STRENGETHENING PRIMARY CARE

AS PART OF THE 2025 MEDICARE PHYSICIAN FEE SCHEDULE

The Center for Medicare

The CMS Innovation Center

DISCLAIMER

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials.

The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

BACKGROUND AND OVERVIEW

- A strong foundational primary care system is fundamental to improving health outcomes, lowering mortality, and reducing health disparities, which is why the Department of Health and Human Services has been taking action to strengthen primary care, including by proposing payment for advanced primary care management services (APCM).
- This new coding and payment would better recognize and describe advanced primary care services, support primary care practice transformation, help ensure patients have access to high quality primary care services, and simplify billing and documentation requirements.
- The proposed APCM coding and payment makes use of 10+ year of lessons learned from the CMS Innovation Center's testing of advanced primary care models, such as Comprehensive Primary Care Plus and Primary Care First.

PROPOSED APCM CODES

- For CY 2025, we are proposing to establish coding and make payment under the Physician Fee Schedule (PFS) for a set of APCM services described by three new HCPCS G-codes.
- Physicians and non-physician practitioners who use an advanced primary care model of care delivery could bill for APCM services for a beneficiary when they are the continuing focal point for all needed health care services.
- The proposed APCM services would:
  - Incorporate elements of several existing care management and communication technology-based codes into a bundle that reflects the essential elements of advanced primary care delivery;
  - Remove some of the more burdensome elements of billing and coding the individual service elements:
  - Not be time-based, but rather based on a set of service elements and practice-level requirements indicative of advanced primary care delivery
  - Be stratified into three levels based on the number of chronic conditions and enrollment as a Qualified Medicare Beneficiary, reflecting both patient medical and social complexity.
  - Be able to be billed on a monthly basis

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

PROPOSED APCM CODE LEVELS

Three levels of coding allow for appropriate payment for APCM service provision on a monthly basis

Level 1	Level 2	Level 3
Patients with **one or fewer chronic conditions**	Patients with **2 or more chronic conditions**	Patients with **2 or more chronic conditions** **AND** who are **Qualified Medicare Beneficiaries**
Proposed RVU: .17	**Proposed RVU: .77**	**Proposed RVU: 1.67**

Proposed APCM Service Elements and Practice-level Capabilities

Consent
Initiating Visit for New Patients
24/7 Access to Care and Care Continuity
Comprehensive Care Management
Patient-Centered Comprehensive Care Plan
Management of Care Transitions
Practitioner, Home, and Community-based Care Coordination
Enhanced Communication Opportunities
Patient Population-level Management
Performance Measurement

***See Table 21 in the Proposed Rule**

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

ADDITIONAL APCM FEATURES

- The APCM performance measurement requirement could be satisfied by registering for and reporting the Value in Primary Care MVP.
  - The performance measurement requirement could also be satisfied by participating in a Shared Savings Program ACO or a REACH ACO, or a Primary Care First or Making Care Primary practice. Providers would meet the performance measurement requirements by virtue of the Shared Savings Program and CMS Innovation Center quality reporting, assessment of quality performance, accountability for total cost of care, and other program and model requirements.
- APCM services could be provided by auxiliary personnel under the general supervision of the billing practitioner.
- The proposal contains duplicate services and concurrent billing restrictions for certain care management codes and communication technology-based services.

REQUEST FOR INFORMATION

CMS released an accompanying Request for Information (RFI) in hopes of gaining insights into hybrid payment and coding for advanced primary care services.

- In the future, APCM services could be revised to include additional elements, including traditional E/M services, to advance the scope of hybrid payments.
- CMS is soliciting feedback on how we can:
  - Further the goal of reducing administrative burden to refocus time on patient care;
  - Better recognize the relative resources involved in furnishing care;
  - Recognize interdisciplinary, team-based primary care;
  - Support primary care sustainability and stability, especially for underserved communities.

The RFI asks questions related to the following categories:

- Value-Based Care Opportunities
- Billing Requirements
- Person-Centered Care
- Health Equity
- Quality Improvement and Accountability

ADDITIONAL PFS PROPOSALS TO NOTE

There are several other areas within the Proposed Physician Fee Schedule that we'd like to bring to your attention. CMS is proposing:

- To allow payment of the O/O E/M visit complexity add-on code G2211 when the O/O E/M base code is reported by the same practitioner on the same day as an annual wellness visit (AWV), vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting.

- Based on Innovation Center's Million Hearts® Model, coding and payment for an Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment service and risk management services.

- A new add-on code, GPOC1, for post-operative care services to more appropriately reflect the time and resources involved in these post-operative visits to compensate the additional resources involved by practitioners who were not involved in furnishing the surgical procedure.