Achieving Healthcare Efficiency through Accountable Design Model

Technical Specifications for Geo AHEAD

Version 1.0

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1.0 Introduction

This document presents Version 1 of the Technical Specifications for Geo AHEAD under the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. The Centers for Medicare & Medicaid Services (CMS) administer Geo AHEAD, a geographically based accountable care organization (ACO) shared savings program that reinforces AHEAD model principles at the state-level.

These specifications describe Geo Entity organizational structures, provider participation requirements, overlap policies, the Medicare beneficiary attribution methodology, and the Model's payment mechanisms for eligible Geo Entities, providers[1], and other stakeholders.

1.1 Model Overview

The AHEAD Model offers a voluntary, state-based alternative payment and service delivery approach that seeks to curb health care cost growth, improve population health, and advance community health outcomes. Through the Model, CMS holds participating states accountable for total cost of care (TCOC), primary care investment, and population health outcomes through flexible payment and service delivery frameworks.

The AHEAD Model brings together multiple aligned components, including Primary Care AHEAD (PC AHEAD), Hospital Global Budgets AHEAD (HGB AHEAD), and Geo AHEAD, to advance these goals. PC AHEAD and HGB AHEAD implement targeted payment reforms at the practice and hospital levels, respectively. Geo AHEAD reinforces these reforms by ensuring that improvements in care coordination, utilization management, and quality performance translate into system-wide cost and outcome gains. CMS administers Geo AHEAD as the connective structure, using a geographically based accountability framework to align incentives and accountability across the broader Medicare provider network.

1.2 Geo AHEAD Overview

Through Geo AHEAD, geographic risk-bearing entities (Geo Entities) assume responsibility for TCOC and quality outcomes for attributed Original Medicare beneficiaries in a geographic area. Geo AHEAD also introduces a novel attribution methodology and competitive bidding structure designed to attribute all Original Medicare beneficiaries with an accountable care delivery system.

Synergy with Other AHEAD Components

- Geo AHEAD strengthens support for PC AHEAD practices and serves as a natural partner for HGB Hospitals by aligning the state healthcare ecosystem around shared goals: coordinated care, improved patient outcomes, and sustainable cost management. PC AHEAD practices and HGB hospitals can participate with Geo Entities by owning or operating Geo Entities or by serving as Geo Participants or Geo Affiliates (**See Section 2.4 Geo Entity Care Delivery Partners**).
- States may choose to support Medicare and Medicaid alignment by establishing a geographic Medicaid ACO program aligned with Geo AHEAD.

[1] For the purposes of this document, unless otherwise specified, provider is used to encompass providers and suppliers, defined as "A Medicare provider is a facility, supplier, physician, or other individual or organization that furnishes health care services. Under Medicaid, a provider is an individual, group, or agency that provides a covered Medicaid service to a Medicaid enrollee." (Medicare Provider Type Glossary | CMS Data)

Aligned Quality Goals

- CMS and AHEAD States incentivize all AHEAD model participants to prioritize quality over volume and expect them to collaborate toward shared goals.
- Geo AHEAD aligns with the quality targets and care transformation requirements applied in PC AHEAD and HGB AHEAD, enabling providers to participate across multiple AHEAD components to work toward consistent, mutually reinforcing outcomes.

Payments that Support Care Transformation

- Geo AHEAD provides Geo Entities with prospective Primary Care Capitation (PCC) for select services, Enhanced Primary Care Payments (EPCP) to support care management, and the opportunity to earn shared savings. These payment mechanisms offer flexibility for Geo Entities to establish financial arrangements with providers that support sustained investment in care transformation and care coordination.

1.3 Geo AHEAD Requirements

To preserve competition in the AHEAD State or Substate Region, CMS will select a minimum of two Geo Entities in a given AHEAD State or Substate Region with fewer than 200,000 attribution-eligible beneficiaries and will select a minimum of three Geo Entities in a given AHEAD State or Substate Region with 200,000 or more attribution-eligible beneficiaries. Regardless of state size, CMS will select Geo Entities such that each Substate Division (**See Section 2.1 Geo Entity Service Area**) is served by at least two Geo Entities.

If CMS does not select at least two Geo Entities (or three in the case of larger geographies) in a given AHEAD State or Substate Region, Geo AHEAD will not operate in that State or Substate Region for the first Performance Year (PY); in such cases, CMS may solicit bids in the second PY. If CMS does not select the minimum number of Geo Entities after two years, Geo AHEAD will not operate in that AHEAD State or Substate Region for the contract period. CMS will limit the maximum number of accepted bids to maintain a minimum of 10,000 attribution-eligible beneficiaries to each Geo Entity, as feasible.

1.4 Geo AHEAD Timeline

CMS will issue two competitive Requests for Applications (RFA), where an eligible Geo Entity may submit an application as a bidding entity to participate in an AHEAD State or Substate Region. CMS will issue one RFA for each of the two consecutive 4-year contract periods (2028 to 2031 and 2032 to 2035).[2] CMS will release the RFA for Contract Period 1 in Quarter 2 (Q2) 2027. **Table 1.1** provides a visual representation of the implementation timeline for Geo AHEAD.

A Geo Entity that participates in Contract Period 1 and wishes to continue their participation in Contract Period 2 must submit a bid during the RFA process for Contract Period 2.

[2] States that receive a Notice of Award after January 2025 may have an opportunity to choose contract periods other than the two listed.

Table 1.1 Geo AHEAD Cohort Implementation Timeline

Contract Period	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
1	Pre-Imp.	Pre-Imp.	PY1	PY2	PY3	PY4	N/A	N/A	N/A	N/A
2	Pre-Imp.	Pre-Imp.	Pre-Imp.	Pre-Imp.	Pre-Imp.	Pre-Imp.	PY1	PY2	PY3	PY4

Abbreviations: PY = Performance Year, Pre-Imp. = Pre-Implementation Period

2.0 Overview of Geo Entities

Geo Entities are geographically based ACOs that assume accountability for TCOC and quality outcomes for attributed Original Medicare beneficiaries within a defined service area. Geo AHEAD permits both provider-led and non-provider-led organizations to participate, provided they meet all model requirements. Provider organizations, health plans, technology companies, digital health organizations, and other entities may own, manage, and operate Geo Entities.

Geo Entities must be authorized to operate and satisfy any risk-bearing requirements in the applicable state (**See Section 2.3 Geo Entity Eligibility and Requirements**), maintain a Federal Taxpayer Identification Number (TIN), and demonstrate the organizational, financial, and operational capacity to manage population health and financial risk. PC AHEAD practices and HGB Hospitals may participate with Geo Entities as owners, operators, Participants, or Affiliates, helping align primary care investment and hospital global budgets with geographic TCOC accountability.

Geo Entities may earn shared savings when their PY Expenditures are lower than their Benchmark Target (**See Section 8.0 Overview of the Financial Settlement Process**).

Geo Entities may offer support services that improve patient access, care coordination, patient experience, and health outcomes in accordance with CMS fraud and abuse waivers and applicable patient incentive safe harbors. These services may include data and analytics capabilities, care navigation tools, Benefit Enhancements (BE), and Beneficiary Engagement Incentives (BEI).

2.1 Geo Entity Service Area

Geo Entities will bid to operate either across an entire AHEAD State or Substate Region, or within a designated Substate Division within the AHEAD State or Substate Region (**See Table 2.1 Geo Entity Coverage**). The AHEAD State or Substate Region is defined as the group of counties to which AHEAD targets apply, as defined in the AHEAD State Agreement with each participating State. The awarded geography defines the Geo Entity's service area, within which the Geo Entity receives attributed beneficiaries and assumes accountability under the Model. Depending on attribution method (**See Section 5.0 Overview of Beneficiary Attribution**), attributable beneficiaries may be drawn from the State- or Substate Region-level, or from the Geo Entity's service area.

Table 2.1 Geo Entity Coverage

Term	Description
AHEAD Substate Division	Groups of one or more counties (or other geographic unit agreed upon by CMS and in consultation with the State) used in Geo AHEAD to determine the service area of Geo Entities. Substate Divisions will reflect historical patterns of care for beneficiaries in these geographies. Only Provider-Led Entities may bid to operate in a Substate Division.
Service Area	The entire state, substate region, or substate division awarded to the Geo Entity. CMS uses the service area to determine the area from which a Geo Entity must accept geographically attributed beneficiaries.

CMS, in collaboration with each AHEAD State, will determine eligible Substate Divisions. Substate Divisions consist of one or more counties (or another mutually agreed-upon geographic unit) and must include at least 20,000 attribution-eligible beneficiaries to support the viability of at least two Geo Entities within each division. CMS will provide defined Substate Divisions to provider-led

bidding entities prior to the application period. Provider-led bidding entities may submit bids to operate within one or more Substate Divisions instead of bidding statewide.[3]

2.2 Geo Entity Types

Geo AHEAD includes two types of Geo Entities, which differ based on control of the Geo Entity's governing body: Provider-Led Geo Entities and Non-Provider-Led Geo Entities.

Provider-Led Geo Entity:

- Required to have at least 51 percent control of the Geo Entity's governing body held by providers.
- May operate across an entire AHEAD State or Substate Region or within one or more Substate Divisions.

Non-Provider-Led Geo Entity

- Submit bids covering the entire AHEAD State or Substate Region.
- May incorporate primary care providers, specialists, and other clinicians at the time of the application (including bid submission) or during the contract period (**See Appendix C.1 Primary Care Specialists** and **Appendix C.2 Selected Non-Primary Care Specialists**).[4]

Attribution under Geo AHEAD may vary across a Geo Entity's service area based on attribution pathways. Geo AHEAD does not guarantee beneficiary attribution from within a Geo Entity's service area; however, Geo Entities must be prepared to accept attributed beneficiaries from across the entire service area.

2.3 Geo Entity Eligibility and Requirements

Applicants must meet the following eligibility conditions to serve as a Geo Entity:

- A Geo Entity must hold a TIN formed under applicable state, federal, or tribal law and must be authorized to conduct business in each state or region in which it operates.
- A Geo Entity must also satisfy applicable risk-bearing requirements and meet one of the following conditions:
    a. The Geo Entity holds a risk-bearing license issued by the state(s) in which it operates.
    b. The Geo Entity can attest to CMS that it is exempt from such licensure or other such requirements.
    c. The Geo Entity operates in a state without licensure requirements for risk-bearing entities or is otherwise not required to maintain such licensure under state law.
- In addition, Geo Entities must attest to compliance with all applicable federal and state laws and regulations, in a manner specified by CMS in the Participation Agreement or subsequent guidance.

[3] A bidding entity that wishes to bid for multiple Substate Divisions within a single AHEAD State or Substate Region will only be required to submit a single application. If a bidding entity wishes to bid for Substate Divisions or groups of Substate Divisions that span multiple AHEAD States or Substate Regions, they will be required to submit an application for each applicable AHEAD State or Substate Region.

[4] Though it may be helpful for a Geo Entity to voluntarily develop provider partnerships, either at the beginning, or during the contract period, it is neither expected nor required.

Participating Geo Entities must meet the following requirements:

- Geo Entities must accept attributed beneficiaries across their entire service area.
- Geo Entities must either obtain and maintain active Part B enrollment under a single TIN to function as a "covered entity" under the Health Insurance Portability and Accountability Act (HIPAA) as defined in 45 C.F.R. §160.103 or enter into an agreement with CMS to facilitate the exchange of Protected Health Information (PHI) for model operations, including entering into a Business Associate Agreement with CMS, consistent with HIPAA requirements.[5]
- Geo Entities must establish and maintain a Beneficiary Advisory Panel (BAP) that convenes at least twice each year and serves to ensure beneficiary input into model implementation. The BAP serves as a regular forum for soliciting beneficiary feedback on topics such as BE and BEI, communication strategies, health literacy, clinical programs, and approaches for addressing upstream health and social needs. Although non-binding, beneficiary recommendations and feedback should be used to inform continuous improvement and support beneficiary experience and engagement. Geo Entities should appoint BAP members who reside within the Geo Entity's service area.
- The Geo Entity must work with CMS toward achieving a sufficient operation scale of 10,000 attributed Original Medicare beneficiaries, as feasible, inclusive of dually eligible beneficiaries, to achieve financial viability, benchmark stability, and meaningful population-level accountability.

2.4 Geo Entity Care Delivery Partners

Geo Entities may establish and manage care delivery systems of providers or organizations, including PC AHEAD practices; HGB AHEAD hospitals; and Community Health Centers (CHC), such as Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), that will work together to drive care coordination and achieve Geo AHEAD program objectives.

Participation in Geo AHEAD is structured at the TIN level, and Geo Entities may leverage existing relationships and recruit new providers to strengthen their care provision and navigation infrastructure and to support their attributed beneficiaries. Geo Entities are not required to engage care delivery partners; however, they may find it helpful to do so through financial arrangements in one of two roles, each with distinct implications for attribution, payment, and accountability (**See Section 3.0 Overview of Participation**):

- **Geo Participants** are Medicare-enrolled organizations, identified by a billing TIN, that contract with a single Geo Entity, contribute to Claims-Based Attribution (CBA), and assume financial and performance accountability under the Model. Primary Care Geo Participants are eligible to receive EPCPs and are required to participate in PCC and consistent with their financial arrangement, will be paid for these services by the Geo Entity.

[5] CMS may treat Geo Entities as business associates (See 45 C.F.R. § 160.103), and Geo Entities must comply with the HIPAA Privacy, Security, and Breach Notification Rules (45 C.F.R. Part 160 and Part 164, Subparts A through E), as well as other applicable federal privacy and security requirements and CMS policies. Under the HIPAA Privacy Rule (45 C.F.R. § 164.502(e)), a business associate may create, receive, maintain, or transmit PHI on behalf of a covered entity only when the covered entity obtains satisfactory assurances, through a BAA, that the business associate will appropriately safeguard the information. The BAA must include the elements required under 45 C.F.R. § 164.504(e), including provisions that clarify and limit the business associate's permissible uses and disclosures of PHI. As a condition of participation in the AHEAD Geo Model, Geo Entities must enter into a valid BAA with CMS. The Geo AHEAD Participation Agreement specifies data collection and sharing requirements, and the BAA is incorporated as an appendix to that agreement.

- **Geo Affiliates** are Medicare-enrolled organizations, identified by a billing TIN, that may contract with one or more Geo Entities and may also participate in other CMS models or programs. Geo Affiliates do not contribute to CBA and do not participate in PCC nor generate EPCPs, but may support care coordination, contribute to Geographic Attribution, and participate in shared savings or other value-based arrangements as specified in their financial agreements with a Geo Entity.

More robust care delivery partners may expand a Geo Entity's attributed beneficiary population, enhance collaboration across settings, and strengthen the Geo Entity's ability to manage TCOC and quality performance. Geo Entities enter financial arrangements with their care delivery partners to incentivize high-value care delivery, improve care coordination, and advance Geo AHEAD program objectives, consistent with CMS participation and overlap policies.

2.5 Application and Bidding Process

Entities seeking to participate in Geo AHEAD must submit an application in response to the RFA, which CMS will release in Q2 2027.[6] CMS will evaluate applications based on applicants' demonstrated readiness across five evaluation domains and their proposed bid discount relative to the TCOC Benchmark.

2.5.1 Bid Evaluation Domains

CMS will apply a common set of evaluation domains across applications to assess readiness, financial alignment, care delivery capability, and beneficiary protections.

Table 2.2 Bid Evaluation Domains

Domain	Description
Compliance Infrastructure	Demonstrated organizational readiness as of PY1 to meet regulatory compliance and governance structure requirements including in cases when deploying technology safely at scale. *Applied only as a pass/fail, prior to calculating the Bid Evaluation Score (**See Section 2.5.2.2 Geo Entity Selection Process**).*
Financial Soundness & Benchmark Alignment	Bid discount and savings trajectory based on transparent pricing assumptions, beneficiary-specific risk mitigation, and as appropriate, technology-enabled efficiency.
Population Health Strategy and Preparedness	Demonstrated strategies for targeting high-needs populations using evidence-based care transformation approaches, innovative technology, and/or interoperable data infrastructures aligned to population health needs and goals.
Care Navigation Infrastructure	Breadth and depth of safe and secure technology, tools, and/or care delivery partnerships to connect beneficiaries to high-value care, including operational alignment and engagement of HGB Hospitals and PC AHEAD practices.
Beneficiary Protections & Experience	Beneficiary engagement, through technology or other approaches, communication, and safeguards that support consumer experience, commitment, and choice protections.

CMS will use these domains throughout various applications. CMS will refine the bid evaluation approach described below and finalize it through future guidance and applicable participation materials, including additional detail regarding evaluation metrics, thresholds and minimum viable score, as well as measurement approaches.

[6] CMS will release the Contract Period 1 RFA in Q2 2027 RFA. CMS will release a second RFA for Contract Period 2.

2.5.2 Geo Entity Selection Process

CMS will use an iterative two-step process to assess bidding entity applications to ensure they meet minimum viability and eligibility requirements and to differentiate among qualified applicants based on their readiness to carry out the requirements of Geo AHEAD and the value of their proposed bid discounts in Contract Period 1. Step 1 results in a pass/fail determination for each applicant based on meeting required thresholds, while the Step 2 involves comparative evaluation of the applicants. Applicants that do not meet the requirements in Step 1 will not proceed to Step 2.

This approach limits participation to applicants that demonstrate sufficient operational readiness and financial viability while allowing CMS to compare proposals based on demonstrated capability. By submitting a bid for a defined geography, a Geo Entity demonstrates that it either has, or will establish prior to the performance period, the operational capacity and necessary infrastructure (which may be technology-based, provider-based, or some combination thereof) to serve beneficiaries throughout its proposed service area.

Table 2.3 Geo Entity Selection Process

Step	Criteria	Assessment	Result
Step 1a: Compliance Requirement	Does applicant meet baseline eligibility, compliance, and operational readiness requirements?	Must meet all compliance requirements outlined in RFA	Pass/Fail
Step 1b: Minimum Viability Screening	Does the applicant meet minimum requirements for financial viability (including the minimum bid discount), population health strategy, care delivery infrastructure, and applicable safeguards?	Must meet all other requirements outlined in RFA	Pass/Fail
Step 2: Comparative Evaluation	See Bid Evaluation Scoring Framework	The sum of the weighted five domain scores	Evaluation Score

2.5.2.1 Bid Discount Process

Geo AHEAD introduces competitive bidding to the application process bidding entities will bid a percentage discount for all four PYs in a contract period using CMS-provided data, expressed as a discount of the estimated TCOC benchmark for each PY (**See Section 6.0 Overview of Benchmark**).

As part of bid evaluation scoring, CMS evaluates the bid discount percentage within the Financial Soundness & Benchmark Alignment Domain, reflecting the extent to which a Geo Entity's proposed discount demonstrates both pricing competitiveness and alignment with the underlying spend and utilization characteristics of the benchmark population. The Geo Entity establishes bid discount percentage prospectively at the time of application and CMS applies it over the full duration of the contract period. Geo AHEAD permits either a fixed bid discount that remains constant across all PYs or a pre-specified schedule in which the bid discount percentage varies by year. This structure provides flexibility for Geo Entities to plan performance improvement and beneficiary spend management over time while maintaining transparency and predictability in benchmark application. The specific requirements and allowable bid structures are defined in the Geo AHEAD application materials.

Prior to releasing the RFA, CMS will establish a Geo AHEAD benchmark for attribution-eligible beneficiaries in each AHEAD State or Substate Region and, if applicable, Substate Division. CMS will include summary-level historical data on attribution-eligible beneficiaries, including historical utilization and spending, risk scores and measures, quality measures, and a benchmark workbook. CMS will not provide beneficiary-identifiable data until CMS and the bidding entity execute a participation agreement.

2.5.2.2 Bid Evaluation Scoring Framework

To support consistent comparison across applicants, CMS will translate domain-level assessments (**See Table 2.2 Bid Evaluation Domains**) into standardized scores and calculate a bid evaluation score for each bidding Geo Entity. CMS calculates the bid evaluation score as the weighted sum of domain scores:

$$\textbf{Eq. 2.1: Bid Evaluation Score} = (D_1 \times W_1) + (D_2 \times W_2) + (D_3 \times W_3) + (D_4 \times W_4)$$

Where:

- D = Domain Score
- W = Domain Weight
- $_1$ = Financial Soundness & Benchmark Alignment Domain
- $_2$ = Population Health Strategy and Preparedness Domain
- $_3$ = Care Navigation Infrastructure Domain
- $_4$ = Beneficiary Protections & Experience Domain

CMS will evaluate applications across the five domains: one (Compliance and Infrastructure) domain on a pass-fail basis and the remaining four domains to calculate the Bid Evaluation Score. CMS will assign a relative weight to each scored domain to reflect its contribution to overall bid competitiveness and program objectives. CMS will compute two versions of the bid evaluation score: (1) a bid evaluation score, which includes the bid discount score and is used for Geo Entity selection, and (2) an adjusted bid evaluation score, which excludes the bid discount score (**See Section 5.4.3.2.2 Weighted Random Geographic Attribution – Bid Discount Score**) and is used for geographic attribution.[7]

2.6 Participation and Award Process

CMS will notify selected applicants of acceptance into the Geo AHEAD Model following completion of the selection process. Selected Geo Entities must execute a participation agreement (PA) with CMS, which establishes program requirements, reporting obligations, payment methodologies, and compliance expectations. CMS will outline award, notification, and PA requirements in the Geo Entity RFA.

2.7 Termination

To support program stability and continuity of care, Geo AHEAD includes provisions that apply when a Geo Entity exits participation before the end of a contract period. Geo Entities that exit Geo AHEAD prior to the third year of a contract period may be subject to early-termination penalties. Geo Entities may reduce the magnitude of early-termination penalties by implementing a transition

[7] For purposes of attribution under the WRGA methodology for the WRGA – Bid Evaluation Score, CMS will use an adjusted composite score that removes the Bid Discount Score from the Financial Soundness & Benchmark Alignment Domain. This is because the bid discount and bid evaluation are considered separately for WRGA attribution.

plan for each of their attributed beneficiaries to support continued access to care for the remainder of the contract period. If one or more Geo Entities exit the Model prior to the end of the first PY of a contract period, CMS will re-release a RFA to accept additional Geo Entities for the second PY, regardless of the number of remaining Geo Entities in the geography. If one or more Geo Entities exit the Model after the first PY of a contract period, CMS will allow the remaining Geo Entities to continue operating for the remainder of their contract period and will not solicit additional applications. CMS will provide more information on termination provisions in the Geo AHEAD RFA.

3.0 Overview of Participation

This section establishes the governance and operational framework for participation in Geo AHEAD.

Geo AHEAD includes multiple categories of Medicare-enrolled providers that may participate in, or support, a Geo Entity's care provision and navigation infrastructure. Eligible Medicare-enrolled provider types include individual practitioners, facilities or institutional practitioners, and organizational providers. This section describes how CMS operationalizes participation through organizational identifiers and participation roles; subsequent sections define specific provider classes and participation pathways.

3.1 Participation Structure

CMS identifies Geo Entities at the organizational level by a Geo Entity TIN. Providers participate in Geo AHEAD through business entity TINs, which may be designated as Geo Participant and Geo Affiliate TINs (**See Section 3.2 Geo Entity Provider Classes**). Approved practice and facility TINs serve as the units of participation and accountability for attribution, payment, and compliance. Individual National Provider Identifiers (NPIs) do not participate independently and are not treated as units of accountability.

While CMS defines participation at the TIN level, attribution reflects underlying provider-beneficiary relationships.[8] Voluntary Attribution (VA) occurs when a beneficiary actively designates a provider, who bills under a Geo Participant TIN, as their primary source of care. CMS does not rely on Individual NPIs as the unit of attribution for VA. A single TIN may serve as both the billing entity and the Geo Participant TIN to support VA. CMS determines CBA using a plurality of primary care services, assessed at the Geo Entity TIN level for Geo Entities (aggregating Participant TINs) and at the individual Organization TIN level for non-Geo Entities. CMS identifies qualifying services and specialties using claims submitted by eligible providers (**See Section 5.3.3.1 Calculation of Allowed Amount**). CMS determines Geographic Attribution based on beneficiary residence within defined geographic areas and assigns beneficiaries to Geo Entities associated with those areas, applying household-level assignment where applicable and linking beneficiaries through associated Geo Participant and Affiliate TIN relationships rather than individual provider selection or claims-based plurality (**See Section 5.0 Overview of Beneficiary Attribution**).

3.2 Geo Entity Provider Classes

Participation roles and provider classes define how organizations contribute to beneficiary attribution, payment, and accountability. **Table 3.1** summarizes differences based on provider class. Subsequent sections describe the concepts referenced in this table, including BEs/BEIs, PCC, and Quality Payment Program (QPP) participation.

Geo Entities may contract with organizations (as defined by a TIN), that include some combination of qualified primary care practices, hospitals, FQHCs, RHCs, CAHs, and others who serve beneficiaries residing in an AHEAD State or Substate Region. Medicare-enrolled providers can participate directly in a Geo Entity by serving as a **Geo Participant** or as a **Geo Affiliate Provider**. Geo Entities are not required to have agreements with Geo Participants or Geo Affiliates. Each provider type must meet different requirements and has access to different model features.

[8] For participating TINs, all associated providers (practices and facilities) billing under the TIN are considered part of the Geo AHEAD Model for participation, attribution, and payment purposes. CMS does not recognize partial participation at the Individual NPI level within a TIN.

Table 3.1 Differences between Geo Participants and Affiliates

Is the provider…	Participant	Affiliate
Required to be Medicare-enrolled?	Yes	Yes
Used for beneficiary voluntary attribution?	Yes	No
Used for claims-based beneficiary attribution?	Yes	No
Used for beneficiary geographic-based attribution?	Yes	Yes
Eligible to participate in Geo AHEAD PCC?	Mandatory, if Primary Care	No
Used for Quality Measure scoring?	Yes	No, unless required through financial arrangement with entity
Eligible to participate in BEs/BEIs?	Yes	Yes, certain BEs
Required to have a contract with the ACO?	Yes	Yes
Eligible to receive Shared Savings?	Optional, depending on financial arrangement with Geo Entity	Optional, depending on financial arrangement with Geo Entity
Eligible for consideration as a Qualifying APM Participant (QP) under Geo AHEAD?	Yes	No

3.2.1 Geo Participants

Geo Participants are Medicare-enrolled providers that participate with only one Geo Entity and may not participate in other CMS TCOC Models or PC AHEAD. Geo Participants drive VA and CBA, assume financial and performance risk, and support coordinated care for attributed beneficiaries. CMS identifies Geo Participants at the TIN level. Geo Participants must meet the following core participation requirements:[9]

- Maintain financial arrangements with the Geo Entity.
- Assume financial and performance risk and may receive shared savings pursuant to their financial arrangement with the Geo.
- Participate in PCC, as applicable.[10]
- Support care delivery and coordination for attributed beneficiaries.

3.2.2 Geo Affiliates

Geo Affiliates are Medicare-enrolled providers that may participate with one or more Geo Entities and may also participate in other CMS TCOC Models and PC AHEAD. Geo Affiliates expand care delivery networks and contribute to Geographic Attribution but do not impact VA and CBA. Geo Affiliates may not participate in Geo AHEAD PCC. Geo Affiliates may access certain BEs/BEIs (**See Section 3.3 BEs/BEIs**) through arrangements with a Geo Entity. CMS identifies Geo Affiliates at the TIN level. Geo Affiliates must meet the following core participation requirements:

[9] Additional operational requirements, including specialty eligibility, Medicaid APM participation, CEHRT use, QPP eligibility, hospital ownership constraints, and access to BEs (e.g., SNF waivers) will be specified in the Geo AHEAD Participation Agreement, RFA, and subsequent CMS guidance.

[10] All Selected Primary Care Specialists who are Geo Participants must participate in PCC (See Appendix C.1 Primary Care Specialists for a list of specialty codes used to identify Primary Care Specialists). Critical Access Hospitals and providers with specialty codes excluded from SPCS are not eligible for PCC.

- Maintain financial arrangements with one or more Geo Entities.
- May assume financial risk and performance accountability pursuant to their agreement with the Geo Entity.
- Do not contribute to PCC or EPCP payments for the Geo Entity.
- Support care delivery, coordination, and beneficiary engagement activities, including through BEs/BEIs as applicable.
- PC AHEAD providers may participate as Geo Affiliates and connect their attributed beneficiaries through Geographic Attribution to a Geo Entity.

3.3 Benefit Enhancements and Beneficiary Engagement Incentives

CMS allows Geo Entities to provide BEs/BEIs to assist Geo Participants and Geo Affiliates with care coordination for attributed beneficiaries.

Benefit Enhancements (BEs) are model-specific waivers or flexibilities that modify standard Medicare coverage or payment rules and enable participating providers to deliver care more effectively (e.g., facilitating care transitions, expanding allowable settings of care, supporting care management activities). BEs are intended to reduce barriers to appropriate care, improve coordination across providers and settings, and support population-level quality and spend outcomes.

Beneficiary Engagement Incentives (BEIs) include non-cash items, services, or supports that encourage beneficiaries to engage in care, adherence to treatment plans, or participation in qualifying programs. BEIs are designed to promote preventive care, chronic disease management, and beneficiary participation in activities that improve health outcomes and experience, consistent with applicable fraud and abuse waivers and beneficiary protection safeguards.

Geo Entities may furnish approved BEs/BEIs to support Geo Participants and Geo Affiliates in coordinating care and engaging attributed beneficiaries. States must ensure that any BEs/BEIs offered comply with Medicaid state plan authority and managed care regulatory requirements, as applicable.

CMS may condition participation in certain BEs on ongoing performance or eligibility requirements. Providers that fail to maintain required participation standards may lose access to specific BEs. CMS prohibits Geo Entities from imposing participation requirements that conflict with CMS policy or that restrict beneficiary access to providers within the service area.

CMS will provide more information on model-specific BEs/BEIs, including any required versus optional offerings, eligibility criteria, and operational requirements, in the Geo AHEAD RFA and PA.

3.4 Geo Entity Participant Management

Participant management activities support beneficiary attribution, administration of PCC and EPCP, access to BEs/BEIs, quality measurement, and compliance oversight under the Geo AHEAD Model.

Geo Entities are required to:

- Maintain accurate and current records of participating TINs and associated NPI-level information required for model operations.
- Ensure that participating organizations meet applicable participation requirements established by CMS and the state.

- Support CMS and state oversight activities related to participant management, including data validation and compliance monitoring.
- Administer participant-related functions in a manner that supports beneficiary choice, competition, and geographic accountability.

CMS will manage participant operations through the 4Innovation (4i) system, including provider enrollment, roster submission, and compliance monitoring. CMS will provide additional guidance in the Geo AHEAD Technical Specifications Version 2.

3.4.1 Provider Rosters and Updates

Geo Entities may submit a complete Provider Roster before the start of each PY to support beneficiary attribution, benchmarking, and calculation of PCC payments and EPCP. The roster may include Geo Participants and Geo Affiliates at the TIN and CCN levels.[11] During the PY, Geo Entities may update the Provider Roster monthly in accordance with CMS submission timelines, requirements, and validation processes. CMS will outline requirements for adding providers during the PY in the PA and related guidance.

CMS will validate Provider Rosters through the 4i system using data from the Provider Enrollment, Chain, and Ownership System (PECOS). CMS and other federal screening entities may conduct additional program integrity reviews, including Center for Program Integrity (CPI) vetting. CMS will exclude providers that do not meet participation requirements.

3.4.2 Participation Effects and Timing

CMS may impose timing constraints on participation changes that affect attribution, payment, or model operations. CMS does not restrict provider eligibility for BEs or PCC based solely on the timing of a provider's addition to the Model. However, CMS may delay access to PCC payments or BEs/BEIs due to processing timelines, attribution mechanics, or other applicable model requirements.

3.5 Overlaps Policy

Geo Entities, health care providers, and other entities may wish to participate in multiple Center for Medicare and Medicaid Innovation (CMMI) models or value-based care initiatives to enhance care delivery, reduce expenditures, and improve population health. Geo Entities, at the Geo Entity TIN level, may participate in other models, including other ACO and shared savings models, and are not subject to geographic restrictions. **Table 3.2** details the overlaps policy across geographic, participant, beneficiary, and financial levels.

Geo Participants may not participate in other TCOC models under the same TIN. The participating TIN refers to the Medicare-enrolled billing entity approved to participate as a Geo Participant, such as a physician group practice, facility, or organizational provider. Individual providers may participate in other CMMI models or PC AHEAD if they bill under a different participating TIN. Geo Affiliates may participate in other models and PC AHEAD.

CMS does not permit beneficiary overlaps between Geo AHEAD and other TCOC models, including the Medicare Shared Savings Program (MSSP), Primary Care Flex (PCF), and Long-term Enhanced ACO Design (LEAD).

[11] CMS will provide more information in the Geo AHEAD Technical Specifications Version 2 regarding Individual NPI level information.

Table 3.2 Overlaps Policy

Domain	Overlaps Policy
Geographic	**Overlaps Permitted** AHEAD may be offered in states or sub-state regions where ACOs participate in other CMMI initiatives (i.e., no geographic restrictions) and these ACOs can include hospitals, primary care clinics, and providers in AHEAD states.
Participation	**Overlaps with Consideration** **Geo Entities,** at TIN level, may participate in other TCOC models. **Geo Participants**, at TIN level, **may not participate** in other TCOC models, however individual providers at the iNPI-level who bill under multiple TINs may participate in multiple TCOC models, PC AHEAD, or participate with multiple Geo Entities under a different TIN. **Geo Affiliates**, at either the TIN or NPI-level, may participate in other TCOC models or PC AHEAD.
Beneficiaries	**Overlaps with Consideration** Beneficiaries cannot be attributed to multiple TCOC accountability models (e.g., Medicare Shared Savings Program (MSSP), LEAD). However, beneficiaries attributed to PC AHEAD may be attributed to a Geo Entity through Geographic Attribution, provided they are not attributed to another TCOC model.
Financial	**Overlaps with Consideration** Geo TCOC includes timely payments, including non-claims-based payments, for Geo-attributed beneficiaries in other non-TCOC models as long as they are final within 3 months following the end of each PY. HGB Payments will also be included in Geo TCOC by calculating the proportion of no-pay claims for HGB services and applying that to the total HGB. EPCP and other care management and infrastructure investments will not be included in TCOC for shared savings determination. Spending with Geo Participants and Geo Affiliates for beneficiaries attributed to ACOs participating in other TCOC models and programs will be included in their TCOC calculation for shared savings determination.

CMS may update the policies included in this section. CMS will reflect overlap policies for new or updated models in an updated version of the AHEAD Overlaps Factsheet on the AHEAD Model webpage. Questions about specific policies not addressed by this Factsheet should be directed to relevant PAs or AHEAD@cms.hhs.gov.

4.0 Overview of Eligible Population and Beneficiary Eligibility

The Geo AHEAD eligible population is the foundation of the Attribution and Benchmark processes. CMS constructs the eligible population by identifying beneficiaries who resided in an AHEAD State or Substate Region at any point during the lookback period associated with a PY or Baseline Year (BY) and were not deceased prior to the end of the lookback period. CMS constructs the attribution-eligible population using a defined historical lookback period.

The eligible population is used in tandem with the attribution methodology (**See Section 5.0: Overview of Beneficiary Attribution**) to generate the Geo Entity-specific Baseline Beneficiary Lists for each BY and the Geo Entity-specific Attributed Beneficiary Lists. In both, CMS applies the attribution methodology to attribute beneficiaries to Geo Entities.

- The **Geo Entity-specific Baseline Beneficiary Lists** are used to calculate the Geo Entity-Specific Historical Baseline Expenditures (**See Section 6.0: Overview of Benchmark**). This process identifies the beneficiaries who would have been attributed to each Geo Entity in each BY had the Geo Entity's current PY Geo Participant Provider List, voluntarily aligned beneficiaries, and geographic service area been in effect during those years.
- The **Geo Entity-specific Attributed Beneficiary Lists** are used to determine the population used to determine PY expenditures for each Geo Entity, used to calculate capitated payments, and to determine Shared Savings or Losses.

After constructing the applicable Geo Entity-specific Baseline Beneficiary Lists for the BYs (BY 1-BY 3) and/or the Geo Entity-specific Attributed Beneficiary Lists for the PY, CMS evaluates beneficiary eligibility criteria for each month in the measurement period. For each beneficiary included on these lists, CMS includes only the months in which the beneficiary meets all the following criteria for purposes of TCOC, capitation payment, and baseline expenditure calculations:

- Is enrolled in both Medicare Part A and Part B;
- Is not aligned to another model with overlap restrictions (e.g., Medicare Shared Savings Program, LEAD, etc.)
- Is not enrolled in a Medicare Advantage plan, cost plan, PACE organization, or other Medicare managed care plan;
- Has Medicare as the primary payer;
- Resides in the United States; and
- Resides in the AHEAD State or Substate Region.

Beneficiaries who are not included on the Attribution-Eligible Beneficiary List for a given BY or PY will not be included in the corresponding Geo Entity-specific beneficiary list unless they voluntarily align to a Geo Entity (**See Step 1.0 – Voluntary Attribution**). CMS may attribute the beneficiary at the start of the subsequent BY or PY, subject to continued eligibility.

Dually Eligible Beneficiaries Eligibility Criteria: Dually enrolled Medicare Beneficiaries are eligible to be attributed to Geo Entities so long as they meet the criteria listed above. CMS may consider additional attribution steps and/or Shared Savings calculation adjustments that account for Dually Enrolled Beneficiaries such as Medicaid enrollment and/or spending in future versions of

the Geo AHEAD financial specifications to improve experience and outcomes for Dually Enrolled beneficiaries.

Beneficiary Data Sharing and Opt-Outs: Beneficiaries attributed to the Geo AHEAD Model remain enrolled in Medicare and retain all standard Medicare rights, including the ability to seek care from any Medicare-enrolled provider. Beneficiaries may opt out of certain data sharing and communication activities, including the sharing of identifiable claims data for care coordination or marketing purposes. Federal law requires additional privacy protections for certain sensitive services, including those related to substance use disorder treatment, and may limit or suppress these data in claims. Beneficiaries may not opt out of attribution to a Geo Entity or from alternative payment arrangements made under the Model. However, beneficiaries may elect to opt out of claims data sharing in accordance with applicable CMS policies. These policies balance beneficiary privacy preferences with the need to maintain the integrity of attribution, payment, and performance measurement under Geo AHEAD.

5.0 Overview of Beneficiary Attribution

CMS attributes beneficiaries to Geo Entities to assign accountability for TCOC, and quality performance under Geo AHEAD. Geo AHEAD connects each eligible beneficiary to a Geo Entity responsible for coordinating and managing their care.

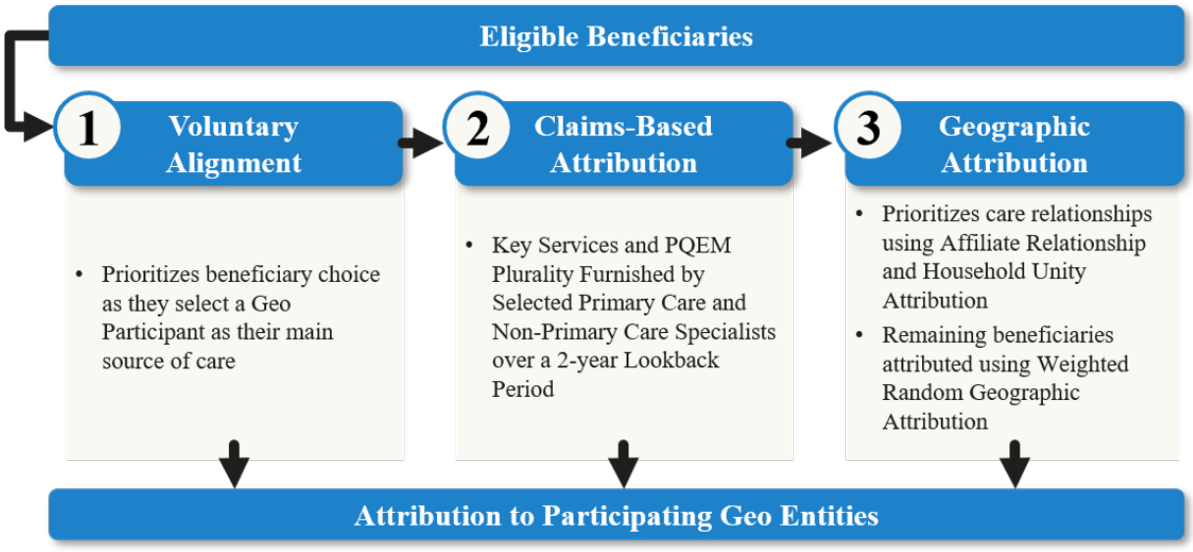
Geo AHEAD uses a prospective hierarchical attribution framework (**See Figure 5.1 Beneficiary Attribution Flowchart**) that balances beneficiary choice, continuity of care, and geographic accountability. CMS designed the attribution methodology to connect beneficiaries to Geo Entities based on demonstrated care relationships or residence within a defined service area while preventing overlapping accountability across CMS models.

(1) **Voluntary Alignment**: Beneficiaries designate a Geo Participant as their main source of care, affirmatively selecting the provider and Geo Entity to which they wish to be attributed.

(2) **Claims-Based Attribution**: CMS attributes beneficiaries based on an ongoing and substantive relationship with a Primary Care Specialist or Selected Non-Primary Care Specialist, determined by receipt of a Key Service or by the plurality of weighted charges for Primary Care Qualified Evaluation and Management (PQEM) services paid by Medicare FFS during the Attribution Lookback Period.

(3) **Geographic Attribution**: CMS attributes beneficiaries who are not attributed through VA or CBA using a three-substep process based on (1) an ongoing and substantive relationship with a Geo Affiliate, (2) the CBA of a household member to a Primary Care Specialist, or (3) through Weighted Random Geographic Attribution (WRGA) to a Geo Entity whose service area includes the beneficiary's residence.

Figure 5.1 Beneficiary Attribution Flowchart



CMS conducts attribution using the CMS-approved Geo Entity Provider Roster, which includes Geo Participant TINs and associated CCNs. The Provider Roster defines the Geo Participants whose services CMS considers for CBA and related attribution steps. CMS also uses the Provider Roster to validate provider participation status and attribution eligibility by TIN, CCN, and specialty, consistent with the Provider Identification rules described in **Step 2.0 Claims-Based Attribution**

and the Participant Management requirements for Provider Rosters and updates (**See Section 3.4 Geo Entity Participant Management**).

CMS conducts attribution prospectively before each PY and updates attribution quarterly (**See Section 5.7 Attribution Cadence and Population Stability**). This approach attributes all eligible beneficiaries to a Geo Entity, supports stable population-level accountability, and enables Geo Entities to invest in care transformation strategies that improve engagement and outcomes and reduce avoidable utilization.

The following sections describe the attribution precedence rules, attribution algorithm, and attribution cadence that CMS uses for payment, benchmarking, and performance measurement under Geo AHEAD.

5.1 Attribution Considerations

CMS employs a formal, cross-agency governance structure to execute hierarchical decision making to prevent the attribution of beneficiaries to multiple models involving shared savings or other value-based initiatives (**See Section 3.5 Overlaps Policy)**. This structure ensures single-entity accountability for each beneficiary and resolves conflicts when overlapping eligibility occurs. This structure also supports consistent application of attribution precedence within Geo AHEAD across varying Geo Entity participation structures, including Geo Entities with differing levels of provider network development.

5.1.1 Attribution Precedence within AHEAD

CMS applies attribution precedence rules to prevent duplicative claims-based attribution across PC AHEAD and Geo AHEAD and to preserve the intended payment and accountability structure across AHEAD components. For prospective attribution at the beginning of a PY, the AHEAD attribution hierarchy is: (1) Geo AHEAD VA, (2) PC AHEAD CBA, (3) Geo AHEAD CBA, and (4) Geo AHEAD Geographic Attribution. Under this hierarchy, PC AHEAD CBA takes precedence over Geo AHEAD CBA, while Geo AHEAD VA takes precedence over PC AHEAD CBA.

During mid-year quarterly attribution, PC AHEAD CBA may attribute otherwise eligible beneficiaries who were geographically attributed to Geo AHEAD at the beginning of the PY, including beneficiaries attributed through WRGA. However, PC AHEAD CBA will not take precedence over beneficiaries already attributed to Geo AHEAD through Geo AHEAD VA or Geo AHEAD CBA. If a beneficiary was geographically attributed to Geo AHEAD in Q1 and is CBA to both Geo AHEAD and PC AHEAD in a subsequent quarterly attribution cycle, PC AHEAD claims-based attribution takes precedence.

Beneficiaries attributed to PC AHEAD may still be geographically attributed to a Geo Entity for Geo AHEAD total cost of care and quality accountability purposes, provided that the beneficiary is not simultaneously attributed through Geo AHEAD VA or Geo AHEAD CBA and duplicative Geo AHEAD primary care payments are not generated.

5.1.2 Attribution Precedence within Geo AHEAD

Once CMS determines that a beneficiary is attribution eligible, the following Geo AHEAD-specific rules apply:

- **VA takes precedence within Geo AHEAD.** The most recent valid VA attestation (**See Section 5.2 Step 1.0 – Voluntary Attribution**) supersedes any prior or invalid designations.

- **CMS validates VA attestation.** CMS considers VA designations valid only when the selected TIN is associated with a Geo Entity's Participant Roster. If a beneficiary attests to a TIN not approved as a Geo Participant TIN for that Geo Entity, CMS rejects the attestation (for use in Geo AHEAD) and does not attribute the beneficiary through VA. However, CMS may still attribute the beneficiary through CBA if the beneficiary has a qualifying relationship with a provider billing under an approved Geo Participant TIN.
- **Single-entity accountability is maintained.** CMS ensures that each beneficiary is attributed to only one Geo Entity for purposes of risk-sharing, TCOC, and quality measurement.

5.1.3 Attribution Considerations for Geo Entities with Limited Provider Networks

Geo Entities without an established provider network or with limited or newly established provider networks at the start of a PY (e.g., Non-Provider-Led Entities) may initially receive a greater share of attributed beneficiaries through geographic attribution methodologies, including WRGA, as VA and CBA rely on established relationships with Geo Participants and Geo Affiliates. To the extent that such relationships are not yet established or reflected in the provider roster, attribution through VA and CBA may be limited.

Through the Model's attribution cadence, including periodic updates to beneficiary attribution, these Entities may begin to receive beneficiaries through VA and CBA as Geo Participant relationships are established and incorporated into the Provider Roster. Because beneficiaries attributed through WRGA remain attributed to a Geo Entity for a two-year period prior to reattribution, unless they develop CBA or VA, Non-Provider-Led Geo Entities have an opportunity to establish care delivery relationships with these beneficiaries and Geo Participants, which may increase VA and CBA over time.

Geo Entities without care delivery partners to support VA and CBA may enroll as Medicare Part B suppliers, which may enable VA directly to the Geo Entity, consistent with applicable CMS enrollment and billing requirements.

As Non-Provider-Led Geo Entities develop and expand their care delivery networks, the composition of their attributed population is expected to shift toward VA and CBA, consistent with the attribution hierarchy.

5.2 Step 1.0 – Voluntary Attribution

CMS attributes beneficiaries to a Geo Entity operating in their State or Substate Region through electronic and paper-based VA mechanisms. VA enables beneficiaries to affirmatively select the Geo Participant that they consider to be their main source of care. Beneficiaries may VA to a Geo Participant using one of the following two methods: Medicare.gov Voluntary Alignment (MVA) or Signed Attestation-Based Voluntary Alignment (SVA).

While participation in Geo AHEAD is defined at the TIN level (**See Section 3.1 Participation Structure**), VA reflects underlying provider-beneficiary relationships. VA occurs when a beneficiary selects a specific provider or supplier; however, attribution is operationalized at the TIN level based on the selected clinician's associated TIN. The Individual NPI is used to identify the clinician selected by the beneficiary but is not the unit of attribution or accountability. A single TIN may serve as both the billing entity and the Geo Participant TIN to support VA.

Geo Entities, including those without a traditional provider network, may enable VA through SVA, under which a beneficiary designates a Geo Participant TIN as their primary source of care. In

contrast, MVA requires selection of an individual clinician, which some Geo Entities may not have an established roster to support. CMS voluntarily aligns beneficiaries to a Geo Entity when the following conditions are met:

- The beneficiary is attribution eligible (**See Section 4.0 Overview of Eligible Population and Beneficiary Eligibility**) as of the effective date of the attribution (e.g., first day of the month following the designation); and
- The beneficiary designates a Geo Participant as their main source of care through MVA or SVA, provided that the designation is valid and more recent than any other prior designation made by the beneficiary.

Note: VA designations are subject to CMS validation and eligibility requirements and must be current, valid, and more recent than any other designation made by the beneficiary.

5.2.1 Medicare.gov Voluntary Alignment (MVA)

A beneficiary may designate a Geo Participant as their primary clinician or main provider through Medicare.gov Voluntary Alignment (MVA), or any successor CMS-designated platform.

5.2.2 Signed Attestation-Based Voluntary Alignment (SVA)

A beneficiary may VA by completing an attestation form designating a Geo Participant as their main doctor, main provider, or main place they receive care through SVA. Although CMS refers to this process as 'signed' attestation, CMS accepts electronic forms and electronic signatures, consistent with CMS requirements.

Geo Entities are responsible for aggregating beneficiary attestations and submitting SVA records to CMS using model-specified data formats and submission processes. This includes compiling attestations into a standardized submission file (e.g., Signed Voluntary Alignment Data Template) and submitting the file through CMS-designated systems (e.g., 4i Document Submission) by established deadlines. CMS validates submitted records and incorporates approved attestations into attribution, with valid SVA taking precedence over CBA, as applicable. Additional details will be provided in the Geo AHEAD Technical Specifications Version 2.

5.2.3 Voluntary Alignment Submission, Validation, and Tracking

CMS collects, validates, and maintains all VA designations submitted through MVA or SVA for tracking, operational use, and transparency. CMS aggregates VA designations submitted through MVA and SVA and maintains them in a single system of record within the Participant Management functionality in the CMS 4i system, which serves as the authoritative source for attribution status and outcomes.

CMS will validate VA submissions to confirm beneficiary eligibility, provider participation status, and attribution recency. CMS will reject invalid or outdated designations, such as attestations to providers that are not Geo Participants, though such rejections do not preclude attribution through other applicable pathways.

5.2.3.1 Expiration of Voluntarily Alignment Designation

For purposes of beneficiary attribution for a given PY, CMS will remove a VA designation for a beneficiary, and proceed to subsequent attribution steps, if both of the following conditions are met:

- The beneficiary VA designation was made more than two years prior to the start of that PY or quarter; AND
- Neither of the following are true:
    - The beneficiary received a qualifying primary care evaluation and management (PQEM) service from the designated Geo Participant TIN during the two years prior to the start of the PY or quarter
    - The Geo Entity attests that they have engaged the beneficiary via non-fee-schedule services during the two years prior to the start of the PY or quarter.

Additional details on the operationalization of this policy will be provided in the Geo AHEAD Technical Specifications Version 2. This policy does not apply to new-to-Medicare beneficiaries and is intended to ensure that voluntary alignment remains beneficiary-driven, reflects an ongoing care relationship, and supports continuity with providers the beneficiary relies on for care.

5.3 Step 2.0 – Claims-Based Attribution

For CBA, CMS uses the CMS-approved Geo Entity Provider Roster to identify participating provider entities eligible for attribution. CMS attributes beneficiaries based on services furnished through participating entities and applies attribution logic using billing and rendering relationships. For professional services, CMS uses the rendering NPI on the claim to identify provider specialty and confirm attribution eligibility criteria but performs attribution at the TIN level. For facility-based services (e.g., FQHCs, CAHs, RHCs), CMS evaluates claims based on CCN-level billing relationships. CMS determines attribution eligibility based on provider specialty, services furnished, and other applicable criteria.

CMS prospectively attributes eligible Original Medicare beneficiaries who do not align to a Geo Entity through VA based on ongoing and substantive relationships with attribution-eligible providers associated with a Geo Entity. CMS identifies these relationships using beneficiary claims for PQEM services furnished by attribution-eligible providers. To support continuity of care within participating AHEAD States or Substate Regions, CMS excludes non-border out-of-state PQEM claims from the CBA process.

5.3.1 Step 2.1 – Key Services Attribution

CMS first evaluates whether a beneficiary received a Key Service (**See Appendix C.3.1 Key Services**) during the Attribution Lookback Period from an attribution-eligible provider billing under a Participant TIN associated with a Geo Entity. Key Services include:

- Chronic Care Management (CCM),
- Welcome to Medicare (WTM) visits,
- Initial preventive physical examinations (IPPE), and
- Annual Wellness Visits (AWV).

If a beneficiary received a Key Service from an attribution-eligible Geo Participant, CMS attributes the beneficiary to the Geo Entity associated with the Participant TIN that submitted the most recent qualifying Key Service claim. If a beneficiary received Key Services only from providers that are not attribution-eligible Geo Participants, CMS does not attribute the beneficiary at this step and proceeds to **Step 2.2 – Plurality of Allowable PQEM**.

5.3.2 Step 2.2 – Plurality of Allowable PQEM

For beneficiaries not attributed through Step 2.1, CMS evaluates paid PQEM claims from the attribution lookback period to identify the Geo Entity associated with the plurality of weighted allowable charges furnished by attribution-eligible providers billing under Participant TINs. Allowable charges include Medicare FFS claim payments and applicable non-claims-based payments (NCBP).

CMS evaluates PQEM services furnished by attribution-eligible Primary Care Specialists and Selected Non-Primary Care Specialists that participate with a Geo Entity (**See Appendix C.1 Primary Care Specialists** and **Appendix C.2 Selected Non-Primary Care**). Attribution and expenditure calculations exclude PQEM services furnished by other specialists within a Participant TIN. CMS will refine the final list of attribution-eligible specialties and release additional information through future guidance and applicable participation materials.

CMS weights allowable charges based on recency within the attribution lookback period. CMS assigns a one-third (1/3) weight to PQEM services furnished during the earlier portion of the attribution lookback period and a two-thirds (2/3) weight to PQEM services furnished during the more recent portion, consistent with the attribution lookback period definition in **Section 5.6 Attribution Look Back Period**.

Beneficiaries fall into one of two attribution tracks:

1. ***Attribution Based on PQEM Services Provided by Primary Care Specialists***. If 10% or more of allowable PQEM charges during the Attribution Lookback Period were furnished by Primary Care Specialists, CMS bases attribution on the plurality of weighted allowable charges from Primary Care Specialists.
2. ***Attribution Based on Primary Care Services Provided by Selected Non-Primary Care Specialists***. If less than 10% of allowable PQEM charges were furnished by Primary Care Specialists, CMS bases attribution on the plurality of weighted allowable charges from PQEM services furnished by Selected Non-Primary Care Specialists participating with a Geo Entity.

CMS determines CBA using a plurality of primary care services, assessed at the Entity TIN level for Geo Entities (aggregating Geo Participant TINs) and at the individual Organization TIN level for non-Geo Entities. CMS identifies qualifying services and specialties from claims submitted by eligible providers, applying service-level logic through connected CCNs or rendering NPIs. Beneficiaries not attributed through Steps 1 or 2 proceed to **Step 3 – Geographic Attribution**.

5.3.3 Primary Care Qualified Evaluation and Management Services

CMS identifies PQEM services using Healthcare Common Procedure Coding System (HCPCS) codes and provider specialty, as defined in **Appendix C.3 Key Services and PQEM Services**. CMS may refine the list of attribution-eligible PQEM services and provide additional guidance in future participation materials, including limited updates before each PY.

5.3.3.1 Calculation of Allowed Amount

CMS calculates an allowed amount for PQEM services using Medicare claims data, inclusive of applicable NCBPs. The calculation approach varies by claim type and provider setting to reflect differences in Medicare billing and payment structures, while ensuring that attribution and related analyses include only amounts reasonably attributable to primary care services.

CMS applies specialized handling to certain claim types, as described below.

5.3.3.1.1 Professional (Physician and Non-Physician Practitioner) Claims

For physician and non-physician practitioner claims, CMS identifies PQEM services at the claim line level based on the reported HCPCS code and the rendering provider's specialty. The allowed amount for PQEM services equals the Medicare allowed amount for the claim line.

5.3.3.1.2 Federally Qualified Health Center (FQHC) Claims

For claims submitted by FQHCs (Type of Bill 77x), CMS treats all services as primary care services for attribution purposes and considers all such services attribution eligible, regardless of provider specialty. CMS calculates the allowed amount by multiplying by 1.25, consistent with Medicare FQHC payment policy. Because FQHC claims reflect payment after beneficiary coinsurance and are not subject to the Part B deductible, this methodology ensures that allowed amounts reflect the full Medicare payment for primary care services.

5.3.3.1.3 Rural Health Clinic (RHC) Claims

For claims submitted by RHCs (Type of Bill 71x), CMS treats all services as primary care services and considers them attribution-eligible regardless of provider specialty. CMS calculates the allowed amount by multiplying by 1.25, and then adding the Revenue Center Cash Deductible Amount, consistent with Medicare RHC payment policy and beneficiary cost-sharing requirements. This approach captures the full allowed amount associated with primary care services furnished in the RHC setting.

5.3.3.1.4 Critical Access Hospital (CAH) Outpatient Claims

For CAH outpatient claims (Type of Bill 85x), CMS identifies primary care services based on HCPCS codes reported on clinic revenue center lines (096X–098X). The methodology used to calculate the allowed amount attributable to primary care services varies depending on whether the CAH is billing under Method I or Method II.

Under CAH Method I billing, professional services furnished by physicians and non-physician practitioners are billed separately on Carrier (Part B) claims, rather than through the hospital (**See Section 5.3.3.1.1 Professional (Physician and Non-Physician Practitioner) Claims**). CMS does not proportionally allocate institutional claim amounts for attribution purposes under Method I billing.

Under CAH Method II billing, the CAH bills and receives payment for professional services through an institutional outpatient claim.

Specifically for CAH Method IIs, CMS:

- Identifies line items representing primary care services based on qualifying HCPCS codes reported on clinic revenue center lines (096X–098X);
- Sums the submitted charges for those qualifying primary care line items.

5.3.3.2 Provider Identification

CMS identifies whether PQEM services were furnished by attribution-eligible providers associated with Participant TINs within a Geo Entity. This determination relies on a combination of provider identifiers and specialty information, as reported on Medicare claims, and ensures that attribution is limited to services furnished by eligible providers participating with the Geo Entity. CMS evaluates

provider participation status using claim-specific identifiers, which vary by claim type and may include TINs, CCNs, NPIs, along with provider specialty information where applicable.

5.3.3.2.1 Institutional Outpatient Claims

For institutional claims, CMS determines whether services were furnished by an attribution-eligible Geo Participant when the CCN reported on the claim corresponds to a CCN associated with a participating TIN on the Geo Entity's approved Provider Roster.

For FQHC and RHC claims, CMS treats all services as primary care and does not base attribution eligibility on NPI or provider specialty. For other institutional claims (i.e., CAH claims), CMS uses the attending NPI reported on the claim to evaluate provider specialty and apply service-based attribution rules, as applicable.

5.3.3.2.2 Professional Claims

For professional claims, CMS determines whether services were furnished by an attribution-eligible Geo Participant by applying the following checks:

- CMS verifies that the rendering TIN on the claim matches a Participant TIN on the Geo Entity's approved Provider Roster; and
- CMS uses the rendering NPI on the claim to identify the provider's specialty and confirm that the service meets attribution eligibility criteria.

CMS uses the rendering NPI solely to determine provider specialty and does not use it as the unit of attribution. Attribution is performed at the TIN level. PQEM services furnished by providers whose specialty does not meet attribution eligibility criteria are excluded from CBA and associated expenditure calculations, even if the provider bills under a Participant TIN.

5.4 Step 3.0 – Geographic Attribution

CMS geographically attributes all eligible beneficiaries not attributed through VA and CBA to a Geo Entity to ensure complete population-level accountability in each AHEAD State or Substate Region. CMS determines Geographic Attribution based on beneficiary residence within defined geographic regions and assigns beneficiaries to Geo Entities associated with those regions, applying household-level assignment where applicable and linking beneficiaries through associated Geo Participant and Affiliate TIN relationships rather than individual provider selection or claims-based plurality.

Geographic Attribution preserves established care relationships, supports household continuity, and limits random assignment to situations where no qualifying relationships exist. Through Affiliate Relationship Attribution and Household Unity (HHU) (**See Section 5.4.1 Step 3.1 Affiliate Relationship Attribution** and **Section 5.4.2 Step 3.2 Household Unity Attribution**), CMS may attribute beneficiaries who reside outside a Geo Entity's service area to preserve ongoing and substantive care relationships with a Primary Care Specialist or Selected Non-Primary Care Specialist participating with a Geo Entity. CMS applies WRGA only for beneficiaries who (1) reside within the Geo Entity's service area and (2) are not attributed through an Affiliate Relationship or Household Unity.

CMS executes Geographic Attribution using the following sequential steps:

5.4.1 Step 3.1 – Affiliate Relationship Attribution

When a beneficiary has an established care relationship with a Geo Affiliate, CMS attributes the beneficiary through Affiliate Relationship Attribution. CMS identifies such relationships based on:

1. The Geo Affiliate that submitted the most recent qualifying Key Service claim in the Attribution Lookback Period.
2. The Geo Affiliate associated with the plurality of weighted allowable PQEM service charges during the Lookback Period.

If either condition is met, attribution assigns the beneficiary to the Geo Entity associated with that Geo Affiliate, regardless of the beneficiary's residence. This step preserves continuity of care for beneficiaries receiving services from providers participating with the Geo Entity as Affiliates. If a Geo Affiliate has a relationship with multiple Geo Entities, CMS attributes the beneficiary to one of the eligible Geo Entities via WRGA (**See Section 5.4.3 Step 3.3 Weighted Random Geographic Attribution**). Beneficiaries who do not meet the criteria for Affiliate Relationship Attribution proceed to **Step 3.2 – Household Unity Attribution**.

5.4.2 Step 3.2 – Household Unity Attribution

To preserve continuity across household members, HHU Attribution applies when beneficiaries reside together. This attribution pathway reflects the principle that household members often share care-seeking patterns and benefit from alignment to a common source of longitudinal primary care.[12,13]

When CMS attributes one or more household members through VA or CBA to a Primary Care Specialist (**See Appendix C.1 Primary Care Specialists**), CMS attributes additional eligible household members who are not otherwise attributed to the same Geo Entity. CMS limits this attribution step to relationships with Primary Care Specialists, as beneficiaries more commonly receive ongoing and comprehensive care through primary care providers than through specialist providers.

HHU Attribution is limited to households that meet the following criteria:

- The household includes two to four attribution-eligible beneficiaries;
- All household members share a non-P.O. Box residential address; and
- At least one household member is already attributed through VA or CBA, while at least one additional household member would otherwise require Geographic Attribution.

All remaining attribution-eligible beneficiaries who do not meet the criteria for Affiliate Relationship Attribution or HHU Attribution proceed to **Step 3.3 – Weighted Random Geographic Attribution**.

5.4.3 Step 3.3 – Weighted Random Geographic (WRGA) Attribution

WRGA is the final method used to attribute all remaining attribution-eligible beneficiaries. WRGA uses a multi-criteria scoring approach that combines Geo Entity bid- and performance-based inputs to calculate a Geo Entity Weighted Composite Score for each Geo Entity. WRGA then converts

[12] Epperly T, Bechtel C, Sweeney R, et al. The Shared Principles of Primary Care: A Multistakeholder Initiative to Find a Common Voice. Fam Med. 2019;51(2):179-184. https://doi.org/10.22454/FamMed.2019.925587.

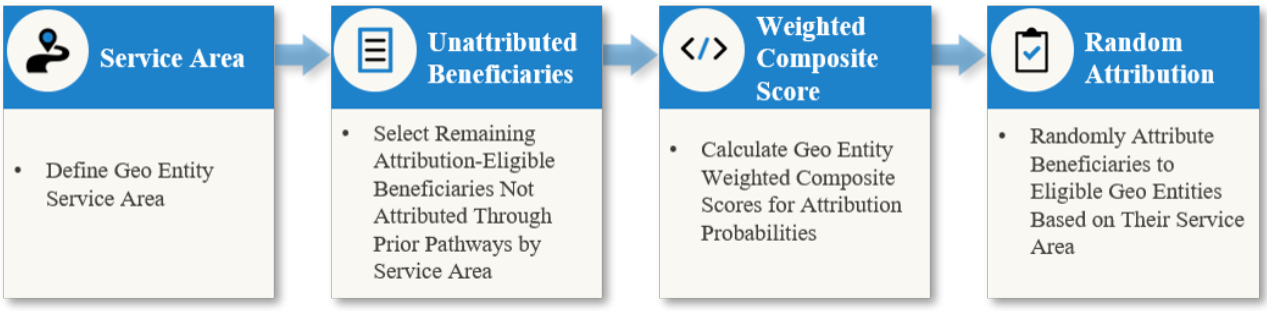
[13] Tu H, Lauer J. Word of Mouth and Physician Referrals Still Drive Health Care Provider Choice. Center for Studying Health System Change. http://www.hschange.org/CONTENT/1028/1028.pdf

these Weighted Composite Scores into attribution probabilities and randomly assigns the beneficiary across eligible Geo Entities (determined by service area coverage) based on those probabilities.

WRGA enables Geo AHEAD to bring all eligible Original Medicare beneficiaries into an accountable care relationship, including beneficiaries who lack sufficient claims history or do not have a direct relationship with a Geo Participant. The weighted random structure reduces structural selection bias by giving each eligible Geo Entity a weighted score used for attribution rather than allowing entities to influence which unattributed beneficiaries they do or do not serve.

WRGA does not seek to enforce an equal distribution of beneficiaries across Geo Entities. Instead, attribution outcomes reflect the interaction of geographic eligibility, metric performance, composite scores, and probabilistic assignment. As a result, Geo Entities with a broader or denser service area, higher composite scores, or both may receive a larger share of WRGA-attributed beneficiaries.

Figure 5.2 Weighted Random Geographic Attribution Framework



5.4.3.1 Geographic Eligibility and Candidate Geo Entities

Beneficiaries are eligible for WRGA only to Geo Entities whose service area includes the beneficiary's residence. Geo Entities that do not cover the beneficiary's residence are not eligible candidates for that beneficiary under WRGA, and their Weighted Composite Score is set to zero for that beneficiary (and are not included in the random draw).

Geo Entities are not required to have Geo Participants or Affiliates within the beneficiary's county of residence to receive the beneficiary via WRGA. This approach recognizes that, particularly in rural areas, provider networks and care patterns commonly span county boundaries and beneficiaries may receive primary care and related services through providers that serve broader catchment areas.

5.4.3.2 WRGA Metrics

WRGA uses a defined set of bid-, performance-, and engagement-based metrics to generate a Geo Entity Weighted Composite Score for purposes of probabilistic geographic attribution. Each metric is designed to capture a distinct policy objective of the Geo AHEAD Model, including entity readiness, spending containment, quality of care, innovation, and demonstrated ability to engage beneficiaries over time. WRGA uses a structured, weighted scoring approach based on Geo Entity characteristics, coupled with random selection. This approach reduces selection bias and provides all eligible Geo Entities with a weighted opportunity for each eligible beneficiary's attribution.

Together, these metrics balance early-stage indicators of Geo Entity capacity and financial commitment with later-stage measures of performance and beneficiary engagement, allowing the WRGA methodology to evolve as more robust data become available across PYs. **Table 5.1 WRGA**

Metric Definitions and Data Sources summarizes the definitions, and data sources for each WRGA metric, with additional detail provided below. All metric definitions, data sources, and calculation approaches are subject to refinement through future CMS guidance and applicable participation materials.

Table 5.1 WRGA Metric Definitions and Data Sources

Metric	Description	Unit of Analysis	Primary Data Source
Bid Evaluation Score	Measures CMS's assessment of a Geo Entity's overall readiness and capacity to implement and operate under the Geo AHEAD Model	Geo Entity	CMS bid evaluation results from the Geo AHEAD selection process, reflecting scores across evaluation domains, excluding the Financial Soundness and Benchmark Alignment discount component.
Bid Discount Score	Reflects the strength of a Geo Entity's proposed Bid Discount relative to other selected Geo Entities, rewarding higher discounts against the CMS-defined TCOC benchmark.	Geo Entity	Geo Entity bid submissions as evaluated under the Financial Soundness and Benchmark Alignment domain, scaled by CMS for WRGA use in the applicable PY.
Quality Performance	Represents a Geo Entity's composite quality performance, using applicable claims-based and/or reported quality measures, and phased in over time to account for data availability and reporting lag.	Geo Entity	CMS quality measurement systems used for Geo AHEAD settlement and quality scoring (e.g., claims-based measures in earlier years and the full Composite Quality Score from prior-year settlement once available).
Engagement Rate	Captures a Geo Entity's demonstrated ability to engage geographically attributed beneficiaries and transition them to VA or CBA.	Geo Entity	CMS attribution data comparing each beneficiary's prior-year WRGA attribution outcome to that same beneficiary's subsequent VA and CBA attribution results in the current PY.

5.4.3.2.1 WRGA – Bid Evaluation Score

Within WRGA, the Bid Evaluation Score (**See Section 2.5 Application and Bidding Process**) serves as a proxy for Geo Entity capability and expected performance when observed performance data (e.g., quality, engagement outcomes) are limited. As a result, this metric carries relatively higher weight in earlier years of the Model (**See Section 5.4.3.3 Metric Weights**), consistent with CMS's objective to prioritize entities that demonstrate strong readiness to manage TCOC and coordinate services for attributed populations.

CMS applies the Adjusted Bid Evaluation Score (**See Section 2.5.2. Bid Evaluation Scoring Framework**), which excludes the Bid Discount Score, at the Geo Entity level and does not vary across beneficiaries. CMS may refine the use, weighting, and calculation of this metric in future PYs and contract periods based on implementation experience and evolving model priorities.

CMS will provide additional details regarding the construction, scoring approach, and component domains of the Bid Evaluation Score in the Geo AHEAD Technical Specifications Version 2.

5.4.3.2.2 WRGA – Bid Discount Score

Within WRGA, the Bid Discount Percentage (**See Section 2.5 Application and Bidding Process**) is translated into a standardized Bid Discount Score to enable consistent comparison across Geo Entities. This translation converts each Geo Entity's proposed bid discount into a bounded, scaled score, ensuring that differences in discount levels are reflected while maintaining comparability with other WRGA metrics.

$$\textbf{Eq. 5.1: Bid Discount Score}_g = \left(\left(\frac{D_g}{D_{max,i}}\right) \times 50\right) + 50$$

Where:

- D_g = Bid Discount Percentage for Geo Entity g and
- $D_{max,i}$ = Maximum bid discount among all Geo Entities eligible for beneficiary i.

CMS calculates the Bid Discount Score by dividing each Geo Entity's Bid Discount Percentage by the maximum bid discount among all Geo Entities, producing a standardized score that enables comparison across entities. CMS may consider alternative scaling approaches, including scaling bid discounts relative to CMS-defined discount ranges rather than the maximum observed discount among participating Geo Entities, as specified through future guidance. The scaled score is bounded and expressed on a 0–100 scale for use within the WRGA composite scoring framework (**See Section 5.4.3.4 Weighted Composite Score**). **Table 5.2 Example Translation from Bid Discount Percentage to Bid Discount Score** shows an illustrative example (whole-number value between 0 and 100).

Table 5.2 Example Translation from Bid Discount Percentage to Bid Discount Score

Geo Entity	Bid Discount Percentage	Bid Discount Score
ACO 1	3%	65
ACO 2	5%	75
ACO 3	7%	85
ACO 4	10%	100

In this example, the highest bid discount (10%) sets the reference point. Proportional scaling to other discounts provides a standardized score.

CMS may refine the translation methodology, scaling approach, weighting, and application of the Bid Discount Score in future PYs based on implementation experience and evolving program priorities.

5.4.3.2.3 WRGA – Quality Performance

The Quality Performance Score reflects Geo Entity's performance across applicable quality measures and is incorporated into WRGA to reward entities that demonstrate the ability to deliver high-quality, clinically effective, and patient-centered care. This metric aligns WRGA attribution incentives with broader Geo AHEAD objectives related to improving health outcomes, reducing avoidable utilization, and promoting high-value care delivery.

Because of timing and data availability constraints, the Quality Performance Score is introduced on a phased basis within WRGA. In early PYs, CMS will not have complete and reliable quality data due to measurement periods, claims run-out, and performance lag. As a result, WRGA initially relies on interim claims-based quality measures, mentioned below, as proxies for performance before

transitioning to the full Composite Quality Score used for Shared Savings and Loss calculations in later PYs.

For PY2, CMS calculates the Quality Performance Score using a defined set of claims-based quality measures (**See Section 8.2.4 Quality Adjustment**). Performance is measured based on beneficiaries who met the requirements for CBA in the year prior to PY1 for the Geo Entity (CY2027 for AHEAD States in Cohorts 1, 2, and 3). This approach provides an observable and timely proxy for quality performance during early model implementation. Geo Entities that do not have sufficient pre-implementation quality data will utilize a proxy score for PY2. More information will be available in the Geo AHEAD Technical Specifications Version 2.

Beginning in later PYs (e.g., PY3 and beyond), WRGA incorporates the Composite Quality Score used in Financial Settlement (**See Section 8.2.4 Quality Adjustment**). While improvement scores are included in the calculation of the Geo AHEAD Quality-Based Adjustment for Shared Savings and Losses, they are not incorporated into the WRGA Quality Performance metric, which reflects achieved performance levels only.

CMS applies the Quality Performance Score uniformly at the Geo Entity level rather than at the beneficiary level. However, the score affects attribution outcomes differently depending on the relative performance of eligible Geo Entities and the applicable PY-specific weights. As the Model matures, CMS places greater emphasis on quality performance within WRGA, consistent with the transition from input-based metrics (e.g., bid evaluation score) to outcome-based performance measures.

The Quality Performance Score used in WRGA may differ from the quality measures used for Financial Settlement in terms of timing, composition, and calculation approach, particularly in earlier PYs. CMS may refine the specification, weighting, and application of this metric in future PYs and Contract Period 2 based on data maturity, operational experience, and evolving program priorities.[14] CMS will release additional details on quality measurement and scoring in future guidance and participation materials.

5.4.3.2.4 WRGA – Engagement Rate Calculation

The Engagement Rate measures a Geo Entity's ability to engage beneficiaries initially attributed through WRGA and transition them to VA or CBA over time. This metric increases the attribution weight for Geo Entities that successfully establish ongoing care relationships with WRGA beneficiaries.

Engagement rates will increase the probability that CMS attributes beneficiaries to Geo Entities that demonstrate stronger engagement outcomes across counties within the Geo Entity's service area. CMS calculates an Engagement Rate for each Geo Entity and expresses the resulting score as a whole number between 0 and 100 for consistency with other WRGA metrics.

CMS incorporates Geo Entity Engagement Rates into the WRGA Weighted Composite Score after scaling the rates within the applicable geographic unit. Stronger engagement performance increases

[14] CMS will release additional information on the WRGA Quality Metric for Contract Period 2 through future rulemaking, guidance, and participation materials.

a Geo Entity's likelihood of beneficiary attribution while maintaining the probabilistic structure of WRGA.

Table 5.3 Geo Entity Engagement Rate provides an illustrative example of the Engagement Rate calculation. The Engagement Rate represents the proportion of beneficiaries attributed through WRGA in a prior PY who subsequently convert to VA or CBA in the current PY, measured on a one-to-one beneficiary basis. Beneficiaries attributed through Affiliate Relationship or HHU attribution are excluded from the denominator, as they are already attributed based on an existing care relationship.

Table 5.3 Geo Entity Engagement Rate

Item	Calculation Step	Geo Entity 1	Geo Entity 2
PY1 Attributed Beneficiaries			
1	WRGA Attributed in Prior PY	5,000	7,000
2	Number of WRGA Beneficiaries Converted to VA or CBA in Current PY	1,250	900
3	Engagement Rate (Line 2 / Line 1)	25%	13%
4	**Engagement Rate Score (Line 3 x 100)**	**25**	**13**

5.4.3.3 Metric Weights

WRGA applies PY-specific weights to each component metric to determine the relative contribution of each metric to the Geo Entity Weighted Composite Score. These weights reflect CMS's policy priorities and the availability of reliable data inputs at different stages of model implementation.

In early PYs, WRGA places greater emphasis on bid- and application-based metrics, such as the Bid Evaluation Score and Bid Discount Score, which serve as proxies for Geo Entity readiness and financial commitment. During this period, outcome-based metrics, such as Quality Performance and Engagement Rate, may receive limited or zero weighting, reflecting the time required to observe, measure, and validate performance outcomes due to measurement periods, claims run-out, and reporting lag.

As the Model matures and more robust performance data become available, WRGA transitions toward increased weighting of outcome-based and behavioral metrics, including Quality Performance and Engagement Rate. This shift ensures that attribution probabilities increasingly reflect demonstrated performance, beneficiary engagement, and alignment with individual care needs, rather than solely prospective indicators of capacity or financial commitment.

CMS designed the weighting structure to support a gradual evolution of attribution incentives, balancing early-stage feasibility with long-term alignment to high-value care outcomes. As demonstrated in **Table 5.4 WRGA Metric Weights by PY**, weights may vary across PYs within a contract period and may continue to evolve in subsequent contract periods.

Table 5.4 WRGA Metric Weights by PY

Metric	PY 1	PY 2	PY 3	PY 4
Bid Evaluation Score (Qualitative)	50%	40%	0%	0%
Bid Discount Score (Quantitative)	50%	40%	40%	40%
Quality Performance Composite	0%	20%	40%	40%

Metric	PY 1	PY 2	PY 3	PY 4
Engagement Rate	0%	0%	20%	20%

The metric weights present are subject to change through future CMS guidance and applicable participation materials.

5.4.3.4 Weighted Composite Score

The Weighted Composite Score represents the combined contribution of all WRGA metrics for each Geo Entity and serves as the basis for determining attribution probabilities under WRGA. This score incorporates PY-specific weights applied to each metric to reflect their relative importance within the WRGA framework.

For each eligible Geo Entity, CMS calculates the Weighted Composite Score as the sum of each metric multiplied by its corresponding PY weight.

Eq. 5.2: Weighted Composite Score =

$$\omega_S^{py} S + \omega_D^{py} D + \omega_Q^{py} Q + \omega_R^{py} R$$

Where:

- ω^{py} = Specified (S, D, Q, R) Metric Weight by PY;
- S = Bid Evaluation Score;
- D = Bid Discount Score;
- Q = Composite Quality Score; and
- R = Engagement Rate.

CMS calculates the Weighted Composite Score for each Geo Entity eligible for attribution for each beneficiary based on service area coverage. Higher scores increase the likelihood of selection under WRGA, reflecting CMS's prioritization of attribution to Geo Entities that demonstrate stronger alignment with model performance, care delivery, and program objectives, thereby increasing their opportunity to earn shared savings.

5.4.3.5 Conversion of Weighted Composite Scores to Assignment Probabilities

After CMS calculates the Weighted Composite Score for all eligible Geo Entities for a beneficiary, WRGA converts those scores into attribution probabilities by dividing each Geo Entity's score by the sum of composite scores. WRGA then uses these probabilities to assign beneficiaries through a random draw, such that Geo Entities with higher composite scores have a higher, though not guaranteed, likelihood of beneficiary attribution (**See Table 5.5 WRGA Beneficiary Assignment Probability Example**).

Table 5.5 WRGA Beneficiary Assignment Probability Example

Item	Step	Geo Entity 1	Geo Entity 2	Geo Entity 3
		A	B	C
1	Weighted Composite Score	75.6	82.4	69.2
2	Total Entity Composite Score by Bene (**Sum Line 1**)	227.2	227.2	227.2
3	Attribution Probability (Line 1 / Line 2)	33%	36%	30%

In this example, Geo Entity B has the highest Weighted Composite Score and therefore the highest probability (36%) of receiving the beneficiary. However, CMS determines the final assignment probabilistically through random selection, ensuring that all eligible Geo Entities retain a weighted opportunity for attribution.

5.4.3.6 Random Selection

After calculating the beneficiary attribution probabilities for each eligible Geo Entity, CMS assigns beneficiaries using a stochastic, probability-based selection process. CMS derives each beneficiary's attribution probabilities from the Weighted Composite Scores and uses those probabilities to inform, but not deterministically dictate, final attribution.

CMS uses a probabilistic WRGA approach to increase the likelihood that beneficiaries attributed to Geo Entities with higher composite scores while continuing to attribute beneficiaries across all eligible Geo Entities within the applicable service area. Unlike a simple random assignment approach that treats all Geo Entities equally, WRGA incorporates performance-based weighting to differentiate attribution probabilities across Geo Entities while preserving probabilistic attribution.

Even when differences in composite scores exist, the random selection process may attribute a beneficiary to a Geo Entity with a lower probability. However, across a large population, the overall distribution of beneficiaries reflects the relative probabilities assigned to each Geo Entity. As a result, Geo Entities with a broader service area, higher composite scores, or both may receive a larger share of WRGA-attributed beneficiaries.

CMS may consider additional distribution guardrails in future refinements, such as minimum or maximum thresholds for WRGA-attributed beneficiaries, particularly in states with a mix of statewide and substate Geo Entities, to promote balanced participation and alignment with model objectives. Any such refinements would be specified through future CMS guidance.

5.5 Attributed Beneficiary Lists

The attribution process produces Geo Entity-specific attributed beneficiary lists for each PY. Each list represents the complete set of beneficiaries assigned to a single Geo Entity based on the attribution methodology described above. Across the Model, these attributions collectively form a complete, non-overlapping, and population-wide set of attributed beneficiaries for which Geo Entities are financially accountable during the PY.

Attribution is performed using a defined reference period to establish an initial attributed population prior to the start (or early in the course) of the PY. This population is subsequently updated in accordance with the Model's attribution cadence, with periodic reassessment of beneficiary attribution based on updated information (**See Section 5.7 Attribution Cadence and Population Stability**). The resulting Geo Entity-specific attributed beneficiary list defines the population for which each Geo Entity is accountable for PY activities (e.g., PCC, performance measurement, Financial Settlement).

5.6 Attribution Lookback Period

The attribution lookback period defines the time frame used to evaluate beneficiary care patterns for CBA and consists of two sequential attribution years. This structure enables CMS to capture both historical care relationships and more recent utilization patterns, ensuring that attribution reflects an ongoing and substantive connection to providers.

The Attribution Lookback Period includes:

- **Attribution Year 1:** the 12-month period ending 15 months prior to the start of the applicable PY or BY, and
- **Attribution Year 2:** the 12-month period ending 3 months prior to the start of the applicable PY.

Table 5.6 Contract Period 1 Attribution Lookback Period for Each PY

PY	Attribution Lookback Period: Year 1	Attribution Lookback Period: Year 2
PY2028	10/1/2025 – 9/30/2026	10/1/2026 – 9/30/2027
PY2029	10/1/2026 – 6/30/2027	10/1/2027 – 9/30/2028
PY2030	10/1/2027 – 6/30/2028	10/1/2028 – 9/30/2029
PY2031	10/1/2028 – 6/30/2029	10/1/2029 – 9/30/2030

5.6.1 Mid-Year Attribution Lookback Periods

Mid-year attribution updates do not introduce new beneficiaries into the PY population; rather, they allow for reassessment and potential reassignment of beneficiaries across attribution pathways (**See Section 5.7 Attribution Cadence and Population Stability**).

To support mid-year attribution (occurring prior to Q2, Q3, and Q4), the attribution lookback period will shift forward by three months each quarter to incorporate more recent claims experience into the attribution process. This rolling adjustment ensures that attribution reflects current care patterns and allows for more timely updates to beneficiary attribution pathways.

Mid-year attribution lookback periods follow the same two-year structure defined for annual attribution, with both attribution years shifting forward in tandem (**See Table 5.7 Quarterly Attribution Lookback Periods**).

Table 5.7 Quarterly Attribution Lookback Periods (PY 2028 Example)

Quarter	Attribution Lookback Period: Year 1	Attribution Lookback Period: Year 2
Q2 2028 (04/01/2028)	1/1/2026 – 12/31/2026	1/1/2027 – 12/31/2027
Q3 2028 (07/01/2028)	4/1/2026 – 3/31/2027	4/1/2027 – 3/31/2028
Q4 2028 (10/01/2028)	7/1/2026 – 6/30/2027	7/1/2027 – 6/30/2028

For example, the attribution lookback period used for Q1 2028 attribution spans 10/1/2025 through 9/30/2027 across the two attribution years. For Q2 2028, both attribution years shift forward by three months, with subsequent quarters continuing this forward progression.

Mid-year attribution lookback periods are used to support ongoing attribution updates, including CBA and other methodologies that rely on recent claims experience, as further described in **Section 5.7 Attribution Cadence**.

5.7 Attribution Cadence and Population Stability

Attribution Cadence. CMS conducts prospective attribution before the start of each PY and performs quarterly attribution updates during the PY. This cadence balances the need for population

stability with the ability to incorporate updated beneficiary care patterns and Geo Entity provider participation changes over time.

Initial Attribution and Within-Year Stability. At the start of a PY, CMS assigns all eligible beneficiaries to Geo Entities through VA, CBA, or Geographic Attribution. Beneficiaries attributed prior to the start of the PY remain attributed to the same Geo Entity for the duration of the PY to ensure stability in the attributed population, except in cases where the beneficiary voluntarily elects to attribute to a different Geo Entity. CMS leaves beneficiaries who become Geo AHEAD-eligible after the start of a PY unattributed unless they VA to a Geo Entity.[15] CMS will address whether beneficiaries prospectively attributed to another ACO program or model may elect VA to a Geo Entity after the start of the PY, including the timing of when such elections become effective, in the Geo AHEAD Technical Specifications Version 2.

Cross-Year Stability for WRGA Attribution. In addition to within-year stability, CMS maintains attribution for beneficiaries attributed through WRGA with the same Geo Entity in the subsequent PY, provided they remain eligible and continue to meet WRGA criteria. After two years of WRGA to a Geo Entity, unless a care relationship with the Geo Entity's Participants or Affiliates is observed through claims or the Geo Entity attests to having provided non-fee schedule services to the beneficiary, such beneficiaries become eligible for reassignment through WRGA to a different Geo Entity. Beneficiaries attributed through WRGA are eligible for re-assignment to another Geo Entity through Voluntary Attribution or Claims-Based Attribution prior to the end of the two-year window.

VA Timing and Updates. Beneficiaries may VA to a Geo Entity at any point during the PY; however, VA is limited to one designation per PY.[16] The designation period for VA effective in a PY spans from three months prior to the start of the PY through the end of the PY. CMS updates VA attribution lists monthly.

Quarterly Attribution Updates. During the PY, CMS conducts quarterly attribution updates to incorporate new claims experience using the updated Attribution Lookback Period (**See Section 5.6 Attribution Lookback Period**). Geographically Attributed beneficiaries who receive qualifying services from providers associated with their Geo Entity may be converted to CBA (to the same Geo Entity) during these quarterly updates. CMS does not reassign beneficiaries during the PY based on services furnished by providers associated with a different Geo Entity (i.e., beneficiaries will not be de-attributed from one Geo Entity and attributed to another due to CBA during the year) and instead reflects those services in attribution updates for the subsequent PY. This policy preserves continuity of attribution avoids frequent reassignment based on short-term utilization changes and reduces the probability that beneficiaries are reassigned across Geo Entities during the PY.

Provider Roster Updates and Eligibility Changes. CMS will allow Geo Entities to update their Geo Participant Roster during the PY (e.g., prior to Q3), which may expand a Geo Entity's Provider Roster and enable conversion of beneficiaries to CBA based on services furnished by newly participating providers. More information will be provided on Provider Roster updates in Geo AHEAD Technical Specifications Version 2.

If a Geo Participant leaves Geo AHEAD during the PY, or if updated claims experience would otherwise change a beneficiary's attribution, the beneficiary will remain attributed to their original

[15] CMS will attribute beneficiaries that do not VA at the start of the following PY.

[16] If a beneficiary submits a second VA within a PY, CMS will honor their most recent VA at the start of the following PY.

Geo Entity for the remainder of the PY. This approach further supports population stability and consistent accountability during the performance period.

Beneficiaries who lose eligibility are removed from attribution at the start of the subsequent quarter.

5.8 Tiebreaker rules

CMS applies the following tiebreaker rules when attribution cannot be determined based on standard methodology.

Claims-Based Attribution – Key Services: In cases where a beneficiary receives multiple qualifying Key Services on the same date from providers associated with different Geo Entities, the beneficiary is attributed to the Geo Entity associated with the provider that submitted the claim with the highest allowed amount for the qualifying Key Service. If the allowed amounts are equal, CMS proceeds to weighted allowable PQEM charges.

Claims-Based Attribution – Weighted Allowable PQEM Charge: In the case of a tie in the weighted allowed amounts for PQEM services across Geo Entities, CMS attributes the beneficiary to the Geo Entity associated with the most recent PQEM service within the Attribution Lookback Period. If still tied, CMS attributes the beneficiary to the Geo Entity associated with the next most recent prior qualifying service within the Attribution Lookback Period.

Geographic Attribution – Affiliate Relationship: In the case of a tie in weighted allowable PQEM charges across Affiliate providers associated with different Geo Entities, CMS attributes the beneficiary to the Geo Entity associated with the most recent PQEM service within the Attribution Lookback Period. If still tied, CMS assigns based on the next most recent prior qualifying service within the Attribution Lookback Period.

Geographic Attribution – Household Unity: In the case of a household with three or more Geo AHEAD-eligible beneficiaries, where household members are attributed to different Geo Entities via Primary Care Specialists, and no single Geo Entity can be assigned based on HHU rules, CMS assigns the remaining beneficiary using the WRGA among the tied Geo Entities.

5.9 Performance Year Beneficiary List Maintenance and Updates

Throughout the PY, CMS may update Geo Entity-specific attributed beneficiary lists to reflect changes in beneficiary attribution and model eligibility. Updates may include the addition of new VA beneficiaries, the removal of beneficiaries due to model overlap restrictions, and other changes that affect a beneficiary's participation in Geo AHEAD.

CMS will maintain beneficiary-level records indicating the months during which each beneficiary is attributed to a Geo Entity and eligible for inclusion in Geo AHEAD calculations. CMS will also maintain updated Geo Entity Provider Rosters during the PY to reflect changes in participating providers.

CMS will use these updated beneficiary and provider records to support benchmark calculations, PY expenditure calculations, capitation payments, and financial settlement. At the conclusion of the PY, CMS will create final beneficiary attribution and provider rosters that will serve as the basis for final financial settlement calculations.

CMS will provide additional information regarding attribution update cycles, provider roster maintenance, beneficiary month calculations, and financial settlement processes in Geo AHEAD Technical Specifications Version 2.

6.0 Overview of Benchmark

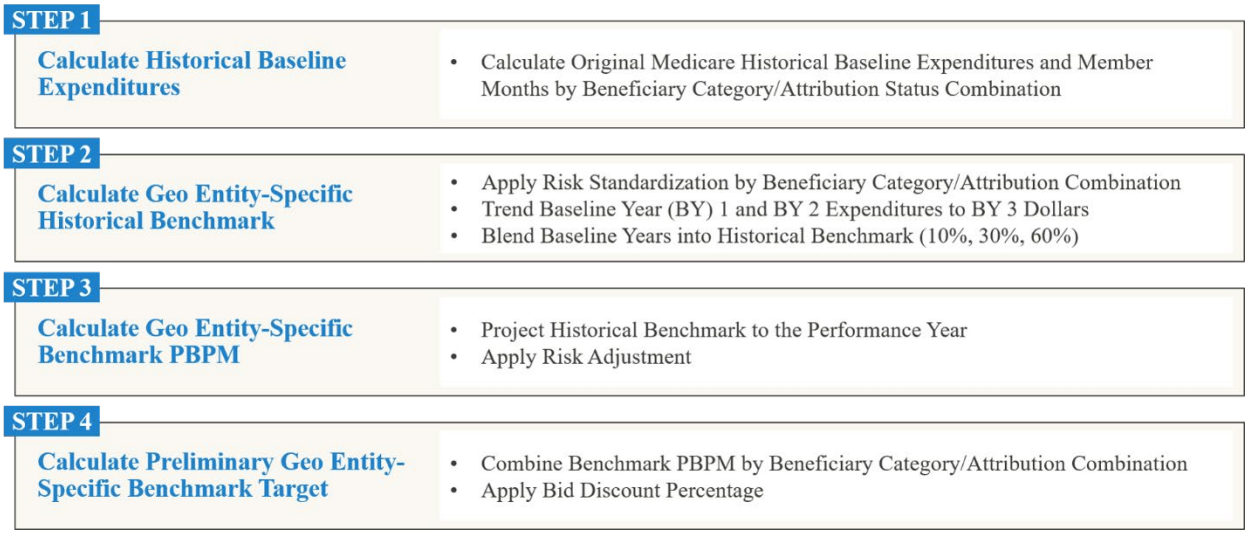
The Geo AHEAD benchmark establishes the financial foundation for evaluating Geo Entity performance under the Model. For each Geo Entity, the benchmark defines the expected TCOC for the attributed Original Medicare population against which actual spending is compared to determine Shared Savings or Losses.

The benchmark construction is built on the following foundational elements:

- **TCOC Accountability**. CMS compares PY expenditures against benchmark expenditures, less the Geo Entity bid discount percentage to determine financial performance.
- **Beneficiary Categories**. CMS establishes distinct baselines and trend factors for meaningfully different groups including, but not limited to, the End-Stage Renal Disease (ESRD) and Non-ESRD populations. Additional details regarding beneficiary categories, including any additional categories (e.g., High Needs, Low Medicare Utilizers) that may be incorporated into the benchmark methodology, will be provided in Geo AHEAD Technical Specifications Version 2.
- **Attribution Types.** CMS calculates historical baseline expenditures and benchmarks separately by attribution type (i.e., VA, CBA, Geographic Attribution) to reflect differences in beneficiary-provider relationships and benchmark construction methodologies. Additional details regarding attribution types and their application in benchmark construction will be provided in Geo AHEAD Technical Specifications Version 2.
- **Shared Savings and Losses**. CMS calculates Shared Savings and Losses based on the difference between actual expenditures and the discounted benchmark, subject to quality performance and applicable risk-sharing parameters.

6.1 High-Level Benchmark Framework

Figure 6.1 Order of Operations for Benchmark Construction



This section describes the framework CMS uses to construct the Geo AHEAD benchmark, beginning with baseline population construction, historical Original Medicare FFS expenditures (**See Section 6.5 Costs Included in Historical Baseline Expenditures**) stratified into beneficiary categories and

attribution type, and progressing through risk standardization, trend, geographic adjustments, risk adjustment, and application of the Geo Entity-specific bid discount percentage.

6.1.1 Benchmark Definitions

Geo Entity-Specific Historical Baseline Expenditures are the Geo Entity's Medicare Parts A and B expenditures for beneficiaries included on the Geo Entity-specific baseline beneficiary lists during the three BYs. CMS calculates separate Historical Baseline Expenditures by each beneficiary category and attribution type.

Geo Entity-Specific Historical Benchmark means the risk-standardized, trended, and weighted-average blend of the Geo Entity's Historical Baseline Expenditures across the three BYs.

Geo Entity-Specific Benchmark PBPM means the beneficiary category- and attribution type-specific benchmark PBPM calculated for a Geo Entity after application of all benchmark construction adjustments, including risk standardization, trend, geographic adjustments, and risk adjustment. CMS uses it to calculate Geo Entity-Specific Benchmark Target by multiplying the applicable Geo Entity-Specific Benchmark PBPM by the corresponding beneficiary months associated with beneficiaries on the Geo Entity-specific attributed beneficiary lists for the applicable PY.

Preliminary Geo Entity-Specific Benchmark Target means the benchmark after CMS combines the beneficiary category- and attribution type-specific benchmarks into a single benchmark amount and applies the Geo Entity's Bid Discount Percentage.

Interim Geo Entity-Specific Benchmark Target means the updated benchmark that CMS provides to Geo Entities during the PY to reflect changes in attribution that impact the benchmark target. The interim benchmark target will be provided to the Geo Entity as a single benchmark amount and applies the Geo Entity's Bid Discount Percentage.

6.1.2 Benchmark Construction by Contract Period

For the initial contract period, CMS will establish the Preliminary Geo Entity-Specific Benchmark Target using a prospective benchmarking methodology. CMS derives the benchmark using a fixed three-year baseline period that precedes PY1 of Contract Period 1.[17] For example, for Geo Entities beginning participation in PY 2028, the baseline period consists of CY 2025 (BY 1), CY 2026 (BY 2), and CY 2027 (BY 3).

The baseline period remains fixed throughout the Geo Entity's participation in the contract period. However, CMS recalculates Geo Entity-Specific Historical Baseline Expenditures prior to each PY using the Geo Entity's Provider Roster and attributed beneficiary population for that PY. As a result, while the underlying baseline years remain unchanged, the Geo Entity-Specific Historical Baseline Expenditures and resulting Preliminary Geo Entity-Specific Benchmark Target may change from year to year to reflect changes in the Provider Roster and attributed beneficiaries.

Once established, CMS updates the Preliminary Geo Entity-Specific Benchmark Target prior to each PY to account for changes in attributed beneficiaries and for expected changes in spending overtime. This approach provides a stable and predictable benchmark trajectory throughout the contract period while maintaining alignment with projected spending growth.

[17] CMS will provide more information regarding the benchmark for Contract Period 2 in future iterations of the Geo AHEAD Technical Specifications.

For future contract periods, CMS may update the benchmark using more recent expenditure experience while balancing continuity and incentive alignment. CMS will provide additional information in future versions of the Geo AHEAD Technical Specifications.

6.2 Baseline Data and Time Period

CMS constructs the Geo-Entity Specific Historical Baseline using Original Medicare FFS claims and payment data for beneficiaries included on the Geo Entity-specific Baseline Beneficiary Lists (**See Section 4.0 Overview of Eligible Population and Beneficiary Eligibility**). Baseline expenditures include only the months during the baseline period in which each beneficiary meets Geo AHEAD eligibility criteria.

The baseline period is three years. BYs are weighted to prioritize more recent experience, with the oldest year (BY 1) assigned a 10 percent weight, the middle year (BY 2) a 30 percent weight, and the most recent year (BY 3) a 60 percent weight.

CMS will provide final specifications for the baseline time periods, any gap period, and any adjustments in the Geo AHEAD Technical Specifications Version 2.

6.3 Baseline Population Construction

For each BY, CMS creates a Geo Entity-specific baseline beneficiary list using the attribution-eligible beneficiary list and the applicable attribution methodology (**See Section 4.0 Overview of Eligible Population and Beneficiary Eligibility** and **Section 5.0 Overview of Beneficiary Attribution**). These lists identify the beneficiaries whose historical expenditures and beneficiary months may be included in the Geo Entity's Historical Baseline Expenditures and benchmark calculations.

Historical Baseline Expenditures and beneficiary months are calculated separately for each Geo Entity using the beneficiaries included on the applicable Geo Entity-specific baseline beneficiary lists. Historical Baseline Expenditures are calculated separately for each beneficiary category and attribution type combination (**See Section 6.4 Beneficiary Categories**). The methodology used to calculate Historical Baseline Expenditures may differ across attribution pathways. Preliminary information regarding benchmark construction by attribution pathway is provided below. CMS will provide additional details regarding benchmark population construction and benchmark methodologies for each beneficiary category and attribution type in Geo AHEAD Technical Specifications Version 2.

CMS calculates expenditures for each BY using paid amounts on Original Medicare FFS claims incurred (**See Section 6.5 Costs Included in Historical Baseline Expenditures**) during that year for beneficiaries included in the corresponding Geo Entity-specific baseline beneficiary list. Expenditures reflect the actual spend experience (paid amount) of the population during that period and include only months in which each beneficiary meets applicable eligibility criteria (**See Section 4.0 Overview of Eligible Population and Beneficiary Eligibility**).

The Preliminary Geo Entity-Specific Benchmark Target is calculated separately for each Geo Entity based on the beneficiaries who are attributed to the Geo Entity in the PY. The methodology used to construct Historical Baseline Expenditures may differ across attribution pathways (i.e., VA, CBA, Geographic Attribution) to reflect differences in beneficiary attribution and sources of historical expenditure experience. CMS will provide final specifications regarding benchmark population construction and expenditure calculation methodologies for each attribution type in Geo AHEAD Technical Specifications Version 2.

6.4 Beneficiary Categories

CMS calculates the historical baseline expenditures separately for each beneficiary category. Beneficiary categories stratify the Geo AHEAD population to account for meaningful differences in expected expenditures across beneficiary categories and attribution types. Although risk adjustment accounts for differences in clinical risk, stratification of the population into beneficiary categories addresses systematic differences in spending levels and growth patterns across beneficiary populations, such as ESRD.

CMS assigns beneficiaries within each BY to model-defined beneficiary category based on characteristics observed during that year. This approach directly incorporates these structural differences into benchmark construction, ensures benchmarks reflect differences in expected spending, and reduces the potential for selection bias. CMS carries these strata forward in the calculation of Benchmark Expenditures, PY Expenditures, and Final Financial Settlement.

CMS calculates Geo Entity-Specific Historical Baseline Expenditures separately for each beneficiary category and attribution type. As a result, a Geo Entity will have separate Historical Baseline Expenditures for each combination of beneficiary category and attribution type.

Attributed beneficiaries are assigned to a beneficiary category based on their Medicare entitlement status during the applicable period.

Table 6.1 Core Beneficiary Category Definitions

Population	Definition
ESRD Beneficiaries	Beneficiaries include those whom CMS identifies as having End Stage Renal Disease based on Medicare enrollment and entitlement indicators (e.g., Entitlement File ESRD status), with supporting identification from claims-based diagnosis and utilization data (e.g., ESRD-related diagnoses captured in Medicare claims and risk adjustment inputs).
Non-ESRD Beneficiaries	Beneficiaries include all other Original Medicare FFS beneficiaries who do not meet the criteria for ESRD during the applicable period.

CMS may incorporate additional beneficiary categories beyond this dichotomy or within the non-ESRD population. CMS will specify the final approach in the Geo AHEAD Technical Specifications Version 2.

6.5 Costs Included in Historical Baseline Expenditures

TCOC under Geo AHEAD is calculated by summing all Original Medicare FFS expenditures for attribution-eligible beneficiaries for each BY. TCOC reflects Medicare payments for covered services, inclusive of applicable adjustments and programmatic modifications, and is intended to capture the full scope of paid amounts for which Geo Entities are accountable under the Model.[18] CMS calculates TCOC expenditures using the equation found in **Eq. 6.1: TCOC Expenditures**.

$$\textbf{Eq. 6.1: TCOC Expenditures} = \sum(A + B + NCBP - APC)$$

Where:

- A = Medicare Part A Claims Payments which include but are not limited to inpatient hospital, skilled nursing facility (SNF), hospice, and home health agency services;

[18] CMS may include the Federal share of Medicaid costs for dually enrolled beneficiaries as part of TCOC. More information will be available in the Geo AHEAD Technical Specifications Version 2.

- B = Medicare Part B Claims Payments which include but are not limited to physician and supplier services, outpatient hospital care, durable medical equipment (DME), and other covered services;
- $NCBP$ = Payments made under prospective or capitated payment arrangements, including those associated with PC AHEAD or other CMS initiatives, may be treated differently from traditional FFS claims to ensure that expenditures reflect comparable underlying service use; and
- APC = Adjusted Payment Categories (e.g., Uncompensated Care, Disproportionate Share Hospital).

Expenditures include all eligible claims with a claim from date occurring during the applicable BY or PY, allowing for a three-month claims run-out period. CMS assigns claims to a BY or PY based on the claim from date. As a result, claims with a from date during the applicable period are included in expenditure calculations, even if the through date occurs in a subsequent BY or PY. CMS excludes denied claims and denied claim lines from expenditure calculations.

These expenditures reflect Medicare claim paid amounts, including any standard adjustments or modifications applied through CMS payment systems. Sequestration is also subtracted, but its removal is reflected in the claim paid and NCBP amounts, unless otherwise noted.

Certain payment categories of expenditure will be excluded to maintain consistency with model design and policy intent, including but not limited to:

- **EPCP:** CMS will exclude EPCP from TCOC expenditures because it represents a prospective payment to support care delivery and care management activities rather than claims-based spending associated with specific services. CMS also excludes EPCP to maintain consistent treatment across AHEAD components (e.g., Geo AHEAD and PCA) and other CMS models, and to avoid penalizing investments in care management and primary care coordination.
- **Uncompensated Care (UCC), Disproportionate Share Hospital (DSH) and Similar Payments:** CMS will exclude or adjust payments associated with UCC, DSH, or other supplemental payments to ensure that expenditures reflect underlying service use and spend patterns.

CMS may apply additional exclusions for adjustments such as those for SAHS billing or exogenous policy changes or payment reforms that materially affect expenditure patterns but are not reflective of underlying care delivery or efficiency. CMS will provide finalized details on the costs included in the Historical Baseline Expenditures in the Geo AHEAD Technical Specifications Version 2.

6.6 Order of Operations for Benchmark Construction

A defined sequence of steps constructs the Preliminary Geo Entity-Specific Benchmark Target using historical Original Medicare FFS expenditures. Throughout benchmark construction, CMS performs calculations separately for each beneficiary category and attribution type combination. Historical Baseline Expenditures, historical benchmarks, trend adjustments, and risk adjustments are calculated independently for each benchmark component and carried forward through the benchmark construction process. CMS combines these benchmark components only after all applicable adjustments have been applied to produce a single benchmark amount for the Geo Entity's attributed

population, after which CMS applies the Geo Entity-Specific Bid Discount Percentage to determine the Preliminary Geo Entity-Specific Benchmark Target.

CMS will provide baseline spending, referred to as the Benchmark Rate, to bidding entities as part of the RFA.[19] Benchmark Rates will be provided separately by beneficiary category.

6.6.1 Step 1: Calculate Historical Baseline Expenditures

CMS calculates the Historical Baseline Expenditures for each beneficiary category, for each BY (See **Section 6.5 Costs Included in Historical Baseline Expenditures**). Historical Baseline Expenditures will be expressed as a PBPM and calculated using provider experience, beneficiary experience, and geographic experience. CMS may use different sources of historical expenditure experience and benchmark development approaches across attribution types. For example, benchmark methodologies for provider-based attribution pathways may rely primarily on provider experience, while benchmark methodologies for Geographic Attribution may rely primarily on beneficiary and geographic experience. CMS may also apply different trend and geographic adjustment methodologies, as appropriate, to support accurate expenditure projections for each attribution type. CMS will provide more information on which level (i.e., provider, beneficiary, geographic) of experience is used for each beneficiary category and how the Historical Baseline Expenditures are calculated across attribution types (i.e., VA, CBA, Geographic Attribution) in the Geo AHEAD Technical Specifications Version 2.

CMS may also apply additional policies or adjustments to address circumstances in which Geo Participants or Geo Entities have limited or no historical claims experience during the baseline period, as well as other attribution type-specific benchmarking considerations. CMS may also establish minimum credibility standards for benchmark components based on beneficiary counts, beneficiary months, historical expenditures, or other measures of statistical reliability. Benchmark components that do not meet CMS-defined credibility thresholds may be subject to alternative methodologies or adjustments designed to improve stability and predictability.

6.6.2 Step 2: Calculate Geo Entity-Specific Historical Benchmark

After CMS calculates Historical Baseline Expenditures for each beneficiary category and attribution type for each BY, CMS applies risk standardization, trends BY 1 and BY 2 expenditures to BY 3 dollars, and blends the weighted baseline years to produce a separate Geo Entity-Specific Historical Benchmark for each beneficiary category and attribution type combination.

6.6.2.1 Step 2.1: Apply Risk Standardization

Risk standardization is a method for standardizing expenditures by removing variation that is due to differences in population health risks. CMS applies risk standardization, using Hierarchical Condition Category (HCC) risk scores, to account for underlying differences in the Geo Entity's population health risk across BYs.[20] This adjustment ensures that expenditure comparisons reflect differences in underlying clinical risk rather than variation in population health. A Geo Entity's

[19] The Benchmark Rate will not be used to hold Geo Entities accountable for expenditures incurred during the PY. A Geo Entity-Specific Benchmark Target will be calculated to determine Shared Savings or Losses.

[20] CMS may incorporate AI Inferred Risk Scores to account for some or all risk adjustment in the benchmark as new CMS risk adjustment tools become available. See Long-term Enhanced ACO Design (LEAD) Request for Applications page 62: https://www.cms.gov/priorities/innovation/files/lead-rfa.pdf.

average risk score by beneficiary category for each BY is calculated as a beneficiary month-weighted average risk score of each Geo Entity's attributed beneficiary.

Risk standardization occurs using the Geo Entity's Historical Baseline Expenditures from Step 1 (expressed as PBPMs) for each BY divided by the Geo Entity's average risk score for attributed beneficiaries by beneficiary category and BY; this creates the risk-standardized Geo Entity's Historical Baseline Expenditures.

More information on the risk adjustment model used for each beneficiary category will be available in the Geo AHEAD Technical Specifications Version 2.

6.6.2.1.1 Normalization and Coding Intensity Controls

CMS may apply risk score normalization (i.e., dividing Geo Entity average risk scores by the national average to account for changes in coding practices over time), and coding intensity controls as part of the risk adjustment methodology. CMS uses these controls to align risk scores across time periods and limit the impact of changes in coding practices that do not reflect true changes in underlying health status. These controls may include:

- **Risk score normalization**, which aligns average risk scores across populations, time periods, and geographic areas; and
- **Coding intensity adjustments or caps**, which limit the impact of coding changes not attributable to true changes in beneficiary health status.

CMS will provide final specifications for risk score normalization and coding intensity controls by beneficiary category in the Geo AHEAD Technical Specifications Version 2.

6.2.2.2 Step 2.2: Trend BY 1 and BY 2 to BY 3 Dollars

CMS trends BY 1 and BY 2 Geo Entity-Specific Historical Baseline Expenditures forward to BY 3 dollars. CMS may apply additional adjustments to ensure comparability of BY expenditures, including adjustments for differences in payment rates or pricing across BYs, as appropriate. CMS will provide more information on the trend methodology and any additional adjustments in the Geo AHEAD Technical Specifications Version 2.

6.2.2.3 Step 2.3: Calculate Weighted Baseline

After BY 1 and BY 2 is trended to BY 3 dollars, CMS blends the risk standardized Geo Entity-Specific Historical Baseline Expenditures into the Geo Entity-Specific Historical Benchmark (**See Eq. 6.2: Weighted Baseline Calculation**) for each beneficiary category and attribution type combination.

BYs are weighted to prioritize more recent experience, with the oldest year (BY 1) assigned a 10 percent weight, the middle year (BY 2) a 30 percent weight, and the most recent year (BY 3) a 60 percent weight. This weighting approach balances the use of recent expenditure experience with the stability provided by a multi-year baseline.

Eq. 6.2: Weighted Baseline $= (10\% \times Exp_{BY1}) + (30\% \times Exp_{BY2}) + (60\% \times Exp_{BY3})$

Where:

- Exp_{BY} = Historical Baseline Expenditure for the specified BY after application of risk standardization and, for BY 1 and BY 2, trend.

The resulting Geo Entity-Specific Historical Benchmark represents a beneficiary category- and attribution type-specific estimate of historical expenditures that serves as the basis for projection to the PY.

6.6.3 Step 3: Calculate Geo Entity-Specific Benchmark PBPM

Following the calculation of the Geo Entity-Specific Historical Benchmark for each beneficiary category and attribution type combination, CMS calculates the Geo Entity-Specific Benchmark PBPM by applying a prospective trend factor to project expenditures to the applicable PY (CMS may apply additional geographic adjustments to account for regional differences) and applying risk adjustment to reflect the average risk of the Geo Entity's attributed beneficiary population in the PY.

6.6.3.1 Step 3.1: Apply Trend

Using the Geo Entity-Specific Historical Benchmark, calculated in Step 2, CMS applies a prospective trend factor to project expenditures to the applicable PY. The Geo AHEAD trend methodology aligns with the broader AHEAD Model framework by incorporating AHEAD State Growth Targets.

CMS may apply different trend factors to each beneficiary category, attribution type, and source of historical expenditure experience used, and may incorporate additional components to reflect variation in expenditure growth across regions or populations. CMS will provide the final trend methodology in the Geo AHEAD Technical Specifications Version 2.

6.6.3.1.1 Step 3.1.1: Geographic/Regional Adjustments

CMS may apply geographic or regional adjustments, where applicable, to account for variation in expenditure levels, payment rates, or spending growth across geographic areas. The structure and application of these adjustments may differ by attribution type. These adjustments, if applied, supplement baseline expenditure measurement and ensure consistency in how geographic differences are reflected in benchmark construction. CMS will specify the precise structure and application of geographic adjustments in the Geo AHEAD Technical Specifications Version 2.

6.6.3.2 Step 3.2: Apply Risk Adjustment

Next, CMS applies risk adjustment to reflect the average risk of the Geo Entity's attributed PY population for each applicable benchmark component. Risk adjustment will be applied within each beneficiary category using the risk adjustment methodology specified for that beneficiary category. For beneficiary categories that include multiple attribution types, CMS may use the same risk adjustment methodology across attribution pathways while calculating risk-adjusted benchmark components separately based on the attributed population associated with each attribution type. CMS will provide final specifications for risk adjustment in Geo AHEAD Technical Specifications Version 2.

This risk adjustment step builds on the risk standardization performed during **Step 2.1: Apply Risk Standardization**. CMS risk-standardizes the Geo Entity-Specific Historical Benchmark by dividing BY expenditures by the applicable average HCC risk score for each BY. As a result, the Geo Entity-Specific Historical Benchmark, after trending to the PY, is expressed in risk-standardized terms. To reflect the risk of the Geo Entity-specific Attributed Beneficiary List, CMS must convert the risk-standardized, trended PBPM for each beneficiary category by multiplying the trended Geo Entity-Specific Historical Benchmark by the Geo Entity's average PY risk score for the applicable beneficiary category. CMS calculates the average PY risk score as a beneficiary month-weighted

average risk score for beneficiaries attributed to the Geo Entity in the applicable beneficiary category. For each beneficiary, CMS includes only the months in which the beneficiary is eligible for attribution. For each Geo Entity, CMS multiplies each beneficiary's risk score by the beneficiary's eligible months, sums those weighted risk scores across attributed beneficiaries, and divides by the beneficiary category's total number of eligible beneficiary months.

Section 6.6.2.1.1 Normalization and Coding Intensity Controls contains more details regarding CMS's application of normalization and coding intensity controls.

6.6.4 Step 4: Calculate Preliminary Geo Entity-Specific Benchmark Target

After calculating the Geo Entity-Specific Benchmark PBPM, CMS must combine the benchmark PBPM for each beneficiary category and attribution type and apply the Geo Entity-Specific Bid Discount Percentage to produce the Preliminary Geo Entity-Specific Benchmark Target.

6.6.4.1 Step 4.1: Combine PBPMs to Calculate Total Trended Risk-Adjusted Historical Expenditures by Beneficiary Category

Up until this point, CMS has completed each step separately for each beneficiary category and attribution type. To create the Preliminary Geo Entity-Specific Benchmark Target that the PY expenditure can be measured against for the purposes of Shared Savings or Losses, CMS multiplies the benchmark PBPM for each beneficiary and attribution category calculated in **Step 3.2** by the corresponding months associated with beneficiaries on the Geo Entity-specific Attributed Beneficiary List for the PY.

6.6.4.2 Step 4.2: Apply the Bid Discount Percentage.

At the conclusion of benchmark construction, CMS applies the Geo Entity-Specific Bid Discount Percentage (**See Section 2.5.1 Bid Discount Process**) to determine the Preliminary Geo Entity-Specific Benchmark Target used for financial settlement.

6.7 Interim Geo Entity-Specific Benchmark Target

Throughout the PY, CMS will update the Preliminary Geo Entity-Specific Benchmark Target to account for attribution attrition and newly attributed beneficiaries through VA. The resulting benchmark target is referred to as the Interim Geo Entity-Specific Benchmark Target.

The benchmark PBPMs (**See Step 3: Calculate Geo Entity-Specific Benchmark PBPM**) established through the benchmark construction process are not recalculated during these interim updates. Instead, CMS updates the PY beneficiary attribution, beneficiary months, and other applicable benchmark inputs used to calculate Geo Entity-Specific Benchmark Target Expenditures (i.e., return to and completes Step 3.3 and Step 3.4). Using the updated attribution and beneficiary month information, CMS recalculates the applicable benchmark expenditure amounts and the resulting Interim Geo Entity-Specific Benchmark Target. CMS will provide more information on the cadence and methodology for the Interim Geo Entity-Specific Benchmark Target in the Geo AHEAD Technical Specifications Version 2. See **Section 8: Overview of the Financial Settlement Process** for more information on the application of the Geo Entity-Specific Benchmark Target.

7.0 Overview of Alternative Prospective Payments

Under Geo AHEAD, Geo Entities receive quarterly prospective payments to support advanced primary care services and comprehensive care delivery. These payments include EPCP and PCC. CMS calculates payment amounts based on the number of beneficiaries attributed to the Geo Entity through VA and CBA. Consistent with the structure of these prospective payments, certain claims corresponding to services included in PCC and EPCP may be reduced or zero-paid, with the expected value of such services reflected in the prospective PBPM payments. Services that are not eligible for inclusion in PCC or EPCP, including services subject to applicable privacy protections (e.g., substance use disorder-related services), continue to be adjudicated under standard Medicare FFS payment rules. These adjustments are incorporated into PY Expenditure calculations to ensure alignment between prospective payments and TCOC measurement.

The EPCP and PCC methodologies described in this section remain under development as Geo AHEAD aligns payment approaches with PC AHEAD and incorporates lessons and design considerations from other CMS capitated payment models. CMS will provide the final methodology, including payment design parameters and calculation specifications, in the Geo AHEAD Technical Specifications Version 2.

7.1 Enhanced Primary Care Payment

The EPCP is structured as a non-visit-based payment and is adjusted for beneficiary medical and population risk. Geographic attribution does not generate an EPCP. It is provided in addition to FFS payments to support the delivery of advanced primary care services (PCS). EPCP is excluded from both PY Benchmark calculations and PY Expenditure calculations; therefore, EPCP does not affect the calculation of shared savings or losses. CMS will publish the final EPCP methodology in the Geo AHEAD Technical Specifications Version 2, including:

- **The Final Primary Care Geo Participant and PCS code sets** and any provider-type-specific variations.
- **The Calculation of the Geo Entity-Specific EPCP**. While The EPCP is calculated using a consistent statewide base rate across all AHEAD Model components. The Geo Entity-specific EPCP incorporates **Medical and Population Risk Adjustment** to reflect difference in beneficiary health status and characteristics.
- **Calculation of Retrospective Debits for Recoupments.** CMS conducts a retrospective reconciliation after each quarter to account for overpayments made to the Geo Entity ("EPCP Eligibility Debit") because of changes in beneficiary eligibility (e.g., death, attribution changes). CMS determines eligibility at the individual beneficiary-level for each month of attribution. The EPCP Eligibility Debit is recouped on a two-quarter lag. CMS may apply recoupments across PYs, and in rare cases, data delays in CMS systems may require recoupments from additional quarters. As a result, CMS may reflect adjustments for Quarters 3 and 4 in subsequent PY payments.
- **Calculation of Geo Entity-EPCP Payable.** The total amount of the EPCP a Geo Entity can expect to receive at the beginning of the quarter includes the prospective EPCP for the next 3 months, less the EPCP Eligibility Debit. As with all Medicare payments, EPCPs are also subject to budgetary sequestration requirements, if active.

- **Zero-Payment for Duplication of Services.** Certain care management services are considered duplicative of the services and supports covered under EPCP. The Medicare Administrative Contractor will "zero-pay" all care management service claims submitted for attributed beneficiaries (by Geo AHEAD Participants) under Medicare. Participants may continue to bill these services and beneficiary cost-sharing will not be reduced. However, no additional FFS payment is made. For beneficiaries not attributed to the Model or attributed through geographic attribution, claims for these services are processed under standard Medicare FFS payment rules.

7.2 Primary Care Capitation

All Primary Care Geo Participants in Geo AHEAD must participate in PCC (**See Appendix C.1 Primary Care Specialists**). PCC provides Geo Entities with additional care delivery flexibility and reduces the volume-based incentives of FFS payment. With capitated payments, Geo Entities receive steady, predictable cash flow that does not depend on the number of services provided. This flexibility frees health care providers to deliver care in innovative and flexible ways, such as non-face-to-face care management, telehealth, and electronic messaging, without worrying about foregone FFS revenue.

Geo Entities receive PCC payments for beneficiaries attributed through VA and CBA. Only Geo Participants that meet CMS-defined criteria for Primary Care Specialists within Geo AHEAD generate PCC payments for the Geo Entity. CMS determines eligibility for PCC based on provider type, participation status, and alignment with model-defined primary care service criteria. Certain provider types and settings are excluded from PCC eligibility. For example, CAHs are not eligible to receive PCC payments under Geo AHEAD. CMS may further specify eligibility criteria in future guidance.

7.2.1 Overview of the Capitated Payment

CMS provides PCC as a prospective, Geo Entity-specific PBPM payment at the beginning of each quarter. PCC replaces standard FFS payments for expected future claims associated with Select Primary Care Services (SPCS) (**See Appendix C.4 PCC Services**). To calculate the quarterly PCC payment, CMS adjusts historical expenditures to the applicable PY using current payment rules, including Physician Fee Schedule (PFS), Prospective Payment System (PPS), and All-Inclusive Rate (AIR), updates, code revaluation, and care-setting conventions. Standard FFS, PPS, or AIR payment rules apply to services furnished to geographically attributed or unattributed beneficiaries.

Geo Participants will continue to submit claims at the time of service for SPCS to collect applicable cost-sharing and demonstrate care patterns. The Medicare Administrative Contractor processes all in-scope claims as zero-pay because the PCC PBPM prospectively covers the expected payment amount at the beginning of the quarter. The PCC PBPM will be paid to the Geo Entity via the Innovation Payment Contractor. Reimbursement for non-PCC services follows the applicable Medicare payment system for each facility or practice type within the Geo Entity, including PFS for physician practices, PPS for FQHCs, and AIR for RHCs, together with sequestration and other applicable payment policies. QPP payment adjustments apply only to PFS-paid services and do not apply to RHC AIR or FQHC PPS encounter payments.

Geo Entities may retain the Capitated Payment, net of prospective eligibility adjustments and additional reconciliations, regardless of the volume of service the corresponding Geo Participants provide. Beneficiary cost-sharing on submitted FFS claims does not affect PCC payments, nor is it

included in the Capitated Payment. Beneficiaries remain responsible for the usual Part B deductible and coinsurance on the portion adjudicated under the applicable payment system. Beneficiary coinsurance for SPCS is calculated based on the original allowed amount prior to application of the capitation percentage. The prospective PBPM does not include coinsurance.

If a Geo Entity includes non-primary care specialists within a Participant TIN, CMS excludes those specialists from the PCC methodology and does not apply claims reductions to their services. This policy focuses PCC on SPCS and prevents capitated payments from affecting specialist services furnished through Participant TINs. CMS will provide additional detail in Geo AHEAD Technical Specifications Version 2, including:

- Select Primary Care Services Included in the capitation payment, including any provider-type-specific variations (**See Appendix C.4 PCC Services**).
- Calculation of the Capitated Payment (i.e., PCC Lookback Period, PCC Payment Rate Calculation, adjustments for CMS payment system updates and code revaluation, QPP Payment Factors, and New or Small-Volume Geo Entities, Rebasing).
- Reconciliation for Outside-of-Geo Entity Utilization.
- Reconciliation for FQHC and RHC Charges.

7.2.2 Select Primary Care Services Included in the Capitation Payment

CMS will set PCC payment rates by provider type to account for different payment methodologies. The specific services included in SPCS, as well as the corresponding coding definitions, may vary across provider types and care settings.

CMS will publish updates to SPCS lists prior to the start of each PY. Unless otherwise specified, changes are effective January 1 of the PY and are reflected in PBPM rate setting and participant technical guidance.

7.2.3 Calculation of the Capitated Payment

CMS calculates the PCC payment that a Geo Entity receives from the Geo Entity's Primary Care Geo Participant's historical revenue during a historical PCC Lookback Period and adjusted forward to the current PY rate.

The PBPM calculation or the PCC Lookback Period may be modified in response to unforeseen developments; including changes in care volume or delivery patterns (e.g., increased use of telehealth services).

7.2.3.1 Step 1: Calculation of Historical Capitation Payment Rate

CMS bases Geo AHEAD PCC payment rates on the paid amounts for in-scope SPCS claims, furnished to beneficiaries attributed via VA or CBA through Selected Primary Care Specialists, to calculate the historical PCC payment. The population of beneficiaries who received services from the Geo Entity providers during the PCC Lookback Period may differ from those prospectively attributed to the Geo Entity for the PY. Because the PCC rate reflects the average volume and mix of services furnished to a typical Medicare FFS beneficiary, these population differences are not expected to materially affect the payment rate.

CMS calculates historical PCC payments by summing allowed amounts for SPCS, less beneficiary deductible and coinsurance (i.e., paid amounts), and dividing by beneficiary months for beneficiaries

attributed through VA or CBA through Selected Primary Care Specialists during the PCC Lookback Period to obtain an average PBPM payment.

Historical PCC payment amounts reflect Medicare-paid amounts for in-scope SPCS claims and exclude payments made by third parties. CMS excludes claims where Medicare is not the primary payer to ensure that capitation rates reflect Medicare financial responsibility only.

CMS determines Geo Entity-level member months used in the calculation by assessing beneficiary eligibility (**See Section 4.0 Overview of Eligible Population and Beneficiary Eligibility**) during each month of the PCC Lookback Period. [21] CMS applies the resulting Geo Entity-specific capitated rate, expressed on a PBPM basis, for payment during the PY (**See Section 7.2.6 Calculation of Final Net Capitation Payment**).

7.2.3.2 Step 2: Adjustments for CMS Payment System Updates and Code Revaluation

To account for changes in Medicare prices between the baseline period and the PY, CMS adjusts historical SPCS payments to reflect updates to Medicare payment systems, including the PFS, PPS, and AIR, as applicable. CMS recalculates historical SPCS amounts using current payment system rules based on provider type to ensure that capitation rates reflect PY payment policies and rates. For Participant practices within Geo Entities, CMS applies current Medicare PFS rules. For CHCs, CMS applies current-year PPS (FQHC) or AIR (RHC) methodologies, except for services paid under PFS-based policies (e.g., distant-site telehealth or specific care management services), which CMS restates using current PFS rules. This PFS restatement includes:

- **National conversion factor (CF) Relative Value Units (RVUs), and Geographic Updates**: CMS recalculates historical allowed amounts using current-year RVUs, the national CF, and applicable GPCI values to reflect PY payment rates, including updates to relative values and geographic payment adjustments.
- **Code Revaluation and Maintenance**: Apply PY relative value and payment rules, including revaluation of existing SPCS codes and crosswalks for retired or replaced codes to their current equivalents, ensuring the rate reflects the current fee schedule.

CMS may introduce new or revised PFS codes that affect capitation payment calculations for a calendar year. To maintain accurate PBPM calculations and claims adjudication under PCC, CMS incorporates necessary updates following final code adoption.

Participant FQHCs within Geo Entities restate historical SPCS amounts using the current FQHC PPS to align historical PCC payments to the PY. This restatement includes:

- **PPS Updates to the Base Rate**: Increase historical payments to reflect the current PPS rate where PPS billing occurs or use the most recent submitted charges where PPS billing does not apply.
- **Geographic Payment Updates**: CMS applies current geographic adjustment factors (e.g., GPCI for PFS, GAF for PPS) when recalculating historical allowed amounts to reflect PY locality-based payment differences.

[21] EPCP exclusion rules for beneficiaries aligned with Medicare Shared Savings Program or LEAD (Section 3.3) do not apply when determining Capitation Payment eligibility.

- **Code Revaluation and Maintenance**: Apply PY relative value and payment rules, including revaluation of existing SPCS codes and crosswalks for retired or replaced codes to their current equivalents, ensuring alignment with the current fee schedule. For FQHCs, this applies only to services paid at the national fee schedule rate and does not apply to services reimbursed under the FQHC PPS.

For Participant RHCs within Geo Entities, historical SPCS amounts are restated using the current RHC AIR payment system to align historical PCC payments to the PY. This restatement includes:

- **AIR Updates**: Increase historical payments to reflect the current AIR where AIR billing occurs, or use the most recent submitted charges where AIR billing does not apply.

7.2.3.4 Step 3: Adjustments for QPP Payment Factors

Geo Entities may include Geo Participants whose Medicare payment rates are adjusted during the PY through QPP factors, including Merit-based Incentive Payment System (MIPS) adjustments or updates to the PFS conversion factor associated with Advanced Alternative Payment Model (AAPM) status. QPP adjustments do not apply to RHC AIR or FQHC PPS encounter payments. Services billed under the PFS outside of the encounter system (e.g., certain telehealth, care-management services) remain subject to QPP adjustments and are incorporated into the restatement.

For Geo Entities with rendering practitioners subject to QPP adjustments, the PBPM is constructed by removing historical QPP effects and applying current PY QPP factors prior to aggregation. This includes:

- **Claim-Level Restatement:** Adjust historical net paid amounts at the individual claim level to remove prior QPP effects and apply the PY QPP factor associated with the rendering practitioner.
- **Practitioners Without Historical Factors:** Assign a historical adjustment factor of 1.0 for practitioners without QPP adjustments during the PCC Lookback Period (e.g., newly participating, newly eligible practitioners).

This approach ensures the Geo AHEAD Capitation Payment rate reflects current PY QPP payment rules while maintaining consistency with other PY restatements elements (e.g., PFS/PPS/AIR updates, sequestration, care-setting mix).

7.2.3.5 Step 4: Adjustment for New or Small-Volume Geo Entities

Most Geo Entities have approximately 24 months of historical data available to construct capitation payment rate estimates. For Geo Entities with a limited Primary Care Geo Participant network, or those with limited historical claims volume, including those operated by new market entrants or other organizations who enroll as Medicare Part B suppliers to enable voluntary attribution, variation due to small cell sizes may disproportionately affect the stability of the rate. To mitigate this effect, CMS may apply standard actuarial credibility adjustments. This may include:

- **Credibility Adjustment and Blending:** CMS applies credibility weighting by blending the Geo Entity-specific capitation payment rate with a geographic reference rate (e.g., at the county or regional level). CMS increases the weight assigned to the Geo Entity-specific rate as observed claims volume increases, such that lower-volume Geo Entities rely more heavily on the reference rate, while higher-volume Geo Entities rely more on their own experience.

Credibility adjustments and blending method stabilize rates for Geo Entities with limited data or provider networks while maintaining appropriate reliance on entity-specific experience as data volume grows.

7.2.3.6 Step 5: Final Geo AHEAD Capitation Payment Rate

Once the historical capitation payment is adjusted to reflect PY conditions, CMS calculates the final Geo AHEAD capitation payment PBPM incorporating all applicable adjustments. The resulting capitation payment rates are specific to each Geo Entity. The capitation payment rate is paid 100% prospectively each quarter, and in-scope claims are processed as zero-payment claims to preserve encounter data and support beneficiary accounting.

7.2.3.7 Rebasing

Rebasing may be conducted to reassess the historical capitation payment rate using an updated PCC Lookback Period. If the in-scope primary care PBPM derived from the updated PCC Lookback Period differs materially from the original base rate, the historical capitation payment rate may be updated accordingly.

7.2.4 Retrospective Debits for Beneficiary Eligibility

Geo AHEAD capitation payments are remitted prospectively at the beginning of each quarter, which may result in overpayment when a beneficiary loses eligibility during the quarter. At the close of the quarter, CMS performs a retrospective reconciliation, and subsequent capitation payments are reduced to account for prior overpayments; these reductions are referred to as the *Capitation Eligibility Debit.*

Due to inherent lags in the reporting of events that affect beneficiary eligibility, removals may not be reflected in available data for several months after occurrence. Consequently, total recoupment amounts reflect overpayments that result from beneficiary removals that occurred at any time since the start of the PY. Recoupments are typically applied with a two-quarter lag (e.g., first-quarter payments are reconciled in the third quarter) and may space PYs. Debits for beneficiary eligibility follow the same timing and beneficiary-month logic used for other prospective Geo AHEAD payments (e.g., EPCP). CMS calculates the debit at the beneficiary-month level for months in which a beneficiary is no longer eligible after a prospective payment has been made.

7.2.5 Reconciliation of Outside-of-Geo Entity Utilization

An annual reconciliation accounts for spending associated with office visit E&M services delivered outside the Geo Entity and limits capitation leakage by aligning prospective payments with observed service utilization. This process serves two primary purposes: (1) limit excess payments for office visit E&M services for attributed beneficiaries; and (2) maintain incentive neutrality, allowing Geo Entities to deliver enhanced services without creating incentives to reduce FFS billing to achieve more favorable financial outcomes.

Outside-of-Geo Entity reconciliation evaluates office visit E&M services furnished by facilities or providers not included on the Geo Entity's Participant Roster for attributed beneficiaries. This evaluation captures changes in the volume of E&M services delivered outside the Geo Entity and reflects how those changes affect overall spending (increases or decreases) for the attributed population.

7.2.6 Calculation of Final Net Capitation Payment

CMS calculates the final quarterly PCC payment for each Geo Entity by multiplying the applicable PCC payment PBPM by the number of beneficiaries prospectively attributed to the Geo Entity through VA and CBA at the start of the quarter and then multiplying by three to determine the total quarterly payment amount. The final paid PCC payment amount is subject to applicable sequestration requirements in effect at the time of payment.

The final net PCC payment reflects the gross capitation payment amount after applying any required adjustments, including eligibility-related debits, reconciliation adjustments, or other applicable payment modifications.

$$\textbf{Eq. 7.1: Final Net Capitation Payment} = P \times (B \times 3) - D$$

Where:

- P = Final PCC PBPM for the current PY after application of all adjustments;
- B = Beneficiaries attributed to the Geo Entity via VA or CBA through a PCS for the current month (first month of quarter); and
- D = Net reconciliation adjustments applied to prior period payments, including Capitation Eligibility Debits, adjustments for outside-of-Geo-Entity utilization, FQHC/RHC reconciliation adjustments, and other applicable payment corrections.

Illustrative Capitation Eligibility Debit Calculation.

The example below demonstrates how CMS calculates the Capitation Eligibility Debit and applied to determine the final net PCC payment.

In this example, 25,000 beneficiaries are prospectively attributed through VA and CBA to a Geo Entity in Q1, forming the basis for the Q1 gross prospective capitation payment. During retrospective eligibility review in Q3, CMS determines 1,000 of these beneficiaries were ineligible during Q1. At the same time, CMS calculates the Q3 gross prospective capitation payment using the 24,000 beneficiaries prospectively attributed for that quarter. The Capitation Eligibility Debit associated with the 1,000 retrospectively ineligible beneficiaries is then applied to the Q3 payment, resulting in the final net payment for Q3.

Quarter 1 Sample Calculation for Hypothetical Geo Entity:

- *P (Final PBPM) = $20*
- *B (Number of Attributed Beneficiaries) = 25,000*
- *D* (*Capitation Eligibility Debit) = Zero* in this example, since this would be the first quarter that we are estimating beneficiary eligibility prospectively for CP calculation.

$$\boldsymbol{Q1\ Final\ Net\ Capitation\ Payment} =$$

$$\$20 \times (25{,}000\ \times\ 3) - 0 = \$\mathbf{1{,}500{,}000}$$

Quarter 3 Sample Calculation for Hypothetical Geo Entity:

- *P (Final PBPM) = $20*
- *B (Number of Attributed Beneficiaries) = 24,000*

- *D* (*Capitation Eligibility Debit)* = 1,000 beneficiaries are retrospectively ineligible for the Q1 CP in this example, so (1,000 × 3 × $20) = *$60,000*

$$\boldsymbol{Q3\ Final\ Net\ Capitation\ Payment} =$$

$$\$20 \times (24{,}000 \times 3) - \$60{,}000 = \$\mathbf{1{,}368{,}000}$$

Note: This example does not include a reconciliation for SPCS provided outside of the Geo Entity ***(See Section 7.2.5 Reconciliation of Outside-of-Geo Entity Utilization****).*

8.0 Overview of Financial Settlement Process

Financial Settlement determines the amount of shared savings earned or shared losses owed by each Geo Entity based on its performance relative to a CMS-established benchmark (**Section 6.0 Overview of Benchmark**). The financial settlement process defines how CMS calculates financial results, including the application of quality adjustments, post-hoc adjustments, and risk-mitigation mechanisms. CMS determines financial outcomes by comparing Final Geo Entity-Specific PY Benchmark Target to Final Geo Entity-Specific PY Expenditures and applying subsequent adjustments to translate the resulting difference into Shared Savings or Losses.

The financial settlement framework balances three objectives: (1) accountability for TCOC, by linking outcomes to differences between expected and observed expenditures; (2) incentives for quality, by incorporating quality performance into financial results; and (3) stability, by applying risk mitigation mechanisms that limit exposure to extreme outcomes. CMS implements financial settlement through a defined sequence of steps (**See Section 8.2 Financial Settlement Calculation**).

The financial settlement process is organized into two overarching components:

- **Settlement Timing and Disbursement Schedule** (**Section 8.1**), which defines when and how CMS calculates financial results and disbursed; and
- **Financial Settlement Calculation** (**Section 8.2**), which defines the methodology used to determine Shared Savings and Losses.

CMS may refine this section in the Geo AHEAD Technical Specifications Version 2.

8.1 Settlement Timing and Disbursement Schedule

CMS establishes a defined schedule for financial settlement under Geo AHEAD to ensure timely reconciliation of financial performance while allowing for sufficient data completeness and accuracy. The settlement process includes both an optional Provisional Settlement and a Final Settlement, each serving distinct purposes within the broader financial framework.

Table 8.1 Final Financial Settlement for PY 2028

Data	Final Settlement
Settlement Date	Q3 2029
Claims Incurred included in Settlement	01/01/2028 – 12/31/2028
Claims Paid included in Settlement (claims-runout)	01/01/2028 – 03/31/2029
Non-Claims Based-Payments	01/01/2028 – 12/31/2028
Risk Scores	Claims Incurred: 01/01/2027 – 12/31/2027 Claims Paid: 01/01/2027 – 03/31/2028
Quality Scores	Claims Incurred: 01/01/2028 – 12/31/2028 Claims Paid: 01/01/2028 – 03/31/2029

8.1.1 Provisional Settlement

Geo Entities may elect to participate in a Provisional Settlement, which provides disbursement or collection of a portion of estimated Shared Savings or Losses during Quarter 1 of the year following

the applicable PY. Provisional Settlement provides earlier access to financial results; however, CMS calculates it using incomplete data due to standard claims runout limitations. Specifically:

- The calculation includes only claims paid as of the provisional settlement date, reflecting less than the full three months of claims runout used in final settlement and resulting in incomplete PY expenditures;
- A stand-in or interim quality score (e.g., prior-year performance, a full-credit placeholder, or a partial-measure composite) may be used in place of the final Quality Composite Score.

CMS will provide more details on the optional Provisional Settlement in the Geo AHEAD Technical Specifications Version 2.

8.1.2 Final Settlement Timing and Data Finalization

CMS determines the definitive financial performance for each Geo Entity during Q3 of the year following each PY (**See Table 8.1 Final Financial Settlement for PY 2028**). Final Settlement reflects fully reconciled Shared Savings or Losses based on complete and mature data, including:

- Full PY claims incurred data with three months of runout, including claims paid through March 31 of the year following the PY; and
- Finalized risk scores, quality performance results, and all applicable post-hoc adjustments (e.g., quality adjustment).

Final Settlement represents the authoritative financial outcome of each PY. If the Geo Entity elects to receive Provisional Settlement, the Final Settlement will reconcile differences between Provisional and Final Settlement.

8.2 Financial Settlement Calculation

The financial settlement calculation defines how CMS determines the final financial outcome for each Geo Entity based on PY TCOC performance. Financial settlement is based on a comparison of the **Final Geo Entity-specific Benchmark Target** and **Final Geo Entity-specific PY Expenditures**, followed by the application of quality-based adjustments, post-hoc adjustments, and risk-sharing parameters.

Rather than representing a single calculation step, financial settlement reflects the cumulative result of multiple interrelated components, including:

- **Benchmark methodology**, which establishes expected expenditures using a standardized, risk-standardized framework and produces benchmark PBPM rates by beneficiary category and attribution type that are used to calculate expected TCOC expenditures for each Geo Entity during the PY, less the Geo Entity-specific Bid Discount Percentage;
- **Observed expenditures**, which reflect actual Medicare Part A and B expenditures incurred by the Geo Entity's attributed population and are risk-standardized using the Geo AHEAD risk adjustment methodology to support comparison with Benchmark Expenditures. These expenditures are used to calculate TCOC and assess financial performance relative to the benchmark;
- **Quality performance**, which links financial outcomes to achievement on defined quality measures;

- **Post-hoc adjustments**, which account for forecast uncertainty, system-wide factors, and trend reconciliation processes; and
- **Risk-sharing mechanisms**, which determine the portion of savings retained or losses owed by the Geo Entity.

8.2.1 Final Geo Entity-Specific Benchmark Target

The **Final Geo Entity-Specific Benchmark Target** represents the final benchmark expenditure amount used in financial settlement. CMS calculates these expenditures using the beneficiary category- and attribution type-specific Benchmark PBPMs established in **Step 3.2** of the benchmark process (**See Section 6.6.3.2 Step 3.2: Apply Risk Adjustment**), the final beneficiary attribution and beneficiary months for the PY for each beneficiary category and attribution type, and the Geo Entity-Specific Bid Discount Percentage. The following inputs are required for this process:

- **PY Beneficiary Attribution**, which reflects all updates applied during the PY, including quarterly attribution and reconciliation of beneficiary attribution status, beneficiary category, and attribution type.
- **PY Eligible Beneficiary Member Months**, which represent the months during which beneficiaries are both eligible for Medicare (**See Section 4.0 Overview of Eligible Population and Beneficiary Eligibility**) and attributed to the Geo Entity, reflecting final attribution and eligibility across the PY by beneficiary category and attribution type.
- **Geo Entity-Specific Benchmark PBPMs**, which include the beneficiary category- and attribution type-specific Benchmark PBPMs established in **Step 3.2** (**See Section 6.6.3.2 Step 3.2: Apply Risk Adjustment**).
- **Bid Discount Percentage**, the Geo Entity-Specific discount applied to the benchmark that represents a prospective reduction to Benchmark Expenditures and reflects the Geo Entity's commitment to manage TCOC below the benchmark.

8.2.2 Final Geo Entity-Specific PY Expenditures

The **Final Geo Entity-Specific PY Expenditures** represents the actual Medicare Part A and Part B expenditures used in financial settlement. CMS calculates these expenditures using finalized claims and payment data, including applicable runout, adjustments, and reconciliations, for beneficiaries attributed to the Geo Entity during months in which the beneficiary is both attributed to the Geo Entity and eligible for inclusion in Geo AHEAD expenditure calculations. For more information on expenditures included in the Final Geo Entity-Specific PY Expenditures, refer to **Section 6.5 Costs Included in Historical Baseline Expenditures**.

CMS calculates Final Geo Entity-Specific PY Expenditures using the same final attributed beneficiary population and beneficiary month framework used in the calculation of **Final Geo Entity-Specific Benchmark Target**. This approach ensures that benchmark expenditures and observed expenditures are calculated using a consistent attributed population and measurement period for purposes of financial settlement. CMS will provide additional details regarding expenditure inclusion, exclusion, and risk adjustment methodologies in Geo AHEAD Technical Specifications Version 2.

8.2.3 Calculation of Gross Shared Savings or Losses

CMS determines gross Shared Savings or Losses by comparing the **Final Geo Entity-Specific Benchmark Target** to the **Final Geo Entity-Specific PY Expenditures**. This comparison represents the initial measure of financial performance and reflects the Geo Entity's ability to manage TCOC relative to expected spend for its attributed population.

Eq. 8.1: Gross Savings or Losses =

$$Final\ Geo\ Entity\text{-}Specific\ Benchmark\ Target - Final\ Geo\ Entity\text{-}Specific\ PY\ Expenditures$$

Where:

- **Final Geo Entity-Specific Benchmark Target** = Expected Geo Entity-specific expenditures for the attributed population; and
- **Final Geo Entity-Specific PY Expenditures** = Actual Geo Entity-specific observed Medicare spending for the attributed population.

A positive value indicates that actual expenditures are below the benchmark target, resulting in gross savings, while a negative value indicates that actual expenditures exceed the benchmark target, resulting in gross losses.

This calculation serves as the starting point for financial settlement and is subsequently modified through the application of the Quality Adjustment, Post-Hoc Adjustments, and Risk Corridor Parameters, which together determine the Final Financial Settlement.

8.2.4 Quality Adjustment

CMS applies the Quality Adjustment to Shared Savings or Losses to align financial outcomes with performance on quality measures under the Geo AHEAD model. Geo AHEAD incentivizes improvement across key domains of care, including hospital utilization, emergency department utilization, prevention, chronic condition management, behavioral health, and patient experience. The Model incorporates incentives for both high performance through attainment benchmarks and continuous improvement through an improvement factor.

Under this approach, 100 percent of Shared Savings is at risk based on quality performance, meaning Geo Entities must meet minimum quality standards to be eligible to retain any earned savings. Inversely, up to 50 percent of Shared Losses can be reduced through quality performance. For example, a Geo Entity that receives a Quality Adjustment Factor of 1.0 would receive 100% of the calculated Shared Savings amount or would owe 50% of calculated Shared Loses amount, before application of post-hoc adjustments and risk mitigation.

To determine the Quality Adjustment, CMS first calculates the Geo Entity's Quality Composite Score which reflects performance across defined set of quality. Second, CMS scales the Quality Composite Score to a Quality Adjustment Factor (ranging from 0.0 to 1.0 for Shared Savings and 0.5 to 1.0 for Shared Losses). The Quality Composite Score is scaled into the Quality Adjustment Factor separately for Geo Entities that earn Shared Savings versus Shared Losses.

8.2.4.1 Quality Measures

Geo Entities will be accountable for performance in five domains (**See Table 8.2 Quality Measure Set**). These metrics offer a balanced approach to quality that ranges from emergency department and

hospital utilization (AHU, EDU, and HWR) to clinically important preventive metrics (cancer screenings, blood pressure control, depression screening, and diabetes control) and patient experience (CAHPS). CMS will review these measures annually and may update measures if appropriate (e.g., issues with benchmarking data, measure specifications).

Table 8.2 Quality Measure Set

Domain	Requirement	Measure
Behavioral Health	Required	Preventive Care and Screening: Screening for Depression & Follow-Up Plan
Healthcare Utilizations	Required	Emergency Department Utilization (EDU)
	Required	Acute Hospital Utilization (AHU)
	Required	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)
	Required	Days at Home for Patients with Complex, Chronic Conditions (DAH)
Patient Experience	Required	Accountable Care Organization (ACO) Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Prevention & Wellness	Requirements in development	Colorectal Cancer Screening
		Breast Cancer Screening: Mammography (BCS-AD)
Chronic Conditions	Requirements in development	Controlling High Blood Pressure (CBP-AD)
		Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

8.2.4.2 Quality Scoring Methodology

CMS calculates quality benchmarks for each measure prior to the PY. CMS evaluates each Geo Entity's performance in three steps:

1. Assess performance across each measure and calculate a single Quality Composite Score
2. Increase the Quality Composite Score through application of an improvement factor when year-over-year improvement is demonstrated; and
3. Convert the Quality Composite Score into a Quality Adjustment Factor, expressed as a scaling factor applied to Shared Savings or Losses.

8.2.4.2.1 Step 1: Calculate the Quality Composite Score

CMS calculates a quality score for each measure by comparing Geo Entity performance against a national or state benchmark.[22] For each measure, CMS establishes minimum and maximum thresholds in advance of the PY using national data. A Geo Entity will receive a score between 0 and 100 for each quality measure:

- Scores of 100 apply when performance meets or exceeds the maximum threshold;
- Scores of 0 apply when performance falls below the minimum threshold; and
- Scaled partial credit applies when performance falls between the minimum and maximum thresholds.

For measures that qualify for partial credit, CMS calculates scores using the following formula, with performance at the minimum threshold receiving at least 50 points:

[22] CMS will provide more information on which quality measures will utilize a state versus national benchmark in the Geo AHEAD Technical Specifications Version 2

Eq. 8.2: Partial Quality Score =

$$\left(50 \times \frac{(Geo\ Raw\ Quality\ Score - Minimum\ Threshold)}{(Maximum\ Threshold - Minimum\ Threshold)}\right) + 50$$

This approach ensures that Geo Entities meeting the minimum threshold receive at least 50 points, with additional performance earning progressively higher scores.

For example, if the minimum and maximum thresholds for colorectal cancer screening are 70 percent and 80 percent, respectively, and a Geo Entity achieves 73 percent, the resulting score is:

Eq. 8.3 Example: $(50 \times \frac{(73-70)}{(80-70)}) + 50 = \mathbf{65}$

CMS aggregates individual measure scores to calculate a single Quality Composite Score, reflecting overall performance across the measure set. Each measure contributes proportionally to the composite score unless otherwise specified. The resulting score represents overall quality performance for the PY prior to the application of any improvement adjustments.

8.2.4.2.2 Step 2. Calculate the Improvement Factor

To determine whether a Geo Entity qualifies for an improvement factor, CMS evaluates year-over-year improvement in the Quality Composite Score relative to a predefined improvement target established in advance of each PY.[23] If the Geo Entity meets or exceeds the improvement target, CMS increases the Quality Composite Score by 10 points, which is added to the Quality Composite Score, up to a maximum score of 100. This approach rewards both high performance and meaningful improvement over time.

For example, a Geo Entity with a Quality Composite Score of 85 that meets the improvement target would receive an adjusted score of 95 after application of the improvement factor.

8.2.4.2.3 Step 3. Determine the Quality Adjustment

To determine Quality-Adjusted Gross Savings or Losses, CMS converts the final Quality Composite Score, expressed as a percentage and inclusive of any improvement factor, into a scaling factor using a predetermined conversion table to be specified in future guidance. The predetermined conversation table differs for Geo Entities that earn Shared Savings versus Geo Entities that owe Shared Losses. The scaling factor ranges from 0.0 to 1.0 for Shared Savings and 0.5 to 1.0 for Shared Losses. CMS applies the Quality Adjustment differently to Geo Entities with Shared Savings versus Shared Losses **(See Eq. 8.4 and Eq. 8.5)**

Eq. 8.4: Quality Adjusted Gross Savings =

$$Gross\ Savings \times Quality\ Adjustment\ Factor$$

Eq. 8.5: Quality Adjusted Gross Losses =

$$Gross\ Losses \times (Quality\ Adjustment\ Factor - 0.5)$$

8.2.5 Post-Hoc Adjustments

Post-hoc adjustments account for differences between projected and realized system-wide factors that affect expenditure comparability. These adjustments may include, but are not limited to updates

[23] Note that CMS will not use an improvement factor in PY1 (as there is no prior year quality data) but will in PY2 and each year thereafter.

to payment rates or settlement factors, and other reconciliation adjustments applied after the initial performance calculation. CMS will provide final specifications on post-hoc adjustments in the Geo AHEAD Technical Specifications Version 2.

8.2.6 Risk Mitigation Corridors

CMS applies Risk Corridor parameters to Post-Hoc Adjusted Savings or Losses to determine the final portion of savings retained or losses owed by the Geo Entity. This step represents the final stage of the Financial Settlement Framework and defines the degree of financial risk sharing between CMS and Geo Entities.

Under this structure, CMS applies financial responsibility incrementally across defined risk-bands. The percentage of savings retained or losses owed decreases as the magnitude of savings or losses increases. This approach balances incentives for cost management in lower performance ranges with protections against excessive financial exposure in higher ranges.

CMS will specify the final risk mitigation strategy in the Geo AHEAD Technical Specifications Version 2.

8.2.7 Final Settlement Calculation

To calculate the Final Financial Settlement representing the net amount owed to or by each Geo Entity for the applicable PY, CMS applies the Quality Adjustment, Post Hoc Adjustments, and Risk Mitigation Corridors.

The Final Financial Settlement reflects the cumulative result of:

- Comparison of the Final Geo Entity-Specific Benchmark Target and Final Geo Entity-Specific PY Expenditures;
- Application of Quality Adjustment;
- Incorporation of Post-Hoc Adjustments (if applicable); and
- Application of Risk Corridor Parameters to determine the final portion of savings retained or losses owed.

Eq. 8.6: Final Financial Settlement =

$$f([Final\ Geo\ Entity\text{-}Specific\ Benchmark\ Target - Final\ Geo\ Entity\text{-}Specific\ PY\ Expenditures] \times Quality\ Adjustment + Post\text{-}Hoc\ Adjustments)$$

Where:

- $f(\cdot)$ = Risk Corridor Function

For Geo Entities that elect a Provisional Settlement, CMS incorporates a final reconciliation to align interim payments with fully adjudicated results, ensuring the Final Financial Settlement is based on complete claims runout and finalized data.

The Final Financial Settlement represents the net payment due to or from the Geo Entity after applying all performance-based adjustments and reconciliation processes defined across the Geo AHEAD specifications.

Appendix A: Key Terms

Table A.1 introduces key terms and descriptions for current programs and payments administered by CMS that intersect with Geo AHEAD, as well as AHEAD terms for elements of the Geo AHEAD methodology.[24]

Table A.1 Key Terms

Term	Description
Adjusted Payment Categories (APC)	Categories of payments, such as hospital global budgets or similar adjustments, that are incorporated into or adjusted within Total Cost of Care calculations to reflect underlying spending patterns.
Affiliate Relationship Attribution	A geographic attribution method that attributes beneficiaries to a Geo Entity based on claims-based relationships with Geo Affiliates that maintain a financial arrangement with one or more Geo Entities.
AHEAD State	States that voluntarily applied and are accepted to participate in the AHEAD Model through a Cooperative Agreement and a State Agreement with CMS.
AHEAD Substate Division	Groups of one or more counties (or other geographic unit agreed upon by CMS and in consultation with the State) used in Geo AHEAD to determine the service area of Geo Entities. Substate divisions will reflect historical patterns of care for beneficiaries in these geographies.
AHEAD Substate Region	States that voluntarily applied and are accepted to participate in the AHEAD Model in a specified substate region through a Cooperative Agreement and a State Agreement with CMS (e.g., downstate New York).
Allowed Amount	The Medicare allowed amount is the capped payment level Medicare sets for a specific service under its fee schedules.
Attributed Beneficiary List	The complete set of beneficiaries assigned to a Geo Entity for a Performance Year based on the attribution methodology that CMS uses for payment, benchmarking, and performance measurement.
Attribution-Eligible Beneficiary List	An Attribution-Eligible Beneficiary List is the set of beneficiaries identified by CMS for potential attribution to Geo Entities, constructed using a defined Attribution Lookback Period and including beneficiaries who resided in the AHEAD State or Substate Region during that period and were not deceased prior to alignment.
Attribution Lookback Period	The defined time frame used to evaluate beneficiary care patterns for Claims-Based Attribution and Affiliate Attribution, including historical care relationships and recent utilization patterns.
Attribution Year	A 12-month period within the Attribution Lookback Period used to evaluate beneficiary care patterns for attribution purposes, structured to capture sequential historical utilization experience.
Baseline Beneficiary Lists	Baseline Beneficiary Lists are year-specific beneficiary populations constructed by CMS for each Baseline Year to support measurement of historical expenditures and development of the benchmark rate. CMS creates these lists using the applicable Attribution Lookback Period for each Baseline Year and includes beneficiaries who resided in the AHEAD State or Substate Region during that period and were not deceased prior to the Baseline Year. Each Baseline Beneficiary List represents an independent cross-sectional population for that year, and CMS uses these lists to calculate baseline expenditures prior to blending across years for benchmark construction.

[24] Key terms are always capitalized to indicate the term's defined purpose in the payment calculation. In some cases, the same or similar words appear in lower case for the purpose of introducing a concept

Term	Description
Baseline Year (BY)	A historical 12-month period used to calculate baseline expenditures for benchmark development.
Benefit Enhancement (BE)	Model-specific waivers or flexibilities that modify standard Medicare coverage or payment rules and enable participating providers to deliver care more effectively. BEs are intended to reduce barriers to appropriate care, improve coordination across providers and settings, and support population-level quality and spending outcome.
Beneficiary Engagement Incentive (BEI)	Beneficiary Engagement Incentives (BEIs) include non-cash items, services, or supports that encourage beneficiaries to engage in care, adhere to treatment plans, or participate in qualifying programs. BEIs are designed to promote preventive care, chronic disease management, and beneficiary participation in activities that improve health outcomes and experience.
Benchmark Expenditure	The target expenditure amount against which a Geo Entity's financial performance is evaluated.
Benchmark Rate	A standardized, risk-adjusted, and trended Per Beneficiary Per Month spending amount established by CMS for a defined geographic area and used as the basis for calculating Geo Entity-specific Benchmark Expenditures.
Beneficiary Data Sharing and Opt-Outs	CMS policies governing the use, sharing, and limitations of beneficiary data and communications under the Geo AHEAD Model. Beneficiaries attributed to a Geo Entity remain enrolled in Medicare and retain all standard Medicare rights, including the ability to seek care from any Medicare-enrolled provider, and may opt out of certain data sharing and communication activities, including the sharing of identifiable claims data for care coordination or marketing purposes.
Bid Discount Percentage	The percentage discount proposed by a Geo Entity and incorporated into benchmark calculations and Weighted Random Geographic Attribution scoring.
Bid Evaluation Score	A score reflecting CMS's assessment of a bidding Entity's readiness and operational capacity that may be incorporated into Weighted Random Geographic Attribution scoring as an input to the Weighted Composite Score.
Business Associate Agreement	A legal agreement governing the use and protection of protected health information shared with CMS.
Capitation Eligibility Debit	A retrospective adjustment that reduces future capitated payments to account for beneficiaries who were prospectively paid but later determined to be ineligible during the covered period.
Claims-Based Attribution (CBA)	An attribution method based on an ongoing and substantive relationship with a provider, determined using Primary Care Qualified Evaluation and Management Service claims during the Lookback Period.
Community Health Centers (CHC)	Federally Qualified Health Centers, Health Centers and Health Center Look-Alikes, and Rural Health Clinics
Contract Period	A contract period is a defined, multi-year participation timeframe during which selected Geo Entities participate in the Geo AHEAD Model pursuant to a Participation Agreement with CMS. CMS establishes contract periods through the application and award process, with each contract period spanning four Performance Years.
Engagement Rate	A measure of a Geo Entity's ability to engage beneficiaries initially attributed through Weighted Random Geographic Attribution and transition them to voluntary or Claims-Based Attribution, calculated as the proportion of prior weighted random geographically attributed beneficiaries who convert to Voluntary Alignment or Claims-Based Attribution.

Term	Description
Enhanced Primary Care Payment (EPCP)	A payment made under the Geo AHEAD Model to support primary care services furnished to eligible attributed beneficiaries.
Final PY Benchmark Expenditures	The finalized estimate of expected Total Cost of Care for a Geo Entity's attributed population during a Performance Year, calculated using benchmark rates, attributed population, and bid discount adjustments.
Final Financial Settlement	The net financial outcome for a Geo Entity after applying quality adjustments, post-hoc adjustments, and risk-sharing parameters to Shared Savings or Losses.
Financial Soundness & Benchmark Alignment Domain	A component of CMS's bid evaluation methodology used to assess a bidding Entity's financial readiness and alignment with benchmark objectives.
Geo Affiliate	A Geo Affiliate is a Medicare-enrolled organization, identified by a billing Taxpayer Identification Number, that maintains a financial arrangement with a Geo Entity and does not contribute to Claims-Based Attribution.
Geo Entity	A Geo Entity is an organization that participates in the Geo AHEAD Model and enters into an agreement with CMS to assume accountability for Medicare services, including the Medicare portion of dual expenditures.
Geo Entity-Specific Benchmark Target	The expenditure target established for a Geo Entity for a Performance Year and used to determine Shared Savings or Losses by comparing the target to actual expenditures.
Geo Participant	An organization identified by a Medicare-enrolled billing Taxpayer Identification Number (TIN) that has a financial arrangement with a Geo Entity. One or more of the providers associated with the Geo Participant TIN must have specialty codes that identify them as a Primary Care Specialist or a Selected Non-Primary Care Specialist. Geo Participants contribute to Claims-Based Attribution.
Geographic Attribution	The final step of Geo AHEAD's attribution method: encompassing Affiliate Relationship Attribution, Household Unity Attribution, and Weighted Random Geographic Attribution.
Gross Shared Savings or Losses	The difference between Final Performance Year Benchmark Expenditures and Total Performance Year Expenditures, representing the initial measure of financial performance before adjustments.
Historical Baseline Expenditure	Aggregated Medicare expenditures from Base Years used as the starting point for benchmark construction.
Household Unity (HHU)	A geographic attribution step that attributes beneficiaries based on the attribution of another household member.
Key Service	Claims for Chronic Care Management, Welcome to Medicare visits, Initial Preventive Physical Examination, and Annual Wellness Visits services listed in Table C.3.1.
Non-Claims-Based Payments (NCBP)	Payments made under prospective or capitated arrangements or other CMS initiatives that are incorporated into expenditure calculations alongside claims-based payments to reflect total spending.
Non-Provider-Led Geo Entity	A Non-Provider-Led Geo Entity is a Geo Entity that is not required to meet the provider ownership threshold specified for Provider-Led Geo Entities and is distinguished based on ownership, management, and control (OMC). A Non-Provider-Led Geo Entity must submit bids covering an entire AHEAD State or Substate Region.
Overlaps	Policies governing participation of providers, entities, or beneficiaries across multiple CMS models.
Performance Year (PY)	The calendar year where beneficiaries are attributed to Geo Entities and financial and quality performance is measured.
Population-Based Accountability	Population-Based Accountability is a model design principle under which CMS determines expected expenditures and evaluates performance based on each Geo Entity's attributed beneficiary population, incorporating beneficiary-level risk and eligibility
Primary Care Capitation (PCC)	Prospective capitated payments replacing certain fee-for-service primary care payments.

Term	Description
Primary Care Capitation (PCC) Lookback Period	The defined time frame used to evaluate beneficiary care patterns for Primary Care Capitation, including historical care relationships and recent utilization patterns.
Primary Care Qualified Evaluation and Management Service	A claim rendered by a Primary Care Specialist or Selected-Non Primary Care Specialist that 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 C.3.2.
Primary Care Services (PCS)	Services identified by CMS for purposes of attribution, payment, or capitation methodologies under the Geo AHEAD Model.
Primary Care Specialist	A Primary Care Specialist is a physician or Non-Physician Practitioner (NPP) whose principal specialty is included in Table C.1. CMS determines a physician's or NPP's specialty based on the CMS Specialty Code recorded on the claim unless it is a specialty code for claims submitted from providers at Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). In the case of a claim submitted by a CAH2, the Center for Program Integrity determines the specialty code based on the physician's or NPP's primary specialty as recorded in the Medicare Provider Enrollment, Chain, and Ownership System. In the case of claims submitted by a FQHC or RHC, all services are considered to be provided by primary care specialists.
Protected Health Information (PHI)	Individually identifiable health information protected under HIPAA regulations.
Provider-Led Geo Entity	A Provider-Led Geo Entity is a Geo Entity for which at least 51 percent of ownership, management, and control (OMC) is held by providers. A Provider-Led Geo Entity may operate across an entire AHEAD State, Substate Region, or one or more Substate Divisions, and is the only Geo Entity type permitted to bid for and operate within Substate Divisions.
Provider Roster	A CMS-approved list of participating Taxpayer Identification Numbers, CMS Certification Numbers, and National Provider Identifiers associated with a Geo Entity, used to support beneficiary attribution, payment calculations, and validation of provider participation.
Provisional Settlement	An interim financial settlement calculated using available Performance Year data that is later reconciled through a Final Financial Settlement when claims runout and final data become available.
Quality Adjustment	An adjustment that scales Shared Savings or Losses based on quality performance.
Quality Composite Score	The Quality Composite Score is a single, aggregated measure of a Geo Entity's performance across a defined set of quality measures, calculated by comparing performance on each measure against CMS-established minimum and maximum benchmarks. CMS assigns a score between 0 and 100 for each measure and aggregates these scores to produce the Quality Composite Score, which reflects overall quality performance for the Performance Year.
Risk Adjustment	The adjustment of expenditures based on beneficiary-level Hierarchical Condition Categories to account for differences in beneficiary health risk.
Selected Non-Primary Care Specialist	A Selected Non-Primary Care Specialist is a physician or Non-Physician Practitioner (NPP) whose principal specialty is included in Table C.2. CMS determines a physician's or NPP's specialty based on the CMS Specialty Code recorded on the claim. In the case of a claim submitted by a Critical Access Hospital, the Center for Program Integrity determines the specialty code based on the physician's or NPP's primary specialty as recorded in the Medicare Provider Enrollment, Chain, and Ownership System. As mentioned above, in the case of claims submitted by a Federally Qualified Health Center or Rural Health Clinic, all services are considered to be provided by primary care specialists.
Service Area	The entire State, Substate Region, or Substate Division that the Geo Entity was awarded. CMS uses the service area to determine where a Geo Entity must accept geographically attributed beneficiaries.

Term	Description
Shared Losses	The portion of losses a Geo Entity owes if expenditures exceed the benchmark.
Shared Savings	The portion of savings a Geo Entity may earn if expenditures are below the benchmark and quality criteria are met.
Standardized Benchmark Rate	The fully adjusted and trended benchmark rate produced after applying baseline development, risk adjustment, normalization, blending, and trend, representing the uniform geographic spending basis across an AHEAD State or Substate Region.
Total Cost of Care (TCOC)	The total allowed amount of Medicare expenditures for covered Part A and Part B services for attributed beneficiaries.
PY Expenditures	The aggregate Medicare expenditures for all covered services furnished to attributed beneficiaries during eligible months in the Performance Year, reflecting observed TCOC.
Trend Factor	The prospective growth factor applied to baseline expenditures to project benchmark amounts.
Voluntary Alignment (VA)	An attribution method whereby beneficiaries affirmatively select a Geo Participant as their main source of care.
Weighted Composite Score	A combined score for each beneficiary-Geo Entity pairing calculated as the sum of Weighted Random Geographic Attribution (WRGA) metrics multiplied by applicable Performance Year weights, used to determine Geo-Entity attribution probabilities under WRGA.
Weighted Random Geographic Attribution (WRGA)	A geographic attribution method that assigns beneficiaries to Geo Entities using a weighted scoring algorithm.
WRGA Attribution Probability	The probability that a beneficiary is assigned to a Geo Entity under Weighted Random Geographic Attribution, calculated by dividing a Geo Entity's Weighted Composite Score by the total composite score across all eligible Geo Entities.
WRGA BE/BEI Implementation Score	A beneficiary-Geo Entity-level score representing the alignment between a beneficiary's health needs and the BEs/BEIs selected and implemented by a Geo Entity. CMS incorporates this into Weighted Random Geographic Attribution scoring as an input to the Weighted Composite Score.
WRGA Bid Discount Score	A standardized score derived from a Geo Entity's Bid Discount Percentage, reflecting its relative discount competitiveness and incorporated into Weighted Random Geographic Attribution scoring as an input to the Weighted Composite Score.
WRGA Bid Evaluation Score	A Geo Entity-level score reflecting CMS's assessment of an Entity's readiness and operational capacity, used within Weighted Random Geographic Attribution as an input to the Weighted Composite Score.

Appendix B: Acronyms

Table B.1 Acronym List

Acronym	Definition
AHEAD	Achieving Healthcare Efficiency through Accountable Design
ACO	Accountable Care Organization
ACP	Advance Care Planning
AHU	Acute Hospital Utilization
AIR	All-Inclusive Rate
APM	Alternative Payment Model
AWV	Annual Wellness Visit
BAP	Beneficiary Advisory Panel
BE	Benefit Enhancement
BEI	Beneficiary Engagement Incentive
BY	Baseline Year
CAH	Critical Access Hospital
CAH2	Critical Access Hospital Method II
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBP	Controlling High Blood Pressure
CBA	Claims-Based Attribution
CCM	Chronic Care Management
CCN	CMS Certification Number
CEHRT	Certified Electronic Health Record Technology
CMS	Centers for Medicare & Medicaid Services
CMMI	Center for Medicare & Medicaid Innovation
CPC	Comprehensive Primary Care
CY	Calendar Year
DAH	Days at Home
EDU	Emergency Department Utilization
EPCP	Enhanced Primary Care Payment
ESRD	End-Stage Renal Disease
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
Geo	Geographic
HGB	Hospital Global Budget

Acronym	Definition
HCC	Hierarchical Condition Category
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HHU	Household Unity
HWR	Hospital-Wide All-Cause Unplanned Readmission Measure
IPPE	Initial Preventive Physical Examination
IY	Implementation Year
LEAD	Long-term Enhanced Accountable Care Organization Design
MA	Medicare Advantage
MCP	Managed Care Plan
MVA	Medicare.gov Voluntary Alignment
NPI	National Provider Identifier
NPP	Non-Physician Practitioner
OMC	Ownership, Management, and Control
PA	Participation Agreement
PACE	Program of All-Inclusive Care for the Elderly
PBPM	Per-Beneficiary-Per-Month
PC	Primary Care
PCA	Primary Care AHEAD
PCC	Primary Care Capitation
PCS	Primary Care Services
PECOS	Provider Enrollment, Chain, and Ownership System
PFS	Physician Fee Schedule
PHI	Protected Health Information
PPS	Prospective Payment System
PQEM	Primary Care Qualified Evaluation and Management
PY	Performance Year
QPP	Quality Payment Program
RFA	Request for Applications
RHC	Rural Health Clinic
SAHS	Significant, Anomalous, and Highly Suspect
SNF	Skilled Nursing Facility
SS	Shared Savings

Acronym	Definition
SVA	Signed Attestation-Based Voluntary Alignment
TCOC	Total Cost of Care
TIN	Taxpayer Identification Number
VA	Voluntary Attribution
WRGA	Weighted Random Geographic Attribution
WTM	Welcome to Medicare

Appendix C: Reference Tables

Appendix C.1 Primary Care Specialists

Table C.1 Specialty Codes Used to Identify Primary Care Specialists

Code	Primary Care Specialty
1	General Practices
8	Family Medicine
11	Internal Medicine
16	Obstetrics/gynecology
17	Hospice and palliative care
26	Psychiatry
27	Geriatric psychiatry
37	Pediatric Medicine
38	Geriatric Medicine
42	Certified nurse midwife
50	Nurse Practitioner
79	Addiction medicine
84	Preventative medicine
86	Neuropsychiatry
89	Clinical Nurse Specialist
97	Physician Assistant

Appendix C.2 Selected Non-Primary Care Specialists

Table C.2 Specialty Codes Used to Identify Selected Non-Primary Care Specialists

Code	Non-Primary Care Specialty
6	Cardiology
10	Gastroenterology
12	Osteopathic manipulative medicine
13	Neurology
23	Sports Medicine
25	Physical medicine and rehabilitation
29	Pulmonology
39	Nephrology
44	Infectious Disease
46	Endocrinology
66	Rheumatology
70	Multispecialty clinic or group practice

Code	Non-Primary Care Specialty
82	Hematology
83	Hematology/oncology
90	Medical oncology
98	Gynecological/oncology

Appendix C.3 Key Services and PQEM Services

Table C.3.1 Key Services

HCPCS Code	Description
Key Services	
G0402	Initial preventive physical examination (Welcome to Medicare), first 12 months
G0438	Annual wellness visit with personalized prevention plan, initial
G0439	Annual wellness visit with personalized prevention plan, subsequent
G0506	Comprehensive assessment and care planning add-on for chronic care management
99424	Principal care management, provider, first 30 minutes per month
99425	Principal care management, provider, each additional 30 minutes per month
99426	Principal care management, clinical staff, first 30 minutes per month
99427	Principal care management, clinical staff, each additional 30 minutes per month
99437	Chronic care management, provider, each additional 30 minutes per month
99439	Chronic care management, clinical staff, each additional 20 minutes per month
99446	Interprofessional telephone, internet, or electronic health record consultation, 5 to 10 minutes
99447	Interprofessional telephone, internet, or electronic health record consultation, 11 to 20 minutes
99448	Interprofessional telephone, internet, or electronic health record consultation, 21 to 30 minutes
99449	Interprofessional telephone, internet, or electronic health record consultation, 31+ minutes
99451	Interprofessional consultation with written report, 5+ minutes
99452	Interprofessional telephone or internet referral, 30 minutes
99457	Remote physiologic monitoring treatment management, first 20 minutes per month
99458	Remote physiologic monitoring treatment management, each additional 20 minutes per month
99487	Complex chronic care management, clinical staff, first 60 minutes per month
99489	Complex chronic care management, clinical staff, each additional 30 minutes per month
99490	Chronic care management, clinical staff, first 20 minutes per month
99491	Chronic care management, provider, first 30 minutes per month

Table C.3.2 PQEM Services

HCPCS Code	Description
Office / Outpatient Evaluation and Management	
99201 ^	New patient office or outpatient visit, approximately 10 minutes
99202	New patient office visit, straightforward medical decision making, 15+ minutes
99203	New patient office visit, low-level medical decision making, 30+ minutes
99204	New patient office visit, moderate-level medical decision making, 45+ minutes
99205	New patient office visit, high-level medical decision making, 60+ minutes
99211	Established patient office visit, may not require provider presence
99212	Established patient office visit, straightforward medical decision making, 10+ minutes

99213	Established patient office visit, low-level medical decision making, 20+ minutes
99214	Established patient office visit, moderate-level medical decision making, 30+ minutes
99215	Established patient office visit, high-level medical decision making, 40+ minutes
Evaluation and Management Add-on / Complexity	
G2211	Visit complexity add-on for continuing focal-point care
G2212	Prolonged office or outpatient evaluation and management, each additional 15 minutes
G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes per month
Prolonged Services	
99354 ^	Prolonged outpatient service, first hour
99355 ^	Prolonged outpatient service, each additional 30 minutes
99358	Prolonged service without patient contact, first hour
99359	Prolonged service without patient contact, each additional 30 minutes
Facility / Nursing Facility Evaluation and Management	
99304	Initial nursing facility care, straightforward or low-level medical decision making, 25+ minutes
99305	Initial nursing facility care, moderate-level medical decision making, 35+ minutes
99306	Initial nursing facility care, high-level medical decision making, 50+ minutes
99307	Subsequent nursing facility care, straightforward medical decision making, 10+ minutes
99308	Subsequent nursing facility care, low-level medical decision making, 20+ minutes
99309	Subsequent nursing facility care, moderate-level medical decision making, 30+ minutes
99310	Subsequent nursing facility care, high-level medical decision making, 45+ minutes
99315	Nursing facility discharge, 30 minutes or less
99316	Nursing facility discharge, more than 30 minutes
99318 ^	Annual nursing facility assessment
Domiciliary / Rest Home Evaluation and Management	
99324 ^	New patient domiciliary or rest home visit, approximately 20 minutes
99325 ^	New patient domiciliary or rest home visit, approximately 30 minutes
99326 ^	New patient domiciliary or rest home visit, approximately 45 minutes
99327 ^	New patient domiciliary or rest home visit, approximately 1 hour
99328 ^	New patient domiciliary or rest home visit, approximately 75 minutes
99334 ^	Established patient domiciliary or rest home visit, approximately 15 minutes
99335 ^	Established patient domiciliary or rest home visit, approximately 25 minutes
99336 ^	Established patient domiciliary or rest home visit, approximately 40 minutes
99337 ^	Established patient domiciliary or rest home visit, approximately 1 hour
99339 ^	Home or assisted living care supervision, 15 to 29 minutes per month
99340 ^	Home or assisted living care supervision, 30+ minutes per month

Home Visit Evaluation and Management	
99341	New patient home or residence visit, straightforward medical decision making, 15+ minutes
99342	New patient home or residence visit, low-level medical decision making, 30+ minutes
99343 ^	New patient home visit, approximately 45 minutes
99344	New patient home or residence visit, moderate-level medical decision making, 60+ minutes
99345	New patient home or residence visit, high-level medical decision making, 75+ minutes
99347	Established patient home or residence visit, straightforward medical decision making, 20+ minutes
99348	Established patient home or residence visit, low-level medical decision making, 30+ minutes
99349	Established patient home or residence visit, moderate-level medical decision making, 40+ minutes
99350	Established patient home or residence visit, high-level medical decision making, 60+ minutes
Preventive Visits	
99385	New patient preventive visit, ages 18 to 39
99386	New patient preventive visit, ages 40 to 64
99387	New patient preventive visit, ages 65 and older
99395	Established patient preventive visit, ages 18 to 39
99396	Established patient preventive visit, ages 40 to 64
99397	Established patient preventive visit, ages 65 and older
G0101	Cervical or vaginal cancer screening; pelvic and breast examination
Preventive Counseling	
99401	Preventive medicine counseling, approximately 15 minutes
99402	Preventive medicine counseling, approximately 30 minutes
Advance Care Planning	
99497	Advance care planning, first 30 minutes
99498	Advance care planning, each additional 30 minutes
Cognitive Assessment & Care Planning	
99483	Cognitive impairment assessment and care planning, approximately 60 minutes
Transitional Care Management	
99495	Transitional care management, moderate complexity
99496	Transitional care management, high complexity
Chronic Care Management	
G2058	Chronic care management, clinical staff, each additional 20 minutes per month
Care Management / Behavioral Health	
99484	Behavioral health care management, 20+ minutes of clinical staff per month
99492	Initial psychiatric collaborative care management, first 70 minutes

99493	Subsequent psychiatric collaborative care management, first 60 minutes
99494	Psychiatric collaborative care management, each additional 30 minutes per month
G0323	Behavioral health care management by clinical psychologist, social worker, or counselor, 20+ minutes per month
G0511	Rural Health Clinic or Federally Qualified Health Center general care management, 20+ minutes per month
G0570	Behavioral health care management, provider-directed, per month
G3002	Chronic pain management, first 30 minutes per month
G3003	Chronic pain management, each additional 15 minutes per month
Behavioral Health / Specialty Management	
G0556	Advanced primary care management, level 1 (one chronic condition)
G0557	Advanced primary care management, level 2 (two or more chronic conditions)
G0558	Advanced primary care management, level 3 (qualified Medicare beneficiary, two or more chronic conditions)
G0560	Safety planning intervention, each 20 minutes
G0568	Initial psychiatric collaborative care management, first calendar month
G0569	Subsequent psychiatric collaborative care management, subsequent month
Care Management / Medication Management	
G2064	Comprehensive care management, single high-risk disease, provider, 30+ minutes per month
G2065	Comprehensive care management, single high-risk disease, clinical staff, 30+ minutes per month
Care Coordination / Navigation	
G0537	Atherosclerotic cardiovascular disease risk assessment, 5 to 15 minutes (once per 12 months)
G0538	Atherosclerotic cardiovascular disease risk management, clinical staff, per month
G0539	Caregiver behavior management training, initial 30 minutes
G0540	Caregiver behavior management training, each additional 15 minutes
G0541	Caregiver direct-care training (no patient present), initial 30 minutes
G0542	Caregiver direct-care training (no patient present), each additional 15 minutes
G0543	Group caregiver direct-care training (no patient present)
G0544	Post-discharge telephone follow-up (emergency department behavioral health or crisis), 4 calls per month
G0519 *	Dementia management, new patient and caregiver pair, low complexity
G0520 *	Dementia management, new patient and caregiver pair, moderate complexity
G0521 *	Dementia management, new patient and caregiver pair, high complexity
G0522 *	Dementia management, new patient, low complexity
G0523 *	Dementia management, new patient, moderate to high complexity
G0524 *	Dementia management, established patient and caregiver pair, low complexity

G0525 *	Dementia management, established patient and caregiver pair, moderate complexity
G0526 *	Dementia management, established patient and caregiver pair, high complexity
G0527 *	Dementia management, established patient, low complexity
G0528 *	Dementia management, established patient, moderate to high complexity
G0076 ~	Care management home visit, new patient, 20 minutes
G0077 ~	Care management home visit, new patient, 30 minutes
G0078 ~	Care management home visit, new patient, 45 minutes
G0079 ~	Care management home visit, new patient, 60 minutes
G0080 ~	Care management home visit, new patient, 75 minutes
G0081 ~	Care management home visit, existing patient, 20 minutes
G0082 ~	Care management home visit, existing patient, 30 minutes
G0083 ~	Care management home visit, existing patient, 45 minutes
G0084 ~	Care management home visit, existing patient, 60 minutes
G0085 ~	Care management home visit, existing patient, 75 minutes
G0086 ~	Care management home care plan oversight, 30 minutes
G0087 ~	Care management home care plan oversight, 60 minutes
Telephone Evaluation and Management	
99441 ^	Telephone evaluation and management, 5 to 10 minutes
99442 ^	Telephone evaluation and management, 11 to 20 minutes
99443 ^	Telephone evaluation and management, 21 to 30 minutes
Digital Evaluation and Management / Online Assessment	
99421	Online digital evaluation and management, 5 to 10 minutes over 7 days
99422	Online digital evaluation and management, 11 to 20 minutes over 7 days
99423	Online digital evaluation and management, 21+ minutes over 7 days
Telehealth / Virtual Visits	
G2010	Remote evaluation of patient-submitted images or video
G2012 ^	Virtual check-in by provider (brief)
G2252	Virtual check-in by provider, 11 to 20 minutes
Remote Monitoring / Data Review	
99091	Collection and interpretation of patient data, 30+ minutes per 30 days
99445	Remote physiologic monitoring, device supply, 2 to 15 days per 30 days
99453	Remote physiologic monitoring, setup and patient education
99454	Remote physiologic monitoring, device supply, 16 to 30 days per 30 days
99470	Remote physiologic monitoring treatment management, first 10 minutes per month
Hospital Outpatient Clinic Visit	

G0463	Hospital outpatient clinic visit for assessment and management
Rural Health Clinic / Federally Qualified Health Center Encounters	
G0466	Federally Qualified Health Center visit, new patient
G0467	Federally Qualified Health Center visit, established patient
G0468	Federally Qualified Health Center visit, initial preventive examination or annual wellness visit
Rural Health Clinic / Federally Qualified Health Center Communication Technology	
G0071	Rural Health Clinic or Federally Qualified Health Center virtual communication services, 5+ minutes
Rural Health Clinic / Federally Qualified Health Center Telehealth	
G2025	Rural Health Clinic or Federally Qualified Health Center telehealth distant-site service
Screening & Risk Assessment	
96160	Patient-focused health risk assessment
96161	Caregiver-focused health risk assessment
G0442	Annual alcohol misuse screening, 5 to 15 minutes
G0443	Brief alcohol misuse counseling, 15 minutes
G0444	Annual depression screening, 5 to 15 minutes
Laboratory & Point-of-Care Diagnostics	
82962	Blood glucose test, handheld device
83036	Hemoglobin A1c
83037	Hemoglobin A1c, home device
87275	Influenza B antigen, immunofluorescence
87276	Influenza A antigen, immunofluorescence
87804	Influenza antigen, immunoassay with optical observation
HIV Prevention (Pre-Exposure Prophylaxis)	
G0011	HIV pre-exposure prophylaxis counseling by provider, 15 to 30 minutes
G0012	HIV pre-exposure prophylaxis drug injection
G0013	HIV pre-exposure prophylaxis counseling by clinical staff
J0739	Cabotegravir injection, 1 milligram (HIV pre-exposure prophylaxis)
Quality Reporting	
G8482	Influenza immunization administered or previously received
GCOL1	Quality reporting code (no descriptor provided in source)
Vaccine Administration	
G0008	Administration of influenza vaccine
G0009	Administration of pneumococcal vaccine
G0010	Administration of hepatitis B vaccine
90480	Administration of COVID-19 vaccine (any), per component

M0201	In-home administration of pneumococcal, influenza, hepatitis B, and/or COVID-19 vaccine
Vaccines (Non-COVID)	
90630	Influenza vaccine, quadrivalent, preservative-free, intradermal
90653	Influenza vaccine, inactivated, adjuvanted, intramuscular
90654	Influenza vaccine, trivalent, preservative-free, intradermal
90655	Influenza vaccine, trivalent, preservative-free, 0.25 milliliters
90656	Influenza vaccine, trivalent, preservative-free, 0.5 milliliters
90657	Influenza vaccine, trivalent, 0.25 milliliters
90658	Influenza vaccine, trivalent, 0.5 milliliters
90660	Influenza vaccine, trivalent, live, intranasal
90661	Influenza vaccine, trivalent, cell-cultured, 0.5 milliliters
90662	Influenza vaccine, high-dose, preservative-free
90670	Pneumococcal conjugate vaccine, 13-valent
90671	Pneumococcal conjugate vaccine, 15-valent
90672	Influenza vaccine, quadrivalent, live, intranasal
90673	Influenza vaccine, trivalent, recombinant
90674	Influenza vaccine, quadrivalent, cell-cultured
90677	Pneumococcal conjugate vaccine, 20-valent
90682	Influenza vaccine, quadrivalent, recombinant
90685	Influenza vaccine, quadrivalent, preservative-free, 0.25 milliliters
90686	Influenza vaccine, quadrivalent, preservative-free, 0.5 milliliters
90687	Influenza vaccine, quadrivalent, 0.25 milliliters
90688	Influenza vaccine, quadrivalent, 0.5 milliliters
90689	Influenza vaccine, quadrivalent, preservative-free, 0.25 milliliters
90694	Influenza vaccine, quadrivalent, adjuvanted, 0.5 milliliters
90732	Pneumococcal polysaccharide vaccine, 23-valent
90739	Hepatitis B vaccine, adult, 2-dose or 4-dose
90740	Hepatitis B vaccine, dialysis or immunosuppressed, 3-dose
90743	Hepatitis B vaccine, adolescent, 2-dose
90744	Hepatitis B vaccine, pediatric or adolescent, 3-dose
90746	Hepatitis B vaccine, adult, 3-dose
90747	Hepatitis B vaccine, dialysis or immunosuppressed, 4-dose
90750	Shingles (zoster) vaccine, recombinant
90756	Influenza vaccine, quadrivalent, cell-cultured, antibiotic-free
90759	Hepatitis B vaccine, 3-antigen, 10 micrograms, 3-dose

Q2034	Influenza vaccine, split virus (Agriflu)
Q2035	Influenza vaccine, split virus, ages 3 and older (Afluria)
Q2036	Influenza vaccine, split virus, ages 3 and older (Flulaval)
Q2037	Influenza vaccine, split virus, ages 3 and older (Fluvirin)
Q2038	Influenza vaccine, split virus, ages 3 and older (Fluzone)
Q2039	Influenza vaccine, not otherwise specified
COVID-19 Vaccine Administration	
0001A ^	Pfizer, 30 micrograms, first dose
0002A ^	Pfizer, 30 micrograms, second dose
0003A ^	Pfizer, 30 micrograms, third dose
0004A ^	Pfizer, 30 micrograms, booster dose
0011A ^	Moderna, 100 micrograms, first dose
0012A ^	Moderna, 100 micrograms, second dose
0013A ^	Moderna, 100 micrograms, third dose
0031A ^	Janssen, single dose
0034A ^	Janssen, booster dose
0041A ^	Novavax, 5 micrograms, first dose
0042A ^	Novavax, 5 micrograms, second dose
0044A ^	Novavax, 5 micrograms, booster dose
0051A ^	Pfizer, 30 micrograms, Tris-sucrose, first dose
0052A ^	Pfizer, 30 micrograms, Tris-sucrose, second dose
0053A ^	Pfizer, 30 micrograms, Tris-sucrose, third dose
0054A ^	Pfizer, 30 micrograms, Tris-sucrose, booster dose
0064A ^	Moderna, 50 micrograms, booster dose
0071A ^	Pfizer, 10 micrograms, pediatric, first dose
0072A ^	Pfizer, 10 micrograms, pediatric, second dose
0073A ^	Pfizer, 10 micrograms, pediatric, third dose
0074A ^	Pfizer, 10 micrograms, pediatric, booster dose
0081A ^	Pfizer, 3 micrograms, pediatric, first dose
0082A ^	Pfizer, 3 micrograms, pediatric, second dose
0083A ^	Pfizer, 3 micrograms, pediatric, third dose
0091A ^	Moderna, 50 micrograms, ages 6 to 11, first dose
0092A ^	Moderna, 50 micrograms, ages 6 to 11, second dose
0093A ^	Moderna, 50 micrograms, ages 6 to 11, third dose
0094A ^	Moderna, 50 micrograms, booster dose

0111A ^	Moderna, 25 micrograms, pediatric, first dose
0112A ^	Moderna, 25 micrograms, pediatric, second dose
0113A ^	Moderna, 25 micrograms, pediatric, third dose
0121A ^	Pfizer bivalent, 30 micrograms, single dose
0124A ^	Pfizer bivalent, 30 micrograms, additional dose
0134A ^	Moderna bivalent, 50 micrograms, additional dose
0141A ^	Moderna bivalent, 25 micrograms, first dose
0142A ^	Moderna bivalent, 25 micrograms, second dose
0144A ^	Moderna bivalent, 25 micrograms, additional dose
0151A ^	Pfizer bivalent, 10 micrograms, single dose
0154A ^	Pfizer bivalent, 10 micrograms, additional dose
0164A ^	Moderna bivalent, 10 micrograms, additional dose
0171A ^	Pfizer bivalent, 3 micrograms, first dose
0172A ^	Pfizer bivalent, 3 micrograms, second dose
0173A ^	Pfizer bivalent, 3 micrograms, third dose
0174A ^	Pfizer bivalent, 3 micrograms, additional dose
COVID-19 Vaccine Products	
91300 ^	Pfizer, 30 micrograms per 0.3 milliliters
91301 ^	Moderna, 100 micrograms per 0.5 milliliters
91302 ^	AstraZeneca
91303 ^	Janssen
91304	Novavax, 5 micrograms per 0.5 milliliters
91305 ^	Pfizer, 30 micrograms, Tris-sucrose
91306 ^	Moderna, 50 micrograms per 0.25 milliliters
91307 ^	Pfizer, 10 micrograms, Tris-sucrose, pediatric
91308 ^	Pfizer, 3 micrograms, Tris-sucrose, pediatric
91309 ^	Moderna, 50 micrograms per 0.5 milliliters
91311 ^	Moderna, 25 micrograms per 0.25 milliliters, pediatric
91312 ^	Pfizer bivalent, 30 micrograms per 0.3 milliliters
91313 ^	Moderna bivalent, 50 micrograms per 0.5 milliliters
91314 ^	Moderna bivalent, 25 micrograms per 0.25 milliliters
91315 ^	Pfizer bivalent, 10 micrograms per 0.2 milliliters
91316 ^	Moderna bivalent, 10 micrograms per 0.2 milliliters
91317 ^	Pfizer bivalent, 3 micrograms per 0.2 milliliters
91318	Pfizer, 3 micrograms, Tris-sucrose

91319	Pfizer, 10 micrograms, Tris-sucrose
91320	Pfizer, 30 micrograms, Tris-sucrose
91321	Moderna, 25 micrograms per 0.25 milliliters
91322	Moderna, 50 micrograms per 0.5 milliliters

***** Codes approved only for use within CMMI models or demonstration projects.

~ Codes approved only for use within CMMI models where services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living, and/or nursing facility within 90 days following discharge from an inpatient facility, no more than 9 times.

^ Retired (deleted) code. Effective deletion dates:

- January 1, 2021 — 99201
- January 1, 2023 — 99318, 99324–99328, 99334–99337, 99339, 99340, 99343, 99354, 99355
- November 1, 2023 — all COVID-19 administration codes (0001A–0174A) and product codes 91300–91303, 91305–91317 (91304 remains active)
- January 1, 2025 — 99441, 99442, 99443; G2012 (deleted by Medicare, replaced by 98016)

Notes

- Non-COVID influenza, pneumococcal, and hepatitis B vaccine codes remain active; some seasonal Q-codes (for example, Q2034 Agriflu) may be discontinued at the product level—verify against the current season's payer file.
- G0519–G0528 (dementia) and G0076–G0087 (care-management home visits) were added from the second file because they carry the CMMI markers; tell me if you want the other second-file additions folded in as well.

Appendix C.4 Primary Care PCC Services

Table C.4 Primary Care PCC HCPCS Codes

Code Group	Primary Care PCC	Community Health Center PCC
Welcome to Medicare	G0402	G0402
Annual Wellness Visits	G0438, G0439	G0438, G0439, G0466-G0468 (FQHC)
Office E&M	99202 - 99205, 99211-99215, G2211, G2212	99202-99205, 99212-99215, G2211, G2212
Home Services	99341 - 99342, 99344-99345, 99347-99350	99341-99342, 99344-99345, 99347-99350 (RHC)
Related Telehealth Codes	99421 - 99423, 98016	G0071[25]

This table demonstrates codes covered by Medicare within the capitation scope; however, CMS expects other payers will include additional codes relevant to their populations, such as preventive codes (99381-99387, 99391-99397, 99401-99404, and 99429).

[25] HCPCS G0071 is included in historical claims but was discontinued by CMS effective December 31, 2025, with reporting prohibited beginning January 1, 2026. RHCs and FQHCs must instead report the individual underlying codes. G0071 should not be used for 2027 PCS identification except when reflecting legacy claims.