Partnering for Next-Level Progress: Payer Policy Alignment on HIE and Social Care Priorities and Policies

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Mission and Approach

Michigan Multipayer Initiatives' (MMI) mission is to convene payers to lead the transformation of primary care to improve health equity, quality of care, patient experience, affordability of care and the health of the populations we serve.

MMI brings together critical stakeholders to develop, implement, evaluate and spread effective models that deliver, pay for and sustain high quality, comprehensive, accountable primary care.

Based at the University of Michigan and hosted by the Center for Healthcare Research and Transformation, Michigan Multipayer Initiatives (MMI) partners with payers, providers, practices, physician organizations, community-based organizations, national groups and patients to develop informed, evidence-based solutions

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

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PAYERS PARTNERING IN VOLUNTARY COLLABORATION

MMI Payer Alignment:

- Advances evidence-based policy
- Works to strengthen and improve primary care and population health
- Seeks provider and PO input on policy development

aetna®

Blue Cross Blue Shield Blue Care Network of Michigan

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES CENTER FOR MEDICARE & MEDICAID INNOVATION

hap

MDHHS Michigan Department of Health & Human Services

meridian

MOLINA HEALTHCARE

PriorityHealth

UPHP UPPER PENINSULA HEALTH PLAN

Informed by PO, Provider and Community Steering Committee

MICHIGAN MULTIPAYER INITIATIVES https://mimultipayerinitiatives.org/

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Collaboration and Alignment

- Multipayer collaboration and policy alignment is a critical element to increasing healthcare value for all
- Providers value payers who work together to commonize requirements so that practices can implement interventions on a panel-wide basis
- Payers, practices, and patients benefit when payers come together and find opportunities of mutual interest to participating payers on key issues
- MMI offers a neutral convening mechanism, support to payers, and infrastructure that connects the stakeholders key to leverage the force of change

MMI Antitrust Policy

The Michigan Multipayer Initiative creates a forum for participating payers, Physician Organization (PO) and Payer leaders to collaborate on program goal achievement and advancement of population health and value.

As such, Michigan Multipayer Initiative participants (e.g., Payer Leadership, 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

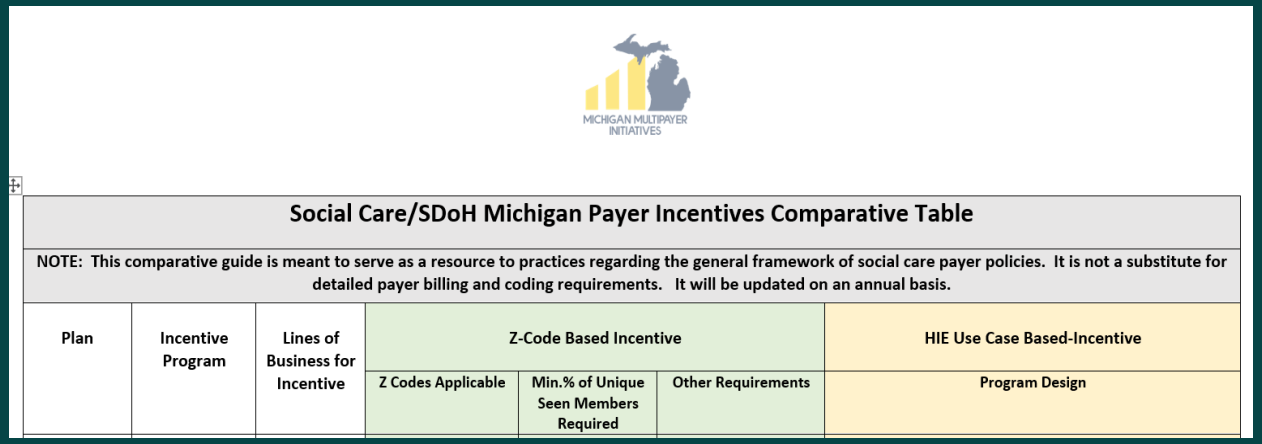
MMI and MiHIN Partnering to Bridge Data and Doing

- Social Care and Health Equity
- HIE Payer Prioritization and Alignment
- Emerging Policy

Social Care Alignment

2024 Social Care Payer Policy Comparison

- *Compares social care incentive policies and requirements across plans*
- *Updated annually in March*
- *Reflects information from all payers (Medicaid, commercial, MA) in the state*
- ***Available on the MiMultipayerInitiatives.org website***



MICHIGAN MULTIPAYER INITIATIVES

Social Care/SDoH Michigan Payer Incentives Comparative Table						
NOTE: This comparative guide is meant to serve as a resource to practices regarding the general framework of social care payer policies. It is not a substitute for detailed payer billing and coding requirements. It will be updated on an annual basis.						
Plan	Incentive Program	Lines of Business for Incentive	Z-Code Based Incentive			HIE Use Case Based-Incentive
			Z Codes Applicable	Min.% of Unique Seen Members Required	Other Requirements	Program Design

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MULTIPAYER SHARED SOCIAL CARE DATA PRINCIPLES

- SDoH and CHW servicing is part of whole-person care and is important to Michigan payers.
- A central HIE increases the efficiency and effectiveness of information exchange.
- It is important for all stakeholders (the State, plans, patients, providers, Physician Organizations, Community-Based Organizations, public health partners, etc.) to have voice in social care data strategy and data governance.
- Decreasing administrative burden and cost increases the dollars available for delivering needed clinical and social services.

MULTIPAYER SHARED SOCIAL CARE DATA PRINCIPLES, cont.

- Community and regional innovation in population health and health information should be encouraged.
- Data security and privacy are important and should be protected and shared on a need-to-know basis that provides for evolution in payment and the evidence base.
- Social care data in Michigan should incorporate national developments.
- Costs should be shared by the government, plans, health systems, and philanthropic organizations.

Social Care Screening Data

- SNS-E measure
- Preparing for social care integration
- Minimizing administrative burden and honoring community screening

Social Care and Health Equity Payer Alignment Group – Examples of Issues

- Incorporating evolving CIE and SDoH Hub infrastructure and MDHHS SDoH Strategy
- Serving as a platform for the collective payers to hear from regions (current services and planned)
- Hearing from the national experts (NCQA on SNS-E; SIREN and the Harvard Health Law Lab on consent and privacy, etc.)

HIE Payer Prioritization and Alignment

Payer HIE Incentives Comparison

Michigan Multipayer HIE Incentives Table - February 2024

Payer HIE incentives encourage providers to participate in use cases to support clinical decision-making and the management of population health. Michigan Multipayer Initiatives (MMI) and MiHIN jointly work to support collaboration among Payers to better prioritize and align provider incentives related to Health Information Exchange (HIE), use case participation, and data-sharing. This table will also contribute to MDHHS HIT 2023 Recommendation #2 (create multipayer HIE incentive inventory) aligned with the MI HIT Roadmap. Annual updating will occur each December.

Payer	Incentive Program Name	Incentive Element (list each separately)	Associated MiHIN Use Case (if applicable)	Provider Types Eligible (e.g., POs, Physicians, Hospitals, SNFs, etc.)	What do providers need to do to earn incentive? (i.e., Send, Receive, Sign Legal Stack, etc.)	How is whether the incentive threshold is met measured? (i.e., self attested, MiHIN report, # of files sent, conformance, etc.)	Applicable products/plan types
Medicare Promoting Interoperability Program	e-Prescribing	e-Prescribing and Query PDMP		Hospitals (incl. Critical Access Hospitals)	Requirement; Send prescriptions electronically via CEHRT for at least one	Hospitals can earn 10 points for each (e-Prescribing and Query PDMP)	Traditional Medicare
	Health Information Exchange	Health Information Exchange	Admission, Discharge, Transfer (ADT), Exchange CCDA; etc.	Hospitals (incl. Critical Access Hospitals)	Hospital must engage in secure, bi-directional exchange of	Hospitals can earn 30 points for sending, receiving and	Traditional Medicare

HIE Payer Alignment and Prioritization Mission

- Discussing organizational and shared HIE goals and objectives;
- Working toward alignment on priorities and requests of MiHIN;
- Sharing developments about national and State HIE requirements and expectations;
- Communicating changes or enhancements to MiHIN services or products;
- Providing conceptual feedback on new/proposed use cases and identifying new Payer needs as well as providing input on the products/services at specific milestones in the Use Case Factory process; and
- Proposing operational and strategic advice to the MiHIN Operations and Advisory Committee (MOAC).

HIE Payer Alignment and Prioritization

Universal Payer Consensus on:

- Alignment on incentives to decrease administrative burden (starting with SDoH)
- Development of collective roadmap to guide HIE incentive evolution
- The need to focus on data quality
- HIT Commission request for HIE Incentive Multipayer Table

HIE Payer Alignment and Prioritization Topics

- Payer best practices and lessons learned re: transitioning from participation to conformation incentives
- Social care data housing: Agreement on merging the SDoH Screening use case into the QMI/PPQC APS format
- ILOS (new Medicaid contract provision)
- Transition to digital measurement
- FIHR
- National Health Directory

New APCM CMS Codes

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

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

- 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

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

- 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.*

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