Submitted online at: http://www.regulations.gov

Meena Seshamani, MD PhD
Director, Center for Medicare
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1807-P,
P.O. Box 8016,
Baltimore, MD 21244-8016

September 6, 2024

Dear Dr., Seshamani,

On behalf of Michigan Multipayer Initiatives (MMI) and its Steering Committee, we are delighted to share our comments on the proposed 2025 Physician Fee Schedule. MMI is a voluntary collective of health plans and providers who work to align payer policy in an effort to promote evidence-based approaches that support and strengthen primary care. MMI includes representation from all health plan payers in the state, as well as an array of practicing physicians and physician organization leaders. We have been proud to have convened four state-wide multipayer CMMI demonstrations and have experience with scaling advanced primary care. As well, our member health plans have a long tradition of supporting provider-delivered care management. Most importantly, MMI acts in the interest of making high quality primary care and population health available to all. Patients are our highest calling.

We are grateful for the CMS' leadership and hard work to improve the well-being of Medicare beneficiaries. The inclusion of Advanced Primary Care Management (APCM) codes speaks volumes about your commitment to whole-person care and to taking courageous and important steps to improve care for Medicare beneficiaries. CMS should be applauded for introducing the codes for 2025. We have long heard from our practices in CMS demonstrations about the pivotal role that per capita funding plays in implementing true advanced primary care for their patients.

As CMS has proposed them, the APCM codes nicely align with elements envisioned in the National Academy of Medicine's call for primary care hybrid[1] and with the recent literature has addressed ways that CMS could operationalize hybrid primary care payment in Medicare FFS.[2] Further, we believe the array of APCM requirements is the right mix, and clearly reduces the administrative burden of billing individual time-based codes. Additionally, we appreciate that

[1] https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care
[2] Robert A Berenson and others, Beyond demonstrations: implementing a primary care hybrid payment model in Medicare, Health Affairs Scholar, Volume 1, Issue 2, August 2023, qxad024, https://doi.org/10.1093/haschl/qxad024

the focus of the codes is on primary care, acknowledging the important role that advanced primary care plays.

We are concerned, however, about the 20% patient cost-sharing for APCM codes. While we understand that CMS is working within its regulatory authority and faces statutory constraints, our experience has been that when even a small share of patients faces cost-sharing, it is a roadblock for engaging patients in care management. Kaiser Family Foundation estimates that 10.4% of Traditional Medicare patients would be exposed to the full 20% cost share[3]. Even for Medicare beneficiaries with Medigap, two plans (K and L) cover only a portion of the cost share.

In Michigan, when our plans initially introduced care management, some patients did indeed face a cost share. The reaction from care manager was so strong that over the years we are proud to report that commercial plans have developed manual workarounds to alleviate this problem. This has been absolutely essential in scaling care management servicing across the state.

We are impressed and heartened by the introduction of the APCM codes but are concerned that their uptake will be limited without eliminating the related cost-sharing. We urge interagency cooperation and creativity in finding a way to remove this barrier. At the same time, we realize that everyone plays a role here, including all those who submit comments on the PFS this year, to work for change and Congressional action at a national level.

There are other aspects of the 2025 proposed rule that we find very constructive, such as the provision for advance payments for MSSP ACOs that meet conditions, and the enhancements to the G2211 code as well.

We noted CMS' invitation on the primary care payment RFI and have compiled suggestions from the field for each domain in the request as follows:

1. Streamline Value-Based Care Opportunities

We support CMS' emphasis on creating multiple pathways for integration of care across settings and engagement in longitudinal care management. We encourage continuation of the use of MSSP ACO as a vehicle to differentially reward providers who succeed in delivering whole-person care. We note with interest the April 2024 Congressional Budget Office (CBO) report on ACO performance that establishes that MSSP ACOs led by independent physicians and those with greater proportions of primary care providers outperform others.[4] As the report suggests, we encourage CMS to permit ACOs to waive beneficiary cost-sharing when members obtain services from ACO providers, especially for primary care services. This could function as a helpful incentive to keep providers in value-based arrangements. As well, the report thoughtfully lays out strategies to increase payment for primary care providers. However, even with substantial additional MSSP ACO expansion, there will still be regions where for multiple reasons, ACOs do not form. This increases the importance and potential of the APCM codes to extend the reach of advanced primary care to more Americans, a key strategy in CMS reaching its goal of having all Medicare and Medicaid beneficiaries in accountable care relationships.

[3] A Snapshot of Sources of Coverage Among Medicare Beneficiaries; Nancy Ochieng, Gabrielle Clerveau, Juliette Cubanski, and Tricia Neuman; Kaiser Family Foundation website study; Published Dec 13, 2023

[4] Medicare Accountable Care Organizations: Past Performance and Future Directions; Congressional Budget Office, April 20

We also believe that measures and metrics for primary care should be proportional to their sphere of influence. Finally, we strongly support properly valuing primary care services. Real progress requires creating separate fee schedules (cognitive and procedural) and restoring the RUC to an advisory role.

2. Billing Requirements

We support a monthly cadence for the APCM codes. In some demonstrations, a quarterly cadence has been used, but monthly timing may be more practical and makes the code more straightforward for implementation.

As stated earlier, we believe that the cost-sharing requirement for APCM services will be problematic to engaging providers in its use. Commercial payers in our state have honored feedback from care managers about this concern and have freed cost-sharing from being a roadblock to care management engagement. Though we understand the statutory restrictions that CMS faces, we do believe that CMS has the authority to permit the exclusion of cost-sharing where there is allowance for program flexibility (e.g., excluding cost-sharing for primary care services when patients seek primary care services from ACO providers, etc.).

3. Person-Centered Care

To support person-centered care, we encourage CMS to further streamline measure and metric expectations for primary care. We applaud CMS' introduction of the APCM codes as they encourage a focus on practice teams, not individual practitioners to support team-based care.

Patient experience is important as the patient is the ultimate arbiter of the success of patient – centered care. We note with interest CMS' inclusion of the Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) and believe it to be a promising tool.

4. Health Equity

We share CMS' emphasis on the pursuit of health equity. Some Michigan payers have begun to adjust for social complexity via the Area Deprivation Index (ADI). We do think that adjusting on the basis of patient residence, not provider location, leads to more equitable allocation of resources. Our practices desire to support patients with social needs but believe that connection to community is key. Community-based organizations (CBOs) have the experience and expertise to help patients navigate and address health-related social needs and we believe that CBOs can only do this with appropriate resources and funding.

5. Quality Improvement and Accountability

We believe that CEHRT technology is an important enabler to optimize the use of data for coordination and optimization of care. Instead of additional requirements on practices, however, we instead encourage CMS to focus on common expectations and requirements of EHR vendors. This is especially important so that primary care practices are not held hostage by them.

In closing, we applaud CMS' hard work and earnest effort to incorporate and implement the National Academy's recommendations into the 2025 PFS and note with appreciation the thoughtfulness with which they have been proposed. We are, however, concerned about the impact of cost-sharing on restricting provider uptake of the codes, and encourage interagency action and coordination. We believe that the new APCM codes could be a gateway for real change and adoption by other payers. We also encourage CMS to watch developments in states (e.g., California) that are experimenting with comprehensive hybrid payment as you further explore additional hybrid payment reform.

We are thankful for the opportunity to provide comments and recommendations on the 2025 PFS and urge your careful consideration of our recommendations. Primary care payment reform is important and your leadership demonstrates a recognition that it is essential as well to progress in value-based care. We appreciate the opportunity to provide feedback. We are happy to discuss any of the concerns identified above further. Questions regarding these comments can be directed to Diane Marriott at dbechel@umich.edu.

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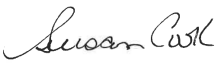

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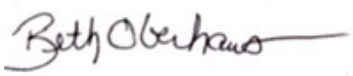

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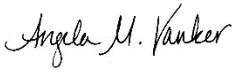

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