Geographic Direct Contracting Model
Webinar

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Speakers

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Model Overview and Goals

CMS Innovation Center Statute

"The purpose of the [CMS Innovation Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles."

Three scenarios under which the duration and scope of an initial model test may be expanded:

1. Quality improves; cost neutral
2. Quality neutral; cost reduced
3. Quality improves; cost reduced (best case)

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking.

Geographic Direct Contracting Model Goals

The Model will initially be tested in 4 10 regions based on participant interest and bids received. There are four primary goals of the Geographic Direct Contracting Model.

Better care coordination for beneficiaries.

Provide beneficiaries with enhanced benefits and incentives for care management.

Provide beneficiaries the possibility of lower out-of-pocket costs.

Protect all beneficiaries' existing Medicare benefits and rights.

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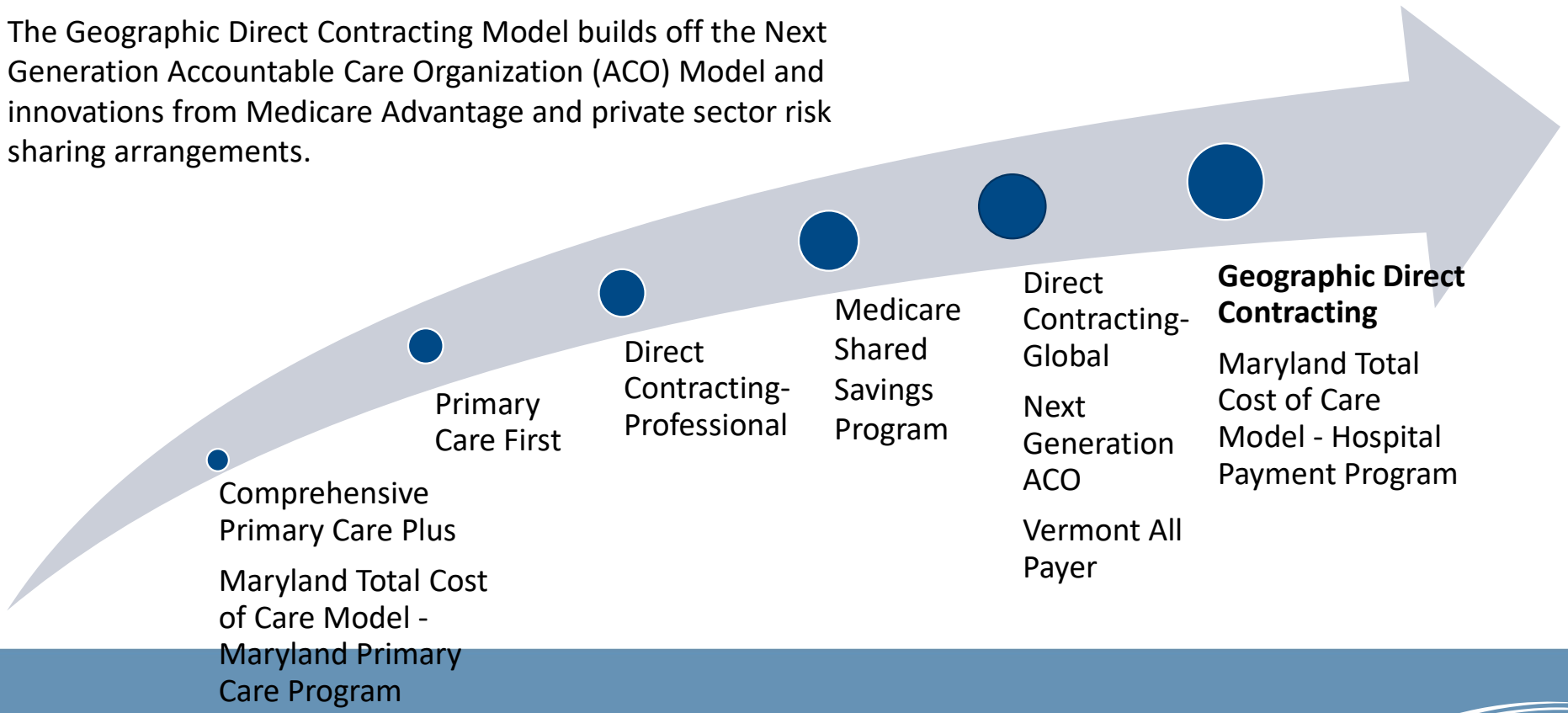
Why Geographic Direct Contracting?

The Geographic Direct Contracting Model seeks to provide beneficiary choice with more universal care coordination and enhanced benefits in a cost effective manner.

Current Medicare FFS	Geographic Direct Contracting Model
No incentives for coordinated care	Significant incentives for coordinated care
No enhanced benefits	Significant opportunity for enhanced benefits
No incentives for Social Determinants of Health (SDOH)	Significant incentives for SDOH
Traditional Medicare deductibles, copays, and premiums	Potential for lower deductibles, copays, and premiums

Geographic Direct Contracting Background

The Geographic Direct Contracting Model builds off the Next Generation Accountable Care Organization (ACO) Model and innovations from Medicare Advantage and private sector risk sharing arrangements.



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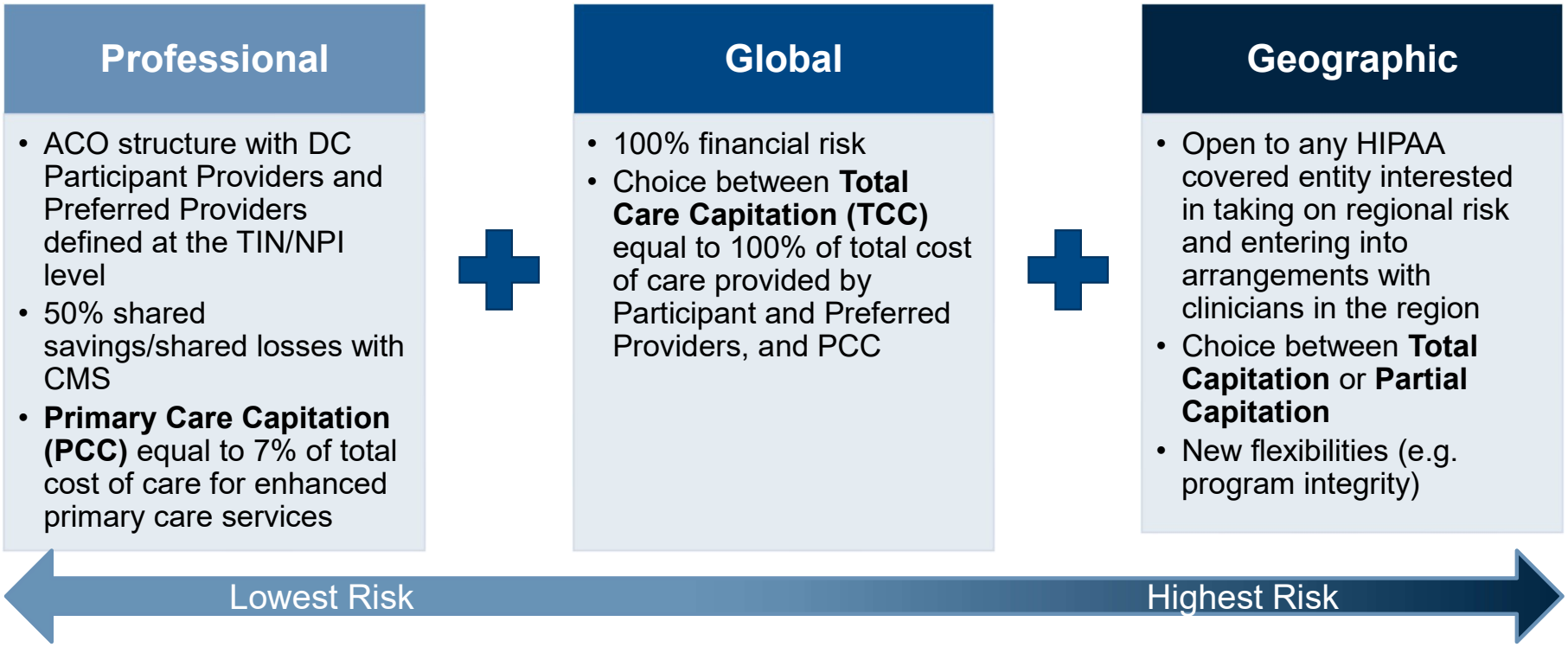
Evolution to Geographic Direct Contracting



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Model Design and Structure

Geographic Direct Contracting Overview

- 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
- Enables Direct Contracting Entities (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
- DCEs will take responsibility for total cost of care for Medicare Fee for Service (FFS) beneficiaries in a specific region
- 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 cost
- The model will enable DCEs the flexibility to utilize a variety of tools described throughout this presentation

What is a Geographic Direct Contracting Entity (DCE)?

- Potential entities include: health care provider organizations, ACOs, health plans, and other entities
- Participants in the model must be covered entities under the Health Insurance Portability and Accountability Act (HIPAA)
- CMS will require that DCEs be experienced and sophisticated organizations with the ability to coordinate care for beneficiaries with complex conditions. Some of their capabilities should include:
  - Strong disease management and clinical management
  - Ability to pay health care providers in value-based care arrangements
  - Beneficiary engagement and education
  - Experience with servicing a large number of Medicare or Medicaid beneficiaries
- Financially responsible for 100% of the cost of Medicare Part A and Part B services

Beneficiary's Perspective

The Geographic Direct Contracting Model will continue to protect the rights of Medicare beneficiaries and Geographic DCEs may offer Enhanced Benefits and Beneficiary Engagement Incentives.

- Beneficiaries will maintain all of their Original Medicare benefits and coverage rights with Geo only enhancing those benefits.
- Beneficiaries will be able to access all Medicare-enrolled providers and suppliers.
- Beneficiary cost sharing will stay the same or come down.
- Beneficiaries may have access to enhanced benefits.
- DCEs are encouraged to address beneficiaries' SDOH and partner with local organizations.
- Beneficiaries will maintain all of their beneficiary protection rights (e.g. Ombudsman, appeals).
- Beneficiaries will have choice of which DCE coordinates their care and can change DCEs.

Beneficiary Eligibility

Eligibility

- Enrolled in both Medicare Part A and Part B
- Not enrolled in a Medicare Advantage (MA) plan, cost plan, PACE organization, or other non-MA Medicare managed care plan
- Have Medicare as a primary payer
- Are residents of the DCE's target region

Model Overlap

- Beneficiaries would be included in Geo if they are aligned to a participant in another alternative payment model (APM); CMS is exploring an exception for the Global Option of Direct Contracting
- Full benefit dually eligible beneficiaries included in state Financial Alignment Initiatives will be excluded

Beneficiary Alignment

For the purpose of assigning accountability for total cost of care, beneficiaries will be aligned to a DCE in the following ways, in the following order of precedence:

- Voluntary Alignment: Beneficiaries will be able to voluntarily align to a Geo DCE both electronically and through paper-based forms. Voluntary alignment will take precedence over all other forms of alignment;
- MCO-Based Alignment for Dually Eligible Beneficiaries: If a 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 DCE;
- ACO-Based Alignment(1): A DCE may enter into an arrangement with an ACO participating in CMS ACO initiatives, in which case the beneficiaries aligned to the ACO and who reside in the DCE's region may be aligned to the DCE;
- Claims-Based Alignment(1): Beneficiaries may be aligned based on primary care services received from a DCE's Preferred Providers, as evidenced in claims utilization data and based on a care link algorithm, which will identify and link beneficiaries that have active care relationships with the DCE's Preferred Providers;
- Random Alignment: Any beneficiaries not aligned through voluntary alignment, MCO-based alignment, ACO-based alignment, or Claims-based alignment will be aligned randomly to a DCE.

(1) The combined number of ACO-based and Claims-based aligned beneficiaries for a given DCE will be capped at 50% of a DCE's Enrollment Allocation.

Application Process

- CMS will select model participants through a two-step application process, first an assessment of operational capabilities and second an assessment of proposed discounts
- CMS will select at minimum three DCEs in a region, with larger regions having more DCEs
- DCEs will receive a minimum of 30,000 aligned beneficiaries per DCE
- DCEs with higher proposed discounts in a given region receiving greater beneficiary alignment
- Only regions with enough viable applications will be included in the model

Operational Criteria

(1) Organizational structure and experience;
(2) Leadership and management;
(3) Financial plan and risk-sharing experience;
(4) Patient centeredness and engagement; and
(5) Clinical care

Proposed Discounts

After proposed discounts are assessed for their actuarial soundness, CMS will select the highest proposed discounts in a region and will not select proposed discounts that are below a minimum discount threshold.

Proposed Discounts

- DCEs will submit a proposed discount for each Performance Year of the Model Performance Period
- Each discount will be expressed as a percentage from a regional benchmark
- The proposed discount will be utilized to set the DCEs Performance Year Benchmark
- To select DCEs in a given region, CMS will select the DCE with the highest proposed discount
- DCEs with higher proposed discounts will receive greater beneficiary alignment
- CMS will be providing applicants with a standard bid tool and bid data, developed from the tools used in MA

Example DCE Bid

Payment Year	Proposed Discount	Regional Benchmark	Benchmark Less Discount
PY1	3%	$1,000	$970
PY2	5%	$1,010	$960
PY3	7%	$1,020	$949

Benchmarking & Risk Adjustment

Benchmarking

- All Medicare Parts A and B spending
- 3-year baseline period
- Prospective trend rates will utilize the most recent data (e.g. 2021 data for 2022 PY1)
- Trend updates during a three year cohort period will use national trends adjusted for a matched region (ensuring DCEs are not impacted for its prior year savings)
- Will update prospective trend rates to adjust for impact of COVID-19

Risk Adjustment

- Risk adjustment will utilize the CMS-HCC prospective risk adjustment model
- CMS will use a region level zero-sum risk adjustment modifier to limit the effect of coding intensity
  - Limits potential risk score growth in a region by re-scaling aggregate DCE risk scores back to the 1.0 average, maintaining the 1.0 average score for the cohort
- Within a region, individual DCE risk scores will be able to change and reflect the relative risk of their population in comparison to other DCEs in the region

Model Overlap

- Beneficiaries aligned to a Geo DCE may be eligible for attribution to other value-based care initiatives (except as noted on slide 14)
- All payments made under MSSP or other Innovation Center models will be included in the DCEs' performance year expenditures used in calculating shared savings/shared losses
- Other initiatives' savings calculations are not impacted by this Model

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	(b – c) * 50%	$20,000
(e) DCE 1 Overlapping Beneficiaries	-	1,000
(g) DCE 1 Overlap Payment	(e / a) * d	$10,000

Quality

The goal of the quality strategy is to incentivize quality in three areas: patient experience, hospital admissions, and prevention.

CMS would assess each DCE's quality performance to ensure that the DCE meets the model goals of improved quality of care and health outcomes for Medicare beneficiaries.

- Geo will include a quality "withhold" in which a percentage of each DCE's benchmark will be held "at-risk" each year
- DCEs would have the opportunity to earn back this withhold through performance or improvement
- DCEs that are among the highest performing DCEs will earn back their withholds and could potentially earn an additional one times their withhold via a High Performers Pool

Quality Withhold by Year

Payment Year	Quality Withhold
PY1 - 2022	1%
PY2 – 2023	2%
PY3+ – 2024+	*3%*

Quality Measures

Quality measures were selected with the following goals:

- Decrease burden for health care providers and participants
- Increase alignment with Medicare Advantage Star Ratings program and other value-based programs
- Increase ability to evaluate measure performance

In addition to performance, DCEs will have the opportunity to increase their quality score through improvement.

Measure	Alignment With Other Quality Programs
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Direct Contracting Global & Professional, Primary Care First (PCF), NGACO, Shared Savings Program, MA
Risk standardized, all cause readmission measure	Direct Contracting Global & Professional, NGACO, Shared Savings Program, MA
Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions	Direct Contracting Global & Professional, NGACO, Shared Savings Program
Colorectal Cancer Screening	MA, PCF
Breast Cancer Screening	MA
Controlling High Blood Pressure	MA, PCF, Shared Savings Program
Diabetes: Hemoglobin A1c (HgbA1c) Poor Control (>9%)	MA, PCF, Shared Savings Program

Tools and Flexibilities

Tools & Flexibilities

To achieve the goals of the model, Geo will enable DCEs the flexibility to utilize a variety of tools described in this section.

Preferred Providers

- DCEs contract with Geo Preferred Providers
- Non-Preferred Providers are Medicare-enrolled providers or suppliers that are not contracted with a Geo DCE

Care Coordination & Clinical Management

- Care Coordination and Clinical Management for care improvement
- Benefit Enhancements & Beneficiary Engagement Incentives for improving care coordination and clinical management

Reducing Unnecessary Services or Payments

- Claims payment
- Payment Integrity
- Utilization Management
- Preferred Providers vs. Non-Preferred Providers

Geo Preferred Providers

What are Geo Preferred Providers?

- Geo Preferred Providers are Medicare-enrolled providers or suppliers who have voluntarily chosen to enter into an agreement with a DCE
- A Geo Preferred Provider is an individual or entity that contracts with a DCE and meets the following requirements:

1. Is a Medicare-enrolled provider or supplier (as described in 42 C.F.R. § 400.202);
2. 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;
3. Is not excluded or otherwise prohibited from participation in Medicare or Medicaid;
4. Is identified on the DCE's list of Geo Preferred Providers; and
5. Has agreed, pursuant to a written agreement with the DCE, to participate in the model.

Geo Preferred Provider Network

- DCEs will have the ability to enter into relationships with Geo Preferred Providers
- Will allow DCEs to provide value-based payments to those providers
- Will allow these providers and suppliers to deliver enhanced benefits to beneficiaries
- DCEs will have the option to offer lower out-of-pocket costs (in the form of lower co-pays or offering Part B premium subsidies) for beneficiaries who receive all or a portion of their care from Geo Preferred Providers

Care Coordination & Clinical Management

- 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
- Subject to certain limitations and compliance with all applicable laws and regulations, DCEs and Geo Preferred Providers will be permitted to provide certain in-kind items or services to improve the care to beneficiaries, such as weight loss and other wellness programs or vouchers for OTC medications
- DCEs can use certain benefit enhancements to improve access to care particularly in less restrictive settings such as the 3-day stay waiver for skilled nursing facilities (SNFs), hospital at home and more flexible home health, and telemedicine
- Subject to certain limitations and compliance with all applicable laws and regulations, CMS will permit 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
- 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

Benefit Enhancements & Beneficiary Engagement Incentives

Beneficiary Engagement Incentives

Subject to certain limitations, DCEs will have the flexibility to provide certain beneficiary engagement incentives. Examples include:

- Medicare Part B cost sharing support for Geo Preferred Providers
- Medicare Part B premium subsidies ☆
- Vouchers or rewards for chronic disease management programs

Subject to certain limitations, DCEs may also offer in-kind items or services to beneficiaries that have a connection to the beneficiary's medical care, such as:

- Vouchers for recommended OTC medications
- Vouchers for transportation services to and from providers
- Items and services to support chronic disease management
- Vouchers for nutrition and meal programs
- Vouchers for dental services (prior to jaw surgery, for example)

Benefit Enhancements

- 3-day SNF rule waiver
- Asynchronous telehealth
- Post discharge and care management home visits
- Homebound home health waiver (broaden access to home health)
- Concurrent care for beneficiaries that elect Medicare Hospice
- Hospital at Home ☆
- Nurse practitioner scope of practice waiver ☆

☆ = new and unique to the Geographic Direct Contracting Model

Reducing Unnecessary Services or Payments

- 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 statutes, regulations, CMS rulings, National Coverage Determinations (NCDs), coverage provisions in interpretive Medicare Manuals, and Local Coverage Determinations (LCDs)
- For Geo Preferred Providers, DCEs may implement a range of program integrity tools including prior authorization, concurrent 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 DCE and the Geo Preferred Provider
- For Non-Preferred Providers, DCEs may implement all the aforementioned tools but with two exceptions. Prior authorization 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. This option will not be available until Performance Year 2023
- CMS expects details on how DCEs may apply program integrity tools for Non-Preferred Providers will be included as part of the Request for Applications that CMS expects to issue in January 2021
- DCEs may receive partially-adjudicated claims data through an Application Programming Interface (API), enabling claims payment and program integrity

Preferred Provider's Perspective

Alternative Payment Arrangements	• Geo Preferred Providers will contract directly with the DCE • Allows more flexibility for how Geo Preferred Providers are paid • May be capitation, sub-capitation, quality bonuses, shared savings, fee for service, or in any other arrangement agreed to between the DCE and Geo Preferred Provider
Quality Payment Program	• May qualify for an APM Incentive Payment under the Quality Payment Program (QPP) • CMS expects that the Geo Model will be an Advanced APM starting in Performance Year 2022 • 5% APM incentive payment on Medicare Part B claims payments for qualifying clinicians
Benefit Enhancements and Care Management	• Will be able to offer beneficiaries enhanced benefits relative to Original Medicare • May have the opportunity to broaden use of telemedicine and care management • Beneficiaries can be treated in less restrictive settings through more flexible access to skilled nursing facility care and home visits
Potential for Decreased Administrative Burden	• For Geo Preferred Providers in value-based arrangements, DCEs will have the flexibility to decrease some of the administrative program integrity requirements that exist in Original Medicare • Will allow Geo Preferred Providers to prioritize patients over paperwork
Lower Cost Sharing and Increased Patient Volume	• Entities assume total cost of care risk for aligned FFS Medicare beneficiaries in a defined region • Financial risk for a portion of all aligned Medicare FFS beneficiaries residing in a geographic area • 100% shared savings/shared losses with CMS

Next Steps

Model Timeline

Timeline	Performance Period DCE Applicants
Letter of Interest	LOIs must be submitted to the Innovation Center by 11:59pm PT, December 21, 2020.
Application Period	January 2021 – April 2021
Technical Webinars (finance, program integrity, etc.)	January 2021 – April 2021
DCE Selection	June or July 2021
Submit Geo Preferred Provider List	September 1, 2021
Deadline for applicants to sign and return Participant Agreement (PA)	December 2021
Initial Voluntary Alignment Outreach and start of PY1	January 2022

This timeline may be subject to change. Please check the Geographic Directing Contracting webpage for future webinar and office hour dates and times: https://innovation.cms.gov/innovation-models/geographic-direct-contracting-model

Questions