Direct Contracting Payment Part 1 Office Hours

February 4, 2020

Recording Transcript

My name is Corey Rosenberg, I'm one of the two co-model leads for the Direct Contracting Model. Today we're going to be covering payment and finance related questions. I'll be doing that along with my colleague Yoni Kozlowski who is the Finance Lead for Direct Contracting. You may recognize our voices from the past two payment focused webinars. A couple of notes I want to point out before we dive into the questions. As I mentioned today, the focus really is on payment, finance, other risk mitigation, reconciliation, other sort of financial related components of the model. We are going to have another office hours next week that's on the 11th. That will be because it's the last in this series, it will be more of a general focus. We do expect to get a lot of finance related questions. We'll have plenty of time to talk about that. But to the extent that folks have questions on other topics, we're going to make some time to speak to those next week as well.

To the extent that it's helpful to reference some of the past materials that we've shared, you can find the two payment-focused webinars available for download on our website as well as in the bottom right corner of your screen where it says download files here. You can find those webinars along with some FAQs and the RFA. Please reference those to the extent that it's helpful.

One more thing to point out before we dive in, we've broken down a bunch of your questions into topic headings here listed on the slide. We've been collecting questions. We don't always get to every single question in every webinar and a number of questions come into our help desk as well, so we've been collecting all those questions. We will start off by, within each section, speaking to a couple of questions that have already come in that we see are sort of commonly asked, and we expect that it will be helpful to talk about. Then we'll also be doing our best to incorporate any questions that are asked live today in each of the section headings. We're going to move throughout the presentation one by one, when we get to the open Q&A at the end that will be a chance to speak to any questions that we haven't been able to address today. For any questions we don't get to, especially those that are non-financial related, that will be -- we're going to record all those questions and then you can expect to hear answers to as many as we can get to in next week's office hours.

Okay, so with that said, let's dive into our first topic, which is payment mechanisms. I'm going to start off with a question that we received, this is really overarching all across the topics, before we dive right into payment mechanisms. When can we expect the full detailed financial methodology and specifications to be released? I'm sure this is a question on a lot of people's minds, so I just want to give you guys a little bit of insight into the timeline here.

Our team plans to release a series of financial specification papers, and these will include details on the financial benchmarking methodology; on payments, both Total Care Capitation and Primary Care Capitation; as well as the Advanced Payment Option within Primary Care Capitation. They will cover the adjusted Medicare Advantage Ratebook and how the regional

expenditure factor will be calculated and factored into our benchmark. They'll cover our risk adjustment policy, financial reconciliation, and risk mitigation as well. There will be a lot more details coming, we expect to release these papers throughout the spring throughout the next couple of months, so please stay tuned for that.

Similarly, a question that stakeholders have asked is when applicants will receive their provisional benchmark, and what essentially will be factored into that? Will there be provisional risk scores included in that? We've had a bunch of questions like this, when can we get PBPM information on our attributed population to make the decision on whether or not we want to participate, or when will we release the performance year benchmarks? The answer to this question is that once the participant lists are finalized, so with the IP application, we're going to asks for your initial participant lists, then we're going to give applicants the opportunities to update that lists in late summer, early fall.

Once the participant list is finalized for performance year one, at that point we'll be able to use that participant list to, one, just determine the final provisionally aligned population. Then based on that attribution, what the provisional benchmark will be for the DCE performance year one. That benchmark will include placeholder risk scores and quality scores as well as GAF adjustments, geographic related adjustments that are driven by where the aligned beneficiaries live. The information there will be the best information that we have at that point in time.

Obviously, as we talked about in past webinars, certain information like the historical baseline, once we have the provider list, the participant list finalized, that component won't change. But there are other components that will change and the risk adjustment, the GAF, and the quality are three components that throughout the year we will have better data on. You can expect to have those updated throughout the year, but the provisional benchmark will be provided to awardees, I should say, in late fall, early winter, that will be used for applicants to make their participation decisions. That benchmark will vacant provisional estimates for the risk score, the quality, and the geographic adjustment.

One more general question before we dive deeper into the payment focus here. Someone asked, when would the geographic option LOI be available? That's a separate process. We're going to release more information about that in the coming months. But at this point, just want to make it clear that our focus right now is on providing information about the global and professional tracks given the fact that these are the tracks that the IP application is open for, and the PY1 application will open later this spring. You can stay tune for more information about the geographic track.

I want to tackle a question now specific to the payment mechanisms, which is a good question here. It says how will CMS come up with the Total Care Capitation withhold amount for new entrant DCEs if they have no previous fee for service experience? Basically, as we covered in our payment webinars, the general principle is that we want to make capitation payments on a prospective basis, and the estimates for those will be based on the historical experience for how DCEs in their participant and preferred providers have cared for the aligned beneficiaries. For provider sets that comprise a larger portion of care, the capitation payments would be

larger in Total Care Capitation versus for participants that provide a small amount of care it would be smaller.

The question here is, well, what happens if there's no claims history to base that on? That's a good question. Let me say first that we expect that essentially all entities will have some claims history that we can base an indication of what the capitation payment will be. Even if you're a new entrant or even if you're a high need patient or you're relying on voluntary alignment, if your patients aren't agents, or if all your patients aren't agent, you'll have some portion of patients that we expect will have some claims history that will be able to inform our estimate of capitation. We're expecting that this situation won't come up very often. But that said, I think the question is still valid, what happens when there's just not enough history to make an accurate prediction? That's something that we'll assess on a case by case basis for a given DCE. We'll look at how much history exists. We'll take that history and decide to what extent it is enough to make an accurate prediction about capitation payments.

In the case that there's insufficient data to do so, then we would consider an option where we would essentially provide infrastructure payments or you can think of it as Enhanced Primary Care Capitation payments that are not included in the benchmark or the capitation to give the entity some cash flow upfront. Then we would delay the capitation payment, and hopefully a short number of months until we have aggregated enough history where we can make an accurate prediction of what the capitation amount would be. That's how we're planning to handle those cases. But I do want to caveat, we don't expect this to be the norm, and we'll handle this on a case by case basis once we see the awardees and their participant lists are finalized.

A similar question came up which is under the Total Care Capitation, how are leakage reduction handled from the fee-for-service, non-capitated providers into the capitated providers from year-to-year? Let me just provide a little bit more context around what this question is getting at. In Total Care Capitation, we start with our benchmark, and then in order to get the capitation amount that's paid on a perspective basis, we look again, as I was just describing in the previous question, we look at the historical utilization, and we figure out how much flows through the participants who are taking capitation, and how much flows through unaffiliated providers or preferred providers that aren't taking capitation. The amount that flows through those providers that aren't taking capitation is what we call the withhold.

The question in here is, if the DCE has a number of participant providers creates a sort of a pseudo network, obviously, the beneficiaries maintain full choice around what providers to see. But the DCEs we expect will create pseudo networks with a providers that they want to work with more often, and we expect that one lever that the DCEs have is that referral patterns can change over time. That may mean that the capitation payments that are set based on historical referral patterns may not accurately reflect the capitation payments needed to basically account for the care as it's being provided in the performance year.

The answer to this question is that we'll essentially be adjusting the capitation payments to account for this on an ongoing basis. We're going to provide more information about this in the

financial specification papers. But if you sort of step back, the vision here is to provide predictable cash flows to DCEs that allow them to create financial arrangements with participants and fund care management that will take the place of fee-for-service claim payments. Remember, we're going to be zeroing out claim payments. Obviously, it's a problem if more care is flowing through the capitated providers than we expected, and because of that, as data comes in on an ongoing basis, we'll be getting an updated view of how this looks and we'll be able to adjust the capitation payments accordingly.

All right, we've also gotten a number of questions around the PCC or Primary Care Capitation and how that's calculated. To start with some questions around how the PCC model payment and reconciliation is determined, and I'll start there and then tackle some more specific questions around this to help clarify. To start with the PCC, the Primary Care Capitation, will be equal 7%, that's how it's defined for DCEs. It has two components. The first component is the Base Primary Care Capitation amount, and the second is the Enhanced Primary Care Capitation amount. The base amount is calculated based on the historical primary care services and the history of utilization of those for participating providers as well as for preferred providers that are opting into the PCC into the capitation. The enhanced, however, is calculated as the difference between the base PCC amount and the total amount or 7%. If the base PCC amount based on historical utilization of primary care services was 2% then the enhanced amount would be 5%, right, two plus five is seven, and if the base is 4%, then the enhanced would be 3%. The primary care services that are used to calculate the base amount are defined at the CPG level, and you can find those in RFA if you're curious about which services we're referring to there. That's how the PCC is calculated.

During reconciliation, this works slightly differently than the Total Care Capitation. In PCC, the base component of the PCC, that's the portion that's truly capitated, and that's considered as a payment when we're looking at year end expenditures, right. What happens there is we'll sum all the fee-for-service claims payments made for aligned beneficiaries and we'll add on to those claims payments the Base Primary Care Capitation amount. That will give us total expenditures which is then compared to the benchmark to determine shared savings or shared losses. The enhanced capitation amount on the other hand is not considered an expenditure because it is fully recouped by CMS outside of calculation of shared savings. In the example above if it was 5%, and CMS would collect that full 5% amount. If it was 3%, CMS would collect that full 3% amount before applying reconciliation calculations to determine shared savings or losses.

To tackle some of the more specific questions we had around the PCC. In the Primary Care Capitation of 7% for base versus enhanced primary care services, you have a list of CPG codes that qualify as base versus enhanced. I addressed this somewhat earlier, but the base versus enhanced portion of the Primary Care Capitation is not directly distinguished at the CPG level. The base is determined by historical primary care utilization and is defined by CPG codes, which as I mentioned are listed in the RFA. The enhanced is defined a 7%, so the total payment for PCC minus the base amount. To clarify here the percentages I'm referring to are as Corey mentioned around PCC, those are based on the benchmark, and so 7% is 7% of the benchmark when we're talking about payment here.

Another question we've received on the PCC is the Base Primary Care Capitation amount determined based on the historical primary care services rendered by the participating providers? The answer to that is yes. How is the payment for additional services the Enhanced PCC recouped by CMS? The answer to that is that it's recouped in full outside of the shared savings calculations. It's not considered an expenditure, you can think about it as recouped before we do any of the shared savings calculations.

We've also received some questions around the impact of the discount and the withholds on capitation payments. For example, is the withhold multiplied by the total benchmark, or is the withhold multiplied by the total benchmark minus the discount? Regarding the quality withholds, will this be applied to our capitation payment? What about the global discount? What about sequestration? I'll start by giving a little bit of context around these questions. We mentioned previously the capitation payment amounts are determined based on the benchmark calculated for a given DCE. This benchmark changes over the course of the performance year as additional information is available to determine the final benchmark, right. The benchmark provided as a preliminary version at the start of the performance year is not necessarily going to be equal to the final benchmark once all the additional factors and data such as final beneficiary alignment and eligibility, final risk scores for beneficiaries, quality scores. As that information comes in, we will get closer to our final performance year benchmark against which the DCE is actually accountable for expenditures.

The capitation payment, however, is made beginning at the start of the year before we have that final benchmark available. It will be based on the available benchmark information that we have that isn't fully complete. However, it's our intent is to base those capitation payments on as accurate a benchmark as possible so that they reflect as closely as we can in the final year end benchmark. CMS intends to set these preliminary and mid-year benchmarks that we provide on a quarterly basis during the performance year in a way that they mirror the year end benchmark as closely as possible with the information available at that time.

With that, how that applies to the discounts and withholds is that -- I'll just go through each of the various discounts and withholds and explain how they apply. The global DCE discount, right, the discount of 2% that applies only to DCEs participating in global, that is included in the final benchmark, and therefore, it will be captured in preliminary and mid-year benchmarks and will be captured in capitation payments. The quality withhold as well as the quality earned back so that's the 5% withholds and the potential to Earned Back all of that 5% based on quality performance. Those will also be in the final benchmark, both the withhold and the earned back.

The withhold is always set at 5%, but the earn back will be dependent on the final quality score for DCE. Because of that the actual earned back will not be available as a final score during preliminary and mid-year benchmarks. However, in order to reflect as accurate of benchmark as possible, and ensure that DCEs are getting the right cash flows through the capitation payment, we'll provide an estimated earned back based on past scores to use an earlier benchmarks so that it's reflected in the capitation payment and captured there. In performance year one, where we're anticipating using pay for performance for quality that that estimated earned back will likely be using a 100% quality score.

Moving down the list, the retention withholds that's a 2% withholds for DCEs that is paid back if a DCE continues participation from performance year one on through performance year two. This is something that we do not anticipate including that 2% reduction in the preliminary benchmark for the purposes of capitation. DCEs would not have that 2% withhold taken out of their capitation payments because we expect that DCEs will participate in the model for two years, and we want to make sure that cash flow is available. If a DCE does leave for performance year two, then we will reconcile and incorporate that 2% withholds as part of reconciliation.

The final component here sequestration, sequestration is a 2% reduction in all payments made by CMS that's federally mandated. For the purposes of our benchmark, we take out the impact of sequestration in calculating the historical expenditures and in comparing it to the expenditures during the performance year, but we do always add back in sequestration on any payments. Sequestration will not be contained within the benchmark, but it will apply to the capitation payments so it will be captured there.

Great. There's been a number of questions coming in about these payment operations. Before we move on to the next topic, I just want to try to hit a couple of the more direct or simple questions that we can, in the time we have. The first here is, are the Total Care Capitation and/or Primary Care Capitation paid to the providers or to the DCE? The answer there is that it's paid to the DCE, so remember that the providers that take capitation, those would be the participant providers and any preferred providers that opt into capitation will have their claims reduced according to that agreement.

Then on the other hand, the DCEs will be the ones receiving the capitation payments that are, in part, informed by how many claims, or I should say the extent of the claims reduction we expect to see in the performance year. It is then up to the DCE and to the providers that have opted into capitation to enter into a financial arrangement that dictates how the DCE will distribute the funding that is in exchange in some respects for the reduced claim payments and that could be similar to a fee-for-service relationship, it could include quality components. We don't really dictate what those financial arrangements look like within certain guidelines.

The next question we have here is how does the capitated payments impact beneficiary coinsurance? Is the rate for the Total Care Capitation or Primary Care Capitation calculated at 80% of the allowable or 100% of the allowable? The short answer here is that the benchmarks -- neither the benchmarks nor the capitation payments -- include the beneficiary coinsurance portion. The benchmarks themselves are calculated based on Medicare expenditures. Therefore, the beneficiary coinsurance portion is excluded. Then the capitation amounts, as Yoni was talking about, are really based ultimately off of the benchmark, and because the benchmark excludes the coinsurance amount, the capitation payments that are made also exclude the beneficiary coinsurance amount.

I will remind folks that one of the options that we make available to DCEs is the ability to reduce the cost sharing for beneficiaries. If that's the lever that you want to make an impact on and you think will be helpful to your care management efforts than it is available to you, it's just

a separate process from the benchmark. You're not on the hook for it within the benchmark, and it is not funded by the capitation payment, that would be something that DCEs would have to fund separately.

Another question we have here is during the alignment period of 2020, I think they're referring to the implementation period, will we still bill and be paid fee-for-service for our patients who will be a part of the model as we transition into the new payment model? This question, I think, is basically: do payment and benchmarks and any sort of financial responsibility exist during the implementation year prior to performance year one? The answer to that is no. The financial responsibility including the payments and the benchmarks will start Jan 1, 2021 with performance year one. There is no payment or benchmarking that happens in the implementation period and providers will continue to submit claims and be paid on a fee-for-service basis.

A question here we have is in the first six months of 2021, which is performance year one, will DCEs receive payments for the participants, or is there a lag time for payments to start? The short answer here is that payments will start right on January of 2021. There is no lag time except for this exception that someone asked about earlier where we don't have the claims history, we need to establish capitation payment. In that case, as I mentioned, it's the exception, not the rule and we'll look at it on a case by case basis. The entity can expect to receive some amount of funding, it just won't be in capitation, it won't count against the benchmark. The short answer there is that the payments will start at the beginning of the performance year. There are a number of other questions coming in. We're going to go on mute for just one second to make sure that we're trying to hit the key ones given the time constraints because we have a lot of other topics to cover. Bear with us for about 30 seconds and then we'll be right back online.

All right, to read through a couple of the questions we've been receiving live. One is Total Care Capitation payment, is the TCC required in the global option? The answer is no it is not required, a global DCE can choose either TCC or PCC. A professional DCE, however, can only participate in PCC. The professional DCE or any DCE that participates in PCC can also choose to have advanced payment as an intent to have more payments going through the DCE as opposed to directly to providers, that is not an option for DCEs participating in TCC.

There are some other questions we've been getting: how is the advanced payment calculation estimated? Advanced payment, similar to the withhold estimate or the base Primary Care Capitation amount, is calculated based on the historical utilization for the providers that are having their claims reduced. It's based on the amount that the providers are reducing their claims as well as on that historical utilization. The difference with advanced payment, it can only apply to for participating providers to non-primary care services. For preferred providers it can apply to both. It is directly reconciled against the actual claims reduction in the performance year. At the end of the year we'll sum all the actual reductions, we'll compare that to the advanced payments and we'll reconcile such that those are equivalent.

There was another question around the Primary Care Capitation enhanced amount. If the base PCC amount is 3% than the enhanced capitation amount will be 4%. If during the performance year, however, additional primary care services are used and the base amount is the amount that was covered by the base, or reduced for the base, and is actually 3.2% for example, what would CMS recoup for the enhanced PCC at the end of the year? Would they recoup the 4% as defined at the start of the year or would they recoup the 3.8% based on the 3.2% of primary care claims that were actually submitted and not paid during the performance year? The answer to that is that CMS will recoup 4%. The enhanced capitation amount is set at the start of the year and will be recouped based on that prospective amount. The reason for this is that the Base Primary Care Capitation amount is the capitation amount. CMS is not looking inside those claims and will not be changing the capitation amount based on the actual claims submitted by the DCEs providers.

Yeah, and just to add on that, because we address a different situation with Total Care Capitation earlier, I think the nuance here to understand is that the base Primary Care Capitation amount, as Yoni said, won't change once we've set it based on the historical. The Total Care Capitation amount will be adjusted to reflect the changing referral patterns as the year goes on, and that's because that amount needs to cover the care that is provided through the capitation channel, whereas in Primary Care Capitation because of the enhanced component we can ensure that even if referral patterns within the primary care space change that the entity will have enough cash on hand to take care of that.

Let me hit at least one more question here that seems to be on a number of folks' minds, because a couple of people have dropped in a similar thought. The question here is how will CMS adjudicate claims it receives for the providers under capitation? Will CMS simply zero out the claims and send the weekly fees to the DCE, or will CMS adjudicate for other discrepancies if not on the front end? Is it the DCE's responsibility or CMS's? Very similar question here we have for participating providers who are working under a DCE and therefore, within capitation will they submit claims as usual? Will those claims to be adjudicated with an explanation of payment, etc. The short answer here is that the adjudication process, the claims submission process, none of that will really change. The participant providers who are subject to the capitation will continue to bill and submit claims as they normally would.

The adjudication for those claims won't change unless there's a benefit enhancement involved. For example, outside of the context of Direct Contracting, a nurse practitioner can't order a home health episode, a physician has to order. But if the DCE decides to make use of that benefit enhancement, then that would be a situation where the adjudication decision might be different in Direct Contracting, but absent of benefit enhancement.

There's really no change to the process. The only processes after the claim goes through the normal process that exist, they'll take a look and see is this patient attributed to Direct Contracting? Is the provider subject to the capitation? If that's the case, they'll reduce the claim payment, but the claim will still have what the allowed charge is and what the reduced amount is on there. When that information is sent in our weekly claim feeds to the direct contracting entity, they'll be able to understand all the normal sorts of information that you'd expect to find

on a claim will be there, in addition to what extent the claim was subject to a payment reduction.

Okay, great. So hopefully that was a helpful discussion of the payment related questions. If we have time at the end, we'll try to hit the questions that have come in that we didn't get to today, but for the sake of time, we do want to move on to another topic. I want to talk next about risk mitigation. We had a number of questions come in that were specific to the risk corridors as well as the stop-loss. Rather than -- because a lot of these questions were sort of very specific, rather than speak to them individually, I think it would be helpful maybe to step back and just remind ourselves of how corridors work and help stop-loss work. Let me take a minute to do so, and then if folks have additional questions that we didn't cover in this explanation, please drop them in the box, and we'll try to speak to them.

First, let me start with risk corridors. For example, one of the questions we have here is, is there a cap on the savings a DCE can earn in global with 100% risk? There is no cap per se, but let's remember how the risk corridors work. Basically, risk corridors are mechanisms to limit ultimately the amount of risk that a DCE bears and that they're symmetric in the sense that they apply to savings equally as they apply to losses. They work basically as corridors or bands of savings or losses that the DCE assumes. Within your band the DCE takes responsibility for a certain amount of payment or a certain amount of the losses over the savings.

In a global track the first corridor is 25% that’s quite a wide band, right, so that means that if the actual expenditure when we do our final reconciliation where we’re within 25% of the benchmark, then this first corridor would apply. That would mean that the entity is at 100% risk, so for example, if the entity has 95% actual expenditures relative to the benchmark, then that 5% the DCE would recoup entirely. If it was all the way up to 25% savings the DCE would recoup that entirely.

Once you exceed 25% savings or losses the second corridor kicks in, and that corridor runs from 25% to 35% savings and losses. In within that band the DCE their responsibility is reduced from 100% to 50%. Let’s take a very extreme case, I mean, as I mentioned the first risk band was quite wide, it would be surprising if there were a lot of results that fell outside of that but let’s take a extreme case were a DCE earns 30% savings, gross savings. The first 25% of that they would recoup entirely, they would get that 25%. The last 5% would fall into the second band and their responsibility is 50% so they would capture 2.5 out of the 5% for a grand total of 27.5% savings out of the 30% gross savings.

I will refer you the RFA or our payment webinars for a full chart of how these risk bands work, and I'll remind you that in the professional track the risk bands are a lot narrower. The first one is only 5% wide, and the savings there -- the responsibility there is 50%, which continues to decline as the savings become further away from the benchmark. One other point to note on this is that the risk corridors are mandatory, so this is not a choice that the DCE’s will make, these will apply regardless for any savings that results or losses that results. The only choice that the DCE can make in this regard is whether or not to choose global which has one set of

corridors or professional which has a different set of corridors, and again I'll just refer you to the RFA for what those actually look like.

Now let's talk about stop-loss. So if you think about corridors as the mechanism to mitigate risk in the aggregate. The stop-loss is the mechanism that DCEs can elect, that can mitigate risk at the beneficiary level. Unlike the corridors, this is optional and DCEs will be able to make this decision prior to each performance year. Basically if we fast forward a little bit once we have our awardees and we are able to provide them with provisional benchmarks along the lines of what we covered earlier in this call. We will then release what the stop-loss attachment points are as well as what the cost of electing stop loss is.

As a reminder, the way stop-loss work is at the beneficiary level, so you take the aggregate cost of the claims that would accrue to a beneficiary. Remember this is absent the claims reduction, so this is what the beneficiaries sort of would incur absent to capitation. The attachment points are the points at which the stop-loss coverage kicks on. Let's say that the stop-loss attachment point is $100,000 that would mean that for a beneficiary that incurs more than a $100,000 worth of medical expense. Starting at the $100,000 point, that's when the stop-loss kicks in and where the DCE is no longer fully responsible for those costs as it relates to reconciling against the benchmark. That's the protection that DCEs can elect and that protection will -- very similar to how third party stop-loss insurers operate, that protection will come at a cost. We will publish prior to each performance year what the stop-loss attachment points are and what the cost of stop-loss is and then DCEs will be able to make their election around stop-loss. That's a decision again that they can change every year based on the attachment points and the cost in a given year.

So hopefully that was helpful. I don't see a ton of -- question's coming in. Let me just pause for one second, we're going to collect these questions we will come right back.

Yeah, two quick questions we receive that are relevant to risk and risk mitigation. The first has to with what a DCE is at risk for. I think for in particular for a DCE choosing a professional risk track which has 50% for which they're accountable for 50% shared savings or losses, at least, for the first of those risk corridors. The question is does that include exposure to all Part A and B spend, right, to the total cost of care for all beneficiaries or is that only relevant to the primary care services? The answer is that it covers the total cost of care for all Parts A and B services which is the -- what the benchmark is intended to capture.

Another question we've had is around how the stop-loss is treated and applied during a year, are DCEs required to make stop-loss payments during the year or is it reconciled as part of final reconciliation? We expect to this as part of a final reconciliation rather than collecting payments on an ongoing basis, but we'll provide further information of that, if that changes.

I think we may have one or two more stop loss questions. Let us go offline for two seconds and we will be right back to address those.

Great. I can take a couple of these quickly. The first question here is will stop-loss also be available at the aggregate population level in addition to the individual level? The answer here

is that it will be offered only at the individual level. I know that third part stop-loss providers offer aggregate stop-loss and they offer what they call specific stop-loss which is at the individual level. In this case, the risk corridors are really our mechanism to handle risk at the aggregate level, and so the stop-loss is really only targeting the individual level.

Another question we have here is will attachment points be set specific to the DCEs each DCE or will they be set globally? The answer here is that they will be set globally in the sense that the stop-loss point won't custom for each entry. They will be offered -- the same choice will be offered to all DCEs

Then one last stop-loss question here. Would the DCE have the opportunity to shop for its own stop-loss? I think the general answer here is yes in the sense that entities are free to engage in any sort of reinsurance activities or free to avail themselves of any services that third party insurers or reinsurers offer. For our specific reconciliation purposes we won't be basically importing other stop loss products and so that -- insofar as the cost that count against the benchmark for reconciliation, only our stop-loss offer would apply to that. But if the entity wants to reinsure themselves against shared savings sort of after we do our reconciliation, I mean that's certainly something that entities can explore.

Okay great with that said we're going to move on to the next topic here and we can try to capture if there are anymore stop-loss or risk mitigation questions, we'll try to capture those at the end. Our next topic here is the benchmarking methodology. There's been a number of questions just in general about sort of the order of operations. As I mentioned at the beginning of the call you know we will be releasing financial specification papers that will lay this out in great detail. But that said, we are able to speak to a bunch of questions that folks have today so we'll take some time over the next couple of minutes to do so.

We've had a number of questions here, I think Yoni has already spoken to these. But I see questions coming in here about in a professional option are we only at risk for primary care services or are we also at risk for total cost of care? I see questions here, what if the DCE only provides primary care and doesn't contract with any other providers like hospitals or specialists? In that case, are they only on the hook for primary care or are they on the hook for everything? Does it matter if I choose PCC, will that effect what I'm on the hook for? I want to make a distinction here as we answer these questions between the benchmark, which is what you're on the hook for in terms of cost, what we're going to be using to reconcile shared savings and losses. I want to distinguish between the benchmark and then the payment mechanism, which is what you get paid in terms of the prospective payments that take the place of fee-for-service claims billing.

For the benchmark, the benchmark is always going to be based off of total cost of care for Parts A and B that are medical expenditures. Again, Part D is not excluded and the coinsurance isn't included. But all services in Part A and Part B not just primary care, including hospital, inpatient spend, specialist spend, etc. Those will all be included in the benchmark and all DCEs will be measured according to performance against that number. Doesn't matter if you're professional only or if you're PCC only or if you only have primary care physicians in your DCE. The choice

that you have around there obviously is the global versus the professional option, which is global higher risk versus professional lower risk.

We want to distinguish between that and the payments which is the Primary Care Capitation and the Total Care Capitation, we've already covered the payments in detail today. But the short answer here is that the benchmark is always going to based off of total cost of care regardless of what you elect your risk track and regardless of what you elect for the payment mechanism.

Another topic that we've received a number of different questions on here is whether or not beneficiaries who are voluntarily align will receive the voluntary alignment benchmarking methodology if they have some claims experience. To read a question here we have, if we have beneficiaries with claims experience, but they get voluntarily aligned, will the benchmark for those beneficiaries be based on the claims or on the regional benchmark? Similarly, if beneficiary is aligned via voluntary alignment, will the benchmark we based on just the regional expenditures or will it include the historical expenditures if the beneficiary has claims experience? It's a good question, and I think it's an important one.

Let me first step back and remind folks if you need a refresher, you can see the most recent webinar we offered. But within a standard DCE we distinguish between the benchmarking methodology for the claims aligned beneficiaries, and for them we're going to include a baseline a historical baseline that's specific to that DCE's historical claims experience. We distinguish between the claims aligned folks and the voluntary aligned folks. The voluntarily aligned folks will receive a benchmark that's driven just off the adjusted Medicare Advantage ratebook for the first three performance years before we incorporate a baseline in performance years four and five. Those are the two methodologies that folks are asking about in the questions that I just read

In terms of how we will treat these beneficiaries for benchmarking purposes, I just want to talk a little bit about the precedence between claims alignment, I should say, and voluntary alignment. We make a distinction between how we treat precedence for alignment purposes and how we treat precedence for benchmarking purposes. To start with alignment, generally speaking, beneficiaries could voluntary align to a DCE, they could also be claims aligned to a DCE. In the event that those results in different DCEs being attributed the beneficiary, so for example, they are voluntarily aligned to DCE A but they are claims aligned to DCE B. In that case, we will basically honor the beneficiary's choice and voluntary alignment will take precedence over claims alignment.

If they happen to be voluntarily aligned and claims aligned to the same DCE, in that case from a benchmarking perspective we were going to treat them as if they are claims aligned. You can think about as first ask yourself if they are voluntarily aligned and claims aligned to the same DCE. If the answer is no then they are attributed to the voluntarily aligned DCE. Then you can ask yourself or if the answer is yes, how will we treat them for benchmarking purposes? The answer will be through the claims methodology.

Another question I have here on a related topic is, can you please clarify and confirm that during performance years one to three the voluntarily aligned beneficiaries in a standard DCE will not have their historical claims included in the benchmark, the benchmark will be solely based on the adjusted MA ratebook. The short answer here is yes, that's correct. For the previous answer, it depends on how we treat them from a benchmarking perspective. If we're talking about the voluntarily aligned folks who aren't also claims aligned, then the answer is yes their benchmark will be based off of the MA ratebook for the first three years.

Another question we have on the difference between these two methodologies is, for the standard DCEs what's the equation for the blend between the historical baseline and the regional expenditure factor? That's a good question, and again, I'll refer you back to the previous webinar we hosted for more information on this. But to cover it quickly today, there's really two different "blends" that I want you to keep in mind. First, let's talk about just the claims aligned folks, we talked about how the methodology is different.

Let's say that we have a situation where we have 4000 claims aligned beneficiaries and 1000 voluntarily aligned beneficiaries. Let's start with the 4000 here. We're going to establish a historical baseline that will apply to those beneficiaries, and then we're going to blend in a regional factor. That's the first blend I'm going to talk about today. The weighting for that factor is listed in the RFA, but it starts out in performance year one, the baseline will be weighed at 65%, the regional expenditure factor will be weighed 35%. By performance year five the regional expenditure factor weights will increase and ultimately it will be 50-50 in performance year five. Keep in mind that we do cap the amount that the final benchmark can move from the baseline at 5% upwards for the USPCC and 2% downwards but basically that's the first blend is we're within the claims aligned folks, we start with the baseline, we blend in a regional factor.

Once we have established a baseline for the claims aligned folks, which includes our first blend and we also know what our benchmark is for the voluntarily aligned folks because it's based on the adjusted MA ratebook then the second blend happens. We're going to blend the 4000 claims aligned with the 1000 voluntarily aligned and that's just a weighted average. Hopefully that shed some light on this question around what ultimately is the equated for the different blends that we do.

Yeah, we've also received a few questions around the differences between the aged and disabled and the ESRD benchmarks. What's the difference in the way we calculate the benchmark for aged and disabled and ESRD populations? How are those used as part of settlement and reconciliation? Both the aged and disabled and the ESRD benchmarks are calculated using the same overall methodology and steps that were described in the second financial webinar two weeks ago. They're calculated in parallel using that methodology and maintained a separate benchmarks throughout the performance years.

Reports that will be sent to DCEs will include a benchmark for aged and disabled with the relevant beneficiaries aligned there, the risk scores and updating risk scores for those beneficiaries. They'll also receive a similar benchmark calculation for the ESRD beneficiaries aligned to their DCE with similar information. The beneficiaries are split at the level of the

month for which they're eligible and for which they fall into each of these categories for the purposes of benchmarking. The benchmarks are kept separate and they are only combined at the end for the purposes of settlement. They're kept separate for the majority of the year end and recording.

Another question, will the trending of historical costs be based on projected growth trends by enrollment type? Meaning will the same adjusted USPCC trend be used for the aged and disabled and the ESRD populations or will there be a different one? The answer is that we will use a different USPCC growth trend for each of these enrollment types. There will be an aged and disabled growth trend and there will be an ESRD growth trend, and those will each apply to the relevant enrollment type for the purposes of benchmarking.

We've also gotten some questions around the blending of the regional expenditures and the historical baseline expenditures. To step back and provide some context if you recall, part of the benchmarking approach which I think Corey mentioned earlier, incorporates blending of the historical expenditures associated with the DCE participant provider aligned beneficiaries. That's blended with the regional expenditure component. That takes into account some of the efficiencies or inefficiencies of the DCE providers relative to their surrounding region.

A couple of other questions we've gotten around that blend. First, how are the regional expenditures blended in with the baseline, what is the percentage blend? In performance year one, we will assign a 35% weighting to the regional expenditures and a 65% weighting to the historical expenditures. The percentage weighting will shift over time towards closer to and even split with more weight going to the regional expenditures. In PY3 it will move to 40% regional, 60% historical. In PY4 45% -- 55% respectively, and finally it'll be a 50-50 split in the performance year five.

The blend will occur using standardized data for both the historical and the regional expenditure components, so performance year risk scores and the discounted quality components will be applied after the blend. The blend will also have, as Corey mentioned a cap on it as well as a floor on the amount that the blending of the regional component into the historical expenditures can change the initial amount. The cap will be such that the blend cannot increase the historical expenditures component by more than 5% of the USPCC, and the floor will be that it cannot decrease that component by more than 2% of the USPCC.

Another question here on the cap and the floor, will that plus 5% minus 2% cap on the adjustment for the regional historical blend, will that also apply to the new entrant and high needs DCE? The answer is that in performance years one to performance years three, the new entrant and the high needs DCEs will not contain any historical expenditures. They'll be entirely dependent on the regional component of expenditures, and therefore there won't be any blending and there won't be any cap and floor as part of a blend. However, beginning in performance year four when historical expenditures begin to be used for these DCE types, then the cap and floor will apply in the same way that it does for the standard DCE. I think we'll pause for a minute and regroup on some of the questions we've been receiving live.

Two quick questions we can hit before we move on. The first tier is that, would the benchmark change throughout the year or is the target set and the results are measured throughout the year? This is the question here. I think the question really gets at to what extent is the benchmark fixed once we've set it? We spoke to this earlier in the call, but just to reiterate, we will issue provisional benchmarks prior to each performance year and those will include our best estimate at, first of all, it will include fixed components like the published Medicare Advantage ratebook as well as the historical baseline based on the finalized provider set. Then we'll include our best guesses at some of the components that will move over the year which include the risk scores, the geographic adjustment and the quality scores.

As we move throughout the year, those factors will change and then ultimately, as a result of that the benchmarks will change. The provisional benchmark is our best guess at the time. It will be used to try to calculate to the best we can the capitation payments, but you can expect for that to change throughout the year.

Another question we have here is about final reconciliation. Does the DCE have to pay Medicare back for the enhanced amount? I think that's Enhanced Primary Care Cavitation they're referring to, prior to reconciliation. If we think of the enhanced amount as a loan to the DCE, when do we need to pay the difference back? The answer is that that will happen through the reconciliation process. We'll remind you that provisional reconciliation is an option available to DCE, so it could theoretically happen earlier than final reconciliation, but it would otherwise occur at final reconciliation which will occur roughly six months after the end of each performance years.

Okay. We'll now move on to the next topic on the historical baseline expenditures component, which we've gotten a number of questions. I think there are a number of questions that we received specifically around what exactly are the claims and expenditures that are included in the baseline? I think we've touched on this tangentially today already. But I think it's important to share that, at a broad level we're including all Medicare Part A and Part B expenditures for aligned beneficiaries in the baseline period. These same set of expenditures are considered during that performance year.

To get into a few of the more specific questions, I think this one we've covered earlier, but it's good to reiterate, did the benchmarking include patient out-of-pocket costs? No, beneficiary cost sharing is not considered an expenditures, and it does not change for beneficiaries that are aligned to a DCE.

How are additional benefits factored into the baselines and benchmark things like transportation, food security, specialty, dental, hearing, vision, etc.? Additional or supplemental benefits such as these they're outside of Medicare Part A and B payments are not included in expenditures and will not appear in baselines or benchmarks.

The next question, do historical expenditures reflect any historical alternative payment arrangements, discounts in place through the Next Gen ACO program? This question is getting at the population-based payments, PBP and AIPBP are the acronyms, they were offered in the Next Generation ACO model. These payments paid ACOs directly for predefined claims

reductions. In many ways this parallels the capitation payments in Direct Contracting, except that these payments were actually directly reconciled against the claims reductions, the way advanced payments are in the direct contracting model. Because of the payments in the Next Gen ACO model occurred during the historical baseline period, so there were these reductions in place between 2017, 2018 and 2019, which are the three baseline years.

The question asks whether CMS takes those into account when calculating historical expenditures. So for example, if there was a 10% reduction that a provider elected on their claims, would CMS count that claim as 90% of the list price, so to speak, or it's 100% as if there wasn't a reduction. The answer is that, yes we do take these into account and we treat expenditures. When we're calculating expenditures, we consider the cost of the service net of any of these claims reductions so they're added back in for the purposes of calculating the expenditures.

Another question similar to this is, when CMS calculates historical Part A and B expenditures do you take into account shared savings or losses that could have been paid for beneficiaries that would have aligned with NGACO or the Medicare Shared Savings Program ACOs? I think the same concept applies here. Shared savings and losses payments are not -- they're not part of Part A and Part B payments, they are outside of those. We don't consider them as part of historical expenditures. So those are separate and they're not accounted for here.

We've also gotten a few questions on the differences between baseline beneficiaries and performance your beneficiaries. Again, I think this is something that we tangentially touched on earlier today. But it's an important thing to reiterate and make sure that people are clear on. To remind you, DC Direct Contracting uses a cross sectional methodology to determine its historical expenditures. What this means is that we're looking at beneficiaries that would have aligned to the direct contracting participant providers in the baseline period to develop these expenditures. These beneficiaries will likely to have a good deal of overlap with performance year beneficiaries, will not actually be the same exact group as performance year beneficiaries.

This is also important context for some questions we've gotten around agents and how to treat beneficiaries that weren't in the historical period. Questions like, for example, if a beneficiary is new to Medicare and ageing that doesn't have a full three years of claims experience, how will they be treated for benchmarking? How do you do benchmarking for new to Medicare aligned beneficiaries who may not have been in Medicare for all three baseline years? If you take the above context that I provided into account, there are a few scenarios for a beneficiary that ages into Medicare or similarly one that switches to Medicare as a primary payer, or leaves Medicare Advantage and joins Medicare. In the DC model, this could apply in a few ways, and it depends mostly on the beneficiaries alignment tied to the DCE.

First, say the beneficiary aged in at the start of the first performance year, so that would be 2021. In this case, because they aged in 2021 they would not have been able to be aligned to the direct contracting entities through claims because they wouldn't have any historical expenditure in the claims alignment window, the claims look back period. Therefore the beneficiary would only be alignable through voluntary alignment and their benchmark would

then not contain historical expenditures for the first three performance years and wouldn't certainly based on regional expenditures. The question doesn't really apply in this context.

If however, the beneficiary had claims experience during the alignment period, and was aligned via that claims history, it is possible that they might have little to no claims history in the historical baseline period. So because of the way these different windows and look back periods overlap, if a beneficiary had claims experience in the first half of 2020 but had no claims experience in 2017 to 2019 it's possible that they could be aligned to the DCE but not have any claims experience in that historical baseline period. However, because the baseline expenditures are determined not based on the beneficiaries aligned in the performance year, but as I mentioned earlier, based on the beneficiaries that would have aligned to the DCE participant providers through claims in any of the baseline years, this really doesn't matter because we're not using that beneficiary's direct historical experience to calculate the historical baseline.

The same applies if the beneficiary aged in earlier and would have aligned to the same provider in the baseline years. In that case, right, say for example, the beneficiary had experience in 2019 and would have aligned to a DCE participant provider in that year. In that case, then some of their experience or all of their experience in 2019 might end up accruing to the historical baseline. If they had experienced in 2018 or 2017 then the same might be true, so because of the beneficiaries in the two periods are not exactly the same, it's less important whether a beneficiary themselves has direct claims experience than the provider's historical experience.

Great. We received a couple of questions around the fixed baseline years as it relates to determining what the historical baseline component will be for a standard DCE in the first couple performance years for their claims aligned beneficiaries. A question here we have is, so the DCE benchmark baseline won't be rebased as cost performance improves for the full five years of the contract. The question here is around the fact that the baseline years are fixed. The answer is yes, that's correct. These years will not update. The baseline years we have are calendar years, 2017, 2018 and 2019. We're going to use the historical experience of a DCE given their preferred participant provider set in that time period to determine what the baseline will be and then we're going to trend it forward and adjust as needed to calculate the baseline in any given performance year.

The intent of the fixed baseline ultimately is to do just that, it's to sort of allow predictability year over year and allow at least part of the formula, the benchmarking methodology to remain fixed. I will just put in the caveat that we all know reality is messier than calculations made on paper. Just like many components of the program, after we accrue a certain amount of experience, it's possible that things may need to change. But the intent certainly first and foremost going into this program is to have these base years remain fixed throughout.

Similarly a question asked, if a DCE experiences significant growth in participant providers, how will the baseline benchmark change if it is fixed for five years? When a new provider joins the DCE and the benchmark is recalculated which beneficiaries are included in the recalculation? Couple things I'd like to point out. First of all, the base years are the things that are fixed, not

the actual baseline. We will recalculate the baseline based on the fixed baseline years every performance year because the participant provider set might change. That's ultimately what we use to go back in time, as Yoni just talked about, figure out what beneficiaries would have been aligned to that participant provider set during our fixed base years and then take that amount and trend it forward to get the baseline. It's the base years that are fixed not the baseline. That gets recalculated based on changes -- participant providers set.

Then the second piece of the question here is which beneficiaries are included in the recalculation? Again, just as Yoni covered, it's not the actual aligned beneficiaries that we're going back and looking at their historical experience, it's using the provider set to see what beneficiaries would have been aligned. In this case, the only thing that changes is the participant provider set. The base years are fixed in the process by which we calculate average expenditure and trend it forward, that won't change either.

We're going to go on mute and just make sure there aren't any incoming questions on this topic that we've missed. Give us about 30 seconds and then we'll be back on line to answer those questions or if we don't find any, we can move on to the next section.

All right, so let's move ahead. We haven't seen any additional questions here. If you have them, feel free to add them now and we'll cover them at the open Q&A at the end. Next we'll talk about some questions relating to the various discounts and the quality components that are applied to the benchmark. First, I want to start by talking about sequestration. I know we've covered some of these, again, earlier in the context of how they apply to capitation. I think it's important to reiterate exactly how they work on the benchmark because there are some more detail worth talking through.

First, I want to talk to sequestration. We've gotten a few questions on how sequestration applies to the Direct Contracting model. As I mentioned earlier, Medicare is federally required to apply a 2% reduction to all payments made as part of sequestration. Given that, I'll respond to a few of the specific questions we've gotten. One was, is sequestration still a part of Direct Contracting? Does it apply in global or is it already included in the discounts? Will the MA ratebook used in the global direct contracting model be subject to the 2% sequestration that Medicare Advantage organizations are subject to? Sequestration does apply in Direct Contracting in both global and professional risk tracks. The discounting global did not include sequestration already, sequestration is applied afterwards on payments, and the same is true for the Medicare Advantage ratebook, which is used to calculate regional expenditures.

The Medicare Advantage ratebook rates as their published do not include sequestration. But we will apply sequestration as part of the direct contracting model. Sequestration applies to all payments made by CMS, which includes fee-for-service claims, and additionally for the purposes of our model, includes capitation payments and shared savings payouts. Anytime CMS makes a payment it has to federally apply to sequestration reduction.

Within the DCE model, as I mentioned earlier in today's session, for the purposes of calculating the benchmark and the expenditures, CMS removes the impact of sequestration so that the benchmarks and expenditures are agnostic of that 2% reduction as opposed to the claims that

are actually paid to the DCE participants during the performance year, which have that 2% reduction already baked in. However, that reduction at 2% sequestration is, as I mentioned, applied to all payments, which includes the capitation payments and shared saving. We calculate without sequestration, but we always pay with sequestration. So it only applies once within the model.

Second, I think there are a number of discounts and withholds that can apply within the Direct Contracting model. We received a bunch of questions around how these apply and in what sequence when they do and don't apply? As I mentioned, we've talked about some of these with regard to the capitation payments, but want to cover them again here. A few other questions, were the 2% retention discount applied in relation to the other discounts? Will the 2% discount be reimbursed by CMS to the DCE at the end of the performance year one or the beginning of performance year two? This again is referring to the retention discount. Or is there an additional 2% withholds separate from the 2% discount, 5% quality withholds and 2% sequestration plan for PY1, is this additional withhold like an incentive for DCEs to continue to participate in the program? Finally, can you explain the difference between the quality discount and the quality withholds? In addition to the 5% withhold is there a 2% discount taken off the benchmark that cannot be earned back?

To step back and explain all of these things in context, right, because it's clear that there are some confusion about how these apply. There are really three components to consider here when we're talking about discounts and withhold. The first is the global DCE discount. Again, this applies only to DCEs on the global track. It is a 2% discount in performance year one, and it begins to increase to 3% in PY3, again by 4% in PY4 and finally at 5% in performance year five. This is a discount on the benchmark, it's not eligible for it to be earned back by direct contracting entities. The intent of this discount is to ensure that that the CMS Trust Funds achieve some of the savings through the model because that with a 100% risk in the global track, all savings would otherwise go directly to the direct contracting entity.

The second component is the quality withholds and the quality earned back. That's a 5% withhold and the potential to earn that back in full based on meeting quality criteria, as I mentioned previously because performance year one is expected to be paper recording, most DCEs will likely be able to get higher full quality scores for that first performance year. The third component is the retention withhold, which is separate from the first two, which apply in all five years. The retention withhold only applies to the performance year one benchmark, and this is a 2% withhold on the benchmark that's applied to direct contracting entities that do not continue participation in performance year two. What that means is that for DCEs that do continue participation in performance year two that withhold is returned to them, it's not counted against them for the benchmark. But if a direct contracting entity cancels participation and does not continue for performance year two CMS will apply an additional 2% withhold on their performance year one benchmark. Those are the three components.

All of these components are calculated on a 100% of the benchmark. The 2% retention withhold is 2% of the full benchmark, in addition to a 2% discount in performance year one for a global DCE and the quality components that 5% withhold and potential earn back. To give an

example that we don't anticipate would come true for anyone, if a global DCE would have a 0% quality score, and not participate in performance year two, their benchmark would have 9 percentage points taken off. So 2% for the retention withhold, an additional 2% for the discount, and additional 5% for the quality and because of a 0% quality score, they would not earn anything back.

More realistically, if a Direct Contracting entity in global were to receive a 100% quality score in performance year one, and maintain performance your to participation, this would amount to a two percentage point reduction off of the benchmark. As I mentioned previously, CMS does not anticipate factoring a retention withhold into capitation calculations. This should only have a tangible impact on Direct Contracting entities that do not participate in performance year two, and because direct contracting entities will have made performance year two participation decisions by early 2022 before final reconciliation for the first performance year. That 2% retention withhold can be applied or removed as part of final reconciliation calculations. I'll pause here, those are the questions we received so far on the discount and quality components. We'll take a look through to see if we've received any others live before moving on to open Q&A.

All right, we're going to move on to the final open Q&A session. We don't see too many questions around the discount and quality specifically coming in. At this point, we're going to try to go back and hit any questions we've missed throughout today. If there's any question on your mind related to finance or payment in any way, please feel free to drop it in the box now. As a reminder, there's none finance related questions we're going to keep track of and we're going to try to answer them next week. We've received a bunch of questions about the financial guarantee that I want to speak to. For example, how much reserves will be required in the case the deficit is incurred, or how is the amount of the letter of credit determined or when will the DCE applicants receive further information required to calculate the financial guarantee? This is something that we'll provide more information on in our financial specification papers. As a reminder that will be coming out over the coming month and into the into the spring. At this point, the general way to think about it is that in terms of mechanisms, we expect to offer the similar range of options for -- that are available under the next generation ACO program that includes the ability to do an escrow account, to do a line of credit, etc.

You can expect that similar options will be made available, and you can also expect that the amount will be tailored to some degree to the amount of risk that each entity holds. As we all know, certain choices around global and Total Care Capitation will ultimately expose the DCE and CMS to more risk than other choices like professional care capitation and professional options -- Primary Care Capitation I should say, and the professional risk track. More information to come on that, but hopefully that's some helpful guidance at a high level that can at least act as a placeholder now before we release more detailed financial information.

Another question we have, and again this is this is our grab bag, topic time. Apologies for the questions seem a little bit all over the place in terms of topics. But we received a question here that says our ACO comprises much of our region, will be MA adjusted ratebook include

expenditures for beneficiaries in the region that are aligned to our own DCE? The short answer here is that the Medicare ratebook which, again, we're going to make some adjustments to for the purposes of direct contracting, is ultimately published on a county by county level. It goes back in time to look at fee-for-service expenditures in that county, and then trend them forward and again layers and some adjustments, more detail to come around those in the financial specification papers. But the short answer here is that if you have an ACO, or in this case a DCE, that has responsibility for a large percentage of the fee-for-service population in a given county, then yes, if that's true over a long period of time, and that time includes the amount of time that would be included in the look back period for the development of the MA ratebook, then, yes, there could be beneficiary experience in the past that contribute to the MA ratebook for beneficiaries that were treated by the Direct Contracting entity's participant providers.

Another question we have here is, does the Medicare Advantage ratebook mean that the expenditures will be adjusted based on the beneficiary's Medicare risk scores? Again, there'll be a lot more information. I know this is a hot topic and an area of interest. Unfortunately, we can't give you the full details yet, those are certainly coming. But the short answer here is that just like the Medicare Advantage ratebook that gets published every year, the published numbers are on a county by county basis, and they represent the cost or the spend associated with what we call a risks standardized beneficiary. That is to say a risk -- a beneficiary that would have a 1.0 risk score. For the purposes of our model, we will be applying the actual beneficiary risk scores for a DCEs aligned population when we apply the Medicare Advantage ratebook, so it won't just be the risks standardized factor blending in, but it will be adjusted to reflect the actual risk of the population that the DCE takes care of.

Another quick question we have here is the provisional reconciliation is paid in January of the year following the performance year, when is final reconciliation paid? I think we've covered this, but just to be perfectly clear, final reconciliation you can expect to occur roughly six months at the end of each performance year. For performance year one, which last calendar year 2021, final reconciliation would occur roughly halfway through 2022, which is performance year two.

There's a couple questions on data sharing, particularly with regard to what information DCEs will receive around the claims that were covered by the capitation payments, in terms of what the frequency is and what information will be provided on that. The answer is that during the performance year DCEs will receive a weekly file that contains not only the actual claims payments which include the reductions, but also information on what Medicare would have paid for the claims adjudicated in the prior week. That means both the reduced amount and the amount had there been no reduction will be provided to the DCEs for the purposes of paying providers with the money accrued through the capitation payments.

We've also received some questions around going back to the capitation payments around what types of payments are included in the capitation. Are fee-for-service claims for nonparticipant and non-preferred providers included in calculation of the capitated payments? The answer is that those are excluded for the purposes of the capitation. The capitation is

offset by reductions in fee-for-service claims payments to participant and preferred providers. Any providers that are not participants or preferred providers in the model will not have any claims reductions and will not be included as part of the capitation payments.

Another related question here is can preferred providers decide to accept different percentages of reduced fee-for-service pay under the same TIN? The answer is that, yes, preferred providers have the choice around what percentage reduction they want to have for their fee-for-service payments as part of the capitation. That that is set at the TIN/NPI level, so the same production amount does not need to be true for an entire TIN.

There's a couple more questions coming in here. We're just going to go on mute shortly to collect our thoughts and we'll be back online shortly.

All right, a couple last questions we can speak to here in the limited time we have. First of all we have a question, this is technically on alignment but closely related to finance. The plurality of Primary Care Services is based on the frequency of visits, services furnished or cost of services provided. The answer here that it's based on the charges, so in this case it's the cost of the services, not the number of -- or the frequency of the visits themselves. Another question we have here is that can you confirm that the DCE, RFA includes institutional claims filed by RHCs, FQHCs like the Next Gen program does? The answer here is essentially yes, the benchmarking in terms of the cost that are eligible or in scope for our benchmarking purposes, it's the same as the Next Gen policy and it would include institutional claims filed by those types of providers.

I see one last question here about when will information regarding the geographic model be available? Spoke to this at the beginning of the call. But just as a reminder, that information is coming, we don't yet have a timeline to give you for when you can expect it. But generally speaking, the focus of our webinar series to date has focused on the global and professional options given the fact that those are the options for which performance year one starts in 2021. The implementation year period starts in 2020. The application periods that are open now and again, will be open in the spring for performance year one is really just specific to global and professional. Just keep that in mind and then you can keep an ear out for additional information that will be released about the geographic model at a later date.

One additional question, and there is a request for more detail on how high cost claimants will be treated for capitation and stop-loss calculations specifically if patients have claims from participating in other providers that in total exceeds the attachment point. The answer to this is that the attachment points are set on the total cost of care for beneficiaries, not based on only the care provided by participant providers or preferred providers. If a beneficiary exceeds the attachment point, then that will start -- when a beneficiary exceeds an attachment point that will start a point where the DCE is only accountable for a portion of those expenditures. That will be determined as part of reconciliation, not incorporated into the capitation payments.

Two other questions coming in here. One, it just ask for a clarification on what you mean by plurality based on the cost of the services? This is talking about beneficiary alignment for the performance year. Yes, this is talking about beneficiary alignment. When we think about claims

based alignment, what we -- what the rule is -- and there's some more detail on the RFA is that we go back to the claims alignment look back period. For a given beneficiary, we see where the primary care utilization landed in terms of providers. We look at the provider set that that had the plurality of, in this case, allowed charges associated with it for primary care qualified evaluation and management claims. That means that, if across a Direct Contracting entity is provider set, if the plurality of charges resided and was billed by their participant providers, then we can consider the beneficiary to be aligned via claims to that DCE. That's the context in which I was addressing that question.

Then I see another question here about how does this model work in group Medicare Advantage plans? As a reminder this model is specific to fee-for-service beneficiary, so the only beneficiaries that would be eligible for alignment to a Direct Contracting entity would be those who have not elected an MA who are in fee-for-service and who meet a variety of other eligibility criteria that are listed in the RFA, for example, enrolled in both Parts A and B and they reside in the US, etc. In this case, we've had this question before around, so what's the role of MA plans? It would be possible for a Medicare Advantage plan to participate in this model either as a convener or as sort of one part of a broader partnership that includes providers. Ultimately, a DCE needs participant providers who are enrolled Medicare providers in order to align beneficiaries. That's sort of the capacity in which a Medicare Advantage plan could participate, so hopefully that answered your question. If not, feel free to follow up with us.

Okay, so I think at this point we're going to close the open Q&A session. We encourage participants to continue to send us questions over the next week, and we do have another office hours which I'll talk through in more detail in the coming slides as part of closing for which we can answer some of these additional questions that you may have. Before we close, just wanted to talk through the model timeline and some logistical information. The Direct Contracting model will begin with an implementation period or an IP, which starts midway through the 2020 year. Applications are currently live for potential IP participants. The application period ends in three weeks on February 25, and we anticipate that DCEs will be selected in May for the implementation period. Participants will then need to sign a performance of Participation Agreement for the implementation period by June 2020 at which point the implementation period will begin.

This period will close at the end of 2020, at which point the first performance year will begin in January 2021. The performance year will run from January through December 2021, and is the point at which participants begin to take on risk for aligned beneficiaries. There will also be a separate application period shown on the right side of the slide between March and May of 2020 for participants or applicants that do not participate in IP but still want to participate in the performance year. DCEs through this application window will be selected in September and will be required to return signed Participation Agreements in December 2020 before the start of the first performance year. I should note that DCEs that are selected for the IP will not need to reapply for the first performance year. However, they will need to sign a separate participant agreement that applies for the first performance period for PY1 on that same time frame so by December 2020.

As I alluded to previously, we have one final office hours for this stage of -- this sequence of webinars and public facing calls. That's scheduled for a week from today on February 11. There's a registration link in the deck. We hope that you guys will join us, and as I mentioned, we will try to respond to additional questions that we received during the week or from anyone that we didn't address on today's call. This is our last office hours before the IP applications are due, so although it's targeted at payment specifically, we'll also open up a good chunk of the time to deal with broader questions around the Direct Contracting model, as well as application specific questions if there are any of those.

As you probably know by now, we like to close with a few things. The first is a poll, how likely are you to participate in the Direct Contracting model? We'll wait for about 30 seconds as responses come in.

Okay, we'll move on from the pole. Our last slide here just has contact information, link to the website for Direct Contracting with additional information, details from past webinars and eventually this office hours when it will be posted, as well as other model specific details. We've also included an email for questions related to the model, the dpc@cms.hhs.gov email address, as well as the email for sales force support related to the application. Thank you all for joining us today and over the past couple months. After the webinar closes, there will be a post event survey to collect stakeholder's feedback on the webinar today. Participants will automatically be launched onto the survey web page. Please complete the survey to help us improve our webinar and communication process going forward. Thank you very much, bye.