The MMI Review: Topnotes of the Proposed PFS 2025 for Primary Care and Population Health

MICHIGAN MULTIPAYER INITIATIVES

Four Key Aspects of the Draft 2025 PFS for Primary Care and Population Health

- Introduction of Advanced Primary Care Management Codes
- MSSP ACO
- Telehealth
- Moving Toward Value Pathways

Advanced Primary Care Management Bundles in the 2025 Draft Physician Fee Schedule (PFS)

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Big News! New bundled payments for advanced primary care teams. Three new codes for Advanced Primary Care Management (APCM) services that bundle elements of several existing care management and communication technology-based services that include principal care management, transitional care management and chronic care management. Also extends to FQHCs and RHCs

TABLE 23: Proposed APCM Bundled Codes and Valuation

Code	Short Descriptor	Crosswalk Codes	CMS Proposed Work RVU	CMS Proposed PE RVU	CMS Proposed MP RVU	CMS Proposed Full RVU	Approximate National Payment Rate
GPCM1	APCM for patients with up to one chronic condition	99490	0.17	0.14	0.01	0.31	$10
GPCM2	APCM for patients with multiple (two or more) chronic conditions	99490, 99439, 99487, 99489	0.77	0.72	0.05	1.54	$50
GPCM3	APCM for QMBs enrollees with multiple chronic conditions	Calculated as a relative increase from GPCM2	1.67	1.57	0.12	3.36	$110

Advanced Primary Care Management Bundles in the 2025 Draft Physician Fee Schedule

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- CMS is learning and incorporating lessons from demonstrations; Demonstrates movement toward a hybrid payment with a capitated portion for care management
- Shows CMS' effort and commitment to implementing the NASEM recommendations that are key to strengthening primary care and delivering value-based care that is patient-centered.
- New codes would be open to 100% of PCPs (including NPs and PAs) if they choose to meet the requirements.
- Reporting satisfied via the Value in Primary Care value pathway for MIPs physicians, or participation in a Shared Savings Program ACO, REACH ACO, Primary Care First, etc.

Advanced Primary Care Management Bundle Requirements

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1. **Patient Consent**: Inform the patient about the service, obtain consent, and document it in the medical record.
2. **Initiating Visit:** for new patients or those not seen within three years.
3. **24/7 Access:** Provide patients with urgent care access to the care team/practitioner at all times.
4. **Continuity of Care:** Ensure continuity with a designated team member for successive routine appointments.
5. **Alternative Care Delivery:** Offer care through methods beyond traditional office visits, such as home visits and extended hours.
6. **Comprehensive Care Management:**
   - Conduct systematic needs assessments.
   - Ensure receipt of preventive services.
   - Manage medication reconciliation and oversight of self-management.
7. **Electronic Care Plan:** Develop and maintain a comprehensive care plan accessible to the care team and patient

Advanced Primary Care Management Bundle Requirements, cont.

8. **Care Transitions Coordination:** Facilitate transitions between healthcare settings and providers, ensuring timely follow-up communication.

9. **Ongoing Communication:** Coordinate with various service providers and document communications about the patient's needs and preferences.

10. **Enhanced Communication Methods:** Enable communication through secure messaging, email, patient portals, and other digital means.

11. **Population Data Analysis:** Identify care gaps and offer additional interventions.

12. **Risk Stratification:** Use data to identify and target services to high-risk patients.

13. **Performance Measurement:** Assess quality of care, total cost of care, and use of Certified EHR Technology.

Advanced Primary Care Management Bundle Observations

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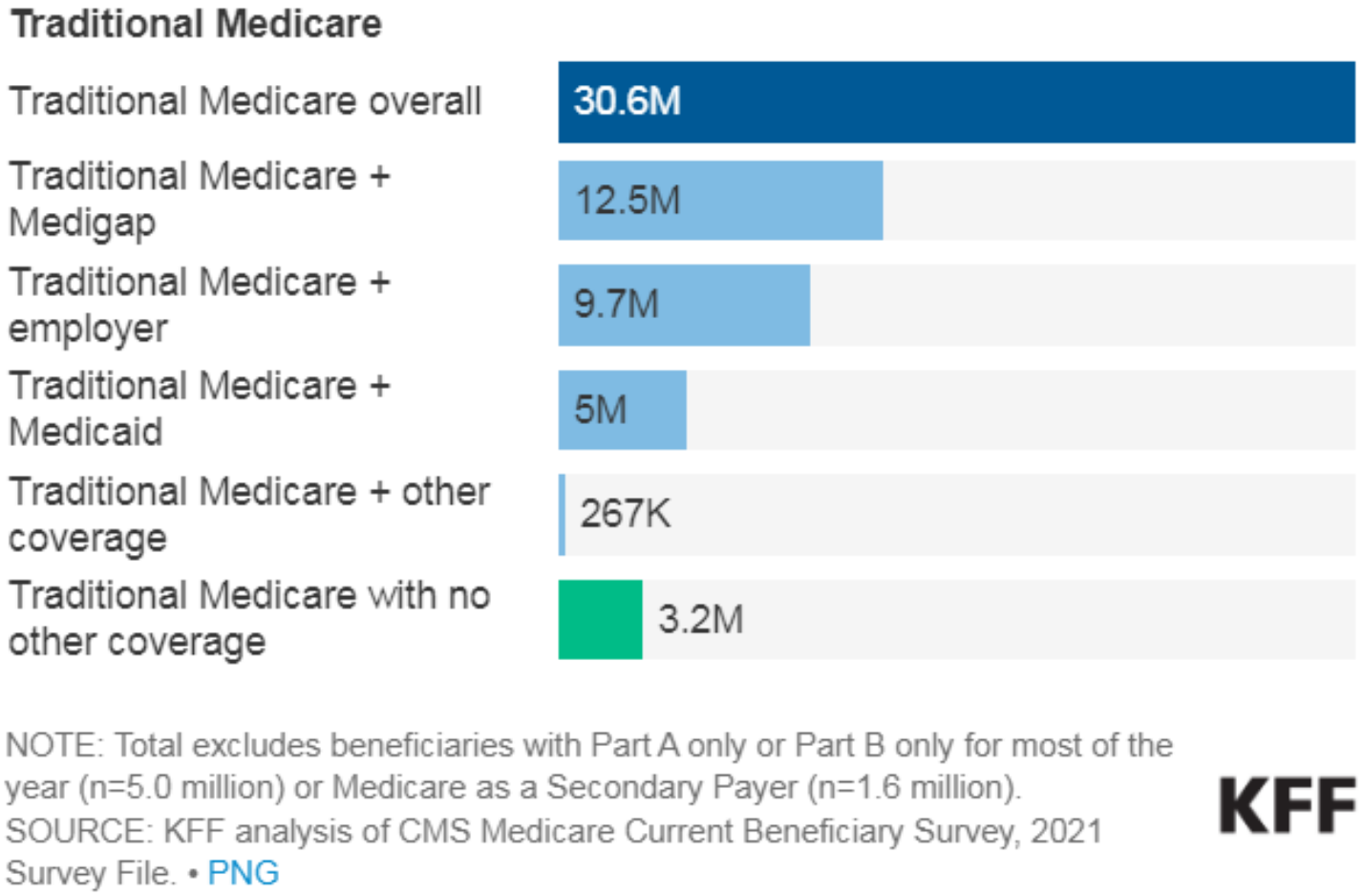
- Decreases administrative burden compared to prior approaches (e.g., removes time-tracking requirement)
- Primum non nocere; Alternative piecemeal codes would still be available.
- *In Michigan, it may be the case that because many practices have already developed advanced primary care capability, that the APCM payment is viable to help support whole-person team-based primary care panel-wide.*
- APCM RFI in PFS offers an opportunity to help CMS shape future design

Advanced Primary Care Management Bundles: Medigap and Patient Exposure to Medicare Cost-Sharing

Medigap Benefit	Plan A	Plan B	Plan C	Plan D	Plan F*	Plan G*	Plan K	Plan L	Plan M	Plan N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓***

Trad. Medicare Beneficiary Financial Liability to Cost Sharing, Kaiser Study of 2021 Medicare Data



*3.2M out of 30.6M or **10.4%** would be exposed to the full 20% Traditional Medicare cost share*

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

Proposed 2025 PFS: MSSP ACO Changes

- Prepaid shared savings option for high-performers (history of earned shared savings)
- For ACOs submitting under APP (APM Performance Pathway), CMS is promoting alignment with the adoption of the Universal Foundation measure set via creation of the APP Plus quality measure set

Quality #	Measure Title	Collection Type	Performance Year Phase In
321	CAHPS for MIPS	CAHPS for MIPS Survey	2025
479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	2025
484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Administrative Claims	2025
001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/Medicare CQM	2025
134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/Medicare CQM	2025
236	Controlling High Blood Pressure	eCQM/Medicare CQM	2025
113	Colorectal Cancer Screening	eCQM/Medicare CQM	2025
112	Breast Cancer Screening	eCQM/Medicare CQM	2025
305	Initiation and Engagement of Substance Use Disorder Treatment	eCQM/Medicare CQM	2026
487	Screening for Social Drivers of Health	eCQM/Medicare CQM	2028
493	Adult Immunization Status	eCQM/Medicare CQM	2028

Proposed 2025 PFS: MSSP ACO Changes, cont.

- eCQM reporting incentive extended that would apply only to those ACOs that report all of the eCQMs in the APP Plus quality measure set AND meet the data completeness requirement for all of the eCQMs.

- Prioritizing eCQMs as the “gold standard” collection type that underlies CMS digital quality measure strategic roadmap

- Medicare CQMs serve as a transition collection type while ACOs adopt digital quality measurement.

eCQMs — Medicare CQMs

(no CQMs and still no CMS Web Interface)

2025 PFS Changes: MVP Transition Breadcrumbs

- “We anticipate that we may be ready to fully transition to MVPs by CY 2029.”

- CMS is proposing to calculate all available population health measures in applicable MVP. The highest scoring population health measures would be used for scoring.

2025 Proposed PFS Highlights for Telehealth

- Because CMS does not have the authority to extend the bulk of Medicare telehealth waivers, the proposed CY2025 draft rule does not include the core waivers that enabled telehealth flexibilities.

- Congress must extend or make permanent the majority of Medicare telehealth waivers through legislation, which is likely to happen in the lame duck session.

2025 Proposed PFS Telehealth Highlights, cont.

- CMS is proposing to change the definition of “interactive telecommunication system” to allow audio-only for any telehealth service (previous change was specific to behavioral health services).

- Includes two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system as defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication, but the patient is not capable of, or does not consent to, the use of video technology

Michigan Multipayer Antitrust Statement

- Michigan Multipayer Initiatives creates a forum for participating payers, Physician Organization (PO) and Payer representatives to collaborate on program goal achievement and advancement of population health in Michigan.
- As such, Michigan Multipayer Initiative stakeholders (e.g., Payer Leaders, Steering Committee, Subcommittees, Initiative meeting attendees, etc.) agree that all activities are in compliance with federal and state antitrust laws. In the course of discussion, no financial information from payer participants will be shared with other payers or the general public.
- During meetings and other activities, including all formal and informal discussions, each payer participant will refrain from discussing or exchanging information regarding any competitively sensitive topics. Such information includes, but is not limited to:
  - PMPM
  - Shared savings or incentive payments
  - Information about market share, profits, margins, costs, reimbursement levels or methodologies for reimbursing providers, or terms of coverage

Questions? Ideas?

Contact Diane Marriott, DrPH at dbechel@umich.edu