Direct Contracting Model (Global and Professional) – Performance Year 1 Application

Frequently Asked Questions

Contents

Overview

This FAQ document addresses common questions associated with the application question content. The document also provides additional details regarding what applicants should enter for certain Direct Contracting Entity (DCE) Types – such as High Needs DCEs. For additional questions regarding how to respond to the application questions, email the Direct Contracting Help Desk at DPC@cms.hhs.gov. For questions regarding technical aspects of the application, email CMMIForceSupport@cms.hhs.gov or call1-888-734-6433, option 5.

Eligibility

Q1. Who can participate?
A1. The Direct Contracting Model provides an opportunity for health care providers that have not previously been eligible for the Shared Savings Program, the Next Generation Accountable Care Organization (NGACO) Model, or both due to an insufficient number of assigned or aligned Medicare FFS beneficiaries. In addition, the Direct Contracting Model offers another model option for NGACO Model participants to consider after NGACO ends in 2020.

Q2. My practice or organization did not submit a letter of intent (LOI). Are we still able to apply?
A2. Submitting a LOI is an eligibility requirement. If one was not submitted prior to the December 12, 2019 deadline, you may not apply. When completing the Request for Applications (RFA), make sure to use the email address associated with your LOI.

Q3. Do DCEs need to be a Medicare-enrolled provider or supplier to participate?
A3. No, DCEs are not required to be a Medicare-enrolled provider or supplier. However, all DCE providers, DC Participant Providers, and Preferred Providers must be a Medicare-enrolled provider or supplier by no later than June 30, 2020 in order to participate in the model during the first performance year (PY1).

Q4. Can DCEs participate in another shared savings initiative during the Implementation Period (IP)?
A4. Participants in shared savings initiative – such as the Medicare Shared Savings Program or NGACO – can apply to participate in the Direct Contracting Model. During the IP, the entities may participate in these initiatives and the Direct Contracting Model.

Q5. Can DCEs simultaneously participate in any other CMMI payment models that offer shared savings during the PY?

A5. No, DCEs participating in the Professional or Global options and their DC Participant Providers cannot simultaneously participate in the Shared Savings Program, a model tested or expanded under section 1115A of the Social Security Act that involves shared savings, or any other Medicare initiative that involves shared savings during PY1.

Q6. Do DCEs need to be recognized as a legal entity in the state in which they are located?

A6: Yes, all applicants must provide a copy of a certificate of incorporation or other documentation demonstrating that they are recognized as a legal entity in the state in which they are located.

Q7. Can a third party submit an application on behalf of the organization interested in participating?

A7. No, the proposed DCE must apply for itself and should submit one single application. DCEs should apply under the tax identification number (TIN) assigned to the collective organization. If there are changes (such as a new TIN) between the submission of the LOI and application, be sure to note them in your application. CMS recognizes that details may change following the submission of the LOI. However, the entity will be held to the details provided in its model application.

Q8. How will geographic regions be defined?

A8. A DCE's service area is defined by the physical practice location of the DCE's. The DCE's service area consists of the Core Service Area (CSA) and the Extended Service Area. The CSA includes the counties in which the DCE's DC Participant Provider has physical office locations. The Extended Service Area includes the counties contiguous to the CSA. Based on the list of the DC Participant Providers submitted by the DCE during the application process, CMS will identify the DCE's service area for purposes of beneficiary alignment. The service area is distinct from the DCE's region, which includes all counties where DCE-aligned beneficiaries reside.

For DCEs that meet the definition of rural, and High Needs Population DCEs where the clinical model does not necessarily rely on a physical practice location, (i.e. through delivery of services in locations other than a provider office, such as beneficiaries' homes), applicants may propose an alternative for CMS's consideration to the county-by-county physical practice location standard and document their capability to operate in the proposed service area to include the provision of face-to-face care and interaction with beneficiaries.

Q9. How do I know which risk-sharing option is right for my organization?

A9. When selecting a model option, there are several factors to consider. Below is a brief comparison table of the level of risk-sharing, types of capitation, and discounts/withholds in Professional and Global. The RFA provides additional detail to help you figure out which model is appropriate for your organization. Additionally, please check the website for an upcoming webinar schedule.

	Policy	Professional	Global
1	Risk Arrangement	50% of savings/losses	100% of savings/losses
2	Capitation Option	Primary Care Capitation Only (set at 7% of the Total Cost of Care)	Both options available: Primary Care Capitation or Total Care Capitation
3	Discount and Quality Withhold	Fixed 5% Quality Withhold; No Discount	Fixed 5% Quality Withhold; Discount scales upward each year

Q10. Do all providers under one organization Tax Identification Number (TIN) need to participate or can providers participate in different models?

A10. No, the Direct Contracting Model is a partial TIN model and all providers under one organization TIN do not need to participate.

Application Timeline

Q11. When is the application due?

A11. The application period for the PY1 application is June 4th- July 6th The application is due by 11:59 PM ET on July 6th.

Q12. When will applicants be notified of offers to participate in the model?

A12. Applicants will be notified in September 2020.

Q13. How long does my organization have to accept our offer for participation in the model?

A13. The deadline to sign and return the participation agreement (PA) to CMS will likely be the end of March 2021. The exact deadline for the PA will be provided upon award.

Selection Process

Q14. What are the selection criteria?

A14. Applicants will be evaluated based on the quality of their organizational structure, leadership and management, financial plan and risk-sharing experience, patient centeredness and beneficiary engagement, and clinical care. For more information on Application Scoring and Selection, please reference Section XIV and Appendix D of the RFA.

Q15. How many applicants will be selected?

A15. Based on the quality and number of applications, CMMI will decide how many DCEs to select for award.

How to Apply

Q17. When will the 2022 PY application portal open?

A17. The application portal will open in early 2021.

Q18. What are the application components?

A18. The application will consist of the following sections: DCE organization profile and contact information, proposed leadership and management structure, financial experience and financial plan if selected for the DCE model, and patient centeredness and beneficiary engagement experience. It will also ask about the applicant's proposed clinical care model, including care coordination, health information technology (IT) capability, and clinical process improvement.

Q19. What information should I have before starting the application?

A19. Please reference the Application Scoring and Selection in Section XIV and Appendix D of the RFA to obtain all information on applying to the Direct Contracting Model as well as Appendix E for the list of questions in the application.

Q20. How do I know the status of my application?

A20. The status of your application can be found on the Salesforce portal.

Q21. Can multiple users access the same application?

A21. Only the Primary and Secondary contact information listed in the Direct Contracting LOI can access the Direct Contracting Model application. The Primary and Secondary Contacts must register to the Direct Contracting application using the same email address listed in the Direct Contracting LOI.

Q22. My information did not save – what should I do?

A22. You will need to re-enter the information. As a tip, we recommend applicants save hard copies of their application responses to their computer prior to submitting in the application portal to ensure not losing any important information.

Q23. Which browsers will the application work in?

A23. The Salesforce application platform is supported on Microsoft® Internet Explorer version 11 and later, Apple® Safari® versions 5.x, 6.x, and 7.x on Mac Operating System (OS) X, and on the most recent stable versions of Mozilla® Firefox® and Google Chrome™.

Q24. Where do I apply?

A24. Applicants may access the application portal at: https://app1.innovation.cms.gov/dcrfa/dcrfaLogin.

Q25. Am I able to make updates after submitting my organization's application?

A25. No, applicants may only make revisions to the application during the application period. Applicants will be unable to edit or revise their application after the deadline. This includes changing any provider information submitted in the Provider List Submission Tool (PLST) for proposed DC Participant Providers and Preferred Providers, as this is due with the submission of your application.

Q26. Who can I contact if I encounter technical issues?

A26. Your question may be answered in the DC RFA Portal User Manual found on the home page of the portal. If you are still having issues, please contact the CMMI Salesforce Help Desk at 1-888-734-6433, option 5, or email CMMIForceSupport@cms.hhs.gov. If you are using Internet Explorer, please make sure the browser you use is Internet Explorer 11 or higher before attempting to navigate through this site. Salesforce does not support prior versions of Internet Explorer.

Q27. Who can I contact if I encounter non-technical issues?

A27. For any non-technical questions about Direct Contracting, please contact the Direct Contracting Model Team at DPC@cms.hhs.gov.

Application Questions and Issues

A. Start New Application

Q28. What is the difference between Direct Contracting Professional and Global?

A28. These are the two different payment options that DCEs can participate in through the Direct Contracting Model. The RFA reviews the differences between these two options in detail.

Q29. What are the DCE Types?

A29. There are three Direct Contracting Entity (DCE) Types: Standard, New Entrant, and High Needs Population. They are defined in detail in the RFA.

B. Background Information

Q30. Can an entity applying to Direct Contracting also apply to the Medicare Shared Savings Program?

A30. Yes, an entity can apply to both Direct Contracting and Medicare Shared Savings Program, but the entity must select which program it plans to participate in by PY 1 (CY 2021). In the application, we ask whether you are planning to participate in the Medicare Shared Savings Program in PY1. If you are applying to both, please select "Yes, I confirm."

Q31. What information is required in the executive summary for High Needs Population DCE applicants?

A31. High Needs Population DCE applicants should include as much information as possible regarding their experience providing quality care to high needs populations – such as care management efforts, care coordination work, care plans, home visits, etc.

In the executive summary, High Needs Population DCE applicants should also indicate if there is a certain subset of patients within the high needs population that they plan to focus on during the model. When describing the subset of patients, the applicant should indicate how this subset of patients will be identified through claims (i.e. relevant codes associated with the subset).

C. Provider List Submission Template (PLST)

Q32. I am a DC Participant Provider, am I obligated to participate in the Capitation Payment Mechanism?

A32. Yes, DC Participant Providers are obligated to participate in whatever Capitation Payment Mechanism their DCE has selected. As a result, the DC Participant Providers will continue to bill claims as usual, but their FFS claim amounts will be reduced. If the DCE selected the Total Care Capitation, all of the DC Participant Providers' claims will be zeroed out. If the DCE selected the Primary Care Capitation, DC Participant Providers will have the choice to reduce FFS claims for primary care services by 0-100%.

Q33. I am a Preferred Provider, am I obligated to participate in the Capitation Payment Mechanism?

A33. No, Preferred Providers have the option of participating in the Capitation Payment Mechanism, but not the obligation to do so. Furthermore, Preferred Providers have additional flexibility regarding the amount of claims reduction they must accept. Whereas DC Participant Providers must accept 100% FFS claims reduction in Total Care Capitation, Preferred Providers can elect to reduce claims by 1 to 100% or not to reduce claims altogether. For Primary Care Capitation, Preferred Providers will also be able to elect whether to reduce claims altogether.

Q34. Can we add multiple files via the PLST in the application portal?

A34. No, you may not upload separate files via the PLST template in the application portal. In order to include additional information, you can merge files prior to uploading them.

Q35. What is a Legacy TIN or CCN provider?

A35. The purpose of a Legacy TIN or CCN is to align beneficiaries for which a proposed DC Participant Provider was billing for primary care services during the 2-year alignment period but will not be using this TIN for primary care services during PY1. A Legacy TIN or CCN provider should not be submitted for Preferred Providers as they are not included in alignment.

Q36. Are Legacy TIN or CCNs optional?

A36.Legacy TIN or CCNs are optional for Standard, and High Needs DCEs but are required for New Entrant DCEs.

Q37. Can Preferred Providers have Legacy TIN or CCNs?

A37. No, only DC Participant Providers may be submitted as Legacy TIN or CCN records, as Preferred Providers are not used for alignment purposes.

Q38. How do we submit Legacy TIN or CCN records in the PLST?

A38. To submit a Legacy TIN or CCN, select "Participant" in the Provider Class column, as well as "Y" in the Legacy TIN column, and complete the remaining information for the provider record. All non-Legacy TIN provider records should be submitted as "N" in the Legacy TIN column. Please remember to submit a Legacy TIN Acknowledgement Form if you are submitting Legacy TIN provider records! If you are submitting a legacy TIN on behalf of multiple providers on your proposed, PY1 DC Participant Provider list who billed under the same legacy TIN, you should populate one Legacy TIN Acknowledgment Form with the names and individual NPIs of each of those providers for signature by an authorized or delegated official from that legacy TIN. You do not need to submit a separate form for each provider under the same legacy TIN.

Q39. What is the alignment period for Legacy TIN or CCN providers?

A39. The 2-year alignment period for the PY1 (calendar year (CY) 2021) is 7/1/2018-6/30/2020.

Q40. How can we add Core Service Areas (CSAs) to our proposed DC Participant Provider List?

A40. In the "CSA" worksheet of the PLST, mark "CSA" using the dropdown arrow for each corresponding county in the state the DCE practices. Please make sure that this worksheet is completed at the time the PLST is uploaded to the Application portal.

Q41. Can I revise/update/change provider identifiers after the submission of our proposed DC Participant Provider List or Preferred Provider List?

A41. Yes, your proposed DC Participant Provider and Preferred Provider Lists can be updated or revised for PY1 after it is submitted with your application. There will be notification when the DCE may update their list, the deadline will be in late September.

Q42. What do I need to do if my DC Participant Provider bills under multiple TINs?

*A42. You will need to add a record (or line) for each TIN that the individual provider bills under when submitting your proposed DC Participant Provider List. (See "**Example 1**" below.)*

***Example 1**: MD Margot Jones works for two primary care practices, a rural health clinic, and in a hospital emergency department. Her individual National Provider Identifier (iNPI) is 098765432*

1. *Primary Practice of Baltimore, TIN 1234567890*
2. *Ellicott City Family Medicine, TIN 2345678901*
3. *Baltimore County Rural Health Clinic, TIN 3456789012, organization National Provider Identifier (oNPI) 987654321, CMS Certification Number (CCN) 123456*
4. *Ellicott City Hospital, TIN 4567890123, oNPI 876543210, CCN 234567*

To add this individual to the DC Participant Provider List, you would make four entries in the template.

Entry	Name	TIN	iNPI	oNPI	CCN
1.	Margot Jones	1234567890	098765432		
2.	Margot Jones	2345678901	098765432		
3.	Margot Jones	3456789012	098765432	987654321	123456
4.	Margot Jones	4567890123	098765432		

*In entries 1, 2, and 4, Dr. Jones is enrolling as an **individual practitioner**. Therefore, you should enter the organization, RHC, and hospital TINs, and her iNPI. In entry 3, she is enrolling as an **individual practitioner at a Federally Qualified Health Center (FQHC)/Critical Access Hospital (CAH[2])/Rural Health Clinic (RHC)**. Therefore, you should enter the organization TIN, CCN, oNPI, and iNPI.*

Q43. How should we submit group practices with multiple doctors? What if a doctor within a group decides not to become a DC Participant Provider?

*A43. You should submit all doctors who have chosen to join using their iNPIs. (See "**Example 2**" below).*

***Example 2**: Wiregrass Group Medicine, TIN 1234567890, oNPI 987654321, has four doctors. One of the doctors chooses not to become a DC Participant Provider. Each of the three doctors that have chosen to participate should be entered as individual practitioners, with their iNPIs.*

Entry	Name	TIN	iNPI	oNPI	CCN
1.	Lincoln Martin	1234567890	123456789		
2.	Abby Brown	1234567890	234567890		
3.	James Hamilton	1234567890	345678912		

Q44. How should we enter the identifiers for a practitioner that works in multiple hospital departments? When should an oNPI be used for an individual practitioner?

*A44. Only the hospital TIN and the iNPI is needed in this case. **An oNPI should only be used for an individual practitioner that works at a FQHC, RHC, or CAH 2.** (See "**Example 3**" below.)*

***Example 3**: Marcus Rao, MD, iNPI 876543210, works part time at Ellicott City Hospital, TIN 4567890123. He works in the emergency department and in the cancer center, each of which bills under a different oNPI. The ED oNPI is 567890123 and the cancer center oNPI is 678901234. Dr. Rao assigns his Medicare payments to the hospital. In this example, Dr. Rao is an individual practitioner, and you should enter the hospital TIN and his iNPI. The oNPI is a*

prohibited entry for individual practitioners and is not needed, even though the hospital uses oNPIs in its internal accounting.

Entry	Name	TIN	iNPI	oNPI	CCN
1.	Marcus Rao	4567890123	876543210		

Q45. How do we submit Preferred Providers?

A45. To submit a Preferred Provider, select "Preferred" in the Provider Class column and complete the remaining information for the provider record.

Q46. What happens to a provider when they are overlapping between two DCEs?

A46. DC Participant Providers, defined by their TIN/NPI, may only be on one DCE's Participant Provider List. Please work with your proposed DC Participant Providers to ensure they will not be on another DCE's Participant Provider List, as overlaps will result in rejection from both DCE's Participant Provider Lists. DC Participant Providers may be on the Provider List of another DCE if a unique and different TIN is being used for that DCE. Preferred Providers may be on multiple DCE Provider lists.

Q47. When will the results of the Center for Program Integrity (CPI) integrity and overlap results for our proposed DC Participant Providers be available?

A47. CPI integrity and overlap results will be made available late Summer, early Fall.

Q48. If a provider does not pass the program integrity check, will they automatically be removed from my final DC Participant Provider List?

A48. Yes, but they will have the opportunity to be resubmitted with your updated PY1 list due in early Fall.

Q49. If a provider does not wish to participate during the IP, will they have the opportunity to enroll as a DC Participant Provider or Preferred Provider in future years?

A49. Yes, if a provider opts to not be included on your proposed DC Participant Provider and/or Preferred Provider Lists in the IP, they may be submitted in future PYs.

Q50. Do you have an estimated time for when we might get the preliminary alignment list?

A50. The Initial Alignment Report that contains aligned beneficiaries will become available once the DCE has signed and returned the PY1 PA.

D. Provider Notification Attestation Form

Q51. What is the purpose of the provider notification attestation form?

A51. This form indicates to CMS that the applicant has made providers aware of the model and their role in participating in the model if the applicant is selected to become a DCE.

E. Paper-Based Voluntary Alignment

Q52. If our DCE decides not to submit an outreach strategy or participate in the paper-based voluntary alignment, can our DC Participant Provider still direct beneficiaries to MyMedicare.gov (also known as electronic voluntary alignment)?

A52. Yes, participation in paper-based voluntary alignment is optional. However, electronic voluntary alignment will be used for all DCEs annually, prior to the start of the PY when they select Prospective Alignment. When a DCE elects Prospective Plus Alignment, electronic voluntary alignment will be used quarterly.

Q53. Is voluntary alignment available throughout the model or only during the IP?

A53. Yes, voluntary alignment will be available during all years of the model. The DCE can elect to change their alignment selection from Prospective Alignment or Prospective Plus Alignment Plus prior to the start of each PY. For DCEs that choose Prospective Alignment, voluntary alignment (paper-based and electronic voluntary alignment) will only be available prior to the start of each PY. For DCEs that choose Prospective Plus Alignment, voluntary alignment (paper-based and electronic voluntary alignment) will be collected quarterly.

Q54. If a beneficiary was previously aligned to the DCE while it was participating in another Medicare Shared Savings initiative with voluntary alignment, does the beneficiary need to reconfirm their alignment using the paper-based voluntary alignment or electronic voluntary alignment (MyMedicare.gov)?

A54. Prior voluntary alignment using electronic voluntary alignment will carry over. Prior alignment using paper-based voluntary alignment does not carry over.

Q55. When should the DCE select between Prospective Alignment and Prospective Plus Alignment? How does it make this selection?

A55. The DCE will elect its choice of alignment in the application portal.

Q56. Is a DCE able to change its selection from Prospective Alignment to Prospective Plus alignment?

A56. Yes, the DCE can elect to change their alignment selection prior to the start of each PY.

F. Leadership and Management

Q57. What contractual and employment relationships should be provided?

A57. CMS is interested in any contractual and employment relationships focused on the provision of health-related services to patients. This includes, but is not limited to, relationships with providers and suppliers, health care technology organizations, care coordination organizations, and more. CMS is interested in relationships with any health-related entities that will work with you to improve quality of care and reduce costs for beneficiaries during the model.

G. Financial Experience

Q58. Is any additional information required for High Needs Population DCE applicants regarding their history of collaboration with stakeholders?

A58. Yes, High Needs Population DCE applicants should provide information regarding their unique collaborations with organizations that address the various needs of high needs populations. If the applicant plans to focus on a certain subgroup of high needs beneficiaries, the applicant should discuss the collaborations that provide unique support to those groups of beneficiaries.

Q59. Is any additional information required for High Needs Population DCE applicants regarding how they intend to fund ongoing DCE activity to support the aim of better health, better care, and lower per capita costs?

A59. Yes, High Needs Population DCE applicants should discuss unique strategies they have in place to improve health care quality, improve outcomes, and reduce costs for high needs populations. If the applicant is focusing on a certain subset of high needs beneficiaries, strategies well aligned with the needs of that group should be discussed.

Q61. What stipulations does CMS place on DCEs concerning use of Capitation Payments?

A61. CMS intends to give DCEs flexibility in terms of their use of the Capitation Payment Mechanism, subject to all applicable laws. DCEs can use the Capitation payments to reimburse their providers and invest in technology and resources to support population health. DCEs are not obligated to use the Capitation Payments to pay providers 100% FFS and can enter into value-based arrangements with their providers if they choose.

Q62. Are DCEs obligated to pursue a Capitation Payment Mechanism?

A62. All DCEs are obligated to select a Capitation Payment Mechanism. DCEs that elect the Professional option must select the Primary Care Capitation. DCEs that elect the Global option can choose between Primary Care Capitation and Total Care Capitation.

Q63. What is the difference between the Advanced Payment and Capitation Payment Mechanisms?

A63. The table below compares the Advanced Payment and Capitated Payment Mechanisms. Advanced Payments are an advance on the FFS claims payments, estimated based on utilization of DC Participant Providers and Preferred Providers. The amount of the Advanced Payment will be reconciled against the actual claims submitted by the providers during Final Financial Reconciliation. Conversely, the Capitated Payment Mechanisms are not reconciled against the actual claims submitted by the providers.

	Capitation Payment Mechanism	**Advanced Payment**
Who receives the payment from CMS?	The DCE	The DCE
Mandatory for the DCE?	Yes	No
Mandatory for DC Participant Providers?	Yes	No – DC Participant Providers have the option to participate
Mandatory for Preferred Providers?	No – Preferred Providers have the option to participate	No – Preferred Providers have the option to participate
What Claims are Suitable for Reduction?	For DCEs doing Total Care Capitation: all Medicare claims For DCEs doing Primary Care Capitation: primary care claims only	For DCEs doing Total Care Capitation: none For DCEs doing Primary Care Capitation: non – primary care claims only
Reconciled Against Billed Claim Amount?	No	Yes

Q64. Are DCEs obligated to participate in Advanced Payment?

A64. No, Advanced Payment is an optional feature of Direct Contracting that is available with the selection of Primary Care Capitation. Both DC Participant Providers and Preferred Providers have the option but not the obligation to participate in Advanced Payment.

Q65. Are DC Participant and Preferred Providers required to participate in Advanced Payment?

A65. No. For DCEs that select Primary Care Capitation, DC Participant Providers and Preferred providers both have the option to choose to participate in Advanced Payment and reduce their claims.

Q66. Who receives the Advanced Payment?

A66. Similar to the Capitated Payment Mechanisms, CMS pays the DCE the Advanced Payment amount monthly. The DCE in turn pays its DC Participant Providers and Preferred Providers based on their negotiated payment arrangement.

Q67. What expenditures count towards Shared Savings/Shared Losses?

A67. Medicare expenditures associated with services delivered to aligned beneficiaries count towards the calculation of Shared Savings / Shared Losses. This includes the capitated payments and any Advanced Payment paid by CMS to the DCE as well as the FFS claims paid by CMS directly for the services provided to aligned beneficiaries. The sum total of these payments is compared against the DCE's Performance Year Benchmark to determine the Shared Savings/Shared Losses.

H. Patient Centeredness and Beneficiary Engagement

Q68. Regarding the approach to beneficiary outreach, is any additional information required for High Needs Population DCE applicants?

A68. Yes, High Needs Population DCE applicants should discuss strategy approaches to overcoming barriers that exist when engaging in outreach focused on high needs beneficiaries. For applicants focused on certain subgroups of high needs beneficiaries, any tailored strategies for outreach to this group should be provided along with the applicant's successes/challenges with these outreach approaches.

Q69. Regarding the assessment of beneficiary satisfaction, is additional information required for High Needs Population DCE applicants?

A69. Yes, CMS would like to know more about the applicant's experience assessing the beneficiary satisfaction of high needs populations. The applicant should discuss any survey instruments or other assessment tools that have been useful, approaches to reaching high risk populations in order to gather data on satisfaction, and approaches to overcoming communication barriers. For applicants focused on certain subgroups of high needs populations, any unique strategies for these subgroups should be discussed in detail.

Appendix

A. Paper-Based Voluntary Alignment Instructions

Voluntary alignment is the process by which beneficiaries can select to align to your DCE for the upcoming PY. This choice by a beneficiary overrides claims-based alignment in Direct Contracting as long as the beneficiary satisfies eligibility criteria. This is an elective process and your DCE does not have to participate. Direct Contracting allows entities to implement both paper-based and electronic voluntary alignment, if they so choose.

If your DCE would like to participate in paper-based voluntary alignment during PY1, the steps and timeline are as follows:

Before the Application Deadline - Submit a description of how your DCE will conduct its voluntary alignment activities during PY1, including your proposed criteria for determining which beneficiaries will receive targeted outreach ("outreach strategy"), as well as any changes to the Voluntary Alignment template letter for CMS approval via the application portal, following the rules below.

a. The DCE shall submit a document to CMS, describing how it will conduct its paper-based voluntary alignment activities during PY1 in which the DCE has selected to participate in paper-based voluntary alignment, including the criteria for determining which beneficiaries will receive targeted outreach.
b. The DCE shall make no changes to the Voluntary Alignment template letter provided by CMS, with the exception of changes made solely for the insertion of the following information where indicated: 1. The name of the DC Participant Provider that the DCE believes may be the beneficiary's main doctor, main provider, and/or the main place the beneficiary receives care; 2. The logo of the DCE or DC Participant Provider; 3. Instructions for how the beneficiary can submit the Voluntary Alignment Form to the DCE.
c. The DCE shall make no changes to the Voluntary Alignment template letter where CMS has indicated content that the DCE cannot amend or remove. The DCE may otherwise make changes, subject to the DCE obtaining CMS approval of the final Letter content including: 1. Formatting for electronic distribution; 2. The name of the DC Participant Provider that the DCE believes may be the beneficiary's main doctor, main provider, and/or the main place the beneficiary received care; 3. The logo of the DCE or DC Participant Provider; 4. Instructions for how the beneficiary can submit the Voluntary Alignment Form to the DCE; 5. The insertion of information about unique care coordination and preventative services offered by the DCE; and 6. The DCE's contact information for answering beneficiaries' questions.

CMS Review - Upon the DCE signing the PY1 Participation Agreement, CMS will review and approve the submitted Voluntary Alignment template letter prior to the DCE conducting paper-based voluntary alignment.