Direct Contracting Model Professional and Global Options
Benefit Enhancements and Beneficiary Engagement Incentives

Benefit Enhancements (BEs) are conditional waivers of certain Medicare payment rules. CMS uses the authority under Section 1115A of the Social Security Act (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements in order to emphasize high-value services and support the ability of Direct Contracting Entities (DCEs) to manage the care of beneficiaries. A DCE may choose which, if any, of these BEs to implement and will be asked to provide information regarding the implementation of the BEs that they have selected.

DCEs will also have the ability to use a range of beneficiary engagement incentives (BEIs) to help improve quality and lower cost for beneficiaries. These BEIs will give DCEs the flexibility to implement care coordination and care management programs for their aligned beneficiaries.

CMS proposes to offer DCEs participating in the Direct Contracting Model Professional and Global Options all of the BEs and BEIs available in the Next Generation ACO (NGACO) model, as well as two new BEs.

Current Benefit Enhancements available in NGACO	**Current Beneficiary Engagement Incentives available in NGACO**	**New Benefit Enhancements for Performance Year 1 of Direct Contracting**
• Telehealth Benefit Enhancement • Post-Discharge Home Visits Benefit Enhancement • Care Management Home Visits Benefit Enhancement • 3-Day SNF Rule Waiver Benefit Enhancement	• Chronic Disease Management Reward • Cost Sharing Support for Part B Services	• Home Health Homebound Waiver Benefit Enhancement • Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit

Summary of Benefit Enhancements for PY1

Telehealth Benefit Enhancement[1]

- Asynchronous telehealth
    - Permits the use of asynchronous telehealth services in the specialties of teledermatology and teleophthalmology.

[1] The Innovation Center recognizes that some of the Benefit Enhancements and Beneficiary Engagement Incentives included in PY1 of the Model are temporarily permitted during the COVID-19 public health emergency (e.g., the SNF 3-day rule waiver and telehealth).

    - Distant site practitioners will bill for these services using Innovation Center specific asynchronous telehealth codes.
    - The distant site practitioner must be a DC Participant Provider or Preferred Provider who has elected to participate in this BE.

- This BE will also allow <u>DC Preferred Providers</u> to:
    - Waive the rural geographic component of originating site requirements;
    - Allow the originating site to include a beneficiary's home; and
    - Waive the originating site fee requirement when the beneficiary's home serves as the originating site for services furnished to an aligned beneficiary by a Preferred Provider using Innovation Center specific synchronous telehealth codes.[2]
- *Please note, the Bipartisan Budget Act of 2018 added section 1899(l) to the Social Security Act, which affords DC Participant Providers the same synchronous telehealth flexibilities without a waiver.* ***I.e. DC <u>Participant Providers</u> do not need to elect the telehealth waiver if they elect to do SYNCHRONOUS telehealth only.***

<u>3-Day Skilled Nursing Facility (SNF) Rule Waiver Benefit Enhancement</u>

- Conditional waiver of the requirement of a 3-day inpatient stay prior to SNF (or swing-bed hospital) admission.
- Aligned beneficiaries are eligible if the following criteria are met:
    - *The beneficiary is not residing in a SNF or long-term care facility at the time of SNF admission under this waiver;*
    - *For purposes of this waiver, independent living facilities and assisted living facilities shall not be deemed long-term care facilities;*
    - *The beneficiary is medically stable and has confirmed diagnoses; and*
    - *The beneficiary has skilled nursing or rehabilitation need identified by a physician or other practitioner that cannot be provided on an outpatient basis.*
- Partner SNFs and swing-bed hospitals may be either DC Participant Providers or Preferred Providers.

<u>Post-Discharge Home Visits Benefit Enhancement</u>

- Under the Post-Discharge Home Visits BE, certain home visits may be provided *under general supervision*—physician (or other practitioner) may contract with auxiliary personnel to provide this service and the service is billed by the physician's (or other practitioner's) office using Innovation Center specific codes.
    - Under existing regulations, this service must be provided *under direct physician supervision* (i.e., physician/other practitioner is present at time service is provided to patient).
- Up to a total of nine post-discharge visits may be furnished within 90 days following discharge from an inpatient facility (e.g., hospital, CAH, SNF, IRF).
- A beneficiary must not qualify for Medicare coverage of home health services.
    - This is not a home health (or homebound) service.

[2] See Appendix A for billing codes.

Care Management Home Visits Benefit Enhancement

- Under the Care Management Home Visits Benefit Enhancement, certain home visits may be provided *under general supervision*—physician (or other practitioner) that are furnished to eligible beneficiaries proactively and in advance of potential hospitalization.
- The items and services provided as part of these home visits are those that would be covered under Medicare Part B as "incident to" the services of a physician or other practitioner and would be furnished by auxiliary personnel (as defined in 42 C.F.R. § 410.26(a) (1)) under general supervision, rather than direct supervision and billed using Innovation Center specific home visit codes.
- A beneficiary will be eligible to receive up to 20 Care Management Home Visits within a performance year.
- DC Participant Providers and Preferred Providers who have elected to use this benefit enhancement will be able to receive payment for services furnished to eligible beneficiaries under the following circumstances:
    - *The beneficiary is determined to be at risk of hospitalization;*
    - *The beneficiary does not qualify for Medicare coverage of home health services (unless the sole basis for qualification is living in a medically underserved area);*
    - *The beneficiary is not currently utilizing the Post-Discharge Home Visits Benefit Enhancement or the Home Health Homebound Waiver Benefit Enhancement; and*
    - *The services are furnished in the beneficiary's home by auxiliary personnel under the general supervision of a DC Participant Provider or Preferred Provider who is a physician or other practitioner after a DC Participant Provider or Preferred Provider has initiated a care management plan that includes such services.*

Home Health Homebound Waiver Benefit Enhancement

- The Home Health Homebound Waiver Benefit Enhancement would:
    - Permit Medicare reimbursement of home health services for beneficiaries with **certain clinical risk factors that are not homebound.**
    - Enhance beneficiaries' ability to return to, remain in, and receive care in their home.
- Aligned beneficiaries are eligible if the following criteria is met:
    - *The beneficiary otherwise qualifies for home health services under 42 C.F.R. § 409.42 except that the beneficiary is not required to be confined to the home;*
    - *The beneficiary has a combination of clinical risks including: 2 or more chronic illnesses along with criteria related to inpatient utilization, frailty, and/or social isolation.*
    - *The beneficiary is not concurrently receiving services under the post-discharge visits or care management home visits benefit enhancements*
- DCEs would identify home health providers that are DC Participant Providers or Preferred Providers who would offer these services to eligible beneficiaries.

Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit Enhancement

- Under this BE, DCEs would work with their hospice providers and non-hospice providers to define and provide a set of concurrent care services related to a hospice enrollee's terminal condition.

    - Generally, beneficiaries who elect hospice care waive their right to Medicare coverage for treatment of their terminal condition.
    - CMS will use its authority to waive the requirement that a beneficiary waive all rights to Medicare payment for services related to the treatment of their terminal illness when electing the hospice benefit.
- The DCE would pay only for concurrent services provided by designated DC Participant or Preferred Providers as specified in the beneficiary's plan of care.
- A beneficiary must have elected the Medicare Hospice Benefit to be eligible for concurrent care services.

Beneficiary Engagement Incentives for PY1

Subject to compliance with all applicable laws and regulations, DC Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to DCE activities will be permitted to provide in-kind items or services to beneficiaries, if the following conditions are satisfied:

1. *There is a direct 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 one or more goals of the Model, 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;*
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 item or service, regardless of whether the DCE selects to participate in such Benefit Enhancement for a given performance year;*
4. *The in-kind item or service is not furnished in whole or in part to reward the beneficiary for designating or agreeing to designate through Voluntary Alignment a DC Participant Provider as his or her primary clinician, main doctor, main provider, or the main place where the Beneficiary receives care; and*
5. *The in-kind item or service is furnished to a beneficiary directly by the DCE, a DC Participant Provider or a Preferred Provider*.

<u>Chronic Disease Management Reward</u>

- CMS will permit DCEs to provide gift cards to eligible aligned beneficiaries, up to an annual limit of $75, for the purpose of incentivizing participation in a chronic disease management program.
- A program may focus on aligned beneficiaries with a specific disease or chronic condition, as long as the program does not discriminate against any aligned beneficiary who would otherwise qualify for participation.
- DCEs will pay for the gift cards out of their own funds and at their discretion.

<u>Cost Sharing Support for Part B Services</u>

- A DCE may enter into a cost sharing support arrangement with its DC Participant Providers and Preferred Providers, where the DC Participant Providers and Preferred Providers would not collect beneficiary cost sharing amounts.
    - DCEs would define the categories of aligned beneficiaries and the categories of Part B services (excluding prescription drugs and durable medical equipment).

- DCEs will make payments to those DC Participant Providers and Preferred Providers to cover some or all of the amount of beneficiary cost sharing not collected.
- In addition, the Cost Sharing Support must advance one or more of the following clinical goals:
    - *Adherence to a treatment plan*
    - *Adherence to a drug plan*
    - *Adherence to a follow-up care plan*
    - *Management of a chronic disease or condition*

Appendix A: Synchronous and Asynchronous Telehealth, Post Discharge Home Visits, Care Management Home Visits - Code Tables[3]

Table 1: Healthcare Common Procedure Coding System (HCPCS) codes for Synchronous Telehealth

HCPCS Code	Short Descriptors
G9481	Remote E/M new pt 10 mins.
G9482	Remote E/M new pt 20 mins.
G9483	Remote E/M new pt 30 mins.
G9484	Remote E/M new pt 45 mins.
G9485	Remote E/M new pt 60 mins.
G9486	Remote E/M established pt 10 mins
G9487	Remote E/M established pt 15 mins
G9488	Remote E/M established pt 25 mins
G9489	Remote E/M established pt 40 mins
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPPS); first visit
G0439	Annual wellness visit; includes a personalized prevention plan of service (PPPS); subsequent visit

Table 2: Healthcare Common Procedure Coding System (HCPCS) codes for Asynchronous Telehealth

HCPCS Code	Descriptors
G9868	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use only in a Medicare-approved Innovation Center model, less than 10 minutes
G9869	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use only in a Medicare-approved Innovation Center model, less than 10-20 minutes
G9870	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use only in a Medicare-approved Innovation Center model, less than 20 or more minutes

[3] These codes are subject to change. CMS will inform model participants of any changes to Innovation Center model codes.

Table 3: Healthcare Common Procedure Coding System (HCPCS) codes for Post Discharge Home Visits

HCPCS Code	Short Descriptors
G2001	Post-Discharge Home Visit new patient 20 minutes
G2002	Post-Discharge Home Visit new patient 30 minutes
G2003	Post-Discharge Home Visit new patient 45 minutes
G2004	Post-Discharge Home Visit new patient 60 minutes
G2005	Post-Discharge Home Visit new patient 75 minutes
G2006	Post-Discharge Home Visit existing patient 20 minutes
G2007	Post-Discharge Home Visit existing patient 30 minutes
G2008	Post-Discharge Home Visit existing patient 45 minutes
G2009	Post-Discharge Home Visit existing patient 60 minutes
G2013	Post-Discharge Home Visit existing patient 75 minutes
G2014	Post-Discharge care plan over 30 minutes
G2015	Post-Discharge care plan over 60 minutes

Table 4: Healthcare Common Procedure Coding System (HCPCS) codes for Care Management Home Visits

HCPCS Code	Short Descriptors
G0076	Care Management Home Visits new patient 20 minutes
G0077	Care Management Home Visits new patient 30 minutes
G0078	Care Management Home Visits new patient 45 minutes
G0079	Care Management Home Visits new patient 60 minutes
G0080	Care Management Home Visits new patient 75 minutes
G0081	Care Management Home Visits exist patient 20 minutes
G0082	Care Management Home Visits exist patient 30 minutes
G0083	Care Management Home Visits exist patient 45 minutes
G0084	Care Management Home Visits exist patient 60 minutes
G0085	Care Management Home Visits existing patient 75 minutes

G0086	Care Management Home Visits care plan overs 30 minutes
G0087	Care Management Home Visits care plan overs 60 minutes