

Direct Contracting Payment Part 2 Webinar

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Recording Transcript

My name is Corey Rosenberg. I am one of the co-model leads for Direct Contracting. Just like last week, I'll be splitting the speaking duties with my colleague Yoni Kozlowski who is the finance lead for Direct Contracting. I wanted to thank everybody for joining us today here. We know how important the benchmarking methodology is to you all, and so we're excited to cover that topic in detail. I want to note that the slides for this presentation are posted on our website. I know that some folks have noted that it's hard to download them through the window. They also are available for download through the window. But if you're having trouble accessing the slides, you can find them on the website.

Before we dive in, I just want to pause for a minute and talk a little bit about what we're going to cover today versus what we're going to provide more information on in the future. As always, we're going to start with a quick overview of some of the key concepts within the Direct Contracting model. I am going to apologize in advance for everybody who's tuned in last week, this will be a little bit of a review, but it's important that we cover the content because it factors prominently into the benchmarking approach. Also, there are folks who are unable to join previous webinars. I'll try to move fairly quickly and hit the key points, but we will be covering that upfront section again.

Most of the time, though, today we're going to spend talking about the details of the benchmarking methodology, and how that varies by DCE type. For anyone who was unable to join last week, we covered the payment mechanisms in detail, including Primary Care Capitation, Total Care Capitation and Advanced Payment, along with risk mitigation in the reconciliation process. I'll point you to the webinar, if you have not yet seen it, to find that on the website for anyone seeking to learn more about those topics.

I want to note also that we will be not covering risk adjustment today, we'll be covering that at a later date. For the Q&A portion, we're going to defer questions on risk adjustment. We are in the process of running our simulations around risk adjustment, which will determine the final policy decisions around that, and as soon as that's finalized and ready to go, we'll be communicating that to you all. Just keep an eye out for that.

Lastly, just like last week, after we get through today's agenda, we're going to have an open Q&A session. Please submit questions at any time through the meeting window. We're going to primarily focus today on questions on payment, which was last week's topic as well as the benchmark in sort of any finance related questions today. We have some office hours coming up in the future where we can tackle additional topics, more general questions or anything covered in the prior webinars. Okay, great, so with that said, let's dive into our first agenda item which is the Direct Contracting overview.

Just like last week, let me start out by addressing some of the overarching model goals. I think that these are important to keep in mind today as we discuss the content because they inform

a lot of the policy decisions in the methodology. The first goal on the slide here listed is to transform risk sharing arrangements in fee-for-service Medicare. Of the three goals here on the slide, this is probably the most relevant today given that our topic is the financial side. There are a number of model design elements that we hope will further this goal. I'll list a couple here. One is the flexible cash flows. We discussed this in-depth last week. But just to remind everyone, in case you didn't listen in, we hope that by providing a range of perspective payment options for participants, we can help DCEs make investments in providing more effective care for beneficiaries which will further this model goal.

The second model feature I'll highlight under this goal is setting a predictable perspective spending target, or we can call it the benchmark, and that's our focus today. We're going to get into a lot more detail on that, but for now I just want to note that ultimately the benchmark methodology was crafted with this goal in mind.

Then lastly, a model design element I want to highlight is providing payment that recognizes the challenges of caring for complex, chronically ill populations. As you all, I would hope, know, we have a specific DCE type, the high needs DCEs, that's crafted specifically around serving this population. We also expect that standard DCEs or new entrants will also be caring for seriously ill patients as well.

The second goal listed here is to empower engaged beneficiaries. Similarly there are a handful of model elements included that seek to further this goal as well. These were mostly discussed on past webinars but they include enhanced voluntary alignment, including the option to recognize newly voluntarily aligned beneficiaries on a quarterly basis, this is what we called prospectivity. They also include the benefit enhancements and the patient engagement incentives that DCEs can opt into.

The third goal on the slide here is to reduce provider burden, so examples of model components that further this goal include a smaller set of core quality measures. We're going to look a little bit today about what this looks like and talk about how quality factors into the benchmark, so stay tuned for that discussion later on. Second model element would be waivers to facilitate care delivery. This is sort of along the lines of the benefit enhancements, which we covered on in previous webinars.

Then lastly, opportunities for organizations new to Medicare fee-for-service to participate. This was covered primarily in our first webinar that focused on the different DCE types. But this factors fairly prominently into our benchmarking discussion as we'll get into because the DCE type ultimately determines your benchmarking methodology.

We just looked at the overall model goals. This slide covers the specific elements within the financial methodology that represent a change from the Next Generation ACO model, which I know many of you are familiar with. These elements are important to keep in mind as we go through the content today just to help orient you where the new methodology sits relative to past programs.

The first bullet listed here is the new performance year benchmarking methodology. Obviously, this is the focus today we're going to talk about it in a lot of detail. I do want to highlight though, right up front, what we consider to be three of the biggest changes from the Next Generation ACO model methodology. Those are, number one, we're going to be blending in a regional expenditure factor which is based on an adjusted MA rate book that we'll release. Number two is that the base period that we look back to, to establish a baseline, is fixed rather than in Next Gen. Those base years are on a rolling basis which some might call sort of a rebasing approach.

Then lastly, the quality withhold works a little bit differently than it does in Next Gen, so all three of these we're going to talk about in more detail. But I would say a number of these features, especially the fixed based year period in the blending of the regional expenditure factor are really intended to increase benchmark stability year over year and ensure DCEs have a good sense of what their benchmark will look like prior to each performance year.

The second bullet here we covered in detail last week, but basically Direct Contracting introduces capitation and makes it mandatory for participant providers. It also offers flexibility and whether that capitation applies to primary care if the DCE elects Primary Care Capitation or whether it applies to all claims if the DCE elects Total Care Capitation. This is a meaningful change from Next Gen as well.

Lastly on another topic that we'll discuss in detail today for the third bullet point is the fact that we have an alternative benchmarking approach for entities that may not have enough claims history to produce a reliable baseline. For new entrants, who may be newer to Medicare and for high needs DCEs who focus on a smaller set of beneficiaries, the benchmark in the initial three performance years will be based on the regional expenditure and won't include a historical baseline specific to that DCEs provider set. This is a new feature as well relative to the Next Gen program, which does not distinguish between ACO types. This is something that we hope helps extend participation opportunities to organizations that maybe haven't had the opportunity to participate in the past.

Now I'd like to talk a little bit about provider relationships. I know we've covered this before, but this is a topic that we continue to get questions about. Hopefully this slide will be helpful. Each DCE must have agreements with Medicare providers and suppliers. There are really two forms that these agreements can take. There's the participant providers, which is shown on the left hand side of the slide, and the preferred providers which are shown on the right hand side of the slide. I'm going to quickly highlight the distinction between the two. To answer a number of questions, I know this can be a confusing topic for some folks.

First of all, having participant providers is mandatory, whereas having preferred providers is optional. A key reason for that is the first bullet listed in each of the boxes here, that's because participant providers are used to align beneficiaries to the DCE whereas preferred providers are not. This means that for claims-based alignment we only look at primary care qualified E&M claims billed by participant providers when we're identifying beneficiaries that have a plurality of their claims with a DCE. We don't look at claims from preferred providers. This also means

that if a beneficiary voluntarily aligns to a preferred provider, it will count for alignment. But if that beneficiary voluntarily aligns to a preferred provider, it will not count. That's an important distinction we want to make clear.

Second here is that participant providers are required to accept capitation, which means that they must agree to have fee-for-service claim payments reduced in exchange for the DCE receiving prospective monthly payments from CMS. Then they need to enter into a downstream arrangement with that DCE to determine how they will be compensated for providing that care. This, on the other hand, is optional for preferred providers. They're allowed to opt in and accept the capitation but it's not mandatory. For a deeper review of these concepts, I'll just point you to the webinar we covered last week that we go into this topic in a lot of detail.

Then one last distinction to highlight here is that participant providers will contribute quality scores to the DCEs, whereas preferred providers do not. We're going to look at how those quality scores are calculated today and how they factor into the benchmark. This distinction is important to keep in mind for that topic.

Before we move on there's two similarities I want to highlight between these two types of providers. Both are eligible to receive shared savings. If we leave it up to the DCE to determine how to distribute those savings, but both groups are eligible to share them. Then second, both have the option but neither are required to participate in the benefit enhancements and the patient engagement incentives.

So we've had a number of questions about why a provider might want to be a participant, given the fact that preferred providers seem to have more flexibility around payment, they don't have to report quality, and yet they still get to share in savings. There are a couple reasons for this that I just want to highlight since the question has come up a number of times in the past. First is that participant providers are considered to be part of an APM, an Alternative Payment Model, whereas preferred providers are not. For Quality Payment Program, QPP purposes, there is an incentive for providers to be participants who want to avoid falling under MIPS.

Then secondly, as I stated before, participant providers are used for alignment purposes. Without any participants a DCE won't have any beneficiaries aligned to them, and that said, that DCE will have an incentive when negotiating its relationships with providers to encourage certain providers to become participants rather than preferred providers.

Next, I'd like to talk about the two options for risk that DCEs can choose from, the professional track and the global track. This will factor in especially when we get to the reconciliation example at the end of our discussion today. But there are three key differences between the two tracks that are displayed on the slide. The first tier is how much the risk the DCE assumes. The second is whether the performance year benchmark is discounted. The third is basically the options available to the DCE for receiving advanced payments. 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 take on responsibility for 100% of savings or losses.

Now related to this is the distinction mentioned on the last bullet in each column here, because global DCEs will receive all of the shared 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 3, 4 and 5 respectively. Yoni is going to cover this again a little bit later on. But the point here is that because professional DCEs share all savings evenly with CMS, there's no need for a benchmark discount, whereas for global DCEs that take on all of the savings, that's where we need to apply a discount.

The last distinction I want to highlight here on the slide is the option that DCEs have for receiving advance payment. We covered this, again, in great detail last week, but the short answer here is that professional DCEs must receive Primary Care Capitation while they have the option to receive advanced payment. On the other hand, global DCEs get to choose between Primary Care Capitation and Total Care Capitation. Under Total Care Capitation, if that's their election, they are not eligible to receive advance payment.

I want to cover one more topic here and then we can get into what everyone is really excited about, the benchmarking discussion, but it's just the summary of DCE types. Again, this will factor in prominently to the benchmarking methodology. 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, as well as potentially some experience in risk models. New entrants, in the middle column here, which we tend to think of as DCEs, have more limited experience delivering care to fee-for-service Medicare beneficiaries as well as more limited experience participating in fee-for-service risk-based models.

And then lastly, on the far right-hand side, the high needs DCEs are focused only on beneficiaries with complex and high needs. There's a lot more information about the DCE types in the RFA, as well as our first webinar. For the purposes of today which is namely the benchmarking methodology, these are very important since that methodology will vary by DCE type. Basically, standard DCEs will follow one methodology, whereas both new entrants and high need DCEs will follow a similar but separate methodology. That's the big key difference, which we're going to explore in detail in a slide or two.

Before we get there, I do want to highlight a couple of other differences. One, which is the minimum threshold for aligned beneficiaries. For standard DCEs, they need to have at least 5000 beneficiaries aligned to them in each performance year. New entrants, acknowledging that they will have more limited experience serving Medicare beneficiaries are going to have a path that will start at a minimum of one thousand beneficiaries aligned to them and it will rise by the end of the performance period PY5 to 5000. High needs DCEs will have a path that starts very low at 250 beneficiaries, and that will rise to 1400 by PY5.

Then lastly, beneficiaries that are aligned to those high needs DCEs will need to meet some additional eligibility criteria to demonstrate that they are in fact high needs. These criteria are listed clearly in the RFA. I hope that covers the major differences, at least they will factor into our discussion today. With that said, let's turn our attention to the benchmarking methodology.

For starters, just to make sure we're on the same page here, we've defined what we mean by benchmark in the first bullet on the slide. We define that as the per-beneficiary per-month dollar amount against which a DCE is held financially responsible for all Medicare expenditures for its aligned beneficiaries. As a reminder, the reason we calculate this number on a monthly basis instead of an annual basis is that some beneficiaries may only be aligned for part of the year. Remember that with prospective plus voluntary alignment, we can add beneficiaries at each quarter. Alternatively, beneficiaries may be removed during the year if they happen to move away from the service area or if they fail to meet one of the eligibility requirements. We usually think about, for these reasons, we think about the benchmark on a monthly basis.

The benchmark is inclusive of the total Part A and Part B spend for a beneficiary. First of all, Part D costs are excluded from our benchmark, but also Part A and B costs are included regardless of what provider bills for these services. In the past, when we're establishing our baseline, for example, and we're trying to figure out what the historical spend was, we count billing from participant providers, we count billing from preferred providers, and we also count billing from providers that are completely unaffiliated with the DCE. All of the Part A and B costs are going to be included in the benchmark, no matter which type of provider is billing for them.

Another point I want to make here when we talk about the benchmarking methodology today that might be helpful to keep in mind is that we go through the same set of calculations separately for the aged or disabled beneficiaries, and then the ESRD beneficiaries. The reason for that is that the average spend for these groups varies widely. Generally speaking, per-beneficiary per-month medical spend for an ESRD beneficiary might be seven times what it would be for an aged or disabled beneficiary.

For the sake of simplicity, we're generally going to be talking about "the benchmark today". But in reality, there are really two sets of calculations that focus on different types of beneficiaries. Yoni is going to cover this a little bit more later on. Ultimately, they do come together, and we can talk about when that happens. But the point here is that this approach, while it is slightly a nuance and slightly more complicated, it ensures that the benchmark will remain fair even if the prevalence of ESRD changes within a DCE's population.

One additional point I'd like to make on this slide is along the lines of the distinction between the age, disabled, and the ESRD beneficiaries. This benchmarking methodology will be repeated multiple times throughout the performance year. The calculations we're going to talk about today were first going to happen at the beginning of the performance year to generate what we call the preliminary benchmark. What this is, is really our best guess at what we expect the final benchmark will be at the point in time, and using the data that we have available to us at the beginning of the year. We use it to determine capitation payments, and we use it to give DCEs an indication of what benchmark they should expect.

Throughout the year, however, especially at provisional reconciliation, as well as at final reconciliation, we're going to be updating the benchmark using more recent data wherever possible. Now we're going to walk through each component of the benchmark today, but just keep that in mind as we talk about our methodology that we do update this throughout the

year. Some of the components won't change. For example, the baseline spending for standard DCEs, if it's based on historical data that's already complete, then that's a known factor it's not going to change throughout the year. But other components that we're going to talk about like the quality score, or the risk score, may change throughout the year and that may ultimately impact or alter the benchmark. For now, I just like to point out that as we go through the content today, keep in mind that this methodology is repeated throughout the performance year, even though we might talk about "the benchmark." It's really sort of a living benchmark that evolves throughout the year.

Lastly, we're going to walk through an example of reconciliation at the end of today's webinar, but I want to point out that as we discussed last week, the benchmark is what we'll use to determine savings or losses after comparing it with all Medicare spend for aligned beneficiaries, which is why as you all know this is such a critical part of the model, talking about the methodology. We're going to look at what that looks like in detail a little bit later.

This slide here provides a visual representation of the two distinct benchmarking methodologies that we use in Direct Contracting. When do they apply to what DCE types and to what beneficiaries? Let me just orient you to the slide here. On the vertical axis, we've got our performance years one through five. Then on the horizontal axis, we've got our DCE types, first and foremost. You can see that for the standard DCE, we distinguish between claims-based alignment and voluntary alignment, whereas we don't make that distinction for the new entrants and for the high needs.

You can see in the chart here that there are three boxes. These boxes really collapse into two major methodologies. In the light gray boxes, is what we call the standard benchmarking approach. You can see on the far left, that's where that term comes from. Then very close to that, and I'll explain the difference in a minute is the modified standard benchmarking approach.

The other distinct benchmarking approach is the darker gray box which is the regional benchmarking approach. The standard benchmarking approach incorporates historical expenditures specific to the DCE and it blends that with a regional factor. Basically, it establishes a baseline and then it adds in a regional expenditure factor that's based on the county spend, not the DCE's particular beneficiaries.

The regional benchmarking approach does not include a baseline, it relies solely on that regional expenditure factor. I'll just repeat that, since it's a critical point. The standard benchmarking approach uses a baseline and blends in with the regional factor, the regional benchmarking approach only focuses on the regional factor and does not include this historical baseline. That's the main difference between what we think of as the major two methodologies. Let me T's out the one nuance between the standard benchmarking approach and the modified standard benchmarking approach.

The modified standard benchmarking approach is really exactly like the standard benchmarking approach with one key difference, and that's the historical expenditure that we use to calculate a baseline, which is more recent in the modified approach. In the standard benchmarking

approach, we're going to be looking to our base years as 2017 through 2019. Whereas in the modified approach, we're going to update this -- as you can see, it only factors in performance years four and five. For performance year four, our base years are going to be the first two performance years of the model. Whereas performance year five, our base years are going to be the first three performance years of the model. As a reminder in both cases, for the standard benchmarking approach as well as the modified standard, the base years are fixed and they will not change throughout the model. That means that for performance year five, for claims-based aligned beneficiaries and a standard DCE, the base years are still 2017 to 2019.

As you can see here on the first box in the left for the standard DCEs we're going to use the standard benchmarking approach for its claims aligned beneficiaries throughout all five performance years. Whereas the voluntarily aligned beneficiaries in a standard DCE will receive the regional benchmarking approach for the first three years before receiving the modified standard benchmarking approach in the final two years. Let me explain a little bit the rationale for this policy choice.

It's essentially as follows. Given the higher beneficiary minimum threshold of 5,000 for standard DCEs, most of whom we expect will be aligned through claims, we can have confidence that there will be enough claim history for us to produce a reliable benchmark tailored to that population. Therefore, that's why the baseline is included for the claims-aligned beneficiaries for standard DCEs. This approach is consistent with other models so Pioneer, MSSP, Next Gen -- they all rely in varying ways on a baseline.

For the voluntarily aligned beneficiaries, however, we cannot necessarily expect that these folks will resemble the claims aligned beneficiary. Remember that if you're a beneficiary who is both voluntarily aligned and claims aligned to the same DCE, we're going to treat you as if you are claims aligned for benchmarking purposes. The folks who would fall into the voluntary alignment column under the standard DCE by definition won't have a robust historical claims relationship with that DCE. By definition, they won't meet the plurality threshold. For that reason, we give the voluntarily aligned beneficiaries of benchmark based on the regional expenditure in the county they reside in rather than one tied to the population that the DCE serves because that population may not be representative of what those beneficiaries look like.

Turning our attention now to the new entrants and the high needs, you can see that as I mentioned before, we don't distinguish between claims aligned or voluntarily aligned beneficiaries. All beneficiaries align to new entrants and to high needs DCEs will receive the same approach regardless of whether how they were aligned. The rationale here is that these DCEs in the initial performance years, performance years one to three, will not have a considerable claims history with enough beneficiaries that we can use to produce a reliable baseline. That's why the benchmark is solely based off of the regional expenditure rather than a blend of the baseline in a regional expenditure. New entrants, by definition, we expect to have less of a presence in fee for-service Medicare relative to standard DCEs, which is also evident in the lower minimum beneficiary threshold and the claims alignment cap of 3000 beneficiaries for the first three performance years.

Similarly, high needs DCEs serve a very specialized population which we expect to be small. Remember that for PY1, that minimum beneficiary threshold is just 250. By PY4 however, that minimum beneficiary threshold for both high needs and for new entrants DCEs will start to increase. As that glide path kicks up, we expect that there will be enough claims history during the early model years to produce a reliable baseline. At that point, we switch them from the regional benchmarking approach to the modified standard benchmarking approach.

Hopefully that's helpful math into which methodology gets applied when. I want to turn our attention now to at, a very high level, what the calculation looks like. You can see here as laid out on the slide the order of operations broken down into six high level steps. These are really the major six steps of calculating the baseline. I'm going to cover these at a high level and then I'm going to turn it over to my colleague who can dive into some of the specifics around each step. But a couple points I want to make before we move on. The first is that if you remember back to the discussion we had on the previous slide about the two main types of methodologies. If we're talking about a standard or a modified standard approach that includes a baseline, all six of these steps will apply. You can see that the first three steps relate to establishing that baseline. If we're talking about the regional benchmarking approach, only the last three steps apply. You can see it starts with the incorporation of the regional expenditures.

This is a high-level view of what actually happens under each methodology, and you can see that if I walk through the whole thing very quickly here. The first step, if we're using a baseline, is to figure out what the historical expenditures look like. That means going back to our base years and understanding which beneficiaries would have been aligned to our DCE participants back then, figuring out the medical expenditure incurred by those beneficiaries. Trending that forward in step number two, to make sure it's current with the performance year that we're actually setting the benchmark for, we're going to use the USPC to do that, and Yoni is going to talk a little bit more about what that means shortly.

Then the next, sort of the last step of the baseline is that basically, the baseline population will be a different population than the performance year population because one is current and one is historical. In order to make sure we're treating that spend fairly, we need to standardize the historical baseline to take out the risk of that population and standardize it to a 1.0 risk score beneficiary. Then we need to standardize it to take out any differences in geography, so basically where those beneficiaries lived. If you look forward two steps, we're going to put the performance year risk and the performance year geography back in. But first we want to incorporate the regional expenditures. Yoni will cover how we blend that, what it's going to look like shortly. But that's really the next step.

Once you've got your standardized baseline, you can incorporate your regional expenditure. Then once that's blended in, we can put the risk and the geographic factors of the performance year population back into that number. The last step here is really just to apply the discount and the quality withhold, and that's ultimately how we get to our benchmark. With that said, I'm going to turn it over to my colleague, and he's going to break down each one of these steps in further detail.

Thank you Corey. I'll spend the bulk of the remaining time we have today walking through each of these benchmarking steps in detail, and then turn it back over to Corey to talk through the high needs and new entrant DCE approach one more time, followed by reconciliation example. I should start by saying before we dive into the steps that these are presented steps for simplicity and for clarity. However, they're not always conducted in direct sequence to one another. Corey mentioned previously that the benchmark is updated over the course of the year the additional information comes in. In addition to that, some of these steps are actually conducted more in parallel. However, the step wise structure is accurate in terms of the overall process that we're following and it's used for simplicity and clarity in presentations.

Another important note here that Corey mentioned is again, we'll be talking about this as a single benchmark. These steps are followed for both the Aged and Disabled or A&D as well as the End Stage Renal Disease or ESRD populations. Those are then blended back in for settlement, but because the steps are consistent for both, we will not be distinguishing them further as part of this presentation.

The first step in the standard DCE benchmarking approach, and again, we'll be starting by going through the standard DCE approach because it uses all six of these steps and layering information about the approach for voluntary aligned beneficiaries as we go. The first step is the calculation of the historical expenditures for the DCE. This is one of the steps that differs for claims-based aligned beneficiaries and for voluntary aligned beneficiaries in Direct Contracting. We'll start by going through the claims aligned approach and then we'll move on to the voluntary aligned approach.

For the claims aligned beneficiaries, and this is an approach that is similar to what's done in Next Generation ACO, DCE will be using a cross-sectional methodology to identify the historical beneficiaries to use for the baseline. What that means is that instead of taking the beneficiaries that are aligned in the performance year and looking back at their historical expenditures, we will be using the participant provider list as the link between the two populations. The beneficiaries, as Corey mentioned, will be different between the historical expenditures and between the performance years. However, the providers will be consistent across the two, and the provider list is what will be used to identify the beneficiaries that would have aligned in each of the base years.

There are a few elements of the methodology that do differ from the approach that was used with the Next Generation ACO though. First, the base years for the DCE model will be composed of three years, the years 2017, 2018 and 2019 instead of two years, which will increase the stability and the accuracy of the historical expenditures. These years were selected because they're the most recent years to the first performance year in which there's a full claims run out that we can use to assess historical expenditures.

The second element that is different here is that the base years will remain fixed for the entire duration of the five-year model instead of rolling forward with each year as is done in the latest iteration of the Next Generation ACO. In PY1, it'll be 2017 to 2019, in PY2 it will remain 2017 to 2019 and so on through each of the performance years over the course of the model. What this

means is that if a DCE were to have the same exact participant providers across multiple performance years, this component of the benchmark would not change each year. However, that's fairly unlikely. There's likely to be some turnover in the participant providers and so there will be some slight differences in this component of the benchmark year over year. But constructing it in this way allows us to increase stability and make it easier for participants to understand their benchmark going into a year.

In addition, these three base years will be weighted together and not in an equal manner in order to form the historical expenditures component. We'll be shifting the weighting to more heavily take into account the more recent baseline year, meaning that 2017 will have a 10% weighting, 2018 will have a 30% weighting, and 2019 will have a 60% weighting in order to provide more accurate and recent data as we do this calculation.

Moving on to the voluntary aligned approach for historical expenditures, as Corey mentioned in the first three performance years, historical baseline expenditures will not be used at all to develop the benchmark for the voluntary aligned beneficiaries. Instead, the benchmark methodology will begin with the regional expenditures, which is in the fourth chevron step and we'll get into that shortly. Corey also mentioned the reason for this is to account for the potential differences between the claims and voluntary aligned beneficiaries. The voluntary aligned beneficiaries are likely to have a somewhat different makeup than claims aligned beneficiaries by the fact that they don't have any claims history with the providers in the DCE.

This is another good point to pause and remind you that if a beneficiary were to be aligned through both claims alignment and voluntary alignment to the same DCE, we would treat them as claims aligned for the purpose of benchmarking, which means that every single beneficiary that has the voluntary aligned benchmarking approach will not have had any enough claims experience with the participant providers to have been aligned in that manner. So there are differences between the two groups of beneficiaries. That's how it will work in the first three performance years.

Beginning in PY4 the standard DCE benchmark for the voluntary aligned beneficiaries will begin to more closely parallel the approach used for the claims aligned beneficiaries. At this stage, there will be a few years of DCE experience that incorporates the voluntary aligned beneficiaries in it. Therefore, a reasonable historical expenditure component can be developed using the actual expenditures for the DCE in the first two to three performance years. Similar to the approach in the claims aligned beneficiaries, these years will be weighted towards the more recent expenditures.

If you look to the right side of the slide this highlights that in more detail. In PY4, the first two performance years 2021 and 2022 will be used to determine the baseline period for voluntary aligned beneficiaries. They'll be weighted one third towards the first performance year and two thirds towards the more recent second performance year. In PY5, in the fifth performance year, we'll be using the first three performance years and we'll use the same weighting approach that was used for claims aligned beneficiaries, so 10%, 30% and 60% respectively for the three years.

Once the historical baseline expenditures have been calculated, they'll need to be trended forward to account for the differences in health care costs between the baseline and the performance years. This is taking into account things like inflation and pricing changes that might cause a difference that we don't want to lead to a different benchmark between the two performance years because it doesn't reflect differences in utilization in health and in care delivery. The way this trend will work is it will use the U.S. Per Capita Costs, the growth rate in the U.S. Per Capita Costs, which is referred to as the USPCC as well. This is a measure that's determined annually by the CMS office of the actuary. It's published each year in April so it's prospective, and it will be used to trend forward each of the three baseline years so that we're looking at comparable expenditures across the baseline years relative to the performance year.

For example, for 2017 expenditures, we'll look at the growth rate in the USPCC from 2017 to the performance year. In PY1, we would look at the growth rate from 2017 to 2021. If the USPCC were for example a \$100 in 2017 and a \$110 in 2021, that would represent a 10% growth, which would be applied to those historical expenditures. For 2018 and 2019, we would look at the growth rate from each of those years to 2021 so a shorter time period.

As I mentioned, the USPCC is going to be published in April and it's in advance of the performance year. The 2021 USPCC will be released in April of 2020. This allows for a prospective trend rate that the DCE will be able to know well in advance of the performance year. I should comment that this process is consistent with the approach used in the Next Generation ACO model, so for any past model participants that are listening in, this should be a familiar approach.

One final note to call out, the baseline trending is that CMS does reserve the right under limited circumstances to retrospectively change the USPCC trend if it is deemed to be significantly inaccurate. The reason for this is to prevent major payment changes that would be outside of a DCEs control resulting in unfair penalties or rewards for a participant. It's intended to control against extreme circumstances, things like a natural disaster or an outbreak of an epidemic, that would make the USPCC unreliable. It is an optional, although it's one that would be avoided except under dire circumstances.

In addition to trending forward the baseline to account for the differences in the health care costs between the base years and the performance years, there are some other differences that need to be accounted for between the base and the performance periods. Because the historical expenditures are developed using the cross-sectional approach I mentioned previously, in which a different, although comparable, set of beneficiaries is used for each of the baseline years. For the performance year we have to take into account additional standardization to remove the factors that would drive the differences between these populations. The first of these is standardization with risk adjustment, and this accounts for the differences in health risk between the two populations.

In the DC model, CMS is planning to apply a modified risk adjustment methodology that's intended to, first, improve the accuracy of risk adjustment for high risk seriously ill beneficiaries for whom risk enough payment is somewhat under predicted and existing models. Second, to

mitigate the influence of coding intensity on risk adjustment. We understand that there are many questions participants have on the risk adjustment methodology, and we do plan to release further information in the coming months. I should comment as Corey mentioned previously, that we're still working simulations on this methodology that will inform the final methodology that we release. We will make sure to release it early enough that participants have a chance to understand it before making final participation decisions. Stay tuned there. That's the first standardization factor.

The second standardization factor is done to account for the differences in the geographic adjustments that are applied by CMS to Medicare payments. For context, each county has a geographic adjustment factor or a GAF, a GAF that's used by Medicare to adjust payments upwards or downwards to account for differences in county level pricing. These are developed using indices like the Medicare Area Wage Index and the Geographic Practice Cost Index. What we do to standardize here is we look at the regional distribution of beneficiaries, and we come up with an Impact factor overall that the geographic adjustment factors have on payment in that historical period and then we divide out that impact. I think Corey mentioned earlier in the example that we standardize all the risk scores to what's considered a 1.0, where that's kind of a standard across everything. It's the same process here with the geographic adjustment factor standardization.

I should also call out here that this parallels a later step in the fifth chevron in which these GAFs and the risk adjustment scores are calculated for the performance year itself and are used to adjust the benchmark. Essentially, we're taking out the base year risk and the base year GAF in this step to get to standard historical expenditures. We're then multiplying back in these same factors but using the performance year data based on the actual aligned beneficiaries.

Before I move on, I'd like to make a couple additional comments here. These steps are done in the Next Generation ACO model for those who have participated or familiar with that model, and will apply in the benchmark in a consistent approach. Second, when I mentioned previously that the steps while presented in sequence are not truly done in an exact stepwise manner. These were the steps that I was primarily referring to, in that the approach for calculating this happens more in a parallel manner. For each base year, we take that base year, we determine the full set of historical expenditures for the beneficiaries that would have aligned to the providers. We then trend that base year forward and apply the risk and GAF standardization for that base year. We repeat that approach for each of the three base years before weighting them together to get the overall historical component of our benchmark. We presented the steps in the stepwise manner in the sequence for simplicity, but they are happening in more of a parallel manner.

Once we've created that historical expenditure component and we standardize it to a risk agnostic and a GAF agnostic performance year value, we can then incorporate the regional component of the benchmark. Well, past models similar to this one have incorporated a regional component. Direct Contracting will be moving towards a more prospective approach through using an adjusted version of the Medicare Advantage or the MA rate book. Each year the Office of the Actuary publishes a rate book for Medicare Advantage that has the payment

rates by county for the program. They published this alongside the USPCC that I mentioned earlier that is used to trend the baseline.

For the purposes of Direct Contracting, we will be adjusting the rate book in order to make it more appropriate for a fee-for-service population that is covered by the program. We will be publishing the adjusted version of that MA rate book before each performance year. We know that here as well there's a lot of interest in additional details on the rate book and the adjustments and in particular about getting access to the actual rate books. Further information on the exact methodology and adjustments will be provided and upcoming papers on the financial methodology. Similar to the risk adjustment, there are final simulations being run now, before that those approaches are finalized. We will pass along that information as soon as we can. In addition, because the MA rate book for 2021 the first performance year, will only be released in April of 2020. We will apply the adjustments and publish the DC version only after we have that 2021 rate book, and so that is likely to happen in a timeframe closer to late Q2 of 2020.

Once we take that rate book and we've applied our adjustments, the rate book will have an expenditure amount or a rate that's associated with each county in the country. CMS will then use the geographic alignment of a Direct Contracting Entities' Beneficiaries to determine what the weighted average regional expenditures component are for the DCE. Essentially, we'll look at where each beneficiary lives, what county they live in, and how many months they contribute to the DCE over the course of the performance year. Then we'll use that to create an overall weighted regional expenditure component using the rates in the Medicare Advantage adjusted rate book.

This regional expenditures value will then be blended with the baseline expenditures that we created using the first three steps. The weight of that blend will increase each year of the model. This blend will incorporate a cap as well as a floor to prevent overly rewarding or penalizing DCEs for their efficiency or inefficiency relative to the region that they are in. The cap will be set at 5% of the USPCC for the performance year, and the floor will be set at 2% of the USPCC for the performance year.

As I mentioned previously, the weighting of the two increases each year, and this is highlighted on the right side of the slide. In the first performance year the historical baseline expenditures component will make up 65% of the weighting for the benchmark expenditures, whereas the regional expenditures via the adjusted MA rate book will make up the remaining 35%. This will hold true in the second performance year as well. But the weight will begin to shift towards a more even split beginning in PY3, 4 and 5. In the third performance year it will be a 60-40 split, in the fourth 55-45, finally within the fifth performance year there'll be a 50-50 split between the baseline expenditures and the regional expenditures. I should also call out here that the cap and the floor will continue to apply in the same manner for each of these performance years regardless of the change in the weighting.

Before we move on to the next step, I do want to pause and call out that the stuff that we've outlined so far, one of the major themes and value they bring is around prospectivity. The

intent of this benchmark is to allow participants to understand as much as possible about their benchmark in advance of the performance year. The first three steps which are used to generate historical expenditures, those are fully defined before each performance year and those do not change during the performance year. That value, that historical expenditure value, is locked at start of the year. In this step, the fourth step around the regional expenditures, well this is not fully locked at the start of the performance year because it depends upon the final geographic distribution of aligned beneficiaries and how many months eligibility they have. It is developed using a rate book that is published well in advance of each performance year, so it's something that DCEs can estimate fairly well at the start of the year based on published information.

After we do the blend of the historical and the regional expenditures components, we begin to incorporate additional performance year specific information about the aligned beneficiaries. In particular we factor in the health risk and the geographic adjustments of the aligned beneficiary population. If you recall, previously in the third step we took out the risk and the gap factors that apply to the historical expenditures, beneficiary population. In this step instead of taking out these factors from the baseline we're now incorporating these factors back in by using the beneficiaries that are actually aligned to the direct contracting entity for the performance year. Other than those two factors, the methodology for actually calculating the risk scores and the gap adjustment factors is actually consistent between these two approaches, so I won't go into further detail on the step.

The final components of the benchmark are the discounts and the quality withholds and earn back. The discount which applies only to global DCEs taking on a 100% risk is a reduction to the benchmark that increases over the course of the model. The reason it is applied is in order to ensure that CMS achieve savings in a model that has a 100% risk in which all savings would be given directly to the entity rather than shared with CMS. The quality component has two pieces. The first is a withhold which is a reduction to the benchmark, and the second is an earn back in which a direct contracting entity can earn back some or all of that reduction based on their performance on quality measures.

A few other call outs about the quality strategy, Direct Contracting will be introducing a few new elements that have not existed in past models. One is a High Performers Pool. In the High Performers Pool excess quality withhold that is not earned back by a DCE will contribute to a pool from which high performing DCEs may earn additional quality earn back. What that means is if a DCE earned an 80% quality score they would earn back 80% of the withhold and the remaining 20% would enter this broader pool for which the high performing DCEs would be able to achieve a portion back to increase their earn back rate. What this means is that a DCE that performs exceptionally well on quality would have the opportunity to potentially have a quality score that exceeded the withholds, meaning that they would earn back more than was taken away and quality performance would increase their benchmark.

A few other comments that I'd like to make on the quality strategy before going into a bit more detail. There have been a few changes since the publication of the RFA and there are some additional criteria that are still under development and being finalized. One call-out I'd like to

make is that the advanced care planning quality measure has been removed and a new care coordination and planning measure is under development in its place. The second call-out is that the Continuous Improvement/Sustained Excellent Performance or CISEP, that will not start until the third performance year and a predefined benchmark will be used for the second performance year. I'll go into more detail about both of these on the following slides when we talk about the specific quality measures and the CISEP criteria in more detail.

Here on this slide, we have a table that shows the actual percentage impacts to the benchmark of the discount and the quality components for each of the performance years. If you'll notice the discount, it starts at a minus 2% discount for each of the first two performance years. Then it increases by 1% in the following performance years, so 3% in the third 4% in the fourth, finally a 5% discount in the fifth performance year. I should note that the discount applies, it's not a cumulative discount, it applies at 2% to the benchmark in PY1 separately at 2% in PY2 and separately at 3% in PY3, etc.

The quality withhold is actually set at 5% for each of the performance years, so that's constant over the life of the model and the quality performance earn back is up to a plus 5% return of that withhold that was held back initially. The High Performers Pool, as I mentioned, can add additional earn back on top of that plus 5%. It will not be available on the first performance year. The methodology for the High Performance Pool is still being finalized and it will be released in detail before the second performance year when it begins to apply.

On the right side of the slide, we call out the specific quality measures that we're planning to evaluate as part of the Direct Contracting Model. We anticipate that these will be paid for reporting for the first performance year, and most of them except the two that are still under development, we anticipate being paid for performance beginning in the second performance year. As I said, I know some of these are still under development, and the quality strategy is evolving. More information on these specific measures and on the quality strategy as a whole will be provided in a future webinar once more information has been determined.

The final piece of the quality strategy which I alluded to earlier is the Continuous Improvement/Sustained Exceptional Performance or CISEP. Beginning in the third performance year, Direct Contracting entities will need to meet the CISEP criteria in order to be able to earn back the full 5% quality withhold. As the name implies, the criteria will require a DCE to either have continuous improvement in their quality or for an organization that is already performing at a high level sustain their exceptional performance. As I mentioned previously, this will start in the third performance year and CMS will use a predefined performance benchmark criteria for the second performance year.

The right side of the slide demonstrates how this will work practically. A DCE will receive a composite quality score each year of up to 100%. If the DCE passes the CISEP criteria then that DCE will be eligible for the full 5% earn back which is calculated as five times that quality score, 5% times that quality score. However, if the DCE does not meet the criteria, they will only be eligible to earn back half of the withholds which will be calculated as 2.5% times the quality score. For example, if a DCE were to achieve a quality score of 80%, if they met the CISEP

criteria, the earn-back would be 80% times 5%, or 4%. If they were to achieve a quality score of 90%, then it would be 90% times 5% or 4.5%. If the DCE did not meet the criteria, they would earn back only half of that amount. If it was an 80% quality score, they would earn back only 2% of the quality withhold.

This actually relates back to the High Performers Pool mentioned earlier in a few ways. A direct contracting entity is only eligible for the High Performers Pool if they meet the CISEP criteria. In addition, the 2.5% of the quality withhold that is forfeited by not meeting the criteria will not enter the High Performers Pool, it will go directly to CMS. Meeting the CISEP criteria will become incredibly important for a DCE to be successful in the model once it begins to apply in later performance years. Time is component overall around the discounting quality back to the benchmark that we've just walked through in detail. This is the last portion of the benchmark. Unlike other benchmark methodology steps, it is not in place as a way to reflect the predicted expenditures of the beneficiary population. Instead, it's intended to drive broader CMMI goals of reducing costs and improving quality.

In the example of the discount, the goal is to generate savings to CMS for participants taking on risk that would not otherwise generate savings. For the quality component the goal is to incentivize and ensure quality performance and improvement to result in the improved quality goal of the models. I'll pause here. I just walked through the steps in a good deal of detail for a standard Direct Contracting entity. I'll pass it back to Corey, and he'll spend a little bit of time talking about how this approach is different and how it would apply for a new entrant and high needs population DCEs. I think then we'll close with an example of reconciliation before opening up to questions.

Thanks Yoni. This slide here lays out ultimately what the benchmarking methodology looks like by performance year for the new entrant DCEs and the high needs DCEs as Yoni suggested. If you remember back to a slide that we covered earlier on in the presentation and sort of mapped out the methodology for all the performance types, you can see from left to right here, we've basically captured the same thing that we captured from top to bottom on that slide. As you can see for the first three performance years in blue highlighted here, new entrant DCEs and high needs DCEs are going to receive the regional expenditure benchmarking approach. That is true regardless of whether or not beneficiaries were claims aligned or voluntarily aligned to those DCEs.

Essentially what that means, if you think back to the six steps that Yoni just covered, it means that we're really picking up on step number four here and covering steps four, five and six. That essentially means that the rate will primarily be dictated by our adjusted MA rate book and then we'll factor in the risk in the geography of the performance year beneficiaries as well as applying the quality withhold and any discount necessary if the DCE has elected the global option.

Now for performance years four and five, this is when the benchmarking methodology changes. It goes back to the rationale that I covered earlier on in the presentation. At this point in time we feel like these organizations who may have lower beneficiary alignment numbers or maybe

newer to Medicare fee-for-service have had a number of years in the program where we can look back to and establish a reliable baseline. You can see here that in performance year four as it is listed in one of the sub bullets, in order to establish the baseline we're going to look back to more recent history and that history will be performance years one and two, so calendar years 2021 and 2022. We're going to weigh those years 33% for 2021 and 67% for 2022. Otherwise, the methodology will be exactly what Yoni described for the standard claims aligned beneficiaries. They just happen to use the earlier base years of 2017 through 2019. You can see then that for performance year five, which is calendar year 2025 our base years become the first three performance years, so 2021 through 2023, and we're going to weigh those 10%, 30% and 60% respectively.

I think it's important to note here that there's a gap year between the performance year that we're calculating the benchmark for and the base years that we look back to. The reason for that is ultimately for claims run out, so that's why for performance year four we performance years one and two for the baseline but we skip performance year three. Similarly, for performance year five we're using the first three performance years and skipping the fourth performance year to allow for that claims run out.

When we take our baseline, that steps one through three that Yoni walked through, we still follow steps four through six. The next step there would be to blend in that regional expenditure factor based on the adjusted MA rate book. That blend is going to mirror the exact same weighting that the standard benchmarking approach that Yoni walked through that that uses. That means then in performance year four, the baseline will be weighted 55% and the regional expenditure factor will be weighted 45%, whereas in performance year five they will be each weighted 50%. Hopefully, I mean, we covered this one fairly quickly, the idea being that really the standard DCE methodology that Yoni walked through is the roadmap. We're just applying the second half for the first three performance years, and then the whole thing with the updated base years for the last two, and that's for the new entrants and the high needs DCE types.

We're certainly happy to come back to anything that was unclear on the benchmark. I see that there are some questions coming through in the Q&A portion. But before we get there, I do want to walk through a detailed example of what reconciliation might look like. Let's go ahead and turn to the slide here. What I want to do is first describe at a high level what you see here and make sure we're all on the same page about what each box represents and what goes into it. Then after I do that, I want to walk through a more detailed example. We're going to do one example for DCE that selected global and then total care capitation. Then we're going to do a separate example for DCE that selected professional as well as Primary Care Capitation.

For the sake of simplicity, we're going to use the same numbers. These are just intended to be round numbers that we can wrap our heads around easily but obviously you know there are more complexity and a little more messiness when we dive into actual benchmarks. That said, you can see here the first box on the far left is the final performance year benchmark. In this example here, it's listed at \$1,000 PBPM. This is the number that we calculated using, in this example, the steps that Yoni walked through, and this is done at final reconciliation. That

means that in this \$1,000 PBPM amount we've already baked into the performance year geography of the aligned beneficiaries as well as the performance year risk.

Then to determine savings and losses, what we do is we compare that first box to the second box moving to the right. In that column there's really two sub components there. First you've got the fee-for-service claim payments made, these are shown in the red box, you can see it's \$410 PBPM in this example. Then in the blue box we've got the capitation which could include advanced payments. Really the two categories here that together represent total Medicare expenditures for aligned beneficiaries are the fee-for-service claim payments that CMS made as well as the prospective payments made to the DCE which include both capitation and advanced payments. In the specific examples, global and professional will tease out where the differences are.

I do want to remind you guys that in the red box here in the fee-for-service claim payments box, we're going to include truly all claim payments that CMS made. That's the providers that could or might have no affiliation with the DCE so long as they were billed for the aligned beneficiaries. But it would also include any claim payments that were made to, for example, preferred providers who did not opt into capitation or to advance payment, as well as under Primary Care Capitation it could be two participant providers for non-primary care services if they didn't opt into advance payment. Really, this red box is all claim payments made to any provider regardless of whether or not they were affiliated with the DCE. It just means that anything that wasn't reduced and translated into a prospective payment will be included in the red box. Anything that is reduced and translated into a prospective payment would be found in the blue box. Again, we're going to walk through the specific examples of how it differs and what falls in each category, depending on the DCE selection.

Let's turn our attention now to the first example here, and I think this might be the easier example, that's why we want to start with it. Let's imagine that a DCE selected global risk and then elected Total Care Capitation. Now we're going to make a couple of simplifying assumptions just to make this an easier example to walk through. First of all, let's assume that the preliminary benchmark in this case was the same as the final benchmark. Remember, I made some comments earlier about how we're going to come up with the preliminary benchmark, and then as data comes in throughout the performance year it might change. Just for the sake of simplicity, let's say that it's always been \$1,000 PBPM I should say.

The second simplifying assumption here I want to make is that, as Yoni and I both talked about, we're really doing these sets of calculations separately for the aged and disabled beneficiaries and then for the ESRD beneficiaries. Let's forget that nuance for a second and just take it one group where the benchmark is \$1,000. You can see here that in the second column we've got \$530 PBPM in our blue bucket, and we've got \$410 PBPM in our red bucket. Let me start with the blue bucket. In Total Care Capitation advanced payment is not an option, so the only payments that will go into the blue bucket are capitation payments. Remember, these are mandatory for participant providers and these are optional for preferred providers.

Let's imagine here that the way we calculated this was we took our DCE, we looked at its participant providers and preferred providers. For the sake of simplicity, let's imagine that they don't even have any preferred providers. We looked at just the participant providers, we looked historically and we said for your aligned beneficiary population they tend to bill for about 53% of the benchmark. That is to say that whatever our benchmark spend is which includes all Part A and Part B spend, the participant providers really bill for about 53% of that. Then we established our preliminary benchmark, which as I mentioned we're going to assume is the same as the final in this case, and that came out to be \$1,000. Then we took that 53%, that was based on historical spend and we applied it to the performance year benchmark 53% times \$1,000 gets us \$530 PBPM. Those capitation payments are going to be made on a monthly basis.

The amount spend that we're going to count in the blue bucket is the amount of payments that were made. I'll get into this distinction when we talk about advanced payment. But let's say for example, that the participant providers in this case actually provided a little bit less care than we thought based on historical or a little bit more care than we thought based on historical. Their claims are going to be zeroed out no matter what and they're going to get the capitation payment that was determined, so that's what goes into the blue box.

What goes into the red box then is any fee-for-service claim payments as I mentioned that were made. In this example where we've got participant providers that have total care capitation, no payments to those providers will be found in the red box because they've all been zeroed out and they've all been factored into our capitation. What would be found in the red box would be claim payments billed by providers that are unaffiliated with the DCE as well as, in this example let's assume that any preferred providers that the DCE had opted not to be considered under capitation, so any payments made to them would fall in the red box as well. That's essentially what falls in each box, and then that's in my mind is sort of the hard part to wrap your head around.

Once we've done that the math is pretty simple. We stack our performance year benchmark and then we stack our Medicare expenditures. In this case, we know the benchmark is \$1,000. We know that we've paid out \$530 per month to our DCE to cover the payments to the providers that have elected capitation. The only thing left to do is to sum up all the fee-for-service claim payments that were made. In this example that comes to \$410 PBPM. Combined, we now have \$940 PBPM of actual Medicare expenditure and we have a performance year benchmark of a \$1,000, which yields growth savings of \$60 PBPM.

Now, remember in the global option, this goes back to the risk corridor discussion we had last week. The global DCEs will take on 100% responsibility for savings and losses for the first corridor, which is up to 25% variation between the performance year expenditures and the benchmark. In this case 60 PBPM divided by 1000 which is our benchmark is only 6%, so that very clearly all falls into the first corridor. In this example, the global DCE would capture all 60 of PBPM dollars of the gross savings that were generated. Okay, so hopefully that was helpful.

Let's repeat this exercise using the assumption that the DCE elected professional and then primary care capitation. Everything I said about the benchmark doesn't change. Our benchmark is \$1,000 PBPM. For the capitation remember that we pay 7% Primary Care Capitation for DCEs that elect Primary Care Capitation and that doesn't change. What does change though is the amount within the 7% that we consider the Base Primary Care Capitation versus the Enhanced Primary Care Capitation. Now remember, the Base Primary Care Capitation, just like we established our capitation payments for the global DCE, we established the Base Primary Care Capitation amount to the same process. We look in the past at the care that was provided to the beneficiaries who would have been aligned to this DCE and we look at what percent of their total Part A and Part B spending would be comprised by primary care services billed by the participant providers.

Let's assume in this case that it's 3%, and on a benchmark of \$1,000, that would come to 30 bucks. That means a couple things. First of all, it means that because we're paying out 7% no matter what, 3% is the base primary care cap and 4% is going to be considered the Enhanced Primary Care Capitation. That 4% does not show up in this process. As we discussed before, we consider that similar to an infrastructure type payment, it is essentially funded to the DCE upfront in order to help the DCE invest in care management and to help with cash flow. But ultimately it is not included in the process of reconciliation, it is recouped in full separately. 4% here of our benchmark is \$40. We're going to pay \$70 which is 7% to the DCE every month. 40 of it we're going to get back at the end of the year no matter what. The other 30 of it we're going to treat just like we treated the capitation in the global example I walked through.

In this case in the blue bar, the blue bar here is \$530 PBPM. Let's assume that 30 of it is our Base Primary Care Capitation, so the other 500 let's assume is advanced payment that the participant in preferred providers have opted into. That process is the exact same as the global, right, we look at the care they provided in the past, and let's say that it came to about 50% of the benchmark, so therefore it's 500 bucks. That's sort of how we calculate our blue box here.

The one distinction I want to tease out between capitation in advanced payment is that ultimately before we go through the process of the reconciliation that's shown on the slide, we first want to make sure that whatever we paid out in advanced payments matches the amount of claims that we reduced, which is the distinction from what I talked about in the global option, right. In Total Care Capitation, we do not compare the cap payment that was paid to the actual care that was provided by those participant providers, on behalf of which the payment, the capitation payment was made.

In advanced payment we do. We look at how much upfront we expected to pay out. Then let's say that we expected to pay out \$490 PBPM, but by the end of the year, we look back and say, oh, we actually reduced \$500 PBPM for advanced payment. In that case, we would first just give the DCE an extra \$10 PBPM. That process happens before we get the final reconciliation. Now that we're on final reconciliation, we have our blue box which is the base primary care capitation amount, plus the actual claim reduction that were made under advanced payment.

At this point, the red box is the exact same process as in the previous example, it's just summing up the fee-for-service claim payments that were made on behalf of the aligned beneficiaries. In this case, it's still \$410. Now what we've done, although the mechanisms are different, the numbers here are the same, right? We've got our benchmark of \$1,000 PBPM we've got our actual Medicare expenditures of \$940 PBPM, which yield \$60 PBPM of gross savings. Unlike the global risk corridor which is very wide, the first risk corridor for the professional option is only 5%. In this case our \$60 PBPM represents 6%, so because this is a marginal exercise, the first 5% of the 6% gross saving falls into the first corridor. In that first corridor, the DCE has 50% risk. Of the \$50 PBPM that is subject to the first risk corridor, the DCE retains \$25 of it.

The last percent of the 6% falls into the second corridor. In that corridor the DCE only has 35% responsibility. In this case the final \$10 the DCE only captures \$3.5 worth of it. Combined, the DCE is taking home \$28.5 PBPM. Now, I will compare that to the global example we walk through where it with 60, remember that that a \$1,000 benchmark in the global would have reflected if this was performance year one, it would have reflected a 2% discount. Whereas in the professional option, that thousand dollar PBPM amount would not be post discount -- there had been no discount applied.

Let me pause there. I hope this was a helpful example for folks. We have some time to walk through questions and I see that there are a bunch of questions being submitted. I'm going to go ahead and put us on mute for a minute. I'm asking you guys to bear with us while we just gather our thoughts and prepare to answer some of your questions. Then we're going to walk through as many as we can in the remaining time. So thanks very much and just hold on for a minute.

We received a number of questions around the various discounts and quality withholds. In particular, there were a number of questions around the 2% retention withholds that applies to the PY1 benchmark. But in order to ensure participation or incentivize participation for multiple years of the model, and so the questions were around, where does that apply? How is that different than the discounted quality withholds? I'll talk about all those in conjunction just to help clarify.

The retention withhold is a 2% withhold applied to the performance year one benchmark. It applies in parallel with the discount for a global DCE and in parallel with the quality withhold. It is refunded at Performance Year 1 reconciliation which happens in the summer after the performance year, if the direct contracting entity is continuing participation for the second Performance Year, so it applies alongside all the other discounts that we've discussed. I should note that in order to help with cash flow, we don't plan to include that 2% retention withhold that's part of the capitation payments. We anticipate that we will be ignoring it so to speak to make sure that DCEs have sufficient cash flow, since we'd expect most DCEs to continue with the program. But it will apply alongside the other discounts for the purposes of the benchmark calculation initially.

In terms of the discounting quality withhold, there were some questions about what the difference is. They both do apply to the benchmark, and so the discount starts at 2%, and then increases over the course of the model up to 5%. That will apply for all the DCEs that are participating in the global risk option. The quality withhold will apply to all DCEs in both global and professional, and will be in addition to the discount for DCEs that are participating in the global option. The quality withhold is 5%, and it can be earned back in full if the DCE achieves a 100% quality performance, or given the High Performers Pool could even exceed the amount of the withhold resulting in an increase to the benchmark and improving shared savings.

Another question we received was on how sequestration fits into all of this. I think sequestration applies just once for payments, right? We're very careful not to double count it. The way we do that is for the benchmark and for shared savings and reconciliation calculations, we do everything on a sequestration agnostic basis. We take out the impact of sequestration for those values, and then for all payments, we add back in the 2% sequestration reduction. That means the capitation payments will incorporate that, and any shared savings or reconciliation will also incorporate that.

We received a couple of questions around how do we get a baseline for agents who don't have a claim history, or if we get a newly voluntarily aligned beneficiary during our performance year, will that affect the baseline? Will we go back and look at that that beneficiaries claims, and will it affect the baseline? I just want to speak to these questions because they hit on a pretty important nuance that we want to be clear to everybody. The baseline population that we're going to look to, to establish what the historical expenditure was, will not necessarily be the same population that is in the performance year. Some models in the past and maybe this is where some of the confusion has entered in if folks on the phone are familiar with those models, use what we might call a cohort approach.

We basically say who is actually aligned during our performance year? For these 100 people or 1000 people or whoever they are – for their actual history let's go take a look at what they cost, Medicare, what they incurred from a medical expenditure perspective, and whenever our base year period is. Let's say it's two years ago or the past couple years. Then we're going to use that predict what they're spend is in the performance year. That cohort approach is not exactly what we're using here. What we're doing is we're going to look at the DCEs participant provider list, and then we're going to go back to our base year period, and we're going to run alignment, just like we would run alignment for our performance year. We're going to look at all the medical expenditure for the beneficiaries that they touched, and we're going to see which beneficiaries would have a plurality of primary care claims with that DCE. The beneficiaries that past that threshold, those are the ones we're going to look to establish a benchmark.

For example, if you are the beneficiary that would have been aligned to a DCE in either 2017, '18 or '19, but then has left the area or enrolled in MA, or made some decision that has made that beneficiary ineligible to participate in the performance year, we're still going to look at that beneficiary's claims. Then alternatively, if you have a beneficiary that came to the DCE when their participant providers after the base year period, so let's say in the second half of 2019 -- or sorry, in 2020, but shows up in our performance year alignment look, then that beneficiary's

baseline is going to be based on the beneficiaries that would have been aligned in the base year, even though that beneficiary him or herself was not actually included in the baseline population.

I just want to make sure it's clear that there is a distinction between the baseline population that we look to, to calculate what the baseline will be in the performance year population. Now, given the fact that a lot of Medicare beneficiaries have been in the program for longer than three years and maybe haven't moved, we expect that there will be considerable overlap for, let's say, performance year one the actual beneficiaries that are aligned in that performance year, and the beneficiaries that we're using to calculate the baseline. But as the performance years continue, the baseline years don't move. Overtime, that overlap may become less and you don't need to be in the historical period to be aligned and vice versa, you don't need to be aligned. You can be aligned without us looking to your historical claims to calculate the baseline. I hope that was helpful.

There's a related question that we're getting here which is, if you're a voluntarily aligned beneficiary to a standard DCE, how might that affect the benchmark? Does that impact the baseline at all? I think one nuance that we want to make clear is, let's say you've got a standard DCE and they have 5000 claims aligned beneficiaries, and they have 1000 voluntarily aligned beneficiaries. The first thing we're going to do is for the 5000 beneficiaries, we're going to follow the steps that Yoni laid out, that includes establishing a baseline for those beneficiaries, blending in a regional factor, all the risks standardization and risk adjustment that we talked about. Then we're going to get a number for those 5000 beneficiaries. Separately, we're going to follow the more abbreviated methodology for the 1000 voluntarily aligned beneficiaries. That starts with the regional factor and also includes the performance year risk.

At that point, we're going to have a separate benchmark for the claims aligned beneficiaries and the voluntarily aligned beneficiaries. Then the last step will be to blend those, and those will be weighted in proportion to the number of beneficiaries. In this example, it's really done on the beneficiary month level but for the sake of simplicity let's say that there are 5000 claims aligned beneficiaries, those will be weighted five, six, and then the 1000 voluntarily aligned beneficiaries will be weighted one, six. I know it's a little confusing, but we do want to make sure it's clear that there are multiple -- there's a bunch of different "blends happening" if you will, right? Within a standard DCE the first blend that happens is for the claims aligned folks where we blend the baseline with the regional adjustment factor. The second blend that happens then is the benchmark that we've established for all the claims line, folks, we blend that with the baseline that we've established for all the voluntarily aligned folks. Not to complicate it too much, there's also the blend between the aged and disabled and ESRD, right, so we're going to really follow that process separately for each cohort.

Great, so I want to address two more questions here. One question we got was that, are ACO comprises much of our region? Will our MA adjusted rate book include expenditure for beneficiaries that are in the region and aligned to our own DCE? The answer to that is the MA rate book is really based on five years of historical fee-for-service claims data. If you have beneficiaries that have been in the program and have claims history in that period, then yes,

their experience would be calculated in the MA rate book. For an organization that has a lot of share within a county, we would expect that their baseline would look pretty similar to the MA rate book because the adjusted rate book is really based on the expenditures across the whole county.

Last question I want to address, there's been a number of folks asking when will we get the more detailed view of what this will look like? The answer is that we're planning to release a number of different specification papers over the coming months. What we'll do in those papers is not only provide more detail into the content that we've walked through today, but we will include a very specific and sort of using "real data" an illustrative example of how the math plays out step by step. I know a number of folks are saying sort of spell out the math. Hopefully, we've done a little bit of that today to the extent that it's possible in a format like this. I think when the specification papers come, it will be much easier to follow a given example from step one to the to the final reconciliation process. We're going to go on mute for another minute, collect a couple more questions and then respond to a number of folks.

Before we wrap up I do want to respond, there a couple of questions around the capitation payment mechanisms. I think there were some questions about how the Primary Care Capitation works. Specifically, the differences between the base portion and the enhanced portion, and how that works in reconciliation, what the 7% is. We went into a lot of detail on the capitation mechanisms and some of the other financial methodology components on a webinar last week. I encourage people to refer to those slides, and I think recording posted online for additional information. But I will respond to these quickly to clarify some of the open questions.

For Primary Care Capitation, that's calculated as 7% of the performance year benchmark, and that includes two components. One is the base capitation amount, which is determined based on historical expenditures for primary care claims. The other is the enhanced capitation amount which represents the difference between that historically calculated component and 7%. I think as Corey's using the example, the base component was 3%, then the difference between 3% and 7% would be 4%, that would be the enhanced component. That enhanced component is like an upfront infrastructure payment, allowing the DCE to make necessary investments to improve care. It will be recouped in full at the end of the performance year before other reconciliation steps are applied. It will take effect before any shared savings or shared losses are calculated, and will be recouped in full beforehand.

There was another question about what the difference between Primary Care Capitation is for DCE that selects global or professional. In terms of how the capitation amount is calculated there aren't any differences. The key differences are around the differences between the global and professional risk tracks. In the global track, the DCE is responsible for 100% risk, the total cost of care for its aligned beneficiaries. While in the professional model they're responsible for 50% of that total cost of care. The risk corridors that mitigate risk as expenditures deviate further from the benchmark are tighter and offer more protection in that professional model, so taking on less risk is the main theme.

I think at this point, given time, we're going to move on from the Q&A. We know that there are some questions we didn't get to. We have a number of office hours and I'll provide more detail and the dates in the coming slides, where we'll answer these and other questions in more detail.

Before we wrap up, I want to provide some logistical information on the model, key dates, as well as the details on additional office hours webinars to receive more information about the model. The DC model begins with an implementation period. It starts midway through the 2020 year. Applications are currently live. For the IP, the implementation period, they close on February 25th, 2020 so about a month left. We anticipate then that DCEs will be selected for the IP in May of this year, and they'll need to sign a Participation Agreement or PA by June of 2020, at which point the implementation period will begin.

The implementation period will close at the end of the 2020 year at which point the first performance year will begin. The performance year will run from January to December 2021. This is the point at which participants begin to take on risk for aligned beneficiaries. There will be a separate application period between March and May 2020 for applicants that are applying only for the performance period, not for the implementation period. DCEs for the performance period will be selected in September and will be required to return signed Participant Agreements for the performance year in December 2020. Of note, if a DCE is selected for the implementation period, they will not need to reapply for the performance year one period separately, they will however, need to sign a new participant agreement that it applies for the performance period by that same cut-off in December 2020.

These dates apply for the global and professional options. They don't refer to the geographic option, and we know we've received a number of questions about that option in past webinars and today. We know that you still have questions, we're still developing final details on the model and we'll release more information when we have it. Again, stay tuned there.

In terms of upcoming webinars and office hours – to learn more information and get more questions answered about the model, and particularly the payment and financial methodology details that we walked through over the last few weeks, this is the last in our sequence of webinars going over the model, for an initial sequence. There may be more webinars in the future, but in this initial stage, this is the last webinar. There are still those two final office hour sessions, the first is going to be scheduled on February 4th. I believe that's a Tuesday, in just a couple of weeks. There are links to register on the slide. I should call out this was initially scheduled for January 28th, but has been rescheduled so keep that in mind.

A second session of office hours for questions on payment and financial topics will be scheduled for the following week, February 11th, 2020. We hope that you'll join us as we use these sessions to respond to many of the questions that we did not cover through the Q&A portal during this week's session and last week's session. I should also call out that we will also be expanding questions to broader than just the financial and payment topics covered because we know these are the last office hours as part of that initial outreach before the implementation period application deadline. Before we close, we'd like to open up a quick audience poll. Just

asking how likely are you to participate in the Direct Contracting model, to help us understand who are our audience is.

All right, so it seems like a number of responses are coming in. It seems like the vast majority are likely or very likely to participate, which is good. We're glad you guys were able to join us. In just one last slide before we go providing some contact information. We have a link to the website at which additional information on the model can be found, including recordings and slides from past webinars, as well as a link to the application for those interested in applying. We've also provided two emails for you to reach out with questions. The first is for general questions about the model and the second is for sales force support relating to the application. Thank you all for joining us today. After the webinar closes there will be a post-event survey to collect feedback on today's webinar. Participants will be automatically launched onto the survey webpage. Please complete the survey so we can improve our webinar and communication process going forward. Thank you very much.

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