Geographic Direct Contracting Model

Request for Applications

1/15/2021

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I. Background and Introduction

Direct Contracting is part of a strategy by the Center for Medicare and Medicaid Innovation (Innovation Center) to test ways for healthcare providers and other entities to improve care for Medicare beneficiaries receiving coverage through Original Medicare. The Geographic Direct Contracting (Geo) Model creates new opportunities for the Centers for Medicare & Medicaid Services (CMS) to test an array of financial risk-sharing arrangements and flexibilities, leveraging lessons learned from other Medicare Accountable Care Organization (ACO) initiatives, such as the Medicare Shared Savings Program (Shared Savings Program) and the Next Generation ACO (NGACO) Model, as well as innovative approaches from Medicare Advantage (MA), Medicaid Managed Care, and private sector risk-sharing arrangements. The Geo Model requires participants to take full risk with 100 percent Shared Savings/Shared Losses for Medicare Parts A and B services for Medicare fee-for-service (FFS) beneficiaries in a defined region. The Geo Model will include a Model Performance Period composed of two three-year periods of participation or Model Agreement Periods. The first Model Agreement Period will start on January 1, 2022, and the second Model Agreement Period will start on January 1, 2025.

In testing the Geo Model, CMS is interested in examining whether increasing risk accountability, together with care management, benefit enhancements, beneficiary engagement incentives, and payment integrity and medical review programs designed to reduce improper payments while maintaining all Original Medicare benefits, will reduce unnecessary utilization and improve care coordination, resulting in improved health and reduced costs for a population in a region.

II. Statutory Authority

A. General Authority to Test Model

Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 U.S.C. Section 1315a) establishes the Innovation Center to test innovative payment and service delivery models that have the potential to lower Medicare, Medicaid, and Children's Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

B. Financial and Payment Model Authorities

Section 1115A(b)(2) of the Act requires the Secretary to select models to be tested where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The statute also provides a non-exhaustive list of examples of models that the Secretary may select to test, which includes models that promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment (see section 1115A(b)(2)(B)(iv) of the Act).

C. Waiver and Safe Harbor Authority

The authority for the Geographic Direct Contracting Model is section 1115A of the Act. Under section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and certain provisions of section 1934 of the Act as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b). Please refer to the Benefit Enhancements section for a list

of programmatic waivers we anticipate offering starting in Performance Year 1 (PY1).

For this model and consistent with the authority under section 1115A(d)(1), the Secretary may consider issuing waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act. No fraud or abuse waivers are being issued in this document; fraud and abuse waivers, if any, would be set forth in separately issued documentation. Thus, notwithstanding any provision of this RFA, individuals and entities must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to section 1115A(d)(1) specifically for the Geo Model. Any such waivers would apply solely to the Geo Model and could differ in scope or design from waivers granted for other programs or models.

In addition to or in lieu of a waiver of certain fraud and abuse provisions in sections 1128A and 1128B of the Act, CMS may determine that the anti-kickback statute safe harbor for CMS-sponsored model arrangements and CMS-sponsored model patient incentives (42 C.F.R. § 1001.952(ii)) is available to protect remuneration exchanged pursuant to certain financial arrangements or patient incentives permitted under the Geo Model participation documentation. No such determination has been issued. Such determination, if any, would be set forth in documentation separately issued documentation by CMS.

III. Scope and General Approach

The model will include 6 Performance Years, during which Geo Direct Contract Entities (Geo DCEs) will engage in beneficiary outreach and education, care coordination, care management, preferred provider network management, and payment integrity and medical review programs designed to reduce improper payments while maintaining all Original Medicare benefits.

The primary goals of Geo are to allow beneficiaries to benefit from:

- **Better Care:** Geo DCEs will be incentivized to coordinate with providers and suppliers to offer a less fragmented health care system that better coordinates care and focuses on preventive services. Geo DCEs may also offer care management and other clinical programs to support care for beneficiaries with chronic and serious illnesses.

- **Benefit Enhancements and Beneficiary Engagement Incentives:** Beneficiaries may have access to benefit enhancements, including enhanced telehealth access for certain specialties, easier access to home health care by modifying the homebound requirement, skilled nursing facility care without a prior three day inpatient hospitalization, and incentives for accessing care management programs such as smoking cessation and weight loss programs.

- **Lower Out-of-Pocket Costs:** Geo DCEs will have the ability to reduce beneficiary out-of-pocket costs through reduced cost sharing in Part A and Part B as well as Part B premium subsidies.

- **Strong Protections:** Beneficiaries will keep all of the protections of Original Medicare, including access to all Medicare providers and suppliers and the same appeals system available under Original Medicare. Beneficiaries will also benefit from the ability to choose and switch among Geo DCEs to find the organization that best fits their needs and implementation of strong CMS oversight of Geo DCE performance.

Geo will enable Geo DCEs to implement region-wide systems to improve the care for beneficiaries through higher quality and lower cost care. To achieve these goals, Geo will enable Geo DCEs – which may include sophisticated Accountable Care Organizations (ACOs), health systems, groups of health care providers, and health plans – the flexibility to utilize a variety of strategies including:

- **Provider Alignment & Engagement:** Geo DCEs will enter into relationships with Geo Preferred Providers, which will allow Geo DCEs to provide value-based payments to such providers and suppliers as well as to allow these providers and suppliers to deliver enhanced services and beneficiary engagement incentives to beneficiaries.

- **Care Coordination & Clinical Management**: Geo DCEs will be able to implement a range of innovative care coordination and clinical management programs to support beneficiaries, including those with serious and chronic health conditions. These programs can include the use of telemonitoring, telemedicine for certain specialties, interdisciplinary care teams, and care management.

- **Reducing Unnecessary Services or Payments:** Geo DCEs will be allowed to perform certain program integrity functions before or after services are rendered to ensure adherence to Original Medicare policies, including determining correct coding practices, adherence to national and local coverage determinations, medical appropriateness, and all other coverage criteria.

CMS is committed to improving care for beneficiaries and thereby reserves the right to modify or terminate Geo Direct Contracting if the model is not achieving its established goals and aims or as may be required under section 1115A of the Act.

IV. Application Process

All entities that want to participate in the Geo Model in a target region are required to submit an application to participate in the Geo Model in that region. For entities looking to participate in multiple target regions, the entity must submit a separate application for each such region. While CMS solicited a Letter of Interest (LOI) from interested organizations to gauge interest in participating in the Geo Model, having submitted an LOI is not required for submitting one or more applications.

A. Application

CMS will have two application periods, one for each Model Agreement Period (2022-2024 and 2025-2027). CMS expects that the application for organizations interested in participating in the Geo Model during the first Model Agreement Period will be made available in January 2021. Please continue to check the CMS website for an updated application timeline. CMS expects that the application period for organizations interested in participating in Geo starting in the second Model Agreement Period will open in spring 2024. Organizations may choose to participate in only one Model Agreement Period. The application questions are provided in Appendix E of this RFA so that all applicants can begin preparing their responses. CMS reserves the right to request interviews, site visits, or additional information related to application responses from applicants in order to assess their applications.

Of important note, and as described in the Legal Entity and State Licensure sections below, applicants to the Geo Model will not be expected to have formed their legal entity or to have verified the requisite state licensure until after selection. However, these requirements must be satisfied before the organization executes the Geographic Direct Contracting Model Participation Agreement with CMS (the "Participation

Agreement") for its first Performance Year. In addition to the application, applicants must submit a list identifying all proposed Geo Preferred Providers, by September 1st 2021 for PY1. All Geo Preferred Providers will be subject to program integrity screening by CMS. Selected applicants also must have written agreements that meet the criteria set forth in the Participation Agreement with each Geo Preferred Provider on their list prior to the model start date.

CMS will post the application portal link when it is available.

To submit an application, applicants must first visit the above URL to create a username and password.

Any questions that arise during the application process may be directed to the Geographic Direct Contracting Model mailbox: DCGEO@cms.hhs.gov with the subject "Application Question."

Additionally, we will provide more detailed information in the coming months on the financial methodology, including risk adjustment and quality performance, prior to the timeframe for review and execution of the Participation Agreements. For example, we anticipate providing more information about the financial methodology and risk adjustment later this spring.

B. Withdrawal of Application

Applicants seeking to withdraw a completed application must submit an electronic withdrawal request to CMS via email to the Geographic Direct Contracting mailbox: DCGEO@cms.hhs.gov prior to signing the relevant Participation Agreement. The request must be submitted as a PDF on the organization's letterhead and signed by an official authorized to act on behalf of the organization. It should include the applicant organization's legal name; the organization's primary point of contact; the full address of the organization; and a description of the reason for the withdrawal. Applicants seeking to withdraw certain CCNs and/or NPIs must specify the CCNs and NPIs the applicant wishes to withdraw to the Geographic Direct Contracting mailbox: DCGEO@cms.hhs.gov prior to signing the relevant Participation Agreement. The request must be submitted as a PDF on the organization's letterhead and signed by an official authorized to act on behalf of the organization. It should include the applicant organization's legal name; the organization's primary point of contact; the full address of the organization; the CCNs and NPIs the applicant wishes to withdraw; and a description of the reason for the withdrawal.

V. Applicant Eligibility and Participation Requirements

The following sections describe the requirements an entity must meet to be eligible to participate in the Geographic Direct Contracting Model. Geo aims to attract a range of health care providers and health plans. We believe this model is well-suited to various types of organizations, including those currently participating in the Medicare Shared Savings Program, and Medicare Advantage Plans that are interested in continuing and deepening their participation in Medicare shared risk arrangements. Regardless of the type of organization, Geo DCEs will be participating in an Organized Health Care Arrangement with CMS and thus are required to be a covered entity as defined in 45 C.F.R. § 160.103.

A. Geo DCE Organization Types, Legal Entity Status, Governance Structure, Leadership, and Participation in Organized Health Care Arrangement with CMS

Geo DCE Organization Types

A key aspect of the Geo Model is providing new opportunities for a variety of different organizations to

participate in value-based care arrangements in Medicare FFS. We anticipate interest from organizations with experience in Medicare ACO initiatives and other value-based care models, as well as health plans participating in Medicare Advantage, Medicaid managed care, and other commercial markets; however, states will not be eligible to participate as a Geo DCE.

Legal Entity

A Geo DCE must be a legal entity identified by a federal taxpayer identification number (TIN) formed under applicable state, federal, or tribal law, and authorized to conduct business in each state in which it operates.

The Geo DCE must also comply with all applicable laws and regulations, as well as all Geographic Direct Contracting Model participation requirements.

Governance Structure

Geo DCEs must have an identifiable governing body with the ultimate authority to execute the functions of the Geo DCE and to make final decisions on behalf of the Geo DCE.

- The governing body must have responsibility for oversight and strategic direction of the Geo DCE and for holding Geo DCE management accountable for the Geo DCE's activities, including the Geo DCE's provision of quality health care to its population of aligned beneficiaries without unlawful discrimination and compliance with the requirements reflected in the Participation Agreement between the Geo DCE and CMS.
- Members of the Geo DCE's governing body must, when acting as a member of the governing body, have a fiduciary duty to the Geo DCE, including the duty of loyalty, and must act consistent with that fiduciary duty.
- The governing body must receive reports periodically, but no less frequently than annually, from the designated compliance officer of the Geo DCE, who cannot serve as legal counsel to the Geo DCE, and who must report directly to the governing body.
- CMS will include common corporate good governance requirements for the Geo DCE governing body in the Participation Agreement. Alternative mechanisms and exceptions to these requirements will be considered, at the discretion of CMS, in instances where compliance with these requirements would create an undue hardship or would conflict with state law or licensure requirements, or where the unique nature of a certain Geo DCE would make the requirement inapplicable.
- The Geo DCE governing body must have a conflict of interest policy that applies to members of the governing body that provides a procedure to determine whether a conflict of interest exists and sets forth a process to address any conflicts that arise and includes remedial actions for members of the governing body that fail to comply with the policy.

Geo DCE Leadership and Management

The Geo DCE's operations must be managed by an executive, officer, manager, general partner, or similar individual who has demonstrated the ability to oversee or direct operations to improve the efficiency of processes and outcomes, and who can evidence sufficient and demonstrated experience with Medicare and any of the following: value-based payment, other shared savings initiatives, other government health programs including Medicaid or Medicare Advantage, and/or the administration of health plans.

Organized Health Care Arrangement (OHCA)

The Geo DCE must enter into an Organized Health Care Arrangement (OHCA), as the term is defined under the HIPAA Privacy Rule at 45 C.F.R. § 160.103, with CMS. To satisfy the definition of an OHCA:

- The Geo DCE must be a Covered Entity (as defined at 45 C.F.R. § 160.103);
- The Geo DCE and CMS must hold themselves out to the public as participating in a joint arrangement; and
- Payment activities under the Geo Model, in which the financial risk for delivering health care is shared by CMS and the Geo DCE through the joint arrangement and any protected health information (PHI) created or received by CMS or the Geo DCE under the Geo Model is reviewed by the other participant (or by a third party on their behalf) for purposes of administering the sharing of financial risk.

Further details and requirements of the OHCA are outlined in the data sharing section of this RFA (XI. Data Sharing) and will be specified in detail in the Participation Agreement.

B. Eligible Geo Preferred Providers

The Geo DCE must be a legal entity that is capable of contracting directly with Geo Preferred Providers (defined in the Glossary at Appendix A). Geo Preferred Providers may include, but are not limited to:

- Physicians or other practitioners in group practice arrangements
- Networks of individual practices of physicians or other practitioners
- Hospitals employing physicians or other practitioners
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Critical Access Hospitals (CAHs)

While a Geo DCE will not be required to be a Medicare-enrolled provider or supplier in order to participate in Direct Contracting, each Geo Preferred Provider under the Geo DCE must be a Medicare-enrolled provider or supplier (as such terms are defined at 42 C.F.R. § 400.202) by no later than June 30, 2021, in order to be eligible to participate in the model during PY1.[1] For subsequent performance years of the model, Geo DCEs will be able to update their list of Geo Preferred Providers to add or remove Medicare-enrolled Geo Preferred Providers that satisfy the requirements of the model and are not Prohibited Participants (as defined in the Glossary at Appendix A).

C. Screening

Applications will be screened to determine eligibility for further review. Screening will determine if the applicant meets the requirements and conditions for participation in the model. Applicant screenings will include the criteria detailed in this RFA for the Geo Model and applicable law and regulations, including 2 C.F.R. Parts 180 and 376.

Applicants will be required to disclose any investigations of, or sanctions or corrective action plans that have been imposed on, the applicant, owners, and key executives in the last five years by an accrediting

[1] For additional information on Medicare provider and supplier enrollment, see CMS website: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html.

body or state or federal government agency. Individuals in leadership positions include key executives who manage or have oversight responsibility for the organization, its finances, personnel, and quality improvement, including without limitation, a Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Operations Officer (COO), Chief Information Officer (CIO), medical director, compliance officer, or an individual responsible for maintenance and stewardship of clinical data. Applicants will also be required to disclose any outstanding debts owed to Medicare.

CMS may perform program integrity screenings of individuals who are part of the Geo DCE, including those for whom information was disclosed in the application process, as well as Geo Preferred Providers. A program integrity screening may assess the following without limitation:

- Medicare enrollment status;
- Past performance in, and compliance with the terms of, other CMS models, demonstration programs, and initiatives;
- Medicare billing history;
- Existence and amount of delinquent Medicare debt;
- History of administrative, civil, or criminal actions related to dishonesty or other factors relevant to participation in an initiative involving Federal funds; and
- Current and past investigations by law enforcement or licensure authorities.

CMS may deny participation to an otherwise qualified applicant on the basis of information found during a program integrity screening or information disclosed by the applicant or any other relevant individuals or entities. CMS may also reject individual Geo Preferred Providers on the basis of the results of a program integrity screening or other information disclosed by the applicant or any other relevant individuals or entities.

D. Geo Regions

CMS is soliciting applications from organizations interested in participating in the model in one or more target regions. Target regions are composed of sets of counties centered on a core based statistical area (CBSA). Given the size and construct of these regions, they include both urban and rural counties. Target regions were identified by CMS as those that:

- Suggested a higher potential for cost savings;
- Demonstrated sufficient applicant interest during the Letter of Interest (LOI) period, although submitting an LOI is not required to submit an application and submitting an LOI in no way affects an applicant's likelihood of being selected for participation in the model.
- Possessed state regulatory characteristics that would enable the model to succeed; and
- Included a range of communities to enable national expansion if successful.

For purposes of the application, the applicant must select one target region out of the ten target regions in which the applicant wishes to participate. Under the Geo Model, organizations are permitted to operate as Geo DCEs in multiple regions. Applicants that wish to participate in multiple regions must submit one application per region in which they wish to participate. The target regions are:

- Atlanta
- Dallas
- Houston
- Los Angeles

- Miami
- Orlando
- Philadelphia
- Phoenix
- San Diego
- Tampa

The individual counties for each region can be found within the Geographic Direct Contracting Proposed Discount Tool and the Geographic Direct Contracting Data Book. To be selected as a model region, a target region must have a minimum of three eligible organizations selected to participate as Geo DCEs. We anticipate that a minimum of four model regions will be selected.

The model regions are the geographic areas in which CMS will test the Geo model. Specifically, CMS will utilize a Geo DCE's model region for purposes of beneficiary alignment to that Geo DCE. A Geo DCE's model region is also used to determine which counties' regional expenditures should be incorporated into the Performance Year Benchmark for that Geo DCE. More details on the benchmarking methodology can be found in Section F of this RFA.

E. State Licensure

In order to participate in the Geo Model, a Geo DCE must demonstrate compliance with all applicable state licensure requirements regarding risk-bearing entities unless it provides a written attestation to CMS that it is exempt from such state laws. Each state has unique regulatory systems for health care delivery, the practice of medicine, fraud and abuse, privacy, and insurance, but CMS understands that states may not have laws that specifically address provider organizations bearing substantial financial risk, distributing savings, or, in the case of certain Capitation Payment Mechanisms, paying claims. Therefore, depending on the particular state laws and the discretion of state authorities, Geo DCEs may be subject to insurer or third-party administrator (TPA) licensure requirements. It is a Geo DCE's responsibility to determine and meet all applicable licensure requirements. The Geo Model does not alter state law requirements, but CMS intends to engage with relevant state agencies to promote an understanding of the Model's features and requirements.

F. Advanced APM Determination

We anticipate that Geographic Direct Contracting will meet the criteria to be an Advanced Alternative Payment Model (APM) (42 C.F.R. § 414.1415) for PY 2022 and future years, as permitted by law.

Geo DCEs will be required to ensure that at least 75 percent of eligible clinicians that are Geo Preferred Providers use CEHRT, as defined at 42 C.F.R. § 414.1305, and in the manner specified at 42 C.F.R. § 414.1415(a)(i). This will satisfy the Advanced APM CEHRT use criterion. The Model meets the requirement for payments based on quality measures at 42 C.F.R. § 414.1415(b) as CMS will implement a quality withhold of 1%-3% that may be earned back by meeting the quality performance standard, as described in section VI.F of this RFA.

The APM meets the generally applicable financial risk standard at 42 C.F.R. 414.1415(c)(1) as CMS will require the entity to repay any shared losses and will reduce payment rates to the Geo DCEs' eligible clinicians if actual expenditures for a performance year exceed the performance year benchmark. The APM also meets the nominal amount standard codified at 42 C.F.R. § 414.1415(c)(3) as participating Geo

DCEs will be at significant financial risk for FFS payment beyond the performance year benchmark, including full financial risk for expenditures up to 105% of the performance year benchmark and shared risk beyond 105% of the performance year benchmark.

Eligible clinicians who are Geo Preferred Providers in the model and who are on a Participation List as set forth under the Quality Payment Program regulations (see 42 C.F.R. Part 414 Subpart N) under the Geo Model will be eligible for Qualifying APM Participant (QP) determinations.

MIPS APM Scoring

The Geo Model is considered a Merit-based Incentive Payment System (MIPS) APM under the definition at 42 C.F.R. 414.1305. Any MIPS eligible clinicians in this model (i.e., those who do not attain QP status for a year, or attain Partial QP status and do not opt to report to MIPS, or are not otherwise excluded from MIPS) who are Geo Preferred Providers on the Preferred Provider list for a Geo DCE participating in the Model may be scored for purposes of MIPS as an APM Entity group as codified at 42 C.F.R. 414.1370.

VI. Model Design Elements

The Geo Model includes a number of key design elements that will test new features in payment and care delivery in Medicare FFS. This section describes beneficiary eligibility, alignment, beneficiary outreach and education requirements, financial risk-sharing arrangements, risk mitigation, and Capitation Payment Mechanisms. It also includes a detailed discussion of the benchmark methodology. In addition, this section describes the benefit enhancements and beneficiary engagement incentives that participating Geo DCEs may choose to implement to support their ability to manage the care of their aligned beneficiaries. Any activities performed by the Geo DCE under the model that may be construed as services to the United States Government will be performed without compensation beyond the compensation described in this RFA and the model Participation Agreement. By signing the Participation Agreement for the model, the Geo DCE will waive its rights to compensation from the Government to which the Geo DCE may otherwise be entitled under law beyond the compensation described in the Participation Agreement. In the event of any inconsistency between the policies described in this RFA and the terms of the Participation Agreement, the terms of the Participation Agreement control.

A. Beneficiary Eligibility

For a beneficiary to be aligned to a Geo DCE, the beneficiary must meet certain eligibility criteria. Beneficiaries will be considered alignment-eligible in a given month if they meet the following criteria:

- Are enrolled in both Medicare Part A and Part B;
- Are not enrolled in an MA plan, Medicare-Medicaid Plan (MMP), cost plan, PACE organization, or other non-MA Medicare managed care plan;
- Have Medicare as a primary payer;
- Are not aligned to a DCE participating in the Global Option of the Direct Contracting Model;
- Are residents of the United States; and
- Live in a Geo region.

All beneficiaries that meet the above criteria will be aligned to a Geo DCE according to the methodology described in the *Beneficiary Alignment* section.

B. Beneficiary Alignment

Beneficiary alignment is used for the purpose of prospectively aligning beneficiaries to a Geo DCE. Geo DCEs assume accountability for the total cost of care of beneficiaries aligned to their organization for a given Performance Year of the model. Upon their initial alignment, beneficiaries will remain aligned to the Geo DCE for the duration of the Model Agreement Period unless they lose alignment eligibility, voluntarily align to another Geo DCE, or their Geo DCE leaves the model. This section of the RFA describes the hierarchy of beneficiary alignment methodologies used in the Geo Model.

Beneficiary Alignment Options

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

1) **Voluntary Alignment:** Alignment-eligible beneficiaries will be able to align to a Geo DCE through electronic and paper-based voluntary alignment.
2) **MCO-based Alignment for dually eligible beneficiaries:** If a Geo DCE operates a Medicaid Managed Care Organization (MCO) (as defined in Section 1903(m) and 42 C.F.R. § 438.2) or the Geo DCE is a legal entity affiliated with such an MCO under common ownership (i.e., at least partial ownership by the same parent entity, where that parent entity also has a controlling interest), we will align all alignment-eligible full-benefit dually eligible beneficiaries who are in Medicare FFS and enrolled in the MCO for Medicaid benefits to that Geo DCE unless the beneficiary has voluntarily aligned to a different Geo DCE.
3) **ACO-based Alignment:** A Geo 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 alignment-eligible beneficiaries aligned to the ACO or Professional DCE may be aligned to the Geo DCE, with the exception of beneficiaries who have voluntarily aligned or been aligned based on MCO-based alignment to a different Geo 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"), which is discussed in further detail below, 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 discussed further below, and is higher for those Geo DCEs with a higher discount relative to the other Geo DCEs in their region.

Alignment will occur prior to the start of each three-year Model Agreement Period and will be updated on a quarterly basis, as described in further detail below. In order to be aligned to a Geo DCE, the beneficiary must also meet the beneficiary eligibility criteria (described above).

Voluntary Alignment

Beneficiaries will be able to choose to align to a Geo DCE voluntarily by selecting a Geo DCE as the Geo DCE they will be aligned to under the Geo Model through voluntary alignment. Voluntary alignment can be completed by a beneficiary either electronically, through a website maintained by the Geo DCE based on a template developed by CMS, or, if the Geo DCE has selected to participate in paper-based voluntary alignment, by completing a paper-based form using a template developed by CMS (the "Voluntary Alignment Form").

A beneficiary who designates a Geo DCE as their Geo DCE via electronic voluntary alignment or by completing a Voluntary Alignment Form will have the option to reverse that designation and may update their selection quarterly. If a beneficiary designates a Geo DCE as his or her Geo DCE through both electronic and paper-based means, the electronic designation will take precedence. A beneficiary's designation of his or her relationship with a Geo DCE through voluntary alignment supersedes all other forms of beneficiary alignment under the Geo Model. For example, beneficiaries who designate a Geo DCE as their Geo DCE will generally be aligned to that Geo DCE, even if MCO-based alignment, ACO-based alignment, or claims-based alignment would not have resulted in alignment.

Beneficiaries who have voluntarily aligned to a Geo DCE will be added to the Geo DCE's aligned beneficiary population on a quarterly basis throughout the performance year. If the beneficiary was aligned to another Geo DCE prior to the voluntary alignment, the beneficiary will be de-aligned from the prior Geo DCE at the same time. Prior to the start of each quarter, CMS will compile a list of beneficiaries who have voluntarily aligned to the Geo DCE and meet all other beneficiary eligibility criteria. If a Geo DCE wishes to utilize voluntary alignment, the Geo DCE will be responsible for submitting to CMS updated paper-based or electronic voluntary alignment information prior to the start of each quarter in order to allow for timely updates to these CMS lists.

CMS will incorporate safeguards into the Participation Agreement to ensure that voluntary alignment is conducted appropriately. Geo DCEs will be prohibited from utilizing voluntary alignment for discriminatory purposes, offering cash incentives or in-kind incentives of more than nominal value to induce beneficiaries to voluntarily align to the Geo DCE, and conducting voluntary alignment activities outside of the Geo DCE's region. CMS will actively monitor the Geo DCEs to confirm that voluntary alignment has been conducted in compliance with these safeguards and all other applicable requirements of the Participation Agreement.

MCO-Based Alignment

If a Geo DCE operates a Medicaid Managed Care Organization (MCO) (as defined in Section 1903(m) and 42 C.F.R. § 438.2) or the Geo DCE is a legal entity affiliated with such an MCO under common ownership (i.e., at least partial ownership by the same parent entity, where that parent entity also has a controlling interest), all alignment-eligible full-benefit dually eligible beneficiaries who are in Medicare FFS and enrolled in the MCO for Medicaid benefits will be aligned to the Geo DCE, unless the beneficiary has voluntarily aligned to a different Geo DCE (in which case the beneficiary will be aligned based on voluntary alignment). These Geo DCEs cannot restrict their aligned beneficiary population to only dually eligible beneficiaries, or beneficiaries for which the Geo DCE or its affiliated MCO provide Medicaid coverage, and are expected to manage care for all aligned beneficiaries.

ACO-Based Alignment

The purpose of the ACO-Based Alignment approach is to enable operational and clinical coordination between a Geo DCE and Shared Savings Program ACOs and Professional DCEs in the Geo DCE's region. In ACO-Based alignment, if a Geo DCE has an arrangement with an ACO or Professional DCE, the alignment-eligible beneficiaries aligned to that ACO or Professional DCE will be aligned to the Geo DCE, subject to the Geo DCE's Care-Alignment Cap. If an ACO or Professional DCE has arrangements with multiple Geo DCEs in a given region, the ACO's or Professional DCE's aligned beneficiaries in that region will be randomly aligned among the Geo DCEs with which the ACO or Professional DCE has such arrangements, up to each Geo DCE's respective Care-Alignment Cap.

Claims-Based Alignment

The purpose of the Claims-Based Alignment approach is to preserve the clinician/patient relationship for those beneficiaries under active and regular care, particularly those with chronic or serious illnesses. Claims-based alignment will utilize a claims-based alignment algorithm to identify and align beneficiaries that have active care relationships with Geo Preferred Providers.

The claims-based alignment algorithm will be based on a Geo DCE's Geo Preferred Providers and will align only those beneficiaries who are cared for actively by those providers and suppliers. To determine the existence of an active care relationship, CMS will utilize claims data to determine care patterns. Beneficiaries will be claims-aligned to a Geo DCE if their relationship with the Geo DCE's Preferred Providers meets the following criteria:

- Geo Preferred Provider is a primary care clinician or a specified type of specialist acting as a primary care physician
- Beneficiary has seen the Geo Preferred Provider within the past 12 months
- Beneficiary is under active and ongoing care with the Geo Preferred Provider as determined by CMS based on the frequency of visits
- Beneficiary seeks the majority of their primary care from the Geo Preferred Provider

In the event a beneficiary has a relationship that satisfies the above criteria with a clinician who is a Geo Preferred Provider with two or more Geo DCEs, the beneficiary will be randomly aligned among the Geo DCEs in which the clinician is a Geo Preferred Provider, up to each Geo DCE's respective Care-Alignment Cap. CMS will issue further guidance on the claims-based alignment algorithm for potential participants prior to the deadline for signing the Participation Agreement.

Market Cap and Care-Alignment Cap

The Market Cap is a Geo DCE-specific cap on the total number of beneficiaries that can be aligned to the Geo DCE. The only types of alignment that are not subject to the Market Cap are voluntary alignment and MCO-based alignment. All beneficiaries who are eligible for alignment to the DCE based on voluntary alignment or their enrollment in the relevant MCO will be aligned to the DCE, even if this results in the Geo DCE exceeding its Market Cap. The Market Cap is also used to calculate the Care-Alignment Cap, which limits the total number of beneficiaries that can be aligned through ACO-based alignment and Claims-based alignment, as described below. The number of randomly aligned beneficiaries for a given Geo DCE will then be determined by the amount of the Geo DCE's Market Cap left after determining the number of beneficiaries aligned to the Geo DCE through MCO-based, ACO-based, and Claims-based alignment.

CMS will determine the Market Cap as a function of the Geo DCE's discount compared to the discount for other Geo DCEs in the region, with Geo DCEs with higher discounts receiving a higher Market Cap. Additional details regarding this calculation are outlined in Section XIV of this RFA. 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 in the region.

The Care-Alignment Cap is a Geo DCE-specific cap on the total number of beneficiaries that can be aligned to the Geo DCE through the two provider-based alignment methods: ACO-based alignment and Claims-based Alignment. The Care-Alignment Cap is equal to 50% of the Geo DCE's Market Cap. The sum of ACO-based alignment and Claims-based alignment cannot exceed the Geo DCE's Care-Alignment Cap.

CMS will issue further guidance on the method by which beneficiaries who would be aligned to the Geo DCE but exceed the Care-Alignment Cap or Market Cap, as applicable, will be distributed among the other Geo DCEs in the region. The applicable requirements will be set forth in the Participation Agreement.

Beneficiary Alignment During the Model Agreement Period

Alignment will be processed quarterly during the Model Agreement Period. The alignment process for beneficiaries that become alignment-eligible during the Model Agreement Period will follow the same alignment process defined above. For beneficiaries who have already been aligned to a Geo DCE through ACO-based alignment, claims-based alignment or random alignment, their initial alignment can be updated for a subsequent quarter during the Model Agreement Period only through voluntary alignment or MCO-based alignment. If a beneficiary revokes their previous voluntary alignment, the beneficiary's alignment will revert to their previous alignment, which may be based on either voluntary alignment, MCO-based alignment, ACO-based alignment, Claims-based alignment, or random alignment.

C. Beneficiary Outreach and Education

Beneficiary outreach and education are critical aspects of the Geo Model to support proactive beneficiary engagement with the Geo DCE. It is also essential that Geo DCE outreach does not confuse beneficiaries and that Geo DCEs are put in a position to successfully engage with beneficiaries. To achieve these goals, we will work with Geo DCEs, as well as beneficiary, health care advocacy and consumer organizations nationally and in each region where Geo DCEs are located, on a messaging and communications strategy highlighting key features of Geo including:

- Beneficiaries will be able to access all Medicare providers and suppliers.
- Beneficiary cost sharing will stay the same or may decrease.
- Beneficiaries may have access to enhanced benefits and beneficiary engagement incentives.
- Geo DCEs will be encouraged to address beneficiaries' social determinants of health (SDOH) and partner with local organizations.
- Beneficiaries will maintain all of their beneficiary protection rights (e.g., Ombudsman, appeals).
- Beneficiaries will have a choice of which Geo DCE coordinates their care via voluntary alignment and can change that choice.
- Beneficiaries will continue to be able to select a Medicare Advantage plan during open enrollment, and thereby be removed from the Geo DCE's population of aligned beneficiaries.

To gain access to these important benefits and to assert their rights, it is important that beneficiaries become aware of the Geo Model in the communities in which it is being tested. The Innovation Center

will work with other CMS components, as well as the Administration on Community Living and beneficiary stakeholder groups to launch a communications strategy to increase beneficiary awareness of the Geo Model. The communications strategy will include 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 who the Geo DCEs in their region are. In addition, this letter would also inform the 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. The initial mailing by CMS will be followed by a mailing from the Geo DCE to which the beneficiary is aligned to alert the beneficiary to important attributes of this model, such as their rights to seek care from any Medicare-enrolled provider or supplier, their ability to receive any enhanced benefits and beneficiary engagement incentives selected by the Geo DCE, the Geo DCE's contact information, and how to report concerns with care. For purposes of the initial CMS outreach, CMS will leverage best practices from Medicare Advantage, the NGACO model, and the Medicare Shared Savings Program, including the potential for welcome calls, beneficiary websites and portals, and/or beneficiary mobile applications. CMS will expect Geo DCEs to leverage these same best practices for purposes of their subsequent outreach.

Geo DCEs will be required to inform aligned beneficiaries about what it means to be aligned to a Geo DCE participating in the Geo Model in terms of the care that they will receive. Geo DCEs must communicate the details of their selected benefit enhancements and beneficiary engagement incentives to all of their aligned beneficiaries, and CMS must approve such written materials prior to use. To simplify the review process for Geo DCEs, CMS will provide optional templates that Geo DCEs may use for initial outreach. The Geo DCE must permit its aligned beneficiaries to maintain the freedom to choose their providers and suppliers, including the ability to select a primary clinician on MyMedicare.gov. The Geo DCE is further required to notify its aligned beneficiaries that they have the freedom to select their own primary clinician and to receive services from the providers and suppliers of their choice according to traditional Medicare FFS rules.

To allow for more robust outreach to beneficiaries regarding the Geo Model, we will permit Geo DCEs to proactively communicate with beneficiaries regarding voluntary alignment for the purpose of education and outreach, provided such communications comply with all applicable laws, regulations, and the terms of the Participation Agreement. For example, Geo DCEs will be able to provide educational materials, hold outreach events to the extent permitted by applicable law, and provide in-kind incentives of nominal value to beneficiaries for the purpose of outreach regarding voluntary alignment, as long as the provision of such incentives does not violate applicable federal laws (including the beneficiary inducements prohibition and the anti-kickback statute). However, we will restrict Geo DCEs' activities to ensure that Geo DCEs are not misleading beneficiaries to believe that alignment to the Geo DCE removes or otherwise affects their freedom to choose a provider or supplier, or that beneficiaries will receive benefits that are not available under either Medicare FFS or otherwise not available under the Geo Model. Geo DCEs will not be allowed to engage in activities that may be intrusive to beneficiaries or discriminate against beneficiaries (e.g., based on the anticipated costs of a beneficiary's care or a beneficiary's income) or improperly influence beneficiary choice. In addition, CMS will prohibit Geo DCEs from preventing or

explicitly discouraging beneficiaries from changing Geo DCEs or from enrolling in a Medicare Advantage plan. We are considering further limitations to prohibit Geo DCEs from engaging in certain activities, including banning the use of brokers and/or paying broker commissions. CMS also reserves the right to hold joint outreach events or require Geo DCEs to cooperate with CMS and/or other Geo DCEs in educating beneficiaries and/or stakeholders about the Geo Model.

CMS reserves the right to review any marketing materials and activities to ensure that the materials comply with the requirements of the Geo model. CMS reserves the right to reject the use of any of the marketing materials and activities based on this review. Additional requirements concerning this review process will be provided in the Participation Agreement.

Geo DCEs will be required to have a Beneficiary Advisory Panel (BAP). The intent of the BAP is to create a regular forum through which Geo DCEs can solicit feedback from beneficiaries about a range of topics that are critical to their health including receptivity to certain benefit enhancements and beneficiary engagement incentives, ways to enhance communication, health literacy and cultural sensitivity, the value of clinical programs, and strategies for addressing SDOH. Although non-binding, these beneficiary recommendations and feedback should encourage Geo DCEs to continually improve their offerings. Members of the BAP must be drawn from the region(s) which the Geo DCE serves, and the BAP must meet no less often than twice a year.

D. Financial Methodology: Risk Arrangement, Risk Corridors, and Financial Reconciliation

The financial methodology for the Geo Model includes the Performance Year Benchmark, risk arrangement, risk bands, Capitation Payment Mechanisms, and Financial Reconciliation. The Performance Year Benchmark is designed to represent the Medicare FFS total cost of care for the Geo DCE's aligned beneficiaries (Geo Beneficiaries) and refers to the target expenditure amount that will be compared to Medicare expenditures for items and services furnished to such beneficiaries during a performance year. This comparison will be used to calculate Shared Savings and Shared Losses. The Performance Year Benchmark and Capitation Payment Mechanisms are addressed in later sections of this RFA (see sections VI.F and VI.K, respectively). First, however, this section of the RFA will address the risk arrangement, risk corridors, and Financial Reconciliation.

Risk Arrangement

The Geo Model will offer a full risk arrangement of 100% of savings/losses, with risk corridors. No Minimum Saving Rate (MSR) or Minimum Loss Rate (MLR) will apply to aggregate savings/losses.

Risk Corridors

The aggregate amount of savings or losses that Geo 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. Geo DCEs will receive a portion of Shared Savings, or be liable for a portion of Shared Losses, above each risk corridor, with the Geo DCE's portion of gross savings/losses decreasing with each risk corridor. The series of Shared Savings/Shared Losses risk corridors are outlined below (Table 6.1):

Table 6.1: Series of Shared Savings/Shared Losses Risk Bands

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

Each of the above risk corridors will be applied to a given Geo DCE's adjusted savings/losses (i.e., gross savings/losses relative to the Performance Year Benchmark minus both its proposed discount and a standard administrative load equal to 5% of the Performance Year Benchmark before the proposed discount). The administrative load is utilized within the risk corridor calculation to account for the potential administrative spend the Geo DCE would expend as a participant in the Geo Model before comparing savings/losses to the risk corridors. All Geo DCEs will receive the same administrative load. Example risk corridor calculations can be found below.

- If a Geo DCE had 18% gross savings and a 5% proposed discount, its gross savings less proposed discount and the administrative load (5%) would be equal to 8% (18% – 5% – 5%). This 8% in adjusted gross savings would then be compared against the risk corridors, resulting in 3% (8% - 5%) of the Geo DCE's savings falling in risk corridor 2. The first 5% of the adjusted gross savings would be fully retained by the Geo DCE as it falls in risk corridor 1. Thereafter, the next 3% of the adjusted gross savings would be shared with CMS as per risk corridor 2. As such, the Geo DCE would earn 70% (the Geo DCE's responsibility) of the 3% in risk corridor 2, or 2.1% (70% x 3% = 2.1%), for a total of 7.1% in adjusted gross savings (2.1% + 5% = 7.1%). CMS will allocate the remaining 30% (CMS's share) of the 3% in risk corridor 2, or 0.9% (30% x 3% = 0.9%), to the risk corridor pool.
- If a Geo DCE had 3% in gross savings and a 5% bid discount, its gross savings less bid discount and the administrative load (5%) would be equal to -7% (3% – 5% – 5%). This 7% in adjusted gross losses would then be compared against the risk corridors. The first 5% of the adjusted gross losses would be the Geo DCE's full responsibility as it falls in risk corridor 1. Thereafter, the next 2% of the adjusted gross losses would be shared with CMS as per risk corridor 2.As such, the Geo DCE would retain responsibility for 70% of this 2% in adjusted gross losses (or 1.4%), and would receive 30% (CMS's share) of the 2% in adjusted gross losses (or 0.6%) from the risk corridor pool, subject to available funds in the pool. Here, of the 7% adjusted gross losses, the Geo DCE would retain responsibility for 6.4% of the adjusted gross losses (5% + 1.4% = 6.4%), while CMS would be responsible for the remaining 0.6%, subject to availability of funds in the risk corridor pool.

The risk corridor pool will be a notional account that will be used to calculate payments made during the yearly reconciliation. Within the reconciliation process, CMS will cover the risk corridor-related portion of a Geo DCE's shared losses only if there are sufficient funds in the risk corridor pool as allocated based on CMS's share of the adjusted gross savings of other Geo DCEs. This risk corridor notional 'funding pool' will persist over the life of the model, such that risk corridor funds allocated to the risk corridor pool in early performance years can be used to reduce shared losses amounts for Geo DCEs in the later performance years. If, in a given Performance Year, there is not enough in the risk corridor notional account to fully

cover the risk corridor-related portion of Geo DCEs' shared losses, CMS will prorate the amount of shared losses covered among all Geo DCEs with shared losses in risk bands 2-4.

For example, if for a given performance year there is $3 million in the risk corridor pool, and for the two Geo DCEs who owe shared losses in risk bands 2-4 the CMS responsibility for such losses is equal to $4 million and $2 million, respectively, CMS would cover only half of these losses through risk corridor payments ($3 million out of $6 million). In this example, the risk corridor payment to each of the Geo DCEs would be prorated by 0.5 and these two Geo DCEs would receive $2 million ($4 million times 0.5) and $1 million ($2 million times 0.5) respectively. If there are insufficient funds in the risk corridor pool to cover the full amount of the risk corridor-related portion of a Geo DCE's shared losses for a given performance year, the Geo DCE would be responsible for the amount of its shared losses not covered. In addition, these amounts will not carry forward to future years; the prorated payment made for a given performance year will represent the sum total of the risk-corridor related adjustments to shared losses the Geo DCE will receive for that performance year unless its Financial Reconciliation for the performance year is revised. If CMS revises a Geo DCE's Financial Reconciliation for a performance year, the risk corridor adjustments for that Geo DCE will be updated based upon the revised Financial Reconciliation, and CMS will cover any additional risk corridor-related adjustment to the Geo DCE's shared losses contingent on the amount in the risk corridor pool at the time of the original Financial Reconciliation. If at the end of the model there is money left over in the risk corridor pool, CMS will retain that amount as savings.

Financial Reconciliation

Financial Reconciliation is the process by which CMS determines Shared Savings or Shared Losses by comparing actual Medicare expenditures during the Performance Year to the Performance Year Benchmark. The Performance Year expenditures used for this purpose include: prospective capitated payments made to the Geo DCE during the performance year pursuant to the Geo Model's Capitation Payment Mechanisms; FFS claims paid by CMS directly to Medicare providers and suppliers for Medicare Part A and Part B items and services furnished to Geo Beneficiaries; and non-claims based payments made under other CMS initiatives that can be attributed to Geo Beneficiaries.

The Financial Reconciliation process is expected to be conducted on/or about July 31st of the calendar year following the close of each Performance Year. This reconciliation will include claims run out through the end of Q1 of the calendar year following the Performance Year for expenditures incurred during the Performance Year. For purposes of Financial Reconciliation, CMS will risk adjust the Performance Year Benchmark using the final risk scores for the Performance Year and then compare the Performance Year Benchmark against Performance Year expenditures for Geo Beneficiaries to determine Shared Savings or Shared Losses. For more details on the calculation of a Performance Year Benchmark, refer to the financial methodology in the following sections.

Table 6.2: Financial Reconciliation Summary

Financial Reconciliation Summary	
Target Date	July 31st of calendar year following the Performance Year
Claims Included	Performance year expenditures incurred through December 31st
Claims Run-out	Through March 31st of the calendar year following Performance Year
Non-claims Based Payments Included	Non-claims based payment made for experience incurred through December 31st
Risk Scores	Final risk scores

The Geo DCE must have the ability to repay all Shared Losses and Other Monies Owed for which it may be liable under this model and must secure a financial guarantee in accordance with the terms of the Participation Agreement. If CMS does not receive payment for all Shared Losses and Other Monies Owed by the date the payment is due, CMS will pursue payment under the financial guarantee and may withhold payments otherwise owed to the Geo DCE under this model or any other CMS program or initiative.

E. Financial Guarantee

Geo DCEs will be required to obtain a financial guarantee equal to at least 10% of the Geo DCE's Performance Year Benchmark. This financial guarantee must remain in effect until after reconciliation for the last Performance Year of the Model Agreement Period is final. CMS shall pursue payment under the financial guarantee for any Shared Losses or Other Monies Owed not timely paid to CMS. Geo DCEs must provide evidence to CMS of their financial guarantee in advance of the relevant Model Agreement Period and must provide evidence to CMS that the Geo DCE has replenished its financial guarantee if any portion of the financial guarantee is used to repay shared losses or other monies owed. A financial guarantee obtained by the Geo DCE may be in the form of escrowed funds, a line of credit, or a surety bond. A Geo DCE may propose an alternative financial guarantee mechanism for approval by CMS at CMS' sole discretion. Each financial guarantee obtained by the Geo DCE must comply with all applicable state laws and regulations regarding risk-bearing entities, as well as the terms of the Participation Agreement. Any proposed alternative financial guarantee mechanism should address the following: state requirements, including attesting that they apply to the Geo DCE, and how the proposed financial guarantee mechanism will offer sufficient protection to CMS for any Shared Losses or Other Monies Owed under the model.

F. Financial Methodology: Performance Year Benchmark

In this section, we describe the methodology for calculating the Performance Year Benchmark. A detailed financial methodology paper will be made available to potential participants prior to the deadline for signing the Participation Agreement. This financial methodology paper will address a variety of issues, including providing additional details regarding the benchmarking methodology (see Table 6.3 below), Capitation Payment Mechanisms, and the methodology for calculating Shared Savings/Shared Losses. In future Performance Years CMS may adjust aspects of the financial methodology, including the potential of shifting from a proposed discount to a dollar bid. The applicable requirements will be set forth in the Participation Agreement.

Table 6.3. Financial Benchmarking Methodology

Prospective Benchmarking Methodology	
Historical Baseline	Regional expenditures, measured via the Geographic Rate Book
Prospective Trend	Based on USPCC, with Geographic Adjustment Factors (GAFs)
Risk Adjustment	CMS-HCC prospective model with Zero-sum Regional Coding Intensity Factor
Discount	Applied to Benchmark based on Geo DCE's proposed discount amount
Quality Withhold	Yes

Benchmarking Methodology

CMS will use a prospective benchmarking methodology to determine the Performance Year Benchmark for Geo DCEs. A per-beneficiary per-month (PBPM) benchmark will be developed for both the Aged & Disabled (A&D) and End Stage Renal Disease (ESRD) beneficiary categories, identified based on the reason

for entitlement to Medicare. Development of the Performance Year Benchmark will include four steps (described in more detail below): (1) determining historical baseline expenditures by county (using a model-specific rate book), (2) trending the historical baseline expenditures forward, (3) risk adjustment, and (4) applying necessary adjustments for quality performance and the discount. The Performance Year Benchmark is used to calculate Shared Savings or Shared Losses for the Performance Year. The Performance Year Benchmark, which reflects the Geo DCE's proposed discount, is also used to derive the monthly capitated payments paid to Geo DCEs during the Performance Year under both the Partial and Total Capitation Payment Mechanisms. For purposes of calculating monthly capitated payments during the Performance Year, CMS will estimate certain inputs of the Performance Year Benchmark that are not finalized until after the end of the performance year (such as the quality adjustment and risk adjustment). These estimates will be finalized and incorporated into the Performance Year Benchmark during the Financial Reconciliation process.

Historical Regional Expenditures – Geographic Rate Book

CMS will utilize a model-specific rate book (the "Geographic Rate Book") in establishing the benchmark, in order to further align Medicare FFS and MA payment policies, as well as to move toward a more predictable calculation of benchmarks in risk-based Medicare FFS models. CMS will utilize a fixed three-year baseline period (CY 2017, CY 2018, and CY 2019) to derive the adjusted Historical Regional Expenditures. The Geographic Rate Book will utilize a methodology similar to the Medicare Advantage Rate Book, which establishes county-level rates for MA Plans for A&D beneficiaries and state-level rates for ESRD beneficiaries. For purposes of the Geographic Direct Contracting Model, CMS will make adjustments to the Medicare Advantage Rate Book as discussed in more detail below to make it appropriate for use in the model, establishing a *Geographic Rate Book* which will be made available to Geo DCEs in advance of each three-year Model Agreement Period. To establish the Performance Year Benchmark for a specific performance year CMS will trend forward the Historical Regional Expenditures to the relevant performance year.

To develop the Geographic Rate Book, CMS will make adjustments to the Medicare Advantage Rate Book methodology to ensure that the rates used for this model serve as an accurate representation of regional costs in the Geographic Direct Contracting Model for purposes of benchmarking. First, CMS will remove the impact of certain adjustments that are incorporated into the MA Rate Book for purposes of MA plan payment, but that are not relevant to Direct Contracting, such as the Quality Bonus Payment (QBP) percentage based on star ratings. Second, CMS will make adjustments to account for differences in expenditure types that are included for purposes of the MA Rate Book, but are not relevant for purposes of Direct Contracting, for example, uncompensated care payments. Third, CMS will make adjustments to account for differences between the subset of FFS beneficiaries eligible to be aligned to Geo DCEs and Medicare FFS beneficiaries generally. For example, Geo Beneficiaries must be enrolled in both Medicare Parts A and B (see the beneficiary eligibility section for other differences between the population of beneficiaries who are eligible to be aligned to Geo DCEs and the general FFS population).

To account for where Geo Beneficiaries live for purposes of calculating a Geo DCE's regional expenditures, CMS will calculate a weighted average of the county rates (or state level rates for ESRD beneficiaries) from the Geographic Rate Book that corresponds to where Geo Beneficiaries live.

Prospective Trend and Regional Geographic Adjustment Factor

Consistent with the goal of further aligning with MA payment methodologies, CMS will utilize a prospective trend that will be based on the projected US Per Capita Cost (USPCC) growth trend, developed annually by the CMS Office of the Actuary (OACT) and announced in the annual Announcement of Calendar Year (CY) Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies released the first Monday in April. The USPCC annual growth trend will be applied to the Geographic Rate Book. CMS will apply the Aged & Disabled and Dialysis-only ESRD ("ESRD") USPCC growth trends to the historical baseline expenditures for the Aged & Disabled and ESRD populations of aligned beneficiaries, respectively. For the purposes of the Performance Year Benchmark, CMS expects to apply the prospective trend in Q2 of the Performance Year, which will utilize observed data from the prior calendar year. For example, for Performance Year 1 (2022), the baseline period will utilize data from 2017, 2018 and 2019, and the prospective trend will be updated in Q2 of 2022 and utilize data from 2020 and 2021.

Under extreme and uncontrollable circumstances (e.g., epidemiological events such as COVID-19), we reserve the right to make retrospective region-specific adjustments to the trend applied to the historical regional expenditures if the difference between the observed and the expected trends for the region is +/- 1%. For example, CMS may use an adjusted projected trend figure in response to unforeseeable events that have a substantial impact on Medicare FFS expenditures. Adjustments to the trend adjustments would be intended to prevent the Geo DCE's benchmark from being unfairly understated or overstated due to major payment changes beyond the Geo DCE's control.

Furthermore, the trended historical baseline expenditures will be adjusted to reflect the anticipated impact of changes in the regional Geographic Adjustment Factors (GAFs) applied to payment amounts under the Medicare FFS payment systems. This GAF adjustment is intended to prevent the benchmark from being unfairly understated (or overstated) because of differences in the local geographic price adjustments that Medicare uses to calculate provider and supplier payments between the baseline period and the performance year. This process accounts for variations in the cost-of-doing-business adjustments that Medicare applies under most of its FFS fee schedules (e.g., the Medicare area wage index, and the geographic practice cost index), which are typically updated annually.

Risk Adjustment

CMS will use risk adjustment to account for the underlying health status of the population of beneficiaries aligned to a Geo DCE. Risk scores will be normalized and also subject to coding intensity limitations to: 1) reduce increases in payments triggered by increases in risk score growth, and 2) reduce payment incentives to engage in activities targeting risk score growth. After normalizing risk scores, a Zero-Sum Regional Coding Intensity Factor (CIF) will be applied to ensure no net growth in the average regional risk scores.

CMS-HCC Prospective Risk Adjustment Model. The CMS-HCC prospective risk adjustment model will be used for Geo DCEs. CMS expects to use the same version of the CMS-HCC risk adjustment model (V24[2]) that is being applied in MA for 2021[3]. CMS recognizes that V24 may be updated in MA for 2022, and

[2] The V24 CMS-HCC risk adjustment model is the 2020 CMS-HCC Model in the CY 2021 Rate Announcement.
[3] MA is using a blended risk score based on the latest model calibration and a prior (V22) one. For DC, risk adjustment will not employ blending with V22.

therefore, CMS will also consider moving to the updated version of the model for Geo DCEs for the first Performance Year (PY1). Over the course of the Model Performance Period, CMS will further assess the need to update the version of CMS-HCC prospective risk adjustment model used for Geo DCEs and may make additional updates.

Beneficiary risk scores calculated with the CMS-HCC prospective risk adjustment model use diagnoses reported in the prior year to predict expenditures during the Performance Year (PY). Data used to generate risk scores will come from Part A and Part B claims.[4] For example, for PY 2022 Geo DCEs will be assigned scores based on their aligned beneficiaries' claims history throughout 2021. Beneficiaries without a complete 12-month diagnostic profile from the prior year will have a "new enrollee" risk score calculated for them, while the risk scores for aligned beneficiaries with ESRD will be calculated using the ESRD risk adjustment model.

New Enrollees Model. Beneficiaries may become eligible for Medicare at any point during a calendar year. Because of this flexibility, certain beneficiaries who are aligned to Geo DCEs may lack a complete 12-month diagnostic profile from the prior calendar year. To address this limited lookback period, a beneficiary's risk score for the Performance Year in which the beneficiary is newly eligible for Medicare will be calculated using the New Enrollees Risk Adjustment Model that only accounts for the beneficiary's demographic factors.

Enrollees with End-Stage Renal Disease Risk Adjustment Model. Because of the unique expenditure profile associated with treating high-acuity patients with ESRD, CMS will continue to use a separate risk adjustment model to calculate the financial benchmark for Geo Beneficiaries with Medicare ESRD eligibility status. The same model used for ESRD beneficiaries in MA (CMS-HCC ESRD model V21[5], as described in the CY 2021 Rate Announcement) will be applied in the Geo Model. This risk adjustment model has a prospective design and was last updated in 2020 with separate sets of risk factors for new enrollees' dialysis, continuing enrollees' dialysis, and transplant recipient beneficiaries. Again, as with the CMS-HCC prospective risk adjustment model (V24), CMMI will reassess the CMS-HCC ESRD model V21 over time and may update V21 and apply a new version of the model, particularly if V21 is updated for MA.

If a beneficiary begins receiving treatment (dialysis or a transplant) for ESRD during the course of the PY, the aligned beneficiary will initially receive a CMS-HCC prospective risk adjustment model (V24) risk score, and after receiving dialysis or a transplant, the same beneficiary will receive a risk score from the appropriate ESRD risk adjustment model. For kidney transplant recipients, risk scores are calculated using the ESRD transplant model for 3 months following the transplant; beginning in the fourth month after transplant the beneficiary transitions to the appropriate ESRD functioning graft model risk score.

Normalization. Risk scores calculated using the CMS-HCC prospective model, including both A&D and ESRD models and the New Enrollees (demographic only) model, will be normalized in each Performance Year. Risk models are estimated based on expenditures incurred during a particular baseline year, also called the denominator year. A normalization factor will be applied to Geo Beneficiary risk scores to adjust for changes in average risk score relative to the denominator year of the risk adjustment model. The normalization factor for each Model Performance Year is the average risk score of the Geo National

[4] The MA EDS data filtering logic will be applied for the calculations of risk scores.

[5] CMS will utilize the 2020 ESRD Model as detailed in the CY 2021 Rate Announcement

Reference Population for that year; Geo Beneficiary risk scores are normalized by dividing by this factor.

Zero-Sum Regional Coding Intensity Factor (CIF). CMS will apply a zero-sum regional coding intensity factor (CIF) to normalized risk scores. The goal of this mechanism is to ensure that overall increases in risk score growth are budget neutral relative to overall financial performance for the region. Within a region, risk scores will be retrospectively re-scaled so that the average risk score for all of the beneficiaries aligned to Geo DCEs operating in the given region is equal to the average used to set the benchmark.

Rebasing the Risk Adjustment Models. In order to provide for the potential for necessary changes in risk scores over the six-year Model Performance Period, CMS may rebase the risk scores periodically, for example, every three years (at the beginning of the model and for PY4 onwards). It may be determined that rebasing is necessary if the CMS-HCC prospective risk adjustment model is replaced with an updated version over the course of the Model Performance Period and/or if we observe large demographic changes in a given market, which may include large changes in mortality or large beneficiary inflow or outflows.

Discount and Quality Incentives

CMS will apply a series of adjustments to the trended, risk adjusted benchmark at this stage in the calculation of the Performance Year Benchmark. These adjustments will serve to incentivize quality performance and help to generate savings under the model.

Discount Applied to the Performance Year Benchmark

CMS will apply a discount to the trended, regionally blended, risk adjusted benchmark. As Geo DCEs will retain 100% of savings relative to the Final Performance Year Benchmark achieved during the performance year, this discount to the benchmark will provide the primary mechanism for CMS to obtain savings from Geo DCEs participating in the model. This discount will be set at the proposed discount amount the Geo DCE submitted within its application for that performance year.

Quality Incentive

A portion of the Performance Year Benchmark will be held "at risk," dependent on the Geo DCE's performance on a pre-determined set of quality measures (see Appendix C for the set of measures). Specifically, this quality incentive will be structured as a quality "withhold," set at 1% in PY1, 2% in PY2, 3% in PY3 and beyond. The quality withhold will apply to the value of the trended, risk adjusted benchmark, before the discount, and will be recalculated for each performance year. The Geo DCE will then have the opportunity to "earn back" some or all of the quality withhold, depending on the Geo DCE's performance on the quality measure set.

G. Program Overlap

Beneficiaries aligned to a Geo DCE participating in the Geo Model will be eligible to be aligned to ACOs participating in the Shared Savings Program and to participants in other population or episodic models, with the exception of Geo DCEs participating in the Global Option of the Direct Contracting Model. All payments that occur under such initiatives for overlapping beneficiaries will be counted as a performance year expenditure and will be reconciled against the Geo DCE's performance year benchmark under the Geo Model. After the completion of each performance year, CMS will calculate the amount of overlap payment for each Geo DCE as part of the Financial Reconciliation process and adjust the Geo DCE's shared

savings/shared losses through either a deduction where the overlap payment is positive (e.g., shared savings or performance based payments for the overlapping initiatives) or a credit where the overlap payment is negative (e.g., shared losses or repayment amounts for the overlapping initiatives).

Overlap payments will include multiple payment types, including shared savings payments, bundled payments, care management fees, and performance-based payments. Overlap payments will be allocated on a beneficiary-weighted basis based on the unit of measure (service, month, episode, or shared savings payment) for the other initiative. An example overlap calculation between a Shared Savings Program ACO and two Geo DCEs can be found in Table 6.4a and Table 6.4b.

Table 6.4a: Example Model Overlap Payment Calculation – Shared Savings

Step	Calculation	Value
(a) Shared Savings Program ACO Beneficiaries	-	2,000
(b) Shared Savings Program ACO Benchmark	-	$2,000,000
(c) Shared Savings Program ACO Performance Year Spend	-	$1,960,000
(d) Shared Savings Program ACO Shared Savings Payment	(b – c) * 50%	$20,000
(e) Geo DCE 1 Overlapping Beneficiaries	-	1,000
(f) Geo DCE 2 Overlapping Beneficiaries	-	500
(g) Geo DCE 1 Overlap Deduction	(e / a) * d	$10,000
(h) Geo DCE 2 Overlap Deduction	(f / a) * d	$5,000

Table 6.4b: Example Model Overlap Payment Calculation – Shared Losses

Step	Calculation	Value
(a) Shared Savings Program ACO Beneficiaries	-	2,000
(b) Shared Savings Program ACO Benchmark	-	$2,000,000
(c) Shared Savings Program ACO Performance Year Spend	-	$2,040,000
(d) Shared Savings Program ACO Shared Losses Payment	(b - c) * 50%	($20,000)
(e) Geo DCE 1 Overlapping Beneficiaries	-	1,000
(f) Geo DCE 2 Overlapping Beneficiaries	-	500
(g) Geo DCE 1 Overlap Credit	(e / a) * d	($10,000)
(h) Geo DCE 2 Overlap Credit	(f / a) * d	($5,000)

Geo Preferred Providers may participate in other Medicare initiatives, including the Medicare Shared Savings Program and other Innovation Center Models, if they meet all applicable eligibility criteria under the applicable demonstration or model. However, Geo DCEs will not be able to receive capitation payments under the Geo Model based on payments that would be prospectively capitated or adjusted under another overlapping model. This approach would exclude Geo DCEs from taking on capitation for

Geo Preferred Providers participating in: End-Stage Renal Disease Treatment Choices (ETC) Model, Radiation Oncology (RO) Model, Comprehensive Kidney Care Contracting (CKCC) Total Care Capitation and Professional Options, or Direct Contracting Model Professional and Global Options.

CMS may issue further guidance that assists Geo DCEs in determining how either Geo DCE or Geo Preferred Provider participation in certain demonstrations, models, or other initiatives can be combined with participation in the Geo Model, as well as additional details regarding reconciliation or adjustment made to account for the potential overlap. The applicable requirements will be set forth in the Participation Agreement.

H. Geo Preferred Providers

Geo DCEs must form relationships with providers and suppliers (referred to as Geo Preferred Providers) for purposes of the Geo Model. Each Geo DCE must have a written arrangement with each of its Geo Preferred Providers that satisfies the terms of the Participation Agreement. Geo Preferred Providers may participate in any of the Benefit Enhancements and Beneficiary Engagement Incentives selected by the Geo DCE for a given Performance Year, as outlined in the sections below. Providers and suppliers may participate as Geo Preferred Providers in more than one Geo DCE and may have financial arrangements with more than one Geo DCE.

Each Geo Preferred Provider must be an individual or entity that:

- Is a Medicare-enrolled (as described in 42 C.F.R. 424.502) provider or supplier (as described in 42 C.F.R. § 400.202);
- Is identified on the Geo DCE's Preferred Provider List by name, NPI, TIN, Legacy TIN or CCN (if applicable), and CMS Certification Number (CCN) (if applicable);
- Bills Medicare directly or pursuant to a valid reassignment for items and services furnished to Medicare FFS beneficiaries using a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations;
- Is not a Prohibited Participant; and
- Has agreed to participate in the model pursuant to a written arrangement with the Geo DCE.

Geo Preferred Providers will be identified by a combination of their TIN and NPI. However, splitting the TIN will be permitted, which will allow providers and suppliers who bill through the same TIN to decide separately whether to enter into a Geo Preferred Provider arrangement with a given Geo DCE. Geo DCEs should note that if a Geo DCE includes an NPI on its list of Geo Preferred Providers who will be billing through a new TIN, the NPI will not be able to contribute claims history to the claims-based alignment process, unless the NPI's former TIN, known as a "Legacy TIN" is also included on the Geo DCE's Preferred Provider List.

I. Benefit Enhancements

In order to emphasize high-value services and support the ability of Geo DCEs to manage the care of beneficiaries, CMS has designed policies using the authority under Section 1115A of the Social Security Act (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of testing the Geo Model. A Geo DCE may choose not to implement all or any of these benefit enhancements. Applicants will be asked to provide information regarding their proposed implementation of these benefit enhancements, but acceptance into the Geo Model is not contingent upon a Geo DCE agreeing to implement any particular benefit enhancement.

Each Geo DCE will be required to submit an implementation plan prior to the start of the first performance year for which the DCE wishes to offer an optional benefit enhancement and at other times specified by in the Participation Agreement. This implementation plan will be required to include: (1) descriptions of the Geo DCE's planned strategic use of the benefit enhancement; (2) self-monitoring plans reflecting meaningful safeguards to prevent unintended consequences; and (3) documented authorization by the governing body to participate in the benefit enhancement. Implementation plans will be reviewed by CMS, but there will be no formal approval or disapproval of implementation plans. However, CMS may reject or terminate the Geo DCE's use of any benefit enhancements at any time due to insufficiency of the implementation plan and/or a concern regarding program integrity or potential beneficiary harm.

Benefit Enhancements Anticipated for PY1

The following are benefit enhancements that are anticipated for PY1 (2022). In pursuit of policy goals based upon accountable care and driving beneficiary value, CMS may continue to explore the operational feasibility and potential effectiveness of additional benefit enhancements for future performance years.

3-Day Skilled Nursing Facility Rule Waiver

CMS will make available to Geo DCEs a conditional waiver of the three-day inpatient stay requirement under §1861(i) of the Act and 42 C.F.R. § 409.30 prior to admission to a skilled nursing facility (SNF) or an acute-care hospital or CAH with swing-bed approval (swing-bed hospital) for SNF services. This benefit enhancement will allow eligible Geo Beneficiaries to receive Medicare-covered SNF services from qualified SNFs or swing-bed hospitals that are Geo Preferred Providers either directly or with an inpatient stay of fewer than three days.

Under Geographic Direct Contracting, beneficiaries residing in a long-term care facility will be eligible to use the SNF 3-Day waiver, a change from previous shared savings initiatives. A Geo DC beneficiary will be eligible to receive covered SNF services under the terms of this benefit enhancement only when the beneficiary meets all other CMS criteria for coverage of SNF services, including that the beneficiary must:

- Be medically stable;
- Have confirmed diagnoses (e.g., does not have conditions that require further testing for proper diagnosis);
- Not require inpatient hospital evaluation or treatment; and
- Have an identified skilled nursing or rehabilitation need that cannot be provided on an outpatient basis or through home health services.

Geo DCEs will identify the SNFs and swing-bed hospitals with which they will partner in this benefit enhancement.

Post-Discharge Home Visits

CMS will make available a conditional waiver of the requirement for direct supervision at 42 C.F.R. § 410.26(b)(5) to allow payment for certain home visits furnished to eligible, non-homebound beneficiaries by auxiliary personnel (as defined in 42 C.F.R. § 410.26(a)(1)) under general supervision, rather than direct supervision, incident to the professional services of physicians or other practitioners that are Geo Preferred Providers.

Payment will be made for these home visits only when they are furnished following the beneficiary's

discharge from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility. Further, the beneficiary must not qualify for Medicare coverage of home health services or qualify for Medicare coverage of home health services on the sole basis of living in a medically underserved area. Additionally, the beneficiary must not be receiving services under the care management home visits benefit enhancement.

Specifically, under this benefit enhancement, a beneficiary is eligible to receive up to nine post-discharge home visits within 90 days following discharge. The nine home visit services do not accumulate across multiple discharges; if the beneficiary is readmitted within 90 days of the initial discharge and before receiving nine home visits, the beneficiary may receive only nine home visits in connection with the subsequent discharge.

Care Management Home Visits

CMS will make available to Geo DCEs a conditional waiver of the requirement for direct supervision at 42 C.F.R. § 410.26(b)(5) to allow for payment for certain home visits that are furnished to eligible beneficiaries proactively and in advance of potential hospitalization. The items and services provided as part of these home visits are those that would be covered under Medicare Part B as "incident to" the services of a physician or other practitioner and would be furnished by auxiliary personnel (as defined in 42 C.F.R. § 410.26(a)(1)) under general supervision, rather than direct supervision. These care management home visits are intended to supplement, rather than substitute for, visits to a primary care practitioner in a traditional routine outpatient health care setting. As such, these home visits are not intended to be performed on an ongoing basis, nor to serve as a substitute for the Medicare home health benefit or as the primary mechanism to meet beneficiaries' care needs.

Further, Geo Preferred Providers who have elected to furnish services under this benefit enhancement will be able to receive payment for services furnished to eligible beneficiaries only under the following circumstances:

- The beneficiary is determined to be at risk of hospitalization;
- The beneficiary does not qualify for Medicare coverage of home health services (unless the sole basis for qualification is living in a medically underserved area);
- The beneficiary is not currently utilizing the Post-Discharge Home Visits Benefit Enhancement; and
- The services are furnished in the beneficiary's home by auxiliary personnel under the general supervision of a Geo Preferred Provider who is a physician or other practitioner after a Geo Preferred Provider has initiated a care management plan that includes such services.

An eligible beneficiary is permitted to receive up to twenty care management home visits within a calendar year. This limit has been revised upwards relative to the twelve care management home visits permitted in other models in response to requests from stakeholders for additional flexibility as they work to keep at-risk and elderly patients out of the hospital and in the home as much as possible.

Home Health Homebound Waiver Benefit Enhancement

Currently, to receive Medicare reimbursement for home health care services, a Medicare beneficiary must be "homebound" as required by Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act, meaning that (1) the

beneficiary must either (a) need the assistance of a supportive device, special transportation, or another person to leave their residence or (b) have a condition that makes leaving his or her home medically contraindicated; and (2) there must be a normal inability to leave the home and leaving home must require a considerable and taxing effort. This policy often prevents a beneficiary who might be able to achieve greater health outcomes through home health care services from receiving these services because they do not meet the statutory definition of homebound.

Under the home health homebound waiver benefit enhancement, CMS will waive the requirement under Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 C.F.R. § 409.42(a) that a beneficiary must be confined to the home to receive Medicare reimbursement for qualified home health services for eligible beneficiaries. Specifically, to qualify for home health services under this benefit enhancement, beneficiaries must (1) otherwise qualify for home health services under 42 C.F.R. § 409.42 except that the beneficiary is not required to be confined to the home; and (2) have at least two chronic conditions, **and** one of the three following indicators: inpatient service utilization, frailty, and/or social isolation. Geo DCEs participating in this benefit enhancement must identify home health providers that are Geo Preferred Providers that will provide these services to eligible beneficiaries. All other requirements regarding Medicare coverage and payment for home health services would continue to apply. Lastly, a beneficiary would not be eligible to receive covered home health services under this benefit enhancement if they are receiving services under the post-discharge visits benefit enhancement or the care management home visits benefit enhancement.

Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit

The concurrent care for beneficiaries that elect the Medicare hospice benefit enhancement would eliminate the requirement that beneficiaries who elect the Medicare hospice benefit give up their right to receive curative care (sometimes referred to as "conventional care") as a condition of electing the hospice benefit. Currently, under Section 1812(d)(2)(A) of the Act, "*if an individual makes such an election for a period with respect to a particular hospice program, the individual shall be deemed to have waived all rights to [Medicare] payment made under this title with respect to— … (ii) related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made[.]*" CMS intends to allow Geo DCEs and their Geo Preferred Providers to provide curative care to beneficiaries who would otherwise have waived their rights to Medicare payment for services related to the treatment of their terminal condition as a result of electing hospice care. All expenditures incurred by Medicare on behalf of such beneficiaries, whether for hospice or non-hospice services, will be included in the Geo DCE's performance year expenditures for the relevant performance year.

Similar to the approach used for the 3-Day Skilled Nursing Facility Rule Waiver benefit enhancement, Geo DCEs will identify the hospices and non-hospice providers and suppliers that will participate in this benefit enhancement with the Geo DCE. These hospices and non-hospice providers and suppliers must be Geo Preferred Providers. The Geo DCE will also be expected to ensure that the beneficiary or, as applicable, their representative is fully aware of the care plan and informed of the beneficiary's right to revoke the hospice election at any time consistent with current law.

For purposes of this benefit enhancement, any hospice that has existing condition level deficiencies that have not been remediated cannot participate in this benefit enhancement; all of the hospice programs that participate in this benefit enhancement with the Geo DCE must readily offer beneficiaries access to the four levels of hospice consistent with clinical need.

Asynchronous Telehealth

CMS will make available to qualified Geo DCEs a conditional waiver of the interactive telecommunications system requirement under section 1834(m)(1) of the Act and 42 C.F.R. § 410.78(b) with respect to otherwise covered dermatology and ophthalmology services furnished using asynchronous store and forward technologies. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunication systems in single media format do not include telephone calls, images transmitted via facsimile machines, and text messages or electronic mail without visualization of the patient. Photographs must be specific to the patients' condition and adequate for rendering or confirming a diagnosis or treatment plan.

Payment will be permitted for dermatology and ophthalmology services furnished to eligible beneficiaries using asynchronous telehealth in single or multimedia formats that is used as a substitute for an interactive telecommunications system. Distant site practitioners will bill for these services using Innovation Center specific asynchronous telehealth codes (G9868 – G9870). The distant site practitioner must be a Geo Preferred Provider who has elected to participate in this benefit enhancement.

CMS will also waive the rural geographic component of originating site requirements in section 1834(m)(4)(C)(i) of the Act and 42 C.F.R. § 410.78(b)(3), waive the originating site requirements in section 1834(m)(4)(C)(ii) of the Act and 42 C.F.R. § 410.78(b)(4) to allow the originating site to include a beneficiary's home, and waive the originating site fee requirement in section 1834(m)(2)(B) of the Act and 42 C.F.R. § 414.65(b) when the beneficiary's home serves as the originating site for asynchronous telehealth services furnished to an aligned beneficiary. Under this Benefit Enhancement, a Geo Preferred Provider must not furnish telehealth services in lieu of in person services or encourage, coerce, or otherwise influence a beneficiary to seek or receive telehealth services in lieu of in person services when the Geo Preferred Provider knows or should know in person services are medically necessary.

New Benefit Enhancements under Consideration for PY1

In addition to the benefit enhancements detailed above, CMS is currently considering two additional benefit enhancements for PY1 under the Geo Model: Home Hospital Care and Nurse Practitioner Services Bundle. These specific benefit enhancements were chosen based on feedback from current NGACO participants, suggestions from potential model participants, and experience from other Innovation Center models.

Home Hospital Care

Studies have shown substantial savings by providing hospital-level care in the home. One study conducted by investigators at Boston's Brigham and Women's Hospital found that costs for patients receiving care at home were 38% lower than the control group.[6] While growing in popularity with private payers, development of this innovative care has not been possible due to regulations that prevent Medicare payment for home hospital care. However, Mount Sinai received an Innovation Center grant to pilot its home hospital care program in 2014 and showed decreased ED visits, readmissions, and SNF admissions with no difference in death rates in the 30-day post-acute period after home hospitalization compared to

[6] https://www.acpjournals.org/doi/10.7326/M19-0600

traditional inpatient care. Additional benefits included decreased length of stay, decreased urinary catheter use, and improved patient experience and communication scores. CMS adopted certain flexibilities aimed at increasing hospital capacity during the public health emergency (PHE) for COVID-19including to allow hospital services to be provided outside a hospital setting. Based on CMS' experience with these flexibilities during the PHE, CMS believes that it may be necessary to issue certain waivers under the authority of section 1115A(d)(1) of the Act in order to allow hospital services to be furnished in a beneficiary's home for purposes of testing the model.

The Home Hospital Care benefit enhancement would allow a Geo DCEs' Geo Preferred Providers that are hospitals to provide care that is typically provided in the inpatient setting to aligned beneficiaries in the beneficiary's home. CMS envisions waiving certain Hospital Conditions of Participation (CoP) requirements, including waivers of physical environment requirements at 42 C.F.R. § 482.41 and § 485.623, and waiving the provider-based status rules at 42 C.F.R. § 413.65 to test a combination of hospital services reimbursable regardless of the place of service. As the Geo DCE will be accountable for the total cost of care for its aligned beneficiaries, CMS does not intend to use issue specific criteria to limit beneficiary eligibility for this benefit enhancement. The responsibility will be on the Geo DCEs to determine which care setting can provide the most high-value care while controlling costs. CMS will impose clinical safeguards to ensure that beneficiaries who are hospitalized at home receive equivalent care to those who are hospitalized in the traditional inpatient manner.

Nurse Practitioner Services Bundle

The Nurse Practitioner (NP) Services Bundle seeks to limit Medicare expenditures by providing a streamlined approach for certifying and ordering care, avoiding duplicative work. This benefit enhancement would capitalize on established relationships between a beneficiary and a nurse practitioner to reduce impediments to better coordinate care for beneficiaries. Building upon NP authorization of Home Health, as authorized by section 3708 of the CARES Act, we are considering issuing conditional waivers that would allow Geo DCEs to offer a benefit enhancement under which NPs could undertake the following activities, including:

- NP Hospice Care Certification - Would allow NPs to provide the initial certification that a patient is terminally ill and in need of hospice care, potentially reducing complexity in the hospice process, delays in placement for patients, and costs.
- NP Certification of Need for Diabetic Shoes - Would allow NPs treating patients with diabetes to document and certify a patient's need for therapeutic shoes, potentially reducing delays in patients accessing this benefit and avoiding the costs of an additional provider visit.
- NP Ordering and Supervision of Cardiac and Pulmonary Rehabilitation – Would allow NPs to order and supervise cardiac and pulmonary rehabilitation, which could increase patient access, promote adherence to preventive medication, improve health, and reduce costs.
- Certification of Plan of Care for Home Infusion Therapy - Even though NPs are "applicable providers" who can be the attending care provider for a patient receiving home infusion therapy, NPs still must have a physician establish and review the plan of care. Allowing NPs to certify plan of care could improve access to care.

J. Beneficiary Engagement Incentives

Beneficiary Engagement Incentives for PY1

We believe that beneficiary engagement is an important part of motivating and encouraging more active participation by beneficiaries in their health care. Beneficiary engagement incentives will provide Geo DCEs with another set of tools to encourage beneficiaries to engage in coordinated care. While these flexibilities are critical to model design, waivers generally have model-specific conditions, defining participant eligibility and conditions of the waiver. CMS will require Geo DCEs to outline the details of certain beneficiary engagement incentives in an implementation plan prior to the start of the first performance year for which the DCE wishes to offer this beneficiary engagement incentive and at such other times specified in the Participation Agreement. In-kind incentives offered by a Geo DCE do not require an implementation plan. However, all applicable criteria for these in-kind incentives must adhere to the requirements set forth in this document. Implementation plans will be considered approved unless otherwise specified by CMS. Please note, CMS may reject or terminate the Geo DCE's use of the beneficiary engagement incentive at any time due to insufficiency of the implementation plan and/or a concern regarding program integrity or potential beneficiary harm. Participating Geo DCEs will be subject to monitoring and compliance activities in connection with the use of beneficiary engagement incentives. To minimize possible abuse beneficiary engagement incentives, CMS will incorporate certain beneficiary protections and other safeguards into the Participation Agreement including monitoring and compliance activities related to the provision of beneficiary engagement incentives.

Cost Sharing Support for Part B Services

Subject to compliance with all applicable laws and regulations and CMS approval, a Geo DCE may enter into a cost sharing support arrangement with its Geo Preferred Providers pursuant to which the Geo Preferred Providers may reduce or eliminate beneficiary cost sharing amounts for categories of Geo Beneficiaries and for categories of Part B services (excluding prescription drugs and durable medical equipment), as identified by the Geo DCE. Geo DCEs could then make payments to those Geo Preferred Providers to cover some or all of the amount of beneficiary cost sharing not collected. The principal aim of allowing Geo DCEs to offer this cost sharing support is to reduce financial barriers so that the categories of Geo beneficiaries identified by the Geo DCE may obtain needed care and better comply with treatment plans, thereby improving their own health outcomes. In addition, permitting Geo DCEs this flexibility will provide a critical tool to engage Geo Beneficiaries, promote the utilization of high-value services, and incentivize Geo Beneficiaries to continue receiving their care from Geo Preferred Providers. Cost sharing support payments must come only from the Geo DCE and, if applicable, the Geo DCE's Geo Preferred Providers. A Geo DCE will be asked to outline its cost sharing arrangement in an implementation plan and will be subject to monitoring and compliance activities in connection with their cost sharing support for Part B services program.

In-Kind Incentives

We believe that beneficiary engagement is an important part of motivating and encouraging more active participation by beneficiaries in their health care. Beneficiary engagement and coordination of care could be enhanced by providing additional incentives to beneficiaries that would potentially motivate and encourage beneficiaries to become actively involved in their care. Subject to compliance with all applicable laws and regulations, Geo DCEs and their Geo Preferred Providers (or an agent of the Geo DCE or Geo Preferred Provider) will be permitted to provide in-kind items or services to beneficiaries if the following conditions are satisfied:

1. There is a reasonable connection between the items or services and the medical care of the beneficiary;

2. The items or services are preventive care items and services or advance a clinical goal for the beneficiary, including adherence to a treatment regime, adherence to a drug regime, adherence to a follow-up care plan, or management of a chronic disease or condition;

3. The in-kind item or service is not covered by Medicare or Medicaid for the beneficiary on the date the in-kind item or service is furnished to that beneficiary (for purposes of this requirement, an item or service that could be covered pursuant to a benefit enhancement is considered a Medicare or Medicaid covered item or service, regardless of whether the Geo DCE selects to participate in such benefit enhancement for a given performance year);

4. The in-kind item or service is not furnished in whole or in part to reward the beneficiary for designating or agreeing to designate through Voluntary Alignment a Geo Preferred Provider as his or her primary clinician, main doctor, main provider, or the main place where the beneficiary receives care; and

5. The in-kind item or service is furnished to a beneficiary directly by the Geo DCE or a Geo Preferred Provider (or by an agent of the Geo DCE or Geo Preferred Provider under the direction and control of the Geo DCE or Geo Preferred Provider).

For example, the provision of blood pressure monitors to patients with hypertension in order to encourage regular blood pressure monitoring would have a reasonable connection to their medical care and advance a clinical goal (e.g., management of a chronic disease or condition). Assuming all other requirements are satisfied, the Geo DCE or a Geo Preferred Provider could furnish home blood pressure monitors to such beneficiaries.

Additional examples of in-kind items and services that Geo DCEs or Geo Preferred Providers could consider offering might include the following, if furnished in a manner that complies with the requirements listed above:

- 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, and home improvements such as railing installation or other home modifications to prevent re-injury.
- Wellness program memberships, seminars, and classes.
- 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 to cover professional and technical fees for vision and dental care services. These items and services must be funded by the Geo DCE or Geo Preferred Provider and therefore, calculation of the Geo DCE's benchmark and performance year expenditures will not account for the cost of any of these items or services. Participating Geo DCEs may be subject to monitoring and compliance activities in connection with the use of in-kind incentives.

Chronic Disease Management Reward Program

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 a chronic disease management program. Use of modest beneficiary incentives and rewards – such as gift cards – has been widely adopted by a variety of payers to influence healthy behaviors. Geo DCEs that choose to offer a chronic disease management reward program must pay for the gift cards out of their own funds, subject to the requirements of the Participation Agreement. We believe that allowing Geo DCEs to incentivize beneficiary participation in a chronic disease management program will promote beneficiary self-management, and ultimately improve quality and reduce costs.

Geo DCEs will be permitted to offer programs that focus on Geo Beneficiaries with a specific disease or chronic condition, as long as the program does not discriminate against any Geo Beneficiary who would otherwise qualify for participation. Geo DCEs that elect to offer a chronic disease management reward program will be required to maintain records of their reward program, including documentation of the amount and type of each gift card awarded and the basis for beneficiary eligibility. A Geo DCE will be asked to outline its chronic disease management programs in an implementation plan and will be subject to monitoring and compliance activities in connection with such programs.

Additional Beneficiary Engagement Incentives under Consideration for PY1

Lower Cost-Sharing for Part A Services

In order to continue to incentivize beneficiaries to seek care from Geo Preferred Providers, CMS is considering an additional beneficiary engagement incentive under which we would provide Geo DCEs with the option of lowering cost sharing for Part A services provided by a Geo Preferred Provider. The Innovation Center believes there is an opportunity for Geo DCEs to offer reduced cost sharing to Geo Beneficiaries by covering some of the Part A deductible for an inpatient admission to a Geo Preferred Provider within a specified number of days of the beneficiary's last visit with Geo Preferred Provider up to a maximum dollar amount specified by CMS. This would provide an additional incentive to beneficiaries to seek care early for conditions that can ultimately result in avoidable hospitalizations without appropriate outpatient care.

For example, a patient who sees her primary care provider (PCP), who is a Geo Preferred Provider, early in the course of a pneumonia would be expected to receive an earlier diagnosis and appropriate antibiotic therapy, if warranted, prior to becoming severely ill. We anticipate that some percentage of these patients would avoid a hospitalization that would have occurred without the PCP's intervention, which would result in decreased total cost of care and savings for the Geo DCE. For Geo Beneficiaries who still require hospitalization despite this early treatment, the Geo DCE would be allowed to reduce some of the

beneficiary's Part A deductible for the inpatient stay at a hospital that is a Geo Preferred Provider. While this amount of cost sharing would represent an expense for the Geo DCE, the Innovation Center anticipates that the decrease in total spending due to avoided hospitalizations will be greater than the cost sharing expense for those who seek early PCP care and still require hospitalization. Beneficiary experience would be enhanced by the opportunity to return to baseline health earlier without a hospitalization, and those who do not seek early intervention still retain access to their normal Part A coverage and would be subject to normal cost sharing requirements.

Similar to the Cost Sharing Support for Part B Services beneficiary engagement incentive, the Geo Model would require adherence to the same requirements regarding advancing clinical goals and having arrangements with Geo Preferred Providers participating in this beneficiary engagement incentive. Specifically, Geo DCEs would make payments to participating Geo Preferred Providers to reduce or eliminate the amount of the Geo Beneficiary's deductible not collected. A Geo DCE must ensure the applicable Cost Sharing Support arrangement advances one or more of the following clinical goals:

1. Adherence to a treatment regime.
2. Adherence to a drug regime.
3. Adherence to a follow-up care plan.
4. Management of a chronic disease or condition.
5. Incentivizing early interventions for an acute illness or chronic disease.

A Geo DCE would be asked to outline its cost sharing arrangement in an implementation plan prior to the start of the first performance year for which the Geo DCE selects to participate in this beneficiary engagement incentive and at such other times specified in the Participation Agreement. Due to the novelty of this beneficiary engagement incentive, an implementation plan will only be considered approved if no action is taken by CMS within 45 days of the receipt of said implementation plan.

Participating Geo DCEs would be subject to monitoring and compliance activities in connection with this beneficiary engagement incentive.

Part B Premium Subsidies

CMS is considering an additional beneficiary engagement incentive under which, as part of their yearly selection, Geo DCEs would have the option to provide Part B premium subsidies to Geo Beneficiaries. This beneficiary engagement incentive would allow Geo DCEs to pay some or all of a Geo Beneficiary's Part B premium for a performance year. Much like the Part B cost-sharing beneficiary engagement incentive, each Geo DCE would be required to structure the terms of this beneficiary engagement incentive to align with the goals and requirements of the model. For example, the beneficiary engagement incentive could be used as a mechanism to split the savings the Geo DCE generates with all Geo Beneficiaries. Alternatively, the Geo DCE could provide the premium subsidy to only a subset of beneficiaries, such as those who seek a percentage of their care or primary care from Geo Preferred Providers or those Geo Beneficiaries who choose to engage in certain care management programs. Geo DCEs that elect to participate in this beneficiary engagement incentive, if adopted, would be required to submit an implementation plan detailing how they would structure their program prior to the start of the first performance year for which the DCE wishes to offer this beneficiary engagement incentive and at such other times specified in the Participation Agreement. Similar to the Part A cost sharing beneficiary engagement incentive above, an implementation plan will only be considered approved if no action is taken by CMS within 45 days of the receipt of said implementation plan. Participating Geo DCEs would be subject to monitoring and compliance activities in connection with this beneficiary engagement incentive.

K. Capitation Payment Mechanisms

CMS is introducing two Capitation Payment Mechanisms for purposes of the Geo Model, which will provide Geo DCEs a prospectively determined revenue stream paid on a monthly basis. Geo DCEs are required to select a Capitation Payment Mechanism. The Capitation Payment Mechanisms may be used by the Geo DCE to support population health and improve care coordination through enabling Geo DCEs to enter into payment arrangements with downstream providers and suppliers or to invest in health care management tools, such as health care technologies, to facilitate better outcomes and lower costs.

The amount of the capitated payment made by CMS to the Geo DCE will depend on the Capitation Payment Mechanism selected by the Geo DCE. The monthly cash flow received by the Geo DCE from CMS through its selected Capitation Payment Mechanism will be included in the calculation of Performance Year expenditures alongside all other expenditures for Parts A and B items and services furnished to Geo Beneficiaries, when comparing the Geo DCE's Performance Year Benchmark to Performance Year expenditures to determine Shared Savings or Shared Losses.

All Geo DCEs must select a Capitation Payment Mechanism. The two Capitation Payment Mechanisms available to Geo DCEs are:

Partial Capitation

In Partial Capitation, Geo Preferred Providers can agree to receive a reduction of their fee-for-service payments for services furnished to Geo Beneficiaries of between 1% and 50%, and the Geo DCE will receive monthly capitated payment equal to the estimated portion of the payments for services provided to Geo Beneficiaries by these Geo Preferred Providers based on the fee reductions they agree to with the Geo DCE. The Partial Capitation payment amount will reflect each participating Geo Preferred Provider's selected fee reduction amount, between 1% and 50%, multiplied by the estimated portion of the total cost of care (i.e., the risk-adjusted, discounted, and trended benchmark) provided by that participating Geo Preferred Provider for the Geo DCE's aligned population.

Total Capitation

In Total Capitation, Geo Preferred Providers may agree to receive a 100% reduction in their fee-for-service payments for services furnished to Geo Beneficiaries. The Geo DCE will receive a monthly capitated payment for all services furnished to Geo Beneficiaries by Geo Preferred Providers who have opted into the capitated arrangement. This Total Capitation payment amount will reflect the estimated portion of the total cost of care (i.e., the risk-adjusted, discounted, and trended benchmark) delivered to the Geo DCE's aligned population by Geo Preferred Providers that have opted into Total Capitation.

In Performance Year 2 (2023), Geo DCEs that have selected Total Capitation can opt to take capitation for all services furnished to Geo Beneficiaries by Geo Preferred Providers and Non-Preferred Providers. In this option, the Geo DCE will receive a monthly capitated payment equal to one-twelfth of the Performance Year Benchmark. The Geo DCE will reimburse Geo Preferred Providers that have elected to participate in capitation in accordance with the terms of the financial arrangement between the Geo DCE and the Geo Preferred Provider, whether on a value-based payment basis (e.g., bundle or sub-capitation) or on a FFS basis. The Geo DCE must pay Geo Preferred Providers that have not elected to participate in capitation, as well as all other health care providers who are not Geo Preferred Providers (Non-Preferred providers) in accordance with Medicare FFS requirements.

Capitation Payment Amount

The capitation payment amount under Partial Capitation is equal to one-twelfth of the Geo DCE's Performance Year Benchmark (which is a historical regional benchmark that has been risk adjusted, discounted, and trended) multiplied by the estimated portion of spending for services performed by Geo Preferred Providers who have agreed to participate in Partial Capitation, reduced to reflect the agreed-upon FFS fee reduction percentage, equal to between 1% and 50%. The capitation payment amount under Total Capitation is equal to one-twelfth of the Geo DCE's Performance Year Benchmark (which is a historical regional benchmark that has been risk adjusted, discounted, and trended) multiplied by the estimated portion of spending for services performed by Geo Preferred Providers who have agreed to participate in Total Capitation. For Geo DCEs that select Total Capitation for services furnished by both Geo Preferred and Non-Preferred Providers for Performance Year 2 or a subsequent Performance Year, the capitation payments would be equal to one-twelfth of the Performance Year Benchmark. Note that for purposes of calculating the capitation payment amounts CMS will use the performance year benchmark as described before application of the retention withhold, as discussed further in section XVII.

Examples of the Partial Capitation Payment calculation and Total Capitation Payment calculation for a Geo DCE with a Performance Year Benchmark of $1,100 PBPM are provided in Table 6.5a and Table 6.5b below.

Table 6.5a: Example Partial Capitation Payment Calculation

Step	Calculation	Value
(a) Performance Year Benchmark Per Beneficiary Per Year	a	$11,000
(b) Estimated percent of payment made by CMS for services furnished by Geo Preferred Providers participating in Partial Capitation	b	70.5%
(c) Estimated percent of payments made by CMS for services furnished by Non-Preferred Providers and by those Geo Preferred Providers who are not participating in Partial Capitation.	1- b	29.5%
(d) Estimated Average Partial Capitation Fee Reduction Percentage	d	25%
(d) Partial Capitation Payment Per Beneficiary Per Year	a * b * d	$1,938.75
(e) Monthly Partial Capitated Payment Per Beneficiary	d / 12	$161.56

Table 6.5b: Example Total Capitation Payment Calculation

Step	Calculation	Value
(a) Performance Year Benchmark Per Beneficiary Per Year	a	$11,000
(b) Estimated percent of payment made by CMS for services furnished by Geo Preferred Providers participating in Total Capitation	b	70.5%
(c) Estimated percent of payments made by CMS for services furnished by Non-Preferred Providers and by those Geo Preferred	1 - b	29.5%

Step	Calculation	Value
Providers who are not participating in Total Capitation.		
(d) Total Capitation Payment Per Beneficiary Per Year	a * b	$7,755.00
(e) Monthly Total Capitation Payment Per Beneficiary	d / 12	$646.25

CMS reserves the right to adjust the amount of the capitation payments in future months of the Performance Year if it is determined that the capitated amount is under- or over-estimating the capitation payment amount by 5% or more per month at the Geo DCE level due to updated prospective trends, updated beneficiary alignment, or updated lists of Geo Preferred Providers. This adjustment will help to prevent under- or over-estimates of the capitation payments made to Geo DCEs, resulting in fewer cash flow issues for the Geo DCE and minimizing the potential for a Geo DCE to owe significant funds as a result of the Financial Reconciliation.

Claims Payment

If the Geo DCE elects Total Capitation, as described above, the Geo DCE will assume responsibility for paying claims for Total Capitation-participating Geo Preferred Providers. For Geo DCEs that elect Total Capitation for both Geo Preferred Providers and Non-Preferred Providers in Performance Year 2 (2023) and beyond, the Geo DCE will take responsibility for administering payments to those Geo Preferred Providers that have agreed to participate in Total Capitation, based on the Geo DCE's agreements with those providers and suppliers, and to those Geo Preferred Providers who have not agreed to participate in Total Capitation as well as all Non-Preferred Providers, according to Medicare FFS requirements.

For both Geo Preferred Providers and Non-Preferred Providers, all claims will be submitted to the Medicare Administrative Contractors (MACs) for initial processing into the Medicare shared systems and then transferred to the Geo DCE through a Claims Application Programming Interface (API). Geo DCEs interested in paying claims for all providers and suppliers, including Non-Preferred Providers, beginning in Performance Year 2 (2023), must demonstrate to CMS that they will meet all of the requirements as outlined for claims payment in the *Medicare Claims Processing Manual* in processing such claims. CMS will issue further guidance for Geo DCEs interested in taking on Total Capitation for all providers and suppliers and the applicable requirements will be specified in the Participation Agreement.

If the Geo DCE has elected Partial Capitation for its Geo Preferred Providers, a claim submitted by a Partial Capitation-participating Geo Preferred Provider will still be sent from the MAC to the Geo DCE; however, the MAC will continue to adjudicate the claim and process the payment to the Geo Preferred Provider, subject to the agreed-upon fee reduction. The Geo DCE will then pay the Geo Preferred Provider any additional funds based on the agreement between the Geo DCE and the Geo Preferred Provider.

Geo DCEs will be responsible for all payment integrity and medical review functions, as described below, on claims that they pay. See *Payment Integrity and Medical Review* (Section VI.L) below for more information on these requirements. As stated with the discussion above of Model Design Elements, any activities performed by the Geo DCE under the Geo model that may be construed as services to the United States Government will be performed without compensation beyond the compensation described in this RFA and the model Participation Agreement.

L. Payment Integrity and Medical Review

The Geo DCE will have a variety of options to validate medical necessity of services, supplies, and sites of care to ensure appropriate payments to providers and suppliers and improve the quality of care for beneficiaries. These processes must align with existing Medicare FFS coding and coverage policies. Improper payments are defined as payments made for claims that do not comply with one or more Medicare coding, billing, and coverage requirements.

The following list of activities (described in further detail below) provides examples of the ways in which a Geo DCE may engage with both Geo Preferred Providers and Non-Preferred Providers to minimize improper payments:

- Monitoring practitioner practice patterns relative to peers and provide education, as appropriate, to practitioners with unnecessarily high utilization rates not consistent with the latest clinical guidelines;
- Pre-service review, pre-claim review (also known as concurrent review) and discharge planning related to appropriate inpatient, subacute, or outpatient level of care;
- Prepayment claims edits; and
- Medical review (pre-payment and post-payment) to determine if services and items meet Medicare coverage, payment, and coding rules.

All program integrity and medical review efforts implemented by the Geo DCE must not diverge from 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). In other words, those Geo DCEs that elect to perform the functions outlined in this section cannot change applicable Medicare FFS coverage, coding, and payment requirements.

Under no circumstances will a Geo DCE be authorized to alter Medicare coverage for beneficiaries except as expressly permitted under the terms of a benefit enhancement described in the Participation Agreement and selected by the Geo DCE. Under no circumstances will a Geo DCE be authorized to alter Medicare payment policies as applied to a Non-Preferred Provider or a Geo Preferred Provider that has not agreed to such modifications through a written arrangement with the Geo DCE. The details regarding these requirements will be specified in the Participation Agreement.

The following sections discuss the guidelines and requirements that will apply to payment integrity and medical review efforts by Geo DCEs and are consistent with the terms of the Medicare Program Integrity Manual (PIM), which can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033. As discussed above in the section on Model Design Elements, any activities performed by the Geo DCE under the model that may be construed as services to the United States Government will be performed without compensation beyond the compensation described in this RFA and the model Participation Agreement.

Provider and Supplier Education

Geo DCEs are encouraged to develop and employ novel ways to decrease overutilization of services and increase adherence to clinical best practice and clinical guidelines. One example is to monitor practitioner practice patterns relative to peers. Geo DCEs could send letters to, or meet with, physicians and other practitioners who have been identified as having historically high utilization rates for identified services.

The Geo DCE's communication could include metrics derived from claims data that identify how the physician or practitioner is performing compared to their peers, adjusted for differences in patient populations. The Geo DCE could also provide clinical guidelines and other educational materials to support the physician in delivering the most appropriate care and an explanation of the potential consequences of consistently referring for and furnishing an excess amount of services. While this is one example of a novel way in which Geo DCEs can decrease unnecessary utilization, Geo DCEs should develop plans that promote appropriate care and practice patterns, aligned with the latest clinical standards, while decreasing health care provider and patient burden.

Pre-Service Review and Pre-Claim Review[7]

In certain circumstances as outlined in this section, Geo DCEs will be authorized to implement pre-service review and pre-claim review programs to prevent, rather than "pay and chase," fraud, waste, and abuse through smart, proactive measures. As described above, these programs must adhere to Medicare FFS coverage and coding policies. Geo DCEs may not implement pre-service review or pre-claim review programs that do not apply existing Medicare FFS coverage and coding policies.

Pre-service review and pre-claim review are similar but differ in the timing of the review and when services may begin. Under pre-service review, the provider or supplier submits the pre-service review request and receives a provisional affirmation or non-affirmation of coverage prior to rendering services. Under pre-claim review, the provider or supplier submits the pre-claim review request and receives the provisional affirmation or non-affirmation of coverage prior to claim submission; however, the provider or supplier can render services before submitting the request. A provider or supplier submits either the pre-service review request or pre-claim review request with all supporting medical documentation for provisional affirmation of coverage for the item or service.

In an effort to reduce provider and supplier burden, pre-service review and pre-claim initiatives must not change any Medicare FFS medical necessity or documentation submission requirements for a claim determination. Similar to Medicare FFS guidelines[8], Geo DCEs will have the discretion to collect documentation related to the beneficiary's condition before and after a service in order to get a more complete picture of the beneficiary's clinical condition. These programs will help providers and suppliers address claim issues early and avoid denials and appeals. Pre-service review and pre-claim review have the added benefit of offering providers and suppliers some assurance of payment for items and services receiving a provisional affirmation decision.

Pre-service review and pre-claim review will not result in an initial determination by the Geo DCE. Instead, pre-service review and pre-claim review may result in a provisional affirmation of coverage for the item or service. A provisional affirmation decision is a preliminary finding that a future claim submitted to Medicare for the service(s) will likely meet Medicare's coverage, coding, and payment requirements. Unless a pre-service review is explicitly required by Medicare rules, if a provider or supplier does not submit a pre-service review prior to rendering the service(s) or supplies, it shall not result in an automatic

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[7] See CMS's current Prior Authorization and Pre-claim Review Initiatives at https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives

[8] PIM, Section 3.2.3 – "Requesting Additional Documentation During Prepayment and Postpayment Review."

denial, but may lead to a prepayment or postpayment medical review by the Geo DCE. In CMMI's Prior Authorization of Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) model, we have found that many providers voluntarily choose to participate in pre-service reviews or pre-claims reviews when the other option is 100% prepayment or postpayment review.

Geo DCEs may also use pre-service review or pre-claim review to improve care coordination efforts and shared decision making for beneficiaries. When pre-service review or pre-claim review are used for care coordination and shared decision making, they will not provide a provisional affirmation of coverage; instead, they will be used to provide transparency of coverage and value to the beneficiary, and to present alternative treatments and sites of care available to the beneficiary.

Geo DCEs may require pre-service review or pre-claim review for their Geo Preferred Providers. Geo DCEs cannot set the same requirements for Non-Preferred Providers; however, if a Non-Preferred Provider should elect not to submit a request for pre-service review or pre-claim review for a service, Geo DCE may require 100% prepayment review on the claim for the furnished service. So, the Geo DCE may offer pre-service review or pre-claim review as a way for the Non-Preferred Providers to avoid 100% prepayment review.

Prepayment Claims Edits[9]

If a Geo DCE elects Total Capitation and pays claims, the Geo DCE may implement additional prepayment claims edits on the claims that it pays. If a Geo DCE elects to implement prepayment claims edits for Non-Preferred Providers, the Geo DCE must demonstrate to CMS that it has the appropriate operational and technological capabilities to implement prepayment edits prior to the Performance Year in which those edits will be implemented. CMS plans to release technical papers describing the details of the prepayment edit implementation process prior to implementation, and the applicable requirements will be set forth in the Participation Agreement. Any prepayment edits implemented by the Geo DCE must adhere to Medicare payment policies, as described above, and must be able to analyze a beneficiary's Medicare beneficiary identifier (Mbi), National Provider Identifier (NPI) and specialty code, service dates, and diagnosis or procedure code(s) (i.e., Healthcare Common Procedure Coding System [HCPCS] and/or International Classification of Diseases diagnoses codes), Type of Bill (TOB), revenue codes, occurrence codes, condition codes, and value codes.

When the Geo DCE is paying claims and implementing prepayment claim edits on those claims, the claims edits implemented by the Geo DCE should be coded system logic that either automatically pays all or part of a claim, automatically denies all or part of a claim, or suspends all or part of a claim so that a trained clinician or claims analyst can review the claim and associated documentation (including documentation requested after the claim is submitted). The purpose of the prepayment claims edits is to make determinations about coverage and payment under Section 1862(a)(1)(A) of the Act to confirm that the item or service is medically reasonable and necessary to diagnose or treat an illness or injury or improve the functioning of a malformed body member. All non-automated review work resulting from claims edits must:

- Involve activities defined under §1893(b)(1) of the Act;

[9] PIM, Section 3.2 – "Overview of Prepayment and Postpayment Reviews; B. Prepayment Edit Capabilities."

- Be articulated in the Geo DCE's medical review strategy; and
- Be designed in such a way as to minimize the Geo DCE's improper payments.

Prepayment and Postpayment Medical Review[10]

Prepayment review occurs when a reviewer makes a claim determination before claim payment has been made. Prepayment review always results in an "initial determination." Postpayment review occurs when a reviewer makes a claim determination after the claim has been paid. Postpayment review results in either no change to the initial determination or a "revised determination" indicating that an overpayment or underpayment has occurred.

Geo DCEs will be authorized to review any claims for items and services furnished to their Geo Beneficiaries on a prepayment or postpayment basis. The Geo DCEs shall target their efforts at error prevention to those services and items that pose the greatest financial risk to the Medicare program. This requires establishing a priority setting process to ensure that medical review focuses on areas with the greatest potential for improper payment.

In order to identify the claims most likely to contain improper billing, Geo DCEs are encouraged to use prepayment and postpayment screening tools or natural language coding software. Whenever possible, Geo DCEs are encouraged to automate this process; however, evaluation of medical records and related documents may be necessary to determine whether Medicare claims were billed in compliance with coverage, coding, payment, and billing policies.

To prevent duplicate claim reviews, the Geo DCE will be required to use the Recovery Audit Contractor Data Warehouse (RACDW)[11] to identify, and exclude from review, claims that were previously reviewed, or that are under current review, by a Medicare contractor. The Geo DCE will also be required to input its completed reviews into the RACDW to prevent Medicare contractors from duplicating reviews that were completed by the Geo DCE.

If the Geo DCE is paying claims, the Geo DCE may conduct prepayment reviews as part of its claims adjudication process. In addition, CMS expects that in Performance Year 2 (2023) of the model, there will be an option for Geo DCEs to implement prepayment claims edits for the claims that the Geo DCE is not paying. More details regarding how this option will work and the necessary technical capabilities will be made available through technical papers prior to implementing this option and the applicable requirements will be specified in the Participation Agreement.

For further guidance on provider, supplier, and beneficiary liability determinations, please see Section 1879 of the Act. Section 1879 of the Act governs provider, supplier, and beneficiary liability in certain situations. According to the provisions of § 1879 of the Act, the provider or supplier is liable for claim denials based on section 1862(a)(1) or (9) of the Act if the provider or supplier knew or could reasonably have been expected to know that the claim for the item or service would be denied.

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[10] PIM, Section 3.2 – "Overview of Prepayment and Postpayment Reviews; A. Prepayment and Postpayment Review"

[11] PIM, Section 3.5.4 – "Tracking Medicare Contractors' Prepayment and Postpayment Reviews."

If the Geo DCE is taking Total Capitation and paying claims for Geo Preferred Providers, the Geo DCE may recover overpayments detected during postpayment review based on the arrangements the Geo DCE has with those providers and suppliers. If the Geo DCE detects an overpayment during its postpayment claims analysis for Non-Preferred Providers or Geo Preferred Providers that have not agreed to a 100% fee reduction, the Geo DCE should notify the MAC that is responsible for overpayment recovery. Sharing overpayment information with the MAC does not guarantee overpayment recovery because the MACs will be required to follow their standard overpayment recovery process as outlined in Chapter 3 and Chapter 8 of the PIM[12]. More information on the Medicare overpayment recovery program and Medicare Contactors' recovery rates can be found in the *Payment Integrity Report* in the *DHHS Agency Financial Report*[13]. If the MACs recover overpayments attributed to a Geo DCE's aligned beneficiaries, those recoveries will be accounted for in the Geo DCE's financial reconciliation.

Geo DCE Payment Integrity and Medical Review Capabilities

The following tables outline the situations in which Geo DCEs are authorized, or not authorized, to perform the functions outlined in this section for Geo Preferred Providers and Non-Preferred Providers, respectively:

Table 6.6 Geo DCE Payment Integrity and Medical Review for Geo Preferred Providers

Function	Additional Detail
Claims Payment	• Available starting in Performance Year (PY) 1 for Geo Preferred Providers that have agreed to participate in Total Capitation
Pre-service review & Pre-claim review	• Geo DCE may require based on the arrangements between the Geo DCE and its Geo Preferred Providers
Prepayment Claims Edits	• In PY1, may only implement if Geo DCE is paying claims
Prepayment Medical Review	• In PY1, may implement only if Geo DCE is paying claims • Starting in PY2, may implement through APIs if Geo DCE is not paying claims
Postpayment Claims Analysis & Medical Review	• Available starting in PY1 whether or not the Geo DCE is paying claims
Overpayment Recovery	• Geo DCE may perform recovery if the Geo DCE is paying the claim or if the Geo DCE has other stipulations in its arrangements with Geo Preferred Providers that allow for withholding or clawing back payments

Table 6.7 Geo DCE Payment Integrity and Medical Review for Non-Preferred Providers

Function	Additional Detail
Claims Payment	• Available starting in PY2
Pre-service review & Pre-claim review	• In PY1, may request, but not require, for improved care coordination • In PY2, may request, but not require, as an option for Non-Preferred providers to avoid prepayment medical review if the Geo DCE implements prepayment review
Prepayment Claims Edits	• Not available in PY1 • In PY2 and beyond, may implement if Geo DCE is paying claims

[12] PIM, Section 8.2.1 – "Overpayment Assessment Procedures."
[13] Department of Health and Human Services, Agency Financial Report, Payment Integrity Report, Table 3 (p. 255) found at https://www.hhs.gov/sites/default/files/fy-2020-hhs-agency-financial-report.pdf.

Function	Additional Detail
Prepayment Medical Review	• Not available in PY1 • In PY2 and beyond, may implement if Geo DCE is paying claims
Postpayment Claims Analysis & Medical Review	• Available in PY1 and beyond, whether or not the Geo DCE is paying claims
Overpayment Recovery	• The Geo DCE may provide overpayment data to the MAC. The MAC will then perform additional analysis and possibly recover overpayments in accordance with applicable law and policy.

Preventing Provider and Patient Burden

Alignment with Transparency and Prior-Authorization Initiatives

All Geo DCEs, regardless of organization structure, will be required under the terms of the Participation Agreement to comply with all applicable requirements of the final rule on Interoperability and Patient Access for MA Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans (QHPs) in the Federally-facilitated Exchanges and Health Care Providers (The final rule is available here: https://www.cms.gov/files/document/cms-9115-f.pdf).

Documentation Requests

As described above, if a Geo DCE chooses to perform medical reviews, it must use technology to automate medical reviews, including pre-service reviews and pre-claim reviews, as much as possible. When more detailed expert reviews are necessary, there will be limitations on the maximum required documentation Geo DCEs may request from providers and suppliers, which will be commensurate with the documentation required in CMS's existing Prior Authorization and Pre-Claim Review Initiatives[14]. These maximum requirements include:

a. Pre-service and pre-payment request content may include documentation from medical records to support the medical necessity of the service.
b. Medicare coverage policies and documentation requirements must be unchanged from documentation needed for payment in Medicare FFS.
c. Geo DCEs will have the discretion to collect documentation related to the beneficiary's condition before and after a service in order to get a more complete picture of the beneficiary's clinical condition.[15]

Time Requirements

If a Geo DCE chooses to implement pre-service review or pre-claim review initiatives, it will be required to render a provisional affirmation decision or a non-affirmation for pre-service reviews and pre-claim reviews within the same time requirements specified in the CMS regulation governing prior authorization of certain hospital outpatient department services as set forth in 42 C.F.R. § 419.82(d). While the

[14] Prior Authorization and Pre-Claim Review Initiatives. https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives
[15] PIM, Section 3.2.3 – "Requesting Additional Documentation During Prepayment and Postpayment Review."

regulation outlines requirements for specific Medicare services, a Geo DCE performing pre-service reviews and pre-claim reviews will be required to adhere to the regulation's timeline requirements, at a minimum. Further detail will be included within the Participation Agreement.

Beneficiary and Provider Notification

If a claim is denied by a Geo DCE that is paying claims, the Geo DCE shall notify the beneficiary and provider or supplier in a manner consistent with the requirements in chapter 3 of the CMS Program Integrity Manual (PIM)[16]. If the provider or supplier is a Geo Preferred Provider, the Geo DCE may notify the provider or supplier in whichever manner is agreed upon between the Geo DCE and the Geo Preferred Provider. If the Geo DCE and Geo Preferred Provider do not establish a notification process, the Geo DCE shall default to the Medicare FFS notification process outlined in chapter 3 of the PIM.

Appeals Process

Once an initial claim determination is made by a Geo DCE, any party to that initial determination, such as beneficiaries, providers, and suppliers – or their respective appointed representatives – has the right to appeal the Medicare coverage and payment decision. All claim determinations and coverage determinations made by a Geo DCE will be subject to the same appeals process employed in Original Medicare.

Section 1869 of the Social Security Act and 42 C.F.R. part 405 subpart I contain the procedures for conducting appeals of claim determinations in Original Medicare (Medicare Part A and Part B). There are five levels in the Medicare Part A and Part B appeals process. The levels are:

1. **First Level of Appeal:** Redetermination by a Medicare Administrative Contractor (MAC)
2. **Second Level of Appeal:** Reconsideration by a Qualified Independent Contractor (QIC)
3. **Third Level of Appeal:** Decision by the Office of Medicare Hearings and Appeals (OMHA)
4. **Fourth Level of Appeal:** Review by the Medicare Appeals Council
5. **Fifth Level of Appeal:** Judicial Review in Federal District Court

Compliance and Coordination with CMS

Geo DCEs implementing Payment Integrity and Medical Review programs will be required to do the following: submit to CMS their plans to ensure compliance with Medicare FFS rules prior to the Performance Year in which those plans will be implemented; participate in discussions with CMS to communicate the effectiveness of their plans; and provide an annual report showing the results of their Payment Integrity and Medical Review programs, including areas in which they detected high instances of potential fraud, waste, and abuse. The Geo DCE must promptly report suspected fraud to CMS for further investigation.

VII. Quality and Performance

The reporting of quality measures and the collection of survey data are key for CMS to verify clinical

[16] PIM, Sections 3.6.3 – "Beneficiary Notification," and 3.6.4 – "Notifying the Provider."

improvements, assess patient health outcomes and care coordination activities, and ensure continued quality of care for Geo Beneficiaries.

The quality measure set can be found in the Appendix C of this RFA. Specifications for the quality measure set and scoring principles will be reviewed annually and may be subject to revision in advance of each PY.

A. Quality in Calculating the Performance Year Benchmark

The goal of the quality strategy is to incentivize quality in three areas: patient experience, hospital admissions, and prevention. The model quality measures will align, to the extent possible, with prior ACO quality programs as well as the Medicare Advantage star ratings program. Given the lack of historical experience of the Geo model the quality strategy is designed to be highly achievable in the first performance year of the first model agreement period and become increasingly challenging during subsequent performance years, encouraging both continuous improvement and high performance.

Geo DCEs will have a percentage of their payment withheld each year (growing from 1% in PY2022 to 3% in PY2024 and beyond) that can be earned back based on their quality performance. In addition, through the High Performers Pool, Geo DCEs will have the ability to earn in excess of their withhold on the basis of their quality performance, which should provide a large incentive to increase quality. To ensure highly competitive bidding, the quality program goals will be clear to Geo DCEs.

Quality Withhold

CMS will apply a quality withhold of up to 3% of the Geo DCE's trended, regionally blended, risk adjusted historical regional expenditures used in calculating the Performance Year Benchmark. The amount of the withhold will be 1% for PY2022 and increase by 1% each year to a maximum of 3% in PY2024 and beyond (see Table 7.1). Geo DCEs that start the model in the second Model Agreement Period will begin with a quality withhold of 3%.

Table 7.1 – Annual Quality Withhold Amounts

Performance Year	Quality withhold
PY2022	1%
PY2023	2%
PY2024+	3%

Quality Measure Set

We expect to use seven quality measures to assess the quality of care furnished by Geo DCEs (see Table 7.2). These measures build on the measures used in the Direct Contracting Model Professional & Global Options, other Innovation Center models, the Shared Savings Program, and Medicare Advantage.

We believe these metrics offer a balanced approach to quality performance measurement that ranges from patient experience (Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[17]) to hospital admissions (all-cause readmissions and acute admission rates) to clinically important preventive metrics (cancer screenings, blood pressure control, and diabetes control). We will determine the best reporting method for the four clinical measures prior to the start of the model and will likely leverage

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

some of the reporting strategies used in Medicare Advantage.

Table 7.2 –Geo Quality Measures and Rationale

Measure	Used in	Comments
Consumer Assessment of Healthcare Providers and Systems (CAHPS) • **Patient experience survey**	Direct Contracting Global & Professional, Primary Care First (PCF), NGACO, Shared Savings Program, MA	• NQF endorsed.
Risk standardized, all cause readmission measure • **Claims-based**	Direct Contracting Global & Professional, NGACO, Shared Savings Program, MA	• NQF endorsed
Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions • **Claims-based**	Direct Contracting Global & Professional, NGACO, Shared Savings Program	• NQF endorsed
Colorectal Cancer Screening • **Specification/reporting method TBD**	MA, PCF	• NQF endorsed
Breast Cancer Screening • **Specification/reporting method TBD**	MA	• NQF endorsed
Controlling High Blood Pressure • **Specification/reporting method TBD**	MA, PCF, Shared Savings Program	• NQF endorsed
Diabetes: Hemoglobin A1c (HgbA1c) Poor Control (>9%) • **Specification/reporting method TBD**	MA, PCF, Shared Savings Program	• NQF endorsed

Earning Back Quality Withhold

The portion of the quality withhold earned back for a given Performance Year is calculated in three steps, which are described in greater detail below: 1) assess the Geo DCE's quality performance against the quality benchmarks; 2) increase the Geo DCE's composite quality score if it demonstrates annual improvement (for Performance Year 2023 and subsequent Performance Years); and 3) apply the composite score to the quality withhold.

Step 1: Calculate Quality Composite Score

Determine a Quality Score on Each Quality Metric

The quality score is calculated by comparing the Geo DCE's performance on each quality measure against a minimum and maximum national benchmark. For each measure, CMS will set and publish a minimum and maximum benchmark 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 Geo DCE's performance on the measure is at or above the maximum benchmark, 0 if the Geo DCE's performance on the measure is below the minimum benchmark, and partial credit if the Geo DCE's score falls between the minimum and the maximum benchmarks. For measures that qualify for partial credit, the quality score will be calculated according to the following formula, where Geo DCEs that reach the minimum benchmark will receive at least 50 points for the measure:

$$\textit{Quality Score} = (50 \text{ X } \frac{(\text{Geo DCE Raw Quality Score} - \text{Minimum Benchmark})}{(\text{Maximum Benchmark} - \text{Minimum Benchmark})}) + 50$$

For example, assume the benchmark range for cervical cancer screening is 80 percent (maximum benchmark) to 70 percent (minimum benchmark) as further shown below in Table 7.3:

- If a Geo DCE has at least 80 percent of eligible Geo Beneficiaries receiving pap smears, then it scores full credit (or 100 points) on that measure.
- If a Geo DCE has 73 percent of eligible Geo Beneficiaries receiving pap smears, it will be awarded 65 points, according to the formula below:
  - $\left(50 \text{ X } \frac{(73 - 70)}{(80 - 70)}\right) + 50 = 65$
- The following Table 7.3 provides additional examples of the translation of raw scores into quality scores:

Table 7.3: Sample Cervical Cancer Table

Raw Score (%)	Quality Score (points)
At least 80	100
78	90
76	80
74	70
72	60
70	50

Determine the Quality Composite Score

To determine the overall *Quality Composite Score*, a Geo DCE's performance on each quality measure will be averaged across all quality measures into a single composite quality score. Specifically, the Geo DCE's quality score for each measure will be added together and divided by 700 points (the total possible points) to derive an overall quality score percentage.

> For example, if a Geo DCE exceeds the maximum benchmark for 6 of 7 measures and misses the minimum benchmark for the last remaining measure, the Geo DCE's quality score would be 85.7% (i.e., 100 points x 6 measures plus 0 points x 1 measure all divided by 700 points).

The PY1 exception: For the first performance year of the model (PY2022), given the lack of a historical baseline for certain measures and lack of experience of the Geo model, the overall quality score will be based on only two measures – successful Reporting and Admissions. The maximum benchmarks for both measures will be set such that most Geo DCEs should receive full quality scores for the first performance year:

1. Reporting – We will assess whether the Geo DCE successfully reported all 7 required quality measures. Successful reporting will require timely, complete, and accurate reporting for all 7 measures, including CAHPS reporting with sufficient minimum returned surveys, passing any

external HEDIS audits, meeting all required data elements on any data transfers, and meeting all reporting deadlines. Assuming a Geo DCE meets this requirement, it will be awarded full points for this measure (i.e., 100 points).

2. Admissions – We will assess the Geo DCE's performance on both of the two admissions measures and use the best one of the two for assessing performance. For the admission metrics, we will use the 30th percentile as the maximum benchmark and the 15th percentile as the minimum benchmark. This range should be very achievable for the Geo DCEs.

For example, if a Geo DCE performs above the 30th percentile for one of the admissions measures, it will have met the maximum benchmark and will be awarded 100 points for the measure. However, if a Geo DCE performs at the 27th percentile, the Geo DCE would only score 90 points (consistent with the formula described above).

The Quality Composite Score for PY2022 will be determined by adding the points on the Reporting measure and the applicable Admission measure and dividing by 200 points.

Step 2: Calculate Improvement Factor

In addition to establishing maximum and minimum national benchmarks for the quality measures, CMS will create an *Improvement Factor* that assesses whether a Geo DCE demonstrates statistically significant quality 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 of the quality measures will be assessed against the mean improvement by all Geo DCEs for that measure. First, CMS will determine on a measure-by-measure basis if the Geo DCE's improvement on each measure is statistically significant at a 95% confidence interval in comparison to all Geo DCEs. If the Geo DCE demonstrates significant improvement on all of the measures, the Geo DCE will be considered to have met the Improvement Factor criteria and would receive the Improvement Factor award. That award will be worth 10 points to be added to the Geo DCE's overall quality composite score, up to the maximum of 100 points.

For example, a Geo DCE met the maximum benchmark in 6 of 7 measures and missed the minimum of the 7th measure (e.g., 69 percentile on Cervical Cancer Screening). Using the formula above, its original score would be 85.7 percent (600 points/700 total possible).

However, if the Geo DCE meets the criteria to be awarded the Improvement Factor because its improvement on each measure is statistically significant at a 95% confidence interval, its original score of 85.7 will be increased by 10 points. The new composite score will be to 95.7 points.

An Improvement Factor will not be used in PY2022 (as there is no prior year quality data) but will be used in PY2 and each year thereafter. New Geo DCEs who enter the model in PY2025 will also be ineligible for the Improvement Factor for their first performance year.

Step 3: Determine the Amount of the Quality Withhold Earned Back

To determine the amount of the quality withhold earned back, the Geo DCE's Quality Composite Score (expressed as a percentage) will be applied to that performance year's quality withhold amount. The Quality Composite Score will include the Improvement Factor, if applicable. If a Geo DCE scores a 100 in PY2022, it will earn back 100 percent of its 1 percent quality withhold for that performance year. If it scores a 50, it will earn back only half of its quality withhold.

For example, using the prior example above for PY2023, the original quality score was 85.7% (600 points / 700 points). After adjusting for the Improvement Factor, the adjusted quality score is 95.7 percent. Therefore, the amount of the quality withhold earned back would go from 1.7% to 1.9% with the inclusion of the Improvement Factor (85.7% x 2% moving to 95.7% x 2%).

High Performers Pool (HPP)

The intent of the HPP is to distribute quality withholds not earned back by the Geo DCEs to high performing Geo DCEs through adjustments to their shared savings/shared losses. For this purpose, we will rank all Geo DCEs by their Quality Composite Score (after taking into account the Improvement Factor, if applicable). Geo DCEs with composite quality scores that fall in the top third of all Geo DCEs nationally will be eligible to receive an additional upward quality adjustment from amounts in the HPP. We will distribute the HPP proportionally to each Geo DCE in the top third of Geo DCEs nationwide. Specifically, we will divide the total available quality withhold amounts not earned back by all Geo DCEs (including any unused HPP funds from the prior Performance Year) by the sum of the quality withhold amounts for those Geo DCEs eligible for an HPP upward payment adjustment (i.e., those Geo DCEs in the top third of quality performance). The HPP upward payment adjustment for a given Geo DCE will then be determined by multiplying that ratio by the Geo DCE's quality withhold amount. The upward payment adjustment for each Geo DCE will be capped by the Geo DCE's quality withhold amount, meaning that a Geo DCE would have the potential to earn an upward payment adjustment of up to a maximum of one time its quality withhold through the HPP. Any unused HPP dollars will roll over to the next year's HPP. The following formula and example show how the HPP upward payment adjustment for a Geo DCE will be prorated based on the available HPP dollars.

$$DCE_1\ HPP\ Upward\ payment\ adjustment = \frac{Total\ Available\ HPP\ dollars}{Sum\ of\ Quality\ Withhold\ dollars\ for\ all\ DCEs\ eligible\ for\ the\ HPP\ upward\ payment\ adjustment} \times (DCE_1\ Quality\ Withhold\ )amount\ (\$)$$

For example, if for a given year there is $3 million in the HPP, and two Geo DCEs are eligible for an HPP upward payment adjustment, and those Geo DCEs have a maximum potential HPP upward payment adjustment (which is equal to the Geo DCEs' original withhold amount) of $4 million and $2 million, they would instead receive $2 million and $1 million respectively. The following highlights the calculation for the first Geo DCE:

$$DCE_1\ HPP\ Upward\ Payment\ Adjustment = \frac{\$3\ million}{(\$4\ million + \$2\ million)} \times \$4\ million\ = \$2\ million$$

A detailed quality methodology paper will be made available to potential participants prior to the deadline for signing the Participation Agreement.

Table 7.4 - Earning Back Quality Withhold

	Calculate Quality Score	Adjust for Improvement Factor	Pay Out High Performers Pool
PY1 – Withhold = 1%			
Example 1 Low performing Geo DCE	1. Completed reporting on all measures *Reporting Quality Score = 100 points* 2. Best Admission measure at 15th percentile	No Improvement Factor in PY1	No HPP awarded **Total earn back = 0.75%** ((100+50)/200 x 1%)

	Calculate Quality Score	Adjust for Improvement Factor	Pay Out High Performers Pool
	Admission Quality Score = 50 points		
Example 2 High Performing Geo DCE	1. Completed reporting on all measures *Reporting Quality Score = 100 points* 2. Best Admission measure at 70th percentile *Admission Quality Score = 100 points*	No Improvement Factor in PY1	Geo DCE is top third. HPP was fully funded and awarded at max **Total earn back = 2%** (200 actual points/200 total + 1% HPP upward payment adjustment)
PY2+ - Withhold for PY2 = 2% Withhold of PY3+ = 3%			
Example 1 PY2 High Performing Geo DCE	*Initial Quality Score = 90%*	Improvement Score reached *Adjusted Total quality score = 100%*	Geo DCE is top third. HPP was fully funded and awarded at max **Total earn back = 4%** (2% earn back + 2% upward payment adjustment)
Example 2 PY3 Low Performing Geo DCE	*Initial Quality Score = 45%*	Improvement Score not reached *Adjusted total quality score = 45%*	Geo DCE is not a top performer **Total earn back = 1.3%** (45% score x 3% withhold + 0 upward payment adjustment)
Example 3 PY3 Average Performing Geo DCE	*Initial Quality Score= 71 %*	Improvement Score not reached *Adjusted total quality score = 71%*	Geo DCE is not a top performer **Total earn back = 2.1%** (71% score x 3% withhold + 0 upward payment adjustment)

B. Quality Monitoring

To ensure quality measures are reported accurately and completely, CMS may conduct data validation audits of Geo DCE quality data. These audits may involve ad hoc or scheduled desk reviews, focused audits, or full audits. These efforts will be in addition to the overall program monitoring and oversight strategy described in the Monitoring and Oversight section of this RFA.

VIII. Geo DCE Compliance and Oversight

Geo DCEs will be required to have a compliance plan for monitoring the Geo DCE's compliance with the

terms of the model and applicable laws and regulations.

Compliance plans are the Geo DCE's first line of defense for preventing, detecting, and correcting noncompliance. If written effectively, a compliance plan should set compliance standards and assist the Geo DCE in identifying risk, which may also reduce the potential for fraud, waste, and abuse. The Geo DCE's compliance plan must be updated, as necessary, to reflect changes in laws and regulations, and at minimum include the following:

- Designated compliance officer with compliance experience, who is not legal counsel to the Geo DCE;
- Mechanisms for identifying and addressing compliance problems related to the Geo DCE's operations and performance;
- Compliance training programs that the Geo DCE must complete periodically, including within its first 90 days in the model;
- A method for Geo DCE employees or contractors, Geo Preferred Providers, and other individuals or entities performing functions or services related to Geo DCE activities to anonymously report suspected problems related to the Geo DCE to the compliance officer; and
- A requirement for the Geo DCE to report probable violations of law immediately to an appropriate law enforcement agency.

Geo DCEs shall also ensure that Geo Preferred Providers comply with the terms of the Geo DCE Participation Agreement that govern the activities of Geo Preferred Providers.

IX. CMS Monitoring

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. CMS will also conduct a program integrity screening on all Geo Preferred Providers.

CMS may request that Geo DCEs participate in site visits or other in-depth reviews for the purpose of ensuring that Geo Preferred Providers and other individuals and 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. If aberrant billing practices, other payment, or medical concerns are noted, CMS may conduct further investigation.

X. Remedial Actions

Noncompliance with the terms of the Participation Agreement will trigger appropriate actions based on the type of issue, degree of severity, and the Geo DCE's compliance record. If CMS determines that any provision of the Participation Agreement may have been violated, CMS may take one or more of the following actions:

- Notify the Geo DCE and, if appropriate, the Geo Preferred Providers of the violation;
- Require the Geo DCE to provide additional information to CMS or its designees;
- Conduct beneficiary interviews or surveys, or take other actions to gather information;
- Provide the Geo DCE education on how to operate in compliance with relevant terms of the Participation Agreement;

- Request a Corrective Action Plan (CAP) from the Geo DCE, that will be subject to approval by CMS, detailing what actions the Geo DCE will take (or will require any Geo Preferred Provider, or other individual or entity performing functions or services related to Geo DCE Activities to take) within a specified time period to ensure that all deficiencies will be corrected and that the Geo DCE will be in compliance with the terms of the Participation Agreement;
- Suspend or terminate data sharing rights;
- Suspend or terminate payments due to the Geo DCE;
- Prohibit the Geo DCE from making payments to a Geo Preferred Provider;
- Require the Geo DCE to terminate a Geo Preferred Provider or other individuals or entities performing services or functions related to Geo DCE activities;
- Suspend or terminate the availability of any or all waivers of existing law made pursuant to section 1115A(d)(1) of the Act;
- Suspend or terminate the use of one or more benefit enhancements or beneficiary engagement incentives by the Geo DCE, and/or its Geo Preferred Providers;
- Suspend or terminate the Geo DCE's ability to engage in activities related to voluntary alignment;
- Suspend or terminate voluntary alignment as an alignment option for the DCE; and
- Terminate the Geo DCE from the Geo Model.

XI. Data Sharing and Reports

The exchange of timely, appropriate and useful data continues to be a top priority for CMS. The Geo Model will build upon the data sharing strategies and data reports established in earlier shared savings initiatives and other Innovation Center models.

As described above, the Geo DCE will participate in an Organized Health Care Arrangement (OHCA), as defined under 45 C.F.R. § 160.103, with CMS under the Geo Model. To satisfy the definition of an OHCA:

- The Geo DCE must be a Covered Entity (as defined at 45 C.F.R. § 160.103);
- The Geo DCE and CMS must hold themselves out to the public as participating in a joint arrangement; and
- The Geo DCE and CMS must perform payment activities under the Geo Model, in which the financial risk for delivering health care is shared by CMS and the Geo DCE through the joint arrangement and any protected health information (PHI) created or received by CMS or the Geo DCE under the Geo Model is reviewed by the other participant (or by a third party on their behalf) for purposes of administering the sharing of financial risk.

Under 45 C.F.R. § 164.506(c)(5), a covered entity that participates in an OHCA may disclose protected health information about an individual to other participants in the OHCA for any health care operations activities of the OHCA.

CMS plans to make several types of Medicare data available to Geo DCEs participating in an OHCA with CMS under the Geo Model. During the Model Performance Period CMS will share with a Geo DCE, as a covered entity participating in the OHCA with CMS, the minimum necessary data regarding the Geo DCE's Geo Beneficiaries for purposes of the health care operations of the OHCA. The health care operations of the OHCA include beneficiary outreach, care management, network management, clinical review, program integrity, claims, and quality improvement activities. The data may be used only consistent with the terms of the applicable CMS agreements, including the Participation Agreement, and applicable law.

During the Model Performance Period, for purposes of the health care operations of the OHCA, CMS will

provide Geo DCEs with detailed claims data that will include individually identifiable Claim and Claim Line Feed (CCLF) reports for services furnished by Medicare-enrolled providers and suppliers to Geo Beneficiaries. At the beginning of each Performance Year, CMS will additionally provide Geo DCEs with the historical CCLF files for newly aligned Geo Beneficiaries, which will capture a 36-month lookback of claims.

During each Performance Year, CMS will provide Geo DCEs with operational reports on a regular basis. These reports may include but will not be limited to: Quarterly and Annual Utilization; Monthly Expenditures; Beneficiary Data Sharing Preferences; Monthly Claims Lag; and Beneficiary Alignment reports.

During each Performance Year, CMS will provide quarterly baseline benchmark reports (BBRs) to Geo DCEs to enable them to monitor their financial performance throughout the performance year. The BBRs will not contain individually identifiable data. The same design and data source used to generate the BBRs will also be used for the final Financial Reconciliation report.

For purposes of the health care operations of the OHCA, CMS will also provide Geo DCEs access to a claims and eligibility API that will provide Geo DCEs with such information on their aligned beneficiaries as it is received by CMS shared systems for processing. We believe that by sharing data that is closer to real-time, Geo DCEs will be able to better execute the health care operations of the OHCA, including creating and operating programs that are better tailored or more effective in meeting the needs of Geo Beneficiaries.

During each Performance Year, the Geo DCEs will receive feedback on their quality performance. CMS will release further information on the reports to be shared with Geo DCEs in subsequent technical papers.

The data and reports provided to the Geo DCEs will include individually identifiable data for Geo Beneficiaries who have opted out of data sharing while an aligned beneficiary in another Medicare shared savings initiative. If a Geo Beneficiary has opted out of data sharing in another Medicare shared savings initiative that permits a model participant to request data for its health care operations (or the health care operations of a covered entity for which the model participant serves as a business associate) pursuant to 45 C.F.R. § 164.506(c)(4), the Geo DCE may only use that Geo Beneficiary's identifiable data for those activities of the OHCA that fall within paragraphs (3) through (6) of the definition of health care operations at 45 C.F.R. §164.501, and may not use that Geo Beneficiary's data for activities described in paragraphs (1) and (2) of that definition without consent from that Geo Beneficiary. CMS and the Geo DCE will jointly communicate CMS's intent to limit the Geo DCE's use of such Geo Beneficiaries' data for purposes of the health care operations activities of the OHCA described in paragraphs (3) through (6) of the definition of health care operations at 45 C.F.R. §164.501and offer the opportunity for Geo Beneficiaries to opt back into data sharing for the health care operations activities of the OHCA described in paragraphs (1) and (2) of that definition.

Geo DCEs may inform each newly-aligned Geo Beneficiary, in compliance with applicable laws, that he/she may elect to allow the Geo DCEs to receive beneficiary-level data regarding the utilization of substance use disorder services, the mechanism by which the Geo Beneficiary can make this election, and contact information for answers to any questions about data sharing of substance use disorder services. CMS will provide Geo DCEs with the Substance Use Disorder Opt-In Form.

XII. Evaluation

All Geo DCEs will be required to cooperate with efforts to conduct an independent, federally funded evaluation of the model by CMS and/or its designees, which may include: participation in surveys; interviews; site visits; attaining state support in the review of analyses of cost shifting between programs; and other activities that CMS determines necessary to conduct a comprehensive formative and summative evaluation. The evaluation will assess the impact of the Geographic Direct Contracting Model on the goals of better health, better health care, and lower Medicare expenditures. The evaluation will be used to inform policy makers about the effect of model concepts. To do so, the evaluation will seek to understand the behaviors of providers, suppliers, and beneficiaries, the impacts of increased financial risk, the effects of various payment arrangements, benefit enhancements, and beneficiary engagement incentives, the impact of the model on beneficiary engagement and experience, and other factors associated with patterns of results. Each Geo DCE must require its Geo Preferred Providers and other individuals and entities participating in Geo DCE activities to participate in and cooperate with any such independent evaluation activities conducted by CMS and/or its designees. If a Geo DCE does not provide the data necessary for CMS and/or its designees to complete the evaluation, upon request, CMS may take remedial action, including terminating the Geo DCE's Participation Agreement.

XIII. Information Resources for Beneficiaries and Providers

The primary resource for beneficiaries with questions about the Geo Model will be 1-800-MEDICARE. CMS has developed scripts for customer service representatives (CSRs) that will answer anticipated questions related to the model. Questions that CSRs cannot answer will be triaged to CMS Regional Offices. Geo DCEs will also be required to establish processes to answer beneficiary queries, which as descriptive materials will be subject to CMS review. Because of potentially substantial enhancements to certain Medicare benefits in the Geo Model, CMS will develop processes for Geo DCEs and CMS to notify and educate beneficiaries of these changes. Finally, CMS will maintain an email inbox for inquiries from Geo DCEs, Geo Preferred Providers, and beneficiaries related to Direct Contracting at DCGEO@cms.hhs.gov.

XIV. Application Scoring and Selection

We will select Geo DCEs for participation in the model using a two-step process: first, selection criteria that demonstrate a Geo applicant's capacity to carry out the requirements of the model; and second, by assessing the Geo DCE's proposed discounts for each performance year.

First, applicant Geo DCEs will be assessed on their capabilities against a defined scoring threshold, based 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. These domains and associated point scores are detailed in Appendix E of this RFA.

Operational capabilities will be scored by a panel of experts that may include individuals from the Department of Health and Human Services (HHS) and other organizations, with an emphasis on individuals with expertise in provider payment policy, care improvement, and care coordination. Final selection for participation in the model will be based on, but not limited to, the Geo DCE clearing a defined scoring threshold utilizing the scoring criteria set forth in Appendix E of this RFA, as well as assessments of program integrity risks. CMS may choose to interview applicants and/or conduct pre-

selection reviews of applicants during the application process in order to better understand applicant organizations and their proposed Geo Preferred Providers. Those applicants that are deemed to be qualified will then be sorted by the target region selected in their application.

Next, 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. 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. 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 be 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.

For a given target region, all applicants will provide a proposed discount that they can offer on trended, regionally blended, risk adjusted historical regional expenditures. Applicant proposed discounts will be actuarially certified by CMS for soundness and then evaluated against minimum acceptable discounts specific to the applicable target region to account for differences between regions.

As part of the bidding process, applicants will receive aggregated, de-identified historical data for their selected target region to enable them to create their proposed discounts. This data will include historical utilization and spending, historical risk scores and measures, historical quality measures, and a benchmark workbook.

Utilizing the data provided by CMS in addition to any internal data, Geo applicants will propose a percentage discount. Applicants will indicate their proposed discount for each performance year of the relevant model agreement period individually as percentage discounts off the relevant region's trended, regionally blended, risk adjusted historical regional expenditures. CMS will align a larger share of the region's beneficiaries to the Geo DCEs that propose the largest proposed discounts, through a weighted distribution of the market by comparing the average proposed discounts of each selected Geo DCE within a region. The average proposed discounts will be calculated by weighting each performance year (PY) as follows:

Table 14.1a – Proposed Discount Weighting by Year for First Model Agreement Period

Performance Year Bid	Weight
PY2022 Bid	40%
PY2023 Bid	30%
PY2024 Bid	30%

Table 14.1b – Proposed Discount Weighting by Year for Second Model Agreement Period

Performance Year Bid	Weight
PY2025 Bid	40%

Performance Year Bid	Weight
PY2026 Bid	30%
PY2027 Bid	30%

The weighted proposed discount average will be used to determine the Market Cap for each Geo DCE for the relevant Model Agreement Period. Each individual Geo DCE's weighted average discount will be divided by the sum of the weighted average proposed discounts across all Geo DCEs in the region to calculate a Market Cap for each Geo DCE in the region. For example, suppose three Geo DCEs proposed discounts as follows:

Table 14.2 – Market Cap Calculation Example (First Model Agreement Period)

	Weight	Geo DCE 1	Geo DCE 2	Geo DCE 3
PY2022 Proposed Discount	40%	2.00%	1.00%	3.00%
PY2023 Proposed Discount	30%	4.00%	5.00%	5.00%
PY2024 Proposed Discount	30%	5.00%	6.00%	5.00%
Weighted Average		**3.50%**	**3.70%**	**4.20%**
Market Cap		*30.70%*	*32.46%*	*36.84%*

Based on this example, for the first Model Agreement Period, Geo DCE 1 would have a Market Cap of $\frac{3.5\%}{3.5\%+3.7\%+4.2\%} = 30.70\%$, Geo DCE 2 would have a Market Cap of 32.46%, and Geo DCE 3 would have a Market Cap of 36.84%. Under the Geo model there will be a fixed upper and lower bound on market share such that no single Geo DCE would control more than 49.9% of the market or less than 10.0%. The Market Cap is a Geo DCE-specific cap on the total number of beneficiaries that can be aligned to the Geo DCE. The only types of alignment that are not subject to the Market Cap are voluntary alignment and MCO-based alignment. All beneficiaries who are eligible for alignment to the DCE based on voluntary alignment or their enrollment in the relevant MCO will be aligned to the DCE, even if this results in the Geo DCE exceeding its Market Cap. The Market Cap is also used to calculate the Care-Alignment Cap, which limits the total number of beneficiaries that can be aligned through ACO-based alignment and Claims-based alignment. The Care-Alignment Cap, is equal to 50% of the Market Cap. The number of randomly aligned beneficiaries for a given Geo DCE will then be determined by the amount of the Geo DCE's Market Cap left after determining the number of beneficiaries aligned to the Geo DCE through MCO-based, ACO-based, and Claims-based alignment. Neither the Market Cap nor the Care-Alignment Cap will limit the number of beneficiaries who may voluntarily align to a given Geo DCE or who could be aligned to a given Geo DCE through MCO-based alignment.

XV. Duration

The Geo Model will consist of a 6-year Model Performance Period with two three-year Model Agreement Periods. CMS reserves the right to modify or terminate the model at any time if it is determined that it is not achieving the aims as required under section 1115A of the Social Security Act.

XVI. Learning and Diffusion Resources

CMS will support Geo DCEs in accelerating their progress by providing them with opportunities to both learn about achieving performance improvements and share experiences with one another and with participants in other Innovation Center initiatives. This will be accomplished through a "learning system" for the Geo DCEs. The learning system will use various group-learning approaches to help Geo DCEs

effectively share experiences, track progress, and rapidly adopt new methods for improving quality, efficiency, and population health. Geo DCEs are required to participate in the learning system by attending periodic learning system events and actively sharing tools and ideas.

XVII. Termination and Withdrawal

A Geo DCE may terminate its participation in Geographic Direct Contracting at any time with advance written notice to CMS. CMS reserves the right to terminate a Geo DCE's Participation Agreement at any point during the model for reasons associated with poor performance, non-compliance with the terms and conditions of the Participation Agreement, or as otherwise specified in the Participation Agreement or required by section 1115A(b)(3)(B) of the Social Security Act.

Upon a Geo DCE withdrawing from the model, whether voluntarily or as a result of the Geo DCE's termination from the model by CMS, all of the Geo DCE's aligned beneficiaries will be randomly aligned to the remaining Geo DCEs in that region following the share distribution outlined in the Bidding Process.

CMS believes that longer participation in the Geo model will facilitate improved performance by model participants and will enhance the evaluation conducted by CMS. In order to incentivize Geo DCEs to stay in the model for a full Model Agreement Period, Geo DCEs will be subject to a retention withhold, in an amount equal to their share of the minimum expected aggregate savings to CMS for that Geo DCE's region for the duration of the relevant Model Agreement Period remaining after the Geo DCE drops out of the model (the "retention withhold"). This policy will be applied for the first Model Agreement Period (PY2022-PY2024) as follows: for PY 2022, each Geo DCE will be subject to a 9% retention withhold applied to the Geo DCE's PY2022 trended, risk-adjusted benchmark after application of the quality withhold and discount; for PY2023, each Geo DCE will be subject to a 6% retention withhold applied to the Geo DCE's PY2023 trended, risk-adjusted benchmark after application of the quality withhold and discount; and for PY2024 each Geo DCE will be subject to a 3% retention withhold applied to the Geo DCE's PY2024 trended, risk-adjusted benchmark after application of the quality withhold and discount. CMS will follow a similar approach for the second Model Agreement Period (PY2025-PY2026). If the DCE's Participation Agreement remains in effect at the time of Financial Reconciliation for the relevant Performance Year, the retention withhold will be refunded to the Geo DCE, as part of the given Performance Year's reconciliation. That is, CMS will conduct Financial Reconciliation for that Performance Year using a Performance Year Benchmark that does not reflect the retention withhold. If, on the other hand, the Geo DCE's Participation Agreement is terminated before Financial Reconciliation for a Performance Year, CMS will not refund the retention withhold to the Geo DCE and instead will conduct Financial Reconciliation for that Performance Year using a Performance Year Benchmark that reflects the retention withhold. As described in Section E of this RFA, if CMS determines that the Geo DCE owes CMS Shared Losses as a result of Financial Reconciliation for a Performance Year and the Geo DCE does not timely pay such shared losses to CMS in full, CMS will purse payment under the Geo DCE's financial guarantee and may withhold payments otherwise owed to the DCE under the model or any other CMS program or initiative. Note that for purposes of calculating the amount of a Geo DCE's monthly capitation payment amounts, CMS will use the performance year benchmark as determined before application of the retention withhold.

Alternatively, the Geo DCE may secure a retention amount, equal to the applicable retention withhold for that Performance Year multiplied by the Performance Year Benchmark for that Performance Year at the start of the Performance Year, either with the same financial guarantee the Geo DCE uses to secure its ability to repay Shared Losses and Other Monies Owed to CMS, or a separate financial guarantee. If a Geo DCE's Participation Agreement is not in effect at the time of reconciliation for a Performance Year, the

Geo DCE will be required to pay CMS the retention amount for the applicable performance year at that time. If the Geo DCE does not timely pay the retention amount to CMS, CMS would collect the retention amount under the terms of the relevant financial guarantee. A Geo DCE must have its financial guarantee in place until settlement of the last Performance Year of the Model Agreement Period is final or until the retention amount is paid to CMS, whichever is later.

An example calculation of the retention withhold retention amount can be found below. Note that as long as the Geo DCE proposes a discount higher than the minimum savings level for that region, its retention amount will be less than 100% of its actual proposed discount. The example below in Table 17.1 illustrates the retention withhold and retention amount:

Table 17.1 – Retention Withhold and Retention Amount Illustration

Performance Year	PBPM	Bene Count	Minimum Savings Percent	Retention Withhold	Retention Amount
PY1	$1,000	50,000	3%	9%	$54,720,000
PY2	$1,010	50,000	3%	6%	$36,720,000
PY3	$1,030	50,000	3%	3%	$18,540,000

Note: Minimum Savings for reach region will be defined during the application review process.

Additionally, CMS reserves the right to terminate a Geo DCE's Participation Agreement at any point during the model for reasons associated with poor performance, non-compliance with the terms and conditions of the Participation Agreement, or as otherwise specified in the Participation Agreement or as required by section 1115A(b)(3)(B) of the Act. If CMS terminates a Geo DCE's Participation Agreement for reasons associated with poor performance, non-compliance with the terms and conditions of the Participation Agreement, or as otherwise specified in the Participation Agreement, the Geo DCE would be responsible for the retention amount.

XVIII. Amendment

CMS may modify the terms of the Geo model in response to stakeholder input, to reflect the agency's experience with the model, or as may be required under section 1115A of the Act or any other applicable provision of law. The terms of the Geo model as set forth in this Request for Applications may differ from the terms of the model as set forth in the Participation Agreement between CMS and the Geo DCE. Unless otherwise specified in the Participation Agreement, the terms of the Participation Agreement, as amended from time to time, shall constitute the terms of the Geo model.

Appendices

Appendix A: Glossary of Key Definitions

The following terms have the meaning set forth below. CMS may modify these definitions for purposes of the Participation Agreement.

BENEFICIARY ENGAGEMENT INCENTIVES: Certain in-kind incentives, chronic disease management rewards, and cost sharing support that may be furnished to Geo Beneficiary under the terms of the model Participation Agreement in a manner consistent with applicable law.

BENEFIT ENHANCEMENTS: Additional benefits that the Geo DCE chooses to make available to Geo Beneficiaries through Geo Preferred Providers in order to support high-value services and allow the Geo DCE to more effectively manage the care of Geo Beneficiaries.

FEDERAL HEALTH CARE PROGRAMS: Health care programs as defined by section 1128B(f) of the Social Security Act.

GEO BENEFICIARY: A Medicare beneficiary who has been aligned to a Geo DCE as described in Section VI.B. for a given Performance Year and has not subsequently been excluded from the aligned population of the Geo DCE.

GEO DIRECT CONTRACTING ENTITY (Geo DCE): An organization/entity participating in the Geo model pursuant to a Participation Agreement with CMS.

GEO PREFERRED PROVIDER: An individual or entity that: (1) is a Medicare- enrolled provider or supplier (as defined in 42 C.F.R. § 400.202); (2) is identified on the Geo DCE's list of Geo Preferred Providers by name, National Provider Identifier (NPI), TIN, Legacy TIN or CCN (if applicable), and CMS Certification Number (CCN) (if applicable); (3) 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; (4) is not a Prohibited Participant; and (5) has agreed, pursuant to a written agreement with the Geo DCE, to participate in the model, to report quality data through the Geo DCE, and to comply with care improvement objectives.

DISCOUNT: The discount is a percentage adjustment to the trended, regionally blended, risk adjusted historical expenditures used to determine the Performance Year Benchmark. For example: Baseline, trend, and risk adjustment calculations indicate that a Geo DCE is projected to spend $10,000 per beneficiary. If the Geo DCE's discount is 2%, the Performance Year Benchmark will be $9,800 per beneficiary prior to the application of the quality withhold. This discount is the primary mechanism for CMS to obtain savings under the model. The discount for each Geo DCE will be determined through a bidding process.

MARKETING ACTIVITIES: The distribution of Marketing Materials or other activities conducted by or on behalf of the Geo DCE or its Geo Preferred Providers, when used to educate, solicit, notify, or contact beneficiaries regarding the model.

MARKETING MATERIALS: General audience materials such as brochures, advertisements, outreach events, letters to beneficiaries, webpages, mailings, social media, sent by or on behalf of the Geo DCE or its Geo Preferred Providers when used to educate, solicit, notify, or contact beneficiaries regarding the model.

MEDICARE FFS FEE REDUCTION: A reduction in Medicare FFS payments to the Geo Preferred Providers

who, pursuant to a written agreement with the Geo DCE, have agreed to receive such reduced FFS payment for covered services furnished to Geo Beneficiaries. One-twelfth of the projected total annual amount of such Medicare FFS fee reductions will be distributed to the Geo DCE as monthly payments.

NPI: National provider identifier.

PREFERRED PROVIDER LIST: The list that identifies each Geo Preferred Provider that is approved by CMS for participation in the Geo model and designates the benefit enhancements and beneficiary engagement incentives, if any, in which each Geo Preferred Provider participates, and includes information on whether the provider or supplier has agreed to a Medicare FFS fee reduction and the applicable fee reduction amount, as updated from time to time in accordance with the Participation Agreement.

PROHIBITED PARTICIPANT: An individual or entity that is: (1) a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier, (2) a drug or device manufacturer, and/or (3) excluded or otherwise prohibited from participation in Federal health care programs.

SHARED LOSSES: The monetary amount owed to CMS by the Geo DCE due to performance year expenditures (inclusive of capitated payments e.g., Total Capitation or Partial Capitation) paid by CMS to the Geo DCE, Medicare Parts A and B payments by CMS directly to Medicare providers and suppliers for care furnished to Geo Beneficiaries, and overlaps payments made during the performance year) being in excess of the Geo DCE's Final Performance Year Benchmark for the applicable performance year.

SHARED SAVINGS: The monetary amount owed to the Geo DCE by CMS due to performance year expenditures (inclusive of capitated payments (e.g., Total Capitation or Partial Capitation) paid by CMS to the Geo DCE, Medicare Parts A and B payments by CMS directly to Medicare providers and suppliers for care furnished to Geo Beneficiaries, and overlaps payments made during the performance year) being lower than the Geo DCE's Final Performance Year Benchmark for the applicable performance year.

TIN: Federal taxpayer identification number.

VOLUNTARY ALIGNMENT: A process whereby CMS aligns to a Geo DCE those beneficiaries who have designated the Geo DCE as their Geo DCE. A beneficiary who designates a given Geo DCE as their Geo DCE will be aligned to the Geo DCE even if the beneficiary would have been aligned to another Geo DCE based on another alignment mechanism.

Appendix C: Quality Measures for PY1

The following quality measures are the measures we expect to use in assessing the quality performance of Geo DCEs in PY1 of the model (CY 2022).

Proposed Quality Measures

Domain	Measure Title	Method of Data Submission	PY1 Pay-for-Performance Phase R—Reporting PY1 P—Performance PY1
Patient/Caregiver Experience	Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Patient experience Survey	R
Care Coordination/Patient Safety	Risk Standardized, All Condition Readmission	Claims	P
Care Coordination/Patient Safety	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Claims	P
Preventive Health	Colorectal Cancer Screening	Claims or Hybrid	R
Preventive Health	Breast Cancer Screening	Administrative / Claims	R
At-Risk Population: Hypertension	Hypertension: Controlling High Blood Pressure	Claims or Hybrid	R
At-Risk Population: Diabetes	Diabetes: Hemoglobin A1c (HgbA1c) Poor Control (>9%)	Claims or Hybrid	R

Appendix D: Summary of Geographic PBP RFI Comments

On April 22, 2019, the Innovation Center released a RFI available at https://innovation.cms.gov/Files/x/dc-geographicpbp-rfi.pdf) to solicit public input on Geo, as requested by OMB. The deadline for submitting comments in response to the Geo RFI was May 30, 2019. Eighty-seven comment letters were received totaling 1,495 comments. The RFI attracted responses from a variety of individuals and entities, including health plans participating in Medicare Advantage (MA) and Medicaid managed care, health systems, current NGACOs, physician-led organizations, health technology companies focused on care management, consulting firms, trade associations, and medical societies. Key themes associated with the RFI comments that were factored into the design of the model include,

- **Number of geographic regions and region selection criteria** - Most commenters agreed with CMS' proposal to limit the model to a small number of geographic regions and stated that the regions should be sufficiently large to support at least two Geo Direct Contracting Entities (Geo DCEs) with the desired minimum number of aligned beneficiaries.
- **Beneficiary alignment** - Commenters generally supported the proposal to permit beneficiaries to voluntarily align to Geo DCEs.
- **Benchmarking methodology** - Many stakeholders asked for a transparent, sustainable, predictable methodology for setting the performance year benchmark, and to avoid penalizing health care providers who are in low-cost areas or participating in other Innovation Center models.
- **Flexible regulations and waivers** - Regulatory flexibility was a common theme, with support for issuing the same programmatic waivers used in the NGACO Model as well as for additional regulatory flexibility, including the ability to reduce or eliminate beneficiary cost-sharing.

Appendix E: Application Template and Applicant Selection Criteria and Scoring

Application Section	Points	RFA Field/Question	Associated Scoring Criteria
Background Information	N/A (all fields required but not scored)	Please Select Target Region	N/A
		Organization Information (legal name, TIN, address, website)	N/A
		Type of applicant organization (practice, hospital, plan, ACO, etc.)	N/A
		Please provide an executive summary. The executive summary must include an overview of the Applicant, its relevant experience, and a high-level description of its proposed approach to meeting model requirements.	N/A
		Certificate of incorporation as a legal entity	N/A
		Evidence that the organization is a Covered Entity as defined in 45 C.F.R. § 160.103.	N/A
		To assist the Federal Trade Commission (FTC) and the Antitrust Division of the Department of Justice (DOJ) in their activities to protect competition in the regions in which the Geo Model will be tested, CMS may provide certain information, including aggregate claims data regarding allowed charges and fee-for-services payments for your organization, to FTC and the Antitrust Division of DOJ to assist in their monitoring of the competitive effects of Geo DCEs in these regions. Please confirm that you understand and agree that CMS may also share a copy of your application (including all information and documents submitted with the application) with the FTC and the Antitrust Division of the DOJ.	N/A
		Please attest that the Applicant Geo DCE has been licensed (if applicable) by the state(s) in which it is located as a risk-bearing entity or that it is exempt from such licensure and/or other such requirements. i. N/A (i.e., state(s) do not have licensure requirement for Geo DCEs or Geo DCE not required to be licensed as risk-bearing entity in the state(s)). ii. Applicant Geo DCE has been licensed as a risk-bearing entity in state(s) in which it will operate. Upload certification/documentation. iii. Applicant is required to obtain licensure as a risk-bearing entity in state(s) in which it will operate, but the Geo DCE is not yet currently licensed as a risk-bearing entity in one or more of these states. Please enter in the date the applicant expects to	N/A

Application Section	Points	RFA Field/Question	Associated Scoring Criteria
		obtain such licensure.	
		Contact Information	N/A
Organizational characteristics	10	Please select current or former participation in CMS models or demonstrations (drop-down question). Please describe your organization's experience with Medicare ACOs, Medicare Advantage, and any value-based initiatives with private payers, if applicable. Please describe your organization's experience serving Medicare beneficiaries, including dually eligible, ESRD, and other high risk populations.	The organization demonstrates broad and deep experience with value-based models and has a track record of working with high-need Medicare fee-for-service beneficiaries (e.g., dually eligible, ESRD, and other high risk populations). Additional credit for longer tenure as well as serving a large population and high needs populations.
		Please describe the applicant's historical presence in the target region as demonstrated by (1) overlap of its health care providers and/or provider network with the target region; (2) overlap of its health insurance coverage service area with the target region (in the case where the applicant is a health plan); (3) written arrangements with other providers, suppliers, and ACOs in the target region; and (4) relationships with community-based organizations (e.g., transportation services, food pantries, housing services) in the target region.	The organization: • Demonstrates a signification amount of historical experience with Medicare health care providers in the target region • Demonstrates a large list of providers and suppliers to serve the entire target region • Demonstrates experience affiliating with or entering into arrangements with ACOs in the target region • Demonstrates experience partnering with community-based organizations to address social determinants of health in the target region

<table>
<tr><th>Application Section</th><th>Points</th><th>RFA Field/Question</th><th>Associated Scoring Criteria</th></tr>
<tr><td></td><td></td><td></td><td>• Demonstrates experience affiliating with or entering into arrangements with Medicaid plans for services, including Medicaid Managed Care Plans, and Managed Long Term Services and Supports (MLTSS)</td></tr>
<tr><td></td><td></td><td>1. Please provide a proposed organizational chart for the Applicant Geo DCE. The proposed organizational chart should depict the legal structure, reporting structures (including for the compliance officer), and board of directors including any relevant committees.
2. Please complete the table below with information specific to the Applicant Geo DCE's proposed leadership team. The leadership team may include but is not limited to: Chief Executive Officer; Chief Financial Officer; Chief Medical Officer; Clinical Improvement Officer(s); Chief Compliance Officer; Chief Information Officer; the Chief Privacy Officer; and the individual responsible for oversight of beneficiary engagement and outreach. If specific individuals have not yet been identified, please note that in the Leadership Team Member column and provide the anticipated date by which the individual will be identified. For each role, indicate years of relevant experience as indicated in Question 1 and the percent of time the individual will be dedicated to the Geo DCE.
<table>
<tr><td>Leadership Team Member</td><td>Position/ Role</td><td>Years Experience</td><td>Percent of time Dedicated to Geo DCE</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
</table></td><td>The organization demonstrates an accountable structure wherein there is a defined Geo DCE leadership team, the CEO is accountable to the board of directors, and there exists a compliance officer within the Geo DCE leadership team who reports to both the CEO and board of directors.

The organization’s management team is experienced in value based models, Medicare Advantage and Medicare generally.</td></tr>
<tr><td></td><td></td><td>Please complete the table below for the applicant Geo DCE’s proposed board of directors: (Name, Title, Expertise, and Independent Board Status).</td><td>The organization describes the composition of its board of directors and can ensure</td></tr>
</table>

<table>
<tr><th>Application Section</th><th>Points</th><th>RFA Field/Question</th><th>Associated Scoring Criteria</th></tr>
<tr><td></td><td></td><td>Please describe how the Geo DCE will ensure that all members of the Board have a fiduciary duty to the organization.

<table><tr><td>Name</td><td>Title</td><td>Experience</td><td>Independent Board Status</td></tr><tr><td></td><td></td><td></td><td></td></tr></table>
To the extent the Geo DCE is a non-public organization, please identify shareholders holding 5% or more of shares in the organization in the following table.

<table><tr><td>Shareholder</td></tr><tr><td></td></tr></table></td><td>that all members of the board of directors have a fiduciary duty to the organization.

The organization demonstrates that all of the owners clear background checks and no conflicts of interest exist.</td></tr>
<tr><td></td><td></td><td>Innovation Center model applications require all applicants to disclose the following with respect to the applicant, owners, and key executives: any investigations of, or sanctions or corrective action plans that have been imposed on, the applicant, owners, and individuals in leadership positions in the last five years by an accrediting body or state or federal government agency. Individuals in leadership positions include key executives who manage or have oversight responsibility for the organization, its finances, personnel, and quality improvement, including without limitation, a Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Operations Officer (COO), Chief Information Officer (CIO), Chief Medical Director, Chief Compliance Officer, or an individual responsible for maintenance and stewardship of clinical data. Please also disclose any outstanding debts owed to Medicare.</td><td>The organization disclosed, with respect to the applicant, its owners, executive officers: (1) any sanctions or corrective action plans imposed under Medicare or Medicaid, or by the Drug Enforcement Agency or state licensure authorities within the last five years; (2) any fraud investigations initiated, conducted, or resolved within the last five years; and (3) any outstanding debts owed to the Medicare program, including any debts owed under an Innovation Center model, CMS demonstration, or other CMS initiative.</td></tr>
<tr><td></td><td></td><td>Please describe the history of the Applicant Geo DCE organization and its major member organizations in terms of prior business relationships (if any) and collaboration between members on care improvement or cost</td><td>The organization has a history of strong collaboration and demonstrated capacity to</td></tr>
</table>

Application Section	Points	RFA Field/Question	Associated Scoring Criteria
		containment efforts (if any), as well as any anticipated upcoming business relationships.	deliver coordinated care at scale.
		Provide an overview of your organization's demonstrated history and experience, including any relevant results, to support the Geo Model, including if applicable: • Conduct outreach to Medicare beneficiaries by multiple methods; • Implement and manage supplemental benefits, benefit enhancements, and beneficiary engagement incentives either in an ACO, Geo DCE, or Medicare Advantage context; • Hold providers and/or suppliers accountable to quality metrics; • Coordinate services to address health disparities and to address social determinants of health either through the Geo DCE's own operations and benefits or through community partnerships; • Perform program integrity functions (e.g., evidence-based decision support tools, monitoring over/under-utilization, monitoring fraud waste and abuse, cost avoidance); • Perform payment functions (e.g., claims processing, capitation).	The organization has demonstrated capacity to engage in some or all functions that will allow it to deliver better care at lower cost and take advantage of the unique features of the model in the areas of: • Beneficiary outreach • Benefit Enhancements • Beneficiary Engagement Incentives • Provider/supplier Arrangements • Care Management • Payment integrity and medical review to validate items and services are medically necessary and billed according to coding and coverage rules • Provider Payment and Claims Adjudication • Quality Measurement and Management

Application Section	Points	RFA Field/Question	Associated Scoring Criteria
Financial Plan and Risk-Sharing Experience	30	Please indicate intended Capitation Payment Mechanism by which CMS would pay the Geo DCE. The capitation payment mechanism dictates the method of payment to Geo DCEs for claims submitted by Geo Preferred Providers with whom the Geo DCE has financial arrangements. Please reference the Request for Application for additional detail on the Capitation Payment Mechanisms. • Total Capitation • Partial Capitation	Required (but not evaluated)
		Please enter what percentage of the organization's total revenues in the organization's last fiscal year was derived from the following sources. i. Medicare Risk-Based Agreements ii. Medicare Advantage Health Plan iii. Medicare Advantage Risk-Based Agreements iv. Commercial health plans v. Commercial Risk-Based Agreements vi. Medicaid health plans vii. Medicaid Risk-Based Agreements	The organization has majority of revenue or large portion of revenue coming from value-based contracts either as a health plan or a risk-bearing health care provider.
		Briefly describe your experience and capabilities to	The organization

Application Section	Points	RFA Field/Question	Associated Scoring Criteria
		implement risk-based and outcomes-based contracts, including payment and IT systems, provider/supplier engagement, and data analytics. Briefly describe how this has been informed by your experience to date with risk-based and outcomes-based contracts. This response may include, but does not need to be limited to, prior ACO, Geo DCE, MA, or other program experience.	demonstrates entering into formal partnerships or other contractual relationships with health care providers or other entities that utilize the following systems and processes: - IT or claims system that can automate capitation payment. - Data analytics to support risk pools - Provider/supplier engagement - Financial systems (reports, reconciliation, finance resources)
		Describe specific at-risk (value-based, shared risk, partial capitation, full capitation) contracts including number of beneficiaries or members under these relationships, duration of these relationships and either the annual revenue (if an ACO) or the annual expenditure (if a health plan) for 2019 or the latest full performance year or contract period. If applicable, please describe the applicant Geo DCE's performance under prior or current outcomes-based contracts. For this purpose, outcomes-based contracts are defined to include: (1) financial accountability; (2) evaluation of patient experiences of care; and (3) substantial quality performance incentives. If applicable, please include performance under CMS programs, demonstrations, and models that meet the definition of outcomes-based contracts. Check N/A if no prior or current risk-sharing arrangements. Please also indicate the number of covered lives in outcomes-based contracts with any of the applicant Geo DCE's proposed Geo Preferred Providers.	The organization documents significant degrees of financial risk and revenue derived from outcomes-based contracts, as well as experience with outcomes-based arrangements at a level that indicates the capability to manage these arrangements for the number of beneficiaries the Geo DCE is planning to serve under this model.
		Describe your experience in distributing funds (either through claims or value based payments) to	The organization demonstrates experience

Application Section	Points	RFA Field/Question	Associated Scoring Criteria
		contracted providers and suppliers. Value-based payments can include quality incentives, clinical performance bonuses, partial capitation, shared risk or full capitation arrangements, including the systems and process to ensure accurate and timely payment	distributing funds to providers and suppliers with which it has written agreements. The experience should include the use of the following: • Systems • Financial controls • Audits • Payment Review • Appropriate staffing
		For the outcomes-based contracts above, please describe the reductions in medical expenditures achieved and improved care quality without resulting in underutilization.	The organization demonstrates ability to achieve appropriate reductions in medical expenditures through previous outcomes-based contracts, including mechanisms to ensure monitoring of under-utilization.
		Please upload a completed proposed discount tool indicating your proposed discount relative to the benchmark.	Required, scored as part of the proposed discount review process.
		Please provide additional narrative and/or documentation supporting the assumptions underlying the utilization and cost factors included in the bidding tool. If contained within the organization's utilization and cost assumption, please specifically provide supporting information about the organization's experience and capabilities, or plans to work with a vendor, around implementing program integrity programs, including the types of programs implemented, the strategies utilized, including the systems, criteria, staff, beneficiary, provider, and supplier notification and outreach, and performance metrics to ensure appropriate decision making. Include your prior experience and your plan as a Geo DCE if applicable regarding the following: • Experience and ability implementing claims edits;	The organization describes a credible plan supporting the assumptions underlying the utilization and cost factors, including types of programs implemented and the strategies used, appropriate protocols, processes, staffing, etc.

Application Section	Points	RFA Field/Question	Associated Scoring Criteria
		• Approach to either pre-service or post-service clinical reviews, including pre-payment and post-payment reviews; • Abilities to do data analysis, health care provider practice pattern analysis and education for appropriate utilization; • Approach to monitor for over- and under-utilization; and • Any outcomes of these program integrity programs (e.g., trend mitigation and/or savings).	
		Given the model's goals of improving health and reducing costs, please describe how the applicant organization intends to fund the Geo DCE in line with model requirements including, where applicable, Geo DCE clinical and other operations, provider/supplier payments, and beneficiary engagement incentives. The Geo DCE's savings and funding plan should include credible estimates of care improvement and cost savings that do not harm beneficiaries or health care providers. Develop a three-year pro forma to include an income statement and statement of cash flows. To the extent applicable, please describe: i. Savings assumptions anticipated by year against the performance year benchmark; ii. Method to fund Geo DCE operations, including quality programs, beneficiary outreach, and other functions; iii. Method to fund BEIs for beneficiaries; and iv. How any potential losses will be financed.	The organization's funding approach demonstrates a credible plan to achieve the three-part aim of better health, better care, and lower costs, including a documented plan for funding care management programs and items and services not covered by Medicare, such as beneficiary engagement incentives and costs related to leveraging community resources to improve health and lower costs in the region. The plan should include savings assumptions and credible methods to achieve them while not harming beneficiaries or health care providers
		Please describe how the applicant Geo DCE plans to ensure payment to Medicare of its Shared Losses, if any, relative to the Performance Year Benchmark as well as any Other Monies Owed. Those plans should include funds placed in escrow, using a line of credit, a surety bond, or propose an alternative financial guarantee mechanism for approval by CMS that complies with all applicable state laws and regulations regarding provider-based risk-bearing entities.	The organization provides a credible plan for ensuring repayment to CMS if losses occur and demonstrates it has the financial capacity to manage risk, including being able to provide financial guarantees and demonstrate that it can

Application Section	Points	RFA Field/Question	Associated Scoring Criteria
		Any proposed alternative approach should address the following: state requirements, including attesting that they apply to the Geo DCE, and how the proposed financial guarantee mechanism will offer sufficient protection to CMS for any Shared Losses or Other Monies Owed under the model. In addition, choose one option below: i. Escrow ii. Line of Credit iii. Surety Bond iv. Other to be approved by CMS	incur financial losses and make repayments to CMS.
		All Geo DCEs that are organized as a subsidiary company must obtain a financial guarantee from its parent organization. Please indicate agreement with this requirement.	The organization has agreed to provide a parental financial guarantee, if necessary.
		Please indicate any bankruptcy or failure to pay its financial commitments for the Geo DCE or its parent and affiliate, or any owner with over 10 percent ownership in the Geo DCE within the past 10 years.	Any bankruptcies for the Geo DCE, its parent or affiliates.
Patient Centeredness and Beneficiary Engagement	15	Please describe the approach and strategies that the applicant Geo DCE will use to conduct beneficiary outreach and education about all aspects of the model including, Geo DCE operations, Geo Preferred Providers, BEs and BEIs, and care coordination. Please indicate experience with conducting outreach to racial and ethnic minorities, sexual and gender minorities, individuals with a disability, rural or underserved areas, and individuals with limited English proficiency. Please describe any specific factors that may be most relevant to the given target region.	The organization offers a feasible plan to conduct patient outreach and education including multiple modalities – outbound calls, call center, web site, mailings (letter, brochure), stakeholder outreach (e.g. advocates, SHIPs). The organization demonstrates experience with multiple languages, including translation services, the ability to produce materials and web sites in multiple languages. The organization demonstrates an

Application Section	Points	RFA Field/Question	Associated Scoring Criteria
			approach that addresses health literacy and cultural diversity. The organization demonstrates an approach to explaining the model, the Geo DCE, preferred providers, and benefit enhancement and beneficiary engagement incentives in a way beneficiaries can understand. The organization demonstrates experiences with beneficiary advocates and other community stakeholders.
		Please describe the process to ensure patient/caregiver engagement and shared decision-making processes employed by providers take into account the beneficiaries' unique needs, preferences, values, and priorities. Mechanisms for promoting patient engagement include, but are not limited to, the use of decision support tools, shared decision-making, and personalized care plans.	The organization demonstrates the ability to meaningfully engage patients in their care, taking into account patient preferences and choices. The organization demonstrates the use of systems and practices that document beneficiary needs and goals, share treatment and care plans with caregivers and other providers, and address health

Application Section	Points	RFA Field/Question	Associated Scoring Criteria
			literacy.
		Please describe plans to routinely assess beneficiary and caregiver and/or family experience of care and to utilize this feedback to improve care.	The organization offers a credible plan for assessing experience of care and using that data to support improvement that includes considerations for caregiver burnout
		Describe past and planned efforts to engage members of vulnerable populations, ensure access to culturally and linguistically appropriate services, and address disparities; include estimates of what vulnerable populations exist in the target region.	The organization appropriately identifies relevant populations and offers credible strategies for engaging all members of the population in care and addressing disparities through beneficiary education, care management, types and capabilities of Geo Preferred Providers, and special programs.
		Please describe how the Geo DCE will ensure that beneficiaries have access to their own medical records.	The organization offers a credible plan for providing beneficiary access to medical records.
		Please describe the existing, or planned, approach towards customer service including call center operations.	The organization provides a specific and feasible customer service strategy that includes call center operations with technology, process, employee training, employee monitoring, call documentation, and call routing.
Quality and Clinical Process Improvement	20	Describe experience and overall approach to improving quality for Medicare beneficiaries. The approach should address at a minimum i. Implementing and managing physician engagement programs around quality ii. Beneficiary engagement including addressing cultural diversity, multiple languages and health literacy iii. Reporting and data analytics to support	The organization demonstrates past experience designing, implementing, and assessing the effectiveness of specific care/quality improvement interventions. The organization documents success at implementing quality improvement efforts

Application Section	Points	RFA Field/Question	Associated Scoring Criteria
		improvement in quality iv. Physician incentives v. Programs to address health disparities vi. Experience with or plans related to quality improvement on the measures included in the Geographic Direct Contracting Quality Measure set. If applicable, include a description of any formal, third-party assessments of quality improvement programs within the past 3 years (2018-2020) of the Applicant Geo DCE's performance on quality of care metrics relative to peers.	and provides a plan for improving quality of care using Geo model's quality measure set. The organization demonstrates past experience with implementing and managing programs to improve beneficiary engagement around quality including: data analytics, beneficiary engagement programs, use of BEs and BEIs to support quality, health care provider education, provider incentives, program development and remediation of underperformance, and addressing health and income disparities.
		Please provide a narrative description and quantitative documentation of at least one illustrative instance in which the applicant organization has designed, implemented, and assessed the effectiveness of specific care improvement interventions. Include information on how the problem(s) were identified, why and how the intervention(s) were selected and designed, how progress (or lack thereof) was measured, and any corrective action or adjustments were made.	The organization provides evidence of a quality improvement plan that includes goals, measurement, interventions, evaluation, and modification of the plan in the instance the organization does not meet goals.
		Demonstrate the ability to perform ongoing data collection, analysis and reporting to support quality improvement and decrease healthcare costs, including provider score cards, utilization patterns, and other performance metrics.	The organization offers significant analytic capabilities to support quality.
Provider Partnerships	15	Please describe your experience and approach with health care provider partnerships, including the types of provider contracts and agreements utilized, the organizational structure to support contracting, and the technology utilized to manage agreements.	The organization demonstrates existing health care provider partnership capabilities and provides a reasonable approach to contracting with Geo Preferred

Application Section	Points	RFA Field/Question	Associated Scoring Criteria
			Providers, including experience from other similar programs. The organization demonstrates experiences that include provider/supplier targeting, data analytics, standard contracts, and provider/supplier outreach, either electronic, telephonic, or in-person.
		Please describe your experience and approach with health care provider education on the programmatic requirements detailed within the RFA, including, but not limited to, the ability to educate health care providers regarding benefit enhancements, beneficiary engagement incentives, and quality. Please detail the different strategies, processes, and systems utilized. Include the key approaches to ensure health care providers are aware of and comply with model requirements including benefit enhancements and beneficiary engagement incentives, Medicare billing and payment rules, data privacy and security, payment integrity and medical review to validate items and services are medically necessary and billed according to coding and coverage rules, and beneficiary rights. Include methods and frequency of education (e.g., in person, virtual, web site).	The organization describes a detailed and reasonable approach to health care provider education on all programmatic requirements detailed with the RFA, including the ability to educate on Geo DCE requirements, benefit enhancements and beneficiary engagement incentives, and quality. The organization demonstrates the capability to use multiple provider education modes, including web-based, in-person, joint operating committees, newsletters, email updates, and classes.
		Demonstrate capabilities, experience and outcomes through contracting strategy and/or health care provider engagement to advance clinical integration to include, if applicable, behavioral health, home supports, social determinants of health, and pharmacy.	The organization demonstrates experience with contracting with behavioral health providers, pharmacists, and organizations that provide services to address social determinants of health (e.g., transportation, meals), home health or other unique programs.

Application Section	Points	RFA Field/Question	Associated Scoring Criteria
			The organization provides evidence of health care provider education and training (materials, visits) that contain strategies to identify complex needs and educates health care providers on how to access these services (newsletters, visit agendas, vendor management/outreach, web)
		Please provide the estimated number of Geo Preferred Providers by types: 1. Primary Care Physicians (General Practice, Family Practice, Internal Medicine, Geriatrics) 2. Specialists 3. Acute Inpatient Hospitals 4. Post-Acute Facilities 5. Home Health	The organization demonstrates a preferred provider network that includes a large number of expected providers and suppliers, including adequacy of diverse provider and supplier types.
		Please describe your experience in implementing call centers, help lines, or other strategies to assist health care providers with claims questions, adjustments and other payment issues, contract status, eligibility, program requirements, appeals.	The organization describes a detailed and reasonable approach to health care provider support including addressing claims questions, adjustments and other payment issues, contract status, eligibility, program requirements, appeals. The approach includes information on processes, staffing, training, and auditing.
Care Management	20	Please describe the organization's historical and future plans to achieve better health, better care, and lower costs through integrated and coordinated care interventions. Please address the following in your narrative: i. The applicant Geo DCE's historical use and approach to care planning including risk stratification, health assessments, care plan development, and use of interdisciplinary care teams to coordinate care for patients, and benefit coordination;	The organization provides a comprehensive overview of approaches to care management, including but not limited to the ability to identify at-risk or emerging risk beneficiaries through stratification, the use of interdisciplinary, technology-enabled care, support of patient-centered care plans and treatment plans that

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		ii. The applicant Geo DCE's historical and future planned use of health information technology, including the use of population health management tools including evidence of engaging beneficiaries in their own health and symptom management, and the use of technology and processes to improve clinical care including sharing information among health care providers and care team members, identifying and resolving care gaps, and developing and managing care and treatment plans, including any innovative examples of facilitating remote monitoring and/or telemedicine; iii. The applicant Geo DCE's strategies to leverage a diverse set of practitioners with the necessary areas of expertise and appropriate staffing to meet the needs of a complex set of patients, including the ability to intervene appropriately and timely to prevent exacerbation or reoccurrence of acute events; iv. The approach and experience working with various care providers and ensuring alignment on care and treatment plans; v. The approach to coordinating care throughout an episode of care and during care transitions, such as discharge from a hospital or transfer of care between health care providers, including use of technology as appropriate (e.g., sharing of electronic summary records across health providers, telehealth, remote patient monitoring, other enabling technologies); and vi. Incorporating medication management; and vii. Additional specific care interventions and tools.	address beneficiaries' goals, and systems to follow up and address beneficiaries' needs and goals as they change. Include all required elements: • Risk stratification - use data analytics • Health risk assessments – regularly updated • Interdisciplinary teams and other care management teams • Use of care management and EHR system to track beneficiary goals, treatment plans, including functionality to follow up • Use of multi-disciplinary care including of behavioral health and pharmacy • Address SDOH in care planning • Population and disease management programs • Methods to increase preventive services • Programs to address health disparities • Methods to engage beneficiaries, care givers • Ability to engage beneficiaries in self-management • Use of telehealth and/or remote monitoring
		Please briefly describe how the Geo DCE will support care integration with community resources to address health-	The organization has a track record of meaningful

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		related social needs and link beneficiaries and their caregivers with services to support community living. Describe both existing and planned organizational partnerships (e.g., with local public health and community-based organizations and social service providers, including but not limited to aging/disability partners like Area Agencies on Aging and Centers for Independent Living) as well as planned processes for integration into patient care (e.g., referral resources, assessment of social needs within care management).	community partnerships and/or care integration with community-based resources (such as local aging/disability partners) and a plan for addressing social determinants of health through linkages and community partnerships. Addresses: • Ability to identify community resources and include them in patient care • Use of stakeholders to engage and educate beneficiaries • Coordination of these services into the organization's care management and other strategies to avoid duplication
		Please describe your experience with implementing and managing benefit enhancements, beneficiary engagement incentives and/or supplemental benefits in an ACO, DCE, or Medicare Advantage context. Please describe the types of beneficiary engagement incentives offered, and the strategies used to design, implement and track their use. If the organization previously participated in a CMS model that allowed for the use of benefit enhancements or the Medicare Shared Savings Program, please identify the benefit enhancements used, and describe how they were implemented and contributed to overall care management and improved health outcomes. Please describe the benefit enhancements and beneficiary engagement incentives that you propose to implement as a Geo DCE, including the planned amount, duration and scope as well as the criteria by which beneficiaries will	The organization demonstrates past experience in providing the types of benefits that will be included as benefit enhancements or the incentives that will be included as beneficiary engagement incentives. The organization provides clear proposals for how it will leverage BEs/BEIs as part of overall care improvement and will ensure consistent use of these services and incentives. Include: • Criteria of how these benefits will be offered and

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		access these services and incentives. Describe how they will contribute to your overall care management and improved health outcomes and lower costs. Describe how the Geo DCE and its Geo Preferred Providers will implement BEs and BEIs in a fair, consistent, and timely manner and any monitoring or education efforts to support this goal.	these incentives will be earned • Method of delivery of these benefits and incentives • Methods to ensure timeline and consistent application of these benefits and incentives • Size of investment into of BEIs compared to other applicants
		Please describe the clinical system that will be used to identify and track beneficiaries' conditions, assessments, care and treatment plans, appropriate follow up, and goals. System should have the demonstrated ability to share information appropriately with the beneficiary and their care providers.	The organization possesses a robust clinical data infrastructure to facilitate care management and the delivery of patient-centered care. Includes key features: • Complies with HIPAA and other applicable data privacy laws • Stores beneficiaries demographics, contacts, goals, treatment plans • Supports Interdisciplinary Team (IDT) or cross provider/discipline collaboration • Triggers tasks and follow up actions to ensure good patient care
		Please describe the applicant Geo DCE's existing, or planned, approach for evaluating beneficiary satisfaction (including but not limited to satisfaction with access and quality of care, such as choice of providers, suppliers, and care settings) in addition to any CMS-required beneficiary experience surveys and how the Geo DCE intends to use such information to	The organization possesses mechanisms to evaluate patient satisfaction and use this data to support care improvement. Include: • Use of CAHPS®

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		improve its care management and coordination processes. Include examples of programs to improve beneficiary satisfaction.	data • Sharing satisfaction data with affiliated providers and suppliers • Creating credible plans to improve satisfaction (e.g., better education, new benefits, new providers/suppliers, simplify procedures)
Compliance	15	Please provide historical compliance work plans for the past three years.	The organization demonstrates proactive efforts at effective identification and monitoring of compliance risks.
		Demonstrate prior experience implementing a compliance program, including personnel recruitment; leadership and board oversight; education and training; development of policies and procedures; and use of auditing and monitoring, including any risk-based, targeted initiatives.	The organization demonstrates experience with implementing compliance programs through multiple types of compliance activities.
		Describe programs to ensure Geo Preferred Providers adhere to the Geo model requirements and overall Medicare fee-for-service rules, including non-discrimination, freedom of choice, beneficiary protections, and Medicare coverage and coding requirements.	The organization has a clear plan for ensuring Geo Preferred Providers comply with Medicare fee-for-service policies through education programs, contract requirements, joint operating committee topics, and use of corrective action plans.
IT Systems	5	Please provide a clear and detailed plan for how the Geo DCE will ensure that the percentage of Geo Preferred Providers that are eligible clinicians that use CEHRT to document and communicate clinical care to their patients or other health care providers meets or exceeds the CEHRT use criterion for Advanced APMs at 42 C.F.R. §414.1415(a)(1)(i).	The organization's plan related to CEHRT requirements is clear and detailed.
		Please describe the Geo DCE's proposed overall approach to operationalizing model features (e.g., care	The organization demonstrates a clear plan

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		management, benefit enhancements, beneficiary engagement incentives, utilization management, population health management, beneficiary and provider engagement) through its technology platform and functions or concrete plans to develop and invest in such tools. Please include the proposed Geo DCE's capabilities to utilize tools to retrieve bulk Medicare claims data related to the Geo DCE's aligned population for purposes of care coordination and quality improvement activities.	to leverage technology to operationalize key program features.
		Please describe the system to support Geo DCE operations and claims and value-based payment including systems, staffing, and processes to ensure accurate and timely payment. Please provide any relevant statistics.	The organization demonstrates a clear plan to execute provider and supplier payments, which includes staffing, systems and processes to ensure accurate and timely payment to providers and suppliers.
		Please describe the organization's systems, processes, and controls for protecting the privacy and security of data in accordance with the HIPAA Privacy and Security Rules, as well as applicable state laws and regulations.	The organization demonstrates a comprehensive set of systems, processes and controls to ensure data privacy and security.
		Please describe the organization's IT disaster recovery plan.	The organization provides a clear and detailed IT disaster recovery plan.