Direct Contracting Checklist

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Welcome

Welcome to your Direct Contracting journey! Salient Healthcare wants to help you and your organization get off the ground as smoothly as possible. There are many early-stage milestones that you will want to work through before you're officially on your way. Feel free to use the checklist, timeline, and resources to help get you started off on the right foot.

Key Points Checklist

□ **Letter of Intent**

- CMS requests Letters of Intent from entities that are interested in participating in the Direct Contracting models. Check the CMS website for the deadline to submit the non-binding Letter of Intent for each performance year.

□ **Participant Providers and Preferred Provider List**

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

DCEs that begin participation during the IP will be required to submit a new DC Participant Provider List and a new Preferred Provider List for PY1 (and each subsequent PY). DC Participant Providers, and Preferred Providers, do not carry over from year to year, although your prior year's list will be pre-populated in 4i as a starting point, which DCEs will have the opportunity to adjust (i.e., add, remove, or edit providers).

DC Participant Providers and Preferred Providers can be added mid-Performance Year as part of an ad-hoc process, however, DC Participant Providers that are added mid-Performance Year will not contribute to claims-based alignment for that PY, and they will not be eligible to participate in payment mechanisms (Total Care Capitation, Primary Care Capitation, and Advanced Payment). Further, DC Participant Providers can only be added if the provider in question (1) bills (at the time of the addition) for items and services he or she furnishes under a TIN that is used by a provider in the same DCE, and (2) did not bill under that TIN when the DCE submitted its provider list. Preferred Providers are not subject to the same restriction.[1]

PREFERRED PROVIDER LIST: The list that identifies each Preferred Provider that is approved by CMS for participation in Direct Contracting, specifies which Preferred Providers, if any, have agreed to receive payments under a Capitation Payment Mechanism, and designates the benefit enhancements, if any, in which each Preferred Provider participates, as updated from time to time in accordance with the Participation Agreement.

[1] https://innovation.cms.gov/files/x/dc-faqs.pdf

DIRECT CONTRACTING (DC) PARTICIPANT PROVIDER: An individual or entity that: (1) is a Medicare enrolled provider or supplier (as described in 42 C.F.R. § 400.202); (2) is identified on the DCE's list of DC Participant Providers by name, National Provider Identifier (NPI), TIN, Legacy TIN or CCN (if applicable), and CMS Certification Number (CCN) (if applicable); (3) bills for items and services it furnishes to Medicare FFS beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations; (4) is not a Preferred Provider nor a Prohibited Participant; and (5) has agreed, pursuant to a written agreement with the DCE, to participate in the model, to report quality data through the DCE, and to comply with care improvement objectives and model quality performance standards. The Capitation Payment Mechanism chosen by the DCE will apply to all DC Participant Providers that have an agreement with that DCE.

PARTICIPANT LIST: The list that identifies each DC Participant Provider that is approved by CMS for participation in Direct Contracting and designates the benefit enhancements, if any, in which each DC Participant Provider participates, as updated from time to time in accordance with the Participation Agreement.[2]

□ **Designated Officials to Create Enterprise Account**

- DCEs must have an identifiable governing body with sole and exclusive authority to execute the functions and make final decisions on behalf of the DCE. The DCE governing body must be separate and unique to the DCE and must not be the same as the governing body of an entity participating in the DCE (unless the DCE is formed by a single DC Participant Provider, in which case the DCE's governing body may be the same as that of the DC Participant Provider).[3]

□ **Understanding Your Benefit Enhancements**

- Benefit Enhancements 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. CMS seeks to emphasize high-value services and support the ability of DCEs to manage the care of beneficiaries through benefit enhancements and patient engagement incentives. DCEs may choose which, if any, of these benefit enhancements and patient engagement incentives to implement.[4]

[2] https://innovation.cms.gov/files/x/dc-rfa.pdf
[3] https://innovation.cms.gov/files/x/dc-rfa.pdf
[4] https://innovation.cms.gov/files/slides/dc-model-options-oh-benefit-app-slides.pdf

- □ **Understanding the Type of Payment Options**
  - CMS currently offers two key payment model options for DCE participants to take on risk and earn savings:
    - Global Model: Highest risk share (100% of savings/losses) with the option to choose a monthly PCC (mentioned above); or monthly Total Care Capitation (TCC) to cover services provided to align beneficiaries by the DCE's Participating and Preferred Providers (optional).
    - Professional Model: Lowest risk share (50% savings/losses) with a monthly Primary Care Capitation (PCC) option to cover primary care services provided to aligned beneficiaries by the DCE's Participating Providers.
- □ **Beneficiary Notification Letters**
  - DCEs must inform beneficiaries who have been aligned to the DCE what that means for the beneficiary in terms of the care that they will receive and how to opt-out of CMS sharing certain data about them with the DCE. The DCE is further required to notify its aligned beneficiaries that they have the freedom to select their own primary clinician and to receive services from the providers and suppliers of their choice according to traditional Medicare rules.[5]
- □ **Participation Agreements**
  - Each DCE must sign a Participation Agreement which specifies the terms of participation in the model. Application can be accessed here: https://app.innovation.cms.gov/dcrfa/IDMLogin
- □ **Data Source Aggregation**
  - CCLF | Quarterly and Annual Utilization | Monthly Expenditures | Beneficiary Data Sharing Preferences | Monthly Claims Lag | Beneficiary Alignment Reports
    - During the IP and the Performance Period, CMS will provide DCEs with detailed claims data that will include individually identifiable Claim and Claim Line Feed (CCLF) reports for services furnished by Medicare-enrolled providers and suppliers to provisionally aligned and aligned beneficiaries during the IP or PY. At the beginning of a PY, CMS will additionally provide DCEs with historical CCLF files, which will capture a 36-month lookback of claims for newly aligned beneficiaries. *Only 12 months of CCLF data will be made available during the IP*. During both the IP and the PYs, CMS will provide DCEs with operational reports on a regular basis. These reports may include but will not be limited to: Quarterly and Annual Utilization, Monthly Expenditures, Beneficiary Data Sharing Preferences, Monthly Claims Lag, and Beneficiary Alignment Reports. During PY1 – PY5, CMS will provide quarterly baseline benchmark reports (BBRs) to DCEs to enable them to monitor their financial performance throughout the performance year. The BBRs will not contain individually identifiable data. The same design and data source used to generate the BBRs will also be used for the interim and final reconciliation report. These reports will not be provided during the IP. During PY1 – PY5, the DCEs will receive feedback on their quality performance. Please review the Quality and Performance section for more information on quality data sharing.[6]

[5] https://innovation.cms.gov/files/x/dc-rfa.pdf
[6] https://innovation.cms.gov/files/x/dc-rfa.pdf

- Benchmarking

	Standard	New Entrant	High Needs Population
Overview of Benchmarking Methodology: Claims-based Alignment	• Prospective benchmark. • Blend of regional expenditures (Adj MA Rate Book) with aligned beneficiary historical expenditures (CY 2017-19). • Risk adjusted, with the intent to better address costlier expenditures for high needs populations. • Discounted for Global.	• Prospective benchmark. • For the first three years of beneficiary alignment to the DCE: - Regional expenditures (Adj MA Rate Book). - Aligned beneficiary historical expenditures not incorporated. • For all subsequent years of alignment to the DCE: - Blend of regional expenditures with aligned beneficiary recent historical expenditures.	• Prospective benchmark. • For the first three years of beneficiary alignment to the DCE: - Regional expenditures (Adj MA Rate Book). - Aligned beneficiary historical expenditures not incorporated. • For all subsequent years of alignment to the DCE: - Blend of regional expenditures with aligned beneficiary recent historical expenditures.
Overview of Benchmarking Methodology: Voluntary Alignment	• Prospective benchmark. • For the first three years of a beneficiary's alignment to the DCE: - Regional expenditures (Adj MA Rate Book). - Aligned beneficiary historical. expenditures not incorporated. • For all subsequent years of alignment to the DCE: - Blend of regional expenditures with aligned beneficiary historical expenditures. - Risk adjusted, with the intent to better address costlier expenditures for high needs populations - Discounted for Global.	• Prospective benchmark. • For the first three years of a beneficiary's alignment to the DCE: - Regional expenditures (Adj MA Rate Book). - Aligned beneficiary historical expenditures not incorporated. • For all subsequent years of alignment to the DCE: - Blend of regional expenditures with aligned beneficiary recent historical expenditures. - Risk adjusted, with the intent to better address costlier expenditures for high needs populations. - Discounted for Global.	• Prospective benchmark. • For the first three years of a beneficiary's alignment to the DCE: - Regional expenditures (Adj MA Rate Book). - Aligned beneficiary historical expenditures not incorporated. • For all subsequent years of alignment to the DCE: - Blend of regional expenditures with aligned beneficiary recent historical expenditures. - Risk adjusted, with the intent to better address costlier expenditures for high needs populations. - Discounted for Global.

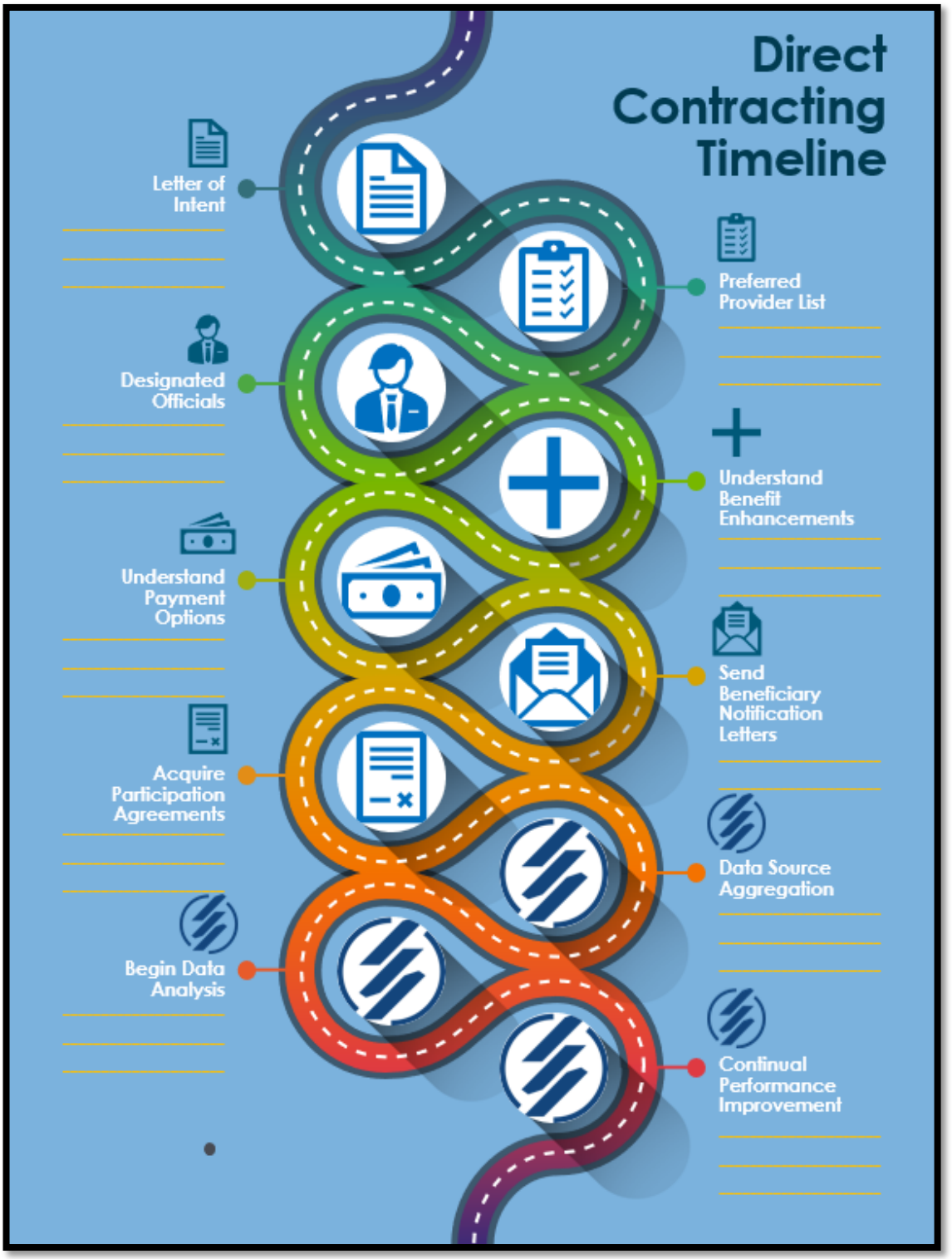
□ **Analyzing Your Data**

- In order to have the best chance at attaining shared savings, each DCE will need to complete the following three functions on a regular basis. Each of these functions require a robust knowledge of data and data analytics, along with a system to aggregate, normalize, and analyze this data. Pro Tip: *You may want to consider partnering with a data analytics vendor, such as Salient Healthcare, to assist you with the following processes*:
  - Identification & Dissemination of Knowledge to Medical Practices
  - Utilization of Data for Continuous Performance Improvement
  - Ensure Success by Reducing Spend While Improving Quality

Anywhere you see this logo, Salient Healthcare can help you with this!

Timeline of Important Events

Use this timeline to map out the important events in the above checklist. Use the blank lines to insert estimated dates of completion to ensure you remain on track to complete all tasks before you officially become a DCE.



CMS RESOURCES

Many of the footnotes in the above sections come from CMS's resources. However, in order to make it easier for everyone, we have compiled a list of some other important CMS resources that we feel are worth looking at.

1. Global and Professional Direct Contracting (GPDC) Model (Overview and Resource Page): https://innovation.cms.gov/innovation-models/gpdc-model
2. Direct Contracting Model: Global and Professional Options Request for Applications: https://innovation.cms.gov/files/x/dc-rfa.pdf
3. Direct Contracting: Global and Professional Options Benefit Enhancements and Application Office Hours: https://innovation.cms.gov/files/slides/dc-model-options-oh-benefit-app-slides.pdf
4. Global and Professional Direct Contracting Model: Quality Measurement Methodology (for PY2021 only - 4/1/2021 - 12/31/2021): https://innovation.cms.gov/media/document/dc-model-quality-methodology-paper
5. Key Dates for the Direct Contracting Model (Global and Professional): https://innovation.cms.gov/media/document/dc-professionalglobal-timeline
6. Direct Contracting Model Financial Methodology - Reconciliation Global and Professional: https://innovation.cms.gov/media/document/dc-model-options-fnclmethrecon-slides
7. Direct Contracting (Professional and Global) Finance-Focused Frequently Asked Questions: https://innovation.cms.gov/media/document/dc-finance-faqs

Thank you for reaching out to Salient Healthcare. We are more than happy to be your Direct Contracting resource. Should you require any more assistance, please contact us at the information below.