Direct Contracting Payment Part 2 Office Hours

February 11, 2020

Recording Transcript

Thanks very much. Hey everybody, my name is Corey Rosenberg. I'm one of the two co-model leads for the Direct Contracting model. I want to welcome everybody to our Payment Office Hours Part 2, thank you guys very much for attending. We hope that these webinars series and officer hour series have been very useful to you all.

A couple of things to note before we jump into the discussion of the questions, this is our currently last scheduled office hours in the series that focuses on questions for the implementation period application. While it's labeled here Payment Office Hours Part 2, finance and payment will be our main topic. We expect that to take maybe about half the time. But since it is the last one in the series, we also want to give folks a chance to ask questions on other topics. We're going to open it up to sort of any questions you have today. As such, we're joined by a number of team members. Here I've got Perry Payne, who's the other co-model lead, Yoni Kozlowski who's our Finance Lead, Ilana Portnoy who is our Operations Lead, and Sarah Wheat who leads the Benefit Enhancement Work. You'll be hearing a number of different voices today.

You can see on the screen here, and just like last week, we've broken up our questions into a number of different topics. Unlike last week, where we really had granular topics within payment and finance, we've sort of combined that into one section today and hope to cover all of those concerns at once. Then you can see that we also want to cover benefit enhancements and patient engagement incentives as well as application and eligibility questions, followed by alignment related questions.

The last bullet point here is the open Q&A session. We really took the questions that we've been collecting through these webinars and through the help desk, and use those to inform what topics we cover. But please don't feel like you need to restrict your questions to these topics. We're happy to take any questions today.

The process today will work fairly similarly like it's done in the past. We'll go topic by topic here. We're going to start with any questions that we've received from past webinars or from the help desk that we feel like are asked repeatedly or that we weren't able to get to on the previous calls. Then we're going to move from there to take any questions that have been submitted live today. We'll take as many questions as we can get to time permitting, and when the questions start to slow down we'll move to the next section. But remember, we do have an open Q&A at the end, so we can circle back and hit any concerns that were missed.

Two other quick notes that I want to point out before we move on. First of all, the slides for today are available for download in the bottom right corner of your meeting window, along with the payment webinars slides that were presented in past weeks. Remember, there's two of those webinars Part 1, and Part 2. In addition to that, the past webinars and office hours, both the slides and the recordings of those sessions are available on our website. The recording

for this session today will be posted soon, so keep an eye out for that in case it's helpful to reference any of the discussions we've had in the past.

With that said, I think we'd like to jump into our first topic of the day, because we had a number of questions come in that were about the capitation and advanced payments as well as requests for more detailed or more granular explanation of the final reconciliation process, we're actually going to start our payment and finance section today with a presentation of just a handful of slides for you before we get into the specific questions. Hopefully that will help answer a number of questions folks have had in the past. Before we jump into that, we always get a lot of questions. I know it's on top of people's minds in terms of when additional information will be made available. I want to make a couple of comments about that, it will hopefully be helpful.

First of all, a number of folks asked, when can we expect more detailed information on the financial benchmarking methodology on the adjusted Medicare Advantage Ratebook or the risk adjustment? As we've said in the past, we're very aware that these are super important to you guys. We're actively working on finalizing some of the details of these policies, and we're working on a series of financial specification papers that we hope to release in the coming month, so it will be in the spring into the early summer. Please keep an eye out for that.

Other questions have asked about when the preliminary performance year one benchmarks would be made available. For awardees, once we get into the late summer, into the fall, more information about that will be coming. But as a general rule, we expect to release the preliminary benchmarks along with the participation agreements so that applicants or sort of awardees, I should say, can review both the contract as well as the benchmark, and then make their ultimate participation decision. We expect that to take place during the fall into the early winter.

Other sets of questions we get are around when you need to make final participation determinations. That would really be made through signing the Participation Agreement. As I mentioned, that'll become first available in the fall and then it would be due to be returned and signed, just up until the end of the implementation period, moving into the performance year one.

One last timing issue to note, we get folks asking about when the geographic option will be released, or more information about that will become available. As a reminder, the discussion today and discussions we've had to date have all focused on the global and professional options. We are actively refining and working on our geographic option policy. We can't release anything concrete today. We hope to do that soon. But just keep an eye out for that, and you can expect it to go through a similar process. There will be an RFA and LOI and so you'll have plenty of lead time for that option. Okay, great. With that said, let's get into the presentation of the key topics that we wanted to discuss today. I'm going to turn it over to Yoni, who can walk us through the first slide here.

Yeah, thank you, Corey. As Corey mentioned we received a number of questions about specifically the capitation payments and the reconciliation. We wanted to start the Q&A finance

related questions by stepping back and providing some additional content here to hopefully clarify some of the questions people have been having. We'll start with the capitation and advanced payments, and then I'll turn it back over to Corey to provide some further reconciliation examples.

We've presented here a table that we think hopefully lays out exactly what claims are included in the various capitation and advanced payments. To orient you to the table, there are essentially two title rows. The first of these focuses on what the type of claim is, it's divided into primary care services and non-primary care services. Primary care services are those defined using the list of CPT codes and the RFA. All other claims fall under non-primary care claims. These are collectively exhaustive category. The third one noted here, are there fee-for-service claims? That can be a little misleading. That's actually referring to both primary care and non-primary care claims, but tied to other providers. That's the first row.

The second row here focuses on the type of provider that's in question. We have three options here. The first are participant providers. These are, if you recall from past presentations, these are essentially the heart of the model, they align beneficiaries to the Direct Contracting Entity, report quality, and they must participate in the capitation payment for all relevant claims. They can also receive Shared savings and use Benefit Enhancements.

The second of these categories of providers are preferred providers. They do not align beneficiaries or report quality. However, they can receive Shared savings, and they can use Benefit Enhancements. With regard to capitation payments, unlike participant providers, preferred providers have a choice whether they want to participate in capitation payments, and they can also choose to what extent they want to have their claims reduced that would instead be paid via the capitation payment mechanisms.

The third category here are non-associated providers or other providers as shown on the slide. These are providers who do not have a contracting relationship with a Direct Contracting Entity. These providers continue to submit claims and receive payments as usual for all types of claims, and are not part of any capitation payment mechanism. Those are the categories we've used to subdivide on this slide on this table.

We dig into the chart itself, the first part here represents the total cost of care for a beneficiary. If you notice, this means the entire width of the slide because it covers all fee-for-service claims across all providers regardless of whether the provider is participant, preferred or non-associated.

The second bar here covers the Primary Care Capitation or the PCC option. In this option, if we move across the slide within primary claims, DC participant providers have all of their claims reduced to zero and included in the Primary Care Capitation amount. Preferred providers, on the other hand, have only the percentage of claims reduced that they elected to receive as part of the capitation payment, and the remainder continues to be paid through fee-for-service.

Each preferred provider can make this decision independently so this slide represents the aggregate, right, these boxes or buckets represent the aggregate of this choice across all

preferred providers. Some preferred providers may choose to have a 0% reduction, others may choose a 100% reduction, and others somewhere in between. The cap amount here represents, as I said, the aggregate impact of those decisions.

If you look at this light blue shading where it says Primary Care Capitation, this covers all of the primary care claims for participant providers and the percentage of the claims reductions for preferred providers. That's what makes up the Primary Care Capitation. This is what we've been referring to as the Based Primary Care Capitation component in past webinars and within the RFA and other documentation.

I should note here, if you look to the left of that Primary Care Capitation box, there's a darker blue box that says Enhanced PCC the Enhanced Primary Care Capitation amount. If you recall, the total of the Enhanced Primary Care Capitation amount and the Based Primary Care Capitation amount is always equal to 7% where the Based Primary Care Capitation amount is calculated based on historical utilization patterns as well as the decisions of the preferred providers on what claims to reduce. The Enhanced Primary Care Capitation amount is calculated as the difference between the based amount and 7% such that the total always equals 7%. This is depicted to the left of the rest of the table. It's outside the total cost of care, because it doesn't take the place of fee-for-service claims, and it's a separate funding mechanism to allow Direct Contracting Entities to invest in care delivery resources and tools. Corey is going to go into more detail on how this fits into reconciliation shortly. But you should recall or note that the enhanced amount is recouped and full at reconciliation before calculation of Shared savings or losses.

Another payment mechanism available within the Primary Care Capitation option is the Advanced Payment. Unlike the capitation, the Advanced Payment is directly reconciled against claims reductions in the performance year such that the two are always equal. The Advanced Payment here, if you notice, falls only under non-primary care claims it only applies to non-primary care claims. Unlike for the Primary Care Capitation, for Advanced Payment, both Direct Contracting participant and preferred providers have a choice about whether they want to opt into the Advanced Payment, and they can choose what percent reduction to apply to claims.

Any remainder that is not reduced, either because a provider chooses not to participate at all or because the provider chooses to reduce only a portion of claims, that remainder would continue to be paid through fee for service claims. To be clear on this, if a provider elected to receive a 15% reduction then CMS would pay the Direct Contracting Entity directly an estimate of that, a 15% of that providers non-primary care claims as part of the monthly Advanced Payment. CMS will then continue to pay the provider 85% of the fee-for-service amount for claims during the performance year. The DCE would be responsible for reimbursing that provider for the reduction based on their pre-negotiated agreement.

If we move down to the third bar here under the Total Care Capitation section, this is somewhat more straightforward than Primary Care Capitation. Similar to PCC, all participant providers see a 100% claims reduction that goes into their capitation payment. Preferred providers have the choice about whether they want to participate and what the percent

reduction is. If you'll notice, within primary care claims this parallels TCC perfectly, right? We're looking at all the same claims that are falling into that. The difference really falls on the non-primary care claims side.

Here, everything that was covered within the Advanced Payment, right, those -- so the claims for non-primary care for participant providers and preferred providers, the same approach that applied for Primary Care Capitation under primary care claims applies for the non-primary care claims under Total Care Capitation. DC participant providers have all of their claims reduced and fall under the Total Care Capitation. Preferred providers have the choice to participate in the Total Care Capitation and they can choose the percentage of what falls under it.

What you'll notice here is that the Advanced Payment in many ways fills the gap between the available claims reductions and what can go into Advanced Payments, what can go into Advanced Payments and capitation payments to a DCE that isn't available in the Primary Care Capitation. The Advanced Payment is an option that a DCE can use to significantly increase their monthly cash flow through payment mechanisms in order to more closely align with the total amount that can be received via Total Care Capitation.

To be clear, there are differences and how these are applied. In Total Care Capitation all participant providers must reduce all of their non-primary care claims by 100%, while in Advanced Payment they can choose whether to reduce claims at all, and by what percentage they want to reduce those claims. Again, the Advanced Payment amount is directly reconciled against performance year claims unlike in Total Care Capitation where there is no direct reconciliation against the performance year claims reductions. But essentially, the potential scope of claims that can be included in payment mechanisms directly to the Direct Contracting Entity is comparable when you take into account Advanced Payment. I'll pause there and turn it over to Corey to talk about the reconciliation. Hopefully it's helpful visual to clarify what we're taking into account and what can fit into each of these computation mechanisms.

Great, thank you Yoni. In the second payment webinar, we walk through an example of what final reconciliation looks like. But it wasn't specific to global or Total Care Capitation versus professional option in Primary Care Capitation. A number of you folks had suggested that it would be helpful to see what that example looks like under each scenario, which we thought was a great idea. That's what we've done essentially today. There's two slides here. The first one I want to walk through is what final reconciliation looks like for a DCE that's elected the global risk option, and then the Total Care Capitation payment option.

Let's go left to right, and we can walk through how this process would actually play out. You can see in the gray bar on the far left, we have the final performance year benchmark. In this situation, just to keep the numbers simple, we set it at $1,000 PBPM. Now as the title says this is the final performance year benchmark. As a reminder, final reconciliation will occur roughly six months after the conclusion of each performance year. At this point in time, we know what the final benchmark includes and that means it includes the final risk scores for the aligned beneficiaries during the performance year. It also would include the quality withhold and

earned back based on the final quality score that the DCE achieved during the performance year benchmark.

In this situation we have a DCE that's elected global and in performance year one, that comes with a 2% discount. Those three factors the $1,000 here is really net of all three of those. We took the risk score that was final, we took the quality performance that was final. We took the discount into account here and as a result we're left with the $1,000. Just want to make sure that sort of that's clear what's in that gray bar.

Let's move over to the next column here, because a comparison as the title say here is what we want to do is we take that final performance year benchmark, and we want to compare it against the total performance year expenditures. We have two boxes here. In this situation, it's fairly simple. We'll see on the next slide that there's a little bit more complexity with the Professional and Primary Care Capitation options. But in this case, we just have two boxes. We have our Total Care Capitation and our fee-for-service claim payments that were made.

Now, Yoni, just sort of walked us through what goes into each of those boxes. But the simple example here, let's start with the blue box, the Total Care Capitation. As you can see that's $530 PBPM, which is 53% of our performance year benchmark. You can reference the slide Yoni walk through to figure out exactly what claims fall into that bucket. But an easy way to think about it is based on the participant providers that were included in the DCE and the preferred providers who opted into the capitation, the claims that they collectively billed represent about 53% of the historical spending for that DCEs population. That's why the capitation is set at 53% of the performance year benchmark.

Now, we've made some simplifying assumptions here, in reality we're going to have a preliminary benchmark that will have preliminary risk scores, preliminary quality performance. We're going to have to take our best guess at what that capitation is relative to the benchmark. In this case, we've assumed that the final performance year benchmark will be roughly the same as the preliminary benchmark. In reality, there might be some movement there. But that's essentially how we got to our $530 PBPM.

The value of that box which is $530 PBPM in this example is actually what was paid to the DCE. That means that CMS was making payments to the DCE in the amount of $530 PBPM for every single month in the first performance year. We don't ultimately adjust this as Yoni was saying to match up with the actual amount of claims that were reduced -- that were related to that Total Care Capitation. Yoni threw that distinction.

Let's just say for example, of this $530 let's say that historically $200 of it was for inpatient stays billed by a hospital participant provider. If during that performance year, only a $150 PBPM of hospital stays was billed and then ultimately those claims were reduced to zero, we don't adjust the TCC amount. The DCE has still been paid $200 PBPM, and the DCE gets that money. We don't essentially "reconcile" the Total Care Capitation amount to the actual claims before we go through the final reconciliation process. It's just simply whatever in that boxes, is whatever what was paid throughout the year.

In the next box above is a red box here, we have our fee for service claim payments. This is another simple one. This is basically any actual fee for service dollar that sort of Medicare paid for care that was provided to the aligned beneficiaries falls into this bucket. That means, as Yoni walk through in the previous slide, that could be for providers unaffiliated with the DCE or it could be for preferred providers who opted not to participate in the Total Care Capitation.

Hopefully, it's fairly simple what falls into each of those buckets and we have a rough understanding of what the performance year benchmark calculation looks like. The math here is then pretty simple. We just add up our total performance year expenditures, in this case that comes to $940 PBPM. We then subtract that from the performance year benchmark which is $1,000 to get our gross savings. In this case, the gross savings is $60 PBPM, which represents 6% of the benchmark.

At this point, we need to look at the application of risk corridors to determine the final shared savings that the DCE will actually capture. If you remember from previous payment webinar discussion, for global DCEs the first risk corridor is fairly wide, it spans 25% shared savings or losses relative to the benchmark. In this case, our 6% shared savings falls well within that risk corridor. Within that risk corridor, the DCEs take on 100% of the risk for any shared savings or losses. In this case, the DCE will capture all of the $60 PBPM of gross savings. You can see in the black text there below the global risk corridor box you can see it's really $60 times a 100%, they capture all 60 of that. Essentially, through this process, it has been determined in this example that CMS owes to the DCE $60 of shared savings per beneficiary per month.

Let's now take a look at the second example here which follows reconciliation for a DCE that elected professional risk in Primary Care Capitation. We intentionally started with the other slide first because this one's a little bit more complicated. We'll start on the left here, the benchmark is still a $1,000 in this example. It is still the final performance year benchmark, which means that it includes the final risk adjustment score, it includes the final quality score. As a reminder though, there's no discount in professional and so while the $1,000 in the previous example was net of a 2% discount, this $1,000, there's no discount applied to it, just as a reminder. We kept the numbers the same, though, just for simplicity.

Let's start now with our performance year expenditures. You can see the blue box labeled Based Primary Care Capitation here. Yoni talked about what goes into this box and you can see the value here in this example $30 PBPM. But fundamentally speaking, this box here functions just like the Total Care Capitation box does on the previous slide. The only difference is that we only put primary care related spending into that box whereas the Total Care Capitation was all claims. What this means here, just like on the previous slide where that box was $530 and that was because the historical spending of claims subject to the capitation represented about 53% of historical spend. What this means here is we've got $30 PBPM. Essentially, the primary care services billed by the participant providers and the preferred providers who have opted into the capitation, historically speaking represent about 3% of the total cost of care.

Now as Yoni mentioned, we also have Enhanced Primary Care Capitation, that's in the white box, and you can see that it's below the bottom line of the graph here. Remember, that the

function or the concept behind capitation in general is to fund care management and to give the DCE enough cash flow to invest in the capabilities it needs to succeed. If we just had the Base Primary Care Capitation, that means the DCE would really only be receiving about 3% of the benchmark on a prospective basis, which from discussions with stakeholders and the expertise of our experts in-house, basically indicates that it's just really not enough to fund the care management required. That's really where the Enhanced Primary Care Capitation enters.

As Yoni said, this is always set at 7% of the benchmark. What the amount of the Enhanced Primary Care Capitation is determined to be is really just the plug between the Based Primary Care Capitation and 7%. As I mentioned before $30 PBPM is 3% of the benchmark that means that 7% of the benchmark will be enhanced. If that Based PCC amount based on historical utilization had been 5% then the enhanced would only be $20 PBPM or 2% of the benchmark.

The reason it's below the line here is that it really is not tied in any way into the financial reconciliation process. The easiest way to think about this, in my mind, is really that the enhanced portion is in advanced loan made to the DCE to help fund care management, and as Yoni said that will be recouped in full, separate from the reconciliation process. Some folks have asked us what does that mean recouped in full? Really, what it means is that CMS is paying out $40 PBPM in Enhanced Primary Care Capitation throughout the year, and then the DCE will owe that amount back to CMS upon final reconciliation in full. It does not factor into the gross savings.

The next box here moving upwards is our Advanced Payment box, and Yoni just walked through how we calculated this. But the important nuance to note here is that the Advanced Payments are ultimately adjusted to match the actual dollars that were reduced for on claims subject to the Advanced Payment. For example, if we had expected to essentially reduce $490 PBPM in Advanced Payment based on the historical look at the claims that were subject to the Advanced Payment based on the elections made by the DCEs providers, then throughout the year we would be making payments of $490. But now we get to the end of the year, we actually have the claims history and we can go back and we can see that, oh, the claim payments that we reduced actually came to $500 PBPM, not $490.

In this case, CMS would essentially owe the DCE an extra $10 PBPM to make sure that the amount that was paid out prospectively for advanced payments matches the amount that was actually reduced on claims throughout the performance year. Now, that is the key distinction between capitation and advanced payment right, because for capitation we don't do that check. The capitation, as I stated on the previous slide, in this case it's $30 PBPM, that amount will be paid to the DCE and will count in final reconciliation regardless of whether the actual amount of primary care claims that were reduced by the participant providers and preferred providers was $25 PBPM were $40 PBPM. The capitation doesn't get adjusted, the advance payment does get adjusted.

The next box moving up here is our fee-for-service claim payments. In this example, it's $410 PBPM. There's no real distinction between this example and the one we just walked through,

that’s just like last time it represents the actual fee-for-service claim payments that CMS made, that were not reduced or made to enfold to unaffiliated providers.

At this point, those are really the two most complicated steps that we need to get through before we do final reconciliation for a professional and PCC electing DCEs. It’s dealing with the Enhanced Primary Care Capitation separately, and it's making the required Advanced Payment adjustment. Once we've done those things, the math becomes simple and just like the slide that we walk through, before the example we walked through on the previous slide. Sorry, guys, we're going to go right back to that example here.

You can see that we're going to sum up our total expenditures. Now importantly, this excludes the Enhanced Primary Care Capitation portion, as we talk about that -- that does not affect the final reconciliation process. But what is included is the Based Primary Care Capitation, the Advanced Payments that had been trued up to the actuals and the fee-for-service claim payments that were actually made. In this example, to keep the numbers simple, we have the same amount essentially, we have $60 PBPM of growth savings.

But remember, for professional risk option, the corridors are different than they are in global. The first corridor is a lot more narrow. It spans 5% of gross savings or losses. In that corridor, the DCE has 50% responsibility. You can see that the first $50 or the first 5% of the gross savings falls into this corridor and the DCE would capture half of it. You got $50 times 50% equals $25 PBPM that will actually be paid to the DCE from the first corridor. The last $10 falls into the second quarter where the DCE’s ease responsibility drops from 50% to 35%. In this case $10 times 35% equals $3.5. What the shared savings amount to that are ultimately paid to the DCE is the $25 PBPM from the first corridor plus the $3.50 from the second corridor for a grand total of $28.50 PBPM that's paid upon final reconciliation.

As I mentioned before, we've had a number of questions about the details of the nuances, I should say, between the professional and the global or the Primary Care Cap and the Total Care Cap. Hopefully this was a helpful exercise. These slides will be posted for future reference, but also feel free to drop additional questions into the question box if there's anything that wasn't clear in that explanation. With that said, I think we want to turn to our financial related questions. I'm going to turn it back over to my colleague Yoni to take the first handful of questions.

Yeah, so a couple questions we got related to capitation. Just to stay topical. There was a question around whether there will be any filter applied to identify provider specialty when calculating the base payment portion of the capitation. For example, if a Direct Contracting Entity had a participant list of mixed specialties with both primary care and cardiology, would the 100% claims reduction on primary care based services apply equally to the primary care doctors and the cardiology practitioners? The answer is that yes it would apply to both of those specialties in the same manner. The reduction associated with the capitation payment are filtered solely based on services as depicted on the prior slide, provider specialty is not part of that filtering. More detail on this can be found within the RFA.

We also received a question around how preferred providers initiate the payment reductions since it is elective. This is something that comes through the Direct Contracting Entity. Direct Contracting Entities have to submit a list of participants and preferred providers. Along with that list, they will need to specify the associated payment reductions selected by preferred providers. In the case of advanced payment for participating providers, that'll be necessary in order for CMS to apply the claims reductions and include those provider services in capitation and advanced payments. DCEs will be required to have contracts in place with each of those providers specifying the details of the reduction and the negotiated reimbursement rates or negotiated reimbursement contracts, however they're specifying that with the provider in order for that to take effect as well.

We got a question on what is included in the benchmarking expenditures? Are IME/DSH uncompensated care accounted for? Currently consistent with what's been done in past models such as Next Generation ACO, Direct Contracting plans to include IME/DSH and hospice expenditures in shared savings expenditures calculations. We do not currently anticipate including uncompensated care based on past decisions to this effect.

A couple of folks have asked in the Primary Care Capitation example that we walked through, what the net effect would look like based on the recoupment of the Enhanced Primary Care Capitation as well as the distribution of the shared savings. Remember, the Enhanced Primary Care Capitation is something that the DCE owes back to CMS, whereas the shared savings is an amount, the dollar amount that CMS owes to the DCE. In this case, for simplicity purposes, there's no reason to cut two checks, one will do. We will look at the net amount. Essentially, there will be a $40 transfer from the DCE to CMS to pay back the Enhanced Primary Care Capitation amount that is sort of ultimately unrelated to any dollars that are specifically associated with expenditures for the IN [PH] population. Then there's the $28.50 that is paid from CMS to the DCE for a net result of the DCE owing back only $11.50 PBPM to CMS. You can essentially think about it as there was this big loan that was made from CMS to the DCE, and the DCE only had to pay back roughly a quarter of it at the end of the period because they generated significant shared savings.

Another question that we've had, which is an interesting one, is that primary care expenditures are approximately 2%-3% of total cost of care. That's correct. I mean, in the example we walked through, it was 3%. But the question is if a DCE primary care historical expenditure is above the 7% that Primary Care Capitation is set at, will they get negative Enhanced Primary Care Capitation or will the 7% be adjusted higher to reflect the primary care cost for the specific DCE? That's a good question. It will ultimately have to be decided based on a case by case basis. We're actively refining this policy. It will be included in some of the details that we release in future financial specification papers. But the short answer is that it would never be the case that you would be receiving less payment than the historical utilization indicated.

If the primary care expenditure was 10%, we wouldn't incur a negative 3% Enhanced Primary Care Capitation amount. We're still actively thinking through exactly how we would handle it. I mean, the DCE would receive at least 10% in capitation. I think we need to figure out if there'll be any enhanced layered on in addition to that. But to respond to the question specifically,

there will never be a negative Enhanced Primary Care Capitation that will be levied on DCEs. At this point, we're just going to go on mute for about 30 seconds to collect some of the questions that have come in and then we'll be back online to answer a few more.

Great, so a couple more questions have come in that we can speak to. This first question, it was just mentioned that the Total Care Capitation is not reconciled against actual claims for the year, i.e. if the hospital typically costs $150 PBPM, but only bill $100 PBPM this year. However, just to confirm that Total Care Capitation will be adjusted based on changes in leakage for the performance year compared to the historical rate between the non-preferred or preferred providers, correct? I think that was mentioned during the last office hours. That is absolutely correct.

There's two distinct concepts here that we want to tease out. One is adjusting the Total Care Capitation based on the actual claims, just sort of forcing it to be equal to the amount of claims reduction that we've seen in the past. That's something that only happened for Advance Payment. However, the question is exactly right that the intent of the Total Care Capitation is obviously to provide enough funding for all the services that are rendered under the capitation. Now, the initial estimate of what the capitation will be is going to be based on historical data.

We understand that as part of the care management activities, and as part of the collaboration that we expect to see across providers, historical referral patterns and utilization patterns may change. That said, we expect that we will need to make some adjustments to the Total Care Capitation amount throughout the performance year to ensure that there is enough capitation being paid to the DCE to cover the services that are handled by participant and preferred providers in the performance year that historically fell outside to unaffiliated providers.

In terms of adjustments made from services flowing from unaffiliated providers to affiliated providers, we will make those adjustments. The adjustments that we aren't making were unlike the Advanced Payments is we're not ensuring that the fee-for-service is zeroed out claim amounts ultimately match exact to the capitation amount that is paid.

I've got another question here that asks for the Primary Care Capitation amount, why was the $60 split into $50 and $10 in that example? As a reminder, this has to do with the risk corridors. This is part of the risk mitigation options that are included in the model. We covered this in detail, and I believe in our first payment webinar, so I'd direct you there if you have any more detailed questions. But at a high level, the concept here is that we impose risk corridors. These are sort of mandatory and they apply symmetrically to both savings and losses for any variance between what the benchmark is and what the actual expenditures are.

In the professional option, the first risk corridor spans 5%. That means that for any expenditures that differ by 5% or less compared to the benchmark, they fall into the first corridor where the DCE has 50% risk. The next corridor, I believe it's from 5% to 10% and the DCE's responsibility drops to 35%. In this example, the $60 represented 6% gross savings. The first 5%, which is $50, fell into the first corridor, the last $10 the last 1% fell into the second corridor. That was necessary to distinguish between each corridor in order to accurately calculate shared savings, and that's why the $60 was split in that example.

We got a question about the quality payment and APMs. If you're a participant provider in a direct contracting model being paid through total care capitation, where does the 5% bonus payment for being in an APM go? Does it go directly to the TIN? Does it go to the Direct Contracting Entity? The answer to that is that the 5% bonus would be applied to the individual providers underlying Part B claim amounts. For any part B claims that were included in the capitation, the 5% bonus will be based off of the underlying claims as if the claims were not capitated. In other words, had the provider not been participating in the model, the 5% bonus would not be applied to the capitated payments themselves, or to any shared savings or losses. Likewise, the 5% bonus would not count against shared savings, it would not be included in expenditures, it's considered totally separate from the payment within this model.

Maybe one last question here and then we can move on to the next section. The Enhanced Primary Care Capitation needs to be recouped prior to the shared savings, so on page six, that second example we walked through. Should the $60 in shared savings, I think they mean in gross savings, be reduced by $40 for the Enhanced Primary Care Capitation so that the gross savings is only $20 PBPM and then do you apply the risk corridors? The answer to this question is no. As we mentioned on that example, the Enhanced Primary Care Capitation really functions independently from the final reconciliation process and the benchmarking process. You can think of that as a separate payment that is made and then it is separately recouped, and because it doesn't factor into the benchmark, the gross savings are not reduced net of the Enhanced Primary Care Capitation. Those the settle up, essentially for both of those functions happens independently.

Okay, well, hopefully that was helpful. Please keep submitting your questions, and if we have time at the end, we'll try to get to any we missed. At this point in time I'd like to turn it over to our colleague Sarah Wheat, who will talk about the questions related to benefit enhancements and patient engagement incentives.

Thanks so much. Hi, everyone. Good afternoon. Now we'd like the opportunity for people to ask questions about the benefit enhancements and patient engagement incentives we'll be offering in the Direct Contracting model. If you have any questions, feel free to submit them in the Q&A pod, but I'm going to go ahead and get started here.

This is a great question. Regarding applications, does the DCE have to submit and intend to participate in the benefit enhancements in their DCE application or can they decide after they're approved? A great question, DCEs will not need to indicate what BEs if any that they'd like to participate in, in their applications. Any benefit enhancements will require an implementation plan but those will be due at a later date and we will provide information on that when it is available.

We have another question here. If a DCE applies to provide benefit enhancements, is it required to provide them throughout the performance year or can it discontinue or modify them? No, if you elect a DCE is not required to implement any of the BEs if elected, a DCE may choose to implement all or none of their BEs they have selected.

We have a great question here, we have been seeing a few questions on this. Can benefit enhancements include social determinants of health, such as food, pharmacy and nonemergency medical transport? Yes, if you take a look under the patient engagement incentive section of the RFA, it's outlined on page 24. A DCE can choose to provide these social determinants of health and I would just reference page 24 of the RFA to see what's allowed under that in addition to the cost sharing and chronic disease management. With that, another question on the chronic disease management gift card. Is there a limit on that or is that up to the DCE's discretion? There is a monetary limit of $75 for that gift card.

Here's a question here. If we are currently using these waivers in another ACO model, do we need to complete an implementation plan for the same DCE waiver? Yes, you will have to complete an implementation plan for each BE even if you've provided the same services previously in a different shared savings model.

Another question here regarding the care management home visits, what is the scope of time for these care management home visits? That's up to 12 visits within a performance year.

Great question here, do the benefit enhancements begin in the implementation period or the performance period? Great question, all benefit enhancements will begin in performance year one or year 2021.

We have a question here, would a curative provider also have to be in the DCE for the concurrent care benefit enhancement? This is referring to our proposed benefit enhancement for concurrent care for beneficiaries that elects the Medicare hospice benefit. For that both the curative care provider and the hospice care provider must be DCE participants, note for that, that benefit enhancement.

We got a question here, can benefit enhancements be introduced in subsequent PYs? Yes, absolutely. I would suggest that if you plan on implementing any of these in PY1 you submit an implementation plan. But if you decide for a future performance year to implement one you have not submitted -- have not done before, that is totally fine.

Okay, so it looks like our questions are slowing down. I want to encourage anyone to submit questions that may come up through the Q&A portal. But with that I will turn it over to Ilana for questions regarding application and eligibility.

Great, thank you so much Sarah, good afternoon everyone. I'm going to highlight and go through some of the questions, the frequently asked ones that we've been receiving through the help desk inbox, as well as some of the ones that have been answered already today. I encourage you to look at the Q&A pod on your screen and you can scroll up and down and see the questions that have been answered and if it pertains to you. One of the questions we receive multiple times is can a DCE move between the global and professional option? Before signing the PY participation agreement you can change your options from global to professional or professional to global. If you applied an IP period for global and you'd like to change for PY1 to professional that can be done. Once the PA for PY1 has been signed, you can only move from professional to global and that's only at the start of the next PY.

There's a lot of questions about updating the list for participant providers and preferred providers that are submitted with your application. A DCE can they update the list of providers and preferred providers after submitting the initial application for the implementation period? There will be an opportunity to update your list for PY1. Once your list is submitted with your application for the implementation period, you will not be able to update that list. However, you are required to submit a new list for PY1 and you can make any additions or deletions at that time.

Providers can be added mid-year as part of an ad hoc process. However, providers that are added will not contribute to alignment until the next PY. They can elect benefit enhancements and the likes for that time period.

Can a DCE choose which of its associated NPIs participate in Direct Contracting which do not? Can a DCE have some NPIs in shared savings and some NPIs in Direct Contracting? Direct Contracting is a split TIN model, meaning that all providers under one TIN do not have to participate in Direct Contracting. Only providers that have submitted on the DCEs provider list will be included in the DCE. DCE participant providers and preferred providers are aligned to the DCE based on the TIN/NPI combination.

During the IP, DCEs and DCE participant providers can participate in both Direct Contracting and the shared savings program during each performance year. However, they may not simultaneously participate in the shared savings program using the same TIN for the DCE or the same TIN/NPI for DCE participant providers. This restriction does not apply to preferred providers, only to DCE participant providers.

Another question we've been asked is, does the DCE itself needs to be a Medicare enrolled provider or supplier to participate? No the DCE itself is not required to be a Medicare enrolled provider. However, all DCE providers, DCE participant providers and preferred providers must be Medicare enrolled provider or supplier by no later than June 30th in order to participate in the model during the first performance year. The date for the IP submission list is April.

Am I able to make any updates after submitting my organization's application? No, applicants may only make revisions to the applications during the application period, which is December 20 and it closes February 25. Applicants will be unable to edit or revise the application after the deadline of February 25. We've received this question in regards to the PY1 application. Your information input in your implementation application will not be carried over to the PY1 application. We encourage you to save that information in a different source so you can use it when applying to your PY1 application. There are some minor edits to the PY1 application, although overall it remains the same as the implementation period application.

Does participation in the implementation period obligate participation in performance year one? No, if you participate in IP your DCE is not required to participate in PY1. However, if you participate in IP, you will not need to be applied for PY1 and you will have the options to differ participation in PY1.

One more common question we've been getting is around the PLST the Provider List Submission tool? Is the zip code required on the provider roster intended to be the practice billing zip code or the practice location zip code? If they practice at multiple offices should we list them in multiple times? Yes, the zip code is required for the counties in which the DCEs, DCE participant provider has a physical office location. If DCE participant providers have multiple office locations, please list their zip codes in the CFA worksheet at the Provider List Submission tool.

I'll just finish with this one question that we received. If you have a change to your TIN or organization name from what was submitted with your LOI, you'll need to submit a change request through the DCE help desk inbox and we can contact you and see about getting that information changed for you. We'll just go on mute for a few seconds to see what other questions we have.

We received numerous questions around the definition of 50% of the participants since participating in an ACO regarding experience. If the 50% of your participants providers have a consecutive 12-month experience in other shared saving models or innovation center models that is considered -- that's the experience that we're using to dictate that. I'm now going to pass it on back the Corey who is going to discuss the questions regarding alignments.

Thanks Ilana. Number of questions have come in here. The first one we have is if a patient is aligned to ACO through claims-based alignment, and that same patient signs up to another DCE through voluntary alignment, does the latter trump the former? This is a question about the precedent of claims versus voluntary alignment. The general rule here is that voluntary alignment that is a valid voluntary alignment attestation will trump claims-based alignment.

There's one nuance to note here though, which we have another question here that I'll read out and then I can speak to both of them. It says prospective plus alignment allows for voluntarily aligned benes to be added to the DCE. It is unclear if the claims aligned benes would be subtracted in prospective plus. The one nuance I want to talk about here is the nuance about timing. Prior to a performance year, what we're going to do is we're going to run a preliminary prospective alignment, that is to say we're going to determine which beneficiaries are aligned to each DCE for that coming performance year. In that process we're going to look at both claims and voluntary alignment.

As I mentioned before, voluntary alignment would trump claims if a beneficiary voluntarily aligns to one DCE, but would be claims align to another. That said once those determinations and that precedence is determined before the year, those beneficiaries are essentially locked in to the DCE for the course of the performance year. Now there are certain exclusions that could apply, they might lose eligibility, they might move, they might enroll in MA, so there might be reasons why they get basically taken out of the aligned population throughout the year, but they will never be stolen essentially by another DCE within the year.

For example, let's say a beneficiary would be claims-aligned to one DCE, and then halfway through the performance year voluntarily aligns to another DCE. The next time we do the annual prospective alignment, basically evaluation, would be prior to the next performance

year. At that point the voluntary alignment attestation would trump the claims algorithm. But for the remainder of that performance year, even if the DCE, to which the beneficiary voluntarily aligned has elected prospective plus, that beneficiary won't be moved from the DCE that they were originally claims align to, to the next DCE that they voluntarily aligned to until the next performance year.

The only way that prospective plus allows you to add beneficiary is for beneficiaries that are not otherwise aligned to an entity within Direct Contracting or to another risk program. For those benes that are essentially unaligned, if you get a voluntary alignment attestation through the performance year, we're going to allow you to recognize that within the performance year. But for the benes that are already aligned to a different DCE or to another program, we're going to essentially make you wait until the next performance year to recognize that alignment.

Another question I have here is does the aligned population update annually based on the participant providers added during the year? The answer to this is yes. Essentially, as I mentioned, once a year we're going to do our prospective alignment evaluation which looks at claims and voluntary alignment. We're going to use the updated provider list that's associated with the Direct Contracting Entity at that point in time. Every single year if the provider list changes, that means that the alignment would be updated accordingly.

Another question we had here is for beneficiary alignment, does it also include Part A and B, just like the benchmark or just Part B? This question, I believe, is referring to claims based voluntary alignment which looks at the plurality of primary care, qualified E&M charges. In this case, because those charges are essentially part -- anything that is a PQEM, which has happened to be a Part B code, that would be counted. Anything that's not a PQEM would not be counted. As a reminder that assessment is essentially we take a look at all the PQEM claims that were billed for services to a given beneficiary and we look at whether or not the plurality of charges falls within one DCE's participant provider. Whichever DCE captures the plurality of charges would be claims-aligned to that beneficiary.

A few more questions have come in here that we can speak to. The first one is what happens with beneficiaries that are attributed to an ACO through claims-based attribution and have, at the same time, voluntarily signed a voluntary alignment form with the DCE, does the latter trump the former? This is an issue that I addressed earlier as I remember the general rule, voluntary alignment will trump claims alignment when it's done through this annual evaluation process. If it happens during the year, you would have to wait until the next performance year to recognize that attribution.

This other question that just came in is sort of a converse of the last question I answered before, which is if we remove providers during the first performance year, will the benchmark in the alignment list be updated accordingly? The answer to that is yes, but it won't happen until the next performance year. We're going to run alignment based on the provider list we have at a given point in time, if those provider lists change, the beneficiaries that are initially aligned will continue to be aligned throughout the rest of that performance year, provided that they don't otherwise lose eligibility.

One last question here is how will you be handling brand new TINs where NPIs have billing history but not to the new TIN? This question, which is to me is sort of part finance part alignment, has to do with the legacy TIN submission. Essentially, what we're allowing DCEs to do is to provide us with their legacy TINs. A legacy TIN, as a reminder, is a TIN that formerly was used for billing by a given provider associated with an NPI but is no longer being used by that physician. Now the TIN may still be in existence or still be used by other physicians or maybe no one's using it. In either case, the claims history that was associated with that TIN can still be counted for a DCE if the provider provides that legacy TIN. As a reminder, legacy TIN submission for new entrant DCEs is required and it's optional for standard DCE. Hopefully that answers your question there. We're going to go back on mute for a minute to collect any other last questions on alignment before moving on to the open Q&A session.

One last question we got asked about how FQHCs will be handled for alignment purposes. The short answer here is that they won't be handled any differently than any other facility or any other provider type. We'll essentially look at the allowed charges of PQEM claims for a given beneficiary. Those claims could be billed by providers in a hospital and a independent practice in an FQHC. It doesn't really matter as long as they are PQEM Medicare charges, and then we'll run our claims alignment algorithm to determine where the plurality lies and make that determination accordingly. There's no distinction between the provider type provided that the claims we're talking about are PQEM.

With that said, I think the alignment questions have started to slow down. We're going to go back on mute, collect ourselves for about 30 seconds and then we are going to enter the open Q&A session. Please feel free to submit questions on any topics at this time.

I just wanted to add some clarifying information around the provider submission list and its deadline. For the providers submission list for the implementation period is due with your application on the deadline of February 25th. You will be required, if you are awarded into the IP, you will be required to submit a new list for PY1 which will be later in the fall. Your PY1 list for those that are not awarded into the implementation period will be due with your PY1 application which is due -- we will provide that date at a later time but likely around the end of May.

Sure, another clarifying point here for regarding the care management home visits. Is the home visit waiver 12 for the PY or 12 visits during the 90 days following an inpatient admission? That's a great question. It is 12 visits for the entire PY. But this, if you're familiar with Next Gen model and this benefit enhancement, this is a change from Next Gen.

Number of questions have come in, these are on topics all over the place, hence the open Q&A session, so apologies guys for jumping around here. The first one I have is if a beneficiary is attributed to our DCE based on claims, but we are able to get them to voluntarily sign up for our DCE as a voluntary member, would a benchmark for this beneficiary move from a claims based history to the adjusted MA Ratebook? Essentially what this question is asking is within a standard DCE remember that we distinguish between claims align beneficiaries and voluntarily align beneficiaries when it comes to the benchmarking methodology, especially for the first

three performance years where the voluntarily aligned beneficiaries received a benchmark that's driven by the adjusted MA Ratebook. The claim align beneficiaries receive a benchmark that is ultimately based on the historical baseline for that DCE which blends in a reasonable expenditure factor.

The question here is, if you start out as claims and then voluntary align, will you switch methodologies? The answer essentially is no. There's a distinction I want to draw between claims versus voluntary alignment precedents for alignment purposes and claims versus voluntary alignment precedents for benchmarking and financial purposes. As I stated before, for alignment purposes, voluntary alignment will trump claims alignment. This really has to do with when the beneficiary has claimed involuntary alignment to two different DCEs.

When we have to decide between two DCEs, the voluntary alignment will trump the claims alignment. When the claims and the voluntary alignment align, and they're essentially both pointing to the same DCE, then for financial purposes we treat that beneficiary as if they are claims aligned. In the situation that this question describes, if the beneficiary was initially claims aligned and then signs the voluntary alignment attestation they would not switch to the different benchmarking methodology, they would stay claims aligned. That's true whether or not both of these things happen in the same year or if you start out with claims in one year and then you add in a voluntary alignment.

Another question I have here, for the new entrant DCEs, is how do you determine the Base Primary Care Capitation since there are no historically aligned beneficiaries to make that calculation for? This is a good question. We address this, I believe, at the last office hours as well. But I'll sort of repeat the answer for folks who are unable to hear it before. Essentially, the question here is that whenever we're establishing a capitation payment amount, it needs to be informed by some amount of historical experience. What happens when we don't have enough historical experience to make that determination? I'll say two things. First of all, even new entrants are allowed up to 3000 beneficiaries to be claims aligned, right? We do expect that many new entrants will at least have some historical fee-for-service experience that we can use to inform the capitation amounts.

Now, that said, it's still theoretically possible that a DCE will not have enough experience to establish a reliable payment amount. We're going to take this on a case by case basis, we're still actively finalizing this policy. But the simple answer here is that, step one, we'll make a determination around whether or not there's enough historical experience. We expect that in most cases there will be. For those exceptions where there isn't, we will decide what to do on a case by case basis. It likely would look something like lagging the capitation, providing only sort of enhanced PCC or infrastructure payments up front to the point where we can accumulate enough experience where we can begin issuing a reliable capitation amount.

Another question we have here is what is the benefit for a preferred provider to accept only partial reduction in payment? It's not necessarily a pro and a con of accepting the full claims reduction amount or not. The intent ultimately of the direct contracting model is to provide flexibility and optionality around how providers structure themselves and create financial

arrangements. The choice here for preferred providers around, first of all, whether or not to opt into capitation or advanced payment at all, and then if they do to be able to set the amount of claims reduction that they're taking is really just to recognize that different things will work for different entities in different circumstances.

Ultimately, it's up to the DCE and the preferred provider in this case to decide if it makes sense to opt in or opt out. But the optionality here is intended to just recognize that different solutions may be required in different circumstances. The reason it's required for the participant providers is that I think one of the goals of the model ultimately is to transition payments away from fee-for-service. That's why it's required for participant providers, but we felt like for preferred provider it's important to maintain that optionality.

We got a question for a new entrant DCE. Will patients that are voluntarily aligned in performance year two have their individual benchmarks based solely on the adjusted MA Ratebook for performance year three, four and five? It's a good question. Just to step back and provide some context here. Since we haven't gone into the different benchmarking methodologies in much detail today, for new entrant DCEs in performance years one, two and three, the benchmarking methodology will be composed of regional expenditures and will not incorporate any historical expenditures from a baseline period. However, beginning in performance year four and five the benchmarking methodology will change for new entrant DCEs where the historical experience for the DCE itself from the first two to three performance years, so the 2021 to 2023 calendar years will be blended with regional expenditures, similar to the methodology for a standard DCE.

In performance year four, it will incorporate recent historical experience from the first two performance years where the weighting will be one third to performance year one, and two thirds to performance year two. In performance year five the first three performance years will be incorporated into that recent expenditure amount with a 10%, 30%, 60% weighting, where the more recent year carries more weight. To be clear, this is different from the proportions with which we blend the historical expenditures and the regional expenditures. For that in performance year four it will be a 45% regional and 55% historical and then a 50-50 split for performance year five. That's just in context to set the stage.

To address the question itself, which again, which asked about how voluntarily aligned beneficiaries are treated in a new entrant DCE. For a new entrant DCE we don't distinguish between how a beneficiary was aligned for the purposes of benchmarking. Both claims aligned and voluntarily aligned beneficiaries are treated the same for all five years of the benchmarking. They're treated differently only in a standard Direct Contracting Entity.

If a beneficiary was voluntarily aligned beginning in performance year two, based on the benchmarking methodology I described above, in performance year two and performance year three they would receive the benchmarking methodology that incorporated just the regional expenditures without any historical component. Beginning in performance year four they would receive this blend of the recent historical experience and the regional expenditures. Again, the

same would hold true for a beneficiary aligned to the new entrant DCE via claims, instead of via voluntary alignment.

I think this question may have also been asked because a beneficiary that was voluntarily aligned later in the model may not have direct historical experience of their own to contribute to those recent expenditures. This gets into the cross-sectional approach that we use to set our historical baseline across the Direct Contracting model and similar models such as Next Gen, where instead of looking at a specific beneficiary in the performance year and looking at expenditures for that same beneficiary and a baseline, we use the provider, the participant providers as the link. We compare the beneficiaries that are aligned in the performance year with those that would have been aligned in the baseline year. If you recall from past presentations on the benchmarking methodology, there are a number of adjustments that we have to make in order to make sure that these different beneficiary populations are -- the differences are being accounted for.

Two questions just came in that are pretty similar, we can address them at the same time. The first tier is if a practice has been serving Medicare fee-for-service beneficiaries but not participating in MSSP or any other shared savings arrangement or ACO/CMS, then will the DCE count as a standard DCE or a new entrant DCE? Relatively we have a question that says, can you clarify the eligibility criteria for new entrant DCEs? Let me just talk about what those criteria are, and then we can talk about whether or not in the example described above the DCE would qualify as a new entrant or a standard. These are spelled out, I think, pretty clearly in the RFA so I would point you there for a refresher. But there's a number of distinctions between a new entrant and a standard DCE.

For standard, there's really only one major requirement, which is you need at least 5000 aligned beneficiaries in all performance years. If you're a new entrant DCE, you need to meet the following requirements. First of all, you have a different minimum beneficiary threshold, in performance year one that's 1000 beneficiaries. But you also have some maximum claims alignment checks. The intent here is because the new entrant DCE type is intended for entities that have less experience in Medicare risk arrangements as well as, generally speaking, less experience serving fee-for-service beneficiaries. Based on your participant provider list you cannot have more than 3000 beneficiaries claims aligned in any of the base years or in the first three performance years. Right off the bat there's a distinction in size right? The standard DCEs need to be over 5000. The new entrant DCEs need to be over a 1000 but they can't exceed 3000 through claims.

The other check, the other eligibility criteria for new entrant DCEs is the risk experience check. Fewer than 50% of the participant providers in a new entrant DCE can have what we call risky experience. The way we define that is a full years participation in ACO or risk demonstration program like Next Gen or Pioneer or SSP. Those are really the two main key distinctions.

Circle back to the first question here. If a practice has been serving Medicare fee-for-service beneficiaries, but not participating in MSSP, will they be a new entrant or a standard? It really depends on the specifics here, so if they haven’t participated in MSSP it means that they'll

certainly pass the risk experience check. But the claims alignment check would still apply. It says that they have some history serving Medicare fee-for-service beneficiaries, if they have enough history that they can align more than 3000 beneficiaries through claims than they would not qualify as a new entrant and they would need to enter as a standard provider that they meet the other eligibility criteria. We're going to go back on mute for another minute or two while we collect the additional questions that have come in.

Okay, so thank you guys for joining us today and submitting all these questions. We are going to move on to the closing section on today's webinar and wrap things up. Maybe we've addressed the vast majority of questions that came in, but feel free to continue sending them to us via the email and other sources. We'll continue to address them through those if you feel like you're questions haven't been fully addressed today.

As our usual, going to wrap up by providing a summary of the timeline and some of the next steps. Again, we have two different sets of applications in two different periods for applications for the DCE model. The first on the left is the implementation period. That application period is currently live. I think it closes two weeks from today and so please continue to get those in if you're interested in the implementation period. We plan to make selections on for the DCEs in May of 2020. Then applicants will need to return sign and return Participant Agreements for the implementation period at some point in June, after which the implementation trade will begin and voluntary alignment outreach can begin.

On the right is the performance period timeline, so we anticipate opening that up in, I think, the later part of March to the later part of May 2020. The actual date will follow in the coming week. We would then make selections on Direct Contracting Entities in September. The deadline to sign the Participant Agreement for the actual performance year would be in December 2020 with the actual performance year starting on January 1st, 2021. For applicants that apply and are selected via the implementation period, they do not need to reapply via the PY1 period. They've already been selected to participate in performance year one if interested. However, they must sign a separate Participation Agreement in December 2020 or by December 2020 committing to participate in the performance year in order to do so.

Again, we'll close with our typical poll question. For those who've been here for a number of the webinars you'll be very familiar with this. Hopefully I'll get it right. How likely are you to apply to participate in the Direct Contracting model? I'll wait a couple seconds so that responses come in.

Okay, I'm starting to see things slow down on the responses, so I think we'll move on from the poll, and wrap things up with some contact information. The first little link to our Direct Contracting webpage on the CMS website, this has more detail about the models including the RFA, and details from past webinars and office hours sessions, including slides and recordings. The last two are sets of emails for which -- through which you can send further questions. The first is the email for general questions about the model and the second and so for support, has to do with application specific questions.

With that, thank you all for joining us today. After this webinar closes, there will be a post-event survey in which we'll collect stakeholder feedback on the webinar. Participants will be automatically launched onto that survey webpage. Please take a minute to complete the survey to help us improve our webinar and communication process going forward. Thank you very much.