(s) or Preferred Provider(s) must be participating in a BE in order to allow beneficiaries to access BE related services.

Payment Mechanisms

17. Q: Our DCE initially elected the Total Care Capitation Payment Mechanism; however, we would like to change our capitation option to Primary Care Capitation. How do we make this change?

The DCE may request this change subject to CMS approval within 4i up until the gate window for BE and Payment Mechanism elections closes by initiating a Change Request via the DCE's 4i Portal.

18. Q: If a Preferred Provider accepts a 5% fee-for-service reduction (per their payment mechanism arrangement), is the discount applied on the charged / billed amount, on the allowed amount, or on the paid amount?

All the FFS reductions are on Medicare Paid Amounts, which are determined after FFS processing and sequestration is applied. If a Preferred Provider accepts a 5% FFS reduction, the discount is applied to what would otherwise have been paid by Medicare, which would result in a 5% reduction in their Medicare payment. The difference, (in this case, the remaining 95%), would be paid out to the Preferred Provider via Medicare FFS.

19. Q: How do BEs, which will be covered services within Direct Contracting, interact with claims reductions providers have agreed to under Capitation or Advanced Payment?

Total Care Capitation (TCC), Primary Care Capitation (PCC), and Advanced Payment Option (APO) each apply to different types of covered services. For FFS payment reduction purposes, BEs will be treated like any other covered services: if the service is subject to TCC, PCC, or APO and the furnishing provider is participating in TCC, PCC, or APO, the claim will be approved but the FFS payment from Medicare will be reduced according to the fee reduction that provider has agreed to. Please note that all BEs proposed to date for the Direct Contracting Model would be subject to TCC and APO (not PCC).

20. Q: Are DCEs able to apply different percentage FFS reductions for the various aligned DC Participant Providers and Preferred Providers who participate in PCC?

Yes, DCEs are able to apply different percentage FFS reductions for their providers. In PY1, both DC Participant Providers and Preferred Providers participation in PCC is optional. However, in a DCE that elects TCC, the requirements surrounding the FFS reduction pertain to the provider-type and the performance year. Please refer to slide 30 in this link: https://innovation.cms.gov/media/document/dc-model-options-fnclmeth-slides for more details.

4 Innovation (4i) System

21. Q: Will BEs be available for election in 4i?

Yes, BEs will be available in 4i for the DCE to elect for the DC Participant and Preferred Providers on their approved final PY1 provider list.

22. Q: When will the gate window open and close in 4i for BE and Payment Mechanism (PM) selections?

The gate window will be open from December 21, 2020 through January 14, 2021.[1]

23. Q: Is the BE assigned at the individual provider level or the provider group level? Do you have to make the elections individually for each provider?

These elections are assigned at the provider TIN/iNPI record level. They can be assigned to the DCE's complete provider list or to each provider individually. A DCE can decide to start enrollment in a specific or all BEs; however, the DCE must have decided prior to the start of the PY which BEs they would like to offer their aligned providers. A DCE may also remove a benefit enhancement from a provider's record during the PY.

24. Q: What is the process for selecting the PM options for our DC Participant Providers and Preferred Providers?

Once the DCE has elected either TCC or PCC, the DCE will be able to apply the PM to their provider records. DC Participant Providers and Preferred Providers may have different percentage reductions so please keep that in mind when adding PMs in 4i. Provider records that have TCC elected will

[1] Please note: These dates are subject to change.

automatically default to 100% reduction. A DCE will also have the ability to elect the Advanced Payment Option (APO) in 4i and enter the desired percentage reduction for each provider.