Frequently Asked Questions on the Direct Contracting Model

The Direct Contracting Model is the latest population health-based payment model from the Center for Medicare and Medicaid Innovation (CMMI). Building upon the Next Generation ACO Model (Next Gen) and incorporating elements of Medicare Advantage, Direct Contracting offers higher levels of risk and reward than other alternative payment models (APMs), allows flexibility with payments through capitation, increases beneficiary engagement and aims to attract new players to Medicare fee-for-service (FFS).

[NOTE: In June 2020, CMMI announced changes to Direct Contracting and many other models in light of the COVID-19 public health emergency. Details are listed below.] Direct Contracting was initially announced in April 2019 and on November 25, 2019, the Centers for Medicare & Medicaid Services (CMS) released the Request for Applications (RFA). The model is scheduled to last for five years with the first performance year starting on April 1, 2021. An optional Implementation Period will begin in the fall of 2020. Two program options —Professional and Global — are available for three types of Direct Contracting Entities (DCEs), which are analogous to ACOs. The DCE types are Standard, New Entrant, and High Needs Population.

NAACOS continues advocating to help shape Direct Contracting. We have met with CMS and CMMI leaders and written letters on the Geographic and Professional and Global Options. **Additionally, NAACOS launched the Direct Contracting Taskforce to strengthen our advocacy and increase provider education and engagement.** NAACOS members automatically receive all benefits of the Taskforce. For those net yet members of NAACOS, we are offering complimentary access to the Taskforce. Members can learn more about the model by watching our on-demand webinar or reading our in-depth review.

This Frequently Asked Questions resource provides answers to many of the questions we have received on the new Direct Contracting structure and policies. We will continue to update this document as we receive additional questions from members and further details on the model from CMS. For additional questions or clarification on Direct Contracting, please email us at DirectContracting@naacos.com.

MODEL PARTICIPANTS

What is the difference between a Participant Provider and Preferred Providers?
Participant Providers are the main clinicians in a DCE. Patients are aligned through visits with them or by identifying one of these providers as the primary source of their care. Participant Providers report quality through the DCE and are eligible to be Qualified Participants (QPs) in APMs under the Quality Payment Program (QPP). They cannot participate in other shared savings initiatives like the Medicare Shared Savings Program (MSSP). As further explained on page 13 of the RFA, Preferred Providers, on the other hand, are not used for alignment, do not report quality through the DCE, and cannot qualify as QPs. They are the "extended network" through which DCEs conduct their work. Preferred Providers are not prohibited from participating in other shared savings initiatives. Both Participant Providers and Preferred Providers may receive shared savings (and be responsible for shared losses) and may participate in the model's benefit enhancements and patient engagement incentives.

Can I create a network with my Participant Providers or Preferred Providers?
Direct Contracting will not limit a beneficiaries' freedom of choice, so their alignment to a DCE will not limit their ability to see providers of their choosing, as CMS explains on pages 22–23 of the RFA.

What role will private payers have in the model?
On page 8 of the RFA, CMS encourages managed care organizations to participate in Direct Contracting. They are free to use their relationships with providers to establish a DCE and can use outreach to signup beneficiaries through voluntary alignment.

COVID-19 CHANGES

How will the start of various performance periods be impacted because of the COVID-19 public health emergency?
CMS stated on June 3 that Performance Year 1 will be delayed by three months and start on April 1, 2021. It was originally intended to start on January 1, 2021. The model's Implementation Period will start in October 2020. It was supposed to start in the summer of 2020. Performance Year 1 will end on December 31, 2021.

I was accepted for the Implementation Period. Do I have to start when the Implementation Period opens in October?
No, CMMI will allow those accepted for the Implementation Period to delay their start until either the start of Performance Year 1 on April 1, 2021 or Performance Year 2 on January 1, 2022. Similarly, DCEs accepted for Performance Year 1 may delay their start until 2022.

If those accepted for the Implementation Period will be able to delay their start to January 2022, does that mean they will have some sort of no-risk period in 2021?
No, as CMMI staff explained to NAACOS on a June 25 session as part of our virtual spring conference, Direct Contracting's Implementation Period precedes Performance Year 1 and ends on March 31, 2021. There will be no additional opportunity for an Implementation Period.

APPLICATION QUESTIONS

What changes were made to the application period because of the COVID-19 pandemic?
CMS announced on June 4 that the applications for Performance Year 1 would be accepted through midnight ET on July 6. CMS also said that DCEs that are accepted for either the Implementation Period or Performance Year 1 may defer their start until 2022. CMS also said it will offer an opportunity to apply in early 2021 to start in 2022.

If I do not want to join Direct Contracting in the Implementation Period or Performance Year 1 starting on April 2021, will there be an option for me to apply later?
Yes, CMS announced in June 2020 that it will hold an application cycle for DCEs to be able to on January 1, 2022, a change advocated for by NAACOS. The application cycle for a 2022 start will be held in the first quarter of 2021.

I did not submit a Letter of Intent (LOI). May I still apply?
CMS announced on June 17 that it would accept LOIs from those who previously did not submit one. An LOI is needed to access the application portal. CMS also announced that an LOI will not be necessary to apply for a 2022 start date.

Can I apply and then choose not to participate?
Yes. Submitting an application doesn't commit you to participate. DCEs are not committed to the model until they sign and return a Participation Agreement.

Will there be a separate application process for the Implementation Period and Performance Year 1?
CMS has said on various webinars and calls held in December 2019 that DCEs participating in the Implementation Period will not need to submit a separate application for Performance Year 1. Those participating in the Implementation Period will be issued a separate Participation Agreement for Performance Year 1 and must update provider lists for Performance Year 1. If you don't participate in the Implementation Period, you will have to submit a separate application for Performance Year 1, even if you applied to participate in the Implementation Period.

Would you need all Participant Providers on your application upon initial submission? Or can you add later? Will DCEs have the ability to add or drop Participant Providers after an application is submitted?
In webinars and office hours, CMS has said those agreements don't need to be in place upon an application's submission, but DCEs do need for those to be finalized by start of Performance Year 1. For those applying for the Implementation Period, DCEs will need to submit a list of Participant Providers and Preferred Providers with their application, but the DCE will submit new lists for Performance Year 1.

PARTICIPATION OPTIONS

I am current an ACO. What happens to my participation in 2021 if I choose to start in Direct Contracting on April 1, 2021? Will I be forced to sit out for three months with no model?
CMS said in various webinars in June 2020 that is still working on a policy how to address this three-month period for both MSSP and Next Gen ACOs. The agency plans to release this policy soon in an FAQ format.

I'm a Next Gen ACO now. Do I have to participate in Direct Contracting? Will I automatically fall into either Direct Contracting or MSSP? What if I want to stay in Next Gen?
Participation in Direct Contracting is purely voluntary. You must apply to be a DCE or agree to participate in a DCE. In June 2020, CMMI announced it would extend the Next Gen model through 2021. While Direct Contracting is meant to be the successor to Next Gen, current Next Gen ACOs must still apply for Direct Contracting. MSSP is also an option and Next Gen ACOs must also apply in order to participate in that program.

Making Next Gen permanent has been and continues to be a priority for NAACOS. We've met with leaders from both the U.S. Department of Health & Human Services (HHS) and CMS on this topic.

What happens if I join Direct Contracting in 2021 and decide to drop out after a year or two? Is there a penalty? Can I just go back to MSSP?
CMS wants DCEs to participate for at least two performance years. In 2021 only, CMS will withhold 2 percent of the benchmark as a "retention withhold" to incentivize DCEs to remain in the model for at least two years. If a DCE remains in the model at the time of final reconciliation in Performance Year (PY) 1 (which will occur during Performance Year 2), the DCE will earn back the full amount of the withhold. CMS explains termination policies on page 69 of the RFA.

As an MSSP ACO or Next Gen ACO, do I have to terminate my MSSP participation prior to participating in the Direct Contracting Implementation Period?
CMS has said that organizations may simultaneously participate in the Implementation Period and other alternative payment initiatives. However, an organization must terminate participation in other initiatives in order to participate in Direct Contracting's performance years, which begin April 1, 2020.

If I start in the Professional Option, will CMS force me to "move up" or graduate to the Global Option? Can I start in the Global Option and move into the Professional Option?
DCEs will not be required to move from Professional to Global. CMS, however, has made it clear in various webinars and office hours that DCEs won't be able to start in the higher-risk Global Option and move to the

lower-risk Professional Option. At the start of Performance Years 3, 4 and 5, DCEs will have the option to transition from Professional to Global, but not the other way around.

Can a provider practice in both a Standard and High Needs Population DCEs?
Participant Providers can only participate in one DCE. If an organization submits applications for both Standard and High Needs DCEs, the providers on each application can't overlap, CMS explained during January 8 office hours. CMS said during a December 17 office hours that a provider may be a Participant Provider in one DCE and a Preferred Provider in another DCE. However, Standard DCEs may still serve beneficiaries who would otherwise qualify as patients under a High Needs Population DCE.

Will CMS allow my organization to "split" my Standard DCE and form a High Needs Population DCE?
In a July 2 announcement, CMS noted a change in policy stated in the RFA as a result of stakeholder feedback. The agency stated Standard DCEs are not allowed to split and form two separate DCEs – one High Needs Population DCE for their high-needs beneficiaries and one Standard DCE for their remaining beneficiaries. If you have applied as a split entity, CMS said it will work with applicants to consolidate applications and plans under the Standard DCE option, including adding the providers submitted with the High Needs DCE to the Standard DCE submitted provider list.

Can my High Needs Population DCE have more than 3,000 claims-aligned beneficiaries?
Because it was unclear in the RFA, CMS clarified on July 2, High Needs DCEs that reach 3,000 claim-based aligned beneficiaries will convert to a Standard DCE for purposes of their benchmark. For New Entrant and High Needs Population DCEs, CMS will not use historical baseline expenditures for Performance Years 1-3. CMS will only use regional expenditures for Performance Years 1-3 and will add in historical baseline expenditures for Performance Years 4-5 using a fixed two-year base period (2021, 2022).

Can High Needs Population DCEs focus on just one specific sub-population?
Yes, so long as each beneficiary within a sub-population still meets the high-needs patient eligibility criteria. The sub-populations must be identified through claims through a process outlined on page 54 of the RFA. Also, DCEs must clearly state the clinical criteria used to define these populations, including patients with one particular disease, a disease at a particular stage, or a combination of diseases. CMS explains this on page 54 of the RFA.

Can I participate in the Implementation Period and then not sign a Participation Agreement for 2021 (Performance Year 1)?
Yes. There will be separate Participation Agreements for the Implementation Period and for the five Performance Years beginning April 2021. A DCE that executes a Participation Agreement for the Implementation Period is not required to sign the Participation Agreement for the model Performance Years.

Can I apply to participate in both Direct Contracting and MSSP and decide which I want to join later?
Yes, a DCE can apply to multiple models simultaneously, even though it can't participate in those models at the same time. CMS stated during January 8 office hours that participants must decide which model they will participate in when it comes time to sign Participation Agreements. DCEs should be mindful that application and Participation Agreement deadlines may be different for each model.

What reasons would you have to <u>not</u> participate in the Implementation Period?
The Implementation Period provides a DCE with the opportunity to conduct voluntary alignment and build its care coordination operations in advance of the first Performance Year. Participants in the Implementation Period will also receive data/claims reports for aligned beneficiaries. However, if you are a

current MSSP or Next Gen ACO you may not need these tools. Also, skipping the Implementation Period allows a DCE more time to put together its application and provider lists.

I am currently a successful MSSP ACO. What reasons do I have to participate in Direct Contracting?
Direct Contracting offers higher levels of risk and reward comparted to other APMs. DCEs will have access to a wider range of benefit enhancements and more flexibilities in outreach around voluntary alignment. But mostly, Direct Contracting offers greater freedoms around payments through capitation. DCEs will be allowed to enter into different payment structures with providers.

MODEL OVERLAP

Are you allowed to participate in both Primary Care First and Direct Contracting?
CMS states on page 15 of the RFA that Participant Providers may not operate in Comprehensive Primary Care Plus (CPC+) or Primary Care First when Performance Year 1 starts in April 1, 2021. This follows the overlap policy of Next Gen and CPC+.

For CPC+ practices, will the care management fees be included in my DCE's benchmark?
Yes, this will be similar to how CMS handles CPC+'s care management fees for ACOs.

Some primary care providers in my ACO want to participate in Primary Care First. But some of their colleagues who operate under the same TIN want to join Direct Contracting. What are their options?
CMS staff indicated during a December 17 office hours that it will allow for some NPIs under one TIN to participate in Direct Contracting as Participant Providers and different NPIs to participate in Primary Care First. A Preferred Provider may participate in both Direct Contracting and Primary Care First.

Are you allowed to participate in any new kidney care models and Direct Contracting?
In the RFA for the Kidney Care Choices Model, CMS states practices participating in the Kidney Care First Model will not be able to participate in Direct Contracting. Participant Providers of Comprehensive Kidney Care Contracting will not be allowed to dually participate in Direct Contracting since CMS does not allow providers to participate in multiple shared savings arrangements.

Can I participate in both MSSP and Direct Contracting?
CMS has made it clear that a Participant Provider can't participate in multiple shared savings arrangements at the same time, including MSSP and Direct Contracting. Accordingly, Participant Providers can only participate in one or the other. Because MSSP has full-TIN participation, a TIN with some of its Participant Providers in MSSP will be precluded from participating in MSSP. This prohibition does not extend to Preferred Providers.

Why is simultaneous participation allowed in 2020, but not 2021?
Financial accountability for Direct Contracting doesn't start until April 1, 2021, when the first Performance Year starts. The Implementation Period starting in October 2020 is mostly meant to help providers build their networks, launch care coordination efforts, gain attribution through voluntary alignment and establish a claims history if you're new to FFS Medicare. Therefore, CMS will allow dual participation in models that will otherwise be barred starting in 2021.

Can a provider participate in multiple DCEs?
A provider may participate in multiple DCEs as a Preferred Provider. However, a provider may only participate in a single DCE as a Participant Provider. Also, CMS said during December 17 office hours that a provider may be a Participant Provider in one DCE and a Preferred Provider in another DCE.

What are the implications for me dropping out of MSSP and joining Direct Contracting?
In December 2018, CMS changed its policies around early termination in the final Pathways to Success rule. CMS will require ACOs in two-sided models that voluntarily terminate after June 30 to share in losses. Conversely, ACOs will not be eligible to share in savings if they terminate during a performance year. MSSP ACOs must notify CMS of their intent to leave the program early at least 30 days before they leave. For more information, visit our in-depth review of the final Pathways rule.

QUALITY PAYMENT PROGRAM

Will Preferred Providers be eligible for the 5 percent QP bonus?
CMS stated in the final MACRA rule in November 2016 that it will only consider providers on an Advanced APM's Participant List as eligible for hitting QP status and therefore eligible for that 5 percent bonus. The agency has made it clear in the Next Gen Model that Preferred Providers aren't eligible for the QP bonus. However, NAACOS will seek to get clarity on this question as it relates to Direct Contracting.

Will the QP bonus be counted as DCE spending?
No. This is the same as the current policy of not counting the QP bonus for MSSP or Next Gen.

CAPITATED PAYMENTS

Since DCEs will be expected to pay downstream providers for services like health plans, will they be required to be licensed by a state as a health plan?
Each state maintains its own requirements. A DCE must check with each state in which it operates to determine whether it will need to be licensed as a health plan. CMS acknowledges on page 14 of the RFA that DCEs may be subject to insurer or third-party administrator licensure requirements.

Do DCEs need to process their own claims?
DCEs will still submit claims for all services like they do in a FFS system. CMS still needs submitted claims for aspects like alignment, but CMS will "zero out" claims from Participant Providers and Preferred Providers who want to participate in capitation. For DCEs with the Primary Care Capitation, this will be qualifying primary care services. For DCEs with Total Care Capitation, this is all claims for those providers. It would then be the DCEs' responsibility to pay Participating Providers and those Preferred Providers who want to participate in capitation in accordance with the written agreements between the DCE and its providers.

On which services can I spend that Primary Care Capitation payment?
CMS stated that it does not plan to restrict how a DCE uses the capitated payments it receives, so long as it complies with all applicable laws. DCEs may creatively contract with their providers.

What are the advantages of the "Advanced Payment" option?
Advanced Payment provides greater contracting flexibility to DCEs. It allows a DCE receiving Primary Care Capitation the flexibility to enter into capitation agreements with its providers for non-primary services. This payment mechanism provides the DCE with increased cash flow. Also, unlike the Primary Care Capitation payments, the Advanced Payments are not true capitation but, rather, are reconciled against claims at the end of each performance year.

Is the Total Care Capitation true capitation? Or will there be allowances for care provided outside of the DCE and to Preferred Providers?
CMS will withhold a percentage of the prospective benchmark to account for "leakage." The withheld amount will be reconciled against the actual percentage of services that a DCE's aligned beneficiaries receive from providers outside of the DCE.

Preferred Providers aren't required to participate under special payment arrangements financed by the capitated payments DCEs received, but can they if they want to and the DCE allows it?
Yes.

VOLUNTARY ALIGNMENT

I'm not participating in the IP. Will I be able to conduct voluntary alignment before my PY?
A DCE cannot use the Direct Contracting voluntary alignment tools until it has entered into a Participation Agreement with CMMI.

What allowances can we expect to see from a marketing standpoint?
DCEs will be allowed to proactively communicate with beneficiaries about voluntary alignment within the DCEs' service areas. This includes providing marketing materials, holding outreach events, and offering gifts of nominal value as long as the gifts aren't considered inducements prohibited by the anti-kickback statute. However, outreach can't be considered misleading or making beneficiaries believe that alignment will change their freedom of choice or Medicare benefits. DCEs cannot discriminate against beneficiaries, such as based on their anticipated costs of care.

CMS has stated marketing guidelines will be influenced by those provided under Medicare Advantage, but the scope of marketing that will be allowed remains uncertain. CMS and the Office of the Inspector General will issue payment rule waivers as well as fraud and abuse waivers to enact the policy. The breadth of these waivers will dictate the usefulness of this engagement. CMS discussed voluntary alignment in more detail on page 20 of the RFA.

Under voluntary alignment, will patients designate their primary provider like they do with ACOs today? Or will they align to a DCE?
Voluntary alignment will work much like it does with ACOs today. Beneficiaries can select their primary provider either through MyMedicare.gov or through a paper-based process. If that clinician is a Participant Provider in a DCE, the beneficiary will be aligned to the DCE. Notably, DCEs joining from another model (such as MSSP or Next Gen) may retain their beneficiaries who previously voluntarily aligned to one of the DCE's Participant Providers. CMS currently does not offer the option for a beneficiary to voluntarily align directly with a DCE.

What are the advantages and disadvantages of using "Prospective Plus" alignment?
Prospective Plus alignment allows a DCE to add beneficiaries during a performance year through voluntary alignment. This could be an effective way for a DCE to grow its beneficiary pool. However, Prospective Plus alignment reduces the reliability of the prospective benchmark, as the benchmark will be updated throughout the year. Additional details on 'Prospective Plus" alignment can be found on page 21 of the RFA.

Could a DCE decide before each performance year between prospective alignment or prospective-plus alignment?
CMS stated during a webinar that a DCE can make this election annually before each Performance Year.

BENCHMARKING AND RISK ADJUSTMENT

When can we expect more information from CMMI on benchmarking and risk adjustment?
In an outline posted on its website, CMS states it will publish a series of papers on the financial methodology of Direct Contracting between September and November. Dates offering more specificity will be released as they move forward.

What are the differences between the Direct Contracting benchmarking methodology and that used for the Next Gen Model?
Some of the most pertinent differences include how the regional adjustment is calculated. Direct Contracting bases it on Medicare Advantage rates, while Next Gen bases it on the national assignable FFS trend. CMMI has not yet released what edits will be made to the Medicare Advantage rate book calculations, although we are expecting there to be at least some changes. The quality withhold starts off as 5 percent under Direct Contracting, while starting at 2 percent under Next Gen.

How is Direct Contracting's benchmarking methodology different from MSSP?
MSSP and Direct Contracting benchmarking have a number of differences, but here are a few of the most salient ones: (1) A DCE's benchmark will be based on two years, while it's one year in MSSP. (2) Under Direct Contracting, the benchmark is set prospectively at the start of the year, while in MSSP where the final benchmark is only known at the time of financial reconciliation. (3) Direct Contracting's regional adjustment plays a much larger role in the benchmark with a more aggressive phase-in than what we see under MSSP. (4) The discount and quality withhold under Direct Contracting will be unfamiliar to MSSP participants, as this does not exist under MSSP.

How does the discount compare to Next Gen?
The Global Option of the Direct Contracting Model will employ a discount, which ensures that CMS realizes some savings generated by DCEs. The discount, which is withheld from the DCE's benchmark, starts at 2 percent in Performance Year 1 and Performance Year 2 to 3 percent in PY3, 4 percent in PY4, and 5 percent in PY5. Under Next Gen, the discount started at 1.25 percent when the program launched in 2016. It increased to 2 percent in 2019 and 3 percent in 2020. Therefore, the discounts being used by Direct Contracting are higher.

How does the risk arrangement under the Professional Option compare to MSSP?
Direct Contracting's Professional Option, the lower-risk option, offers 50 percent shared savings and losses of the first 5 percent of the DCE's benchmark. This is the same savings rate offered in Level C, D and E of the Basic Track of MSSP. (The Enhanced Track offers 75 percent shared savings.) However, shared losses in Levels, C, D and E are 30 percent and capped at 1 percent, 2 percent and 4 percent respectively. Unlike MSSP, Direct Contracting provides risk bands for higher levels of savings and losses. More detail on MSSP's risk arrangements can be found in this NAACOS analysis of Pathways to Success.

By PY5 (2025), a Global DCE will have 10 percent of its benchmark withheld (granted it can earn back some of that quality reporting and performance). That's a lot. What are the odds it can be financially successful and generate savings?
For participants in the Global Option, the discount to benchmark is set at 2 percent of the benchmark for Performance Year 1 and Performance Year 2. For each subsequent performance year, the discount increases by 1 percentage point. The goal of the increasing discount is to incentivize continuous improvement throughout the five-year agreement since the benchmark is not rebased. In other words, the DCE will need to beat trend by 1 percent each year to generate shared savings. A 1 percent annual trend reduction target has been achieved by other ACOs in MSSP and Next Gen, according to public use files. For Professional DCEs, the performance year benchmark does not include the discount.

QUALITY

Will CMMI use the Next Gen scoring approach for quality assessments in Direct Contracting?
Appendix C of the RFA lists the measure set CMMI intends to use for Direct Contracting. However, few details have been shared to date regarding the scoring methodology that will be used to evaluate quality performance on these measures. CMMI staff have noted they plan to share additional information on quality assessment in the coming months. The quality measure set relies on fewer measures than the Next

Gen Model, putting a heavy emphasis on patient satisfaction measures and introducing new measures such as Gains in Patient Activation at 12 Months and a Days at Home Measure that has not yet been developed.

Will CMMI add quality measures to the Direct Contracting Quality Measure Set listed in the RFA?
The RFA lists three claims-based measures ACOs are familiar with which evaluate readmissions, as well as the patient satisfaction survey measures found in the CAHPS for ACOs survey. Additionally, CMMI includes a measure on Advanced Care Planning, which will be evaluated through claims analysis and an optional, patient-reported survey measure on Gains in Patient Activation at 12 Months. Finally, CMMI notes they intend to include a measure on days at home for DCE-aligned beneficiaries with overall HCC risk scores of 2+. However, this measure has not yet been developed.

How could a DCE earn money with the new High Performers Pool?
As explained on page 46 of the RFA, Direct Contracting is introducing a concept not currently in Next Gen or MSSP called a High Performers Pool. CMS will fund the pool with a portion of quality withhold money not earned back through performance on the specified quality measures. CMS has not yet announced how exactly it will distribute the High Performers money, but the RFA states it will be based on an individual DCE's performance on the specified measures in the current performance year compared to the prior performance year, on performance against the quality measure benchmark, or a combination of both. It's also important to note the uncertainty in how much money will be available through the pool since most DCEs could earn back the majority of their quality withhold and/or exceed the thresholds to qualify for the bonus.

BENEFIT ENHANCEMENTS AND PATIENT INCENTIVES

When do the benefit enhancements and incentives start?
CMS stated during a December 18 webinar on benefit enhancements that none are available during the Implementation Period of 2020. All will be available starting in the first performance year of 2021.

Do I have to offer all of the provided benefit enhancements and incentives?
CMS states on page 57 of the RFA "a DCE may choose not to implement all or any of these benefit enhancements," so DCEs can choose which, if any, enhancements and incentives to implement. However, the use of incentives and enhancements will need to be explained in the DCE's application and in an implementation plan. A DCE may update its elections annually.

Can I apply to add a benefit enhancement or incentive mid-year?
CMS indicated in a December 18 webinar that there may be an opportunity to apply to add enhancements mid-year. CMS says they will release more guidance on this later.

For the benefit enhancements allowed under Next Gen today, are there any changes I should be aware of?
Direct Contracting will allow DCEs using the Care Management Home Visits Benefit Enhancement to provide up to 12 visits a year, per page 59 of the RFA. Next Gen is limited to two visits over a 90-day period. Also, Direct Contracting will offer additional benefit enhancements including allowing a nurse practitioner to certify a beneficiary for in-home care, waiving the homebound requirement for certain conditions, and allowing concurrent conventional care with hospice care.

Particularly with the Chronic Disease Management Program, but with any of the benefit enhancements and incentives, can I target specific populations? Or do I have to offer it to all my aligned beneficiaries?
CMS said in a December 18 webinar that DCEs can target select populations with their enhancements and waivers. DCEs just need to detail that in the implementation plan they submit to the agency.

For the Part B Cost Sharing Support, who covers the cost of that?
The cost of patient engagement incentives like Part B Cost Sharing Support come out of DCEs' own pockets, as stated on page 25 of the RFA. Therefore, that money doesn't count against the DCE's benchmark.

Are there only certain types of visits or services for which I can provide cost sharing support?
A DCE may provide cost sharing support for all types of visits and services except for prescription drugs and durable medical equipment. See page 24 of the RFA.

How do home health agencies bill for patients covered under any of these enhancements?
According to a CMS webinar on December 18, a home health agency would bill for services delivered just like they would in Medicare FFS. If the beneficiary and home health agency are both participating in Direct Contracting, then the claim would be assigned to either for the purposes of the model's financial reconciliation. The same is true of the hospice benefit.