Direct Contracting Payment Part 1 Webinar

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Recording Transcript

This is Corey Rosenberg. I am one of the co-model leads for Direct Contracting. I'll be sharing the primary speaking duties today with my colleague Yoni Kozlowski, who heads up the financial work stream for our model. I just want to really reiterate, thank you guys again for joining today. I know that there's been a lot of interest and a lot of questions about the financial methodology since the RFA was released. We're excited to begin sharing that content with you today. That said, before we dive in, I just want to pause on the agenda for a minute and talk a bit about what we're going to cover today versus what we'll provide more information on in the future.

Today, we're going to start, as we often do in these webinars with a quick overview of some of the key concepts within the Direct Contracting model. I know that we've covered some of these items multiple times before in the past, but we know that not everyone has the chance to dial into all webinars. But more importantly, a lot of these concepts factor prominently into the financial methodology we'll be discussing. It's sort of an important place to start.

From there, we're going to spend most of our time today talking about the details of payment mechanisms. Those are the various options that are available to DCEs, how they mechanically work, etc. Then the final two agenda items today that we want to cover are the risk mitigation mechanisms that will be available to DCEs in the reconciliation process. As you can see on the slide, I just want to call out that next week's session is reserved for a detailed discussion of the benchmarking methodology. I know there's a lot of interest in that topic. Additionally, we'll be covering risk adjustment at a later date as well, but those are not the focus of today's webinar.

After we finish these four agenda items, we're going to open it up for a Q&A session. Please be submitting questions at any time through the meeting window. Given what I just said about when we want to address certain topics, we're going to really try to focus on questions that are about the topics covered in detailed today, as well as more general questions about Direct Contracting or the RFA. Any questions specific to benchmarking or risk adjustment, we're going to reserve for those feature sessions. One last thing to note and then we can jump into the content. These slides have been posted on our website and they're also available for download in the meeting window. For future reference, please feel free to grab this. Okay, with that said, let's jump into the first agenda item.

I want to start by talking about the broad model goals that the design of the Direct Contracting model seeks to further. These are important to keep in mind, I think, as we discuss the financial methodology today. The first goal as you can see on the slide is to transform risk sharing arrangements in fee for service Medicare. Of the three goals listed on the slide this will probably be the most relevant today, since our topic is finance. Some examples of the model design elements that we hope will furthers this goal include, one would be flexible cash flows. Yoni is going to cover this topic in-depth, but basically, we tried to allow a range of different options that participants may select around perspective payment.

A second model feature that furthers this goal is setting a predictable prospective spending target, which we call the benchmark. We'll cover this as I mentioned in greater detail in next week's webinar. But you can look forward to some content and know that the methodology is really intended to be designed with this goal in mind. Then the last model design element I want to highlight is providing payment that recognizes the challenges for caring for complex chronically ill population. This is primarily accomplished through our updated risk adjustment methodology, which again is another topic for another day.

The second goal on the slide here is to empower and engage beneficiaries. There are number of model design elements that were included to further this goal as well. They include enhanced voluntary alignment and the benefit enhancements and patient engagement incentives that the DCEs can often do, probably not the focus today, but we've covered these in-depth in previous webinars.

Then lastly, the third goal listed here is to reduce provider burden. The examples of how we try to do this is to set a small set of core quality measures. That discussion will take place as part of the benchmarking that we'll cover next week. We also have some waivers to facilitate care delivery, these are sort of similar to benefit enhancements and more covered in detail in previous webinars. Then lastly, we have opportunities for organizations new to Medicare fee for service to participate as part of this goal to reduce burden. We'll be touching on that a little bit more next week as well when we talk about the benchmarks

The previous slide really set out the overarching model goals, and this slide covers the specific elements within the financial methodology aligned with those goals that represent a change from the next generation ACO model. For those of you who are familiar with that methodology, these are three elements that we just want to highlight again. I would say that the second bullet, capitation bullet, is the key focus of today. DCEs will receive monthly capitated payments from CMS as well as if the DCE elects other advanced payments under certain narrative. Yoni will cover this in-depth in just a few minutes so I'll pause there.

The other two bullets really involve the benchmarking approach. First, we have a new performance year benchmarking methodology that will be applied for the purposes of recognizing savings and offers. We think that will help promote payment stability and payment predictability.

Second, we expect that the new benchmarking approach will provide better participation opportunities for organizations that do not have experience or significant experience in the fee-for-service space, as well as entities that focus their care on populations that have complex conditions or who are chronically ill. As I mentioned, we just want to highlight these features are different than next gen, but again, these will be covered in more detail.

Next, I'd like to talk a little bit about provider relationships. I would say the structure of the DCE and its relationships to its providers is critical for understanding exactly how the payment mechanisms work. We just want to pause for a minute and make sure this is clear, so that when Yoni references these later on, everyone has a clear understanding.

Basically, each DCE must have agreements with Medicare providers and suppliers. There are two forms that these agreements can take. You have participant providers shown on the left and then preferred providers shown on the right. Let me quickly highlight the distinction between the two. First off, having participant providers is mandatory, whereas having preferred providers is optional. A key reason for this is the first bullet listed in each box which brings us to the second distinction, which is participant providers are used to align beneficiaries to the DCE, whereas preferred providers are not. In practice, what this means is that for claims-based alignment, we look only at the primary care qualified E&M claims filled by participant providers when identifying beneficiaries that have the plurality of these claims with the DCEs. We don't look at claims from the preferred provider.

This also means that if a beneficiary voluntarily aligns to a participant provider, it will count for the purposes of alignment. But if the beneficiary voluntarily aligns to a preferred provider, it will not count. The next distinction between participant providers and preferred providers is that participant providers are required to accept capitation, which means they must agree to have fee for service claim payments reduced in exchange for the DCE receiving perspective payments. Then they need to enter into a downstream arrangement with the DCE to determine how they will be compensated for providing that care, and this is optional for preferred provider. They're allowed to accept capitation, but it's not mandatory. Yoni will elaborate on all this very shortly. The last distinction I want to highlight is that participant providers contribute quality scores to the DCEs, whereas preferred providers do not. This will come into play more so next week, when we talk about the benchmark.

Before we move on, two similarities to highlight between these two different types of providers, first, both are eligible to receive shared savings. We leave it up to the DCEs to decide ultimately how to distribute those savings, but both groups are eligible for sharing that. Then second, both have the option but neither are required to participate in the benefit enhancements and patient engagement incentive. That's another option that would be available to both groups.

Next, I'd like to talk about the two options for risk that DCEs can choose from, the professional track and the global track. There are three key differences between these two tracks that are displayed on the slide that I'd like to highlight quickly. The first is how much risk the DCE assumes. The second is whether the performance year benchmark is discounted, and the third is the options that the DCE has for receiving advance payment.

As you can see on the slide here, DCEs choosing the professional option will split any savings or losses 50/50 with CMS, whereas DCEs choosing the global option will take on responsibility for 100% of those savings or losses. Related to this distinction is the other distinction which is mentioned in the last bullet in each column, so because global DCEs will receive all of the savings in the event that savings are generated, a discount will be imposed on their benchmark to ensure that CMS generates some savings as well. That discount begins at 2% in the first two performance years, before rising to 3%, 4%, and 5% in performance years three, four, and five respectively. Because professional DCEs share all savings evenly with CMS, there's no need to

apply a similar discount for their benchmark, there is no discount for professional, there is a discount for global.

Then the last distinction I want to highlight here before Yoni elaborates on it a little bit later on is that the options for DCEs regarding advanced payment are a little bit different. The short answer is that professional DCEs must take Primary Care Capitation, and they have the option to receive advanced payment. Whereas global DCEs get to choose between Primary Care Capitation and Total Care Capitation while they are not eligible to receive advance payments. I'll let Yoni define and explain those in a bit.

The last topic I want to cover before we dive into the payment mechanisms is the three DCE types that applicants are able to choose from. In general, I think it's helpful to think of standard DCEs as most likely being applicants that have a substantial historical claims-based experience serving fee-for-service Medicare beneficiaries, and potential experience in risk models as well. New entrance on the other hand, we tend to think of as DCEs with more limited experience delivering care to fee-for-service Medicare beneficiaries as well as more limited experience in participating in fee-for-service risk models like SSP or Next Gen.

Lastly, high needs DCEs are focused on beneficiaries with very complex and high needs. There's a lot more information about these DCE types in the RFA as well as in our first webinar. But for our purposes today, namely the payment mechanisms, risk mitigation and reconciliation, I would just say that there aren't any meaningful differences between these options as it relates to those three topics. All DCE types are able to choose the professional or the global option that we talked about on the previous slide. Within each option, all DCE types will have the same choices around payment mechanisms, that is to say, Primary Care Capitations or Total Care Capitations.

Let me just highlight a key set of differences between these DCE types. The benchmarking methodology for the standard DCEs differs in a meaningful way from the benchmark for new entrants in heights. This will be covered in great detail next week. The second distinction I want to highlight is about the minimum threshold of aligned beneficiaries. Standard DCEs may require at least 5,000 aligned beneficiaries in every single performance year.

New entrants, on the other hand, acknowledging that they are newer to fee-for-service, Medicare, or have less experience, have a glide path that they need to meet. That starts at 1000 beneficiaries minimum in performance year one, and it rises to 5000 where ultimately they'll be the same -- at least the same size as standard DCEs. Then lastly, high-needs DCEs acknowledging that they serve a very focused population have lower thresholds. It starts at only 250 beneficiaries at a minimum in performance year one and it rises to 1400 by the last performance year.

The last distinction I want to highlight is that the beneficiary is aligned to the high needs DCEs need to meet some additional eligibility criteria to demonstrate that they are in fact high needs. These criteria are listed in the RFA so I would point you there for any questions on that. Hopefully this covers the main differences, at least, as we will factor into our discussion today. Again, I would point you to the RFA or previous webinars for other differences or feel free to

just drop a question in the box and we can try to address it at the end. With that said, I mean that concludes the overview section. I'd like to turn it over to my colleague Yoni who will walk us through the payment mechanism section.

Thank you, Corey. One of the central elements of Direct Contracting is the enhanced payment mechanisms offered in the model. This builds heavily on the alternative payment arrangements that were available to participants in the next generation ACO model. The critical feature of these payment models is the ability for a DCE to receive stable monthly payments directly from CMS, which provide the DCE with improved cash flow and allow them to control funds being passed on to providers. This allows the DCE to do a few things, first, the DCE can make investments necessary to improve the care provided to their beneficiaries. Second, they can develop tailored value-based arrangements directly with the downstream providers that provide the right incentives for their providers to deliver high quality, low cost care to beneficiaries. These investments and the additional control that DCEs will have over funds will help achieve the broader goals of all CMS models, CMMI models, which are reducing health care cost, and improving healthcare quality and outcomes.

Here we go into a bit more detail demonstrating how the funds flow from CMS to the DCE, and how we would intend for the DCE to be able to use those funds to improve care to beneficiaries. The payment mechanisms in the Direct Contracting model are paid directly from CMS to the DCE, and this takes the place of a portion of payments that would have been paid through fee for service claims outside of the model. The DCE can then do a few things with these payments. They can invest in enabling technology, and analytical tools that support beneficiary care delivery and coordination, or better support beneficiary engagement. These could be things like analytics tools to support population health management, to identify beneficiaries that could be receiving better care or receiving unnecessary or avoidable care.

The DCE can also increase staffing and resources to better provide care coordination to beneficiaries and support beneficiaries through their healthcare journey. This could include additional access to patients to have 24/7 access or putting together assigned care teams to help beneficiaries manage their journey through healthcare. Finally, the DCE will be responsible for making arrangements directly with providers that are part of the DCE to reimburse them for the reductions, the claims that they had, that led to these payment mechanisms. We expect that DCEs will be able to be flexible with these payment arrangements and tailor them to provide the right incentives for providers. This could be based on outcomes or quality performance. We're excited for DCEs to be able to explore different approaches to achieve success through this.

Throughout a central element of this model is that flexibility for the DCE, we think there are variety of ways that DCEs can improve care and upfront cash flow allows them to test different approaches that can be successful.

There are two types of broad payment mechanisms that are available to DCEs, the first are capitation payment mechanisms, and the second are the advanced payment option. The capitation payment mechanisms are mandatory. All DCEs must participate in the capitation

payment mechanism. The unique element of this is that these are new. We haven't applied these in past ACO like models, and these are not reconciled against the actual claims expenditures, unlike past population based payments. On the other hand, the advanced payment type of mechanism is voluntary, and DCEs will not be required to participate in it. This payment mechanism closely mirrors the population-based payments that were offered within past ACO models such as Next Generation ACO.

Unlike the capitation payments, this payment will be directly reconciled against the actual claims accrued in the performance year and the reductions associated with those claims. I'll go into further detail on each of these payment mechanisms in the coming slides.

First, we will discuss the capitation payment mechanisms in detail. As I mentioned earlier, these are mandatory. Every DCE will need to select one of the two mechanisms. These payments are not reconciled against the actual claims expenditure. There are two capitation mechanisms available to a DCE, and this depends on the risk arrangement that Corey alluded to earlier that a DCE can select. The first type of mechanism, Total Care Capitation, covers the total cost of care for a beneficiary and is available only to DCEs participating, a 100% risk global track. The second mechanism, Primary Care Capitation, covers primary care services only, and is available to DCEs participating in both the global track and the professional track. For both capitation sites, the flow of funds is consistent.

The differences in the capitation sites relate to the types of services that are covered within the payment, and the payment amount relative to the benchmark. In all cases, DCEs will receive a monthly payment directly from CMS. This monthly payment amount will always be determined in some capacity based on the DCE’s performance year benchmark. Providers in the DCE will have fee-for-service claims for aligned beneficiaries reduced by a predefined amount based on the capitation payment, or in lieu of the capitation payment. The DCE will then be responsible for reimbursing its providers using the money it receives from CMS in exchange for those reductions.

The other payment mechanism type, the advanced payment, is optional for DCEs. As I mentioned previously, it closely mirrors the population-based payments that are available in the Next Generation ACO model. Similar to the capitation payments, DCEs are paid at a monthly upfront amount that is offset by reductions to provider fee-for-service plans. This amount is estimated prospectively based on historical utilization, but unlike the capitation payments, it will be directly reconciled against the actual claims reduction during final reconciliation.

As Corey mentioned previously, this option is only available to DCEs participating in the Primary Care Capitation. The intent of this option is to allow those DCEs to increase the proportion of their benchmarks that is being paid through the payment mechanisms, rather than through fee-for-service claims. While in the Total Care Capitation, that covers all services, the Primary Care Capitation covers only primary care services, and the advanced payment mechanism allows the DCEs to have a larger portion of -- to have some portion of those non-primary care services paid directly to them, rather than through fee-for-service claims.

I'll now dig a little bit deeper into the two payment mechanisms and discuss some of the operational processes I think everyone is really interested in, which is how we calculate the actual payment amount. From a process perspective, the capitation mechanism will begin with the DCEs selecting the capitation payment mechanisms for their entities. This will apply for both capitation options. As a reminder, global DCEs can choose either TCC or PCC, while professional DCEs must participate in PCC, Primary Care Capitation.

The DCE will then be responsible for negotiating contracts directly with their participating and preferred providers that define the payment reduction and reimbursement approach for each individual provider. I think this is an important point. This is where the model gets its name, right, this is the Direct Contracting that we're referring to. Based on those contracts, the DCEs will then be paid monthly capitated payments from CMS and will be responsible for reimbursing the providers according to the negotiated arrangements that they have with each provider.

The payment reduction amount that a provider gives will depend on the relationship of the provider to the DCE. A participating provider will have all relevant claims for the capitation reduced to zero dollars. That's a mandatory requirement for participant providers. Preferred providers on the other hand will have an option, they can choose whether they want to reduce their claims at all and be covered within the capitated payments. They can also choose what portion reduction they want to have for fee for service claims. It could be 0% reduction not participating, it could be 100% reduction, the same way that the participant providers have. It could be any percentage points in between that. Providers that are not associated with the DCE will continue to be paid 100% of fee for service claims.

Talking about the last chevron here, the reimbursement fee, this amount is not fixed by CMS. We don't predefine this, and DCEs will have flexibility here to pursue the types of tailored value-based care arrangements with providers that will best lead to improvements in care, quality and cost reduction. We've alluded to the capitation payment mechanisms type a few times now, but I want to be clear about what the two capitation methods are and how they apply to the DCE model. The first Primary Care Capitation, we also refer to as PCC applies only to primary care services, which are defined in the RFA at the level of CPT code. The second total care complication, which we'll also called TCC, applies to all services furnished to aligned beneficiaries.

Again, these capitation payment mechanisms are a mandatory component of the model. They apply to all DCEs, regardless of the DCE type. Standard, new entrants and high need DCEs will all be selecting one of these capitation payment mechanisms. However, the capitation option available to a DCE will depend on the risk traffic of DCE. Again, a DCE participating in the global tracks can choose to participate in either TCC or PCC, while a DCE in the professional track must participate in PCC. PCC is not available to those DCEs.

Regardless of the capitation payment mechanisms that a DCE is participating in, all providers must continue to submit claims to CMS. Many of these claims will be reduced even to zero dollars due to the payment mechanism. However, it is still important that CMS receive the

claims in order to support the DCE model. While CMS will not be directly reconciling the claims to the capitated payments, the data itself is still critical for program monitoring, and to provide reporting for participating DCEs. Claims data will also be used to calculate quality scores for DCEs during a performance year, and are a major input for evaluating the success of the model in its attempts to reduce cost and improve quality.

Now that we've described the capitation payments in detail, now we expect the DCE to use them. I'd like to dedicate some time walking through how CMS will actually calculate these capitated payments to be paid to a DCE. This is a more complex topic, and one that's important for DCEs and financial planning, so I'll spend a few minutes on this topic. For both TCC and PCC, the capitation amount will be developed based on a performance year benchmark that represents the estimate of total cost of care. For Total Care Capitation on the left side of the slide, this covers all services provided to the beneficiaries.

The TCC payment amount will be defined as equal to the performance year benchmark minus a withhold amount that accounts for the estimated claims payments that are outside of the capitation payment reduction. This withhold will include claims that are paid to providers that are not associated with the DCE, you can think of that as leakage. It will also include the portion of claims paid to preferred providers that have not reduced their claims by 100%. If a preferred provider chose to reduce their claims by 30%, then the remaining 70% of that fee for service claims amount for that preferred provider would be factored into the withhold estimate. This withhold represents the total summation of these decisions for all preferred providers and providers that are not associated with the model.

A few key notes to consider about this, the capitation payments will be calculated based on a provisional benchmark that is calculated prior to the start of the performance year. It is very likely that the actual benchmark for a DCE will change over the course of the year. However, in order to maintain a perspective and predictable cash flow, CMS does not plan to update the capitation announced using midyear adjustments to the benchmark.

Second, the withhold amount will also be estimated prospectively based on historical utilization patterns for participating for preferred providers. The intent of the withhold is to minimize the need for CMS to recoup significant sums from DCEs at final reconciliation. Beneficiaries are unlikely to receive all of their care from providers that are covered within the DCE's capitation payment. If CMS were to pay the full benchmark amount without any withholds, then this would likely lead to large amounts owed back to CMS at the end of the performance year.

On the right side of the slide for Primary Care Capitation, which covers primary care services provided to a beneficiary, this amount is defined in a different manner than the Total Care Capitation. The PCC amount is always going to be equal to 7% of the provisional performance year benchmark. The PCC is constructed of two components. The first component is the base Primary Care Capitation amount. This is determined based on a historical primary care experience of beneficiaries in the DCE. This portion of the PCC is a part that takes the place of the fee-for-service claims reduction that providers will be accepting during the performance year for their primary care services.

The second component of the Primary Care Capitation amount is the enhanced Primary Care Capitation amount. This is equivalent to the difference between the base PCC amount and 7% of the performance year benchmarks such that the total PCC, again is always equal to 7% of the performance year benchmark.

This portion of the PCC is intended to allow the DCE additional funds to invest in expanding primary care capabilities, such as the technology or the additional staffing and resources for care coordination that we described earlier in the presentation. The entire value of this enhanced amount will be recouped by CMS at the end of the performance year. To provide an example of this, if a DCE's historical primary care utilization was calculated at 3% of the total cost of care, then the base PCC will be equal to 3% of the performance year benchmark. The enhanced PCC will then be equal to the difference between the base PCC amount and the total PCC, or 4% of the benchmark, such that the 3% base and the 4% enhanced equals 7% of the benchmark. This 4% payment will allow the DCE to make the investments necessary to improve beneficiary care, but CMS will recoup the entire 4% amount before calculating reconciliation after the performance year ends.

A few additional notes on the Primary Care Capitation payments. Like the TCC, it is calculated based on a preliminary benchmark calculated prior to the performance year that is likely to change over the performance year. CMS does not plan to update the PCC amount to account for midyear changes to that benchmark. The other things to think about the enhanced Primary Care Capitation amount is that for participants who are familiar with the Next Generation ACO model, this is in many ways analogous to the infrastructure payments that are available in that model.

We spend some time talking about the capitation payments, I'd like to dedicate some time to the advanced payments before we wrap things up and move on to the other financial topics in today's webinar. As we alluded to previously, the Primary Care Capitation is always equal to 7% of the total cost of the care benchmark. We anticipate that a DCE may benefit from having control of the flow of additional funds than just that 7%. The advanced payment mechanism allows a DCE the ability to increase the proportion of the benchmark that flows directly through the DCE rather than through traditional fee for service claims. This allows a DCE to make the additional investments in care and then provide arrangements that we've been describing throughout this presentation.

The advanced payment mechanism is optional, and the first step is that a DCE must choose to participate. After a DCE chooses to participate, providers will then -- each be individually able to choose whether they want to participate in advance payment. The advanced payment amount will be determined based on the participant and the preferred providers that choose to participate in this payment mechanism. This payment mechanism applies only to non primary care services, and providers can here choose to have their fee for service claims for those non primary care services reduced by anywhere from 1%e to 100%. If a provider chooses not to participate in the advanced payment, they would have their claims reduced by 0%. Similar to the way things function with the capitation payments, CMS will then pay the DCE a monthly

amount that accounts for the estimated value of those claims reduction and will reduce claims accordingly to the providers that have chosen to participate.

As with the capitation payments again, the DCE will need to have agreements in place with the providers that define the amount of the payment reduction in the negotiated reimbursements of the provider from the DCE. However, unlike the capitated payments, the advance payments are purely a cash flow mechanism to increase the fundings of the DCE. They will be reconciled directly against the fee for service claims reduction that they replace.

Before we move on from the payment mechanisms in Direct Contracting, I would just step back and summarize the different mechanisms available to a DCE and how they would apply with the different types of providers included in the model. On the left is a Total Care Capitation, and this is available only to DCEs that are participating in the global risk option. In this approach, for DC participant providers, all fee for service claims both primary care and non-primary care are reduced to $0. For preferred providers on the other hand, they can choose to participate in this, and they can also choose the proportion of their fee for service claims that they want to be reduced. Again, this is one selection for a preferred provider. If they choose to have their claims reduced by 30% in the PCC model, that would apply to both primary care services and non-primary care services, there's no ability to segment between the two.

In Total Care Capitation because it covers all fee for service claims, there is no advanced payment option available for either participant providers or preferred providers. On the right side of the slide for Primary Care Capitation, this is available to both professional and global track DCE. It has a similar paradigm as Total Care Capitation but with only the primary care fee for service claim is included in the capitated payment. Again, all participant providers have these claims reduced to zero dollars. Again, preferred providers are given the choice to reduce claims by between 0% and 100%. However, these reductions apply only to primary care fee for service claims.

In this case, advanced payment is available as an option to the DCE and available to both participant providers and preferred providers for the non-primary care claims that could not have been covered by the PCC payment. For these advanced payments, both participants and preferred providers can choose whether to participate and they can choose how much they're willing to reduce their claims by between 0% and 100%. I'll now pass it back to Corey to walk through the risk mitigation and reconciliation options available in the model.

Thanks very much Yoni. I'll now address the two key components of the risk mitigation mechanisms that are available in Direct Contracting, and namely, those are Risk Corridors and Stop Loss. First, let me start with the discussion of the Risk Corridors. For those of you who are new to this concept, Risk Corridors limit the overall amount of risk that the DCE bears by decreasing the portion of savings or losses that the DCE is responsible for the further away the actual results, yet from the benchmark. When reconciliation happens, and this is the next section, so I'll cover what that means in a minute. But basically, what we do is we compare the benchmark or the predicted expenditure amount to the actual expenditure amount. The difference between the two, if any exist, could be expressed as a percentage of that

benchmark. For example, the actual expenditure might be 5% higher or 5% lower than what the benchmark predicted they were.

What a Risk Corridor does is it expands a range of percentages by which those actuals might differ from the benchmark. For example, a corridor might stretch from 0% difference between actuals and benchmark to 5% difference between actuals and benchmark. Then within that range the corridors will specify how much responsibility of the difference that DCE bears versus CMS bearing. We're going to take a closer look at the specific corridors on the next slide. But it's important to note first that these corridors are automatically applied to savings and losses for all DCEs. This is not something that the DCE has to opt into, nor is it something that a DCE could opt out of. It's a mandatory component of the model.

As I mentioned, the Risk Corridors are expressed as a percent of the benchmark typically, which means that they applied to aggregate savings or losses that the DCE has generated. At the end of the year you'll see across all the aligned beneficiaries, how much was expected to be spent versus how much actually was spent and the Risk Corridors manage that aggregate level of risk.

Now I'll turn my attention to Stop Loss, which has a couple of key differences from the Risk Corridors. First off, for anyone unfamiliar with Stop Loss it's a mechanism that protects at-risk entities, in this case DCEs, from infrequent but high cost expenditures for aligned beneficiary. Let's unpack what that means. It's helpful, I think, to consider the differences that exist between Risk Corridors to get a better understanding. First, unlike Risk Corridors, this is an optional risk mitigation mechanism that DCEs can opt into and this decision whether or not to elect to have Stop Loss can be made prior to each performance year. DCEs are allowed to change that selection every year if they so choose.

A second key difference is that Stop Loss kicks in at the individual beneficiary level rather than at the aggregate level. Basically, the way it works is that CMS will develop Stop Loss attachment points for each performance year, and what that means, what those attachment points are, is they dictate the amount of expenditure within a performance year that a given beneficiary needs to incur before the Stop Loss kicks in, in the amount of spend that the DCE is responsible for is reduced. For example, if the attachment point is set at $200,000, any individual beneficiary incurring more than $200,000 of expenditure within a given year, at that point the DCE had they elected Stop Loss would begin to be protected from that additional spent. That's how Stop Loss works at the individual beneficiary level whereas Risk Corridors will kick in at the aggregate savings level.

Now let's take a closer look at the specifics of the Risk Corridors that are built into Direct Contracting. This slide lays out those specific corridors and it notes how they vary between the global option and the professional option. At the beginning of this presentation and as well as in past webinars, we've described these two tracks, global and professional. Generally we speak about the global track as having 100% responsibility for savings and losses, and the professional track for having 50% responsibility for savings and losses. As you can see here, while that's true in general, those amounts really just apply to the first corridor.

Now that said, for global the first corridor is very wide. If you look at the top row of our slide here, for any savings or losses in aggregate within a performance year, that are up to 25% of the benchmark, the DCEs are 100% responsible for that spend or for that extra spend or for those savings. That is why we tend to speak about global as having 100% responsibility. In the event, however, that savings or losses would exceed that amount, the next corridor or would kick it. In this case, as you can see in the next row, that next corridor ranges from 25% to 35% savings or losses relative to the benchmark. In that corridor, you can see, as following the chart to the right that the DCEs responsibility drops from 100% for the savings or losses to 50%. Then as the next few rows kick in, you can see it continues dropping all the way down to only 10% responsibility in the event that savings or losses, or to exceed 50% of the benchmark.

For professional in the bottom half of the slide, you'll notice that the corridors are much narrower. In the first corridor, it's only five percentage points wide, meaning that if savings or losses are 5% or less relative to the benchmark, then the DCE will bear 50% responsibility. That will continue to decrease. The next corridor spans from 5% to 10% and the DCEs responsibility drops from 50% to 35% responsibility. All the way at the bottom of the corridor, you can see that if savings or losses are greater than 15%, the DCE will only bear or only get credit for 5% of those savings or losses.

I think before we move on there's a couple important points I just want to note here. The first is that the corridors are the same for savings or losses, so they're essentially mirrored around the benchmark. Their function, in essence, is really to limit extreme instances of savings or losses that a DCE might experience. Second, these corridors are applied marginally, meaning they function, I like to think of it like income tax bracket. Let me sort of walk through an example of what that means in the professional context.

If a DCE that elects professional risk were to generate, let's say, 7% of savings relative to the benchmark in a given performance year, the first 5% of those 7% gross savings would fall into the first corridor, and then DCE would keep half of it. The DCE would keep, within that first corridor, about 2.5% of the total benchmark in savings. Now the last 2% of the 7% growth savings that were generated would fall into the second corridor. The DCE would only keep 35% of those savings, so that's how the corridor’s work, it's a marginal basis. It's not determined by the highest corridor you hit.

Hopefully that was a helpful summary of the two key risk mitigation mechanisms. I'd like to spend a couple minutes now talking about reconciliation before we open it up to a Q&A. At a high level, reconciliation is the process by which we determine savings and losses. We do this by comparing the benchmark to all Medicare expenditures for services delivered to aligned beneficiary. This would include the capitated payments, so the total cost, Total Care Capitation or Primary Care Capitation that Yoni talked about, and it would also include any fee for service claims paid. That would include any fee-for-service claims paid under advanced payment. Yoni talked about this before, but this reconciliation process is where the key difference of advanced payments being reconciled, the actuals, comes into play. That said, all expenditures regardless of whether it's delivered in capitation or fee-for-service claims are considered when we compare actuals to the benchmark.

Now after we make those adjustments to advance payments, we can compare the benchmark to all Medicare expenditures and sort of not worry about any claim reduction complication. As Yoni stated before, the capitation portion of the spending does not need to be adjusted. The capitation sort of is what it is to the DCEs and that will count towards the benchmark in the exact amount that was paid throughout the performance year.

As you can see on the bottom right hand side of the slide, the final reconciliation will occur roughly six months after the conclusion of each performance year. This allows time for full claims to run out to ensure that our numbers are complete and based on a full data set for that performance year. That said, in the past we've heard stakeholder feedback that six months ultimately is a long time to wait to find out how you did basically. What we've done in this model and this is a new feature with Direct Contracting is we've added the option of engaging in a provisional reconciliation. Under this option, what we'll do is we'll estimate and distribute interim shared savings and losses based on data from the first six months of the performance year. As you can see on the slide, this will occur in January, just following the performance year, so within a month or two of the conclusion of that performance year.

Regardless of whether or not a DCE elects to engage in provisional reconciliation, a final reconciliation based on the full data set will still need to occur. In the event that we do a provisional reconciliation, we're going to make our best efforts based on the data that we have to make -- to distributed shared savings or shared losses as accurately as possible. But that said, once the full data set comes in, we're going to need to rerun the numbers, and then we're going to further adjust in the event that there were any differences.

Next week, we're going to cover the benchmark in great detail and that's going to help everyone to get their heads around how exactly reconciliation works as the benchmark is really a huge component of it. We're also going to walk through a more detailed example of reconciliation, but just for the sake of being illustrative today, I want to walk through a really simple example within Total Care Capitation.

Let's just imagine to keep it very simple that the benchmark is $100 and of that $100 based on historical expenditures, let's say that $25 was comprised of services from participants providers. Let's say that, for the sake of simplicity, that there are no preferred providers in this example. In this situation, we expect essentially the benchmark at $100, means we expect to spend about $100 for the care of any aligned beneficiary, and $25 of that will be paid out under Total Care Capitation. The remaining $75 we then expect to be billed in fee-for-service claims. Remember, there's no advance payment in Total Care Capitation and we've excluded preferred providers just to keep it really simple in this example.

At the end of the year, what we do is we have our benchmark of $100. We know that the $25 that was paid out in Total Care Capitation will count against that benchmark, so the only thing left to do is to look at the amount of fee-for-service claims that were billed. If, for example, only $70 of fee-for-service claims were billed, that would yield $5 in savings. If $80 were billed, the $25 in capitation, plus the $80 in fee-for-service claims would yield $105, which is $5 over the benchmark, and therefore $5 in losses would be the results of that year. Hopefully that at a

high level that allows people a general understanding, and again next week we'll walk through a much more in depth answer with -- that takes into account more of the intricacies of the different options.

This next slide just adds a little bit of detail on the difference between the provisional and final reconciliation options that I talked about on the previous slide. As you can see, the provisional reconciliation will include claims data from the first half of the performance year only, and we will use this to extrapolate what we expect the full year claims to look like incorporating seasonal adjustments to try to get the best guest that we possibly can. Final reconciliation, on the other hand, includes the full set of claims billed in the performance year for services provided through aligned beneficiaries. Now the claims run out for provisional reconciliation will be six months, which will essentially put us at the end of the performance year, whereas the run out for the final reconciliation will be three months. That will give us a couple months until final reconciliation actually occurs roughly in June or July following the performance year.

One last point to note because I talked about Stop Loss a little bit earlier on, the Stop Loss attachment points will only be included in the final reconciliation. It's just because it's very difficult to predict the amount of expenditure that will be subject to Stop Loss protection when you only have six months of data given that by definition, instances of this expenditure is unpredictable in nature as these episodes tend to be sort of very high cost and very infrequent.

That concludes the four topics that we wanted to cover in today's webinar. At this point, we would like to open it up for questions. I know I can see in the meeting window that a bunch of questions have come in already. I'd encourage you to continue submitting questions, if you have any. Please go ahead and continue doing that in hang out on the line for a minute. We are going to go on mute for a short period of time, just to make sure that we have a handle on all the questions coming in, and then we'll go off mute and begin answering questions shortly. Just please be patient with us and we'll be back to you very quickly. Thank you.

Hi this is Yoni again, thank you everyone for your patience. We're going to start answering a few questions. We received a number of questions around what happens when a DCEs participating in the global risk track chooses the Primary Care Capitation option. Can that DCE then have advanced payment? The answer is yes. The advanced payment option is available for all DCEs that choose Primary Care Capitation independent of whether that DCE has global a 100% risk or professional 50%.

Another question, does the capitation payments apply during the implementation period? The answer is no. The capitation payments are tied to performance year and will first be relevant in performance year one, which begins in the 2021 year.

We also receive some questions on how claims will flow and data will flow to the Direct Contracting entities. Will the DCEs be required to set up processes to collect claims directly from providers? What information will CMS be sharing with DCEs? The answer is that CMS will provide the CCLF the claims line feeds that have all the data on the claims submitted by providers that are associated with beneficiaries aligned to the DCE. The DCE will not need to set up direct reporting processes with their providers in order to get that claims-based data.

There were also a number of questions around the capitation payments and reconciliation and what that means. We said a few times that the capitated payments will not be reconciled directly against the actual claims amount. There were some questions about how that applies in the context of final reconciliation. I think this is a good area to spend some time on because it is easy to be complex.

During final reconciliation, CMS will be comparing the final benchmark for a DCE to all of the Medicare payments made for the beneficiaries aligned to the DCE. When we say all the Medicare payments, we're referring to Part A and Part B, they're not Part D, but we are including the capitated payments and fee-for-service claims. Any advanced payments that are derived from reductions on fee-for-service claims will also be accounted for. But those will be accounted for in advance of the reconciliation to make sure that that advanced payment amount does not -- is equal to the fee for service claims reduction.

I think to give you another example, if we were paying out $100 in advance payments, but $110 were actually reduced from claims on a per beneficiary per month basis, then CMMI would return $10 to the DCE, such that for the purposes of comparing the benchmark to fee-for-service claims, we would be considering it as $110 of spent.

To continue with some other examples that hopefully will help clarify this point. If the benchmark was $1,000, right, and I think Corey gave an example about this earlier, but it's helpful to talk through it again. The withhold was estimated at $500 based on historical utilization, which means that our best guess is that $500 PBPM and fee-for-service claims will be paid out and not reduced during the performance year. $500 will be paid through capitated payments and that amount is locked in and counts towards the expenditures that are being compared against the benchmark, no matter what services that are subject to the cap are actually provided by the participant and the preferred providers that are reducing claims for the capitated payment.

When we say that the capitation payments will not be reconciled, what that means is we will not be taking that $500 and comparing it to the actual services that were provided in lieu of that $500 payments, right, or that would have been paid through fee for service claims, but are now being paid through the capitated payment. However, at the end of the performance year, we will take that $500 and we will add to it all fee for service claims payments that CMS made for aligned beneficiary. The total of those two amounts, right, will be equal to the expenditures and will be compared to the benchmark for the purposes of savings or losses.

If the benchmark is $1,000 at the end of the year and $500 was paid out for capitated payments over the course of the year, then if the expenditures through fee-for-service claims are greater than $500 then expenditures will be greater than the benchmark and there will be losses for the DCE as part of reconciliation. Conversely, if expenditures for fee-for-service claims are less than $500, then expenditures will be less than that benchmark amount and savings will be generated and paid for the DCE as part of reconciliation. Again, this is independent of the actual services provided within the DCE's capitated payments.

The idea behind this is that if services move away from the Direct Contracting entity, then they will show up in fee-for-service claims and will be included in reconciliation, and vice versa if services move away from fee for service claims towards the providers that are within the Direct Contracting entity and the capitated payments. Again, we will provide more information on this next week when we talked about the benchmark. Hopefully, that'll help clarify this further. We understand that this is one of the more complex areas of the Direct Contracting model to understand, and so we'll try to explain it a few different ways over the coming weeks and months.

We've received a number of other questions around preferred providers, I just want to try to take those all in a row here. The first question is, are preferred providers required to take at least a 1% reduction in their claims in order to be a preferred provider? Or can they be a preferred provider but leave the financial rates at the fee for service rate? It's a good question. I think I understand where the confusion comes in, because some of the charts you'll see, their choices are between a 1% and 100% reduction rather than a 0% and 100% reduction. But really what we mean here is that they are not required to take any reduction if they don't want to.

They really have two choices to make, this is the explanation for why the chart looks like it is, and again I acknowledge that I understand where some of the confusion is coming from. The first choice that they can make is whether or not they're going to participate in these prospective payments and claims reduction mechanisms at all. If the answer is no, which it certainly can be, and they can still be preferred providers, then their claims wouldn't be reduced at all. If, however, they do decide to participate, that's why that chart says, then they get to choose if they want to reduce it anywhere between 1% and a 100%. They couldn't choose zero in that option if they've indicated that they want to have some participation, which requires some claims reduction. I think that's a good question, but hopefully that takes care of that.

Another question about preferred providers we got was essentially what is the incentive to be a participant provider rather, if the preferred providers have the options and the flexibilities and still get to share in the shared savings? In other words, why would any practice want to be a participant provider, and what would be a reason why they would choose that? It's a good question, but there's a couple important differences that I'd remind you, between the two. The first is that preferred providers are not -- don't factor into alignment. In order for a DCE to have beneficiaries aligned to them, they need participant providers. Those participant providers will contribute a claims history if they billed primary care qualified evaluation and management claims that can contribute to beneficiaries being aligned to them to claim. Those participants providers will also contribute to alignment if a beneficiary is voluntarily aligned to them.

If you're a preferred provider, your claims history and any beneficiary choosing you for voluntarily alignment does not contribute to the DCE’s alignment. From the DCE’s perspective, there's a big incentive to have participant providers otherwise they will have no beneficiaries aligned for them. The second piece is that ultimately, yes, preferred providers have more flexibility in terms of the arrangements, they also get to share in the savings. But it's ultimately up to the DCEs, the participant providers and the preferred providers to negotiate those

arrangements. It may be the case that DCEs decide that participant providers because they're contributing to alignment, because they're contributing quality data, because they may be taking a larger reduction on their claims than some preferred providers. They may end up being able to share in more of the savings, that's not something we decide, it's sort of up to the DCE and its providers. But those would be two reasons why you might want to be a participant provider rather than preferred provider.

There's one more preferred provider question here. I think Yoni partially answered it already. The question is, under either model, wouldn't it be incumbent for preferred providers to bill twice, once to CMS for encounter capture and no pay, and then again for the DCE for their payment? That's a possibility. But we ultimately leave that up to the DCE. As Yoni said, providers will continue to bill Medicare, and Medicare will provide all those claims billed to the providers in the CCLS monthly file. The DCEs will know what claims are being submitted by their participant and their preferred providers and how much if any of those claims have been reduced. If the DCE wants to set up a process where those providers also notify them that may be a solution, if they want to use the CCLS files that may be a solution that avoids providing having to double submit. That's something that we leave up to the DCEs, but we do want to again highlight that the claims data will be made available to them.

I've got another question here. I think that we can answer quickly. Does CMS make payments to the DCE's TIN or does it make payments to the individual TINs that are a part of the DCE? The short answer here is that when CMS makes payments, those payments might be capitation, or advanced payment, any prospective payment that's going through the DCEs, or it could be in savings or losses after reconciliation. Those payments are always made to the DCEs, and then it is incumbent upon the DCE to distribute those payments amongst the providers in accordance with the agreements that it's set up with those providers. The only payments that CMS will make directly to providers will be for fee-for-service claims that have not been reduced due to capitation or due to advanced payment.

This is Yoni again. A couple of additional questions we received. There were some questions around the monthly capitated payment versus the annual capitated payment. I think it's good to clarify that in the Primary Care Capitation, for example, which is defined as 7% of the preliminary performance year benchmark. That 7% isn't annual 7% right, so it is not that a provider will be receiving 7% of the annual benchmark each month. The cumulative monthly payments will equal 7% of the annual benchmark amounts.

There are also some questions around patient financial responsibility and cost sharing and how that might play into the capitated payments and the reconciliation. The answer is that, this does not. Beneficiary cross-sharing is not counted in the benchmark or in the expenditures. If a DCE elects to engage in Part B Cost Sharing Support, that would not impact the benchmark either. That would be fully funded by the DCE separately from the reconciliation process.

Another question: how these payments are similar or different from the alternative payment arrangements offered in Next Generation ACO. The population-based payments, the all-inclusive population-based payments and infrastructure payments. The major difference is that

the capitation payments are not reconciled against the actual claims directly. The advanced payments I think are best thought of as analogous to population based payments that are in Next Generation ACO because they are reconciled against the actual claims. I think as we've mentioned previously that the enhanced portion of the Primary Care Capitation amount is in many ways similar to the infrastructure payments that were part of Next Generation ACO, and that the entire amount is recouped from the DCE before the reconciliation process takes effect.

There's a couple more questions I want to get through. Let me just first add one thing to the question I answered about preferred providers and the incentives for why you might want to be a participant provider rather a preferred provider, and this is an important thing which I neglected to mention, which is that the preferred providers will not be counted as AOM so they don't qualify for the BPCI. That would be another big incentive for organizations that want to be considered participating in the APM to become participant providers rather than preferred providers.

We've gotten two questions around Stop Loss that I'd like to address. The first question is for each performance year, when do I have to make a decision about Stop Loss? I mentioned that this was a decision that the DCEs could elect annually and they could change that decision every year. The short answer is that for each performance year, we will release the Stop Loss attachment points, which is again the expenditure cut offs when Stop Loss kicks in along with the preliminary benchmark. We haven't exactly finalized timing but these will be once all the PY1 applicants are awarded then -- and we have their final provider list, we'll be able to calculate their preliminary benchmark and at that time we'll also be releasing the Stop Loss information and DCEs will be able to make that choice.

A related question to Stop Loss which is a good question is: is there any downside? Clearly there is an upside. It prevents you from infrequent and high cost expenditure, but what's the downside? The short answer here, and this is something that will also be released once the benchmarks in the Stop Loss attachment points are released: Stop Loss will come with a charge, and so it will be up to the DCEs to ultimately weigh the cost of participating in Stop Loss with the benefits of being protected from very high and infrequent instances of individual beneficiary expenditure.

Another question we got is why is the PCC, or the Primary Care Capitation, at 7% of the total cost of care? Yoni talked a little bit about this, but I think it's an important point so let me just expand on it a little bit more. In general, in a general fee-for-service Medicare population, primary care expenditures tend to be approximately 2% to 3% of the total cost of care. But CMS has decided to set that Primary Care Capitation at the higher value of 7% of the performance your benchmark rather than 2% to 3% or whatever the actual experience of the DCP is to promote the delivery of enhanced and more comprehensive Primary Care Services. The intent here is to provide cash flow up front that the DCEs can then invest in whatever care of management activities they feel like they need in order to succeed.

Yoni covered this, but just again, to reiterate, because I know this is the point of confusion, that the Primary Care Capitation of 7% will include the two components. The base amount will be

based on the actual primary care expenditure as a percent of the historical total cost of care that a DCEs participant providers have experienced. Then everything else, let's say that actually for a DCE that was 3%, everything else up to 7%, in this example 4%, is what we call enhanced Primary Care Capitation. Again, as Yoni mentioned, the base amount functions very similarly to the Total Care Capitation in the sense that it's paid prospectively and when it comes time to do the final reconciliation, it is included amongst the expenditures that we compare to the benchmark. The enhanced amount is treated completely separately from that. It is provided on a monthly basis to the DCEs and then CMS will recoup that amount in full at the conclusion of the performance year.

We received some questions about the calculation of the provisional benchmark that will be used to determine capitated payments. As Corey has alluded to a few times, next week's session we'll go into much more detail on the benchmarking methodology. But to clarify a few things, that provisional benchmark will incorporate our best estimate of what the final benchmark will be. There are factors that will change that over the course of the year related to the actual risk scores of the population, the actual beneficiaries that are aligned and how that changes over the year, the final quality scores. To the extent possible, CMS will be putting estimates or placeholder scores for those values to provide a benchmark that is as accurate as possible at that point. In the quality withhold, for example, a placeholder quality score would be used to estimate the earned back for quality prior to calculating capitated payments, right. Again, that would allow the capitated payments to be as accurate as possible at the start of the performance year.

Two other questions I'd like to address, first, I think is a quick one, are shared savings and loss is calculated based on the total cost of care or only the services furnished by participants of the Direct Contracting entity? The simple answer here is that they're calculated based on the total cost of care that includes services that are provided and billed by providers that have no affiliation to the DCE. We've talked about this a little bit, and we're going to continue talking about it next week. But for some DCEs that maybe Primary Care Capitation are on the smaller side, the amount of spend that goes through their participants and preferred providers as a percentage of the benchmark might be fairly low.

For other DCEs that maybe include a hospital or a lot of providers in a given metro area, the portion of the benchmark that is ultimately comprised of its participant and preferred providers might be really high. In either case, it doesn't matter. We're always looking at total cost of care. The two components of the total cost of care is basically everything that flows through the providers in terms of capitation, or advanced payment, and then everything else. That includes any fee-for-service claims paid out to preferred providers, for example, as well as claims paid out to providers with no affiliation with the DCE whatsoever.

One more question I'd like to address is, are the capitation payments to DCEs subject to sequestration? The short answer here is yes. In accordance with the balanced budget in Emergency Deficit Control Act of 1985 CMS will reduce the payments made to DCEs for sequestration by 2%. We're going to cover this in a little bit greater detail next week. But just as a preview, the benchmark and the performance year expenditures will be calculated on a pre

sequestration basis. Then any capitation payments Total Care Calculation or Primary Care Capitation, as well as any advanced payments will be calculated on a post sequestration basis where the sequestration will result in a 2% reduction to all those payments. At provisional and final financial reconciliation, any shared savings will be also calculated on a post sequestration basis where any shared savings earned by the DCE will also be reduced by 2%. Hopefully that shed some light on that issue. I imagine we'll be talking about that a little bit more next week as well.

Again, guys, the questions are continuing to come in, give us another minute or two to just gather our thoughts, and then we'll hop back on the line and continue going through questions. Just please be patient and bear with us. Thank you.

All right, thanks everyone for your patience. We're going to take a couple more questions here, and then we're going to wrap up and give you guys a little more information about what to expect in the coming webinars. Let me run through a couple of these last questions that are coming in. The first is, are we allowed, so within the global track, are we allowed to switch between TCC which is Total Care Capitation, and PCC which is Primary Care Capitation? The short answer to that is yes. You'll be able to make that switch before each performance year. That is an option that the DCEs will have, but remember, only within the global risk track. If you're in the professional risk track, you need to take Primary Care Capitation.

We've answered these questions before about can we switch between risk track? The short answer is, before performance year one, so if you're applying for the implementation period, you would be able to switch between global or professional. Once you've made your election for performance year two, that will be locked in for the first two performance years. Starting at performance year three, we'll allow you to move from professional to global and you can make that selection at any year before performance year three, four, or five. But we will not allow DCEs to go from global to professional.

Another question we had was whether or not the discount that will be applied to global DCEs will be cumulative or whether or not it would apply only within a year? I guess the interpretation that I have this question is if it were cumulative, and we've shown that it's 2% in the first year, and 2% in the second year, does that mean that by performance year two, it's actually 4%? The answer that is no it is not cumulative. Those percentages that you see which start at 2%, and then move all the way up to 5% by performance year five, will impact only within a base year. For every single year, we will calculate your benchmark, and if you're a global DCE we'll apply the discount that's listed for that year only.

There was a related question which I sort of already started to answer, I suppose which was, will we reset the benchmark every year? The short answer to that is yes. We're going to cover this in a lot more detail next week, so I will hold off on the details for now. But DCEs will receive a different benchmark for each performance year.

Then one last thing I want to point out is that because there's been a bunch of questions about risk adjustment coming in. As I laid out at the beginning of the presentation, the focus of next week will be about benchmarking and then a more detailed example of reconciliation. We will

cover risk adjustment -- we have not quite finalized the date. I would keep checking our website, keep checking the listserv for updates, because we expect to release those very soon. But there will be a risk adjustment webinar that will be scheduled in the near future. Look out for that, but please know that it is going to be a separate topic and will not be covered next week, and because of that, sort of similarly with how we treated benchmarking this week, we're going to defer any questions about risk adjustment until we've had the opportunity to sort of present the information in a little bit more detail. With that said, thanks everybody for submitting questions. I hope this was very helpful. I'm going to turn it over to my colleague Yoni to help us wrap up.

Yeah thank you Corey. For those of you who have been with us for a few other webinars now, you're probably familiar with it, but it's good to go over the model timeline. The DC model starts with an implementation period that will take place during the latter half of the 2020 year. The application period is underway right now for the implementation period, and it closes on February 25th. Potential participants that are interested should work on their applications now.

We will then be selecting DCEs for the implementation period in May of this year, and applicants will be required to sign and return participation agreements for the implementation period in June. I think it's important to note here, applicants that are selected for the implementation period will then be allowed to choose again whether they want to participate in the performance period in PY1. They will have to make that choice by choosing to sign and return a Participant Agreement by December 2020.

The second important period here for Direct Contracting is performance year one, what's referred to as the performance period on the right side of the slide. The application period for this has not opened. Again, DCEs that are selected as part of the implementation period will not need to apply again for the performance period. They will be able to sign their participant agreement without submitting a second application. For the performance period applicants DCEs will be selected in September. As with the IP selected DCEs, they will be required to submit and sign Participant Agreements by December 2020 in order to participate. The actual performance year will start in January 2021 and will run through the end of December of 2021.

We also have a number of upcoming webinars as well as some office hours in the coming weeks. We've referenced this a few times today. Next Wednesday is the Payment Part 2 webinar with a heavy focus on benchmarking. We hope to address a lot of the questions that were raised around the specifics of our approach for benchmarking during that webinar, as well as others that arise there. This session will not be covering anything about risk adjustment, as Corey mentioned, we plan to have that as a future event. We also are planning to schedule additional office hours in the future to respond to further questions on the financial methodology. Stay tuned for those.

Before we go, there's one quick audience poll question. How likely are you to apply to participate in the Direct Contracting model and there are five options from unsure to very likely. Please take some time to respond.

We've gotten a good deal of responses in so far. It looks like more than half of our participants are likely or very likely to apply. Glad to hear that we're reaching the appropriate audience with these webinars, and we hope you'll join us next week as well.

Finally, I'd like to close with some contact information. There's a link here to the Direct Contracting web page, which has a link to the application as well as other published information on the model, as well as emails for questions to the Direct Contracting team, as well as to sales force support as part of the application. This webinar is posted and available for download, so listeners should be able to view it already. Okay. Thank you very much for joining us. Again we hope to see you next week. Enjoy the rest of your day.