December 28, 2020

Welcome to the Direct Contracting Model as we move forward to plan for your participation beginning April 1, 2021. CMS looks forward to working with your organization to improve quality of care, enhance outcomes, and lower cost of care for Medicare beneficiaries.

This Performance Year (PY) 2021 Onboarding Packet provides you with general information regarding your participation beginning in PY2021 in the Direct Contracting Model and important documents for you to review. Please review the documents enclosed carefully. If you have any questions on the contents of this packet, please do not hesitate to contact the Direct Contracting team through the following means:

Phone Inquiries: Direct Contracting Entities (DCEs) can contact the Accountable Care Organization Information Center by calling 1-888-734-6433, Option 1 for ACO and then option 3 for Direct Contracting Model, between the hours of 8:30 a.m. to 7:30 p.m. Eastern Time Monday through Friday.

Electronic Inquiries: DCEs can email DPC@cms.hhs.gov and will receive confirmation that their email was received within 24 hours.

Sincerely,

The Direct Contracting Model Team

1. **Welcome Letter**

2. **Content Explanation** (This document)

3. **Direct Contracting Model Timeline**
    - **a.** This timeline shows important dates for the Direct Contracting Model PY2021 participants, including the PY2021 Introductory webinar.
    - b. Onboarding Webinar Invitation

4. **CMMI Incidence Response Processes and Template (found in separate attachment)**
    - a. This document details important information about protecting CMS data and responding to potential violations of Federal security/privacy laws and/or CMS security/privacy policies.

5. **Direct Contracting Model Learning System Introduction**
    - a. This document provides an introduction to the Direct Contracting Model Learning System and details some of the upcoming activities.

6. **Beneficiary Notification Template (found in separate attachment)**
    - a. This document provides a beneficiary notification letter template to alert beneficiaries of your participation in the Direct Contracting Model. Additional guidance will be forthcoming but PY2021 participants will be expected to send their beneficiary notification letters by August 31, 2021 after signing the participation agreement.

7. **Financial Methodology Resources**
    - a. This document provides an overview of important financial terms.

8. **Innovation Payment Contractor (IPC) Overview**

9. **Fee Reduction Agreement (found at the end of this packet)**

    The Fee Reduction Agreement is a binding attestation that should be completed by each DCE's aligned provider or organization as defined by the billing Tax Identification Number (TIN). This Agreement codifies the TIN's participation in one or more of three alternative payment mechanisms: Total Care Capitation (TCC), Primary Care Capitation (PCC), and/or Advanced Payment Option (APO). This Agreement should be completed by the Authorized or Delegated Official of the TIN aligned to the DCE. Please note that this

Agreement does not implement a TIN's participation in an APA, which can only be executed through the application of an APA to a provider record in 4i.

10. Marketing Guidelines

a. This document highlights the requirements and restrictions regarding marketing to beneficiaries.

11. Voluntary Alignment Overview

a. This document provides an overview on the voluntary alignment process.

12. MyMedicare.gov Fact Sheet (found in separate attachment)

a. This document provides information on how beneficiaries use MyMedicare.gov to electronically voluntary align.

13. Voluntary Alignment Attachments (found attached)

a. Template Letter: This document is edited with the DCE information and provided to the beneficiaries to voluntarily align.
b. Paper Based Voluntary Alignment Template
c. Voluntary Alignment Frequently Asked Questions

14. Data Overview

a. This document provides an overview of the data to be received in PY2021.

15. Overview to 4i

a. 4i is a technology platform in which the DCE will manage many aspects of the model, for example: provider list processing, accessing reports, and submitting benefit enhancements.

Model Timeline – PY 2021		
Task	**Date**	**Notes**
Final DC Participant Provider and Preferred Provider List for PY2021	Currently Available in 4i	
DCEs nominate their Designated Officials Designated Officials create a CMS Enterprise Account	Now - January 14, 2021	This is the first step that DCEs and DOs must take in order to receive prospective payments. The webinar held on 12/17/20 provides additional information on this topic. The recording can be found here. The passcode to access the recording is: 7ibc7Zz^
CMS sends DCEs survey link to collect information from DOs to facilitate IPC Portal Access. Link available during Survey Gate Window.	December 21, 2020-January 14, 2021	A link to the IPC Portal Access survey can be found here. Prompt completion of this survey will help assure DOs have gain access to the IPC Portal.
Benefit enhancement and payment selections for PY1 providers available in 4i	December 21, 2020-January 14, 2021	DCEs can change their TCC or PCC elections as well as assign BEs to providers on their PY1 provider list.
Beneficiary Enhancement Implementation Plans due to the helpdesk	January 14, 2021	Send plans to DPC@cms.hhs.gov. CMS has shared this guidance in the 12/11/20 Newsletter but does not provide a standard template for these plans.
CMS Onboarding Webinar	January 13, 2021	Please see following page for registration information
Aggregate Beneficiary Alignment Lists sent to DCEs	Late January 2021	
Reporting and Data Sharing Overview	Late January 2021	This overview will provide information on the expected PY2021 reports as well as how data will be shared with the DCEs.
DOs gain access to the IPC Portal. Notifications will be sent to DOs informing them they are able to access the IPC Portal.	January 14, 2021 – February 7, 2021	DOs should promptly begin submitting banking information into the IPC Portal to ensure bank accounts are validated in preparation for payment.
PY2021 Participation Agreement (PA) available for review	March 1, 2021	
PY2021 preliminary benchmarks available for review	March 1, 2021	
Deadline to sign PA and Data Disclosure Form	March 29, 2021	No beneficiary data may be shared with the DCEs until the PA and this form is signed.
Beneficiary Notification Letters deadline	Due to CMS for Review: May 15, 2021 Due to be sent to beneficiary: August 31, 2021	The DCE sends these letters to its beneficiaries as notification that they have been aligned to the DCE. All DCEs are required to send these letters once the Participation Agreement is signed.

CMS to produce and send Historical Claim and Claim Line Feeds (CCLFs) to DCEs	Late April 2021	Please note that DCEs should set up their own IT systems to store CCLFs (or any reports) prior to this date. More information on these reports is provided in the Data Sharing Overview.
PY2021 Begins	April 1, 2021	
First capitation (and Advanced Payment, if applicable) payments sent to DCE's established bank accounts	April 26, 2021	

Please join CMS for an introduction to the many work streams that make up the Direct Contracting Model.

The webinar is scheduled for

January 13th, 2021

2:00-3:30 PM Eastern Time

To register in advance for this meeting, please click here.

After registering, you will receive a confirmation email containing information about joining the meeting.

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The Direct Contracting Model Learning System

Welcome to the Direct Contracting Model learning system! We look forward to meeting you and working with you to provide educational programs, collaboration settings, and tools that help you achieve your goals and the goals of the Model. Below is an overview of the Learning and Diffusion Group (LDG) at The Innovation Center, the goals of the Direct Contracting Model learning system, and how the learning system will be supporting your organization:

The overarching LDG goals for all Innovation Center model learning systems:

- Identify and disseminate new knowledge and practice
- Leverage data and participant input to guide change / improvement
- Use learning communities and networks to share and spread new knowledge and practice

Within the Direct Contracting Model learning system, we will learn with and from you to:

- Make the model successful (reduce expenditures, improve quality)
- Help you achieve success within the model (provide high quality care and earn shared savings)
- Learn what it takes to make the Direct Contracting Model work for CMS beneficiaries, for providers, and for CMS

The Direct Contracting Model learning system will provide opportunities for continuous, collaborative learning and data-driven decision-making through a variety of tools and activities, such as:

- An infrastructure, both virtual and in-person, for encouraging collaboration, sharing, and problem solving
- Learning activities that address the needs of participants; examples include technical assistance, benefit enhancement implementation support, webinars, and affinity groups
- The capability to create and efficiently deploy tools that support learning and improvement, including, but not limited to, needs assessments, data feedback reports, case studies, webinars, and toolkits
- A process for keeping model participants and CMS up-to-date on promising practices in the areas of care delivery, beneficiary/provider/supplier engagement, risk sharing financial management, payment methodologies, multi-payer alignment, and other areas relevant to the model

To inform learning system activities and resources, the learning system team will stay aligned on the key concerns and objectives through a combination of an annual assessment survey, driver diagrams, planning groups, and other informal data collection activities.

Please stay tuned for an upcoming webinar on January 20th to introduce the next steps on how to become engaged in the Direct Contracting Model learning system.

Financial Methodology

For the Professional and Global Options

The financial methodology is the process by which CMS calculates benchmarks, expenditures, and the other elements used to determine shared savings or shared losses for entities participating in Direct Contracting. It also encompasses the prospective payment mechanisms, financial settlement, and risk mitigation options. Definitions are provided below for a selection of key terms and additional detail on the methodology can be found in the Request for Applications (RFA) and other publications on the CMS Direct Contracting website: https://innovation.cms.gov/innovation-models/direct-contracting-model-options. The website contains a series of papers with further details on each component of the financial methodology, including:

- **Financial Operating Guide Overview (& Companions):** Describes the process for calculating benchmarks, with companion documents for each DCE type that provide example calculations.
- **Capitation and Advanced Payment Mechanisms (& Companion):** Describes the process for determining Capitation and Advanced Payment amounts and the payment mechanism options available to DCEs.
- **DC/KCC Rate Book:** A final version of the PY2021 DC/KCC Rate Book, with rates for each county for Aged & Disabled (A&D) and End-Stage Renal Disease (ESRD) beneficiaries.
- **DC/KCC Rate Book Development:** Describes the methodology used to construct the DC/KCC Rate Book and the differences with the Medicare Advantage Rate Book.
- **DC/KCC Risk Adjustment:** Describes the risk adjustment approaches used for each DCE type and KCC, including detailed descriptions of the CMS-HCC (prospective) and CMMI-HCC (concurrent) models as well as the coding intensity approach.
- **Financial Reconciliation:** Describes the process by which CMS calculates the Shared Savings / Losses and Total Monies Owed to / from a DCE at Financial Settlement, including the timing of settlement, benchmark adjustments, risk corridors, and stop-loss reinsurance.
- ***(Coming soon)* Quality Overview:** Describes the quality approach for Direct Contracting, including the quality withhold, calculation of quality scores and the quality withhold earnback, and an overview of the quality measures used in PY2021.
- ***(Coming soon)* Reporting Overview:** Describes the various reports DCEs will receive in PY2021, including the proposed content, data fields, cadence, file format and templates for each report, where available.

Benchmark

The benchmark is a Per Beneficiary Per Month (PBPM) dollar amount against which a DCE is held accountable for performance year (PY) Medicare Fee For Services (FFS) expenditures for its aligned beneficiaries. It is determined based on a combination of historical and regional expenditures and reflects the total cost of care for Medicare Parts A and B services. The methodology for determining the benchmark varies based on the DCE type, how beneficiaries are aligned to the entity, and performance year.

Regional Expenditures

The Direct Contracting model incorporates the regional dynamics in Medicare expenditures through the development of the DC/KCC Rate Book. The regional expenditures for a given DCE will reflect the weighted average county rates based on the distribution of its aligned beneficiaries.

Shared Savings / Shared Losses

A DCE can earn a payment from CMS (shared savings) or be required to repay CMS (shared losses) based on its performance in the model. If the expenditures incurred by a DCE's aligned beneficiaries are less than the PY benchmark, the DCE will earn shared savings from CMS; if the expenditures exceed the benchmark, the DCE will be required to repay shared losses.

Risk Adjustment

Risk adjustment is a method for measuring the health risks of a population and modifying payments to reflect the predicted expenditures of that population. A risk score is assigned to each beneficiary based on demographic characteristics, medical diagnoses (Hierarchical Condition Categories (HCCs)), and other risk factors.

Capitation & Advanced Payments

The Direct Contracting model includes prospective payments mechanisms (Total Care Capitation, Primary Care Capitation, and the Advanced Payment Option) in which the DCE is paid directly by CMS for a subset of provider services in lieu of reduced FFS claim payments to the DCE's providers. These prospective payments, known as non-claims based payments, will not be made during the Implementation Period – they will begin in April 2021 for Performance Year 2021 (PY2021) and will be distributed on a monthly basis throughout the performance period. Payments will be made to the DCE's designated bank account by the Innovation Payment Contractor (IPC), a CMS contractor authorized to issue payments to and recover overpayments from CMMI model participants.

More information regarding the financial methodology and payment mechanisms can be found in the financial specification papers listed above and will also be described in the Participation Agreement.

Innovation Payment Contractor (IPC) Overview

Innovation Payment Contractor

The Innovation Payment Contractor (IPC) is a contractor established by the Innovation Center to support non-claims based payment (NCBPs) needs of current and future model tests. The IPC provides general financial services, including processing payments, recouping outstanding debt, and referring uncollected debt to the Treasury. The IPC infrastructure was developed to comply with federal regulatory requirements and Office of Financial Management (OFM) standards. DCE participants will access the IPC via the IPC Portal, an internet-based method for managing banking and financial information and replaces the paper-based CMS-588 form (used in prior models). All banking information in the IPC Portal is for the sole purpose of issuing Innovation Center payments. Once the model is operational, the IPC will distribute NCBPs on a monthly cycle to the bank account established by the Designated Official for each DCE.

Designated Official (DO)

The DO is authorized by the DCE to be responsible for ensuring bank account information is accurate and current to ensure timely payments. Only the DO can access the banking information displayed after logging into the IPC Portal application. The DO is responsible for verifying or updating bank account information before initial payment by CMMI, and at least once annually.
Responsibilities include:

- Review and verify banking information is correct;
- Change/update existing banking information, as needed;
- Submit new/additional banking information if not displayed on IPC Portal screen;
- View Overpayment Summaries and Demand Letters;
- View Payment Summaries and EFT Remits.

Note: The Model team and CMS Help Desk staff cannot access Participant-level data in the IPC Portal Application. Participant-level data can only be viewed by the DO.

Registering for a CMS Enterprise Portal (EIDM) Account
Once the DCE has nominated their DO, the first step the DO must take to gain access to the IPC Portal is to register for a CMS Enterprise Portal (or EIDM) account. Please refer to the Model Timeline – PY 2021 to understand the planned steps for onboarding DCEs to the IPC Portal. More details regarding specific dates to complete the access process and upload banking information have been communicated to DCEs in a webinar held on December 17th, 2020.

Note: Individuals who already have an EIDM account can skip this step

- Step 1: Navigate to: https://portal.cms.cmsgov/wps/portal/unauthportal/selfservice/newuserregistration/
    - Choose the application: IC: Center for Medicare and Medicaid Innovation (CMMI) Innovation Center (IC) and review the Terms and Conditions. If you agree, check the box and select **[Next]**.
    - Enter the required personal and contact information. **[Next]**

- Create a Username and Password, then select and answer your Challenge Questions. [Next]
  - **Note: Safe-keep this Username, it will be required to gain access to the IPC Portal**
- The EIDM system will create your account. **[OK]**.

Note: If you have questions regarding EIDM account registration, please contact the CMS Information Center Help Desk at 1-888-734-6433, then Press 1 for Accountable Care Organization Program, then Press 3 for Direct Contracting Model.

Requesting access to the Innovation Center (IC) Area

- Step 2: Login to https://portal.cms.cmsnet/wps/portal/unauthportal/selfservice/newuserregistration/ with your user credentials, and **on the main page, click** [Request/Add Apps]
  - Click on "Start typing to filter apps" and type "**IC**". The page will display an IC box**. Click [Request Access].**
  - On the Request New System Access screen, choose: System Description: **IC-Innovation Center** and Role: **Innovation Center Privileged User [Submit]**
  - Review the summary of what Remote Identity Proofing collects. **[Next]**
  - Review the Terms and Conditions. If you agree, check the box. **[Next]**
  - Review the fields on the "Your Information" screen. **[Next]**
  - The system confirms it has your information. **[Next]**
  - The system uses information from the Experian credit bureau to verify your responses to several multiple-choice questions about your past addresses, bank accounts, etc. Choose the correct answers. **[Next]**
  - **You will receive a success message. [Finished]**

Note: If the Remote Identity Proofing fails, you will receive a message to call Experian at 866-578-5409. If Experian cannot provide immediate assistance, please contact your Model's Help Desk. They will provide a manual process for Remote Identity Proofing. Additionally, if your DO changes during the PY, please email the helpdesk (DPC@cms.hhs.gov) and include the subject line, "Requesting change to DO."

Once the DCE's DO has created a CMS Enterprise Portal (or EIDM) account, they should complete the IPC Portal Access Survey, available via the link below. The purpose of this survey is to collect information from each Direct Contracting Entity's (DCE) Designated Officials (DO) to facilitate prospective payments for PY2021. Each DCE may only have one Designated Official and each DCE should only complete this survey once. Please contact the Direct Contracting Model email address if you experience any difficulties with completing this survey at DPC@cms.hhs.gov, and include the subject line, "IPC Portal Access Survey." In addition, in the event that your DO departs from your DCE during the PY, please email the model team and include the subject line, "Requesting change to DO." This survey must be completed by close of business January 14th in order to ensure timely payments in April 2021.

Link to IPC Portal Access Survey: https://cms.gov1.qualtrics.com/jfe/form/SV_1MiyXJxeBjMLllz

Marketing Guidelines

In order to allow for more robust outreach to beneficiaries regarding the Direct Contracting Entity (DCE) and its participation in the Direct Contracting Model, CMS will permit DCEs to produce marketing materials and engage in marketing activities during the Performance Period of the Direct Contracting Model, provided such communications and activities comply with all applicable laws, regulations, and guidance[1] and with the requirements of the Direct Contracting Model Participation Agreement. For example, DCEs will be able to provide marketing materials and hold outreach events to the extent permitted by applicable law. The following marketing guidelines can be referenced when developing marketing materials and when conducting marketing events.

Please note that this guidance is subject to change.

KEY TERMS & DESCRIPTIONS

- **"Marketing Materials"** is defined as general audience materials such as brochures, advertisements, outreach events, letters to Beneficiaries, webpages published on a website, mailings, social media, or other materials sent by or on behalf of the DCE or its DC Participant Providers or Preferred Providers, when used to educate, notify, or contact Beneficiaries regarding the DCE's participation in the Model. Marketing Materials do not include communications that do not directly or indirectly reference the Model (for example, information about care coordination generally would not be considered Marketing Materials); materials that cover Beneficiary-specific billing and claims issues; educational information on specific medical conditions; referrals for health care items and services; and any other materials that are excepted from the definition of "marketing" under the HIPAA Privacy Rule (45 CFR Part 160 & Part 164, subparts A & E).
- **"Marketing Activities"** is defined as the distribution of Marketing Materials and other activities, including Voluntary Alignment Activities (defined below), conducted by or on behalf of the DCE or its DC Participant Providers or Preferred Providers, when used to educate, notify, or contact Beneficiaries regarding the DCE's participation in the Model.
- **"Voluntary Alignment Activities"** is defined as any marketing activities or other activities conducted by or on behalf of the DCE or its DC Participant Providers or Preferred Providers, when used for purposes of educating, notifying, or contacting Beneficiaries regarding Voluntary Alignment.
- **"Marketing Events"** is defined as Marketing Activities that are events designed to educate Beneficiaries about the DCE's participation in the Model. In conducting Marketing Events, the DCE may engage in activities including, but not limited to:
    - Hosting the Marketing Event in a public venue;
    - Answering Beneficiary-initiated questions regarding the DCE's participation in the Model; or

[1] Applicable laws, regulations, and guidance include, but are not limited to: (a) Federal criminal laws; (b) the False Claims Act (31 U.S.C. § 3729 et seq.); (c) the anti-kickback statute (42 U.S.C. § 1320a-7b(b)); (d) the civil monetary penalties law (42 U.S.C. § 1320a-7a); (e) Health Insurance Portability and Accountability Act of 1996 (HIPAA); and (f) the physician self-referral law (42 U.S.C. § 1395nn).

- Distributing the DCE's, a DC Participant Provider's, or a Preferred Provider's business cards and contact information to Beneficiaries.

REPORTING & REVIEW OF MARKETING MATERIALS AND ACTIVITIES

- The DCE must submit to CMS, a plan for implementing the Marketing Activities described in the Participation Agreement ("Marketing Plan") via email at DPC@cms.hhs.gov, subject to CMS review and approval.
- The DCE and its DC Participants, Preferred Providers, and any other individuals or entities performing functions or services related to DCE Activities may not use Marketing Materials or engage in Marketing Activities until such Marketing Materials and Marketing Activities are reviewed and approved by CMS. Any material changes to CMS-approved Marketing Materials and Marketing Activities must be submitted to CMS via email at DPC@cms.hhs.gov to be re-approved.
- Marketing Materials do not include:
  - Communications that do not directly or indirectly reference the Model (for example, information about care coordination generally would not be considered Marketing Materials);
  - Materials that cover Beneficiary-specific billing and claims issues;
  - Educational information on specific medical conditions;
  - Referrals for health care items and services; and
  - Any other materials that are excepted from the definition of "marketing" under the HIPAA Privacy Rule (45 CFR Part 160 & Part 164, subparts A & E).
- There is an initial ten business day review period for Marketing Materials and Marketing Activities; however, CMS reserves the right to issue a written notice of disapproval of any Marketing Materials and Marketing Activities at any time. CMS may disapprove Marketing Materials and Marketing Activities that are inaccurate or misleading or that do not comply with the requirements of the Participation Agreement, including because they are discriminatory or used in a manner that is discriminatory, state or imply that alignment to a DCE removes or otherwise affects a beneficiary's freedom to choose a provider or supplier, or are likely to result in program integrity concerns.

LANGUAGE/FORMAT GUIDANCE

- Direct Contracting Marketing Materials and Marketing Activities should indicate that the DCE is participating in the Direct Contracting Model and provide a brief description of the Model, including contact information for CMS, where applicable.
- Any press release that materially and substantially references the DCE's participation in the Direct Contracting Model must be prior approved by CMS and should include correct contact information for the DCE. Both a telephone number with the correct hours of operation, and, if applicable, the DCE's website should also be listed.

PROHIBITED ACTIVITIES

DCEs, DC Participant Providers, Preferred Providers, and other individuals and entities performing functions or services related to DCE Activities are prohibited from conducting Marketing Activities before the start of PY2021.

- The following are prohibited as part of any Marketing Events:

    - Health screenings or any other activity that could be perceived as, or used to avoid treating At-Risk Beneficiaries or to target certain Beneficiaries for services for the purpose of trying to affect alignment to the DCE for a future Performance Year.
    - Requiring attendees to provide their contact information as a prerequisite for attending the Marketing Event; any sign-in sheets used for purposes of the Marketing Event must be clearly labeled as optional.
- Beneficiary contact information provided at a Marketing Event (e.g., for a raffle or other drawing) may not be used for any purpose other than the purpose for which it was solicited.
- The DCE is prohibited and must prohibit its DC Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to DCE Activities from using Marketing Materials or conducting Marketing Activities through the use of:
    - Door-to-door solicitation, including leaving information such as a leaflet or flyer at a residence;
    - Using telephonic solicitation, including text messages and leaving voicemail messages; or
    - Approaching Beneficiaries in common areas, such as parking lots, hallways, lobbies, sidewalks. This restriction does not apply to solicitation in common areas of a health care setting.
- The DCE is prohibited and must prohibit its DC Participant Providers, Preferred Providers, and other individuals and entities performing DCE Activities on behalf of the DCE from conducting Marketing Activities—other than the distribution and display of Marketing Materials—in restricted areas of a health care setting. Restricted areas of a health care setting include, but are not limited to:
    - Exam rooms, hospital patient rooms, treatment areas (where patients interact with a health care provider and his/her clinical team and receive treatment, including dialysis treatment facilities); and
    - Pharmacy counter areas (where patients interact with pharmacy providers and obtain medications).
- DCEs will not be allowed to engage in activities that discriminate against or selectively target beneficiaries (e.g., based on the anticipated costs of a beneficiary's care).

If you have any questions, please email us at DPC@cms.hhs.gov.

Voluntary Alignment

Voluntary Alignment is the process whereby CMS aligns to a Direct Contracting Entity (DCE) those beneficiaries who have designated a Direct Contracting (DC) Participant Provider as their primary clinician or main source of care. A beneficiary who indicates that a DC Participant Provider is his or her 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. There are two ways for a beneficiary to be voluntarily aligned to a DCE—Electronic and Paper-based Voluntary Alignment.

Electronic Voluntary Alignment is the process of a beneficiary going into the MyMedicare.gov portal on Medicare.gov and designating a DC Participant Provider as their primary care clinician, main doctor, main provider, and/or the main place they receive care. Electronic Voluntary Alignment is part of normal Medicare operations and can be done by a beneficiary at any time. Instructions on Electronic Voluntary Alignment are included in this Welcome Packet.

For Paper-based Voluntary Alignment, the DCE will provide the beneficiary with a form to sign electing their primary clinician, main doctor, main provider, and/or the main place they receive care. The DCE can collect this information through the provider's electronic portal, if applicable (though for simplicity will still be referred to as a 'paper-based' election, since it is in lieu of the physical paper form).

Participation in Voluntary Alignment through the paper-based process is optional. In order to participate in paper-based Voluntary Alignment starting in PY2021, the DCE must update the Voluntary Alignment marketing plan and outreach strategy submitted with their application. This can be found in 4i* as an editable field on the My Entity Page. When the DCE has updated their plan and is ready for CMS to review, they will send an email which will include their updated Voluntary Alignment Template Letter (found in this packet) to the helpdesk requesting review. CMS will review your outreach strategy and changes to the Voluntary Alignment template letter within two weeks of submission. The template for submitting your Voluntary Alignment List to CMS is included in this Welcome Packet.

Once the Participation Agreement is signed, PY2021 has begun and your DCE has received CMS approval for your Voluntary Alignment template letter and outreach strategy, your DCE may begin reaching out to beneficiaries using the Voluntary Alignment Form, CMS-approved Voluntary Alignment template letter, and the attached instructions on the use of MyMedicare.gov. These may be mailed to eligible beneficiaries and given to beneficiaries at the offices of your DC Participant Providers or Preferred Providers.

More information regarding conducting Voluntary Alignment will be available in the Participation Agreement and in upcoming webinars.

* Please see the 'Introduction to 4i' section for a description of 4Innovation portal.

PY2021 Data Overview

The exchange of timely, appropriate, and useful data continues to be a top priority for CMS. The Innovation Center will provide a number of reports to assist Direct Contracting Entities (DCEs) in their PY activities. All data will be made available to the DCE in their 4Innovation (4i) portal. To assist DCEs in preparing for the PY, CMS intends to provide more extensive resources on PY data in January 2021. The data described below may be used only in a manner consistent with the terms of the applicable CMS agreements, including the Participation Agreement and HIPAA-Covered Disclosure Request Attestation and Data Specification Worksheet. All requests for data will be granted or denied at CMS' sole discretion based on CMS' available resources and technological capabilities, the limitations in applicable CMS agreements, and applicable law.

During the Model Performance Period CMS will offer DCEs an opportunity to request certain beneficiary-identifiable data and reports. The beneficiary-identifiable reports that the DCE may request include:

- **Alignment** reports describing the beneficiaries attributed to a DCE.
- **Risk Adjustment** data describing beneficiary risk.
- **Claim and Claim Line Feed (CCLF)** reports for services furnished by Medicare-enrolled providers and suppliers to aligned beneficiaries during the performance year. CMS will additionally provide DCEs with historical CCLF files, which will capture a 36-month lookback of claims for newly aligned beneficiaries.
- **Claims Reduction Files** to assist the DCEs in implementing capitation and advance payment.

CMS will also provide aggregate reports that do not include beneficiary-identifiable data. These aggregate reports will include:

- **Expenditure** and utilization data,
- **Benchmark** and other financial reports, and
- **Quality** reports.

Overview of 4i

4Innovation (4i) is a user-friendly system that uses modern cloud technology to support Alternative Payment Models (APMs). The 4i system provides a secured mechanism to verify, validate, and protect users' identifiable information. This allows users to securely login and access sensitive data using a common login ID and password shared across other CMS hosted applications, relieving users of managing multiple user IDs and passwords. All DCEs have been invited to 4i.

4i allows participating DCEs to perform the following functions:

- **Manage Users Accessing Entity Details:** Invite users in your organization to manage your Entity's information without CMS Help Desk support.
- **Manage Legal Agreements**: Attest and sign legal agreements between the Model and your organization.
- **Manage Participant List:** Add DC Participant Providers and Preferred Providers participating in the Entities, provide real-time feedback on the providers' Medicare enrollment, and manage the start and end dates of all providers in the organization.
- **Manage Benefit Enhancements and Payment Mechanism**: Add your entity-level and provider-level elections for your benefit enhancements and payment mechanisms.
- **Submit Change Request:** Request important changes such as change in Tax Identification Number (TIN) in participating Entities for CMS review and approval, and view the status of the request in real time.
- **Get Resources:** use the Knowledge Management feature to find model resources and documents.
- **Notification:** Get notification on pending actions or completed actions for your Entity.
- **Extract Entity Information:** View and download Entity's Agreement Details or Benefit Enhancement Reports in Excel and csv format.
- **Secure File Delivery**: Provide access to download files that contain Protected Health Information and Personally Identifiable Information PHI/PII details such as Claims and Claim Line Feed (CCLF), beneficiary details, etc.

Please note that additional functionalities will continue to become available in 4i. The Innovation Center will continue to provide entities the resources they need to navigate new functionalities as those features become available, and we encourage you to contact the helpdesk with any questions you may have regarding 4i.

DIRECT CONTRACTING MODEL: FEE REDUCTION AGREEMENT

GENERAL INFORMATION

From April 1, 2021 – December 31, 2021, as part of the Center for Medicare & Medicaid Services (CMS) Direct Contracting Model , _____, herein referred to as the Direct Contracting Entity (DCE), has elected to participate in one or more of three Alternative Payment Arrangements (APA): Total Care Capitation (TCC), Primary Care Capitation (PCC), and/or Advanced Payment Option (APO) as described in the Direct Contracting Model Participation Agreement (PA).[2] The APA Payments will result in a lump sum monthly payment to the DCE that reflect **a percentage** of total expected Medicare Fee-For-Service (FFS) payments to selected providers and suppliers participating in the Direct Contracting Model ("Direct Contracting (DC) Participant Providers" and/or "Preferred Providers") for items and services furnished to Medicare beneficiaries who are aligned to the DCE ("Direct Contracting Beneficiaries"). The expected Medicare FFS payments are calculated based on historical claims billed by the selected DC Participant and/or Preferred Providers under the Medicare billing number assigned to the Taxpayer Identification Number (TIN) of each selected DC Participant Provider and/or Preferred Provider.

The DCE has indicated that one or more providers in your organization (as identified in your DCE's Benefit Enhancement Report) has agreed to receive FFS Reductions. Under this arrangement, your organization will not be reimbursed by CMS for the applicable Medicare FFS amount for each Medicare Part A and/or Part B claim that is submitted for covered items and services furnished to Direct Contracting Beneficiaries by a selected DC Participant Provider or Preferred Provider. Instead, reimbursement for the applicable Medicare FFS amount related to claims for covered items and services furnished to Direct Contracting Beneficiaries will be paid by the DCE, based upon the agreement between the provider (or organization) and the DCE. Not all DC Participant and/or Preferred Providers assigned to your TIN are required to receive FFS Reductions and those that do are not necessarily required to receive the same percentage reductions, subject to the participation rules of the Direct Contracting Model. You (or your organization) and the DCE have identified and agreed upon which DC Participant and/or Preferred Providers billing for items and services furnished to Direct Contracting Beneficiaries through your TIN will receive FFS Reductions and the percentage reduction for each provider based on the DCE's DC Participant and Preferred Provider List in the Appendix to this form.

Please note that you as a provider or your affiliated organization may only attest to APAs that your DCE elects. For example, if your DCE elects TCC, all DC Participant Providers must elect TCC, and all Preferred Providers may elect TCC if they so choose. However, if your DCE elects PCC, DC Participant Providers may elect PCC with or without APO, and all Preferred Providers may elect PCC with or without APO if they so choose. Finally, due to their unique billing requirements and the populations they serve, Critical Access Hospital Method-2 facilities only eligible for APO, and providers working in a Rural Health Clinics (RHCs) or Federally Qualified Health Centers (FQHCs) are only eligible for PCC.

By signing this form, you certify that you have read the contents of this agreement and that you are

[2] This agreement is for those DCEs who elect to participate in FFS Reductions for Performance Year (PY) 1 (April 1, 2021 – December 31, 2021). This form will only take effect for those DCEs that sign the Participation Agreement and any applicable amendments, and this form may be subject to change based on the Participation Agreement.

authorized to legally bind yourself (or your organization) identified below and the DC Participant and/or Preferred Providers identified in the Appendix to this form that bill through the TIN of that organization. You further certify that you (or your organization) and the selected DC Participant and/or Preferred Providers that bill under the organization's TIN consent to receive a reduced FFS reimbursement of the applicable Medicare FFS amount for all covered Medicare items and services that are furnished to Direct Contracting Beneficiaries during the period of April 1, 2021 – December 31, 2021 from CMS, and that instead, the DCE will pay these claims as agreed upon with the DCE, and, that your TIN has verified which DC Participant Provider and/or Preferred Providers, based upon the applicable individual NPI, organizational NPI, CCN, or TIN, billing for items and services furnished to Direct Contracting Beneficiaries as assigned to your TIN will receive FFS Reductions.

AUTHORIZATION OF FFS REDUCTION

I understand that the knowing and willful omission, misrepresentation, or falsification of any information contained in this document or in any communication supplying information to Medicare may be punished by criminal, civil, or administrative penalties, including fines, civil damages, and/or imprisonment.

Legal Business Name (*as Reported to the Internal Revenue Service)*			Tax Identification Number — — — — — — — — —
First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.
Authorized or Delegated Official's Signature[3] *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*			Date Signed *(mm/dd/yyyy)*

[3] Please refer to the Medicare enrollment provider and supplier glossary for specific definitions, which can be located at: https://pecos.cms.hhs.gov/pecos/help- main/glossary.jsp#d.

APPENDIX – LIST OF INDIVIDUAL AND ORGANIZATIONAL IDENTIFIERS

From April 1, 2021 – December 31, 2021, as part of the Center for Medicare & Medicaid Services (CMS) Direct Contracting Model, _____ [DCE] has elected to participate in Alternative Payment Arrangements (APA) as described in the Direct Contracting Model Participation Agreement.[4] This DCE has identified the following Individual Providers/Suppliers, Organizational Providers, Federally Qualified Health Centers (FQHCs)/Rural Health Centers/Critical Access Hospital Method 2 (CAH-2), Facility or Institutional Providers that are participating in APAs under:

TIN __ __ __ __ __ __ __ __ __and,

Legal Business Name _____.[5]

Note: When completing this Agreement, please ensure that your DCE retains a copy of the Beneficiary Engagement (BE) and Payment Mechanism (PM) Report ("Benefit Enhancement Report") for providers aligned to your TIN. The Benefit Enhancement Report will contain the complete list of provider's aligned to a DCE, their associated identifiers, along with their effective start and termination date of their enrollment in each BE and PM. The DCE may download the Benefit Enhancement Report via the 4i Application under *Reports* once the DCE's BEs and PMs have been submitted and finalized. Please store the signed Agreement with the Benefit Enhancement Report once signed for auditing purposes. As a reminder, this Agreement will not be submitted to CMS, however, it may be audited during the PY. The Agreement must be completed by April 1, 2021.

[4] This Agreement is for those Direct Contracting Entities who elect to participate in one of three Alternative Payment Arrangements for Performance Year (PY) 1 (April 1, 2019 – December 31, 2021). This form will only be operative for those DCEs that sign the Participation Agreement, and this form may be subject to change based on the Participation Agreement.

[5] Participating in an APA as an FQHC/RHC/CAH-2 may result in every provider that bills under that facility receiving the reduction to claims for Direct Contracting Beneficiaries. RHC/CAH/FQHCs should inquire with the DCE more information when considering participation in an APA.