MILLIMAN WHITE PAPER

New Geographic Direct Contracting Model is a game changer

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On December 3, the Center for Medicare and Medicaid Innovation (CMMI) released a fact sheet[1] and related information on the Geographic Direct Contracting Model (Geo). While Geo shares some general characteristics with the other Direct Contracting (DC) Model Options, it is a fundamentally different approach in many key respects.

Perhaps most importantly, for the regions selected by CMMI to be part of Geo, the vast majority[2] of Medicare fee-for-service (FFS) beneficiaries in the region will be assigned to one of the Geo Direct Contracting Entities (DCEs) in that region. These DCEs will take on full risk with 100% shared savings/losses for the cost of those beneficiaries' Part A and B services. In addition, the current timeline for decision-making is very compressed—non-binding Letters of Interest (LOIs) (where participants indicate which of the proposed regions they would like to see in the final program) are due December 21, 2020, and the Request for Applications (RFA) will be released in January 2021. Applications will be due April 2, 2021, and the performance period will begin on January 1, 2022.

The Geo model is being rolled out amid a presidential transition, which introduces additional uncertainty into the model, particularly for model parameters CMMI has not yet specified (e.g., the Geo rate book rates). As of the date of publication, it remains to be seen what, if any, changes the new administration may seek to make to the Geo model.

In short, while the new Geo model may provide a great opportunity for health plans and health systems in certain regions, it may also pose a more significant challenge than previous models have. By performing regional analyses now, healthcare organizations in the Geo regions can be well positioned to capitalize on the opportunities and minimize the threats.

Similarities across DC models

As with the DC Global and Professional Models, the Geo Model provides an opportunity for entities to shift their Medicare FFS population towards value-based care (VBC). All DC models provide DCEs with the ability to accept capitation and also allow for some of the enhanced care management tools needed to support VBC, e.g., beneficiary engagement incentives, enhanced Medicare benefits, and reduced beneficiary cost. Beyond that, however, Geo is materially different from the other DC models both at its core and in a number of important details.

KEY DIFFERENCES BETWEEN GEO AND OTHER DC MODELS

Some of the core differences between the Geo Model and the DC Global and Professional Models relate to:

- Geo DCE eligibility requirements
- Beneficiary alignment to Geo DCEs
- Criteria used to select regions and Geo DCEs within each region
- Geo's relative position on a VBC spectrum

Each of these is discussed in further detail below.

[1] https://innovation.cms.gov/media/document/dc-geo-fact-sheet

[2] Medicare FFS beneficiaries will only be included in the Geo model if they satisfy the following requirements:

- Are enrolled in both Medicare Part A and B
- Are not enrolled in a Medicare Advantage (MA) plan, Medicare-Medicaid Plan (MMP), cost plan, PACE organization, or other Medicare managed care plan
- Have Medicare as a primary payer
- Are a resident of the United States
- Have their address of record be in one of the selected regions

Geo DCE eligibility requirements

Participants in the model must be covered entities under the Health Insurance and Portability Accountability Act (HIPAA) and must have "significant experience taking risk in VBC models." [3] This means that Geo allows health plans to be DCEs. This is understandable given that almost all of the Medicare FFS beneficiaries in a Geo region will be assigned to one of the Geo DCEs – meaning successful DCEs will most likely need to have strong infrastructure, significant capital, and an ability to move quickly to be operational on January 1, 2022.

Beneficiary alignment to Geo DCEs

Because Geo is intended to cover the vast majority of Medicare FFS beneficiaries in the region, beneficiary alignment includes several additional steps beyond those used for the Global and Professional Options. In order of precedence, beneficiaries will be aligned to Geo DCEs as follows:

1. Voluntary alignment—Similar to voluntary alignment for the other DC options
2. Medicaid Managed Care Organization (MCO)-based Alignment—For Geo DCEs that include an MCO, dual eligible beneficiaries who are in Medicare FFS will be aligned with that Geo DCE
3. ACO-based alignment—A Geo DCE can arrange with a Medicare Shared Savings Program (MSSP) ACO to align the MSSP's beneficiaries in that region to the Geo DCE (capped at 50% of DCE enrollment allocation)
4. Claims-based Alignment—Similar to claims-based alignment for the other DC Options (in combination with ACO-based alignment, capped at 50% DCE enrollment allocation)
5. Random alignment—Remaining eligible beneficiaries in the region will be randomly aligned across Geo DCEs in the region.

The Centers for Medicare and Medicaid Services (CMS) might also exclude beneficiaries aligned to a Standard Global DCE from Geo.

Criteria used to select regions and Geo DCEs within each region

CMS has proposed 15 potential regions, defined as individual Core Based Statistical Areas (CBSAs), for the program and CMS will narrow these down to a final selection of 4 to 10 regions when they release the RFA in January. Figure 1 provides our estimates of the potential Medicare FFS beneficiaries and payment amounts by region.

FIGURE 1: POTENTIAL MEDICARE FFS BENEFICIARIES AND MEDICAL PAYMENT AMOUNTS BY REGION

Region (CBSA)	Medicare FFS Beneficiaries	PMPM	Medicare FFS Payments (in Billions)
Los Angeles	780,000	$1,079	$10.1
Philadelphia	658,000	$894	$7.1
Miami	412,000	$1,054	$5.2
Dallas	491,000	$900	$5.3
Detroit	427,000	$931	$4.8
Houston	379,000	$962	$4.4
Atlanta	404,000	$730	$3.5
Phoenix	374,000	$751	$3.4
Tampa	278,000	$939	$3.1
Orlando	194,000	$869	$2.0
Riverside	218,000	$868	$2.3
San Diego	209,000	$828	$2.1
Denver	169,000	$759	$1.5
Minneapolis	173,000	$730	$1.5
Pittsburgh	154,000	$733	$1.4

The numbers shown in Figure 1 have been developed using 2018 fee-for-service Aged and Disabled beneficiary counts and medical payment levels (paid claims) from the 2021 Medicare Advantage rate book. They have been adjusted to estimate data for beneficiaries that are enrolled in both Medicare Parts A and B. Where available,

[3] https://innovation.cms.gov/media/document/dc-geo-fact-sheet

beneficiary counts have been updated to reflect those provided in the GeographicDirectContractingModel-DataBook_1_15_21. The values shown are not risk-adjusted. Regions are defined using Core-Based Statistical Areas (CBSAs).

The LOI (due December 21, 2020) asks potential applicants to rank their interest by region. Although neither mandatory nor binding, the LOI provides a valuable opportunity for potential applicants to influence CMS's final selection of regions.

In addition to identifying the final Geo regions, the RFA will include other key information for potential Geo DCEs to use when developing their applications:

- The minimum and maximum number of DCEs for each region. This will be based on the number of eligible beneficiaries in each region and is expected to range from three to seven DCEs. Each Geo DCE will be aligned a minimum of 30,000 beneficiaries; there is no maximum beneficiary limit.
- Aggregate historical data by region.

The RFA will require applicants to propose annual discounts as a percentage of the region's performance year benchmark for each year in the first performance period (2022-2024). Only applicants with proposed discounts between a regional minimum (expected to be 2% to 3%) and a regional maximum (expected to be between 8% and 9%) will be eligible to be selected.

CMS will then use a two-step process for selecting DCEs in each region:

- DCEs will first be assessed to ensure they meet or exceed model requirements pertaining to compliance and organizational structure (using a nine-domain rubric and a predetermined scoring threshold).
- For DCEs meeting this threshold and whose discounts are in CMS's "acceptable percentage ranges" (which are expected to be those listed above), CMS will choose those applicants with the highest weighted average discount for the performance period (weighted 40% PY1, 30% PY2, and 30% PY3) to be the Geo DCEs for the region. This aggregate discount will also affect the "Enrollment Allocation" for each Geo DCE in the region.

Geo's relative position on a VBC spectrum

CMS has designed Geo to enable DCEs to move further along the VBC spectrum than the other DC Models by taking financial responsibility for all of a region's Medicare FFS beneficiaries whether or not they directly interact with those beneficiaries. To that end, Geo DCEs will be empowered with a handful of tools such as:

- Certain utilization management tools such as "prior authorization, concurrent or pre-claim review, pre-payment claim edits, and pre-payment and post-payment medical and payment review."[4] This will likely spark the interest of health plans or integrated health systems with their own provider health plan to be Geo DCEs due to their experience with utilization management and claims processing infrastructure.
- Flexibility to subsidize Part B premiums and lower beneficiary cost sharing at preferred providers.
- New benefit enhancements to facilitate better care management, including Hospital at Home and nurse practitioner scope of practice waiver.
- Contracting with community organizations to better integrate clinical care and social needs of beneficiaries.

In addition, CMS plans to play an active role in the initial outreach to and education of Geo beneficiaries –likely more than it has for other models.

OPPORTUNITY/THREAT ANALYSIS

As part of their process of evaluating the Geo model, health care organizations in the potential regions need to consider not only how they will be affected if they are one of the Geo DCEs in their region, but also how they will be affected if they aren't. This analysis may be very different from region to region. Some of the most important issues to examine include:

- Operational readiness
- Business impact of not being one of (or partnered with one of) the Geo DCEs (e.g., shifting utilization patterns, changes in referrals, etc.)
- Analysis of applicant's cost level relative to regional cost level in order to assess potential savings opportunity
- Beneficiary alignment strategy relative to likely market competitors to optimize member assignment
- Provider and payor contracting strategy to maximize revenue under the arrangement
- Comparative advantage in utilizing available enhanced care management tools
- Ability to earn back quality withhold and potential high-performance bonus
- Evaluation of improvement opportunities (e.g., cost, quality, provider satisfaction) associated with taking on certain program integrity functions
- Potential accountable care organization (ACO)/managed care organization (MCO) partnership opportunities in order to leverage the impact of other organizations' care management tools to generate savings

[4] https://innovation.cms.gov/media/document/dc-geo-fact-sheet

- How the program could affect populations in other Medicare FFS risk contracts (i.e., MSSP, BPCI Advanced, DC Professional and Global, etc.)

Other details of the Geo model—many of which are still in the process of being fully defined—should also be considered. These include:

- Effect of financial parameters unique to the Geo model (e.g., large penalty for withdrawal prior to end of performance period, smaller quality withhold, risk score normalization, 5% administrative load adjustment, effect of Geographic Rate Book once known, etc.)
- Evaluating Geo Preferred Provider strategy in light of unique elements of Geo Model such as:
  - Geo Preferred Providers are something of a hybrid of the DC Global and DC Professional Option Participant Providers and Preferred Providers. There are no Participant Providers in Geo.
  - Providers who don't affiliate with a Geo DCE will still be paid 100% of Medicare FFS rates and their fees will accrue to the Geo DCEs

While the model is not yet fully defined, healthcare organizations in the 15 proposed regions have a narrow window of opportunity to analyze their market position and determine whether or not the Geo DC model is a good fit for their organization.

Conclusion

The introduction of the Direct Contracting Geo has the potential to be a large opportunity for some organizations. However, potential participants will need to be fully aware of the intricacies of the model in order to understand whether or not they are well positioned to succeed in their target region(s). The potential for upside in the Geo model is balanced with a significant downside risk exposure. Considerable planning and preparation will be critical to success in this program.

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