TABLE 25: APCM 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, 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. In the event of afterhours communication with a beneficiary, whoever is responsive to the patient's concerns must document and communicate their interaction with the beneficiary to the primary care team/practitioner. • 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 communitybased 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 practitioners 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 practitioners who are 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 REACH ACO, a Making Care Primary, or a Primary Care First practice satisfies this requirement by virtual of meeting requirements under the CMS Innovation Center ACO REACH, Making Primary Care Primary, or Primary Care First models.

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

** See discussion in section II.G.2.c.(10) of the CY 2025 PFS proposed rule for a description of the timeline of MIPS reporting, and information for eligible clinicians who are not MIPS eligible or QPs. MIPS eligible clinicians who furnish APCM services in 2025 who intend to report on for the CY performance year/2027 MIPS payment year must register to report the Value in Primary Care MVP as described under § 414.1365(b). For more details, see the 2024 MIPS Quick Start Guide, available at https://qpp.cms.gov/mips/reporting-options-overview.

*** See requirement in section III.G. of the CY 2025 PFS final rule for practitioners in Shared Savings Program ACOs to report the APP Plus quality measure set.