Geographic Direct Contracting Model ("Geo")

Overview

What is the Geographic Direct Contracting Model?

The Geographic Direct Contracting Model (also known as the "the Geo model") is a new payment and service delivery model being tested by the Centers for Medicare & Medicaid Services (CMS) Innovation Center. The Model will test whether a geographic-based approach to value-based care can improve quality of care and reduce costs for Medicare beneficiaries across an entire geographic region. Leveraging best practices and lessons learned from prior Innovation Center models, the Geo model will enable Direct Contracting Entities (Geo DCEs) to build integrated relationships with healthcare providers and community organizations in a region to better coordinate care and address the clinical and social needs of Medicare beneficiaries.

Geo DCEs will take responsibility for total cost of care for Medicare Fee for Service (FFS) beneficiaries in a specific region. Geo DCEs will implement region wide care delivery and value-based payment systems with the goal of improving care for beneficiaries through higher quality and lower costs. To achieve these goals, the model will enable Geo DCEs – which may include sophisticated Accountable Care Organizations (ACOs), health systems, health care provider groups, and health plans – the flexibility to utilize a variety of tools described in more detail below.

The Geo model builds on lessons the CMS Innovation Center has learned from prior Medicare Accountable Care Organization (ACO) initiatives, including the Medicare Shared Savings Program and the Next Generation ACO Model, as well as innovative approaches from Medicare Advantage, Medicaid Managed Care, and commercial health plan risk-sharing arrangements. The Geo model requires participants to take full risk with 100 percent shared savings / shared losses, with risk corridors, for Medicare Parts A and B services for aligned Medicare FFS beneficiaries in a defined target region. The Geo model will be tested over a six-year period in four to ten regions and will include two three-year model agreement periods, the first of which starts on January 1, 2022 and the second of which starts on January 1, 2025.

What are the goals of the Model?

The goal of the Geo model is to test whether Geo DCEs are able to improve quality of care and lower costs for Medicare beneficiaries across an entire region. Beneficiaries in the region will maintain all their Original Medicare benefits but may receive enhanced benefits and may have lower (but never higher) out-of-pocket costs for certain services than in Original Medicare. Health care providers in the region will have the option to enter into value-based payment arrangements with Geo DCEs. Health care providers that choose not to enter into an arrangement with a Geo DCE will continue to be reimbursed at 100% of Medicare FFS rates.

How does the Model differ from the Global and Professional Options of Direct Contracting?

The Geographic Direct Contracting Model builds on the design of the Direct Contracting Global and Professional Options. However, unlike in the Global and Professional Options of Direct Contracting, the Geo model requires Geo DCEs to take financial risk for a portion of all Medicare FFS beneficiaries residing in a geographic area rather than only the Medicare FFS beneficiaries seeing particular providers and suppliers. In order to allow Geo DCEs to take on this broader level of risk, Geo provides DCEs with a range of tools outlined in more detail below.

What is the timeline for the Model?

The Geographic Direct Contracting Model will have two three-year Model Agreement Periods. The first Model Agreement Period will take applications in 2021 and have a performance period from January 1, 2022 through December 31, 2024. The second Model Agreement Period will take applications in 2024 and have a performance period from January 1, 2025 through December 31, 2027.

The Innovation Center has released a Request for Applications for the first Model Agreement Period. In addition to the Request for Applications, the Innovation has released a Geographic Direct Contracting Data Book, which will include the aggregated historical data needed for potential participants to submit a proposed discount for their selected target region (see bidding details in the Geo DCE section below). The Request for Applications solicits participants in ten target regions for the first Model Agreement Period.

CMS expects applications to be due April 2, 2021. CMS then expects to announce participants by June 30, 2021, and that Geo DCEs will be required to submit their Geo Preferred Provider lists by September 1, 2021. The first performance period will start on January 1, 2022.

Where are the list of target regions in the Request for Application?

For the Model, CMS will define a target region as a Core Based Statistical Area (CBSA), which includes both metropolitan and micropolitan communities. For each CBSA, CMS expects to follow the delineations defined by the U.S. Office of Management and Budget (https://www.census.gov/programs-surveys/metro-micro/about/delineation-files.html). For the Request for Application for the first Model Agreement Period, CMS has identified 10 target regions:

- Atlanta
- Dallas
- Houston
- Los Angeles
- Miami
- Orlando
- Philadelphia
- Phoenix
- San Diego
- Tampa

How were these regions chosen?
Target regions were selected through a variety of qualitative and quantitative factors, including cost and quality trends, number of beneficiaries, and APM penetration. After completing a Letter of Interest (LOI) process from December 3 – December 21, 2020, CMS selected these ten regions for inclusion in the Request for Application.

Beneficiaries

Which beneficiaries will be included in the Model?

Beneficiaries included in the model must meet each of the following criteria:

- Be enrolled in both Medicare Part A and Part B;
- Not be enrolled in a Medicare Advantage plan, Medicare-Medicaid Plan (MMP), cost plan, PACE organization, or other Medicare managed care plan;
- Have Medicare as a primary payer;
- Be residents of the United States; and
- Have their address of record in a region included in the Model.

Will beneficiaries lose any of their Original Medicare benefits?

No. Beneficiaries will maintain all of their Original Medicare benefits.

Can beneficiaries still see any Medicare provider or supplier they want to see?

Yes. Beneficiaries can continue to see any enrolled Medicare provider or supplier of their choosing.

Do beneficiaries maintain all of their appeal and grievance rights?

Yes. Beneficiaries maintain all of their appeal and grievance rights under Original Medicare.

What benefit enhancements may be available under the Model?

Geo DCEs also have the option to offer certain enhanced Medicare benefits such as:

- Streamlined access to a skilled nursing facility through a waiver of Medicare's 3-Day SNF Rule;
- Home visits for beneficiaries following a discharge from an inpatient hospital, psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility;
- Home visits for care management;
- Increased access to home health care by waiving the homebound requirement for access to home health services in Medicare;
- Asynchronous telehealth services for certain conditions; and
- Access to curative care while receiving the hospice benefit.

Will beneficiaries' out-of-pocket costs increase or decrease?

Beneficiaries' out-of-pocket costs will not increase as a result of their alignment to a Geo DCE participating under the Geo Model. Geo DCEs have the option to lower beneficiaries' out-of-pocket costs in certain circumstances. Consistent with Geo model requirements, Geo DCEs may lower out-of-pocket costs by reducing co-payments for Part A or Part B services or offering a Part B premium subsidy.

How will beneficiaries be aligned to a Geographic Direct Contracting Entity?

Beneficiaries will be aligned to a Geo DCE in the following ways, in the following order of precedence (e.g., voluntary alignment prioritized first):

1) **Voluntary Alignment:** Beneficiaries will in the first instance be aligned to a Geo DCE through voluntary alignment. The Innovation Center will be working with beneficiary groups to design the voluntary alignment process that will be used in the Geo Model and expects to release more details in Spring 2021. Beneficiaries will be able to voluntarily align to a Geo DCE both electronically and through paper-based forms.
2) **MCO-Based Alignment for Dually Eligible Beneficiaries:** If a Geo DCE or its affiliate operates a Medicaid Managed Care Organization (MCO), all full-benefit dually eligible beneficiaries who are in Medicare FFS and enrolled in the MCO for their Medicaid benefits will be aligned to that Geo DCE, with the exception of a beneficiary who has voluntarily aligned to a different Geo DCE.
3) **ACO-Based Alignment:** A DCE may enter into an arrangement with an ACO participating in the Medicare Shared Savings Program or with a DCE participating in the Professional Option of the Direct Contracting model ("Professional DCE"), in which case the beneficiaries aligned to the ACO or Professional DCE and who reside in the DCE's region may be aligned to the DCE with the exception of a beneficiary who has voluntarily aligned or been aligned based on MCO-based alignment to a different DCE. The number of ACO-based aligned beneficiaries for a given Geo DCE will be limited by a cap on beneficiary alignment via certain alignment mechanisms (the "Care-Alignment Cap"), and is higher for those Geo DCEs with a higher discount relative to the other Geo DCEs in their region.
4) **Limited Claims-Based Alignment:** Alignment-eligible beneficiaries not otherwise aligned based on voluntary alignment, MCO-based alignment, or ACO-based alignment may be aligned to a Geo DCE based on primary care services received from the Geo DCE's Geo Preferred Providers, as evidenced in claims utilization data and based on a claims-based alignment algorithm, which will identify and link beneficiaries that have active care relationships with Geo Preferred Providers. The number of claims-based aligned

beneficiaries for a given Geo DCE will be limited by the Care-Alignment Cap.

5) **Random Alignment:** Any alignment-eligible beneficiaries not aligned to a Geo DCE through voluntary alignment, MCO-based alignment, ACO-based alignment, or claims-based alignment will be aligned randomly to a Geo DCE. The number of randomly aligned beneficiaries for a given Geo DCE will be determined by the Geo DCE's Market Cap, which is higher for those Geo DCEs with a higher discount relative to the other Geo DCEs in their region.

How will beneficiaries be informed that the Geo model will be tested in their region?

Beneficiary outreach and education are critical aspects of the Geo Model to support proactive beneficiary engagement with the Geo DCE. Beneficiaries will be informed via a pre-mailing by CMS to inform beneficiaries of what the Geo Model is and why CMS is testing it in their region, how their benefits stay the same, including their right to see any Medicare-enrolled provider or supplier, and the Geo DCEs in their region. In addition, this letter will inform beneficiaries to which Geo DCE they are aligned and how they can voluntarily align to another Geo DCE in the region and report concerns with care during the Model Performance Period. Finally, the letter will explain that the Geo DCE and CMS are part of a joint arrangement, known as an Organized Health Care Arrangement, in which the parties participate in joint payment activities and the Geo DCE will receive access to the beneficiary's protected health information (PHI) for the purposes of any health care operations activities of the Organized Health Care Arrangement.

Can beneficiaries change Direct Contracting Entities?

Yes. Beneficiaries will have the option to select a DCE in their region at the start of each performance period as well as to change Geo DCEs either quarterly or annually. Beneficiaries will have the option of at least three Geo DCEs per region. Additional details on the ability of beneficiaries to change Geo DCEs after the start of a performance period will be provided in the Request for Applications.

Can beneficiaries opt out of alignment to a Geo DCE?

No. Because beneficiaries in Geo maintain all their Original Medicare benefits and rights (while having the possibility of receiving additional benefits and lower out-of-pocket costs), beneficiaries will not be able to opt out of alignment to a Geo DCE participating in the Geo model. Including all Medicare FFS beneficiaries in the selected regions that meet the eligibility criteria is critical for avoiding adverse selection in the Model.

What recourse do beneficiaries have if they believe the DCE is stinting on their care?

Beneficiaries will maintain all of their beneficiary protection rights under Original Medicare (e.g., Ombudsman, appeals).

How will the model be monitored to ensure beneficiaries are not subject to care stinting?

CMS will implement a monitoring plan designed to protect beneficiaries and address potential program integrity risks. CMS will employ a range of methods to monitor and assess compliance by the Geo DCE with the terms of the Participation Agreement. CMS may monitor ongoing and future activities that the Geo DCE implements, conduct audits of medical records and other data from the Geo DCE, and analyze program integrity trends. If aberrant billing practices, other payment, or medical concerns are noted, CMS may conduct further investigation. CMS may also request that Geo DCEs participate in site visits or in-depth reviews to ensure all entities performing Geo DCE activities continue to adhere to Medicare rules and regulations and comply with the terms of the Participation Agreement that govern the activities of Geo Preferred Providers.

Direct Contracting Entities

Who may apply to be a DCE?

Participants in the model must be covered entities under the Health Insurance and Portability Accountability Act (HIPAA). Covered entities include most types of provider organizations as well as health plans. We anticipate interest from organizations that have significant experience taking risk in value-based care models including sophisticated Accountable Care Organizations (ACOs), health systems, health care provider groups and health plans. We also anticipate some applications might include innovative partnerships between health plans and

health care providers.

How will DCEs be selected?

The Geo Model will select participants through a two-step process. First, applicants will be assessed on their capacity to carry out the requirements of the model. Specifically, applicants will be judged against a rubric on eight domains: (1) organizational structure and experience; (2) financial plan and risk-sharing experience; (3) patient-centeredness and beneficiary engagement; (4) quality and clinical process improvement; (5) provider partnerships; (6) care management; (7) compliance; and (8) IT systems. CMS will assess program integrity risks of all applicants who meet a defined scoring threshold on this rubric. Those applicants that are deemed qualified will then be sorted by the target region specified in their application.

Second, applicants' proposed discounts will be compared both against a regional minimum and against the other applicants within the region, with those applicants with higher average proposed discounts receiving preference. Applicants will propose a discount (expressed as a percentage of their region's Performance Year Benchmark) for each of the three years of the relevant model agreement period. Final applicant selection may be based on a combination of application score and average proposed discount. Only target regions in which at least three qualified Geo DCE applicants exceed the regional minimum discount will be included as model regions for the first three-year Model Agreement Period. Only target regions in which at least three qualified Geo DCE applicants exceed the regional minimum discount will be included as model regions for the first three-year Model Agreement Period. For regions with greater than three qualified Geo DCE applicants the minimum number of DCEs per region will be at least three and the maximum number of DCEs per region will between three and seven, dependent on the number of Medicare FFS beneficiaries in a region. The regional minimum discount is expected to be between 2-3%, and will be set by CMS through an analysis of historical trend and regional spending patterns. All applications for a target region that does not have at least three qualified Geo DCE applications will be rejected, regardless of whether the Geo DCE's operational capabilities or proposed discounts meet the defined thresholds. At least three Geo DCEs will be selected to participate in each of the target regions included as model regions for the first three-year Model Agreement Period.

Only applicants with proposed discounts above a regional minimum (expected to be between 2-3%) and that are actuarially sound (expected to be a maximum discount of between 8-9%) will be eligible to be selected. Average discounts will be calculated by summing the discount for each Performance Year (PY) multiplied by the Performance Year Weight (PY2022 40%, PY2023 30%, PY2024 30%).

How many beneficiaries will be aligned to each Geo DCE?

Each DCE will be aligned a minimum of 30,000 beneficiaries. There is no maximum number of beneficiaries that may be aligned to a Geo DCE. To determine a Geo DCE's number of aligned beneficiaries, CMS will calculate a Market Cap, which will be equal to the DCE's average discount across the three relevant performance years divided by the sum of all Geo DCEs' average discounts in the Geo DCE's region. DCEs with a higher average discount in comparison to the other DCEs in their region will receive a higher number of aligned beneficiaries for that Model Agreement Period. The Market Cap will be equal to a percentage of the total beneficiaries in the region, less those beneficiaries that have voluntarily aligned or are aligned via MCO-based alignment at the time of alignment. An example calculation of the Market Cap can be found below:

Performance Year Bid Discount	**DCE1**	**DCE2**	**DCE3**
PY1 Bid Discount	4.00%	4.00%	3.00%
PY2 Bid Discount	4.00%	5.00%	5.00%
PY3 Bid Discount	5.00%	7.00%	5.00%
Weighted Average	**4.30%**	**5.20%**	**4.20%**
Market Cap	*31.39%*	*37.96%*	*30.66%*

What tools will Geo DCEs have to help improve quality and lower cost?

Geo will have three primary tools for improving quality and lowering costs:

- **Preferred Providers:** Geo DCEs will be required to enter into relationships with Geo Preferred Providers, which will allow Geo DCEs to provide value-based payments to those providers as well as to allow these

providers to deliver enhanced benefits to beneficiaries. Geo DCEs will also have the option to offer lower out-of-pocket costs (in the form of lower cost-sharing or a Part B premium subsidy) to beneficiaries who receive all or a portion of their care from Geo Preferred Providers.

- **Care Coordination & Clinical Management**: Geo DCEs will be able to implement a wide array of care coordination and clinical management programs to support aligned beneficiaries, including those with serious and chronic health conditions. These programs can include the use of telemonitoring, telemedicine, interdisciplinary care teams, and care management.
- **Reducing Unnecessary Services or Payments:** Geo DCEs will be allowed to perform certain program integrity functions to ensure adherence to Original Medicare policies, including review of coding practices, assessing adherence to national and local coverage determinations and medical appropriateness, and reducing fraud, waste and abuse.

What tools will Geo DCEs have for care coordination and clinical management?

Subject to certain limitations and compliance with all applicable laws and regulations, Geo DCEs, Geo Preferred Providers, and other individuals or entities performing functions or services on behalf of Geo DCEs will be permitted to provide certain in-kind items or services to beneficiaries that have a connection to the beneficiary's medical care. Examples of these beneficiary engagement incentives that Geo DCEs could consider offering might include:

- Vouchers for over-the-counter medications recommended by a health care provider.
- Prepaid, non-transferable vouchers that are redeemable for transportation services solely to and from an appointment with a health care provider.
- Items and services to support management of a chronic disease or condition, such as home air-filtering systems or bedroom air-conditioning for asthmatic patients or a blood pressure monitor for patients with high blood pressure, and home improvements such as railing installation or other home modifications to prevent re-injury.
- Wellness program memberships, seminars, and classes.
- Decision support tools to support informed decision making and beneficiary education.
- Electronic systems that alert family caregivers when a family member with dementia wanders away from home or gets up from a chair or bed.
- Vouchers for those with chronic diseases to access chronic disease self-management, pain management and falls prevention programs.
- Vouchers for those with malnutrition to access meal programs.
- Phone applications, calendars or other methods for reminding patients to take their medications and promote patient adherence to treatment regimens.
- Vouchers for vision and dental care services.

Additionally, to influence healthy behaviors, subject to compliance with all applicable laws and regulations and CMS approval, CMS will permit Geo DCEs to provide gift cards to eligible aligned beneficiaries up to an annual limit of $75 for the purpose of incentivizing participation in chronic disease management programs. Geo DCEs may also provide Medicare Part B cost sharing support to beneficiaries who seek care from high-performing Geo Preferred Providers, subject to certain limitations and compliance with all applicable laws and regulations.

What tools will Geo DCEs have for program integrity?

Geo DCEs will have a variety of options for validating the medical necessity of services, supplies, and sites of care to ensure appropriate care is furnished to beneficiaries. All program integrity functions must rely on applicable Medicare requirements set forth in statutes, regulations, CMS rulings, National Coverage Determinations (NCDs), coverage provisions in interpretive Medicare Manuals, and Local Coverage Determinations (LCDs) when conducting these program integrity functions.

For Geo Preferred Providers, Geo DCEs may implement a range of program integrity tools including pre-service review, pre-claim review, pre-payment claim edits, and pre-payment and post-payment medical and payment review so long as such tools are referenced in the agreement entered into between the Geo DCE and the Geo Preferred Provider. Guidelines and requirements that will apply to payment integrity and medical review efforts by Geo DCEs are consistent with the terms of the Medicare Program Integrity Manual (PIM).

For Non-Preferred Providers[1], DCEs may also implement all the aforementioned tools, many available starting in PY2023, but with one exception. Pre-service review cannot be required of Non-Preferred Providers but may only be offered as an option to avoid other forms of pre-payment or post-payment review.

Further details on how Geo DCEs may apply program integrity tools for Non-Preferred Providers are described in Request for Applications.

Will Geo DCEs be able to take capitation?

Yes. There will be two voluntary capitation payment mechanisms available to Geo DCEs and Geo Preferred Providers:

- **Total Capitation**: Geo DCEs and Geo Preferred Providers will opt into reducing Geo Preferred Providers' fee-for-service billing paid by MACs by 100%. In turn, Geo DCEs will receive a monthly capitated payment equal to the projected reduction in fee-for-service billings and be responsible for all downstream payments to Geo Preferred Providers that have agreed to a fee reduction. Geo Preferred Providers will still be required to submit claims to MACs but those claims will treated as no-pay claims.
- **Partial Capitation**: Partial capitation will work the same as Total Capitation but Geo Preferred Providers' fee-for-service billing will be reduced by MACs by between 1% and 50%. In turn, DCEs will receive a monthly capitated payment equal to the projected reduction in fee-for-service payments to Geo Preferred Providers that have agreed to a fee reduction. DCEs may make additional downstream payments to Geo Preferred Providers as agreed upon between the Geo DCE and Geo Preferred Providers.

Providers

What are Geo Preferred Providers?

Geo Preferred Providers are Medicare-enrolled providers or suppliers who have voluntarily chosen to enter into an arrangement with a Geo DCE.

At a minimum, Geo DCE and Geo Preferred Provider arrangements must include: (1) an attestation by the Geo Preferred Provider that it is willing to participate in Geo as a Geo Preferred Provider, including following the applicable requirements of the model as set forth in the Participation Agreement between CMS and the Geo DCE; and (2) specify the payment terms, if any, between the Geo DCE and the Geo Preferred Provider. Geo DCEs' arrangements with Geo Preferred Providers may also include additional terms and conditions related to other payment and billing rules, care coordination, quality goals, and/or operational functions such as program integrity.

Geo DCE and Geo Preferred Provider arrangements may be added as amendments to any existing contracts that already exist between Geo DCEs and DC Preferred Providers, such as contracts that exist for the purposes of ACO or Medicare Advantage programs.

Who is eligible to be a Geo Preferred Providers?

A Geo Preferred Provider is an individual or entity that:

- Is a Medicare-enrolled provider or supplier (as described in 42 C.F.R. § 400.202)
- Bills for items and services it furnishes to Medicare FFS beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations
- Is not excluded or otherwise prohibited from participation in Federal health care programs;

[1] Non-Preferred Providers refers to Medicare-enrolled providers and suppliers that are not Geo Preferred Providers.

- Is identified on the DCE's list of Geo Preferred Providers; and
- Has agreed, pursuant to a written agreement with the DCE, to participate in the model.

CMS expects to require Geo DCEs to submit Geo Preferred Provider lists the Innovation Center by September 1, 2021.

Can an individual or entity be a Geo Preferred Provider with more than one DCE?

Yes. An individual or entity may choose to be a Geo Preferred Provider with one or more Geo DCEs in a region.

What are the benefits of being a Geo Preferred Provider?

Being a Geo Preferred Provider offers providers many benefits including:

- **Alternative Payment Arrangements**: Geo Preferred Providers will contract directly with the Geo DCE, allowing more flexibility for how Geo Preferred Providers are paid. For example, Geo Preferred Providers can be paid capitation, sub-capitation, quality bonuses, shared savings, or through any other arrangement agreed to between the DCE and Geo Preferred Provider.
- **Quality Payment Program ("QPP") Bonus**: Geo Preferred Providers may qualify for an APM Incentive Payment under the Quality Payment Program. CMS expects that the Geo Model will be an Advanced APM for Performance Year 2022 and future years. For more information on APMs and the Quality Payment Program, please visit following link: https://qpp.cms.gov/about/qpp-overview.
- **Benefit Enhancements and Care Management**: Geo Preferred Providers will be able to offer beneficiaries enhanced benefits relative to Original Medicare. For example, Geo Preferred Providers may have the opportunity to broaden their use of telemedicine and care management, and the beneficiaries they treat may receive SNF services without a 3-day inpatient hospital stay, post-discharge home visits, home health visits when not homebound, and continue curative care while transitioning into hospice.
- **Decreased Administrative Burden**: For Geo Preferred Providers in value-based arrangements with Geo DCEs, the Geo DCEs will have the flexibility to decrease some of the administrative program integrity requirements that exist in Original Medicare. This will allow Geo Preferred Providers to prioritize patients over paperwork.
- **Lower Cost-Sharing and Increased Patient Volume**: DCEs may offer beneficiary cost-sharing support and other incentives for beneficiaries to seek care from Geo Preferred Providers. Accordingly, being a Geo Preferred Provider may result in an increase in patient volume driven by the lower cost-sharing and the health care provider's relationship with the DCE.

Does a provider or supplier have to be a Geo Preferred Provider?

No. Being a Geo Preferred Provider is 100% optional (although required to access the benefits described in the prior question).

If a provider or supplier is not a Geo Preferred Provider, how much is that provider or supplier paid?

Non-Preferred Providers will be paid 100% of Original Medicare rates.

If a provider or supplier is a Geo Preferred Provider, can that provider or supplier be in another Innovation Center model?

Yes. Geo Preferred Providers may participate in other Innovation Center models

If a provider or supplier is a Geo Preferred Provider, can that provider be in Medicare Shared Savings Program?

Yes. Geo Preferred Providers may participate in the Shared Savings Program. A Geo Preferred Provider's participation in Geo will not impact its ability to participate in the Shared Savings Program.

Financial Methodology

How do the finances of the Geographic Direct Contracting model work for DCEs?

The Geographic Direct Contracting Model financial methodology is based on a Geo DCE's performance against its Performance Year Benchmark. During the application phase, DCEs will propose a discount that will be applied to its benchmark. Geo DCEs will be responsible for 100% of savings or losses above or below this discount, subject to the application of risk corridors. The model also includes risk adjustment and quality adjustments as outlined in detail below.

How will the Performance Year Benchmarks be set?

Performance Year Benchmarks will be set using a Geographic Rate Book. The goals of the Geographic Rate Book are to move toward a more predictable calculation of benchmarks in risk-based Medicare FFS models and further align Medicare FFS and MA payment policies. The Geographic Rate Book will utilize a methodology similar to the Medicare Advantage Rate Book, which establishes county-level rates for MA Plans for Aged and Disabled beneficiaries and state-level rates for ESRD beneficiaries.

To create the Geographic Rate Book, CMS will utilize a fixed three year baseline period (CY 2017, CY 2018, and CY 2019) to derive the adjusted Historical Regional Expenditures. To establish the yearly Performance Year Benchmark, CMS will then trend forward the Historical Regional Expenditures to the performance year utilizing a prospective trend. For Performance Years 2023 and 2024, CMS will utilize a national matched prospective trend, therefore not causing prospective trends to decrease due to prior Performance Year performance.

How does risk adjustment work in the Model?

CMS will use the Hierarchal Chronic Conditions (HCC) risk adjustment methodology to account for the underlying health status of the population of beneficiaries aligned to a DCE. Risk scores will be normalized and subject to a zero-sum coding intensity factor to ensure there is no increases in payments triggered solely by coding intensity increases. Specifically, within each region, risk scores will be retrospectively re-scaled by dividing the raw risk score by the normalization and zero-sum coding intensity factors, so that the average DCE risk scores within a region are equal to the 1.0 average used to set the Performance Year Benchmark.

How is model overlap taken into consideration in the financial methodology?

Beneficiaries aligned to a Geo DCE may be eligible to be aligned to participants in other value-based care initiatives, including the Medicare Shared Savings Program and all other Innovation Center models except for the Direct Contracting Model Global Option. For overlapping models, all payments (inclusive of shared savings payments, care management fees, and/or other performance-based payments) made under other Innovation Center models or the Shared Savings Program will be included in the performance year expenditures that are compared against the Performance Year Benchmark for purposes of calculating shared savings or shared losses for the DCE to which the beneficiaries have been aligned. Calculation of payments for overlapping initiatives, including the Shared Savings Program or Innovation Center models, will not be affected by the Geo Model. An example model overlap calculation can be found below.

Example Model Overlap Payment Calculation

Step	Calculation	Value
(a) MSSP ACO Beneficiaries	-	2,000
(b) MSSP ACO Benchmark	-	$2,000,000
(c) MSSP ACO Performance Year Spend	-	$1,960,000
(d) MSSP ACO Shared Savings Payment	(a – c) * 50%	$20,000
(e) DCE 1 Overlapping Beneficiaries	-	1,000
(g) DCE 1 Overlap Payment	(e / a) * d	$10,000

How do the risk corridors work in the Model?

The aggregate amount of savings or losses that DCEs will be eligible to receive as shared savings or be required to repay as shared losses will be constrained by a series of risk corridors. DCEs will receive a portion of shared savings, or be liable for a portion of shared losses, above each risk band, with the portion of gross savings / losses decreasing with each risk band. Risk corridors will be applied to a given DCE's savings minus its bid discount and after adding a standard 5% percentage point administrative load. Within the reconciliation process, CMS will cover risk corridor related shared losses only to the extent that it receives risk corridor payments from other DCEs. This risk corridor notional funding pool will persist over the life of the model, where risk corridor payments made by DCEs in early years can be used to make risk corridor payments to DCEs in later years. If in a given Performance Year there are not enough funds in risk corridor notional funding pool to fully pay out DCEs' risk corridor payments, the DCEs will receive payments that are prorated using their total expected risk corridor payments. Risk corridor bands will be as follows:

Adjusted Gross Savings/Losses (Gross Savings / Losses Relative to Performance Year Benchmark - Proposed Discount - Administrative Load)	Geo DCE Shared Savings/ Shared Losses cap	CMS Shared Savings/ Shared Losses cap
Risk corridor 1: 0 < Adjusted Savings/Losses <= 5%	100% of savings/losses	0% of savings/losses
Risk corridor 2: 5% < Adjusted Savings/Losses <= 10%	70% of savings/losses	30% of savings/losses
Risk corridor 3: 10% < Adjusted Savings/Losses <= 15%	40% of savings/losses	60% of savings/losses
Risk corridor 4: 15% < Adjusted Savings/Losses	10% of savings/losses	90% of savings/losses

Is there a financial guarantee required to participate as a Geo DCE?

Yes. Geo DCEs will be required to provide a financial guarantee equal to 10% of the Geo DCE's benchmark for each Performance Year. CMS shall pursue payment under the financial guarantee for any shared losses or other monies owed. Geo DCEs shall submit their financial guarantee plans, which must include escrowed funds, a line of credit, a surety bond, or a proposal for an alternative financial guarantee mechanism for approval by CMS (for example, other risk-based capital reserves the DCE is already holding). Any proposed alternative financial guarantee approach must address how the proposed financial guarantee mechanism will offer sufficient protection to CMS for any shared losses or other monies owed under the model. A financial guarantee must comply with all applicable state laws and regulations regarding risk-bearing entities.

Is there a financial incentive for Geo DCEs to continue their participation in the model?

Yes. DCEs will be subject to a retention withhold that will be equal to 100% of the minimum expected savings of that region (likely 2% to 3% depending on the region) for the remaining performance years for a given Model Agreement Period after a Geo DCE withdraws from of the model. Additional information on the retention withhold be found in the Geographic Direct Contracting Model Request for Applications.

Quality

What is the Model's quality strategy?

The goal of the quality strategy is to incentivize quality in three areas: patient experience, hospital admissions, and prevention. All Quality Withholds (see details below) will be paid out to Model participants such that the Quality Withhold will not result in additional savings to CMS but may result in redistribution of payments among Model participants.

What are the Model's quality measures?

The Model's quality measures are designed to align with prior ACO quality programs as well as the Medicare Advantage STAR ratings program. There are seven quality measures:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2]
- Risk standardized, all cause readmission measure
- Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions
- Colorectal Cancer Screening
- Breast Cancer Screening
- Controlling High Blood Pressure
- Diabetes: Hemoglobin A1c (HgbA1c) Poor Control (>9%)

Data on each quality measure will be collected by CMS using a combination of strategies employed in existing ACO initiatives and Medicare Advantage including following the specifications in the STAR ratings program where applicable. For example, CMS will collect results of the CAHPS survey from a contractor hired by the DCE, and the readmission and admission metrics will be collected via submitted claims data. Cancer screening metrics, blood pressure control measures, and diabetes control measures will be collected in a manner consistent with the Medicare STAR ratings program. CMS expects to provide additional details on how these measures will be collected in the forthcoming Request for Applications.

How large is the Model's quality withhold?

The quality withhold begins at 1% in Performance Year 2022, is 2% in Performance Year 2023, and is 3% in Performance Year 2024 and beyond. The quality withhold amount will be calculated by applying the withhold percentage to the DCE's Performance Year Benchmark prior to the application of the DCE's proposed discount.

How do DCEs earn back their quality withhold?

DCEs may earn back their quality withholds based on their quality scores. CMS will calculate the quality score in three steps:

Step 1: Calculate the Composite Quality Score: The quality score will be calculated by comparing the DCE's performance on each quality measure against a national benchmark[3]. For each measure, CMS will set and publish a minimum and maximum benchmark threshold ahead of each performance year utilizing national data. A Geo DCE will receive a score between 0 and 100 for each measure, 100 if the measure is at or above the maximum benchmark, 0 if the measure is below the minimum benchmark, and partial credit if the score falls between the minimum and the maximum benchmarks. For partial credit, the Geo DCE will receive a minimum score of 50 on that measure if the Geo DCE's score is greater than or equal to the minimum benchmark.

Step 2: Improvement Factor: Beginning in Performance Year Two, CMS will create an Improvement Factor that assesses whether a Geo DCE demonstrates statistically significant improvement annually that exceeds most of its peers. To determine if a Geo DCE warrants an improvement factor, the Geo DCE's year over year improvement for each and all of its measures will be assessed against the mean improvement for all measures by all of its peers. CMS will determine on a measure-by-measure basis if the Geo DCE's improvement on that measure is statistically significant at a 95% confidence interval in comparison to all Geo DCEs. If the Geo DCE demonstrates significant improvement on all measures, the Geo DCE will be considered to have met the Improvement Factor criteria and would receive an Improvement Factor award worth an increase of 10 points to the Geo DCE's overall Composite Quality Score up to the maximum of 100 percent.

Step 3: Determine the Quality Payout: To determine the quality payment, the DCE's Composite Quality Score (expressed as a percentage) will be applied to that year's withhold amount. The Quality Composite Score will

[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[3] Performance Year One Exception: For the first year of the model, it will be difficult to set appropriate benchmarks for all quality measures. As a result, a DCE's overall quality score will be based on only two measures – admissions and successful reporting. For admissions, CMS will assess the Geo DCE's performance on the two admissions measures and use the best one of the two to assess the DCE's performance. For reporting, CMS will assess that the DCE successfully reported for all 7 required quality measures. Successful reporting will require passing any external HEDIS audits, meeting all required data elements on any data transfers, and meeting all reporting deadlines. CMS expects the vast majority – if not all – DCEs to earn back their full Quality Withhold in Performance Year One.

include the Improvement Factor if applicable. For example, if a DCE scores 80 in a given year, it will receive 80% of its withhold back for that year.

How does the High Performers Pool work?

The intent of the High Performers Pool ("HPP") is to distribute any quality withholds not earned back by a Geo DCE to Geo DCEs who have exceptional quality performance. To distribute the HPP, CMS will rank all Geo DCEs by their Composite Quality Score (after taking into account the Improvement Factor). Geo DCEs with Composite Quality Scores that fall in the top third of all Geo DCEs nationally will be eligible to receive payment from the HPP. To determine the HPP amount for each Geo DCE, CMS will take the ratio of available HPP dollars to the sum of quality withhold dollars for all DCEs eligible for the HPP (i.e., those DCEs in the top third of quality performance) and multiply that ratio by the DCE's quality withhold amount. In other words, an individual DCE's HPP would be calculated using the formula:

$$DCE_1\ HPP\ Bonus = \frac{Total\ Available\ HPP\ dollars}{Sum\ of\ Quality\ Withhold\ dollars\ for\ all\ DCEs\ in\ the\ HPP} \times (DCE_1\ Quality\ Withhold\ dollars)$$

The payout to each DCE will be capped by the DCE's quality withhold amount, meaning that a DCE would have the potential to earn up to a maximum of twice its quality withhold. Any unused HPP dollars will roll over to the next year's pool.