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PY 2022 Direct Contracting Program

Frequently Asked Questions

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The information provided herein is based on CMS Direct Contracting Program requirements & guidance as of November 1, 2021 and may change based on new or revised requirements & guidance as provided by CMS from time to time.

Direct Contracting Program Overview

What is the Direct Contracting Program?

The Direct Contracting (DC) Program applies to Medicare Fee-For-Service (original Medicare) beneficiaries. The DC Program is sponsored by the Center for Medicare and Medicaid Innovation (CMMI) and structured to test an array of financial risk-sharing arrangements designed to reduce Medicare expenditures while preserving or enhancing the quality of care furnished to original Medicare Service beneficiaries.

The DC Program offers levers that allow you as the provider to better manage the care continuum of original Medicare beneficiaries and total wellbeing through enhanced care coordination, data availability, and engagement through various payment, financial, and operational mechanisms.

The DC Program leverages lessons learned from other Medicare Accountable Care Organization (ACO) initiatives, such as the Medicare Shared Savings Program (MSSP) and the Next Generation ACO (NGACO) Model, as well as innovative approaches from Medicare Advantage (MA) and private sector risk-sharing arrangements.

The DC Program is a five-year program beginning on January 1, 2022.

What is a Direct Contracting Entity (DCE)?

A DCE is the entity that holds the DC Program agreement with CMS and administers the DC Program on behalf of participating providers. Northeast Georgia Health Partners Network has partnered with Lumeris to help facilitate the DC Program through Lumeris' affiliated DCE**.** Lumeris will also help administer and drive outcomes within the DC Program. Lumeris has extensive experience and proven outcomes with risk/outcomes-based contracts and deep collaborative relationships that will be leveraged to serve the DC population.

What are the benefits of participating in the Direct Contracting Program?

- The DC Program provides the opportunity for advance payments for Primary Care Specialists through a capitation rate for certain Primary Care Services rather than relying strictly on volume-based payments.
- The DC Program provides the opportunity for high performing providers who are able to provide quality care to their aligned beneficiaries in a cost-effective manner to earn shared surplus as a reward for their effort.

How does the Direct Contracting Program differ from Medicare Advantage?

Unlike beneficiaries who enroll in Medicare Advantage, beneficiaries aligned to organizations participating in the DC Program are not choosing to leave original Medicare and their health care coverage does not change. However, both the DC Program and Medicare Advantage allow entities to assume upside/downside risk on the care management of Medicare beneficiaries.

What is the difference between DC Participant Providers and Preferred Providers?

DC Participant Providers are the core providers and suppliers under the DC Program. Beneficiaries are aligned to the DCE through Participant Providers. These providers and suppliers are responsible for, among other things, reporting quality through the DCE and committing to beneficiary care improvement.

Primary Care Specialists that are DC Participant Providers are paid a monthly capitated rate by the DCE for certain Primary Care Services furnished to aligned beneficiaries.

CMS defines "Primary Care Specialists" as the following codes:

Code	Specialty[1]
1	General Practice
8	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Clinical Nurse Specialist
97	Physician Assistant

DC Preferred Providers contribute to DC Program goals by extending and facilitating valuable care relationships beyond the DC Participant Providers. Services furnished by Preferred Providers will not be considered in beneficiary alignment and Preferred Providers are not responsible for reporting quality. Preferred Providers are not paid monthly capitation and will continue to receive payments from CMS.

What PQEM Codes are considered "Primary Care Services"?

The list of codes considered as *Primary Care Services* by CMS is set forth in Attachment I.

Attribution and Beneficiary Alignment

How will beneficiaries be attributed?

CMS will attribute original Medicare beneficiaries based on a 2-year claims lookback of where they received the plurality of Primary Care Services. Beneficiaries that received the plurality of primary care from a Participant Provider will be attributed to the DCE. The DCE will use claims lookback consistent with CMS methodology to align beneficiaries to specific participant Providers.

Does the Direct Contracting Program allow for Voluntary Alignment?

Original Medicare beneficiaries can also be attributed through Voluntary alignment (VA). Voluntary is the process in which a beneficiary chooses what DC participant provider they want to be aligned to. Voluntary Alignment takes precedence over claims-based alignment. Beneficiaries who are already aligned by CMS through claims-based alignment can complete a Voluntary Alignment Form for a more "sticky" alignment under the DC Program. Net new Medicare beneficiaries that do not have claims history with CMS can also be aligned to a DC participating provider through Voluntary Alignment.

Lumeris and Northeast Georgia Health Partners Network will support Voluntary Alignment by making VA Forms available in provider front offices. Additional guidelines on how to manage and process the Voluntary Alignment Forms in provider front offices will be provided ahead of the DC Program launch in 2022.

How will I know which beneficiaries are attributed to me under the Direct Contracting Program?

As soon as attribution data is received from CMS, the DCE will make available to Participant Providers a copy of the Beneficiary Roster file which includes a list of all beneficiaries attributed to certain providers. The DCE will send quarterly updates of the Beneficiary Roster file to provider groups to ensure that beneficiary information is as current and accurate as possible in alignment with CMS data

Will attributed beneficiaries know they are in the Direct Contracting Program and attributed to providers?

Yes, all attributed beneficiaries will be sent a welcome packet from the DCE and Northeast Georgia Health Partners Network.

Provider Payment Structure

How will providers be compensated?

Participant Providers that are considered *Primary Care Specialists* will receive $0 from CMS on certain *Primary Care Services* (identified in Appendix I). In lieu of payment from CMS, these providers will be compensated through a monthly PBPM capitation rate from the DCE as compensation for Primary Care Services provided to aligned beneficiaries. For all other services, providers will continue to be compensated through Fee-For-Service by CMS. The monthly capitation rate will be determined based on historical beneficiary primary care experience during a look-back period consistent with CMS methodologies.

AS noted earlier, CMS defines "Primary Care Specialists" as the following codes:

Code	Specialty[1]
1	General Practice
8	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Clinical Nurse Specialist
97	Physician Assistant

All other providers including Preferred Providers and specialists will continue to be paid Fee-For-Service on all claims by CMS.

Will providers continue to submit claims to CMS consistent with historical practice?

Yes. All claims will continue to be submitted to CMS consistent with historical practice (this applies to both Participant and Preferred Providers). No claims will be submitted directly to the DCE.

How will Surplus/Loss be calculated?

The DC Program is an upside/downside risk program in which performance is compared to the Total Cost of Care Benchmark for attributed beneficiaries. Final shared savings/losses for each Performance Year will be calculated at the Northeast Georgia Health Partners Network level based on the performance of providers in managing cost and outcomes for beneficiaries relative to the total cost of care benchmark set by CMS.

Under the Direct Contracting Program, all Part A and B services for aligned beneficiaries count toward the calculation of shared savings/shared losses.

What Quality Measures are Included as Part of the DC Program?

CMS has tied a portion of surplus opportunity to the achievement of certain quality measures by applying a 5% discount to the Total Cost of Care benchmark. This 5% must be earned back through the achievement

of certain quality measures. Therefore, a focus on quality measures is required to be successful in this program. The measures for PY2022 include:

- Risk-Standardized All-Condition Readmission (ACR)
- All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC)
- Timely Follow-up After Acute Exacerbations of Chronic Conditions

Will my Compliance obligations change due to participation in the Direct Contracting Program?

Providers remain subject to all CMS compliance requirements consistent with participation in Medicare. Additional guidance and training regarding DC Program specific compliance will be provided with the DC Program's launch in 2022.

How Does Risk Adjustment Work Under the Direct Contracting Program?

Will Risk Adjustment be Used Under the Direct Contracting Model?

Yes. Risk Adjustment is used to ensure payment to the DCE reflects the health status of attributed beneficiaries.

How Will Risk Scores be Calculated in Direct Contracting?

The Direct Contracting Model uses the CMS-HCC (Hierarchical Condition Category) Prospective Risk Adjustment Model (v24) – the same version that is applied in Medicare Advantage. Beneficiary Risk scores calculated with the CMS-HCC prospective model use demographics (age, sex, Medicaid status, etc.) and diagnoses (ICD-9/10 codes on claims mapped to HCCs) reported in the prior year to predict expenditures in the Performance Year. Risk Scores for PY2022 will include diagnosis reported for the full twelve-month period of 2021.

Risk Adjustment under the Direct Contracting Program is also subject to (in order of operations): (1) "normalization"; (2) a symmetric 3% upside/downside annual cap; and (3) an annual retrospective Coding Intensity Factor (CIF). Notably, new Voluntarily Aligned beneficiaries are not subject to the 3% annual cap or the CIF during the first year of alignment.

What is Normalization?

Under the Direct Contracting Program, Risk Scores are normalized relative to the DC National Reference Population such that the DC National Reference Population maintains a Risk Score of 1.0. The "DC National Reference Population" includes all Medicare beneficiaries that are eligible for alignment under the Direct Contracting Program. Normalized Risk Scores are calculated by dividing the Risk Score by the average Risk Score of the DC National Reference Population. A preliminary normalization factor will be estimated prior to the start of each Performance Year with the final normalization factor applied retrospectively after the end of the Performance Year.

What is the 3% Cap?

Following application of normalization, a 3% cap is applied to each individual DCE that limits the normalized Risk Score change of any individual DCE Risk Score to a maximum 3% increase/decrease relative to a defined Reference Year. The Reference Year for PY2022 is 2019 (see table below).

What is the Coding Intensity Factor?

The retrospective coding intensity factor (CIF) is applied following the application of normalization and the 3% cap. The CIF is designed to ensure that the change in normalized Risk Scores across all Direct Contracting claims-aligned beneficiaries is zero between the baseline year (2019) and the Performance Year. The CIF is applied annually following the end of each Performance Year. The CIF is applied as a multiplier to the normalized DC risk scores.

What Data Sources Will be Used to Submit Diagnosis for Risk Score Calculation?

Diagnoses from allowable professional, inpatient and outpatient Medicare FFS claims data are used for risk score calculation.

Does Direct Contracting Allow for the Submission of Diagnosis for Risk Adjustment to be Pulled from Retrospective Medicare Record Chart Review Linked to Claims?

No, diagnoses for risk adjustment will be collected directly from FFS claims data that meet the risk adjustment requirements. A separate data stream of diagnoses pulled from medical record reviews will not be used for risk adjustment.

What Dates of Service are Used for Each Performance Year?

Coding Dates of Service	DC Performance Year	3% Cap Reference Year	CIF Baseline Year	Can Influence After 10/1/2021
2021	PY2022	[2019]* x 1.03	2019	Performance
2022	PY2023	[2021] x 1.03	2019	Performance
2023	PY2024	[2022] x 1.03	2019	Performance + Cap
2024	PY2025	[2023] x 1.03	2019	Performance + Cap
2025	PY2026	[2024] x 1.03	2019	Performance + Cap

Partnership with Lumeris

How can providers succeed in this model?

Providers can succeed under the Direct Contracting Program by enhancing access to care, coordinating beneficiary care, and accurately documenting and coding beneficiary health status. Northeast Georgia Health Partners Network has partnered with Lumeris to help facilitate the DC Program, administer, and drive outcomes within the DC Program, and help providers be successful.

Why has Northeast Georgia Health Partners Network Chosen to Partner with Lumeris?

Northeast Georgia Health Partners Network has partnered with Lumeris to help facilitate the DC Program and help administer and drive outcomes within the DC Program. Lumeris has extensive experience and proven results with risk/outcomes-based contracts and deep collaborative relationships that will be leveraged to serve the Direct Contracting population. Specifically, Lumeris will provide risk/outcomes-based strategic advice, operational expertise, technology and enhanced analytic capabilities to promote high quality, more affordable, and more personalized care to attributed original Medicare beneficiaries.

Lumeris' model for value-based care delivery has achieved recognition and validated results regarding its ability to improve outcomes across populations. For more than 10 years, Lumeris has leveraged a unique value-based care model to operate one of the highest performing Medicare Advantage plans in the country as measured by clinical and financial outcomes as well as member and physician satisfaction.

What Administrative Services will Lumeris Provide?

Lumeris will provide a number of administrative operations in support of the DC Program – including:

- Capitation processing, payment, and distribution (for Primary Care Specialists)
- CMS data ingestion and integration
- Voluntary Alignment processing and support
- Beneficiary attribution management
- Quality tracking and reporting
- Provider data management & provider search capability
- DC Program benchmark management & reporting
- Compliance oversight
- CAHPS survey administration
- DC Program customer service support
- DC Program beneficiary website

Where can I learn more about the DC Program?

Additional information about the DC Program can be found on the CMS website: https://innovation.cms.gov/innovation-models/gpdc-model

Appendix I
Primary Care Services
(as of January 1, 2022)

Administration of HRA	
96160	Administration of patient-focused health risk assessment instrument
96161	Administration of caregiver-focused health risk assessment instrument
Office or Other Outpatient Visit for New Patient	
99201	New Patient, brief
99202	New Patient, limited
99203	New Patient, moderate
99204	New Patient, comprehensive
99205	New Patient, extensive
Office or Other Outpatient Visit for Established Patient	
99211	Established Patient, brief
99212	Established Patient, limited
99213	Established Patient, moderate
99214	Established Patient, comprehensive
99215	Established Patient, extensive
Professional Services Provided in a Non-Skilled Nursing Facility (where LINE.CLM_POS_CD does not equal 31)	
99304	Initial Nursing Facility Care
99305	Initial Nursing Facility Care
99306	Initial Nursing Facility Care
99307	Subsequent Nursing Facility Care

99308	Subsequent Nursing Facility Care
99309	Subsequent Nursing Facility Care
99310	Subsequent Nursing Facility Care
99311	Subsequent Nursing Facility Care
99312	Subsequent Nursing Facility Care
99313	Subsequent Nursing Facility Care
99314	Subsequent Nursing Facility Care
99315	Nursing Facility Discharge Services
99316	Nursing Facility Discharge Services
99317	Nursing Facility Discharge Services
99318	Other Nursing Facility Care
Domiciliary, Rest Home, or Custodial Care Services	
99324	New Patient, brief
99325	New Patient, limited
99326	New Patient, moderate
99327	New Patient, comprehensive
99328	New Patient, extensive
99334	Established Patient, brief
99335	Established Patient, moderate
99336	Established Patient, comprehensive
99337	Established Patient, extensive
Domiciliary, Rest Home, or Home Care Plan Oversight Services	
99339	Brief
99340	Comprehensive

Home Services	
99341	New Patient, brief
99342	New Patient, limited
99343	New Patient, moderate
99344	New Patient, comprehensive
99345	New Patient, extensive
99347	Established Patient, brief
99348	Established Patient, moderate
99349	Established Patient, comprehensive
99350	Established Patient, extensive

Telephone Visits – Online Digital or Audio Only	
99421	Online digital, Established Patient, 5–10 mins
99422	Online digital, Established Patient, 10–20 mins
99423	Online digital, Established Patient, 21+ mins
99441	Phone, Established Patient, 5–10 mins
99442	Phone, Established Patient, 10–20 mins
99443	Phone, Established Patient, 21+ mins
Cognitive Assessment and Care Plan Services	
99483	Cognitive assessment and care plan services

Behavioral Health Integration (BHI) Services	
99484	Monthly services furnished using BHI models
99492	Initial psychiatric collaborative care management, first 70 mins
99493	Subsequent psychiatric collaborative care management, first 60 mins
99494	Initial or subsequent psychiatric collaborative care management, additional 30 mins

G2214	Psychiatric collaborative care management
Care Management Home Visit	
G0076	Brief (20 minutes) care management home visit for a new patient.
G0077	Limited (30 minutes) care management home visit for a new patient.
G0078	Moderate (45 minutes) care management home visit for a new patient.
G0079	Comprehensive (60 minutes) care management home visit for a new patient.
G0080	Extensive (75 minutes) care management home visit for a new patient.
G0081	Brief (20 minutes) care management home visit for an existing patient.
G0082	Limited (30 minutes) care management home visit for an existing patient.
G0083	Moderate (45 minutes) care management home visit for an existing patient.
G0084	Comprehensive (60 minutes) care management home visit for an existing patient.
G0085	Extensive (75 minutes) care management home visit for an existing patient.
G0086	Limited (30 minutes) care management home care plan oversight.
G0087	Comprehensive (60 minutes) care management home care plan oversight.

Chronic Care Management (CCM) Services	
99X21	Chronic care management services each additional 30 minutes by a physician or other qualified health care professional, per calendar month
99X22	Principal care management services for a single high-risk disease first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
99X23	Principal care management services for a single high-risk disease each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
99X24	Principal care management services, for a single high-risk disease first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month
99X25	Principal care management services, for a single high-risk disease each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99439	Non-complex chronic care management services, additional 30 min

99487	Extended care coordination time for especially complex patients (first 60 mins)
99489	Additional care coordination time for especially complex patients (30 mins)
99490	Comprehensive care plan establishment/implementations/revision/monitoring
99491	Chronic care monitoring service, moderate
G2064	Comprehensive care management, physician
G2065	Comprehensive care management, clinical staff
G0506	Additional work for the billing provider in face-to-face assessment or CCM planning
Wellness Visits	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit
Transitional Care Management Services	
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)

Depression and alcohol misuse	
G0442	Annual alcohol misuse screening
G0443	Annual alcohol misuse counseling
G0444	Annual depression screening
Professional Services Provided in ETA Hospitals	
G0463	Professional Services Provided in ETA Hospitals
Prolonged Care for Outpatient Visit	
99354	Prolonged visit, first hour
99355	Prolonged visit, additional 30 mins
G2212	Prolonged visit, additional 15 mins
Advance Care Planning (where LINE.CLM_POS_CD does not equal 21)	

99497	ACP first 30 mins (subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation)
99498	ACP additional 30 mins (subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation)
Virtual check-ins	
G2010	Remote evaluation, Established Patient
G2012	Brief communication technology-based service, 5-10 mins of medical discussion
G2252	Brief communication technology-based service, 11-20 minutes of medical discussion

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13900 Riverport Drive St. Louis, Missouri 63043