South Carolina Academy of Family Physicians

2025 Summer Breakaway and Annual Meeting

Population Health Management: It's More Than Just Seeing Patients in 2025

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Disclaimer/Conflicts

E. G. "Nick" Ulmer, Jr., MD CPC is the owner of the entire content of this presentation. Any questions related to interpretation of the coding guidelines discussed herein should be directed to Dr. Ulmer at:

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The ultimate authority on the interpretation of CMS guidance rests with your Medicare Administrative Contractor (MAC).

- Search www.cms.gov and "Who are the MACs" to locate yours.

Spartanburg Regional Healthcare System is in no way related to the educational content of this presentation.

Objectives

- Define “Population Health Management” through the ambulatory lens of care
- Understand ambulatory quality measures where focus is needed to succeed in managing contracts (a population)
- Be able to state strategies needed for your practice to remain aligned and succeed in this aspect of medicine.

Population Health ↔ Population Health Management

- Helping get a population healthy takes work ("management")

Population Health Management

- Addressing a group of patients through a lens that addresses their clinical conditions in a way that optimizes quality and cost while keeping the patient's best interest in the center of the process.
  - The "triple aim"

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- …now we add to this the health and well-being of the provider community that is caring for this population.
  - The "quadruple aim"

Population Health ***IDEAL VALUE***

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  - The "quadruple aim"...The goal of any population health management program

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  - The "triple aim"
- …now we add to this the ***health and well-being of the provider community*** that is caring for this population.
  - The "quadruple aim"…The goal of any population health management program
- Globally, US spend on healthcare as % gross domestic product (GDP) still exceeds other industrialized nations, so opportunities exist

Risk Stratify the Population for Management Direction

- High-cost conditions that can be lessened (cancers, condition mgmt, debility,?)
  - Prevention (colon CA screening, Mammograms, DEXAs, etc.) vs upstream Chr Dz Mgmt
- High costs that can be corrected (high utilizers) – access
  - Emergency Department use that is inappropriate (*10-20x more costly in ED*)
  - Admissions to the hospital (ED "gate", access → delay care, exac. of comorbid illnesses)
- High costs that can be mitigated (ancillary services – meds, tests, imaging, etc)
  - Generic vs name brand and step therapy re: treatment paths (semaglutide now vs 1500 cal diet with exercise x 6wks…?)
  - Right test, right time (MRI of the C/L/T spine before plain films and PT for LBP)
  - Independent facility use vs hospital-owned
- Chronic disease burden – address now (manage lipids, weight, stress) to avoid negative outcomes (CP →MI → CABG → debility → STR etc.)

Population Health Management

- Devise strategies to keep patients out of hospital/ED, and when care is needed, be efficient
  - Optimize acute care disease management, optimize length of stay. Right test, Right time.
  - Deploy TCM (reduce readmissions), make same-day office appt slots available

innovation.cms.gov/initiatives/medicare-diabetes-prevention-program
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Population Health Management

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  - Optimize acute care disease management, optimize length of stay. Right test, Right time.
  - Deploy TCM, (reduce readmissions), make same-day office appt slots available
- The hard part: Ambulatory to promote wellness and prevention strategies → manage chronic disease with cost containment as backdrop interfacing with patient buy-in
  - Health maintenance screenings, aggressive chronic disease management, optimal lifestyle choices
  - "Roadmap" to assist …

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2025 Stars/ACO Quality Metrics (updated 11.2024)

Measure	Program		Star Category & Weight		Thresholds 10/23/2024	
	Stars	ACO	Part C or D?	Weight	4 Star	5 Star
Care for Older Adults - Functional Status Assessment	✓		C	1	77%	91%
Care for Older Adults - Medication Review	✓		C	1	92%	98%
Care for Older Adults - Pain Screening	✓		C	1	92%	96%
Medication Adherence for Diabetes	✓		D	3	87%	91%
Medication Adherence for Hypertension (RAS)	✓		D	3	90%	92%
Medication Adherence for Cholesterol (Statins)	✓		D	3	89%	93%
TRC: Medication Reconciliation Post-Discharge	✓		C	0.5	73%	87%
TRC: Patient Engagement After Inpatient Discharge	✓		C	0.5	63%	77%
Follow-Up After ED Visit for MCC	✓		C	1	60%	69%
Plan All-Cause Readmissions*	✓		C	3	10%	8%
Osteoporosis Management in Women w/ Fracture	✓		C	1	52%	71%
Kidney Health Evaluation for Patients with Diabetes	✓		C	1	52%	67%
Statin Use in Persons with Diabetes	✓		D	1	89%	93%
Eye Exam for Patients with Diabetes	✓		C	1	77%	83%
Glycemic Status Assessment for Patients with Diabetes (<=9%): HbA1c Control	✓	✓	C	3	84%	90%
Breast Cancer Screening	✓	✓	C	1	75%	82%
Colorectal Cancer Screening	✓	✓	C	1	75%	83%
Controlling Blood Pressure	✓	✓	C	3	80%	85%
Statin Therapy for Cardiovascular Disease	✓	✓	C	1	88%	92%
Falls: Screening for Future Fall Risk		✓				
Depression Screening		✓				
Depression Remission at Twelve Months		✓				
Influenza Immunization		✓				
Tobacco Screening and Cessation Intervention		✓				

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Medicare Advantage and Some Commercial

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Traditional Medicare and Medicare Shared Savings (MSSP)

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Population Health Management (PHM): Ambulatory Focus

- Delivering on Quality – the real work in PHM
  - Clinical acumen: Practice medicine at highest level
  - Where to focus…? Triple weighted:
    - BP Control
    - DM Control
    - Medication Adherence: BP, DM, Statins (lipid)
    - Readmissions (30d)

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    - BP Control: Percentage of patients 18-85 w/ HTN with BP <140/<90 (both need to be below). The last BP of the year is measured in quality reports (all providers count – except ED, hospital care). Office visits, patient reported (validated device), video visits. CPT II code submission may automate – but valid numbers need to be caught

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      - Exclusions: Hospice and ESRD/Dialysis patients, ED and hospital-based encounters.
      - Strategy for Success: Correct BP collection (upper arm, not wrist), Reach out to Q3/Q4 hypertensives that are out of control. Bring them back in or do f/u phone calls for patient reported BPs. Also, RECK elevated BPs at each office visit.

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  - Where to focus…? Triple weighted: DIABETES
    - DM Control: 18-75yoa whose most recent A1c is <9% (higher number - good control - is best – commercial carriers may use other numbers ("8") and may use "> than")… optimal A1c "shoot for 7-ish" (NU) since is a population measure
    - Strategy for Success: It is another "end of the year" measure, so a similar "work the out of control" diabetics with an end of year reach-out. May take more time to get A1c down, but "control" is <9 …. Focus on marginal patients first. November push…?
      - A1c (83036) is now approved for screening w/o co-insurance (Z13.1) for DM. Use "-TS" if patient has pre-diabetes. For DM, can check A1c q6m if stable, q3m if not at goal. Use the code for "DM w **hyperglycemia**" E11.**65** (DMII w **hyperglycemia**) and E10.**65** (DM I with **hyperglycemia**) or E08.**65** (DM from underlying condition with **hyperglycemia**.)

xxx.65 is the "hyperglycemia" dx code → *Helps get test paid*

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Population Health Management (PHM): Ambulatory Focus

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  - Where to focus…? Triple weighted: MEDICATION ADHERENCE
    - BP Control
    - DM Control
    - Medication Adherence: BP, DM, Statins (lipid)
    - Readmissions (30d)

Medication Adherence Defined[5]

- A patient taking their medications (getting the med filled on time) over the course of the year 80% of the time (292 days if on med 01/01 of that year)
  - ~80% of Americans > 50 years of age have one or more chronic conditions
  - If new Rx during the year, then it is 80% of the time left in the year
  - 90d Rx have higher fill rates and more likely to pass measure
    - Only requires 4 refills in the year rather than 11 with 30d supply (…but missing one makes it 75% and a failure) … some push "disp 100 w 3 RF"… case by case
- Top 3 diseases: DM, HTN, and Hyperlipidemia (think "Stars")
- Exclusions: hospice, ESRD

What counts in **DM** Med Adherence?

- Certain medication classes (NOT insulin) are tracked
  - Biguanides, sulfonylureas, Di-Peptidyl Peptidase (DPP)-IV Inhibitors, Glucagon-like peptide-1 (GLP-1) receptor agonists, sodium glucose cotransporter 2 (SGLT2) inhibitors, thiazolidinesdiones (TZDs), incretin mimetics, and meglitinides.
    - 2 prescription claims in the calendar year for any of the above medications will put the patient in the adherence measure
  - Exclusions: if on insulin, if in hospice or with ESRD

What counts in **HTN** Med Adherence?

- Patients 18 years of age and older with HTN and given a Rx for treatment for Renin-Angiotensin System (RAS) Antagonist drugs
  - Angiotensin Converting Enzyme Inhibitor (ACEI), Angiotensin Receptor Blocker (ARB), or Direct Renin Inhibitor (DRI)
- Exclusions include those patients in hospice, those with ESRD, and those who have one or more Rx fill for sacubitril/valsartan

[1]Lau DT, Nau DP. Oral antihyperglycemic medication nonadherence and subsequent hospitalization among individuals with type 2 diabetes. Diabetes Care. 2004; 27(9):2149-53.
[2]Whelton PK, Carey RM, Aronow WS, et al. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. J Am Soc Hypertens. 2018; 12(8):579.e1-579.e73.
[3]Sokol MC, McGuigan KA, Verbrugge RR, Epstein RS. Impact of medication adherence on hospitalization risk and healthcare cost. Med Care. 2005; 43(6):521-30.

What counts in **Statin** Med Adherence?

- Patients 18 years and older prescribed a statin medication
- Adherence is filling the medication 80% or more of the time during the calendar year
- Exclusions include those patients in hospice or those with ESRD

Medication Non-Adherence Reasons (depends…)

- Lack of understanding of benefit, of side effects.
- Cost of meds, weighing of social determinants (food, living expenses, etc.)
- Complexity of regimen (qd vs QID)
- Transportation to get meds or to office visits
- Forgetfulness impacts meds that are different from the rest- link to a daily activity (evening/bedtime, after meal/before meal, brushing teeth)

How to "fix" Medication Adherence

- 90d fills vs 30d (100 pills…?)
- Simplify regimen (qd vs QID)
- Pill dispensary (family member to fill it)
- Connect med taking to daily activity (brush teeth, etc.)
- Educate on the disease and the need for the meds
- Focus on care transition ball drops
- "Repeat offender" list management (early and often)

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Population Health Management (PHM): Ambulatory Focus

- 30d All-case Readmission
  - Ambulatory that is tied to hospital admissions – best solution is TCM
    - See within ONE week after hospital d/c
    - Medication reconciliation and clinical stability post-discharge

Population Health Management (PHM): Ambulatory Focus

- Delivering on Quality – the real work in PHM
  - Clinical acumen
  - Patient engagement/experience

Medicare Advantage Stars Breakdown

	Category	MY 2023	MY 2024
1	**CAHPS** Consumer Assessment of Healthcare Providers and Systems	32%	22%
2	**HOS** Health Outcomes Survey	3%	7%
3	**HEDIS®** Healthcare Effectiveness Data and Information Set	18%	26%
4	**IRE** Independent Review Entity	8%	5%
5	**CMS** Centers for Medicare & Medicaid Services	19%	14%
6	**Patient Safety**	10%	13%
7	**Improvement**	10%	13%

Patient Experience (CAHPS/HOS) = 29%

HEDIS (Part C): Chronic Disease Mgmt., TCM, Readmit, and Preventative Care =26%

Patient Safety (Part D): Statins in Diabetics and Medication Adherence=13%

Patient ***Experience*** matters on quality

- Patient surveys are done by CMS and these scores translate into the overall quality report a plan gets. Focus is not on satisfaction, but how they perceived care to be delivered
- Focus questions … "has your provider talked to you about"
  - Talk about issues getting medications filled and need for compliance. Make note of all meds – yours and other consultants to have a source of updated medication list
  - Make note of other consultants and discuss the care from specialists – be an informed PCP
  - Address issues with falling or balance – investigate
  - Urinary incontinence is often a hidden issue with men and women, often hidden. Address.
  - Discuss your patient's level of exercise or physical activity and advise them on a plan

Population Health Management (PHM): Ambulatory Focus

- Delivering on Quality – the real work in PHM
  - Clinical acumen
  - Patient engagement/experience
  - Meeting the patient's needs – often takes a deeper focus

SDOH Risk Assessment Option (since 2024)

- Risk Assessment that focuses on 4 areas
  - Food insecurity
  - Housing insecurity
  - Transportation needs
  - Utility difficulties
  - Interpersonal Safety

Focus is on the patient's social risk factors that influence the diagnosis and treatment of medical conditions – assumption is that there are unmet needs present that affect care

- If during the assessment in the AWV (not noted for IPPE) coinsurance and deductible is waived if …
  - Billed w AWV, by the same provider, with -33, using an evidence-based tool. https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf
    - https://prapare.org/
- Outside of AWV, coinsurance/deductible applies (5-15 minutes; 0.18 wRVU; $18.66 non-facility) – G0136. Every 6-month limit.
- Choose any diagnosis code consistent with a patient's exam. If you perform this assessment, assumed you can act on findings – or refer to meet needs

Population Health Management (PHM): Ambulatory Focus

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  - Clinical acumen
  - Patient engagement/experience: SDOH screen/assessment **$**
  - Proven Clinical Strategies – CMS has provided a roadmap
    - Medicare Wellness Visits (was one→three)
      - MWV for pop health and value-based – proven winner

Medicare Wellness Visits as Pop Health Strategy

- Beckman, et al. in American Journal of Managed Care (03.2019)
  - Patients had substantially more falls risk screens than non AWV pts
  - Higher A1c control rate than non-AWV patients
  - Saw a higher percentage of patients being offered guideline-directed medical therapy
  - Had a decreased total cost of care of 5.7% (esp in the patients with the highest HCC scores) – yearly savings outpaced the fees generated to primary care (most savings from hospital-linked care).

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    - Medicare Preventive Services
      - Behavioral Health Integration – Psychiatric Collaborative Care
      - Procedural: AAA screen, DEXA, CRC screens, mammograms, etc.
    - Transitional Care Management
    - Chronic Care Mgmt (CCM), Principal Care Management (PCM)
    - Home Health and Care Plan Oversight Certifications
    - Advance Care Planning

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    - Home Health and Care Plan Oversight Certifications
    - Advance Care Planning
  - In 2025, more strategies to consider ….

Population Health Management: Ambulatory Focus

Atherosclerotic Cardiovascular Disease Risk Assessment, Management

- **G0537**: for patients WITH ASCVD RISK FACTORS, 5-15 min. Once per 12 months. Risk factors like obesity, a family history of cardiovascular disease, a history of hypertension, hyperlipidemia, pre-diabetes or diabetes, history of smoking/substance use. Need at least one condition that puts at risk. Can be done same day as E&M.
- Evidence-based tool (ACC ASCVD Risk Estimator or the AHA PREVENT, for example)

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- ***wRVU 0.18 ($18.44)***

Population Health Management: Ambulatory Focus

Atherosclerotic Cardiovascular Disease Risk Assessment/Management

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Population Health Management: Ambulatory Focus

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- **G0538** (wRVU 0.18/$15.20): Risk management part - for those **WITHOUT** ASCVD **diagnosis** but at *intermediate* → *high* risk based on previous risk assessment. Use a **ASCVD Care Plan** (generated/revised/implemented) that is focused on risk factors. Shared Decision Making needed (focus: aspirin, BP, cholesterol/cigarettes, DM/dietary, and exercise -- ABCDE's of Primary Prevention[1]). Need patient consent (verbal or written) for charging.

[1] https://pmc.ncbi.nlm.nih.gov/articles/PMC9480535/

Population Health Management: Ambulatory Focus

Advanced Primary Care Mgmt Services: Care for patients with chronic conditions expected to last 12 months (or until death). Conditions place patient at risk of death, acute exacerbation/decompensation or functional decline. Provided by clinical staff under physician (or other qualified health professional - QHP) who is focal point of care delivery. Per month. No time interval. Consent is needed (verbal OK).

- G0556 (wRVU 0.25/$15.20): one chronic condition
- G0557 (wRVU 0.77/$48.84): two or more …
- G0558 (wRVU 1.67/$107.07): two or more in a dual eligible Medicare pt.

Think "CCM" without the time interval. Service delivery is required and expansive, but not all services delivered each month….need a visit to set up (no specific code), 24/7 access, enhanced options (e-visits, etc.), qualified EHR, risk stratification and population health strategies (think ACO-type care). Permission up front as not "free" *unless you are dual eligible* (**G0558**). NO "duplicate" service billing same month: TCM, CCM/PCM, interprofessional consultations, remote evaluation of videos/images, virtual check-ins and e-visits

Population Health Management: Ambulatory Focus

Caregiver Training Services, Behavior Management/Modification: Focus is on individual training of caregivers dealing with mental/physical health diagnoses. This would be directed to a person-centered treatment plan for a patient. For example, teaching tactics to de-escalate aggressive situations.

- G0539 (wRVU 1.00/$52.08): First 30 minutes. Patient does not need to be present.
- G0540 (wRVU 0.54/$25.55): Each additional 15 minutes

Population Health Management: Ambulatory Focus

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Population Health Management: Ambulatory Focus

Caregiver Training Services, Direct Care Strategies: would focus on "direct care services and supports" that apply to hands-on care training (change wound dressings or ways to prevent decubitus ulcer formation, manage infections). Can be under other CMS programs – Home Health, etc. Note why each activity is needed w/ specifics in the treatment plan. Not expected to be longitudinal – "sometimes therapy" (like PT, OT, SLT – so these could be directing CTS)

Population Health Management: Ambulatory Focus

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- G0541 (wRVU 1.00/$52) CTS for patients with an ongoing condition or illness and to reduce complications [without the patient present], face-to-face; initial 30 minutes)
- G0542 (wRVU 0.54/$25) …each additional 15 minutes
- G0543 (wRVU 0.23/$22) Group caregiver training …[without the patient present], FTF with multiple sets of caregivers

Population Health Management: Ambulatory Focus

Post-discharge Telephonic Follow-up Contacts Intervention allows a behavioral health follow-up phone call after an ED visit "or other crisis encounter" (inclu psych facility). For mental health intervention – esp. suicide/deliberate harm situations. "Follow-up Contacts Intervention" (FCI). *Audio-only*. For review of a "safety plan" (code G0560 – Safety Planning is not mandated) for 4 *successful* contacted calls (10-20 min ea) per month (bundled). Document verbal/written consent. Auxillary staff.

- G0544 (wRVU 1.00/$61) – "bundle" of 4 calls over the month

Safety Planning Intervention is separate and is 20 min increments to work with the patient and staff on strategies to manage the clinical condition (coping strategies, support services. Any person authorized to provide services to the patient (clinical psychologists, Marriage/Family Counselors, Mental Health Counselors, Clinical Social Workers, etc.)

- G0560 (wRVU 1.09/$41)

Population Health Management

- Cost, Quality, Patient Engagement/Experience ….?

  …..Provider Satisfaction!!

To douse the flames of burnout, consider ….

- Quadruple Aim: WE Matter!!
  - We are programmed that patients come first, but we must manage that for us as well
  - Allow partners to cover, have set times that you are "off limits" and protect personal time
  - Rarely what we do as merits as "insignificance", so manage the little things – learn to say "no"
  - Non-emergent can wait; messages can be shared with coworkers (office visits can replace the message)
- Develop a Physician-Led Team model of care w NPP and/or staff
  - Out of Office message use and similar separations to keep "work at work" and "on work time"
  - Lead the co-management of difficult patients (alternate q 2-3 months visits). Messaging, gap closure, etc.
  - Deploy your office manager as a direct resource to help you manage your team (and YOU)
- 2020 National Academy of Medicine report stated personal stress management strategies alone are insufficient to deal with burnout. Need a system/team focus!

Stop Physician Burnout: What do Do When When Working Harder Isn't Working. Dike Drummond, MD

Closing

- Many tools covered in this session to help manage your population – use staff to help manage and collect added revenues in doing so
- Reach out for details

- THANKS for inviting me to present!

- Questions ….
  - NUlmer@protimellc.com

South Carolina Academy of Family Physicians

2025 Summer Breakaway and Annual Meeting

Population Health Management: It's More Than Just Seeing Patients in 2025

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