STROUDWATER

MEDICARE'S ADVANCED PRIMARY CARE MANAGEMENT PROGRAM

Amy Graham, Principal

Lindsay Corcoran, Principal

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OUR TIME TOGETHER

- The Advanced Primary Care Management (APCM) Program is a healthcare initiative designed to improve the delivery, coordination, and outcomes of primary care services. The APCM focuses on enhancing the quality of care while managing costs and improving the experiences of both patients and providers. Programs like APCM are often implemented in healthcare systems aiming to transition from fee-for-service models to value-based care.
- Upon conclusion of this webinar, participants will be able to:
  - Understand the APCM program more thoroughly
  - Incorporate strategies for implementing an APCM program
  - Identify new revenue streams related to the APCM program

INTRODUCTION TO ADVANCED PRIMARY CARE MANAGEMENT

WHAT IS ADVANCED PRIMARY CARE MANAGEMENT?

- CMS introduced the Advanced Primary Care Management (APCM) Program in the 2025 Physician Fee Schedule
- APCM allows more Medicare beneficiaries to access care management and preventative care services and has a greater focus on quality
- APCM is CMS's shift from fee-for-service to value-based care by improving outcomes and reducing costs without the downside risk
- Primary care practices can expand patient care approaches while benefiting from an additional revenue stream

CCM VS. APCM

Chronic Care Management

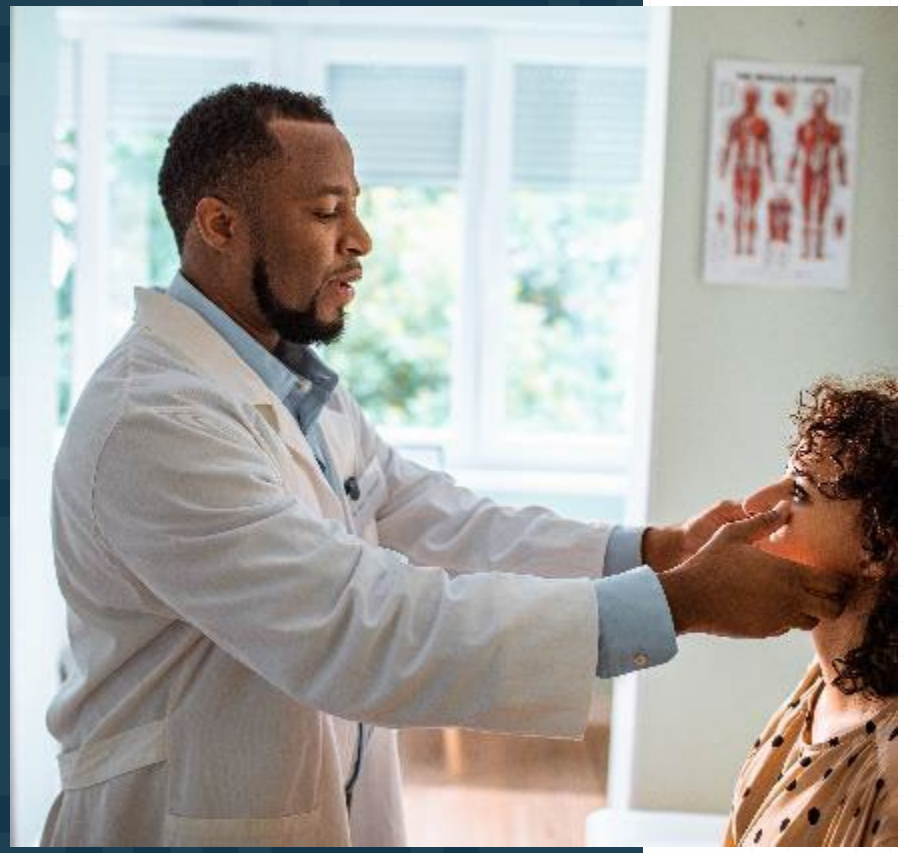
- Provides general support for patients with multiple chronic conditions
- Timed-based coding
- Minimum time requirement monthly
- No quality measures

Advanced Primacy Care Management

- Meets the needs of a wider range of patients with varying levels of need
- Coding based on patient complexity
- Focus on activities/outcomes
- Quality measurement component
- Does not require monthly call to patient with care team member
- Only primary care can bill for APCM

A practice can continue to offer CCM, Principal Care Management (PCM), TCM, and APCM. You just can't enroll one patient in all the programs at the same time.

GOALS OF APCM



- Improve Quality of Care
- Enhance Patient Experience
- Reduce Healthcare Costs

KEY FEATURES OF APCM

ONBOARDING AND ACCESS ELEMENTS

Patient Consent

Inform the patient about the service, obtain consent, and document it in the medical record (verbal or written)

Initiating Visit

Require a visit for new patients or those not seen within three years

24/7/365

Provide a phone or text line for patients to ask health-related questions anytime

CHRONIC CARE MANAGEMENT ELEMENTS

Continuity of Care

Ensure continuity with a designated team member for successive routine appointments

Alternative Care

Offer services like home visits or expanded hours to accommodate different patient needs

Comprehensive Care Management

Conduct systematic needs assessments, ensure receipt of preventive services, manage medications, and provide general clinical oversight

TECHNOLOGY AND COMMUNICATION ELEMENTS

Patient-Centered Care Plan	• Develop care plans collaboratively with patients, make them available electronically, and update them in a timely manner
Transition of Care	• Oversee transitions from hospitals, ERs, or skilled nursing facilities to patients' homes and follow up with patients within seven days
Ongoing Communication	• Coordinate with various service providers and document communications about the patient's needs, goals, and preferences • Form relationships with other practitioners and home- and community-based services to assist patients
Enhanced Communication Opportunities	• Enable communications through secure messaging, email, patient portals, and other digital means

POPULATION HEALTH ELEMENTS

Population Data Analysis

- Identify care gaps and offer additional interventions as appropriate

Risk Stratification

- Use data to identify and direct services to patients

Performance Measurement

- Assess quality of care, total cost of care, and use of certified EHR technology
- Evaluate program effectiveness based on quality measures. MIPS-eligible providers must report for the Value in Primary Care MVP.

QUALITY REPORTING

MIPs Value Pathway – VALUE IN PRIMARY CARE

- Quality
- Improvement Activities
- Cost
- Foundation layer – Promoting Interoperability
- Foundation layer – Population Health

Medicare Shared Savings Program or Advanced Primary Care models (ACO REACH or Making Care Primary)

Reporting to begin in 2026 based on the 2025 performance year

BENEFITS OF APCM

For Patients:

- Improved patient outcomes, such as reduced hospitalizations and better management of chronic diseases
- Access to more personalized care and greater patient satisfaction

For Providers:

- Financial incentives for providing value-based care
- Support for primary care teams through resources and tools

For the Healthcare System:

- Potential to reduce overall healthcare spending through effective prevention and early intervention

IMPLEMENTATION & STRUCTURE

SHOULD YOUR PRACTICE IMPLEMENT APCM OR CCM?

It depends on your organizational needs and factors

What types of patients do you serve?

Do you have a care management program in place today?

- If not, CCM may be the first option
- If you do, APCM might better suit your practice and patients

A practice can provide both care management programs, billing some patients under APCM and others under CCM, PCM, or TCM

- There is an added complexity for running multiple programs

IMPLEMENTATION OF APCM

- Already have a CCM program? Now what?
  - Stratify your patients into low, medium, and high complexity
  - Enroll newly eligible patients
    - Patients must provide written or verbal consent, which must be documented in the medical record
  - Re-consent existing patients
  - Work with billing/coding to ensure appropriate capture of revenue based on patient level
  - Conduct regular training sessions for staff on program requirements, CMS guidelines, documentation
  - Ensure compliance

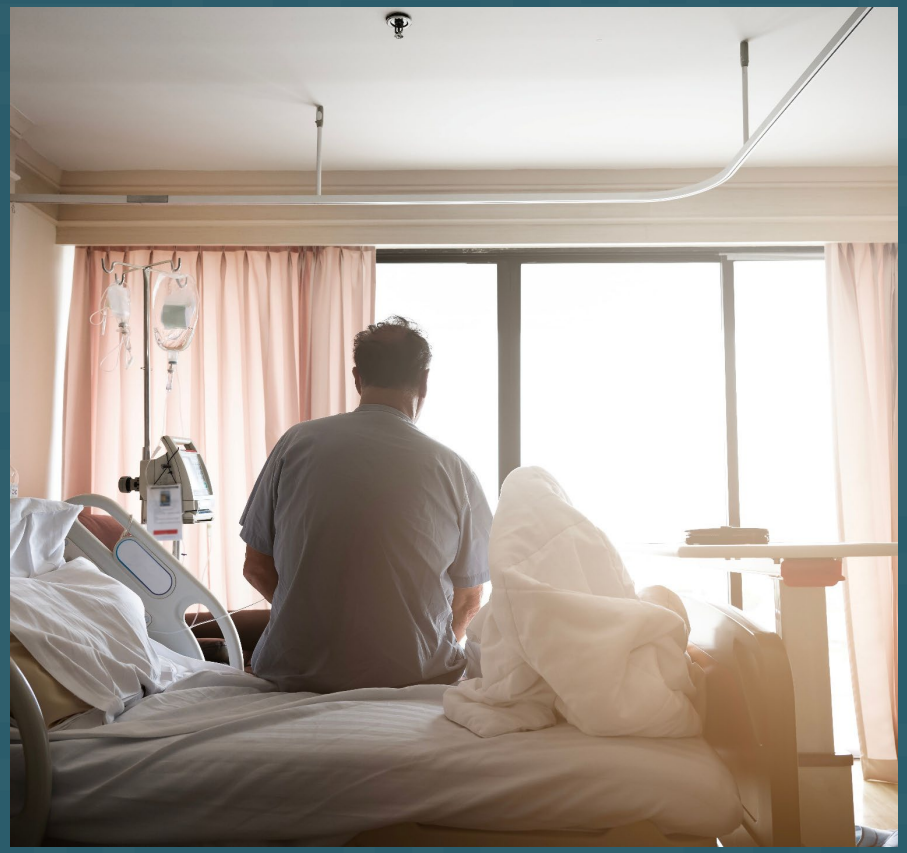
WHO IS ELIGIBLE FOR APCM?

All Medicare Part B and C patients are eligible for APCM, but they must be stratified into levels based on their care needs.

Level one: one or fewer conditions

Level two: two or more condition

Level three: dual-eligible QMBs with two or more conditions



PATIENT STRATIFICATION

- Risk stratification: The process of assigning a risk status to patients, then using this information to direct care and improve overall health outcomes
- Leverage of EHR and screening tools
- Condition count stratification or multiple criteria?
  - Clinical conditions: heart disease, chronic lower respiratory disease, asthma, diabetes, hypertension, obesity, depression
  - Social drivers of health
  - Clinical lab values
  - Medications
  - Utilization data, i.e., frequent hospitalizations, unnecessary ED visits

REIMBURSEMENT

CPT/HCPCS	Description	National Reimbursement
G0556	Level 1 – One or fewer chronic conditions	$15.00 / PMPM
G0557	Level 2 – Two of more chronic conditions	$50.00 / PMPM
G0558	Level 3 - Dual-eligible QMBs with two or more conditions	$110.00 / PMPM

- After a patient enrolls in the program, you can bill APCM monthly
- APCM has no monthly time thresholds—providers and care managers are expected to adjust the amount of care provided based on the patient's needs
- All service elements must be available monthly, whether or not the patient uses them
- APCM can be billed once per calendar month once the patient enrolls in the program
- APCM includes Remote Patient Monitoring (RPM) as a complementary service, helping practices capture more revenue while meeting the complex care needs of APCM patients

REMOTE PATIENT MONITORING

Use of digital devices to monitor patients' health and allow for early intervention and prevention of complications

Vital signs (BP, HR, etc.), weight, blood glucose, O2

FINANCIAL PROJECTION

500 Medicare beneficiaries who qualify for APCM:

- Low-complexity patients (G0556): 250 patients x $15 = $3,750k/month
- Moderate-complexity patients (G0557): 200 patients x $50 = $10k/month
- High-complexity patients (G0558): 50 patients x $110 = $5,500k/month
- Total monthly revenue = $19,250
  Total annual revenue = $231,000

Consider adding RPM - 500 Medicare patients who qualify for both APCM and RPM, assuming each patient meets requirements for CPT 99454 (RPM device supply code, ~$43 PMPM):

- Low-complexity patients (G0556): 250 patients x ($15 + $43) = $14,500/month
- Moderate-complexity patients (G0557): 200 patients x ($50 + $43) = $18,600/month
- High-complexity patients (G0558): 50 patients x ($110 + $43) = $7,650/month
- Total monthly revenue = $40,750
  Total annual revenue = $489,000

By adding RPM, the revenue potential expands further, making APCM a highly profitable service that supports continuous patient engagement

QUESTIONS?

STROUDWATER

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTH CARE.

Our team of rural and community health care experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

Lindsay Corcoran, Principal
lcorcoran@stroudwater.com

Amy Graham, Principal
agraham@stroudwater.com

USEFUL LINKS

- https://www.chartspan.com/blog/advanced-primary-care-management-what-it-is-and-frequently-asked-questions/
- https://www.thoroughcare.net/blog/what-is-advanced-primary-care-management
- https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services