Global and Professional Direct Contracting Model

PY2022 Financial Operating Guide: Overview

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Reference Documents

Title
Global and Professional Direct Contracting Model: Financial Companion to Operating Guide Overview: Standard DCE
Global and Professional Direct Contracting Model: Financial Companion to Operating Guide Overview: New Entrant DCE
Global and Professional Direct Contracting Model: Financial Companion to Operating Guide Overview: High Needs Population DCE
Global and Professional Direct Contracting Model: Financial Operating Policies: Capitation and Advanced Payment Mechanisms
Global and Professional Direct Contracting Model: Financial Companion to Capitation and Advanced Payment Mechanisms
Global and Professional Direct Contracting and Kidney Care Choices Models: DC/KCC Rate Book Development
Global and Professional Direct Contracting and Kidney Care Choices Models: Risk Adjustment
Global and Professional Direct Contracting Model: Financial Reconciliation Overview
Global and Professional Direct Contracting Model: Quality Measurement Methodology
Kidney Care Choices Model: Financial Operating Guide: Overview

Acronyms

A&D	Aged & Disabled
ACO	Accountable Care Organization
APO	Advanced Payment Option
BHI	Behavioral Health Integration
BY	Base Year
CAH2	Critical Access Hospital Method 2
CEC	Comprehensive ESRD Care
CCM	Chronic Care Management
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CPC+	Comprehensive Primary Care Plus
DCE	Direct Contracting Entity
ESRD	End Stage Renal Disease
GAF	Geographic Adjustment Factor
GPDC	Global and Professional Direct Contracting
HCC	Hierarchical Condition Category
HCPCS	Healthcare Common Procedure Coding System (HCPCS)
MA	Medicare Advantage
NGACO	Next Generation ACO
NPP	Non-Physician Practitioner
NPO	No Payment Option
OACT	Office of the Actuary
PBPM	Per-Beneficiary-Per-Month
PCC	Primary Care Capitation
PECOS	Provider Enrollment, Chain, and Ownership System
PQEM	Primary Care Qualified Evaluation and Management
PY	Performance Year
TCC	Total Care Capitation

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Section 1: Introduction

This document is the first in a series of documents that provide Direct Contracting Entities (DCEs) with all the necessary details to understand the financial aspects of the Global and Professional Direct Contracting (GPDC) Model. It provides an overview of each component of the financial methodology but primarily focuses on the detailed calculation of the benchmark and relevant components. Additional policy documents provide detail on other specific elements of financial operations, including the following:

- Use of risk adjustment models to set the benchmark,
- Development of the DC/KCC Rate Book,
- Total Care Capitation/Primary Care Capitation and APO Payment Mechanisms, and
- Settlement and Financial Reconciliation, including stop-loss reinsurance and risk corridors.

Section 2 provides a general overview of GPDC Model features relevant to financial operations, including a high-level description of the risk arrangements and payment mechanisms that are available to a DCE and the GPDC financial settlement and reconciliation process.

Section 3 provides background on GPDC benchmarking components such as risk adjustment and the DC/KCC Rate Book, which will be used at multiple points in the calculation of the Benchmark. Separate policy documents specify the detailed operational approach for the development of risk scores and DC/KCC Rate Book for the GPDC Model.

Section 4 provides details for the calculation of the Performance Year (PY) Benchmark, including the development of the historical baseline expenditures, the prospective trend, the geographic adjustment factors, the regional rate, and the blended Benchmark calculation. This section focuses on the process for calculating the benchmark, aided by the referenced companion documents.

Section 5 provides an overview of the operating policies for financial settlement and reconciliation, including the application of risk mitigation mechanisms and the timing of the preliminary and final Financial Reconciliation (also referred to as Financial Settlement). Detailed settlement and risk mitigation policies are further specified as part of a separate operating policy document.

Section 2: Overview of GPDC Model Financial Operations

GPDC creates a variety of pathways for taking on financial risk. As a result of this flexibility, the details related to many of the aspects of the financial methodology (benchmark calculation, capitation payment options, risk sharing and mitigation details, and reconciliation) are specific to DCE type and risk arrangement (also referred to as risk option) type. A summary of the different combinations of financial options available to DCEs is provided in **Figure 2.1**. The specific variations reflect (1) the basis for a beneficiary's alignment to the DCE, (2) the risk arrangement selected by the DCE, (3) the payment mechanism(s) selected by the DCE, (4) the risk mitigation mechanism(s) selected by the DCE, and (5) the reconciliation payment timeline selected by the DCE.

Figure 2.1: Overview of DCE Financial Arrangement Options

Financial Arrangement Options			
Beneficiary Alignment	Voluntary and Claims-Based[1]		
Risk Arrangement	Global[2]		Professional[3]
Capitation Arrangement	Total Care	Primary Care	Primary Care
Advanced Payment Option	N/A	Optional[4]	
Stop-Loss Reinsurance	Optional		
Provisional Reconciliation	Optional		

[1] All DCE types use both voluntary and claims-based alignment.
[2] A DCE electing the Global risk arrangement can choose between Total Care Capitation and Primary Care Capitation.
[3] A DCE electing the Professional risk arrangement must participate in Primary Care Capitation.
[4] Advanced payment is not an option for a DCE that elects to participate in Total Care Capitation.

2.1 DCE Types

Under GPDC, there are three types of DCEs, defined based on the experience of DC Participant Providers with Medicare fee-for service (FFS) risk-based contracting and the populations the entities primarily serve:

- A Standard DCE is an organization with substantial experience with risk-based FFS contracts. Many of the DC Participant Providers in a Standard DCE will have participated in another CMS program or innovation model that involves risk sharing, such as the Medicare Shared Savings Program, Next Generation Accountable Care Organization (NGACO), Comprehensive Primary Care Plus (CPC+), or Comprehensive ESRD Care (CEC), among others. Some DCE organizations may have experience participating in section 1115A models involving Shared Savings whereas others may be newly formed to participate as a DCE.
- A New Entrant DCE is an organization with limited experience with risk-based FFS contracts. Most of the DC Participant Providers in a New Entrant DCE have not participated in another CMS program or innovation model that involves risk sharing in Medicare FFS.
- A High Needs Population DCE is an organization that serves Medicare FFS beneficiaries with complex needs, including dually eligible beneficiaries. These DCEs are expected to use a model of care designed to serve individuals with complex needs, similar to the Program of All-Inclusive Care for the Elderly model, to coordinate care for their aligned beneficiaries.

For each of the three DCE types, there are specific approaches to benchmark calculations. This paper elaborates on these approaches in each section, where applicable. Additional operating policy papers,

including the three companion documents for Standard, New Entrant, and High Needs Population DCEs, provide further detail and example calculations.

2.2 Alignment

A DCE is responsible for the cost and quality of the care received by beneficiaries who are aligned to it. A beneficiary is aligned to a DCE either because the beneficiary

- Has designated a qualifying DC Participant Provider as their principal source of care (voluntary alignment); or
- Has historically received the plurality of primary care services from DC Participant Providers (claims alignment).

The methods used to determine the voluntary and claims-aligned populations are described in detail in Appendix B: Beneficiary Alignment Procedures.

Both voluntary and claims alignment are used for all three DCE types. Beneficiary alignment mechanism, DCE type, and performance year may determine the approach used for benchmark calculation. This is described later in Section 4.

2.3 GPDC Risk-Sharing Arrangements

GPDC offers both risk-sharing arrangements and risk mitigation strategies. The two risk-sharing arrangements are the Global Option and the Professional Option.

- Under the Global Option risk arrangement (hereafter referred to as Global), the DCE assumes "full reward" for any savings and "full risk" for any losses. Under this arrangement, the benchmark is discounted (e.g., 2% in PY2022) and the DCE is eligible for a "reward" of up to 100% of any savings but is also "at risk" for up to 100% of any losses.
- Under the Professional Option risk arrangement (hereafter referred to as Professional), the DCE assumes "partial reward" for any savings and "partial risk" for any losses. Under this arrangement, the benchmark is not discounted, but the DCE is eligible for a "reward" of up to only 50% of savings while being at risk for up to only 50% of any losses.

2.4 GPDC Risk Mitigation Strategies

GPDC includes two risk mitigation strategies available for DCEs: risk corridors and stop-loss reinsurance. Risk corridors determine the percentage of the savings or losses that are retained by the DCE. Within both the Global and Professional risk arrangement options, each risk corridor is a range (or "band") of savings/losses as a percent of a DCE's Benchmark for a performance period. The savings or losses that fall within each specific band are associated with a specific level of responsibility for the DCE, with lower levels of responsibility as savings/losses increase. The size of the risk corridor bands and the percent of savings of losses that a DCE is responsible for vary based on the risk-sharing arrangement selected.

Another risk mitigation strategy is the optional stop-loss reinsurance. The purpose of the stop-loss arrangement is to reduce the financial uncertainty associated with infrequent but high-cost expenditures for aligned beneficiaries. Stop-loss protects DCEs from financial liability for individual

beneficiary expenditures above the stop-loss "attachment points" (i.e., dollar thresholds at which stop-loss protection begins). Stop-loss arrangements are an optional feature of both Global and Professional options.

The full details of the risk corridors and stop-loss arrangement are provided in the ***Global and Professional Direct Contracting Model: Financial Reconciliation*** operating policy document.

2.5 GPDC Payment Mechanisms

GPDC offers two payment mechanisms in which DCEs are paid a monthly capitated amount based on claims reductions made for DC Participant Providers and Preferred Providers. All DCEs must participate in one of the Capitation Payment Mechanisms:

1. Under Total Care Capitation (TCC) the capitated payment to the DCE applies to all services covered by Medicare Parts A and B that are provided to aligned beneficiaries by (a) DC Participant Providers and (b) Preferred Providers participating in TCC. Providers will receive FFS payments only for the portion of claims that are outside the scope of the TCC (which may include any unreduced portion of claims for Preferred Providers and any beneficiaries who had opted out of data sharing, or claims related to alcohol and substance use treatment).
2. Under Primary Care Capitation (PCC) the capitated payment to the DCE applies only to certain primary care services provided to aligned beneficiaries by (a) DC Participant Providers (who are Primary Care Specialists) and (b) Preferred Providers (who are Primary Care Specialists) participating in PCC. Those providers will continue to receive FFS payment for non-primary care services that are outside the scope of the PCC payment. A DCE electing PCC may also elect to receive reduced FFS payments for services not subject to PCC under the optional Advanced Payment Option (APO).

TCC is available only to a DCE that elects the Global (Full Risk) Option, but Global DCEs may choose to participate in PCC instead. However, a DCE that elects the Professional (Partial Risk) Option must participate in PCC, as summarized in **Figure 2.2.** Note that the claims reduction amounts selected by providers must be integer values.

Figure 2.2: Overview of DCE Capitation Mechanisms

Payment Mechanism Elected by the DCE	DC Participant Providers	Preferred Providers
TCC	Must Participate[1] 100% Claims Reduction, all PYs	Optional for all PY's If selected, 1%–100% Claims Reduction, all PYs
PCC	Must Participate starting PY2022 [2,3] PY2021: Primary Care Claims Reduction 1%–100% (optional) PY2022: Primary Care Claims Reduction 5%–100% PY2023: Primary Care Claims Reduction 10%–100% PY2024: Primary Care Claims Reduction 20%–100% PY2025: Primary Care Claims Reduction 100% PY2026: Primary Care Claims Reduction 100%	Optional for all PYs If selected, 1%–100% Claims Reduction for Primary Care Claims, all PYs
APO (only available if PCC is also elected)	Optional If selected, 1%–100% Non-Primary Care Claims Reduction, all PYs	Optional If selected, 1%–100% Non-Primary Care Claims Reduction, all PYs

[1] DC Participant Providers added during the Performance Year by TCC DCEs are not able to elect TCC FFS claims reductions, with the exception of existing DC Participant Providers impacted by a TIN change during the Performance Year.
[2] DC Participant Providers added during the Performance Year by PCC DCEs are not able to elect PCC FFS claims reductions, with the exception of existing DC Participant Providers impacted by a TIN change during the Performance Year.
[3] DC Participant Providers in DCEs that have selected the PCC payment mechanism for PY2022 must elect to participate in PCC and have a fee reduction amount of at least 5% selected in 4i for PY2022, but only if the DC Participant Provider bills PCC-eligible services.
Note: All claims reduction amounts must be integer values only. In order for a provider to terminate claims reductions for TCC/PCC/APO during the Performance Year, the DC Participant or Preferred Provider must terminate their participation in the model.

For TCC, all DC Participant Providers must participate in the payment mechanism elected by the DCE and have relevant FFS claims reduced by 100%. Conversely, Preferred Providers may individually choose whether to participate in the payment mechanism and may choose the desired percent reduction for relevant FFS claims (1%–100%).

For PCC, all DC Participant Providers must participate in the payment mechanism elected by the DCE starting in PY2022 but are able to choose the percentage by which relevant FFS claims are reduced (above an established floor). This floor is set at 5% for PY2022, 10% for PY2023, 20% for the PY2024, and 100% for the PY2025 and PY2026. Conversely, Preferred Providers may individually choose whether to participate in the payment mechanism and (if they choose to participate) may choose the desired percent reduction for relevant FFS claims (1%–100%) in all performance years.

A DCE electing PCC may also elect to participate in the optional APO. The APO is available only to Preferred and DC Participant Providers of a DCE electing PCC. It is up to each individual provider to decide whether they want to pursue claims reduction via the APO, and each participating provider may choose the desired percent reduction for relevant FFS claims (1%–100%). Because APO applies to services for which PCC does not apply, APO is complementary to PCC in that APO and PCC will never apply to the same service.

The full details of the payment mechanisms are provided in the ***Global and Professional Direct Contracting Model: Capitation and Advanced Payment Mechanisms*** operating policy document and companion.

Section 3: Background on Benchmark Components

The GPDC benchmarking approach relies on a number of components outside the scope of this paper, such as risk adjustment and the DC/KCC Rate Book. These features are described in detail in separate papers but are introduced below with a focus on where they apply within the benchmarking methodology to provide context for when they are referenced in subsequent sections.

3.1 Risk Adjustment

Risk adjustment is a method for measuring population health risk and modifying payments to reflect the predicted expenditures of that population. Measurement of a population's health risks is achieved by designing and estimating models to predict expenditures based on demographic characteristics and medical conditions (Hierarchical Condition Categories [HCCs]). The risk score is the measurement of a beneficiary's risk status. Beneficiaries with risk scores greater than 1.0 are expected to incur higher medical costs than average, and beneficiaries with risk scores less than 1.0 are expected to incur lower medical costs than average.

The benchmark expenditure for GPDC is adjusted to reflect the risk, or expected cost, of DCE-aligned beneficiaries. GPDC risk adjustment uses two risk adjustment models: (1) the CMS-HCC risk adjustment model (Aged & Disabled [A&D] and End Stage Renal Disease [ESRD]) used in the MA program and (2) a new risk adjustment model (A&D) developed specifically for use in GPDC.

The existing CMS-HCC A&D model is used for risk adjustment in Standard DCEs and New Entrant DCEs. The existing CMS-HCC ESRD risk adjustment model is used for risk adjustment in all models (Standard DCEs, New Entrant DCEs, and High Needs Population DCEs).

The new risk adjustment model, which is broadly based on the CMS-HCC A&D risk adjustment model, has been modified to improve payment accuracy for beneficiaries with serious or acute illness in the concurrent year. This new model is used for risk adjustment of A&D beneficiaries in the High Needs Population DCEs.

The details of GPDC risk adjustment methodology are described in the ***Global and Professional Direct Contracting and Kidney Care Choices Models: Risk Adjustment*** paper.

3.2 DC/KCC Rate Book

The MA Rate Book establishes county-level rates for MA Plans for A&D beneficiaries and state-level rates for ESRD beneficiaries. The methodology for the most recently available MA Rate Book was the starting point to develop the DC/KCC Rate Book specifically for GPDC, for the purposes of establishing regional expenditures for the calculation of a DCE's financial benchmark. A DCE's region is defined as all counties in which one or more beneficiaries aligned to the DCE in the performance year reside. The regional rate for each DCE is an eligible-month weighted average of the counties where the DCE's aligned beneficiaries reside.

The DC/KCC Rate Book is based on the same methodology used for the MA Rate Book with adjustments to (1) remove factors applied to the MA Rate Book that are not relevant for GPDC (e.g., FFS spending quartiles and quality bonus payment percentage for star ratings), (2) add components of Medicare FFS

expenditures not included in the MA Rate Book (e.g., hospice services), and (3) include only the experience of FFS beneficiaries who are eligible to participate in GPDC. As with the MA Rate Book, this DC/KCC Rate Book establishes a county rate for the A&D beneficiaries and a state-level rate for ESRD beneficiaries (with county-level Geographic Adjustment Factor (GAF) adjustments).

The role of the regional rate (from the DC/KCC Rate Book) in the benchmark will be described in Section 4 in greater detail but generally varies based on the DCE type, beneficiary alignment method, and performance year. In some cases, it is incorporated into DCEs' historical baseline expenditures to arrive at a blended benchmark (described in Sections 4.1.5 and 4.1.6). There are limits on the maximum upward (a ceiling of 5% of the FFS USPCC for the performance year) and downward (a floor of 2% of the FFS USPCC for the performance year) adjustment that can result from incorporating regional expenditures into the benchmark. In other instances, the regional rate is used as the entirety of the baseline experience (Section 4.2).

The details of the DC/KCC Rate Book construction are described in the ***Global and Professional Direct Contracting and Kidney Care Choices Models: DC/KCC Rate Book Development*** methodological paper.

Section 4: Benchmark Expenditure

The Performance Year Benchmark is the target amount for Medicare expenditures on covered items and services furnished to a DCE's aligned beneficiaries during a performance year. As shown in **Figure 4.1**, the Performance Year Benchmark is calculated differently across DCE types (Standard, New Entrant, High Needs Population), basis for beneficiary alignment (claims-aligned and voluntarily aligned), and performance year (PY2021, PY2022, PY2023, PY2024, PY2025, and PY2026).

Figure 4.1: Calculation of Benchmark Expenditure by DCE Type and Basis for Beneficiary Alignment[1]

<table>
<tr><th>DCE Type</th><th colspan="2">Standard DCE</th><th>New Entrant DCE[2]</th><th>High Needs Population DCE[3]</th></tr>
<tr><td></td><td>Claims-Aligned Beneficiaries</td><td>Voluntarily Aligned Beneficiaries</td><td>All Beneficiaries</td><td>All Beneficiaries</td></tr>
<tr><td>PY2021</td><td rowspan="6">Blend of historical baseline expenditure[4] and DC/KCC Rate Book (Historical Blended Benchmark)</td><td colspan="3" rowspan="4">Driven primarily by the DC/KCC Rate Book (Rate Book Driven Benchmark)</td></tr>
<tr><td>PY2022</td></tr>
<tr><td>PY2023</td></tr>
<tr><td>PY2024</td></tr>
<tr><td>PY2025</td><td colspan="3" rowspan="2">Blend of historical baseline expenditure[5] and DC/KCC Rate Book (Historical Blended Benchmark Benchmark)</td></tr>
<tr><td>PY2026</td></tr>
</table>

[1] Beneficiaries who could be aligned to the same DCE via both voluntary and claims-based alignment will be treated as having claims-based alignment for benchmarking.
[2] If a New Entrant DCE has greater than 3,000 claims-aligned beneficiaries in any of the three base years (2017, 2018, or 2019), they will be offered the option to participate as a Standard DCE and will use the Standard DCE methodology.
[3] If a High Needs Population DCE has greater than 3,000 claims-aligned beneficiaries in any of the three base years (2017, 2018, or 2019), their benchmark will be calculated using the Standard DCE methodology.
[4] The historical baseline period for claims-aligned beneficiaries in a Standard DCE is 2017, 2018, 2019.
[5] The historical baseline period for voluntarily aligned beneficiaries in PY2025 is 2021, 2022, 2023 for all DCE types. The historical baseline period for voluntarily aligned beneficiaries in PY2026 is 2022, 2023, 2024 for all DCE types. For claims-aligned beneficiaries to New Entrant and High Needs Population DCEs, in PY2025 the historical baseline period is 2021, 2022, 2023 and in PY2026 is 2022, 2023, 2024.

This section primarily focuses on the basic methodology for Standard DCEs with specific call outs to the unique features associated with New Entrant and High Needs Population DCEs, where applicable. This paper focuses on the Standard DCE methodology because, as **Figure 4.1** shows, the benchmarking methodology for New Entrant and High Needs Population DCEs parallels the Standard DCE methodology for voluntarily aligned beneficiaries.

For all DCE types, a per-beneficiary per-month (PBPM) benchmark will be developed separately for both the A&D and ESRD beneficiary categories. This paper introduces all the steps and concepts applied in the calculation of the benchmark; the companion documents illustrate a complete benchmark calculation for each of the DCE types. We encourage you to reference the companion documents as you read this section, and we have called out where each step can be found in the corresponding companion documents.

4.1 Benchmark Expenditure for Beneficiaries Aligned Based on Claims (Standard DCE)

4.1.1 Historical baseline expenditure

For beneficiaries aligned via claims to a Standard DCE, the historical baseline is established based on aggregating all Medicare Parts A and B expenditures incurred by beneficiaries who would have been

claims-aligned to the DCE in base years (BYs) 2017, 2018, and 2019. These historical expenditures from 2017, 2018, and 2019 are combined and weighted, giving more weight to the more recent historical year (10%, 30%, and 60%, respectively). For every performance year of the model, the historical BYs remain the same, although the expenditures themselves are recalculated each performance year to reflect any changes in DC Participant Providers who are participating in the model, which correspond to changes in the beneficiaries who would have been claims-aligned to those providers in the same BYs.

Expenditures include the amounts paid on all claims for covered services provided to each beneficiary during months of eligible alignment and all associated claims, including any reductions or payment adjustments from other Medicare programs. For example, amounts paid on claims that were zeroed out or reduced because of participation in the NGACO program would be counted before any payment reductions.

In order for CMS to construct a reliable baseline, Standard DCEs must have at least 3,000 claims-aligned beneficiaries in at least one of these BYs; Standard DCEs without 3,000 claims-aligned beneficiaries for all three BYs are not eligible to participate in the model starting in PY2022. Conversely, New Entrant DCEs must have fewer than 3,000 claims-aligned beneficiaries for all three of these BYs; if a New Entrant DCE has at least 3,000 claims-aligned beneficiaries in at least one BY, they will be given the option to participate as a Standard DCE, provided they meet other eligibility criteria. High Needs Population DCEs with at least 3,000 claims-aligned beneficiaries for any of the three BYs will follow the benchmarking methodology for Standard DCEs, except that risk adjustment will continue to be applied using the High Needs Population DCE methodology.

- Standard DCE Companion Document detail: See Section 2.1, Figure 2.2

Beneficiaries attributed via voluntary alignment will not contribute any historical expenditures for the first 4 performance years of this model. In PY2021-PY2024, only regional expenditures via the DC/KCC Rate Book (described in Section 4.2) will be used to generate a benchmark for these beneficiaries. For PY2025 and PY2026, the recent historical expenditures for these beneficiaries will be used to calculate the historical baseline expenditures for the benchmark. The historical baseline period for voluntarily aligned beneficiaries in PY2025 is 2021, 2022, 2023, and the historical baseline period for voluntarily aligned beneficiaries in PY2026 is 2022, 2023, 2024.

For the New Entrant DCE and High Needs Population DCE types, the benchmarking in PY2021–PY2024 will also be based entirely on regional expenditures, measured via the DC/KCC Rate Book, whether or not beneficiaries are aligned through voluntary alignment or claims-based alignment. For PY2025 and PY2026, the recent historical expenditures for these beneficiaries will also be used to calculate the historical baseline expenditures for the benchmark. The historical period for New Entrant DCE and High Needs Population DCE in PY2025 is 2021, 2022, 2023, and the historical baseline period for New Entrant DCE and High Needs Population DCE types in PY2026 is 2022, 2023, 2024. Note that for High Needs Population DCEs with greater than 3,000 claims-aligned beneficiaries, the benchmark will be calculated using the Standard DCE methodology.

4.1.2 Application of prospective trend

The USPCC growth trend is developed annually by the CMS Office of the Actuary (OACT) and announced in the annual Announcement of calendar year MA Capitation Rates and Part C and Part D Payment

Policies released no later than the first Monday in April of the prior calendar year.[1] An adjusted version of the USPCC annual growth trend, which removes costs associated with uncompensated care and adds in hospice expenditures, will be applied to the DCE's historical baseline expenditures to trend them forward to be equivalent with performance year expenditures.

The prospective trend rate is calculated separately for each BY relative to the USPCC for the performance year. Each of the 3 BYs is then independently trended forward to the performance year instead of applying the average trend across BYs. The A&D and dialysis-only ESRD USPCC growth trends are applied separately to the historical baseline expenditures for the A&D and ESRD populations of aligned beneficiaries, respectively.

The trend derived from the USPCC figures will be determined preceding each performance year and established at the time of publication of the DC/KCC Rate Book for the performance year. However, if this adjusted USPCC trend differs by at least 1% from the observed expenditure trend in the DC National Reference Population (the full population of beneficiaries eligible for alignment to a DCE in GPDC), CMS may apply a retrospective trend adjustment to the benchmark that reflects this difference. In addition, CMS may apply a placeholder retrospective trend adjustment to account for significant changes to the USPCC that occur following the release of the relevant Rate Announcement, in order to support payment accuracy during the performance year. The adjusted USPCC trend is set for each performance year using the most current USPCC preceding that performance year. Thus, if the USPCC for a prior year has been altered it is used to set the trend for future performance years.

- Standard DCE Companion Document detail: See Section 2.1, Figure 2.3

4.1.3 Risk Standardization

Risk standardization is a method for standardizing expenditures for population health risks. Every beneficiary has a risk score that is a measure of their total risk status based upon demographic characteristics and medical conditions (HCCs). The DCE's risk score is a weighted average of the risk of all aligned beneficiaries. To risk standardize expenditures, the DCE's trended baseline expenditure for each BY is divided by the DCE's risk score.

- Standard DCE Companion Document detail: See Section 2.1, Figure 2.4

4.1.4 Geographic Adjustment Factors (GAFs) adjustment

The DCE's trended, risk-standardized baseline expenditure for each BY is then adjusted to reflect the anticipated impact of changes in the regional GAFs applied to payment amounts under the Medicare FFS payment systems. Every county has its own GAF, determined by the regional differences in various factors such as area wage indices. The GAF Adjustment is applied by multiplying the Trended Risk-Standardized Baseline Expenditure by the DCE's regional GAF Adjustment for each BY.

[1] More information is available at **https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Trends** and **https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents**

- Standard DCE Companion Document detail: See Section 2.1, Figure 2.4

4.1.5 Historical baseline (3-year average)

The DCE's trended, risk-standardized and GAF-adjusted baseline expenditures for each of the 3 BYs are then combined but with more weight placed on the more recent BY. BY1 is weighted 10%, BY2 is weighted 30%, and BY3 is weighted 60%. The result is a weighted 3-year average that serves as the final historical baseline.

If the DCE does not have sufficient claims history to calculate the historical baseline expenditure for any of the three BYs, that BY will not be used in the calculation of the final historical baseline. If the DCE has sufficient claims history for two of the three BYs, CMS will average the historical baseline expenditures for BYs with the more recent BY weighted two-thirds and the less recent BY weighted one-third. If the DCE has sufficient claims history for one of the three BYs, CMS will use only that BY to calculate the historical baseline.

- Standard DCE Companion Document detail: See Section 2.1, Figure 2.5

4.1.6 Regional rate for claims-aligned beneficiaries

For claims-aligned beneficiaries, regional expenditures are also incorporated into the benchmark to account for the DCE's efficiency relative to its region. Separate from the historical baseline, the weighted average of the county rates (or state-level rates for ESRD beneficiaries) based on the DC/KCC Rate Book (see Section 3.2) are calculated for each DCE in each BY. To incorporate regional expenditures into a DCE's benchmark, the DCE's region includes all counties in which one or more beneficiaries aligned to the DCE in the baseline period reside, and the weighted average depends on both the county rates and the number of aligned beneficiaries residing in each county in each of the BYs. The regional rate for each BY is also combined with more weight placed on the more recent BY. BY1 is weighted 10%, BY2 is weighted 30%, and BY3 is weighted 60%, resulting in a weighted 3-year average that serves as the final historical regional rate.

If the DCE does not have sufficient claims history to calculate the historical baseline expenditure for any of the three BYs, that BY will not be used in the calculation of the DCE's historical regional rate either. If the DCE has sufficient claims history for two of the three BYs, CMS averages the regional rate for the BYs with the more recent BY weighted two-thirds and the less recent BY weighted one-third. If the DCE has sufficient claims history for one of the three BYs, CMS uses only that BY to calculate the regional rate.

- Standard DCE Companion Document detail: See Section 2.1, Figure 2.6

4.1.7 Blended benchmark

CMS blends the regional expenditures (Section 4.1.5) with the DCE's historical baseline expenditures (Section 4.1.4), to determine the blended Performance Year Benchmark. The proportion of the blended benchmark made up of historical baseline expenditures relative to regional expenditures changes over the model performance years with more weight shifting to regional expenditures, as summarized in **Figure 4.2**.

Figure 4.2: Composition of the Performance Year Blended Benchmark

Performance Year	% of Blended Benchmark Historical Expenditures	% of Blended Benchmark Regional Expenditures
PY2021	65%	35%
PY2022	65%	35%
PY2023	65%	35%
PY2024	60%	40%
PY2025	55%	45%
PY2026	50%	50%

In **Figure 4.3** below, blended benchmark historical expenditures are 65%, the DCE risk-standardized, GAF-adjusted baseline expenditure "PBPM Historical Rate" is $801.96, and the DCE Regional Rate based on the DC/KCC Rate Book is $810.75. Thus the blended benchmark (before applying ceiling/floor) is $805.03.

Furthermore, there are limits on the maximum upward (ceiling) and downward (floor) adjustment that can result from incorporating regional expenditures into the benchmark. The ceiling for incorporating the regional expenditures is a flat dollar amount increase equal to 5% of the adjusted FFS USPCC for the performance year. The floor for incorporating the regional expenditures is a flat dollar amount decrease equal to 2% of the adjusted FFS USPCC for the performance year. These caps are applied for the A&D and the ESRD Benchmarks separately; therefore, it is possible for blending to hit the cap for one category but not the other.

For example, **Figure 4.3** below illustrates that in a hypothetical performance year in which the Adjusted FFS USPCC (A&D) estimate is $1,010.90 PBPM, the ceiling for adjustment to the historical benchmark (A&D) would be 5% of that $1,01.90 or $50.55 PBPM, and the maximum floor to the historical benchmark (A&D) would be −2% of that $1,01.90 or −$20.22 PBPM. Because the difference between the blended benchmark and DCE baseline falls between those two values, the floor/ceiling adjustment does not need to be applied in this example.

Finally, the DCE Regional Rate Baseline Adjustment factor is calculated as the ratio of the blended benchmark, divided by the weighted average DCE Regional Rate based on the DC/KCC Rate Book. In **Figure 4.3**, this is illustrated in the $805.03 divided by $810.75, arriving at a DCE Regional Rate Baseline Adjustment of 0.993. This factor is prospective and does not change during the performance year. It is multiplied by the performance year DCE Regional Rate (based on the DC/KCC Rate Book), along with the performance year risk score and number of eligible months in the performance year, to arrive at the final Performance Year Benchmark.

In this example, the DCE Regional Rate Baseline Adjustment factor of 0.993 establishes that in the historical period, the blended benchmark is 99.3% of the Regional Rate; this same rate is then applied in the performance year. The Performance Year Benchmark is set at 99.3% of the performance year's Regional Rate. By directly incorporating the regional rate based upon performance year alignment, this approach accounts for any significant changes in the counties where the DCE's aligned population resides over time.

Figure 4.3: Blended Benchmark Calculation

7.	EQUALS: PBPM Historical Rate	$801.96
8.	DCE Regional Rate based on DC/KCC Rate Book	$810.75
9.	Blend Percentage (% historical)	65%
10.	Blended Benchmark (Before applying ceiling/floor)	$805.03
11.	Difference between Blended Benchmark and DCE Baseline	$3.08
12.	Ceiling on Blended Benchmark Adjustment	$50.55
13.	Floor on Blended Benchmark Adjustment	($20.22)
14.	Blended Benchmark	$805.03
15.	DCE Regional Rate Baseline Adjustment	0.993

* The proportion of regional expenditures that will be blended with the historical baseline expenditures will increase incrementally over the course of the GPDC Performance Period, beginning with regional expenditures comprising 35% of the benchmark in PY2021 and increasing to 50% of the benchmark by PY2026.

- Standard DCE Companion Document detail: See Section 2.1, Figure 2.7 and Figure 2.8

4.2 Benchmark Expenditure for Voluntarily Aligned Beneficiaries (Standard DCE)

In PY2021 through PY2024, the benchmark for beneficiaries aligned to a Standard DCE through voluntary alignment is the regional rate for those beneficiaries (Rate Book Driven Benchmark). Beginning in PY2025, the benchmark for voluntarily aligned beneficiaries will begin to incorporate historical expenditures (Historical Blended Benchmark). This change in benchmarking approach and baseline period is summarized below in **Figure 4.4**.

Figure 4.4: Benchmark for Voluntarily Aligned and Claims-Aligned Beneficiaries

Performance Year	Benchmark for Claims-Aligned Beneficiaries	Benchmark for Voluntarily Aligned Beneficiaries
PY2021	Blend of Historical Baseline for CY2017, CY2018, CY2019[1] and CY2021 Regional Rate (Historical Blended Benchmark)	2021 Regional Rate (Rate Book Driven Benchmark)
PY2022	Blend of Historical Baseline for CY2017, CY2018, CY2019[1] and CY2022 Regional Rate (Historical Blended Benchmark)	2022 Regional Rate (Rate Book Driven Benchmark)
PY2023	Blend of Historical Baseline for CY2017, CY2018, CY2019[1] and CY2023 Regional Rate (Historical Blended Benchmark)	2023 Regional Rate (Rate Book Driven Benchmark)
PY2024	Blend of Historical Baseline for CY2017, CY2018, CY2019[1] and CY2024 Regional Rate (Historical Blended Benchmark)	2024 Regional Rate (Rate Book Driven Benchmark)

Performance Year	Benchmark for Claims-Aligned Beneficiaries	Benchmark for Voluntarily Aligned Beneficiaries
PY2025	Blend of Historical Baseline for CY2017, CY2018, CY2019[1] and CY2025 Regional Rate (Historical Blended Benchmark)	Blend of Historical Baseline for CY2021, CY2022, CY2023[2] and CY2025 Regional Rate (Historical Blended Benchmark)
PY2026	Blend of Historical Baseline for CY2017, CY2018, CY2019[1] and CY2026 Regional Rate (Historical Blended Benchmark)	Blend of Historical Baseline for CY2022, CY2023, CY2024[3] and CY2025 Regional Rate (Historical Blended Benchmark)

[1] The historical baseline for claims-aligned beneficiaries is the blend of the baseline expenditure for beneficiaries that would have been claims-aligned in CY2017, CY2018, and CY2019 based on the performance year DC Participant Provider list.

[2] The historical baseline for voluntarily aligned beneficiaries is the average of the baseline expenditure for beneficiaries who were voluntarily aligned in CY2021, CY2022, and CY2023.

[3] The historical baseline for voluntarily aligned beneficiaries is the average of the baseline expenditure for beneficiaries who were voluntarily aligned in CY2022, CY2023, and CY2024

- Standard DCE Companion Document detail: See Section 2.1, Figure 2.9 and Section 3.0, Figure 3.1.

4.2.1 Benchmark during first 4 years of voluntary alignment

In the first 4 performance years, regional expenditures based upon the DC/KCC Rate Book serve as the source for the financial benchmark. The regional payment for voluntarily aligned beneficiaries is a person-month weighted average of the county rates for those voluntarily aligned beneficiaries. The payment for every county in which a voluntarily aligned beneficiary lives is based on the number of eligible beneficiary-months attributed to the DCE multiplied by the DC/KCC Rate Book value for that county. These county payments are then combined and divided by the total eligible months across all voluntarily aligned beneficiaries to arrive at the voluntarily aligned beneficiary standardized benchmark.

- Standard DCE Companion Document detail: See Section 2.1, Figure 2.9
- New Entrant DCE Companion Document detail: See Figure 2.2 and Figure 2.3
- High Needs Population DCE Companion Document detail: See Figure 2.2 and Figure 2.3

4.2.2 Benchmark during fifth and subsequent years of voluntary alignment

Beginning in PY2025, the benchmark for voluntarily aligned beneficiaries will be calculated similarly to claims-aligned beneficiaries, as a blend between historical baseline and regional rate. However, the approach for voluntarily aligned beneficiaries will still differ slightly from the approach previously described for claims-aligned beneficiaries, in that it uses a different reference population and there is a different baseline period for the voluntarily aligned beneficiaries, as summarized in **Figure 4.4**. For claims-aligned beneficiaries, the baseline period for the historical expenditure component of the benchmark will continue to be 2017–2019. For voluntarily aligned beneficiaries, however, the baseline period for the historical expenditure component of the benchmark in PY2025 is 2021, 2022, 2023 (with BY1 weighted 10%, BY2 weighted 30%, and BY3 weighted 60%) and in PY2026 is 2022, 2023, 2024 (with BY1 weighted 10%, BY2 weighted 30%, and BY3 weighted 60%). The claims used for each of the BYs will come from the beneficiaries voluntarily aligned to that DCE during each of those prior performance years (2021–2023 for PY2025 and 2022–2024 for PY2026).

The historical baseline will be developed from the expenditure incurred in each base year by any beneficiary who was voluntarily aligned to the DCE in that year. For example, the historical voluntary alignment baseline expenditure for CY2021 is the expenditure incurred by beneficiaries who were voluntarily aligned to the DCE in PY2021/CY2021; the historical voluntary alignment baseline expenditure for CY2022 is the expenditure incurred by beneficiaries who were voluntarily aligned to the DCE in PY2022/CY2022.If the DCE does not have sufficient claims history to calculate the historical baseline expenditure for any of the three BYs, that BY will not be used in the calculation of the DCE's historical baseline or regional rate. If the DCE has sufficient claims history for two of the three BYs, CMS will average the historical baseline and the regional rate for the BYs with the more recent BY weighted two-thirds and the less recent BY weighted one-third. If the DCE has sufficient claims history for one of the three BYs, CMS will use only that BY to calculate the historical baseline and the regional rate. If no BYs have sufficient claims history for beneficiaries who were voluntarily aligned to the DCE in the baseline period, CMS will use the DCE Regional Rate Baseline Adjustment for claims-aligned beneficiaries in calculating the benchmark for voluntarily aligned beneficiaries.

- Standard DCE Companion Document detail: See Section 3.0, Figure 3.1
- New Entrant DCE Companion Document detail: See Section 3, Figures 3.1–3.7
- High Needs Population DCE Companion Document detail: See Section 3, Figures 3.1–3.7

4.3 Combined Benchmark (Standard DCE)

As previously described, up until this point benchmarks have been calculated separately for A&D populations and ESRD populations, and within each of those populations have been calculated separately for claims-aligned and voluntarily aligned beneficiaries. These separate benchmarks are then combined to arrive at a single PBPM target benchmark.

4.3.1 Combined claims-aligned and voluntarily aligned benchmarks

First, the claims-aligned and voluntarily aligned benchmarks are combined based on a person-month weighted average of the two benchmarks. Note that claims-aligned and voluntarily aligned benchmarks are combined separately for A&D and for ESRD. These benchmarks can be expressed as PBPM values or can be multiplied by the number of eligible person-months to arrive at aggregate benchmark amounts.

- Standard DCE Companion Document detail: See Section 2.3, Figure 2.11

4.3.2 Combined A&D and ESRD Benchmark

The aggregate A&D Benchmark and aggregate ESRD Benchmark are then combined to arrive at the total benchmark expenditure. This is calculated based upon a simple sum of the two benchmarks because both are in aggregate dollars.

- Standard DCE Companion Document detail: See Section 2.3, Figure 2.11
- New Entrant DCE Companion Document detail: See Section 2.3, Figure 2.3
- High Needs Population DCE Companion Document detail: See Section 2.3, Figure 2.3

4.4 Retrospective Trend Adjustment (Standard DCE)

CMS may apply a placeholder retrospective trend adjustment to account for significant changes to the USPCC that occur following the release of the relevant Rate Announcement, in order to support payment accuracy during the performance year. The retrospective trend adjustment is described in full detail in the ***Global and Professional Direct Contracting Model: Financial Reconciliation Overview*** operating policy document.

4.5 Discount (Standard DCE)

The discount applied to the total benchmark expenditure is determined by the risk arrangement selected by the DCE (see Section 2.4). For DCEs participating in the Global risk track there is a 2% discount applied to the trended, regionally blended, risk-adjusted benchmark in PY2022 (3%–5% in PY2023–PY2026). For Professional DCEs, the Performance Year Benchmark does not include this discount.

- Standard DCE Companion Document detail: See Section 2.4, Figure 2.12
- New Entrant DCE Companion Document detail: See Section 2.4, Figure 2.4
- High Needs Population DCE Companion Document detail: See Section 2.4, Figure 2.4

4.6 Retention Withhold (Standard DCE)

To incentivize participation in GPDC for at least 2 years, DCEs must either secure an additional financial guarantee or be subject to a retention withhold applied to their benchmark in their first year of model participation. The retention withhold parameter is 2% of the benchmark expenditure that is held at-risk and can be earned back by the DCE during Financial Settlement based on its continued participation within the GPDC model. The full details of the retention withhold is described in the ***Global and Professional Direct Contracting Model: Financial Reconciliation Overview*** operating policy document.

4.7 Quality Withhold

For both Global and Professional DCEs, a 5% quality withhold is also applied to the total benchmark expenditure for all aligned beneficiaries. A portion of this is held at risk and can be earned back by the DCE's reporting of and performance on a pre-determined set of quality measures in the performance year.

- Standard DCE Companion Document detail: See Section 2.4, Figure 2.12
- New Entrant DCE Companion Document detail: See Section 2.4, Figure 2.4
- High Needs Population DCE Companion Document detail: See Section 2.4, Figure 2.4

The portion of the quality withhold tied to reporting versus performance and the set of quality metrics measured will vary based on the model performance year. The first 2 performance years have 1% of the quality withhold tied to performance and 4% of the quality withhold tied to reporting, whereas subsequent performance years will have the full 5% quality withhold tied to performance, as shown in **Figure 4.5**.

Figure 4.5: Application of Quality Withhold by Performance Year

Performance Year	Pay-for-Performance Withhold	Pay-for-Reporting Withhold
PY2021	1%	4%
PY2022	1%	4%
PY2023	5%	0%
PY2024	5%	0%
PY2025	5%	0%
PY2026	5%	0%

The details of the quality approach are described in the ***Global and Professional Direct Contracting Model: Quality Measurement Methodology*** paper.

Section 5: Financial Settlement and Reconciliation

Financial reconciliation is the process by which CMS determines Shared Savings or Shared Losses for a DCE by comparing actual Medicare expenditures in the performance year with the total benchmark expenditure after earned quality. Medicare expenditures are inclusive of TCC or PCC payments and the advanced payments (after they have been reconciled against actual reductions) paid by CMS to the DCE, as well as FFS claims paid by CMS directly to the Medicare providers and suppliers for Medicare Parts A and B items and services furnished to DC Beneficiaries.

5.1 Risk Mitigation

As described in Section 2.4, there are two different risk-sharing arrangements that determine the portion of savings or losses for which a DCE is at risk.

- Under the Global risk arrangement, the DCE assumes full risk for any savings or losses.
- Under the Professional risk arrangement, the DCE assumes partial risk for any savings or losses.

In addition, there are risk mitigation strategies in GPDC, including risk corridors and optional stop-loss reinsurance.

5.1.1 Risk Corridors

Under both Global and Professional options, risk corridors (bands) determine the percentage of the savings retained by the DCE, as shown in **Figure 5.1**. For example, for all savings or losses up to 5% of the Performance Year Benchmark (risk band 1), the DCE in the Professional option is responsible for 50% of savings or losses and CMS is responsible for the remaining 50%. DCEs will be responsible for a progressively smaller portion of additional savings or losses as their savings or losses reach risk bands 2, 3, and 4.

Figure 5.1: GPDC Model Risk Corridors: Percentage of Savings/Losses Retained by DCE

	Risk Arrangement			
	Global Option (Full Risk)		Professional Option (Partial Risk)	
Risk Band	% of Benchmark	Savings/Losses Rate[1]	% of Benchmark	Savings/Losses Rate[1]
Corridor 1	Less than 25%	100%	Less than 5%	50%
Corridor 2	25% to 35%	50%	5% to 10%	35%
Corridor 3	35% to 50%	25%	10% to 15%	15%
Corridor 4	More than 50%	10%	More than 15%	5%

[1] Percentage of savings or losses within the corridor retained by the DCE.

5.1.2 Optional Stop-Loss Reinsurance

All DCEs also have the option of participating in a stop-loss reinsurance arrangement, which is designed to reduce the financial uncertainty associated with infrequent but high-cost expenditures for aligned beneficiaries. Stop-loss protects DCEs from financial liability for individual beneficiary expenditures that

are above the stop-loss "attachment points" (i.e., dollar thresholds at which stop-loss protection begins).

The stop-loss attachment points are developed based on expenditure data derived from the DC National Reference Population of Medicare FFS beneficiaries and adjusted to reflect regional differences in Medicare payment rates for each DCE, using the GAFs used in calculating the Performance Year Benchmark.

The stop-loss payout rate is equal to a percentage of the expenditure incurred by an aligned beneficiary whose total expenditure exceeds the established attachment point for that beneficiary. That percentage depends on the difference between that beneficiary's incurred expenditure and the stop-loss attachment point. The amount that is paid out under the stop-loss arrangement will increase as the expenditure incurred by the beneficiary during alignment increases according to a schedule—referred to as stop-loss bands.

Under the stop-loss arrangement, DCEs retain liability for a portion of expenditures above each attachment point, if the option is selected. A PBPM stop-loss "charge" is applied to the DCE's Performance Year Benchmark. This charge is based on the percent of expenditures above each of the DCE's attachment points in the baseline period. The net impact of stop-loss charges and payouts will impact the total expenditures incurred by the DCE in a performance year, as described in Section 5.5.3. The full details of the stop-loss attachment point calculations are described in the ***Global and Professional Direct Contracting Model: Financial Reconciliation Overview*** operating policy document.

5.2 Timing of Financial Settlement and APO Reconciliation

Provisional Financial Reconciliation. DCEs have the option for a provisional Financial Reconciliation. The purpose of this option is to provide timely distribution of provisional Shared Savings or repayment of provisional Shared Losses following the end of the performance year. The target for this reconciliation is within a month after the performance year ends (January 31 target). The provisional reconciliation includes claims experience from the first six months of the performance year and does not account for the full claims processing run-out.

Final Financial Reconciliation. Final Financial Reconciliation is conducted approximately seven months after the performance year ends for all DCEs. This reconciliation includes claims run-out through the end of the first quarter of the calendar year following the performance year for expenditures incurred in the performance year. Final Financial Reconciliation is based on risk, adjusting the Performance Year Benchmark using the final risk scores for the performance year and then comparing the Performance Year Benchmark with performance year expenditures for aligned beneficiaries to determine Shared Savings or Shared Losses.

Figure 5.2: Provisional Financial Reconciliation and Final Financial Reconciliation

Reconciliation Data and Timing	Provisional Financial Reconciliation	Final Financial Reconciliation
Date for Reconciliation	January 31 of the CY following the PY	July 31 of the CY following the PY
Claims Included in Reconciliation	PY expenditures incurred through June 30	PY expenditures incurred through December 31
Claims Run-out	Through December 31 of the PY	Through March 31 of the CY following the PY
Risk Scores	Preliminary risk scores[1]	Final risk scores

[1] CMS will use the most recently available risk scores in Provisional Reconciliation calculations.

5.3 Total Benchmark Expenditure

As described previously, reconciliation involves comparing the total benchmark expenditure amount for the DCE with the actual incurred expenditures in the performance year. Section 4 described in detail the methodology for determining the total benchmark expenditure. For DCEs participating in the Global risk arrangement, there is a discount applied to the total benchmark expenditure, and for both Global and Professional DCEs, there is a quality withhold applied. See Section 4 for details.

5.4 Earned Quality Withhold

As described in Section 4, for both Global and Professional DCEs there is a 5% quality withhold held at risk, depending on the DCE's performance on a pre-determined set of quality measures. A DCE's quality score is determined based on their performance and improvement in specified quality domains. This quality score is then multiplied by the amount withheld to determine the Earned Quality Withhold. In the example in **Figure 5.3**, the DCE had a 100% on the quality score and therefore received back the entire amount of the quality withhold through the Earned Quality Withhold.

Figure 5.3: Calculation of Earned Quality Withhold PBPM Calculation

Benchmark Expenditure for All Aligned Beneficiaries	$1,305,989,805.42
LESS: Discount	$0.00
LESS: Retention Withhold	$0.00
EQUALS: Benchmark Expenditure after Discount & Retention Withhold	$1,305,989,805.42
LESS: Quality Withhold	($65,299,490.27)
PLUS: Earned Quality Withhold	$65,299,490.27
EQUALS: Benchmark Expenditure after Earned Quality	$1,305,989,805.42

5.5 Performance Year Expenditure

The performance year expenditure is the total payment that has been made by Medicare for services provided to DCE-aligned beneficiaries during months in which they were alignment eligible and aligned to the DCE. It is equal to the payments made to the DCE for services within the scope of the capitation Payment (either TCC or PCC) plus the FFS payments made to providers by the Medicare Administrative

Contractors, including any reduction in FFS payments made under the APO (after they have been reconciled against actual reductions). An example is provided in **Figure 5.4**.

Figure 5.4: DCE Performance Period Expenditure

	Benchmark to which Experience Accrues		
	AD	ESRD	TOTAL
DCE Performance Period Expenditure			
Capitation Payment	$50,021,100.44	$54,279,608.03	$104,300,708.47
PLUS: Claims-Based Payments	$590,788,191.40	$609,406,458.53	$1,200,194,649.93
EQUALS: Total Cost of Care before Stop-Loss	$640,809,291.84	$663,686,066.56	$1,304,495,358.40

5.5.1 Capitation payments to DCE

The capitation payment amount is calculated for A&D and ESRD beneficiaries separately and then summed together. The capitation payment amount reflects the final ("true") performance year capitation amount based upon final beneficiary alignment and risk scores. For TCC, this includes final updates to the withhold percentage at the end of the PY; for Primary Care Capitation, this includes the final Base PCC amount. Enhanced PCC Payments and APO payments are reconciled separately from the Shared Savings Calculations.

5.5.2 Claims-Based Payments

Beneficiaries aligned to a DCE will continue to accrue claims payments outside of the capitation arrangement, and these payments to Participant, Preferred, and non-DCE providers are also included in the DCE Performance Period Expenditure. These claims can occur for a number of reasons.

FFS payments to DCE providers participating in the capitation arrangement: DCE providers may continue to receive FFS payments for select services in addition to the capitation payments, depending on the payment arrangement selected. If applicable, these FFS payments will be included in the total cost of care. These could be claims for beneficiaries who had opted out of data sharing or claims related to substance use treatment, for example. Because not all Preferred Providers are required to participate in the capitation arrangement, a larger portion of the expenditures in the example is paid through FFS claims.

FFS payments to DCE providers participating in the APO: For DCE providers who elected to participate in the APO (available only to DCEs electing PCC), those payments must also be included into the total cost of care, after they have been reconciled against actual reductions. The provider claims amounts used to generate the performance period expenditures reflect this reconciliation of APO to actual reductions.

FFS payments to other providers: Payments that were made to other (DCE and non-DCE) providers not participating in the capitation payments or APO are also included in the total cost of care. This includes Preferred Providers who had opted out of the capitation arrangement or had less than a 100% fee reduction and non-DCE providers.

5.5.3 Net stop-loss payout under optional stop-loss arrangement

The total cost of care is summed together before any of the optional stop-loss thresholds are applied. In this example, the DCE's stop-loss payout and charge is based upon the blended benchmark with quality withhold added back in, multiplied by the DCE's risk score, the beneficiary-months aligned to the DCE, and the agreed upon stop-loss payout rate. **Figure 5.5** illustrates an example of the stop-loss calculation.

The stop-loss reinsurance option is described in Section 5.1.2, and full details of the stop-loss attachment point calculations are provided in the ***Global and Professional Direct Contracting Model: Financial Reconciliation Overview*** operating policy document.

Figure 5.5: Stop-Loss Calculation

	Benchmark to which Experience Accrues		
	AD	ESRD	TOTAL
EQUALS: Total Cost of Care before Stop-Loss	$640,809,291.84	$663,686,066.56	$1,304,495,358.40
LESS: Stop-Loss Payout			($27,272,023.03)
PLUS: Stop-Loss Charge			$27,058,718.93
EQUALS: Total Cost of Care after Stop-Loss			$1,304,282,054.30

5.6 Gross Savings (Losses) and Shared Savings After Application of Risk Corridors

Gross Savings (Losses) are calculated based on the difference between the total benchmark expenditure after the Quality Withhold earn back and the total cost of care after Stop-Loss.

Gross Savings (Losses) have risk corridors applied to arrive at the Shared Savings (Losses). Each DCE participates in either full risk (Global Option) or partial risk (Professional Option) arrangement. Each risk arrangement has unique risk corridors (described in **Figure 5.1**). The Shared Savings received by a DCE, or the Shared Losses for which a DCE is liable, depend on the risk arrangement and the application of the risk corridors.

In the example in **Figure 5.6**, the DCE is a participating in the Professional/partial-risk option. The DCE's Gross Savings (Losses) fall within the first risk corridor (up to 5% of the benchmark). Following the savings/losses rate for the Professional risk arrangement, the DCE retains 50% of the savings/losses in the first corridor to equal the total Gross Savings (Losses) to be Shared with the DCE. More information about Gross Savings (Losses), the application of risk corridors, and Shared Savings (Losses) is detailed in the ***Global and Professional Direct Contracting Model: Financial Reconciliation Overview*** operating policy document.

Figure 5.6: Calculation and Expression of Savings (Loss)

Savings (Losses)	
Gross Savings (Losses)	$1,707,751.12
Gross Savings (Losses) in Corridor 1	$853,875.56
Gross Savings (Losses) in Corridor 2	$0.00
Gross Savings (Losses) in Corridor 3	$0.00
Gross Savings (Losses) in Corridor 4	$0.00
Gross Savings (Losses) to be shared with DCE	$853,875.56

5.7 APO Reconciliation

Under the APO, DCE providers may elect to receive reduced FFS payments for non-primary care services. In return, the DCE receives a monthly payment intended to be equal to the amount of the reduction in FFS payments made to providers participating in APO. As part of the annual Financial Reconciliation, the APO payments made to the DCE will be reconciled against the amount of the reduction that was made in FFS payments to the providers electing to participate in the APO. If the reduction in FFS payments to those providers is greater than the APO payment made to the DCE, the difference will be paid to the DCE; if the FFS payment reduction is less than the APO payment made to the DCE, then the difference will be returned to CMS.

Because it is directly reconciled to the actual observed claims reductions, the APO does not either decrease or increase the performance period expenditure and therefore has no impact on the calculation of Shared Savings (or Shared Losses). The APO merely affects the timing of cash flows.

Appendix A: Glossary of Terms

Adjusted FFS USPCC
The adjusted fee-for service (FFS) US per capita cost (USPCC) removes uncompensated care and adds hospice back into FFS expenditures.

Adjusted FFS USPCC Trend
The Adjusted FFS USPCC trend is the performance year adjusted FFS USPCC divided by the baseline year adjusted FFS USPCC, which is applied to express BY expenditures as performance year expenditures.

Benchmark Before Discount or Quality Withhold
The calculated Performance Year Benchmark for a Direct Contracting Entity (DCE), with performance year risk scores and eligible months, before applying the discount or quality withhold.

Blend Percentage
The blend percentage is the percentage of the blended benchmark that is the trended historical baseline expenditures. One minus the blend percentage is the percent that is the DCE Regional Rate based on the DC/KCC Rate Book.

Blended Benchmark (Before Applying Ceiling or Floor)
The blend of trended historical baseline expenditures and the DCE Regional Rate (based on the DC/KCC Rate Book), before applying the ceiling or floor on the blend.

Blended Benchmark (After Applying Ceiling or Floor)
The blend of trended historical baseline expenditures and the DCE Regional Rate (based on the DC/KCC Rate Book), after applying the ceiling or floor on the blend.

Blended Benchmark Ceiling
The limit on the maximum upward adjustment that can result from incorporating regional expenditures into the benchmark, equaling 5% of the adjusted FFS USPCC for the performance year.

Blended Benchmark Floor
The limit on the maximum downward adjustment that can result from incorporating regional expenditures into the benchmark, equaling 2% of the adjusted FFS USPCC for the performance year.

Combined Benchmark
The combined benchmark created by adding the claims-aligned and voluntarily aligned benchmarks for Aged & Disabled (A&D) and End Stage Renal Disease (ESRD) separately and then combining the A&D and ESRD Benchmarks.

DCE Regional Rate
The weighted average of all the county rates (or state-level rates for ESRD beneficiaries) in which one or more beneficiaries aligned to the DCE in the baseline period reside, based on the DC/KCC Rate Book.

DCE Regional Rate Baseline Adjustment
The ratio of the blended benchmark divided by the weighted average performance year DCE Regional

Rate based on the DC/KCC Rate Book, expressed as the benchmark as a percentage of DCE Regional Rate.

Discount
The discount that is applied to the benchmark expenditure before discount or withhold. It is determined by the risk arrangement selected by the DCE; applying only to DCEs that select the Global Option.

FFS USPCC
The FFS USPCC that is developed annually by the CMS Office of the Actuary (OACT).

GAF Adjustment
An adjustment made to the DCE's trended, risk-standardized baseline expenditure for the baseline years to reflect the anticipated impact on county expenditure of differences in the regional Geographic Adjustment Factors (GAFs).

Historical Baseline
The weighted average of the DCE's trended, risk-standardized, and GAF-adjusted baseline expenditure per-beneficiary-per-month (PBPM) for each of the 3 baseline years, with more weight placed on the more recent baseline year (BY1 is weighted 10%, BY2 is weighted 30%, and BY3 is weighted 60%).

Historical Base Year Expenditure
The total Medicare Parts A and B expenditure incurred by beneficiaries who would have been claims-aligned to the DCE in each BY.

Prospective Trend
A factor applied to each of the three BY DCE expenditures, independently trending the expenditure forward to be comparable with performance year expenditure. The trends are applied separately to the historical baseline expenditure for the A&D and ESRD populations.

Quality Withhold
A percentage withhold applied to the total benchmark expenditure for all aligned beneficiaries that is held "at risk" and can be earned back by the DCE's reporting of and performance on a pre-determined set of quality measures in the performance year.

Total Benchmark Expenditure
The total benchmark expenditure amount for which a DCE is at risk in a performance year, without consideration of risk mitigation, before application of the discount or quality withhold/earn back.

Total Benchmark Expenditure after Discount
The total benchmark expenditure amount for which a DCE is at risk in a performance year, without consideration of risk mitigation, after application of the discount but before application of the quality withhold/earn back.

Total Benchmark Expenditure after Earned Quality
The total benchmark expenditure amount for which a DCE is at risk in a performance year, without consideration of risk mitigation, after application of the discount and the quality withhold/earn back. This is the benchmark compared with expenditures to determine gross savings/losses.

Appendix B: Beneficiary Alignment Procedures

B.1 GPDC Beneficiary Alignment Procedures

A beneficiary is aligned to a DCE based on either claims-based alignment or voluntary alignment. CMS automatically runs claims-based alignment before each performance year for every DCE based on the final DC Participant Provider list submitted for that performance year. Voluntary alignment consists of electronic voluntary alignment and paper-based voluntary alignment. CMS also automatically runs electronic voluntary alignment for all DCEs for the purposes of beneficiary alignment effective at the start of each performance year; paper-based voluntary alignment is optional, and a DCE must choose to participate in paper-based voluntary alignment.

The annual process in which CMS prospectively runs alignment for a given performance year prior to that performance year is called Prospective Alignment and applies to all DCEs automatically. DCEs will have the option to elect Prospective Plus Alignment, in which voluntary alignment is also performed prospectively before the start of the second through fourth calendar quarters of a performance year. **Table B.1.1** shows the alignment process and choices available for DCEs.

Table B.1.1 Alignment Options

Type of Alignment	Prospective Alignment	Prospective Plus – Q2	Prospective Plus – Q3	Prospective Plus – Q4
Claims-Based Alignment	Mandatory	N/A	N/A	N/A
Electronic Voluntary Alignment	Mandatory	Optional	Optional	Optional
Paper-Based Voluntary Alignment	Optional	Optional	Optional	Optional

B.2 Claims-Based Alignment

B.2.1 Definitions

1. Alignment Period

Each performance year and base year (BY) are associated with an alignment period that consists of 2 alignment years. The first alignment year for PY2022–PY2026 and for each BY is the 12-month period ending 18 months prior to the start of the relevant performance year or BY, as applicable. The second alignment year is the 12-month period ending 6 months prior to the start of the relevant performance year or BY, as applicable.

Table B.2.1 specifies the alignment years for each performance year and, for a Standard DCE, each of the relevant BYs.

Table B.2.1 Alignment Years for each Performance Year and Base Year

Year	Period Covered	Alignment Year 1	Alignment Year 2
Base Year 1	CY2017	7/1/2014 – 6/30/2015	7/1/2015 – 6/30/2016
Base Year 2	CY2018	7/1/2015 – 6/30/2016	7/1/2016 – 6/30/2017
Base Year 3	CY2019	7/1/2016 – 6/30/2017	7/1/2017 – 6/30/2018
Performance Year 1	April 1, 2021 – December 31, 2021	7/1/2018 – 6/30/2019	7/1/2019 – 6/30/2020
Performance Year 2	CY2022	7/1/2019 – 6/30/2020	7/1/2020 – 6/30/2021
Performance Year 3	CY2023	7/1/2020 – 6/30/2021	7/1/2021 – 6/30/2022
Performance Year 4	CY2024	7/1/2021 – 6/30/2022	7/1/2022 – 6/30/2023
Performance Year 5	CY2025	7/1/2022 – 6/30/2023	7/1/2023 – 6/30/2024
Performance Year 6	CY2026	7/1/2023 – 6/30/2024	7/1/2024 – 6/30/2025

2. Claims-Alignable Beneficiary

The population of "claims-alignable beneficiaries" includes all beneficiaries who had at least one Primary Care Qualified Evaluation and Management (PQEM) service that was paid by Medicare FFS during the alignment period.

3. Alignment-Eligible Beneficiaries

Alignment eligibility is verified on a monthly basis. The population of alignment-eligible beneficiaries includes all beneficiaries who meet all of the following criteria[2]:

- Alive;
- Enrolled in Medicare Parts A and B;
- Not enrolled in Medicare Advantage or other Medicare managed care plan;
- Do not have Medicare as a secondary payer; and
- Reside in a county that is included in the DCE service area.

For a High Needs Population DCE, a beneficiary must also meet one or more of the following conditions to be considered an alignment-eligible beneficiary (see Section B.5 for more details on eligibility checks for High Needs Population DCEs):

- Have one or more conditions that impair the beneficiary's mobility listed in **Table B.6.1** (for PY2022);

[2] Criteria for Medicare Part A and B, Medicare Advantage and managed care enrollment are verified on the first day of the month (e.g., January eligibility is determined as of January 1). Medicare as a secondary payer is determined using a 3-month lag (e.g., January eligibility is checked on April 1). In PY2021, service area residence was determined on a 3-month lag as well. CMS is currently considering whether service area residence will continue to be determined on a 3-month lag in PY2022, or whether it will be determined on the first of the month with no lag.

- Have at least one significant chronic or other serious illness (defined as having a risk score of 3.0 or greater for A&D beneficiaries or a risk score of 0.35 or greater for ESRD beneficiaries using the CMS-HCC methodologies);
- Have a CMS-HCC risk score between 2.0 and 3.0 for A&D beneficiaries (or a risk score between 0.24 and 0.35 for ESRD beneficiaries) and two or more unplanned hospital admissions[3] in the previous 12 months; or
- Exhibit signs of frailty, as evidenced by a claim submitted by a provider or supplier specifically for a hospital bed or transfer equipment for use in the home listed in **Table B.6.2** (for PY2022).

5. Base Years

Base year means "Base Year One," which is the calendar year that is 4 years before PY2021; "Base Year Two" is the calendar year that is 3 years before PY2021; and "Base Year Three" is the calendar year that is 2 years before PY2021. The 3 months immediately following each BY will be used for claims run-out for that BY.

6. PQEM Services for Claims-Based Alignment

PQEM Services means a Primary Care Service (furnished by a Primary Care Specialist or a Selected Non-Primary Care Specialist).

7. Primary Care Services

In the case of claims submitted by physicians and non-physician practitioners (NPPs), a Primary Care Service is identified by the Healthcare Common Procedure Coding System (HCPCS) code appearing on the claim line and identified by one of the HCPCS codes listed in **Table B.6.3** (for PY2022).

In the case of claims submitted by a Federally Qualified Health Center (type of bill = 77x) or Rural Health Clinic (type of bill = 71x), all services are considered primary care services.

In the case of claims submitted by a Critical Access Hospital Method 2 (CAH2) (type of bill = 85x), a Primary Care Service is identified by the HCPCS code appearing on the line item claim (for revenue centers 096x, 097x, or 098x) for the service.

8. Primary Care Specialist

A Primary Care Specialist is a physician or NPP whose principal specialty is included in **Table B.6.4** (for PY2022).

A physician or NPP's specialty is determined based on the CMS Specialty Code recorded on the claim. In the case of a claim submitted by a CAH2, the specialty code is determined by the Center for

[3] An unplanned hospital admission is defined as the claim for the inpatient stay being coded as non-elective, specifically based on the "reason for admission" code (CLM_IP_ADMSN_TYPE_CD is not 3).

Program Integrity based on the physician's or NPP's primary specialty as recorded in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).

9. Selected Non-Primary Care Specialists

A Selected Non-Primary Care Specialist is a physician or NPP whose principal specialty is included in **Table B.6.5** (for PY2022).

A physician or NPP's specialty is determined based on the CMS Specialty Code recorded on the claim. In the case of a claim submitted by a CAH2, the specialty code is determined by the Center for Program Integrity based on the physician's or NPP's primary specialty as recorded in PECOS.

B.2.2 Claims-Based Alignment Process

1. General

Claims-based alignment of a beneficiary is determined by comparing the following:

a. The weighted allowable charges for all PQEM Services that the beneficiary received from DC Participant Providers in each DCE (separately) participating in GPDC, and
b. The weighted allowable charges for all PQEM Services that the beneficiary received from each provider or supplier that is not a DC Participant Provider and identified by a Medicare-enrolled billing Taxpayer Identification Number.

2. Weighted Allowable Charges

The allowable charge on paid claims for services received during the 2 alignment years associated with a performance year or BY will be used to determine the DCE or other provider or supplier Taxpayer Identification Number from which the beneficiary received the plurality of PQEM Services.

a. The allowable charge for PQEM Services provided during the first (earlier) alignment year will be weighted by a factor of one-third.
b. The allowable charge for PQEM Services provided during the second (later, or more recent) alignment year will be weighted by a factor of two-thirds.

The allowable charge that is used in alignment will be obtained from claims for PQEM Services that are

a. Incurred in each alignment year as determined by the date-of-service on the claim line item; and
b. Paid within 3 months following the end of the second alignment year as determined by the effective date of the claim.

3. The Two-Track Algorithm

Alignment for a performance year or BY uses a two-track alignment algorithm.

a. *Alignment based on PQEM Services provided by Primary Care Specialists.* If 10% or more of the allowable charges incurred on PQEM Services received by a beneficiary during the 2 alignment years are furnished by Primary Care Specialists, then beneficiary alignment is based on the allowable charges incurred on PQEM Services furnished by Primary Care Specialists.
b. *Alignment based on Primary Care Services provided by Selected Non-Primary Care Specialists*. If less than 10% of the PQEM Services received by a beneficiary during the 2 alignment years are furnished by Primary Care Specialists, then beneficiary alignment is based on the PQEM Services furnished by Selected Non-Primary Care Specialists.

4. Tie-Breaker Rules

In the case of a tie in the dollar amount of the weighted allowed charges for PQEM Services, the beneficiary is aligned to the DCE if a DC Participant Provider has billed the most recent PQEM service for the beneficiary in the alignment period.

5. Alignment to the DCE

Subject to the precedence rules described in 4.0, CMS aligns a Beneficiary to the DCE based on claims alignment if CMS determines that (1) the beneficiary is a claims-alignable beneficiary; (2) the beneficiary is an alignment-eligible beneficiary as of January 1 of the performance year; (3) the beneficiary received the plurality of his or her PQEM Services during the 2 Alignment Years from the DCE's DC Participant Providers; and (4) the beneficiary is not already aligned to a participant in the Medicare Shared Savings Program or other Medicare value-based initiatives that take precedence over the GPDC Model for purposes of beneficiary alignment (see Section B.4.1).

B.3 Voluntary Alignment

B.3.1 Paper-Based Voluntary Alignment Definition

If the DCE elects to participate in paper-based voluntary alignment, subject to the precedence rules described in Section B.4, CMS aligns a beneficiary to the DCE based on paper-based voluntary alignment if the beneficiary:

1. Is an alignment-eligible beneficiary (as defined in Section B.2.1) as of the effective date of the beneficiary's alignment (e.g., January 1, or the first day of Q2-Q4 for Prospective Plus Alignment); and
2. Has completed a voluntary alignment form designating a DC Participant Provider as their main doctor, main provider, or the main place they receive care, provided that the designation is valid (see Section B.4.2) and more recent than any other designation made by the beneficiary. Note: although this alignment mechanism is historically referred to as paper-based voluntary alignment, electronic forms and signatures are also acceptable.

CMS aligns the beneficiary to the DCE through paper-based voluntary alignment regardless of whether the beneficiary would be aligned to the DCE based on claims alignment.

B.3.2 Electronic Voluntary Alignment Definition

Subject to the precedence rules (see Section B.4), CMS will align a beneficiary to a DCE based on electronic voluntary alignment if the beneficiary:

1. Is an alignment-eligible beneficiary (as defined in Section B.2.1) as of the effective date of the beneficiary's alignment (e.g., January 1, or the first day of Q2-Q4 for Prospective Plus Alignment); and
2. Has designated a DC Participant Provider as their primary clinician through MyMedicare.gov (or any successor site), provided that the designation is valid (determined in accordance with Section B.4.2) and more recent than any other designation made by the beneficiary.

CMS will align the beneficiary to the DCE through electronic voluntary alignment regardless of whether the beneficiary would be aligned to the DCE based on claims alignment.

B.3.3 Removal of Voluntarily Aligned Beneficiaries

A beneficiary aligned to the DCE for a performance year via voluntary alignment is removed from alignment to the DCE for purposes of financial settlement for the performance year if (1) none of the DCE's DC Participant Providers or Preferred Providers furnished any services to the beneficiary during the performance year and (2) a provider or supplier that is not a DC Participant Provider or Preferred Provider submitted a claim for a PQEM service furnished to the beneficiary during the performance year.

B.4 Alignment Precedence Rules

B.4.1 Alignment across models and programs

CMS employs a formal, cross-agency governance structure to execute hierarchical decision making to prevent the alignment of beneficiaries to multiple models involving Shared Savings or other value-based initiatives and resolve conflicts when they occur. For PY2022, the following initiatives will take precedence over GPDC for beneficiary alignment (if applicable): the Independence at Home Demonstration, the Maryland Primary Care Program, the Kidney Care Choices Model, the Medicare Shared Savings Program (Prospective Alignment only), and the Vermont All-Payer ACO Model.

B.4.2 Alignment within GPDC

Once it is determined that a beneficiary will be aligned to GPDC per the rules in Section B.4.1, the following rules specific to GPDC will apply.

First, a voluntary alignment attestation (i.e., designation of a DC Participant Provider as a beneficiary's primary clinician, main doctor, main provider, or the main place they receive care), whether through electronic voluntary alignment or paper-based voluntary alignment, is considered "valid" for a given performance year of the model performance period, if either

1. The designation was made no earlier than 2 years before the start of that performance year; or

2. The DC Participant Provider designated by the beneficiary has submitted a claim for a PQEM service furnished to the beneficiary in the 24 month period ending one month before the start of that performance year.

Within the GPDC Model, the most recent valid voluntary alignment attestation (whether through electronic voluntary alignment or paper-based voluntary alignment) takes precedence over any prior or invalid designations, and voluntary alignment takes precedence over claims-based alignment. In addition, if the most recent valid voluntary alignment attestation is to a provider or supplier that is not a DC Participant Provider or participant in any other Shared Savings model (by definition, this would have to be electronic voluntary alignment), the beneficiary will not be aligned to a DCE, even if there is a less recent valid paper-based voluntary alignment attestation or the beneficiary would be claims-aligned to a DCE.

B.4.3 Prospective Plus Alignment Process and Precedence

Before the start of each quarter, CMS compiles a list of beneficiaries who have voluntarily aligned via electronic voluntary alignment or paper-based voluntary alignment since the previous lists were collected and who meet all other beneficiary eligibility criteria. DCEs are responsible for submitting to CMS updated Paper-Based Voluntary Alignment information prior to the start of each quarter to allow for timely updates to these CMS lists (note: CMS will set a deadline prior to each quarter by which updated information is due in order for it to count in the next quarter, which will generally be roughly one month prior to each quarter). Only those beneficiaries who were not already aligned to another DCE or an organization participating in another value based initiative for which beneficiary overlap with GPDC is prohibited for the performance year are aligned to the DCE mid-year under Prospective Plus Alignment. See **Table B.6.6** for a list of initiatives for which beneficiary overlap with GPDC is prohibited for PY2022 (and **Table B.6.7** for a list of initiatives for which provider overlap with GPDC is prohibited for PY2022).

B.5 High Needs Eligibility

In recognition of how the health of High Needs beneficiaries can deteriorate quickly and that eligibility determinations must be made in a timely manner to provide the necessary support to at-risk beneficiaries when they need it most, CMS is checking High Needs eligibility quarterly. Beneficiaries who, barring eligibility, would otherwise be aligned to a High Needs Population DCE either through claims or voluntary alignment have up to four chances to become eligible each performance year. Once a beneficiary is determined to be eligible they are aligned starting in the next quarter for the remaining months of the performance year, for example January 1, April 1, July 1, or October 1 as applicable (unless the beneficiary does not meet general eligibility requirements in Section B.2.1 or is otherwise retrospectively removed from alignment). Once a beneficiary is determined to be High Needs eligible and is aligned to a DCE, that beneficiary is considered High Needs eligible for the remaining performance years, even if they cease to meet High Needs eligibility criteria (again, unless they cease to meet general eligibility requirements in Section B.2.1 or are otherwise retrospectively removed from alignment). This is to ensure continuity of care for High Needs beneficiaries and to avoid punishing High Needs Population DCEs for providing effective care.

Table B.5.1 Opportunities within a Performance Year to Meet High Needs Eligibility

Effective date	January 1 of PY	April 1 of PY	July 1 of PY	October 1 of PY
CA[1] prior to PY	Check eligibility	If not eligible for Jan 1, re-check	If not eligible for Apr 1, re-check	If not eligible for July 1, re-check
VA[2] prior to PY	Check eligibility	If not eligible for Jan 1, re-check	If not eligible for Apr 1, re-check	If not eligible for July 1, re-check
VA for April 1[3]		Check eligibility	If not eligible for Apr 1, re-check	If not eligible for July 1, re-check
VA for July 1[3]			Check eligibility	If not eligible for July 1, re-check
VA for October 1[3]				Check eligibility

[1] CA = Claims-Aligned
[2] VA = Voluntarily Aligned
[3] Prospective Plus Alignment

For each quarterly eligibility check, CMS uses the most recent period (updated quarterly) of claims history available at that time, limiting run-out to the extent possible. To generate risk scores for the eligibility criteria listed above, diagnoses from the most recent 12-month period are run through both the prospective CMS-HCC risk adjustment model and the concurrent CMMI-HCC risk adjustment model, and a beneficiary will be considered eligible if they meet the requirements with either risk score. This allows us to identify High Needs beneficiaries who are both chronically ill and more acutely ill. This 12-month period is also used to check for claims-based eligibility criteria like mobility and unplanned hospitalizations (see Table B.5.2). The most recent 60 month period will be used for the frailty claims-based eligibility criteria, in recognition that DME equipment does not need to be replace annually (see table B.5.3).

Table B.5.2 Clinical Measurement Periods to Determine High Needs Eligibility (all eligibility criteria except Frailty)

Lookback Period for Data to Determine High Needs Eligibility				
Effective date	**January 1 of PY**	**April 1 of PY**	**July 1 of PY**	**October 1 of PY**
PY2021 (Apr–Dec 2021)	N/A	12/1/19 – 11/30/20 OR 2/1/20 – 1/31/21	5/1/20 – 4/30/21	8/1/20 – 7/31/21
PY2022 (CY2022)	11/1/20 – 10/31/21	2/1/21 – 1/31/22	5/1/21 – 4/30/22	8/1/21 – 7/31/22
PY2023 (CY2023)	11/1/21 – 10/31/22	2/1/22 – 1/31/23	5/1/22 – 4/30/23	8/1/22 – 7/31/23
PY2024 (CY2024)	11/1/22 – 10/31/23	2/1/23 – 1/31/24	5/1/23 – 4/30/24	8/1/23 – 7/31/24
PY2025 (CY2025)	11/1/23 – 10/31/24	2/1/24 – 1/31/25	5/1/24 – 4/30/25	8/1/24 – 7/31/25
PY2026 (CY2026)	11/1/24 – 10/31/25	2/1/25 – 1/31/26	5/1/25 – 4/30/26	8/1/25 – 7/31/26

Table B.5.3 Clinical Measurement Periods to Determine High Needs Eligibility (Frailty only)

Lookback Period for Data to Determine High Needs Eligibility				
Effective date	**January 1 of PY**	**April 1 of PY**	**July 1 of PY**	**October 1 of PY**
PY2022 (CY2022)	11/1/16 – 10/31/21	2/1/17 – 1/31/22	5/1/17 – 4/30/22	8/1/17 – 7/31/22
PY2023 (CY2023)	11/1/17 – 10/31/22	2/1/18 – 1/31/23	5/1/18 – 4/30/23	8/1/18 – 7/31/23
PY2024 (CY2024)	11/1/18 – 10/31/23	2/1/19 – 1/31/24	5/1/19 – 4/30/24	8/1/19 – 7/31/24
PY2025 (CY2025)	11/1/19 – 10/31/24	2/1/20 – 1/31/25	5/1/20 – 4/30/25	8/1/20 – 7/31/25
PY2026 (CY2026)	11/1/20 – 10/31/25	2/1/21 – 1/31/26	5/1/21 – 4/30/26	8/1/21 – 7/31/26

B.6 Reference Tables

Table B.6.1. Mobility Impairment ICD-10 Codes for High Needs Population DCEs

The following diagnoses for mobility-related conditions are drawn primarily from the list of Other Chronic or Potentially Disabling Conditions in the CMS Chronic Condition Data Warehouse. Per the Chronic Condition Data Warehouse guidelines, one inpatient claim (claim type 60) with a diagnosis from B.6.1 will be sufficient for meeting High Needs Population DCE eligibility, or two claims with diagnoses from B.6.1 with different dates of services for any other claim types.

Cerebral Palsy

G80.0, G80.1, G80.2, G80.3, G80.4, G80.8, G80.9

Cystic Fibrosis and Other Metabolic Developmental Disorders

D81.810, D84.1, E00.0, E00.1, E00.2, E00.9, E03.0, E03.1, E25.0, E25.8, E25.9, E56.9, E70.0, E70.1, E70.20, E70.21, E70.29, E70.30, E70.310, E70.311, E70.318, E70.319, E70.320, E70.321, E70.328, E70.329, E70.330, E70.331, E70.338, E70.339, E70.39, E70.5, E70.8, E70.81, E70.89, E70.9, E71.0, E71.110, E71.111, E71.118, E71.19, E71.2, E71.310, E71.311, E71.312, E71.313, E71.314, E71.318, E71.32, E71.41, E72.10, E72.11, E72.12, E72.19, E72.20, E72.21, E72.22, E72.23, E72.29, E72.3, E72.4, E72.50, E72.51, E72.59, E72.8, E74.20, E74.21, E74.29, E74.810, E74.818, E74.819, E74.89, E84.0, E84.11, E84.19, E84.8, E84.9

Mobility Impairments

G04.1, G11.4, G81.00, G81.01, G81.02, G81.03, G81.04, G81.10, G81.11, G81.12, G81.13, G81.14, G81.90, G81.91, G81.92, G81.93, G81.94, G82.20, G82.21, G82.22, G82.50, G82.51, G82.52, G82.53, G82.54, G83.0, G83.10, G83.11, G83.12, G83.13, G83.14, G83.20, G83.21, G83.22, G83.23, G83.24, G83.30, G83.31, G83.32, G83.33, G83.34, G83.4, G83.5, G83.81, G83.82, G83.83, G83.84, G83.89, G83.9, I69.031, I69.032, I69.033, I69.034, I69.039, I69.041, I69.042, I69.043, I69.044, I69.049, I69.051, I69.052, I69.053, I69.054, I69.059, I69.061, I69.062, I69.063, I69.064, I69.065, I69.069, I69.131, I69.132, I69.133, I69.134, I69.139, I69.141, I69.142, I69.143, I69.144, I69.149, I69.151, I69.152, I69.153, I69.154, I69.159, I69.161, I69.162, I69.163, I69.164, I69.165, I69.169, I69.231, I69.232, I69.233, I69.234, I69.239, I69.241, I69.242, I69.243, I69.244, I69.249, I69.251, I69.252, I69.253, I69.254, I69.259, I69.261, I69.262, I69.263, I69.264, I69.265, I69.269, I69.331, I69.332, I69.333,

I69.334, I69.339, I69.341, I69.342, I69.343, I69.344, I69.349, I69.351, I69.352, I69.353, I69.354, I69.359, I69.361, I69.362, I69.363, I69.364, I69.365, I69.369, I69.831, I69.832, I69.833, I69.834, I69.839, I69.841, I69.842, I69.843, I69.844, I69.849, I69.851, I69.852, I69.853, I69.854, I69.859, I69.861, I69.862, I69.863, I69.864, I69.865, I69.869, I69.931, I69.932, I69.933, I69.934, I69.939, I69.941, I69.942, I69.943, I69.944, I69.949, I69.951, I69.952, I69.953, I69.954, I69.959, I69.961, I69.962, I69.963, I69.964, I69.965, I69.969

Multiple Sclerosis and Transverse Myeliti

G35, G36.0, G36.1, G36.8, G36.9, G37.1, G37.2, G37.3, G37.4, G37.8, G37.9

Muscular Dystrophy

G71.0, G71.00, G71.01, G71.02, G71.09, G71.11, G71.2, G71.20, G71.21, G71.220, G71.228, G27.29

Spina Bifida and other Congenital Anomalies of the Nervous System

G90.1, Q00.0, Q00.1, Q00.2, Q01.0, Q01.1, Q01.2, Q01.8, Q01.9, Q02, Q03.0, Q03.1, Q03.8, Q03.9, Q04.0, Q04.1, Q04.2, Q04.3, Q04.4, Q04.5, Q04.6, Q04.8, Q04.9, Q05.0, Q05.1, Q05.2, Q05.3, Q05.4, Q05.5, Q05.6, Q05.7, Q05.8, Q05.9, Q06.0, Q06.1, Q06.2, Q06.3, Q06.4, Q06.8, Q06.9, Q07.00, Q07.01, Q07.02, Q07.03, Q07.8, Q07.9

Spinal Cord Injury

G96.11, S12.000A, S12.001A, S12.100A, S12.101A, S12.200A, S12.201A, S12.300A, S12.301A, S12.400A, S12.401A, S12.500A, S12.501A, S12.600A, S12.601A, S12.9XXA, S12.000B, S12.001B, S12.100B, S12.101B, S12.200B, S12.201B, S12.300B, S12.301B, S12.400B, S12.401B, S12.500B, S12.501B, S12.600B, S12.601B, S14.0XXA, S14.0XXS, S14.101A, S14.102A, S14.103A, S14.104A, S14.105A, S14.106A, S14.107A, S14.108A, S14.109A, S14.111A, S14.112A, S13.113A, S14.114A, S14.115A, S14.116A, S14.117A, S14.118A, S14.119A, S14.121A, S14.122A, S14.123A, S14.124A, S14.125A, S14.126A, S14.127A, S14.128A, S14.129A ,S14.131A, S14.132A, S14.133A, S14.134A, S14.135A, S14.136A, S14.137A, S14.138A, S14.139A, S14.141A, S14.142A, S14.143A, S14.144A, S14.145A, S14.146A, S14.147A, S14.148A, S14.149A, S14.151A, S14.152A, S14.153A, S14.154A, S14.155A, S14.156A, S14.157A, S14.158A, S14.159A, S14.101S, S14.102S, S14.103S, S14.104S, S14.105S, S14.106S, S14.107S, S14.108S, S14.109S, S14.111S, S14.112S, S14.113S, S14.114S, S14.115S, S14.116S, S14.117S, S14.118S, S14.119S, S14.121S, S14.122S, S14.123S, S14.124S, S14.125S, S14.126S, S14.127S, S14.128S, S14.129S, S14.131S, S14.132S, S14.133S, S14.134S, S14.135S, S14.136S, S14.137S, S14.138S, S14.139S, S14.141S, S14.142S, S14.143S, S14.144S, S14.145S, S14.146S, S14.147S, S14.148S, S14.149S, S14.151S, S14.152S, S14.153S, S14.154S, S14.155S, S14.156S, S14.157S, S14.158S, S14.159S, S22.009A, S22.019A, S22.029A, S22.039A, S22.049A, S22.059A, S22.069A, S22.079A, S22.089A, S22.009B, S22.019B, S22.029B, S22.039B, S22.049B, S22.059B, S22.069B, S22.079B, S22.089B, S24.0XXA, S24.101A, S24.102A, S24.103A, S24.104A, S24.109A, S24.111A, S24.112A, S24.113A, S24.114A, S24.119A, S24.131A, S24.132A, S24.133A, S24.134A, S24.139A, S24.141A, S24.142A, S24.143A, S24.144A, S24.149A, S24.151A, S24.152A, S24.153A, S24.154A, S24.159A, S24.0XXS, S24.101S, S24.102S, S24.103S, S24.104S, S24.109S, S24.111S, S24.112S, S24.113S, S24.114S, S24.119S, S24.131S, S24.132S, S24.133S, S24.134S, S24.139S, S24.141S, S24.142S, S24.143S, S24.144S, S24.149S, S24.151S, S24.152S, S24.153S, S24.154S, S24.159S, S32.009A, S32.019A, S32.029A, S32.039A, S32.049A, S32.059A, S32.009B, S32.019B, S32.029B, S32.039B, S32.049B, S32.059B, S32.10XA, S32.2XXA, S32.10XB, S32.2XXB, S34.01XA, S34.02XA, S34.101A, S34.102A, S34.103A, S34.104A, S34.105A, S34.109A, S34.111A, S34.112A, S34.113A, S34.114A, S34.115A, S34.119A, S34.121A, S34.122A, S34.123A,

S34.124A, S34.125A, S34.129A, S34.131A, S34.132A, S34.139A, S34.3XXA, S34.01XS, S34.02XS, S34.101S, S34.102S, S34.103S, S34.104S, S34.105S, S34.109S, S34.111S, S34.112S, S34.113S, S34.114S, S34.115S, S34.119S, S34.121S, S34.122S, S34.123S, S34.124S, S34.125S, S34.129S, S34.131S, S34.132S, S34.139S

Functional Quadriplegia

R53.2

Heart Failure

I50.84

Alpers Disease

G31.81

Pressure Ulcers

L89.013, L89.014, L89.022, L89.023, L89.103, L89.104, L89.113, L89.114, L89.123, L89.124, L89.133, L89.134, L89.143, L89.144, L89.153, L89.154, L89.203, L89.204, L89.213, L89.214, L89.223, L89.224, L89.303, L89.304, L89.313, L89.314, L89.323, L89.324, L89.43, L89.44, L89.503, L89.504, L89.513, L89.514, L89.523, L89.524, L89.603, L89.604, L89.613, L89.614, L89.623, L89.624, L89.813, L89.814, L89.893, L89.894

Ventilator Dependence

Z99.11

Table B.6.2. Frailty codes used to Determine Eligibility for Alignment to a High Needs Population DCE

Transfer equipment	
E0172	Seat lift mechanism placed over or on top of toilet, any type
E0621	Sling or seat, patient lift, canvas or nylon
E0625	Patient lift, bathroom or toilet, not otherwise classified
E0627	Seat lift mechanism, electric, any type
E0628	Separate seat lift mechanism for use with patient owned furniture-electric
E0629	Seat lift mechanism, non-electric, any type
E0630	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s)
E0635	Patient lift, electric with seat or sling
E0636	Multi-positional patient support system, with integrated lift, patient accessible controls
E0637	Combination sit to stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels
E0638	Standing frame/table system, one position (e.g., upright, supine, or prone stander), any size including pediatric, with or without wheels
E0639	Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories
E0640	Patient lift, fixed system, includes all components/accessories
E0641	Standing frame/table system, multi-position (e.g., three-way stander), any size including pediatric, with or without wheels
E0642	Standing frame/table system, mobile (dynamic stander), any size including pediatric

E0700	Safety equipment, device or accessory, any type
E0705	Transfer device, any type, each
E0710	Restraints, any type (body, chest, wrist, or ankle)
E0910	Trapeze bars, aka patient helper, attached to bed, with grab bar
E0911	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar
E0912	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar
E0940	Trapeze bar, free standing, complete with grab bar
E1035	Multi-positional patient transfer system, with integrated seat, operated by care giver, patient weight capacity up to and including 300 lbs
E1036	Multi-positional patient transfer system, extra-wide, with integrated seat, operated by caregiver, patient weight capacity greater than 300 lbs
Hospital Bed	
E0194	Air fluidized bed
E0250	Hospital bed, fixed height, with any type side rails, with mattress
E0251	Hospital bed, fixed height, with any type side rails, without mattress
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress
E0256	Hospital bed, variable height, hi-lo, with any type side rails, without mattress
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress
E0261	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress
E0265	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress
E0266	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress
E0270	Hospital bed, institutional type includes oscillating, circulating and stryker frame, with mattress
E0271	Mattress, innerspring
E0272	Mattress, foam rubber
E0273	Bed board
E0274	Over-bed table
E0277	Powered pressure-reducing air mattress
E0280	Bed cradle, any type
E0290	Hospital bed, fixed height, without side rails, with mattress
E0291	Hospital bed, fixed height, without side rails, without mattress
E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress
E0296	Hospital bed, total electric (head, foot and height adjustments), without side rails, with mattress
E0297	Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress

E0301	Hospital bed, heavy duty, extra-wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress
E0302	Hospital bed, extra heavy duty, extra-wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress
E0303	Hospital bed, heavy duty, extra-wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress
E0304	Hospital bed, extra heavy duty, extra-wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress
E0305	Bed side rails, half length
E0310	Bed side rails, full length
E0315	Bed accessory: board, table, or support device, any type
E0316	Safety enclosure frame/canopy for use with hospital bed, any type
E0370	Air pressure elevator for heel
E0371	Nonpowered advanced pressure-reducing overlay for mattress, standard mattress length and width
E0372	Powered air overlay for mattress, standard mattress length and width
E0373	Nonpowered advanced pressure-reducing mattress
E0462	Rocking bed with or without side rails

Table B.6.3: Evaluation & Management Services

Administration of HRA	
96160	Administration of patient-focused health risk assessment instrument
96161	Administration of caregiver-focused health risk assessment instrument
Office or Other Outpatient Visit for New Patient	
99201	New Patient, brief
99202	New Patient, limited
99203	New Patient, moderate
99204	New Patient, comprehensive
99205	New Patient, extensive
Office or Other Outpatient Visit for Established Patient	
99211	Established Patient, brief
99212	Established Patient, limited
99213	Established Patient, moderate
99214	Established Patient, comprehensive
99215	Established Patient, extensive
Professional Services Provided in a Non-Skilled Nursing Facility (where LINE.CLM_POS_CD does not equal 31)[1]	

99304	Initial Nursing Facility Care
99305	Initial Nursing Facility Care
99306	Initial Nursing Facility Care
99307	Subsequent Nursing Facility Care
99308	Subsequent Nursing Facility Care
99309	Subsequent Nursing Facility Care
99310	Subsequent Nursing Facility Care
99311	Subsequent Nursing Facility Care
99312	Subsequent Nursing Facility Care
99313	Subsequent Nursing Facility Care
99314	Subsequent Nursing Facility Care
99315	Nursing Facility Discharge Services
99316	Nursing Facility Discharge Services
99317	Nursing Facility Discharge Services
99318	Other Nursing Facility Care
Domiciliary, Rest Home, or Custodial Care Services	
99324	New Patient, brief
99325	New Patient, limited
99326	New Patient, moderate
99327	New Patient, comprehensive
99328	New Patient, extensive
99334	Established Patient, brief
99335	Established Patient, moderate
99336	Established Patient, comprehensive
99337	Established Patient, extensive
Domiciliary, Rest Home, or Home Care Plan Oversight Services	
99339	Brief
99340	Comprehensive
Home Services	
99341	New Patient, brief
99342	New Patient, limited

99343	New Patient, moderate
99344	New Patient, comprehensive
99345	New Patient, extensive
99347	Established Patient, brief
99348	Established Patient, moderate
99349	Established Patient, comprehensive
99350	Established Patient, extensive
Telephone Visits – Online Digital or Audio Only	
99421	Online digital, Established Patient, 5–10 mins
99422	Online digital, Established Patient, 10–20 mins
99423	Online digital, Established Patient, 21+ mins
99441	Phone, Established Patient, 5–10 mins
99442	Phone, Established Patient, 10–20 mins
99443	Phone, Established Patient, 21+ mins
Cognitive Assessment and Care Plan Services	
99483	Cognitive assessment and care plan services
Behavioral Health Integration (BHI) Services	
99484	Monthly services furnished using BHI models
99492	Initial psychiatric collaborative care management, first 70 mins
99493	Subsequent psychiatric collaborative care management, first 60 mins
99494	Initial or subsequent psychiatric collaborative care management, additional ’30 mins
G2214	Psychiatric collaborative care management
Care Management Home Visit	
G0076	Brief (20 minutes) care management home visit for a new patient.
G0077	Limited (30 minutes) care management home visit for a new patient.
G0078	Moderate (45 minutes) care management home visit for a new patient.
G0079	Comprehensive (60 minutes) care management home visit for a new patient.
G0080	Extensive (75 minutes) care management home visit for a new patient.
G0081	Brief (20 minutes) care management home visit for an existing patient.
G0082	Limited (30 minutes) care management home visit for an existing patient.
G0083	Moderate (45 minutes) care management home visit for an existing patient.

G0084	Comprehensive (60 minutes) care management home visit for an existing patient.
G0085	Extensive (75 minutes) care management home visit for an existing patient.
G0086	Limited (30 minutes) care management home care plan oversight.
G0087	Comprehensive (60 minutes) care management home care plan oversight.
Chronic Care Management (CCM) Services	
99437	Chronic care management services each additional 30 minutes by a physician or other qualified health care professional, per calendar month
99424	Principal care management services for a single high-risk disease first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
99425	Principal care management services for a single high-risk disease each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
99426	Principal care management services, for a single high-risk disease first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month
99427	Principal care management services, for a single high-risk disease each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99439	Non-complex chronic care management services, additional 30 min
99487	Extended care coordination time for especially complex patients (first 60 mins)
99489	Additional care coordination time for especially complex patients (30 mins)
99490	Comprehensive care plan establishment/implementations/revision/monitoring
99491	Chronic care monitoring service, moderate
G2064	Comprehensive care management, physician
G2065	Comprehensive care management, clinical staff
G0506	Additional work for the billing provider in face-to-face assessment or CCM planning
Wellness Visits	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit
Transitional Care Management Services	
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)
Depression and alcohol misuse	

G0442	Annual alcohol misuse screening
G0443	Annual alcohol misuse counseling
G0444	Annual depression screening
Professional Services Provided in ETA Hospitals	
G0463	Professional Services Provided in ETA Hospitals
Prolonged Care for Outpatient Visit	
99354	Prolonged visit, first hour
99355	Prolonged visit, additional 30 mins
G2212	Prolonged visit, additional 15 mins
Advance Care Planning (where LINE.CLM_POS_CD does not equal 21)	
99497	ACP first 30 mins (subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation)
99498	ACP additional 30 mins (subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation)
Virtual check-ins	
G2010	Remote evaluation, Established Patient
G2012	Brief communication technology-based service, 5-10 mins of medical discussion
G2252	Brief communication technology-based service, 11-20 minutes of medical discussion

[1] Note: per the proposed Medicare Shared Savings Program methodology, claims will be excluded from alignment if a beneficiary has a skilled nursing facility stay with overlapping dates of service.

Table B.6.4. Specialty Codes Used to Identify Primary Care Specialists

Code[1]	Specialty
1	General Practice
8	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Clinical Nurse Specialist
97	Physician Assistant

[1] The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at **https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf**

Table B.6.5. Specialty Codes Used to identify Selected Non-Primary Care Specialists

Code[1]	Specialty
6	Cardiology
10	Gastroenterology
12	Osteopathic manipulative medicine
13	Neurology
16	Obstetrics/gynecology
17	Hospice and palliative care
23	Sports medicine
25	Physical medicine and rehabilitation
26	Psychiatry
27	Geriatric psychiatry
29	Pulmonology
39	Nephrology
44	Infectious disease
46	Endocrinology
66	Rheumatology
70	Multispecialty clinic or group practice
79	Addiction medicine
82	Hematology
83	Hematology/oncology
84	Preventative medicine
90	Medical oncology
98	Gynecological/oncology
86	Neuropsychiatry

[1] The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at **https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf**

Table B.6.6. Initiatives for which Beneficiary Overlap with GPDC is Prohibited

Initiative
Independence at Home Demonstration
Kidney Care Choices Model
Medicare Shared Savings Program
Vermont All-Payer ACO Model
Primary Care First Model
Maryland Primary Care Program
Another GPDC DCE

Table B.6.7. Initiatives for which Provider Overlap with GPDC is Prohibited

Initiative	DC Participant Provider Overlap	Preferred Provider Overlap
Independence at Home Demonstration	Prohibited	Allowed
Kidney Care Choices Model	Prohibited	Allowed
Medicare Shared Savings Program	Prohibited	Allowed
Vermont All-Payer ACO Model	Prohibited	Allowed
Primary Care First Model	Prohibited	Allowed
Maryland Primary Care Program	Prohibited	Prohibited
Another GPDC DCE	Prohibited	Allowed