Healthcare Consulting | Valuation

CY 2025 Medicare Physician Fee Schedule Proposed Rule

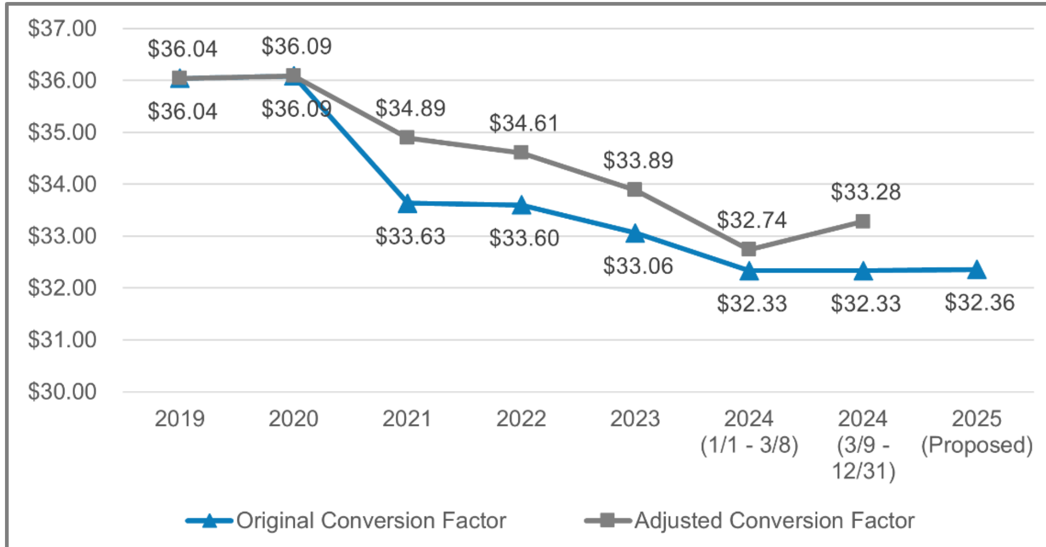
The Centers for Medicare and Medicaid Services (CMS) recently released the Calendar Year (CY) 2025 Medicare Physician Fee Schedule (MPFS) Proposed Rule, which includes a ***conversion factor of $32.36 resulting in a 2.8% decrease from the current rate.*** *Industry groups claim that continuing reductions in reimbursement in an era of rising costs are unsustainable and will have a negative impact on Medicare patients' access to care. This article recaps key provisions contained in the rule and current activity in the push for legislative changes.*

Conversion Factor

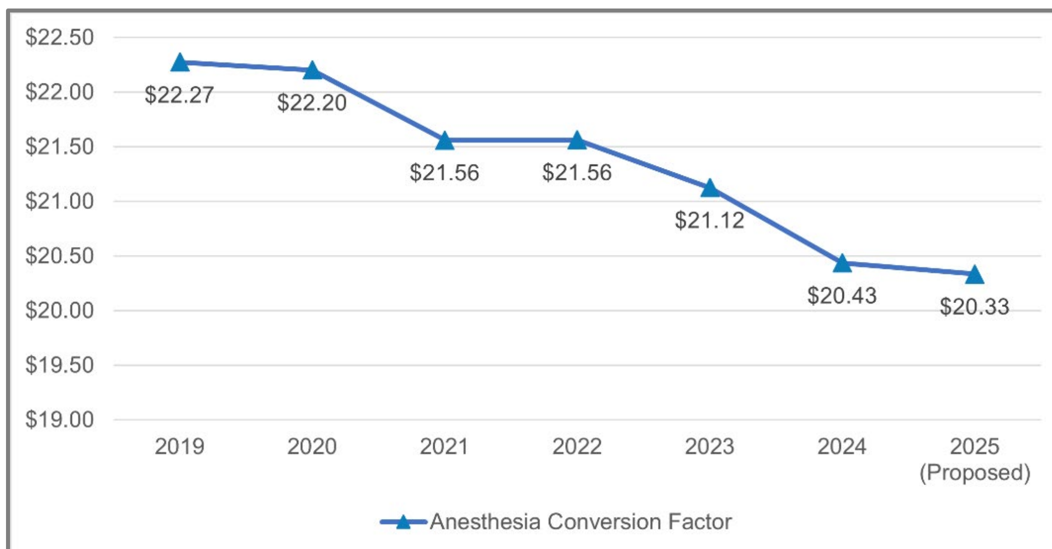
The proposed rule reflects a conversion factor of **$32.36** for 2025, which is a **decrease of $0.93 (2.8%) from the current rate**. This marks the fifth consecutive year of decreases, while inflation continues to increase costs. The proposed rate reflects a **7.8% decrease from the 2020 conversion factor**. According to the American Medical Association (AMA), **Medicare physician payments have declined 29% from 2001 to 2024 when adjusted for inflation in practice costs**.[1]

Medicare reimbursement for professional services is generally determined by multiplying the applicable relative value unit (RVU) amounts for billed services by the conversion factor in place on the date the service was rendered, adjusted for the specific locality. Significant volatility in the conversion factor began in 2021 in response to substantial increases in Work RVUs (wRVUs) for many office visits and similar services that were determined to be undervalued historically. That increase in wRVUs resulted in a significant reduction in the conversion factor to achieve budget neutrality, as required by law. Congress intervened and staved off the expected 10.2% reduction. However, the impact of the wRVU increases remained, so the conversion factor for 2022 was once again set to be significantly reduced in light of budget neutrality requirements. Again, the rate was increased as a result of last-minute legislation. Continuing the pattern, legislation passed at the end of 2022 averted what would have been a 4.5% decrease in the conversion factor. This legislation also stipulated that a 1.25% adjustment would be applied to the rates that would otherwise be calculated by CMS for 2024, which ultimately yielded a 3.4% decrease in the conversion factor based on the CY 2024 MPFS Final Rule compared to the rate in effect for 2023. The legislative fix for 2024 did not come until March, when the Consolidated Appropriations Act, 2024 (2024 CAA) applied an adjustment that effectively increased the rate by 1.7% for services rendered through the remainder of 2024.

[1] American Medical Association. *2024 Medicare updates compared to inflation chart* (Updated March 2024). https://www.ama-assn.org/system/files/2024-medicare-updates-inflation-chart.pdf



The anesthesia conversion factor has followed a similar storyline:



Sequestration Impact

It should be noted that the rates reflected above do not incorporate the impact of sequestration. Sequestration is a required across-the-board spending cut resulting from three budget enforcement rules:

- The Statutory Pay-As-You-Go Act of 2010 (PAYGO);
- The Budget Control Act of 2011 (BCA); and
- The Fiscal Responsibility Act of 2023 (FRA).

Only the sequestration stemming from the BCA is currently in effect, and it will impact Medicare payments through fiscal year 2032. Under this law, cuts to Medicare benefit payments cannot exceed 2%. The sequestration adjustment only applies to the portion of the payment made by Medicare and excludes the patient share.

PAYGO requires spending cuts across the federal government if legislation enacted in a given year results

in an increase in projected budget deficits. Subsequent legislation has postponed these spending cuts through the end of 2024. Without additional Congressional action, PAYGO could be triggered in 2025. PAYGO cuts to Medicare benefit payments would be capped at 4%. However, neither PAYGO nor the BCA include details on how the two sequesters would be implemented together.

The FRA sequester applies to discretionary funding and can be triggered if applicable budget enforcement rules are broken. Since the Medicare program is funded by both mandatory and discretionary spending, any FRA sequester could impact Medicare. However, this sequester would impact only discretionary components of the Medicare program, such as administration and fraud investigation activities. Payments to providers for services rendered to Medicare beneficiaries would not be impacted.

Other Key Provisions

The 2025 MPFS Proposed Rule contains additional provisions that impact billing and reimbursement for a variety of services. While this is not a comprehensive summary, key components are recapped below.

Advanced Primary Care Management Services

CMS proposes establishing three new HCPCS G-codes for a set of advanced primary care management (APCM) services in an effort to provide a mechanism for continued and intentional improvements to primary care. The practitioner who bills for APCM service would be responsible for the patient's primary care and serve as the continuing focal point for all needed health care services. It is anticipated that these codes will most often be used by primary care specialties (family medicine, internal medicine, geriatric medicine, and pediatrics) but could also be used by certain specialists in some instances (such as OB/GYN or cardiology). CMS expects that APCM services would ordinarily be provided by clinical staff incident to the professional services of the billing practitioner. The G-codes may only be billed once per calendar month and only by the single practitioner who assumes the care management role.

The proposed APCM codes are not time-based, but rather are based on certain patient characteristics that are deemed to be indicative of patient complexity and therefore resource intensity:

Level 1 (GPCM1)	Level 2 (GPCM2	Level 3 (GPCM3)
Patients with 1 or fewer chronic conditions	Patients with 2 or more chronic conditions	Patients with 2 or more chronic conditions and who are Qualified Medicare Beneficiaries

Derived from Table 20: Patient-Centered Risk Stratification for Billing APCM Codes.

The Qualified Medicare Beneficiary (QMB) status was included as a method of identifying beneficiaries with social risk factors that often require greater resources to effectively furnish advanced primary care. The proposed rule notes that there are approximately 8.5 million QMBs, comprising 66% of the Medicare-Medicaid dual eligible population. These beneficiaries are believed to be the most at-risk for poor clinical outcomes.

The proposed rule includes a lengthy list of practice capabilities and requirements that are considered inherent to the provision of APCM services, which are detailed in Appendix A attached hereto. Not all elements must be furnished during a given calendar month when the code is billed, but the billing practitioner must have the ability to furnish every element as appropriate for any individual patient during any calendar month. Practitioners who participate in the ACO REACH model, the Making Care Primary model, and the Primary Care First model are deemed to satisfy certain of the required elements simply by virtue of their participation in these CMS Innovation Center models.

Global Surgery Payment Accuracy

CMS currently requires transfer of care modifiers to be used when there is a formal documented transfer of care agreement. However, the modifiers have been rarely used other than for ophthalmology services. Further, there are mismatches between the number of claims billed with modifier -54 (for procedures) and -55 (for post-operative care), which may result in duplicative payment (i.e., payment of the global rate to one provider and payment for post-op care to another provider for the same case). Therefore, beginning for services furnished in 2025, CMS is proposing to require the use of the appropriate transfer of care modifier (-54, -55, or -56) for all 90-day global surgical packages whenever a practitioner plans to furnish only a portion of a global package. This would include formal, documented transfers of care, as well as informal, nondocumented – but expected – transfer of care. The proposal for 2025 relates only to 90-day global periods, but CMS is seeking comment on whether these changes should also be applied to 10-day global packages in the future.

Additionally, CMS is proposing a new add-on code that could be utilized by a practitioner that provides post-operative care for a patient but did not have the benefit of a formal transfer of care. This is intended to account for additional complexity involved since the practitioner may not have been involved in creating the surgical plan and may not have access to the operative notes. HCPCS code GPOC1 should not be billed by another practitioner in the same group practice as the practitioner who performed the surgical procedure, or in the same specialty. Documentation in the medical record must justify use of the add-on code, and the code could be billed only once during the 90-day global period.

Cardiovascular Risk Assessment and Risk Management

The CMS Innovation Center's Million Hearts® Cardiovascular Disease Risk Reduction model was found to reduce the risk of death from a cardiovascular event by 11%. To encourage greater cardiovascular-focused risk management services, CMS is proposing two new codes:

- **ASCVD Risk Assessment** – HCPCS code GCDRA would be used for administration of a standardized, evidence-based Atherosclerotic Cardiovascular Disease (ASCVD) Risk Assessment, which includes a review of the patient's demographic characteristics, modifiable risk factors, and risk enhancers for cardiovascular disease. This must be provided on the same day as an evaluation/management (E/M) visit and could be billed once a year. This code would not be billable for patients with a cardiovascular disease diagnosis or a history of heart attack or stroke.
- **ASCVD Risk Management Services** – HCPCS code GCDRM would be used for risk management services for patients without a current ASCVD diagnosis, but determined to be at medium or high risk for ASCVD as determined by the ASCVD Risk Assessment. Risk management services include the development, implementation, and monitoring of an individualized care plan for reducing cardiovascular risk. This code could be billed once a month. While there are no minimum service time requirements, there are certain elements that must be addressed to bill this code. Consent must be obtained from the patient before starting ASCVD risk management services.

Evaluation/Management Add-On Codes

A separate add-on code – HCPCS code G2211 – was added in 2024 to provide additional reimbursement to compensate for the increased time and resources related to the intensity and complexity inherent in office or outpatient E/M visits that are part of ongoing care related to a patient's single, serious, or complex condition. However, under the current rules the add-on code may not be utilized when an E/M code is billed with payment modifier 25, which is used to indicate that a minor procedure was performed on the same day. In response to concerns raised by some practitioners, CMS is now proposing to allow payment for G2211 when the office or outpatient E/M code is reported by the same practitioner on the same day as an annual well visit, vaccine administration, or any Medicare Part B preventive service provided in the office or outpatient setting.

Additionally, for 2025 CMS is proposing a new add-on code – HCPCS code GIDXX – to provide additional reimbursement to infectious disease specialists for disease transmission risk assessment and mitigation and public health investigation, analysis, and testing. This code may be used as an add-on to hospital inpatient or observation care codes.

Expansion of Colorectal Cancer Screening

To update coverage for colorectal cancer (CRC) screening to align with current standards of care, CMS is proposing to make the following changes:

- Eliminate coverage for barium enema procedures, which are rarely utilized and no longer recommended in clinical guidelines;
- Add coverage for the computed tomography colonography (CTC) procedure, which uses x-rays and computers to produce images of the entire colon; and
- Expand coverage to include a follow-up screening colonoscopy after a Medicare-covered blood-based biomarker CRC screening test.

CMS believes these changes will allow patients and their doctors to make the decision regarding the most appropriate choice in CRC screening, considering the risks, burdens, and benefits of each approach.

Behavioral Health Services

In response to increased death by suicide in older adults, CMS is proposing to establish coding and payment for Safety Planning Interventions (SPI). As described in the proposed rule, SPIs involve a patient working with a clinician to develop a personalized list of coping strategies and sources of support that the individual can use when experiencing thoughts of harm to themselves or others. This is not a suicide risk assessment, but rather an intervention provided to people determined to have elevated risk. CMS proposes to create an add-on G-code – GSPI1 – that would be billed along with an E/M visit or psychotherapy when SPIs are personally performed by the billing practitioner. It is assumed that the typical amount of time spent on SPIs would be 20 minutes.

The proposed rule also notes that research has shown that patients seen in the emergency department (ED) with deliberate self-harm, intentional overdose, and/or suicidal ideation have a substantially increased risk of suicide or other mortality during the year following their ED visit. In response, CMS is proposing to create coding and payment for post-discharge telephone Follow-up Contacts Intervention (FCI). FCI is described in the proposed rule as a specific protocol of services for individuals with suicide risk involving a series of telephone contacts between a provider and a patient in the weeks or months following discharge from the ED or other relevant care settings. It is designed to reduce the risk for subsequent adverse outcomes. FCI calls are intended to encourage use of the Safety Plan and update it to optimize effectiveness, express psychosocial support, and facilitate engagement in any indicated follow-up care. These are specifically structured to be audio-only calls and are not within the scope of Medicare telehealth services.

CMS is proposing a monthly billing code – GFCI1 – as a bundled service describing four FCI calls in a month, each between 10 to 20 minutes in duration. This code could be billed regardless of whether GSPI1 was also provided and billed for the same patient. At least one real-time telephone interaction with the patient would be required, not including unsuccessful attempts to reach the patient. The treating practitioner will be required to obtain the patient’s consent prior to providing FCI services and document it in the patient’s medical record. Advanced consent would include: (1) ensuring that the patient is aware that Medicare cost-sharing applies to FCI services; (2) furnishing and receiving necessary information to enable the patient to receive services (e.g., obtaining the patient’s telephone number); and (3) confirming that the patient consents to the contacts.

CMS is also proposing to create three new HCPCS codes for digital mental health treatment (DMHT) devices. Beginning in 2025, qualified practitioners would utilize GMBT1 to bill for furnishing a DMHT device that has been cleared by the Food and Drug Administration (FDA) if the billing practitioner is incurring the cost of furnishing the device to the patient. The device must be part of an ongoing treatment plan, and the billing practitioner must diagnose the patient and prescribe or order the DMHT device. Two additional codes would then be utilized for monthly treatment management – GMBT2 for the first 20 minutes, and GMBT3 for each additional 20 minutes. These codes should not be utilized when the patient discontinues use of the device.

The proposed rule adds six new G codes to further expand access to behavioral health services. These codes would all be used to bill for interprofessional consultations provided by practitioners whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including substance use disorders. This includes clinical psychologists, clinical social workers, marriage and family therapists, and mental health counselors. The treating practitioner would be required to obtain the patient’s consent in advance of these services and document it in the patient’s medical record. In obtaining consent, the practitioner must ensure that the patient is aware that Medicare cost-sharing applies to these services, and there may be a charge for two services – one for the treating/requesting practitioner’s service and another for the consultant practitioner’s service.

Telehealth Services

Medicare telehealth frequency limitations were suspended during the COVID-19 public health emergency (PHE) for a variety of services. Although the limitations resumed upon expiration of the PHE in 2023, they were again suspended through the end of 2024 for the following services:

- Subsequent Inpatient Visit CPT Codes (99231, 99232, and 99233);
- Subsequent Nursing Facility Visit CPT Codes (99307, 99308, 99309, and 99310); and
- Critical Care Consultation Services (HCPCS Codes G0508 and G0509).

The proposed rule seeks to extend the suspension of frequency limitations for these services through 2025

CMS also proposes to allow audio-only communication technology for telehealth services provided to a beneficiary in their home, so long as the practitioner has the technical capability to provide two-way, real-time interactive audio and video communication but the patient is either not capable of or does not consent to the use of video technology. Applicable services must be billed with a modifier to verify that these conditions have been met. The proposed rule would continue to allow practitioners to utilize their currently enrolled practice location rather than their home address when providing telehealth services from their home, through the end of 2025.

According to the proposed rule, physicians may continue utilizing real-time audio and video interactive telecommunication to meet the presence and “immediately available” requirement for direct supervision through the end of 2025. CMS is proposing to *permanently* define “direct supervision” to include audio/video communication technology for certain services determined to inherently carry lower risk. These services do not ordinarily require the presence of the billing practitioner or direction by the supervising practitioner, and are not services typically performed directly by the supervising practitioner. Specifically, the proposed rule defines these as services with CPT Code 99211 and services with a HCPCS status indicator of ‘5’. For all other services, audio/video supervision will be extended only through the end of 2025.

Teaching physicians would be allowed to have a virtual presence during the provision of telehealth services in 2025 under the proposed rule, but must provide real-time observation utilizing audio/video technology (not audio-only). Additionally, current flexibilities that allow audio-only telecommunications for periodic assessments in connection with opioid treatment programs when video is not available would be made *permanent* beginning on January 1, 2025, under the provisions of the proposed rule.

Medicare Shared Savings Program

The MPFS Proposed Rule includes numerous revisions to the Medicare Shared Savings Program (MSSP). One component is the introduction of a new prepaid shared savings option for certain established accountable care organizations (ACOs) that have a history of achieving shared savings. These ACOs could receive quarterly advances that would be used to make investments that would aid beneficiaries. At least 50% of the prepaid amounts must be spent on direct beneficiary services that are not generally available through traditional Medicare. This could include items such as transportation or dental/vision/hearing services. Up to 50% of the advance payments could be spent on staffing and healthcare infrastructure. If the prepaid amounts exceed the actual shared savings, the ACO would be required to pay back the different. According to the proposed rule, interested ACOs would apply to participate in the prepared shared savings program in 2025 for a January 1, 2026, start date.

Other proposed revisions to the MSSP include the following:

- A Health Equity Benchmark Adjustment for periods beginning January 1, 2025, based on the proportion of the ACO’s assigned beneficiaries who are enrolled in the Medicare Part D low-income subsidy or dually eligible for Medicare and Medicaid;
- Expansion of quality measure sets that would be incrementally incorporated from 2025 through 2028;
- Modification to eligibility requirements that would allow ACOs to fall below 5,000 assigned beneficiaries during an agreement period;
- Modification to the beneficiary assignment methodology; and
- Modification to beneficiary notification requirements.

Specialty Impact

CMS performed an analysis to estimate the ranges of impact for practitioners within each specialty, based on 2023 utilization data. According to this analysis, most specialties will see a minimal change (plus or minus 1%) in Total RVUs as a result of the provisions reflected in the proposed rule. In fact, CMS notes that based on 2023 utilization, more than 80% of practitioners would experience a change of +/- 1% in total RVUs. For these specialties, the most significant impact comes in the form of the lower Conversion Factor, which when applied to a similar level of Total RVUs will yield lower revenue.

However, there are some “winners” and “losers” that are anticipated to see more significant swings in Total RVUs. Those expected to see an increase are shown below:

Specialty	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Clinical Social Worker	3%	1%	0%	4%
Clinical Psychologist	3%	1%	0%	3%
Anesthesiology	1%	1%	0%	2%

According to CMS, the increases for these specialties are largely attributed to the Year 4 update to clinical labor pricing and/or the proposed adjustments to transfer of postoperative care for global surgical procedures. Some of the increases are also related to increases in Work RVU values for specific services based on recommendations from the AMA Relative Value Scale Update Committee and CMS review, and increased practice expense (PE) RVU values resulting from supply and equipment pricing updates. For these specialties, the increase in Total RVUs may mitigate the impact of the decreased Conversion Factor.

On the other hand, a few specialties are likely to see a decrease in Total RVUs:

Specialty	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Diagnostic Testing Facility	0%	-2%	0%	-2%
Interventional Radiology	0%	-2%	0%	-2%
Vascular Surgery	0%	-2%	0%	-2%

CMS explains that these decreases are due to the redistributive effects of the Year 4 update to clinical labor pricing and/or the proposed adjustments to transfer of postoperative care for global surgical procedures, and by the redistributive effect of Work RVU increases for other codes. Additionally, they rely on supply and equipment for their practice expense costs and were therefore negatively affected by the updated Year 4 clinical labor update due to budget neutrality requirements. The estimated impact also encompasses decreases resulting from the continued phase-in implementation of previously finalized supply and equipment pricing updates. Unfortunately, these practitioners will have the compounded impact of reduced RVUs *and* a reduced conversion factor, which will result in even lower reimbursement.

In the proposed rule, CMS also provides the impact on selected procedures. This indicates that commonly used office visit codes (99203, 99213, and 99214) would all receive a 2% cut in payment. Likewise, several hospital inpatient/observation, emergency department visits, and critical care codes would all see payment cuts ranging from 2% to 4%.

Industry and Legislative Response

Long before CMS released the CY 2025 MPFS Proposed Rule, industry advocates were pushing for change. The AMA has been lobbying for months that a comprehensive legislative solution is needed. According to AMA president Bruce A. Scott, M.D., "In addition to the cut, CMS predicts that the Medicare Economic Index (MEI) – the measure of practice cost inflation – will increase by 3.6%. Facing this widening gap between what Medicare pays physicians and the cost of delivering quality care to patients, physicians are urging Congress to pass a reform package that would permanently strengthen Medicare." AMA has emphasized that on an inflation-adjusted basis, Medicare physician payment has been cut 26% since 2001 (not including the proposed 2025 decrease).

The push for a change is coming from other avenues as well. In its March 2024 report to Congress, the Medicare Payment Advisory Commission (MedPAC) noted that "expected increases in clinicians' input costs are larger than the increases in FFS Medicare payment rates scheduled under current law." In response, MedPAC recommended that the payment rate for physicians and other healthcare practitioners should be increased for 2025 by 50% of the projected increase in the MEI. This mirrored the recommendation made by MedPAC in its March 2023 report to Congress. However, it still has not been adopted by CMS because Congressional intervention is required to remove the budget neutrality requirement.

The 2024 Medicare Trustees Report similarly noted concern with the current payment levels for physicians, stating that physician payment amounts "do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. These rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. … If the health sector cannot transition to more efficient models of care delivery and if the provider reimbursement rates paid by commercial insurers continue to be based on the same negotiated process used to date, then the availability, particularly with respect to physician services, and quality of health are received by Medicare beneficiaries would, under current law, fall over time compared to that received by those with private health insurance." Again, this mirrored exactly the observations from the 2023 Medicare Trustees Report, but nothing has been done to address the concerns.

There has been a bill introduced in Congress that would be at least a first step in ending the trend of conversion factor reductions. In April 2023, the Strengthening Medicare for Patients and Providers Act (H.R. 2474) was introduced that would adjust the conversion factor each year by a percentage equal to the MEI, starting in 2024. The bill has bipartisan support, with 149 cosponsors currently, and broad support from industry groups such as the AMA and the Medical Group Management Association. It is crucial for the Medicare payment system to reflect the economic reality of practice operating expenses, which the current budget neutrality requirements do not allow.

Additionally, the Senate Committee on Finance held a hearing in April focused on the importance of high-quality, accessible clinician care. The hearing highlighted the challenges of the current MPFS structure, especially as practice costs rise, the administrative burdens of operating a medical practice increase, and the population ages. In response, the Committee issued a white paper in May to describe key issues and explore potential policy solutions.

With a presidential election on the horizon, it's unclear what will happen next – or when – in the form of legislative action. Without that, physicians will be faced with a fifth consecutive cut in the reimbursement rate.

JTaylor's healthcare consulting team includes a group of professionals who specialize in physician practice dynamics, as well as individuals who focus on strategy and operations. If you are interested in finding out how the 2025 MPFS Proposed Rule would impact reimbursement for your practice, with its unique services and payer mix, we can help. Our team can also support you from a strategic perspective as you plan for impact of these proposed rules, including the impact of reduced reimbursement. To find out more or to contact a member of our team, please visit our website. We will continue to monitor developments related to legislative activity impacting the healthcare industry.

Sources:

- Proposed Rule - *Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments (CMS-1807-P).* Federal Register. (Unpublished.)
- Fact Sheet: 2025 MPFS Proposed Rule – Center for Medicare and Medicaid Services (CMS). *Fact Sheet: Calendar Year (CY) 2025 Medicare Physician Fee Schedule Proposed Rule.* (10 July 2024).
- Fact Sheet: 2024 MPFS Proposed Rule – MSSP Proposals– CMS. *Fact Sheet: Calendar Year (CY) 2025 Medicare Physician Fee Schedule Proposed Rule (CMS-1807-P)-Medicare Shared Savings Program Proposals.* (10 July 2024).
- MedPAC 2024 Report to Congress – Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy*. (March 2024.)
- 2024 Medicare Trustees Report – The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. *2024 Annual Report of The Boards of Trustees of The Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.* (6 May 2024.)
- AMA: *Congress must act on Medicare payment reform as CMS warns of more cuts*. American Medical Association. (10 July 2024.)
- AMA: *Latest proposed cut – 2.8% - shows need for Medicare pay reform.* AMA. (10 July 2024.)
- Senate Finance Committee white paper – Senate Committee on Finance. *Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B.* (17 May 2024.)

Appendix A
Advanced Primary Care Management
Required Service Elements and Practice-Level Capabilities

Consent
- Inform the patient of the availability of APCM services; that only one practitioner can furnish and be paid for these services during a calendar month; of the right to stop services at any time (effective at the end of the calendar month); and that cost sharing may apply* (may be covered by supplemental health coverage)
- Document in patient's medical record that consent was obtained

Initiating Visit for New Patients (separately paid)
- Initiation during a qualifying visit for new patients
- An initiating visit is not needed: (1) if the beneficiary is not a new patient (has been seen by the practitioner or another practitioner in the same practice within the past three years) or (2) if the beneficiary received another care management service (APCM, CCM, or PCM) within the previous year with the practitioner or another practitioner in the same practice.

24/7 Access to Care and Care Continuity
- Provide 24/7 access for urgent needs to care team/practitioner with real-time access to patient's medical information, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week
- Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
- Deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours, as appropriate

Comprehensive Care Management
- Overall comprehensive care management may include, as applicable
  - Systematic needs assessment (medical and psychosocial)
  - System-based approaches to ensure receipt of preventive services
  - Medication reconciliation, management and oversight of self-management

Patient-Centered Comprehensive Care Plan
- Development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan which is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver

Management of Care Transitions (for example, discharges, ED visit follow-up, referrals, as applicable)
- Coordination of care transitions between and among health care providers and settings, including transitions involving referrals to other clinicians, follow-up after an emergency department visit, or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities, as applicable
  - Ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care.
  - Ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after ED visits and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated

Practitioner, Home-, and Community-Based Care Coordination

- Ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), as applicable, and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors in the patient's medical record

Enhanced Communication Opportunities

- Enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication technology-based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/EHR referral service(s), to maintain ongoing communication with patients, as appropriate
- Ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and E/M visits (or e-visits)

Patient Population-Level Management

- Analyze patient population data to identify gaps in care and offer additional interventions, as appropriate
- Risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients
- A practitioner who is participating in a Shared Savings Program ACO, REACH ACO, Making Care Primary, or Primary Care First satisfies this requirement

Performance Measurement

- Be assessed on primary care quality, total cost of care, and meaningful use of CEHRT, which can be met in several ways:
  - For MIPS-eligible clinicians, by registering for and reporting the Value in Primary Care MVP**
  - A practitioner who is part of a TIN participating in a Shared Savings Program ACO satisfies this requirement through the ACO's reporting of the APM Performance Pathway
  - A practitioner who is participating in a Shared Savings Program ACO, REACH ACO, Making Care Primary, or Primary Care First satisfies this requirement through the quality reporting, assessment and performance requirement and other program and model requirements.

** Medicare beneficiaries who are enrolled in the QMB eligibility group do not have any Medicare cost-sharing responsibility for copays, deductibles, and coinsurance.*

*** For APCM services billed in 2025, practitioners would register to report the MVP in 2025, and report the MVP in 2026 for the 2025 performance year/2027 MIPS payment year. For more details, see the 2024 MIPS Quick Start Guide, available at https://qpp.cms.gov/mips/reporting-options-overview.*

Derived from Table 21: APCM Service Elements and Practice-Level Capabilities