Advanced Primary Care Management

Ensuring the Bundled Payment Delivers Better Health

2026 PRIMARY CARE COLLABORATIVE EVIDENCE REPORT

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Prepared by

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Institutional Review Board (IRB) Statement

The following report was found to not be human research and was exempt from IRB by Virginia Commonwealth University.

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The Primary Care Collaborative used generative AI tools — notably Otter AI and ChatGPT — to help transcribe conversations and conduct research for this report. All citations were confirmed within the original source material, and quotes from transcripts have been confirmed and affirmed by their authors. The PCC has not used generative AI to generate text, graphics or other materials used in this report. For the PCC's full policy on the use of AI, please visit thepcc.org/privacy-policy.

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Dear Colleagues,

In 2021, the National Academy of Sciences, Engineering and Medicine released its landmark report on the state of primary care. The report detailed how the U.S. health system consistently underfunds primary care, leaving care teams around the country shorthanded and under-resourced, even as they serve as the backbone of the American health system.

Since that report was released, the Primary Care Collaborative (PCC) and our organizational members have pushed policymakers to reenvision how and what we pay primary care. Our vision is holistic: we believe in a health system that provides care teams with the resources they need to deliver whole-person primary care that prevents disease, empowers patients to partner with their clinicians to manage chronic conditions and, ultimately, improves the health of all Americans.

To further those efforts, the PCC and our members have urged two Administrations and Congress to explore new payment approaches for supporting primary care.

The introduction of the Advanced Primary Care Management services in 2025 is a sign that our efforts to educate policymakers on the need for new approaches to funding primary care are bearing fruit. By creating a population-based payment in the form of a bundled code — which covers multiple services that primary care is underpaid for or not paid for at all — the Centers for Medicare and Medicaid Services has begun to move toward building a more sustainable and effective health system.

As you will see from this report, the APCM bundle is not perfect, and there are challenges that may mean this approach is not the right fit for all of primary care. But for many practices across the nation struggling to keep their doors open, the program may well be a vital lifeline. It is also an important step toward revaluing primary care and moving away from a flawed payment system that has — for far too long — underpriced primary care.

We are grateful to our partners at **West Health**, who recognized the importance of this moment and provided us with the strategic guidance and support needed to compile the report. Their support enabled us to educate ourselves and our community through a webinar, a survey, engaging our PCC workgroups, interviewing early adopters and analyzing early claims data. We appreciate the help that our partners at **Innovaccer** provided to help find potential case studies.

And we are thankful to our reviewers, whose feedback and commentary made this report the best possible version of itself: **Kameron Matthews**, MD, JD, from IMPaCT Care; **Sophia Tripoli**, MPH, from Families USA; and **David Meltzer**, MD, PhD, from the University of Chicago.

I hope that you find reading this report as informative as we did writing it.

Warmly,



Ann Greiner
President and CEO, Primary Care Collaborative

Report Summary

Introduction

In 2025, the Centers for Medicare and Medicaid Services (CMS) launched Advanced Primary Care Management (APCM) services. The APCM services and associated billing codes serve as an alternative bundled payment option for primary care clinicians to deliver and receive monthly payment for a group of care management activities.

The codes built on previous efforts by Medicare to bolster primary care, but the new APCM codes had two major differences — they did not require care teams to track their time and they encompassed a broad set of services that either went uncompensated, required multiple billing codes under previous cycles or were so modestly paid that clinicians did not think the juice was worth the squeeze.

The Primary Care Collaborative (PCC) welcomes the introduction of Medicare APCM services and their potential to improve the health outcomes of beneficiaries with chronic conditions by providing *new* resources to strengthen primary care's capacity to provide ongoing care and support to an important subpopulation of Medicare beneficiaries.

The bundled payments will finally compensate clinicians for essential work that too often goes unrecognized under the physician fee schedule, allowing them to keep their doors open and meet their patients' needs. The payments also provide resources for practices to build new capabilities, expand services and deliver more comprehensive care, leading to better patient health.

APCM also marks an important shift in conversations about Medicare payment reform. For many primary care practices, the new APCM bundled services may be a pathway away from fee-for-service (FFS) to hybrid payment — a mix of a monthly population-based payment and FFS. Hybrid payment provides more flexibility in how care may be delivered and more predictability — allowing some visits to be longer and for the practice to build out its team.

However, while the new APCM services hold enormous potential, it is unclear how broadly the program will be adopted or how effectively it is being implemented. To better understand the state of APCM adoption, the PCC has conducted research drawing on an assessment of the first year of Medicare claims (Jan. 2025 to Dec. 2025), a PCC survey of the primary care community, and five case studies.

> **"APCM is an opportunity that, "allows [primary care] to hire support staff for unfunded services that patients rely on in primary care settings."**
>
> **Response to Survey of the PCC Community on APCM**

Quantitative Results

APCM adoption grew in its first year 2.7 fold, but overall reach remains modest. Growth has been driven primarily by new clinician entrants rather than expansion among early adopters, and clinician turnover is notable. APCM growth, however, was more rapid than chronic care management during its first year. Nearly two-thirds (63%) of APCM volume growth from Q1 to Q4 came from clinicians who were not billing APCM in the first quarter. At the same time, a meaningful share of clinicians stopped billing the program from one quarter to the next, with 12 to 16% attrition observed across quarters in year one.

APCM is functioning largely as a primary care service. Family medicine, nurse practitioners and internal medicine accounted for most APCM claims, with **93.6% originating from primary care specialties**.

Looking ahead, APCM spending is very likely to remain extremely small in the context of total Medicare expenditures. An unanswered question is whether APCM services will generate offsetting savings through reduced downstream utilization, which will affect the long-term value in addition to measurable improvements in beneficiary outcomes.

The PCC Community's Perspective on APCM

In July 2026, the PCC conducted a short survey to gain a deeper understanding of the primary care community's awareness and perspective on APCM services. Key findings include:

- When asked to rank potential benefits of APCM services, a plurality (42%) of respondents selected "regular monthly revenue to support previously unpaid care such as after-hours coverage" as the top opportunity.
- When asked to rank potential hurdles to effectively implementing APCM services, most respondents ranked collecting cost-sharing as the biggest challenge (42%).



Case Studies of Early Adopters

The PCC's strong interest in the role of primary care teams informed the decision to interview a range of key informants from different specialties and in different roles. Based on the interviews, the following factors were identified as key enablers or barriers to APCM adoption:

Enablers for APCM Adoption

The cost-sharing waiver for Qualified Medicare Beneficiaries (QMB) enrolled in APCM. A QMB is a low-income individual enrolled in both Medicare and Medicaid.

Developing clear and compliant workflows for teams and clinicians, including electronic health record (EHR) documentation and access to care plans (including by patients and their caregivers).

Scripts and templates to support clinicians and administrative staff who are onboarding beneficiaries to APCM services.

Experience in value-based payment (VBP) models and existing care management teams, together with data and decision support infrastructure to build out with additional support from APCM.

Organizational leadership and internal support to work through APCM financial modeling, IT, revenue cycle and other collaboration needed with primary care leadership and teams.

Automated triggers for care teams to update care plans or take other action to begin the billing cycle.

Barriers to APCM Adoption

Medicare Part B cost-sharing rules that discourage beneficiaries without supplemental coverage for cost-sharing liability from consenting to APCM services.

A lack of clarity on what role auxiliary staff and other members of the team can play in supporting the focal clinician with care plans and other documentation.

A complex process for obtaining consent and the need for re-consenting when a patient transitions to a new "focal point" clinician.

Lack of multipayer alignment, with some plans competing with practices and population health teams by offering their own in-house care management and refusing to cover it when done outside their own model.

Primary care clinicians are not always engaged in payment and resource decisions. Larger organizations should demonstrate how the flow of funds from APCM goes to build out primary care teams, reduces workloads and supports care innovation.

Policy Recommendations

Remove burdensome beneficiary cost-sharing

For the 13% of standard beneficiaries without supplemental coverage,[1] APCM services are subject to Part B cost-sharing rules, creating an additional financial hardship that often serves as a barrier to enrollment in APCM services.

Alleviating cost-sharing for APCM is important because:

- Medicare's cost-sharing is a burden on beneficiaries in Original Medicare.
- As covered Part B services, APCM services should also be covered by Medicare Advantage (MA) plans, but there is ambiguity over the beneficiary cost-sharing in MA plans.
- There is an inability for care teams to determine beneficiary cost-sharing amount owed across Medicare supplemental and MA coverage at time of consent.

Create incentives for multipayer alignment across Medicare and Medicaid

While APCM aims to streamline care management for primary care in Original Medicare, the addition of a new set of codes does create more potential paperwork for primary care teams. Creating alignment around the simpler billing implemented by APCM by encouraging other payers to follow CMS's lead — especially in MA and Medicaid Managed Care — can help alleviate administrative burden *and* expand access to a valuable set of services for more people.

Streamline beneficiary onboarding, re-consenting to APCM, care documentation

More clarity is needed from CMS on the details of the beneficiary consent process, such as how auxiliary staff can assist the focal point clinician with beneficiary notification, education and consent process.

Build an on-ramp from APCM to accountable care

The capabilities APCM requires are necessary but not sufficient for accountable care. Accountable care is a term used to describe care models in which teams are responsible for improving quality and outcomes, coordinating care and avoiding unnecessary costs. CMS could design APCM so that practices that build these capabilities have a clear, low-friction path to the next step:

- **Recognize sustained APCM participation as a readiness signal.** Practices that bill APCM consistently across a meaningful share of their panel have shown the operational capacity accountable care requires.
- **Carry the APCM relationship into attribution (accountable clinician) for VBP models.** The APCM consent process creates a documented, patient-affirmed relationship with a focal (primary) point clinician. CMS could align this designation with voluntary alignment (a patient selects their primary care clinician) in the Medicare Shared Savings Program, so the relationship persists when a practice joins an accountable care arrangement.
- **Allow APCM to convert into prospective payment (paid in advance, usually monthly) within Accountable Care Organizations (ACOs).** For ACO participants, CMS could permit APCM revenue to be paid as a prospective per-beneficiary amount rather than billed code-by-code each month.
- **Equip APCM practices with the data that accountable care requires.**

Conclusion

Medicare's introduction of APCM in 2025 represents a significant investment in strengthening comprehensive, longitudinal primary care. By supporting the important work that occurs between visits, APCM gives practices a practical starting point for building the team-based, longitudinal capabilities that whole-person care requires.

As APCM enters its third year in 2027, policymakers have an opportunity to strengthen it on two fronts. The first is removing the barriers that slow adoption: beneficiary affordability, administrative complexity, multipayer misalignment and ambiguity about how interdisciplinary teams participate. The second, and ultimately more consequential, is connecting APCM to what comes next. The capabilities required to participate in APCM are the same capabilities required for success in accountable care or VBP models. Such models can offer even greater opportunities for primary care teams to lead care transformation and create a more satisfying and sustainable practice environment.

Introduction

What are APCM services?

In January 2025, Medicare began covering Advanced Primary Care Management (APCM) services. According to the Centers for Medicare and Medicaid Services (CMS), APCM services and related billing codes were designed to "better describe advanced primary care management services broadly, to provide more stability in payment and coding for practitioners."[2, 3]

The APCM services and associated billing code serve as an alternative bundled payment option for primary care clinicians to deliver and receive monthly payment for a group of care management activities described separately as transitional care management (TCM), principal care management (PCM) and chronic care management (CCM). Care management activities range from technology enhanced communications (such as those related to test results, prescription refills and medication questions) to coordinating care transitions, referrals and ensuring timely follow-up after a hospital stay. The rapid growth of artificial intelligence applications in health care is likely to generate more interest in APCM services as a channel for patient-care team communication.

The Primary Care Collaborative (PCC) welcomes the introduction of Medicare APCM services and their potential to improve the health outcomes of beneficiaries with chronic conditions by providing *new* resources to strengthen primary care's capacity to provide ongoing care and support to an important subpopulation of Medicare beneficiaries. Previous work by the PCC has demonstrated the central role that primary care plays in addressing chronic conditions and ways that Medicare can address it by strengthening primary care.[4]

Goals of the report

The goal of this report is to first describe APCM services, practice requirements and payment details defined by CMS. With a mixed-methods approach, PCC also sought to learn from the experiences of early APCM adopters.

We are interested in the barriers and enablers for successful adoption and sharing our findings with policymakers, the primary care community and health care leaders. We analyzed billing data and interviewed a diverse group of five early adopter organizations and asked a group of experts to guide our methods and review our findings.

We also surveyed the PCC community to gather its early impressions of APCM. We offer policy options that may contribute to greater adoption of APCM.

APCM adoption can also help expand primary care participation in alternative payment models by giving practices the opportunity to experience receipt of a population-based monthly payment. Such models can achieve better beneficiary outcomes, slow growth in per-beneficiary spending, transform primary care and strengthen and grow the primary care workforce.

> **"What the patients have is more complex and the demands they have start to rise as things get more complex because more self-management is landing on them."**
>
> **Gayle Kricke, Director of Operations System Primary Care, Northwest Medicine**

Why APCM is a significant step forward and offers new investment for primary care

The 2021 National Academy of Sciences, Engineering and Medicine (NASEM) landmark report, *Implementing High-Quality Primary Care; Rebuilding the Foundation of Health Care*, called for greater investment in primary care teams and a shift from predominantly fee-for-service (FFS) payment to hybrid models that combine prospective, population-based payment with FFS.[5]

The NASEM report claims that FFS payment does not adequately support longitudinal relationships, whole-person care or population health activities. Regular, risk-adjusted payments tied to patients can support proactive care, interdisciplinary teams, health information technology, patient engagement and accountability for outcomes.[6]

Value-based payment (VBP) models, which connect payment to outcomes like quality and costs, often rely on patient attribution to a primary care clinician, team or organization and may use prospective payment. Other VBP models, such as shared savings, rely more on FFS payment and may finance nonvisit-based care management and population health activities with shared savings from lower FFS per-beneficiary spending relative to an earlier period. Value-based models require collection of standardized quality measures, which also play a role in total payment. Hybrid primary care payment would share features of VBP.

Historically, CMS has attempted to address underpricing of primary care within the complexity inherent in a FFS model. Since 2014, CMS added the set of CCM codes noted above — CCM, TCM and PCM. CMS also introduced add-on codes for evaluation and management (E/M) visits for complex patients. For example, Medicare billing code G2211 is intended to support ongoing care for a patient with ongoing complex needs when the clinician is serving in a focal point role with the aim of better compensating primary care for CCM.[7]

However, many of these codes are time-based or require extensive documentation. Despite increased payment values and an attempt to reflect the complexity of managing primary care, they remain not broadly used.

APCM represents a departure. This new bundled payment **eliminates time tracking and creates a more comprehensive bundle of services paired with additional compensation**, rendering APCM services less administratively burdensome.

This new approach, represented by APCM, is a shift away from traditional FFS, which has long dominated payment under the Medicare Physician Fee Schedule (MPFS). FFS has come under criticism by policymakers for creating misaligned incentives and undervaluing primary care.



Requirements of APCM

To bill for APCM services, primary care clinicians must be practicing in a setting with the capability to do all the following activities:

- Obtain patient consent and document consent in the medical record.
- As part of the consent, inform the patient of the availability of the service, their right to stop at any time, that cost-sharing may apply and that only one practitioner can furnish and be paid for the service during a calendar month.
- Initiate APCM services for new patients and within three years of a current patient's last visit.
- Provide 24/7 access to the care team/clinician for urgent needs.
- Ensure continuity of care with a designated member of the care team with whom the patient can schedule routine appointments, including in ways outside traditional office visits during business hours.
- Provide overall comprehensive care management and establish and update a plan of care that is available to the patient and/or caregiver.
- Coordinate care transitions, including timely communication with the patient and/or caregiver.
- Ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care.
- Be measured on performance domains including quality, total cost of care and meaningful use of certified EHR technology.[8]

Who Can Provide APCM Services?

Only one primary care clinician can bill APCM for a particular beneficiary in a particular month. This clinician should serve as **"the continuing focal point for all needed health care services and responsible for all primary care services for a patient,"** according to CMS.[9] As part of the consent process, the beneficiary must acknowledge that this primary care clinician will play this "focal point" role. We refer to the billing clinician as the **"focal point clinician"** throughout this report to distinguish from other members of the primary care team.

In the final rule establishing APCM services, Medicare acknowledges that "advanced primary care encompasses the work of interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships, which necessarily involves time spent by primary care practitioners and their clinical staff outside of individual evaluation and management (E/M) visits."[10]

APCM: Can It Expand Participation in VBP?

The introduction and adoption of APCM in Original Medicare may expand the number of primary care clinicians and practice organizations prepared to participate successfully in VBP, including hybrid payments. The form of payment for Medicare APCM services — a monthly payment billed for a qualified beneficiary and adjusted for the number of chronic conditions and other needs — shares some characteristics of population-based payment.

However, APCM services are not paid prospectively and require monthly billing by the practice. The regular payments do provide flexibility for team-based care delivered outside of office visits and office hours. By identifying a "focal point" primary care clinician responsible for ongoing care and a written care plan, APCM fosters care that is accountable and "attributable" for payment and performance measurement. Clinicians already participating in quality reporting for designated Medicare value-based models will fulfill the APCM quality and performance requirement. Others will have to report quality and performance via Medicare's Merit-based Incentive Payment Program.[11]

Background and Literature Review

APCM services support comprehensive, longitudinal primary care through three monthly Health Care Common Procedure System codes based on the number of beneficiary chronic conditions and beneficiary status as a low-income Qualified Medicare Beneficiary (QMB):

- The code G0556 is used for beneficiaries with one or fewer chronic conditions.
- The code G0557 is used for those with two or more chronic conditions.
- The code G0558 is designated for those with two or more chronic conditions that are also QMBs, a category of beneficiaries also eligible for Medicaid coverage that picks up their Part B cost-sharing responsibilities.

APCM combines elements of CCM, PCM, TCM and communication-based services into a monthly bundle.[12]

Unlike several predecessor codes, APCM services are not time-based, which may reduce documentation burden. Billing practitioners must obtain written or verbal beneficiary consent and be capable of providing access and continuity, comprehensive care management, care planning, transition management, coordination, enhanced communication, population health management and performance measurement (CMS, 2024; CMS, 2026a).[13]

Because APCM services are new, published evidence on uptake of previous Medicare services and models can inform assumptions about APCM adoption. Specifically, earlier Medicare services offer useful evidence about how quickly new primary care payments spread, which barriers persist after launch and how beneficiary uptake differs from clinician participation.

- **CCM** is the closest analogue because it is longitudinal, consent-based and billed monthly.
- **TCM** illustrates the uptake of a workflow-intensive service tied to a clear clinical event.
- The **Annual Wellness Visit (AWV)** provides the most relevant comparison for a primary care service without beneficiary cost-sharing.
- Voluntary models launched by the Center for Medicare and Medicaid Innovation (CMMI) such as **Comprehensive Primary Care Plus (CPC+)** and **Primary Care First (PCF)** demonstrations provide additional information about organizational readiness and retention to use regular care management fees to improve care, although their self-selected participants are not representative of all primary care practices.

CCM: Slow Growth and Limited Persistence

Evidence from CCM shows that establishing a billing code does not, by itself, produce broad use. A 2018 study from Agarwal and colleagues found that 1.2% of potentially eligible Medicare beneficiaries received CCM in 2015 (its first year), increasing to 2.3% in 2016. Only 6.9% of primary care practices billed CCM in 2016, and recipients averaged 4.3 billed months during the year.[14] A separate study found that only 0.65% of almost 1.7 million potentially eligible Medicare FFS beneficiaries had a CCM claim in 2015.[15] Together, these studies suggest that practice adoption, patient enrollment and recurring monthly delivery are separate dimensions affecting uptake.

More recent work shows continued growth, but not widespread penetration of CCM. Using a 5% sample of Medicare FFS beneficiaries aged 65 and older with at least two chronic conditions, Jang and colleagues found that CCM uptake rose from 1.1% in 2015 to 3.4% of eligible beneficiaries with at least two chronic conditions in 2019. Persistence improved but remained limited: in 2019, 46.6% of recipients received no more than three months of CCM, 15.8% received at least 10 months and 21.6% did not continue after the initial service.[16]

A separate federal analysis of all 2019 Medicare FFS claims estimated that 4.0% of approximately 22.6 million potentially eligible beneficiaries received CCM, essentially confirming the previous analysis.[17]

Transitional Care Management

The TCM services spread faster than CCM services. A plausible explanation is that hospital discharge provides a clear event for identifying eligible patients and beginning the service.

National uptake increased from 3.7% of eligible beneficiaries in 2013 to 9.3% in 2016, while the share of primary care practices billing TCM reached 21.5%.[18] An Office of the Assistant Secretary for Planning and Evaluation (ASPE)-sponsored analysis later found that 17.9% of eligible Medicare FFS beneficiaries discharged from short-term acute care hospitals received TCM in 2019.[19]

Medicare Annual Wellness Visit

Medicare's AWV offers a higher-uptake comparison and is particularly relevant to discussions of an APCM coinsurance waiver. Medicare generally covers a properly billed AWV *without* beneficiary coinsurance or any deductible. This waiver of cost-sharing for beneficiaries removes a financial barrier that may discourage beneficiary uptake of AWV and other high-value services.

AWV use increased from 7.5% of Medicare beneficiaries in 2011 to 15.6% in 2014,[20] while national volume rose from 2.58 million visits in 2011 to 9.56 million in 2018.[21] The number of physicians billing AWVs more than doubled between 2012 and 2019, and the average AWV rate among adopting physicians increased from 21.9% to 34.1%.[22]

This history shows that primary care service without cost-sharing can achieve substantial use for patients and for clinicians, while also showing that diffusion was gradual and varied with clinician adoption and penetration across patient panels. It does not isolate the causal effect of removing cost-sharing because AWV and APCM differ in frequency, payment, eligibility and clinical workflow.

Other Evidence Related to Adoption

The broader literature reinforces the importance of clinician capability when it comes to the adoption of new payment approaches.

An analysis of all Medicare professional claims during 2020-2023 by Joo and colleagues identified 25.27 million CCM, PCM and TCM services in a 100% sample of Medicare professional claims during 2020-2023. Primary care clinicians supplied 68%, medical subspecialists 23%, and other specialists 9%; 87% occurred in physician offices.[23]

The CPC+ and PCF models likewise identify a segment of practices prepared for advanced primary care, but they also illustrate selection and attrition.

Monthly risk-adjusted care management fees share similarities with the design of APCM payments, and the model also aligned some commercial plans. In contrast to APCM, CPC+ participants did not have to bill for the care management fee, but they had a performance-based incentive payment. The CPC+ model included 2,610 participating practices across 18 regions. The PCF model began with 846 Cohort 1 practices in 2021 and 2,228 Cohort 2 practices in 2022, or 3,074 starting practices. The latest evaluation reports substantial attrition through 2023, primarily related to financial concerns, and CMS's current model page describes approximately 1,700 participating practices.[24]

These counts are indicators of organizational readiness and retention, not beneficiary uptake rates.

An independent evaluation of the CPC+ model found that practices cited the prospective care management fee as the most useful payment they received. Practices used the nonvisit-based fee to support additional team members, including care managers and behavioral health staff. It also found that primary care practices that were part of Medicare Accountable Care Organizations (ACOs) and independent practices tended "to have more favorable results" than other model participants as measured in cost savings.[25]

Impact of APCM on Medicare ACOs

Over 50% of Medicare beneficiaries enrolled in Original Medicare were estimated to receive care coordinated by ACOs in 2025, and primary care-centric ACOs have demonstrated high performance in the largest ACO program, the Medicare Shared Savings Program (MSSP).[26]

Some experts have noted that APCM and the associated advanced primary care capabilities it requires brings accountable care concepts into Original Medicare, as APCM codes can "only be billed if clinicians intend to be responsible for all of the patient's primary care."[27] Others express concern that APCM could add new spending to ACO benchmarks for primary care clinicians who participate in ACOs and adopt APCM services, which could reduce ACO shared savings.[28]

Leaders at CMS appear to have recognized the need to make ACO participation more attractive to primary care and have proposed higher payment opportunities for primary care clinicians participating in ACOs beginning in 2027.

First, a new modifier would be added to the G2211 evaluation and management (E/M) complexity code and increase its value by 16%. A second modifier would double that increase *exclusively for ACO participating clinicians in recognition of longitudinal care costs incurred by these clinicians and/or related organizations*. As proposed, clinicians could include the modifier for all beneficiaries they serve — both in and outside ACOs.[29] Costs associated with the new modifier would be included in assignment calculations, historical benchmarks and performance year spending in MSSP. One important difference between E/M visits and APCM services, however, is the flexibility of APCM for delivering between visit and team-based longitudinal care.

Literature Review Conclusion and Relevance

The literature supports a cautious but optimistic view of APCM adoption.

First, uptake should be expected to begin well below the eligible population. Even relatively mature predecessor services reached a minority of eligible beneficiaries.

Second, adoption is a function of three factors: whether a practice participates, how broadly it enrolls its eligible panel and how consistently it delivers and bills the service over time. A projection based only on the number of eligible beneficiaries will miss these constraints.

Third, CCM provides the strongest conservative analogue because of its monthly, consent-based, longitudinal structure; TCM offers a moderate-growth comparison, while AWV provides a higher-adoption comparison under no beneficiary cost-sharing.

The evidence also sets an important limit on what can be claimed about a coinsurance waiver. The AWV experience makes it plausible that removing beneficiary cost-sharing could reduce friction and support higher APCM uptake. However, no study identified in this review directly estimates how an APCM waiver would affect consent, clinician billing or monthly persistence. Clinician capacity, care management staffing, workflow integration and payment adequacy would remain relevant factors even if beneficiary cost-sharing were eliminated. APCM still requires an eligible beneficiary, a capable billing clinician, consent and monthly service delivery.

QUANTITATIVE ANALYSIS

APCM Claims

Initial Findings from APCM Year 1

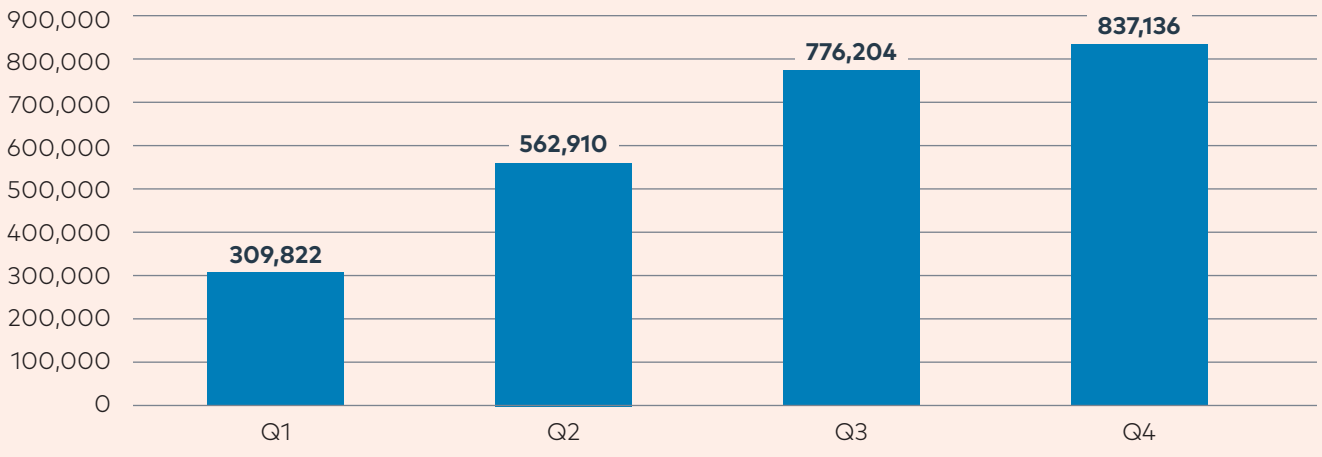
The APCM services took effect on January 1, 2025. An initial analysis of Medicare FFS claims from the CMS Virtual Research Data Center (VRDC) provides insight into first-year participation, including the number of clinicians, billing entities and beneficiaries involved; the specialties most represented; and initial claims volume and spending. Estimating how the model can reach the beneficiaries most likely to benefit from APCM services, as well as the number of additional providers that could participate and projected cost savings, is more challenging. All data was based on 2025 quarterly claims data releases, meaning that numbers may change slightly when the final full-year 2025 data is released.

Volume

APCM volume grew substantially during its first year, reaching 310,000 beneficiary-months in the first quarter of 2025 and increasing 2.7-fold (170%) by the fourth quarter. Figure 1 illustrates this growth. Across the full year, APCM accounted for 2.49 million beneficiary-months and $130.7 million in allowed spending, with participation from 9,748 clinicians and 1,951 billing entities. The allowed amount represents the maximum set by the payer (i.e., Medicare) and includes any patient share.

Because APCM services may be billed once per patient per calendar month, each claim represents one beneficiary month. This makes APCM claim volume more directly interpretable than claim counts for many other services.

Figure 1 APCM Volume (Beneficiary-Months) by Quarter



Beneficiaries Served

In Q4 2025, there were about 344,000 distinct beneficiaries served under APCM — representing 1.2% of Medicare FFS beneficiaries. This uptake is stronger than the initial uptake of the CCM; the CCM had a similar adoption percentage of eligible beneficiaries, but the CCM requires two chronic conditions to be eligible, while the APCM is available for all. This represents a steady increase from Q1 when around 150,000 distinct beneficiaries received APCM. The once-per-month billing rule makes quarterly beneficiary counts a close approximation of distinct beneficiaries.[30]

Claims and Costs

The major share of claims for APCM is concentrated in Level 2, billed under G0557. As shown in Figure 2, four out of five claims and two-thirds of dollars in 2025 are captured by G0557.

Level 3 is restricted to QMBs. Because QMBs are protected by federal law from being billed for Medicare deductibles or coinsurance, they already pay nothing. The cost-sharing waiver for QMBs makes this low-income group more likely to consent to APCM services. Moreover, CMS has assigned the QMB population a per-beneficiary per-month (PBPM) significantly higher than Level 2, likely making it attractive to practices to serve. Actual beneficiary coinsurance exposure lives only in Levels 1 and 2: about $3 to $10 a month, respectively. In Figure 2 below, "allowed dollars" refers to the maximum amount that Medicare agrees to pay a health care provider for a covered service (including any beneficiary cost-sharing). The average allowed payment per-beneficiary month was $13.85 for Level 1, $44.84 for Level 2 and $98.33 for Level 3.

Growth in APCM adoption can come from two places: existing adopters billing more, or new adopters entering. As seen in Figure 3 (see next page), of the 527,000 beneficiary-month increases from Q1 to Q4, 63% came from clinicians who were not billing APCM in Q1. Only 37% came from the original Q1 cohort scaling up.

Additionally, the Q1 cohort peaked in Q3 at 570,676 and then fell to 505,609 in Q4; this can be attributed to a reduction in clinicians who billed APCM codes (active clinicians in the cohort fell from 2,741 to 2,477), while those who continued billed at nearly the same volume per clinician. Among Q1 adopters who kept billing, volume per clinician more than doubled, from 91 claims per quarter in Q1 to 208 in Q3 (about 30 to 69 patients per clinician each month), consistent with practices enrolling patients gradually over several months, before leveling off in Q4.

Figure 2 APCM Share of Allowed Dollars and Share of Claims, by Level

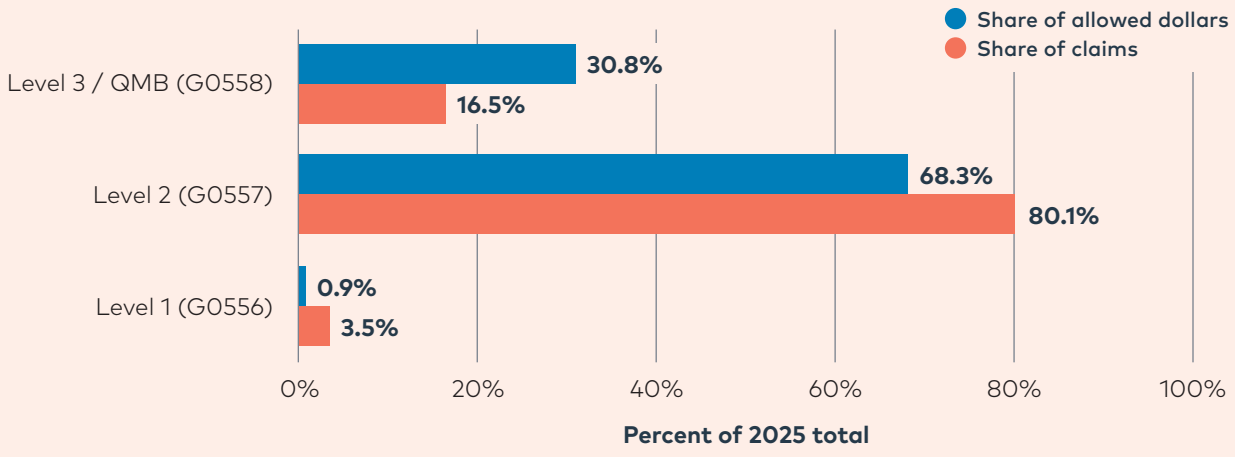
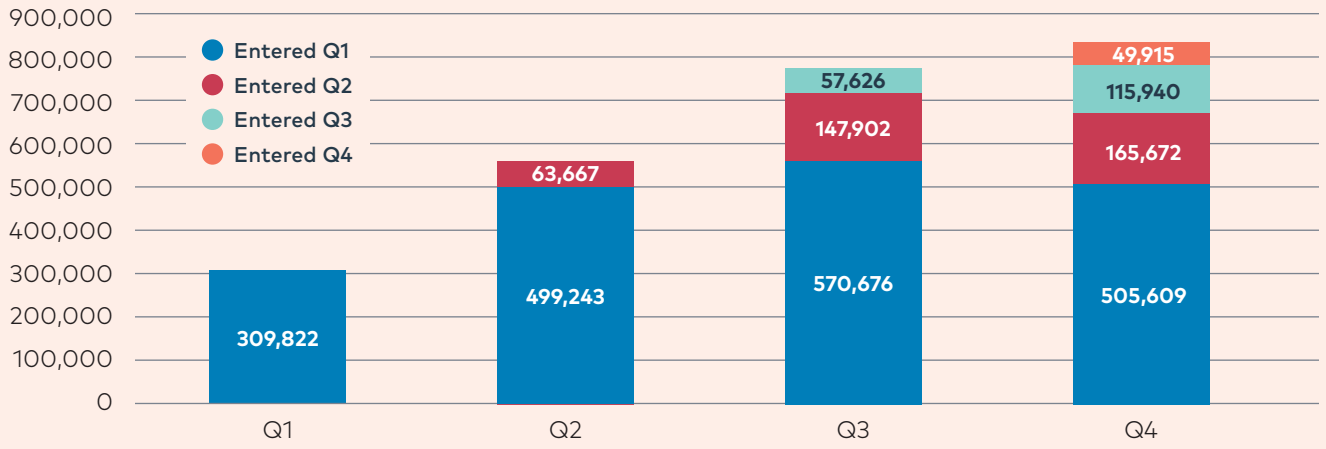


Figure 3 APCM Claims by Clinician Entry Cohort



Clinician Types & Specialties

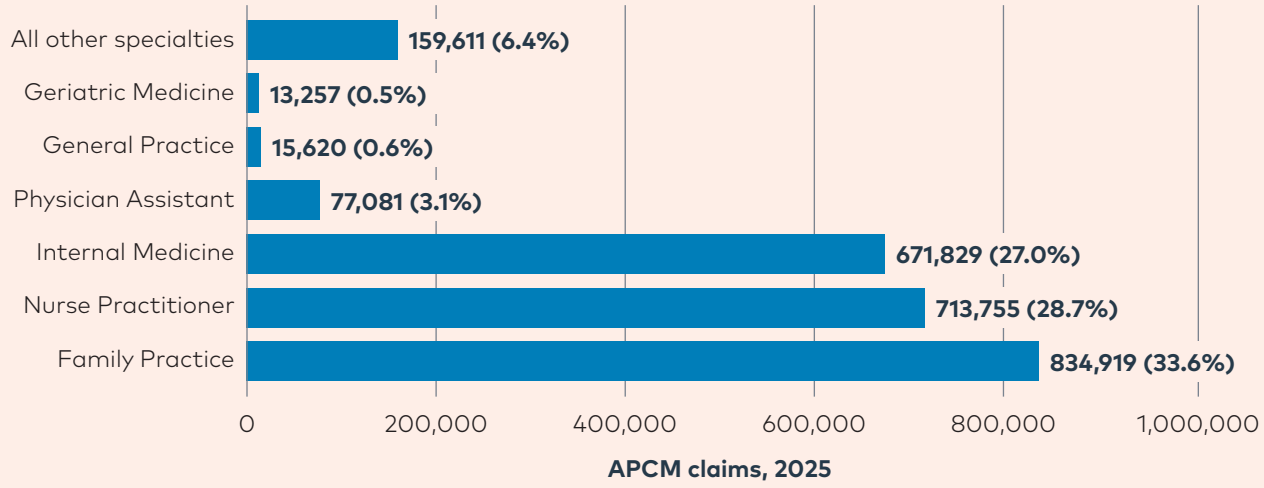
Three specialties dominate APCM adoption: family practice, nurse practitioners and internal medicine. Together, they account for 89% of claims, which reflects the intent of the program.

Nurse practitioners represent 39% of APCM clinicians and 29% of claims. The large share of claims filed by nurse practitioners may reflect their growing role in delivering primary care.

Specialty mix is overwhelmingly primary care — 93.6% of claims come from clinicians with a primary care taxonomy. Family medicine, internal medicine and nurse practitioners (NPs) dominate; only 221 clinicians outside primary care taxonomies bill APCM at all.

One notable pattern is that NPs and physician assistants (PAs) bill higher Level 3 shares than physicians. Twenty percent of NP claims and 26% of PA claims are at the QMB level, against 15% for physicians. Advanced practice clinicians are serving a lower-income APCM population, which is a useful data point in thinking about model access.

Figure 4 APCM Claims by Specialty



Number of Clinicians and Continuity

In 2025, 9,748 clinicians billed an APCM code at some point. In Q1 2025, approximately 3,400 clinicians billed an APCM code, which grew to nearly 8,000 in Q4 (see Table 1). However, during this time, significant numbers of clinicians failed to bill in the following quarter — of the clinicians who billed in Q3, 15.6% no longer billed an APCM in Q4.

> **"If I can prevent a single significant inpatient event, it likely pays for a year's worth of APCM services for multiple patients."**
>
> **Sam Hiatt, former Director of Medicare Program Operations, Community Care of North Carolina**

Outlook

APCM is being used largely in primary care, and at $130.7 million in allowed spending in 2025, it represents a very small share of Medicare spending. Any cost impact on Medicare spending from APCM is very difficult to project with the limited timeframe that APCM has been in existence. We only have one year of data, and the initial rate of adoption is different from other Medicare programs.

Additionally, the high rates of clinician or beneficiary attrition quarter after quarter raise difficulties in projecting the long-term impact. While we did model a number of different adoption scenarios, the high sensitivity to multiple, varied assumptions makes any estimate suspect. Due to these limitations, we have decided not to share those projections. Due to its current low adoption and small monthly payments, though, APCM is not expected to be a significant driver of Medicare costs.

Table 1 APCM Clinicians by Quarter

Transition	Billed in Earlier Quarter	Continued	Stopped	% Continued	% Stopped	New to APCM	Returned After a Gap	Billed in Later Quarter
Q1 → Q2	3,404	2,990	414	87.8%	12.2%	2,188	—	5,178
Q2 → Q3	5,178	4,569	609	88.2%	11.8%	2,223	67	6,859
Q3 → Q4	6,859	5,791	1,068	84.4%	15.6%	1,933	106	7,830
Billed at any point in 2025								9,748

Conclusions

In short, APCM adoption grew in its first year, but overall reach remains very modest. Growth has been driven primarily by new clinician entrants rather than expansion among early adopters, and clinician turnover is notable.

Nearly two-thirds (63%) of APCM volume growth from Q1 to Q4 came from clinicians who were not billing APCM in the first quarter. At the same time, a meaningful share of clinicians stopped billing the program from one quarter to the next, with 12 to 16% attrition observed across quarters in year 1.

APCM is functioning largely as a primary care service. Family medicine, internal medicine and nurse practitioners accounted for most APCM claims, with 93.6% originating from primary care specialties. Level 2 services, which are provided to beneficiaries with two or more chronic conditions, dominate utilization and spending.

Looking ahead, APCM spending is very likely to remain extremely small in the context of total Medicare expenditures. An unanswered question is whether APCM services will generate offsetting savings through reduced downstream utilization, which would affect the bundled payment's long-term value in addition to measurable improvements in beneficiary outcomes.



The PCC Community's Perspective on APCM

In July 2026, the PCC conducted a short survey to gain a deeper understanding of the primary care community's awareness and perspective on APCM services.

The survey was a convenience sample drawn from the PCC's distribution list of nearly 11,000 subscribers, which includes: clinicians and care delivery leaders; consumer advocates; payers; employers; policymakers; and other champions of primary care.

The survey was conducted from July 16 to August 6, 2026 and included 268 total respondents. Survey respondents who were not very familiar with or unaware of APCM were filtered out of the survey, leaving a pool of **176 respondents**.

Limitations of the Sample

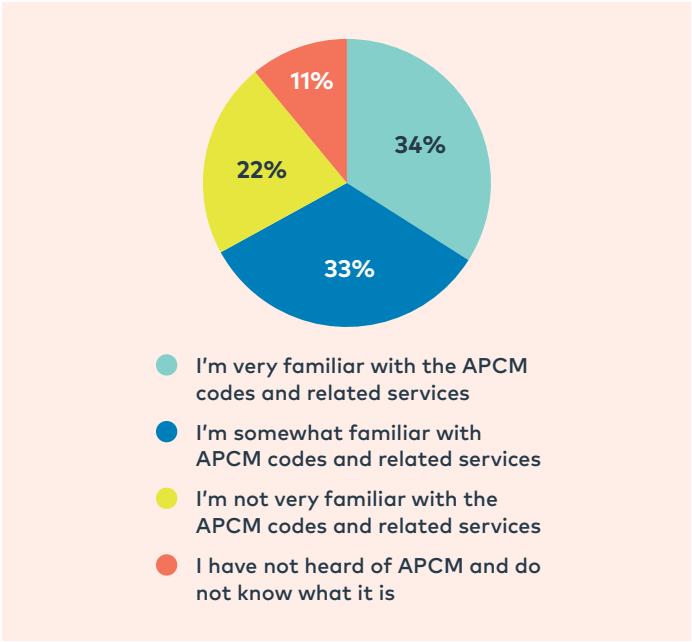
Because the sample is drawn from subscribers to the PCC — which has drawn attention to APCM services — respondents were likely to be more aware of the new services. Likewise, the PCC's enthusiasm for the program and endorsement of a shift toward new payment models means subscribers to our list are likely more inclined to view the services positively.

Because of these limitations, the sample was not intended to be, and cannot be interpreted as a representative sample of the entire primary care community; however, it does provide interesting insights into how some in the primary care community are viewing the program.



General Awareness and Interest in APCM

Survey participants were asked about their familiarity with APCM and provided four options:



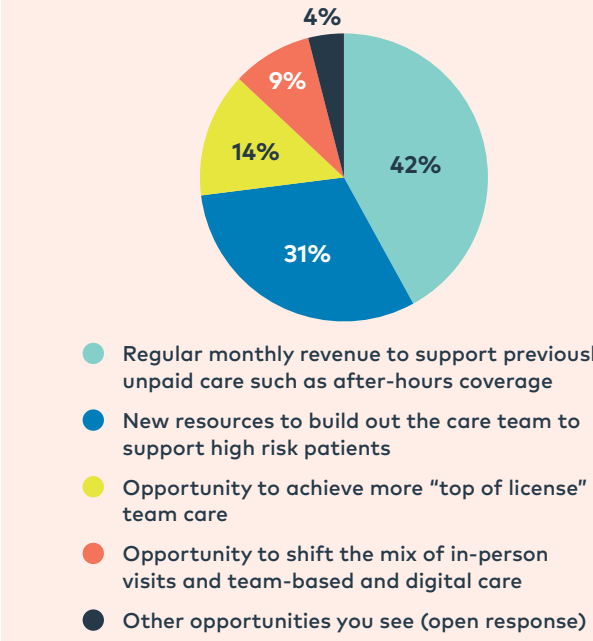
Awareness of APCM among survey participants was high. Only 11% of respondents had not heard of APCM and roughly 67% of respondents said they were either very or somewhat familiar with the new services.

Survey participants also indicated that their organization was interested in the new services. Nearly 78% of care delivery or clinician respondents who had heard of the program indicated their organization was interested in APCM, and roughly half of care delivery or clinician respondents indicated their organization was considering or had begun to adopt APCM.

The Draw of APCM

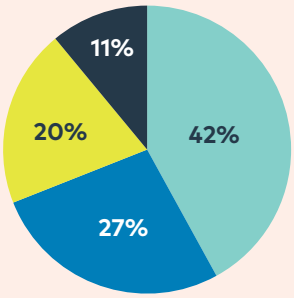
Overall, respondents seemed to view APCM services as a path to address the low (or nonexistent) pricing that exists for primary care services or to expand the team to better meet patients' needs.

When asked to rank potential benefits of APCM services, a plurality (42%) of respondents selected "regular monthly revenue to support previously unpaid care such as after-hours coverage" as the top opportunity. Respondents also believed that APCM could bring "new resources to build out the care team to support high-risk patients," with 31% of respondents selecting it as the greatest potential benefit of APCM.



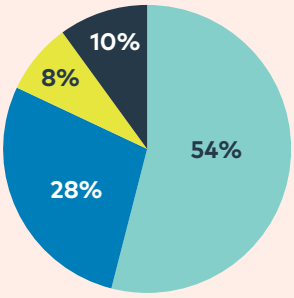
Participants were also given the opportunity to write in other potential benefits from the services, and respondents consistently mentioned the potential to better address population health, broaden whole-person care offerings (such as nutrition counseling and stress management) and reiterated their interest in building out care teams.

Potential Hurdles to APCM



- Collecting monthly copays from beneficiaries creats a financial burden and creates friction for clinicians
- The decision about APCM adoption made at the organizational leadership level. The frontline is not well-engaged in staffing, tech, and workflow changes
- Concerns that APCM revenue for Medicare patients won't be sufficient, especially for growth in the teen and change in workflows
- Other barriers

When asked to rank potential hurdles to effectively implementing APCM services, most respondents ranked collecting monthly co-pays as the biggest challenge (42%). Likewise, when asked what one change Medicare could make to best help scale APCM adoption, 54% of respondents indicated that waiving co-pays for beneficiaries who lack supplemental coverage would be the most effective.



- Waive copays for beneficiaries who lack supplemental coverage (while holding billing clinicians harmless)
- Require MA plans to incorporate APCM in their primary care payment models (with no cost-sharing)
- Encourage ACOs and other practice support entities to support practice enrollment activities such as patient education materials and engagement tactics
- Other (please specify)

Behavioral Health Integration

Respondents were also asked about their organization's current status with implementing behavioral health integration (BHI) and the importance of including BHI in standard APCM services (rather than as an add-on code).

While only 59% of the 135 care delivery respondents indicated they currently "provide and bill for behavioral health integration", a notable 89% of total respondents believed it was at least "somewhat important" that "Medicare include integrated behavioral health in APCM."



QUALITATIVE METHODOLOGY

Case Studies of Early APCM Adoption

The PCC used a purposive sampling approach to identify potential early adopters of Medicare APCM services. We asked leaders at PCC member and partner organizations and others in the PCC's broad primary care community to identify practices that are adopting APCM services and able to share early experiences. Our sample is therefore oriented toward practices that are likely to have developed advanced primary care capabilities.

We conducted one-hour interviews with representatives from the practice or organization during the summer of 2026. With permission from the representatives, interviews were recorded and transcripts were generated and used to analyze practice experiences with adoption. Two reviewers independently listened to interviews and read transcripts to reduce the potential for bias and error. One representative requested and was granted anonymity due to a pause in their implementation plans. Case study summaries were shared with representatives to ensure accuracy. All quotes were provided with permission from the representatives.

This study protocol was reviewed by the institutional review board at Virginia Commonwealth University and deemed to not be Human Trial Research.

The PCC's strong interest in the role of primary care teams informed the decision to interview a range of key informants — physicians, clinicians and professionals with vital roles in planning and implementing APCM services.

We made a concerted effort to include interviews that capture experiences from various geographies and types of organization (practice types, sizes, affiliations, ACOs and other enabling organizations) but we acknowledge our five cases are not likely to capture the full range of practice experiences — or even capture the full experience of organizations similar to the ones represented here. They are simply a snapshot of experiences from some early adopters and may provide some insight into factors that enabled or hampered adoption.

The goal of the case studies was to understand the motivations and experiences of early adopter practices and supporting organizations. We developed three key areas of questions to help guide the interviews and inform interested stakeholders:

1. What appealed to them about Medicare APCM services, the payment structure and levels, and CMS requirements?
2. How did they assess their readiness to implement APCM services and the financial viability and sustainability of APCM for their practice and organization(s)?
3. What enablers/facilitators and barriers have they encountered as they have implemented APCM services?

On the next page is a list of the representatives who were interviewed, with one informant and affiliated organization blinded.

Name	Title	Organization	Location
Jason Lofton, M.D.	Founder & Medical Director	Lofton Family Clinics	De Queen, AR
Alex Krist, M.D.	Senior Faculty, Professor of Family Medicine; Research Director	Inova Primary Care; Virginia Commonwealth University; Virginia Ambulatory Outcomes Research Network	Fairfax, VA
Sam Hiatt, Pharm.D.	(former) Director of Medicare Program Operations (left position after interview)	Community Care of North Carolina (Clinically Integrated Network)	Garner, NC
Gayle Kricke, MSW, Ph.D.	Director of Operations, System Primary Care	Northwestern Medicine	Chicago, IL
Rebecca Frieders, MPH, CHES, CPH	Program Director, Operations	Northwestern Medicine	Chicago, IL
Anonymous Representative	Population Health Leader	Unnamed health system	United States

Key Takeaways and Lessons Learned

Motivation for early adoption of Medicare APCM services

Early adopters indicated they were driven by the opportunity to:

- Secure new resources to support services that primary care, population health and case management teams were already providing.
- Obtain regular monthly support that is risk-adjusted in a simple, tiered approach in contrast to long wait times and uncertain amounts for shared savings or other VBPs.
- Focus new resources on high-risk, highly complex patients.
- Address access challenges in both primary and specialty care by strengthening primary care teams to manage more complex patients.
- Use teams and technology to address administrative burden or expand capacity for primary care teams, with examples including:
  - Support for in-basket management and triaging.
  - Outbound patient calls taken off clinic teams and given to centralized population health teams.
  - Easy access to interdisciplinary team members such as clinical pharmacists, social workers and community health workers shared across multiple practice sites.
  - Pilot APCM with support from an enabler organization like an ACO or Clinically Integrated Network (CIN), which was especially important for those who had limited prior experience with VBP.

Readiness assessment and decision-making process

Representatives made clear that decisions to adopt APCM services cannot be made lightly. They indicated that prior to implementing APCM:

- Financial modeling should be conducted to determine if the number of eligible Medicare beneficiaries meets a revenue threshold that can defray start-up and ongoing implementation costs.
- Beneficiaries at highest risk of avoidable downstream utilization and costs should be identified and prioritized with tailored care plans.

- Start-up costs are considerable:
  - Many EHRs and revenue cycle programs are not currently designed to support APCM services.
  - Busy information technology (IT) and revenue cycle departments must be persuaded of APCM's potential financial benefits. Their assistance is needed, and they have many priorities.
  - Compliance teams must be comfortable that documentation and workflows will consistently meet CMS requirements.
- Ongoing costs and new workflows include:
  - Consenting each patient to a single responsible "focal point" clinician responsible for overall care coordination.
  - As part of the consent process, notifying beneficiaries that they may face cost-sharing in the form of coinsurance or the full allowed amount during any deductible period.
  - Ongoing costs of the teams and infrastructure to meet Medicare APCM requirements. Some of these costs may be shared across other service lines or payers.
- Readiness indicators may include:
  - Experience and infrastructure already built to be successful in value-based models, including Medicare VBP models such as MSSP.
  - Capacity to collect and report quality measures and implement quality improvement initiatives.
  - Mixed experience with CCM and TCM services (most APCM early adopters were providing and billing for TCM services, but were not billing CCM due to the high administrative burden).
  - Using EHR and claims data systems to stratify patients and target resources using interdisciplinary teams (data driven systems are paired with practice-level patient identification to prioritize beneficiaries for APCM services).

Decision-making process insights

The following are additional factors that helped our case study representatives and their respective organizations decide if, how and when to begin implementing APCM services.

- An adoption strategy to start small and focus first on the highest risk beneficiaries, including QMBs. QMBs are a category of beneficiaries that are dually eligible for Medicaid and Medicare and exempt from Medicare cost-sharing, with state Medicaid programs assuming those costs.
- Of the organizations interviewed, most used 2025 — the first year APCM went live — to assess and improve their readiness, marshal resources internally and bring the decision to key leaders as well as clinic teams.
- Smaller practices are nimbler with flatter organizations for decision-making, but may lack infrastructure for data analytics, revenue cycle and compliance risk analysis. Their ACO or CIN partners can strengthen these capabilities, but the adoption decision is made by the practice. Large delivery systems must get aligned internally across multiple departments or teams, including revenue cycle management, contracts, compliance/legal, and clinical leadership. Organizations with established population health departments or infrastructure are well-positioned to leverage APCM.
- Organizations participating in Medicare ACOs or other total cost-of-care payment models must consider the impact of APCM billing on total per-beneficiary cost of care. Billing for APCM services will add to the costs counted against spending benchmarks. Most of those interviewed believe APCM will contribute to slowing per-beneficiary total cost-of-care growth.

Enablers for APCM Adoption

The cost-sharing waiver for Qualified Medicare Beneficiaries (QMB) enrolled in APCM. A QMB is a low-income individual enrolled in both Medicare and Medicaid.

Developing clear and compliant workflows for teams and clinicians, including electronic health record (EHR) documentation and access to care plans (including by patients and their caregivers).

Scripts and templates to support clinicians and administrative staff who are onboarding beneficiaries to APCM services.

Experience in value-based payment (VBP) models and existing care management teams, together with data and decision support infrastructure to build out with additional support from APCM.

Organizational leadership and internal support to work through APCM financial modeling, IT, revenue cycle and other collaboration needed with primary care leadership and teams.

Automated triggers for care teams to update care plans or take other action to begin the billing cycle.

Barriers to APCM Adoption

Medicare Part B cost-sharing rules that discourage beneficiaries without supplemental coverage for cost-sharing liability from consenting to APCM services.

A lack of clarity on what role auxiliary staff and other members of the team can play in supporting the focal clinician with care plans and other documentation.

A complex process for obtaining consent and the need for re-consenting when a patient transitions to a new "focal point" clinician.

Lack of multipayer alignment, with some plans competing with practices and population health teams by offering their own care management in-house and refusing to cover it when done outside their own model.

Primary care clinicians are not always engaged in payment and resource decisions. Larger organizations should demonstrate how the flow of funds from APCM goes to build out primary care teams, reduce workloads and support care innovation.

CASE STUDY

Lofton Family Clinics

Background

Lofton Family Clinics is an independent rural practice founded by Dr. Jason Lofton that has been operating in De Queen, Arkansas, for nearly 20 years.

The practice belongs to an Aledade-sponsored Medicare ACO and participated in the CPC+ model sponsored by CMMI and a Patient-Centered Medical Home (PCMH) program sponsored by Arkansas Blue Cross and Blue Shield. Lofton recently opened a second clinic in Oklahoma, where he is bringing primary care to a rural community that currently lacks a physician.

Introduction

In the summer of 2026, Dr. Jason Lofton found himself relaxing at the lake over the weekend when a message came in from a home health nurse: a patient had been discharged from the hospital. Within minutes, Dr. Lofton was able to text the patient and begin the process of transitional care. Under a standard FFS method, the effort to go above and beyond for a patient would have gone uncompensated. That's a big reason why Lofton — who founded Lofton Family Clinics — is so excited for the launch of Medicare's APCM services.

Motivation

Lofton owns and operates two independent practices in two small, rural towns. He feels a responsibility to be there for patients whenever they need him. He has made an effort to let patients know his clinic has 24/7 availability — but he's found patients are sometimes reluctant to take advantage of that availability.

"I have patients who, the most common thing I would hear would be, 'Hey, I don't want to bother you, so I went to the ER,'" said Lofton. "So now I tell them, 'Well you don't feel like you're bothering me because I'm getting paid a little bit.'"

As a small independent practice, Lofton can estimate the potential revenue from APCM adoption and know that it will come directly to his practice, like the revenue he might earn from Medicare shared savings participation. He can direct resources to investments and care redesign that he thinks will increase the sustainability of his practice and even enable service expansion.

The extra revenue from participating in a shared savings ACO and adopting care management and remote monitoring has allowed Lofton to really focus on building relationships, rather than a large churn through patients.

> **"I see the problems with fee-for-service, particularly the pace at which you have to see patients to make the economics work. Patients want more time with us. We want more time with patients."**
>
> **Dr. Jason Lofton, Founder, Lofton Family Clinics**

Readiness

Lofton's patients, like many rural residents, may lack reliable broadband and the devices that rely on it, but they are increasingly using a texting feature and a messaging service that enables the practice to stay connected with them. Important features, such as the clinic's phone number, help reassure patients that the message is from a trusted source.

In contrast, Lofton reports his patients hesitate to pick up unknown calls from health plans or other care management vendors. Clinic staff also help teach patients how to use the texting feature. He notes that clinic staff spend so much time on prior authorization phone calls that alternative patient communication channels have become essential.

As he implements APCM services, Lofton is using the Annual Wellness Visit (AWV) with his Medicare patients at the beginning of the year to update care assessments and plans. He explains that with APCM he hopes to perhaps only need to see them twice a year for in-person visits, reduce the number of medications they need and reduce their odds of needing to go to the emergency room.

He describes his team as responsive, "if somebody sees a need, they try to take care of it, especially for things like prescription refills, bladder symptoms, etc." Standing test orders help the team address common patient needs.

Lofton Family Clinics already had 24/7 access capabilities. He had already been providing TCM services for his patients but not CCM due to the administrative burden.

He has added remote patient monitoring (RPM) services for blood pressure management. The transition to APCM services required changes in billing and administration, which the small team had to do themselves, but the increase in revenue is a difference-maker.

Barriers

While early implementation has gone well, Lofton has still encountered challenges.

Some patients balk at the required Medicare coinsurance for APCM services, unclear why they have payments due during months when they did not have a visit. He's found that a frank conversation about how the program works and how the program helps the clinic get most patients onboard.

"I'm real upfront," explains Lofton. "I tell the patients about what the payment is, how it helps us, how it can help them."

Interoperability of technology has also been a problem, as his messaging platform does not integrate with his EHR; he would like to see the EHR implement tools designed for tracking APCM activities.

Lofton also acknowledges that, while the APCM payments help, he won't be able to transform his practice off those payments alone. Instead, he sees the pairing of APCM with RPM, along with shared savings payments earned in ACO participation as essential to creating financial security for his practice.

Conclusion

As he considers what comes next, Lofton's goal is to strengthen his practice by expanding his team.

"My goal for hopefully in the next year or two would be to find a couple of doctors to help partner with me in these two clinics."

Enablers for APCM Adoption

Past participation in various primary care payment models and CMMI demonstrations.

Current participation in Medicare shared savings ACO provides significant recurring revenue.

Adding APCM and RPM services billed regularly brings additional revenue and enables changes in patient visit length and cadence that expand visit capacity.

ACO and specialty societies provide learning opportunities for sustaining independent rural practice.

Barriers to APCM Adoption

Lack of multipayer alignment: large commercial payer ended care management fees when it ended a PCMH model.

Lack of sufficient broadband to serve all rural residents.

Patients who are enrolled in Medicare Advantage (MA) plans are targeted by plan for Average Wellness Visit conducted by a vendor — undermining APCM enrollment and care planning opportunities for the practice.

Lack of investment in rural-based primary care training sites to grow the workforce pipeline.

CASE STUDY

Northwestern Medicine

Background

Northwestern Medicine (NM) is an academic multispecialty medical group affiliated with the Northwestern University Feinberg School of Medicine in Chicago, IL. The service area of these sites extends from urban to suburban, to the Wisconsin border and halfway to Iowa.

Gayle Kricke, MSW, Ph.D., is Director of Operations, System Primary Care at Northwestern Medicine, and is helping oversee implementation of APCM for NM. Rebecca Frieders, MPH, CHES, CPH, is a program director helping with implementation.

Introduction

When APCM was first announced, leaders at NM recognized the program as a unique opportunity to bolster their existing efforts at delivering comprehensive primary care.

To start implementation, the program focused on high-risk patients who already require the type of comprehensive, high-touch care that APCM is designed to support. Kricke and Frieders explain that by taking a targeted approach, they have been able to test the waters with APCM and gain a better understanding of how and when the services can be rolled out more completely across the broader NM system.

As a large system with a shared EHR already participating in MSSP, NWM can stratify patients based on their costs as well as clinical data. They can, for example, identify patients who have utilized hospital services but do not appear to have a regular primary care clinician.

Motivation

As NM has participated in VBP models, it has been building infrastructure for population health with a centralized interdisciplinary team. It has also organized senior-focused clinics and formed three complex care clinics to serve different geographies.

As the revenue cycle team looked at the new Medicare APCM services and codes, they saw an opportunity to bring additional resources to these newer, more specialized practice models.

NM was already doing TCM and exploring CCM and PCM but was deterred by the complexity involved with time tracking and billing in those programs. By contrast, APCM billing is focused on activities and patient criteria, which is less onerous and more appealing.

As Dr. Kricke described the decision to move forward, she noted it was about "recouping a little bit of revenue for work we were already going to do."

Readiness

It took NM a full year to plan for adoption. NM used EHR and claims data to identify and stratify patients based on high risk, complexity, utilization and costs and has organized senior-focused and complex care clinics to specialize in care for these patient populations.

When they looked at adopting APCM services, they identified 20,000 patients — a small subset of their very large total Medicare population — as candidates for APCM.

"We also look at people who don't have a relationship at all with primary care," said Kricke. "Maybe they're attributed to us or we've seen them once, but they're coming in and out of the hospital, and so we want to tie them to someone to take ownership of their care."

Primary care physicians also refer patients to these care models if they believe they would benefit from more intensive services.

NM was able to leverage existing programs designed to support broader team-based approaches to care, including the Collaborative Care Model. As a result, the organization has full care teams that include registered nurses, population health teams, clinical pharmacists and psychiatrists ready to support patients who opt into APCM.

Barriers

Legal review was an important and lengthy step and mostly focused on implementing consent/opting into the program. NM worked with their EHR partner to create a custom build in the EHR to support APCM documentation — an arduous task that prevented the billing burden from falling on the clinicians.

Consent has also been a challenging topic for both clinicians and support staff. Clinicians are reluctant to wade into the conversation lest they give the impression that lack of consent will lead to a change in quality of care; front desk staff and other administrative teams are equally uncomfortable asking for consent for services patients have already been receiving, especially when it involves new cost-sharing.

Once the workflows and consenting are complete, the billing system can pull data from the EHR based on a discrete field that indicates consent. NM primary care has been using non-clinician administrative staff to help address administrative burden, as well as asking nurses to take a first pass at portal messages and triage messages for physicians.

Conclusion

For NM, APCM has been an important opportunity to strengthen the existing work the system was already doing to improve Medicare beneficiaries' health.

> **"We have this investment in complex care management. This is a nice way to acknowledge the physician and bring a little extra revenue in for that work."**
>
> **Gayle Kricke, MSW, Ph.D., Director of Operations, System Primary Care, Northwestern Medicine**

Enablers for APCM Adoption

Population Health team already established to support ACO participation, other value-based contracts.

Complex care clinics and senior-focused clinics in early phases of organization to bring resources, specialized teams to high-risk, high-need populations.

Other early adopter learnings from BHI in primary care.

Barriers to APCM Adoption

Electronic Medical Records are not designed for documenting and billing APCM services.

Addressing internal concerns about compliance risk associated with a new Medicare service with new rules and forms of payment.

Consenting patients and addressing cost-sharing hesitation.

CASE STUDY

CCNC: Enabling Independent Practices Across North Carolina

Background

Community Care of North Carolina (CCNC) is a CIN supporting independent primary care practices, including Community Health Centers, across payment models and payers in North Carolina.

As the former director of Medicare Program Operations, Sam Hiatt, Pharm.D., led the team supporting APCM adoption. Dr. Hiatt has since left the organization. Hiatt describes the Medicare population served by Community Care Physician Network (CCPN) practices as representing about 20% of their adult panels, with those beneficiaries disproportionately enrolled in Medicare and Medicaid.

Introduction

CCNC has a long history of bringing innovation to community-based primary care practices across North Carolina and convening them to learn from and support each other. CCNC has partnered with North Carolina's Medicaid program to improve care and access for vulnerable communities, including as early adopters of the PCMH model and targeted care management strategies for children and adults. CCNC-affiliated practices also serve commercial and Medicare patients.

The organization now helps practices succeed in value-based contracts and offers tools to help clinics adopt APCM.

Motivation

For CCNC, implementing APCM is part of their core mission to ensure North Carolinians have access to high-quality primary care.

"When patients have to wait 345 days to get in for their appointment, we're seeing them go to the emergency department or urgent care," said Hiatt. "If I can prevent a single significant inpatient event, it likely pays for a year's worth of APCM services for multiple patients."

The CIN has begun to work with practices to implement APCM — providing an alternative pathway for clinics to shift toward value-based programs that are designed to support stronger relationships between patients and their care teams.

> **"We know all the challenges facing primary care and especially independent primary care right now. Our solution really tries to be turnkey."**
>
> **Sam Hiatt, Pharm.D., Former Director of Medicare Program Operations, Community Care of North Carolina**

Readiness

Member practices range in size, location and sophistication. When it comes to technology, there are major differences in practices' Medicare beneficiaries use of digital portals, access to reliable internet service and smart phone use.

"As a CIN, we support independent primary care practices: from multisite, sophisticated practices to single clinician practices, across the whole state of North Carolina," explained Dr. Hiatt. "It varies pretty significantly when it comes to practice readiness."

To support APCM implementation, interested practices can get clinical support from the CIN level team. CCNC tries to offer end-to-end solutions because interested practices may not be able to afford an extra medical assistant on their team.

Barriers

Hiatt says that a lot of education is needed upfront for both practices and beneficiaries. He likes to compare APCM to a subscription model payment, which helps patients who face cost-sharing understand why they are seeing a monthly bill.

He also noted that independent practices use many different electronic health records (EHRs), and CCNC helps facilitate data transfer and integration. CCNC has built a platform that helps practices risk stratify their patients, identify care gaps and identify the best way to reach and engage patients.

CCNC requires engagement by the primary care physician or lead practice clinician as part of APCM adoption.

This is critical for keeping care plans updated and timely responses to emergency department or inpatient admissions.

Conclusion

Hiatt sees APCM as a pathway toward delivering the type of longitudinal care that keeps people healthy and happy.

"When you're thinking about the end goals of APCM, it's to improve outcomes," said Hiatt. "It's keeping patients out of the hospital. It's to better coordinate care between sites of service and reduce hospital readmissions. All those things are going to have a much larger impact when done well."

Enablers for APCM Adoption

CCNC partner CCPN is a CIN with origins in Medicaid PCMH. Member practices include Community Health Centers serving a high number of QMB Population is largely exempt from cost-sharing.

CCNC has also created scripting and a patient onboarding and consent process help reduce some of the administrative burden on practices

CCNC's ability and willingness to provide clinical and technology resources has allowed participation by independent practices that might not be able to meet APCM requirements otherwise.

CCNC's IT tools help eliminate some of the challenges created by compatibility issues with EHRs.

Barriers to APCM Adoption

Beneficiary co-pays make it difficult for some patients to opt into the program and create additional complexity in the patient relationship.

Clinical and technical requirements are a challenge for independent practices.

Recruiting clinicians in rural and remote practices can be difficult.

APCM adoption requires a mindset change about how to structure visits, patient panels and other core components of running the practice.

EHR interoperability continues to be a challenge, though CCNC has worked to address those factors.

CCNC seeks to incorporate BHI after a firm footing for the baseline program has been established.

CASE STUDY

Implementing APCM at a Large Safety Net Organization

Due to the sensitive nature of this case study, our interview subject has requested anonymity. To honor that request, we will refer to the interview subject as "Jordan Doe" throughout the interview.

Background

This case study captures the experience of planning APCM implementation at a health system and medical center. The health system has paused implementation and is still considering whether to proceed with APCM; due to the sensitive nature of the implementation, the PCC has anonymized this case study at the organization representative's request.

For this interview, we spoke with the Director of Population Health Care Management, who will be referred to by the alias Jordan Doe for the case study.

Introduction

In 2026, after months of preparation, Jordan Doe, MSN, RN, was excited to see APCM go live at the academic safety net health system where they serve as Director of Population Management. The organization was set to go forward — until the true complexity of implementing such a program across a large system caused it to pause and reassess.

Doe's experience reflects the reality that many large health systems face at a challenging time serving beneficiaries of government programs. While APCM shows enormous promise, implementing it requires confidence in systems that are new, and early program guidance lacks clarity in some areas. The larger the system, the more complex the cost/benefits become.

While efforts have paused, the system is still considering implementing APCM. But the complexity of different requirements — particularly the beneficiary consent, documentation and cost-sharing requirements — means that implementation will be slower than Doe had initially hoped.

Motivation

At the health system, Doe's department's centralized care coordination team is empaneled to primary care practices. As the health system took more accountability for the total cost of care in value-based contracts with different payers, it expanded what had been a small primary care footprint into a large, geographically spread-out network.

The population health teams demonstrate value to primary care, other parts of the health system, payers and patients by helping mitigate avoidable admissions and readmissions, improving chronic disease outcomes, facilitating community linkages and partnerships, taking some administrative burden off clinicians, and contributing to earning shared savings in value-based contracts.

When they first learned about APCM, Doe and the rest of the leadership at the organization were enthusiastic. Doe and colleagues saw the program as a way to provide additional revenue to cover the costs of proactive care coordination.

> **When leadership learned about Medicare APCM services in 2025, they thought, 'this could be magical.' If I can get a patient to yes and they'll take my call, engage in our programs, we can mitigate an avoidable instance."**
>
> **Jordan Doe, Director of Population Health Care Management, large health system and medical center**

Readiness

As the teams (population health, IT, compliance, primary care) got deeper into planning APCM adoption, the reality of Medicare rules set in. With years of experience and success adding valuable service lines, adopting new Medicare services with new billing codes is easy enough given the electronic medical record, but getting them coded consistently by clinicians is an administrative burden. The regular monthly nature of APCM revenue is attractive, but not compatible with existing billing processes or systems.

Nurses in the population health department have line of sight into the medical record and can assist primary care in updating care plans, but physician orders and sign-off are still needed every month according to a strict interpretation of the APCM rules. This adds administrative burden and compliance risk on top of the challenge of asking the patient to consent to cost-sharing.

Moreover, rules restrict APCM billing to one "focal point" clinician who is responsible for coordinating a beneficiary's care. When a patient leaves one panel for another, or their APCM clinician is no longer available, the consent process must be redone with a new clinician before recommencing billing. In addition, nurses are calling high-risk patients post-discharge within 48 hours on behalf of primary care. Coordination across specialists and primary care is important not just for updating the care plan but also for deciding how post-discharge visits are billed.

Barriers

Despite having experience in VBP models and robust population health and care management teams, it can be challenging to adapt existing workflows and ensure consistent clinical documentation to support regular care plan updates and billing.

For example, the APCM consent process is unlike other consent processes. Patients are taken aback by the inclusion of cost-sharing in the consent process — particularly when neither the clinician, support staff nor the beneficiary can confirm monthly cost-sharing amounts at the time of consent. Many patients balk at a monthly bill. The population health team has found that patients will eagerly accept the primary care team-based services and will verbally consent to help with ongoing care coordination, but they will decline as soon as a co-pay and unknown deductible are mentioned.

When there is ambiguity around CMS rules, a high administrative burden, patient cost burden or a perception of high compliance risk, organizations may wait for more clarity before proceeding with implementation — a path this organization has decided to take.

Conclusion

Doe remains committed to the program and plans to continue exploring ways to implement it at the health system. In addition, these services' costs are not fully covered by the revenue they bring in, and there is a concern of program elimination given health system budget constraints.

But they make it clear that reducing the complexity around cost-sharing and consent would go a long way toward making adoption easier and support the ongoing strategy for value-based care with the help of a team-based model like the one this health system has built and funded.

Enablers for APCM Adoption

Deep experience with population health and case management for high-needs, complex populations.

Experience in risk-based contracts in Medicare, Medicaid.

A high share of Medicare QMBs in the patient population eases cost-sharing concerns.

Barriers to APCM Adoption

Large organizations with multiple departments need to align on APCM adoption and implementation details.

Heightened attention on fraud in Medicare, Medicaid.

For a high share of low-income beneficiaries that are not QMBs, cost-sharing is a major burden.

CASE STUDY

Inova Primary Care Fair Oaks

Background

Inova Primary Care is a primary care clinic in Northern Virginia. It operates as part of a large integrated system called Inova with geographic reach across the region, including both relatively affluent communities and those with higher needs.

Alex Krist, M.D., a family medicine doctor with 30 years of experience, co-leads the clinic's and system's APCM implementation.

Introduction

In the summer of 2026, nurses at Inova Primary Care began reaching out to engage patients, provide proactive care and gain a deeper understanding of patients' needs. The calls are a part of the practice's efforts to implement the kind of whole-person primary care that Medicare envisioned when it launched APCM in 2025.

The practice, which is part of a large integrated system called Inova, covers both high-needs and relatively affluent communities across Northern Virginia. Alex Krist, M.D., a family medicine physician who has practiced for more than 30 years, is co-leading the development and implementation of their APCM effort.

Motivation

"APCM is really potentially transformative for us," said Krist. "We've done the math and the modeling, and it can double or potentially triple the revenue we might generate for people with Medicare."

He says that increased revenue is an opportunity to reinvest in his practice by expanding care teams and building new infrastructure to better meet the needs of his patients. The program will also allow his practice to gain revenue for the kind of services that had previously gone uncompensated, including lifestyle management, patient portal messaging, RPM and proactive outreach to deliver overdue care.

"I think that we have to have things like APCM to be able to build our teams and to give our clinicians time to be able to do this work that's just not covered in fee-for-service," said Krist.

Readiness

As one of the authors of the National Academy of Science, Engineering and Medicine's (NASEM) 2021 landmark report on implementing high-quality primary care, Krist has been a long-time champion of new payment models that are designed to strengthen primary care's ability to deliver whole-person care.

Krist and his system's prior commitment to innovative approaches meant that the infrastructure for success already existed — including a care team open to new approaches and a shared technology platform that minimized interoperability challenges.

Due to their dedication to trying innovative approaches, Inova Primary Care has participated in a variety of alternative models, including PCMH, MSSP, CCM and TCM. But they see APCM as a unique opportunity for their practice to evolve.

Barriers

Krist has still encountered some notable hurdles rolling out the program — mostly related to beneficiaries' ability to access the program.

In particular, he describes Medicare beneficiary cost-sharing for APCM as a "massive problem."

"I think with the co-payment we could get 30-40% of our patients to sign up. If they had no co-payment, I think we could get 80-90% of our patients to sign up," explained Krist.

As their practice tests out approaches to attaining patient consent, they find the message that "the APCM program is going to allow us to hire more people to build our team to take better care of you" is an effective one.

"A lot of my patients are saying, 'well, if it helps you, I'll do it,'" explained Krist. "But it creates this conflict and makes the clinicians feel like they are selling something to their patients."

The lack of clarity about whether MA will cover APCM has also caused consternation among clinicians at Krist's practice and in the affiliated health system. Some clinicians have expressed concern that limiting MA patients' access to services would mirror behavior by concierge practices that have come under criticism for gatekeeping care.

> **"That's a barrier for us because we want to provide advanced care to every patient and every person and our whole community that we serve. Having this system where we can offer it to some people but not offer it to other people, I think that's a problem."**
>
> **Alex Krist, M.D., Family Medicine Doctor**

Conclusion

Despite those challenges, Krist still thinks the program has enormous potential.

"I think the policy needs some refinement… and there's some things that Medicare has to do to make sure it's a success," said Krist. "But I think if we can refine the APCM policy… this could have a big public health impact, and it could help a lot of people with Medicare get better care."

Enablers for APCM Adoption

Inova Primary Care's experience with advanced models has prepared them for a change mindset.

A shared EHR has eliminated technology challenges other organizations may face.

Having an interprofessional team of clinicians, nurses, behavioral therapists and social workers supports the practice in providing APCM service.

Barriers to APCM Adoption

Beneficiary co-pays have the potential to strain relationships and limit patient opt into APCM.

Potential lack of coverage under MA or commercial payers may limit access for some Inova Primary Care patients, concerning some clinicians.

Fragmentation of care, such as MA plans outsourcing AWVs to vendors, disrupts continuity and weakens longitudinal patient-primary care relationships.

Policy Options for Expanding APCM Services

There is bipartisan recognition that the U.S. health care system — Medicare included — comes up short on prevention and managing chronic conditions. One framework for accelerating primary care's adoption of APCM services is to consider the needs of two broad and different types of primary care practices and clinicians:

1. Practices and clinicians with current experience in VBPs who can build on these capabilities and infrastructure to adopt APCM services.
2. Practices and clinicians currently lacking value-based care experience, resources, technical support or agency to develop the readiness and infrastructure to adopt APCM services.

With its focus on early adopters, this report focuses primarily on Group 1.

However, APCM's greatest potential may lie in motivating and supporting practices and clinicians that fall into Group 2. Scaling the capabilities for delivering APCM to reach the largest number of eligible beneficiaries requires activating both groups.

Policy options supporting APCM adoption should focus on removing the barriers faced by both groups and help all potential APCM adopters progress toward accountable, prospectively paid primary care.

Early APCM adopters and those considering adoption have identified actions that CMS and/or Congress could take to lower adoption barriers and ensure APCM services fulfill their potential to improve health outcomes and quality of life for *all* Medicare beneficiaries with chronic conditions.

Remove burdensome beneficiary cost-sharing

CMS already exempted QMBs — a category of dual Medicare-Medicaid eligible beneficiaries for whom Medicaid covers Medicare premiums and cost-sharing liabilities. CMS also assigned QMBs with two or more chronic conditions the highest APCM reimbursement level. This valuation and cost-sharing exemption incentivizes primary care to target APCM outreach and enrollment to these high-risk patients most likely to benefit from the APCM services.

For standard beneficiaries, APCM services are subject to Part B cost-sharing rules for those beneficiaries without supplemental coverage. According to KFF, 87% of Medicare beneficiaries in Original Medicare have supplemental coverage that picks up some amount of their cost-sharing expenses. However, the 13% that do not have supplemental coverage are likely to have modest incomes and find APCM cost-sharing to be a financial hardship.[31]

Congress could take the broadest approach by designating APCM services as preventive, as it did for the AWV. The 2025 Medicare final rule indicates that this change or other CMS authority to waive applicable APCM cost-sharing would require congressional action.[32] This approach would likely carry very low administrative costs. Although current monthly cost-sharing amounts are modest, they could become a larger barrier for beneficiaries and more costly to Medicare if CMS raises APCM payment rates over time to include additional services in the bundle.

Nevertheless, alleviating cost-sharing for APCM is important because:

- **Medicare's cost-sharing is a burden on beneficiaries in Original Medicare.** APCM services can be billed every month. Under current rules, the 13% of beneficiaries without supplemental coverage for Part B cost-sharing are responsible for paying cost-sharing each month (and the full amount if it is billed before the deductible is met). Primary care clinicians do not want to selectively provide APCM services to beneficiaries who qualify to receive APCM with no cost-sharing, and sorting out which beneficiaries fall into which category is administratively burdensome.
- **As covered Part B services, APCM services should also be covered by MA plans, but there is ambiguity over the beneficiary cost-sharing in MA plans.** CMS could put out guidance reminding MA plans of their responsibility to cover APCM services and the flexibility to lower or remove coinsurance.
- **There is an inability for care teams to determine actual beneficiary cost-sharing amount owed** across Medicare supplemental and MA coverage at the time of consent. Beneficiaries understandably seek certainty about their cost-sharing amount and frequency, but this can be difficult to provide at the time of care.

CMS, CMMI and the Office of Inspector General should use their authorities to permit practices to waive the collection of cost-sharing for select Part B services when delivered in qualifying VBP models such as MSSP or other Medicare ACO models. The 2027 physician fee schedule proposed rule includes such a proposal.[33]

Create incentives for multipayer alignment across Medicare and Medicaid

Different billing and reporting requirements across different payers have been a consistent challenge for primary care clinicians. While APCM aims to streamline care management for primary care in Original Medicare, the addition of a new set of codes does create more potential paperwork for primary teams. Creating alignment around the simpler billing implemented by APCM by encouraging other payers — especially in MA and Medicaid Managed Care — to follow Medicare's lead by covering and paying for APCM. This can help alleviate administrative burden *and* expand access to a useful set of services for more people.

Streamline beneficiary onboarding, re-consenting to APCM, care documentation

More clarity is needed from CMS on the details of the beneficiary consent process, such as how auxiliary staff can assist the focal point clinician with the beneficiary notification, education and consent process.

Other questions arise when the beneficiary changes their focal point clinician, either voluntarily or involuntarily.

- CMS should provide flexibility in the re-consenting process to prevent disruption in services and billing when the patient remains within the same practice organization but transitions to a new focal point clinician.
- Billing should not be interrupted if there is a temporary absence or lag in the sign-off by the focal point clinician for APCM services and care plans that have been documented and updated.

CMS should provide more clarity on medical record documentation requirements, and the agency should better delineate which professionals on an interdisciplinary team can document activities in the EHR and revise care plans under the general supervision of the billing clinicians.

Build the on-ramp from APCM to accountable care

The capabilities APCM requires are necessary but not sufficient for accountable care. CMS could design APCM so that practices that build these capabilities have a clear, low-friction path to the next step:

- Recognize sustained APCM participation as a readiness signal. Practices that bill APCM consistently across a meaningful share of their panel have shown the operational capacity accountable care requires. CMS could count this track record in MSSP entry pathways, glide paths or eligibility for prospective primary care payment options.
- Carry the APCM relationship into attribution. The APCM consent process creates a documented, patient-affirmed relationship with a focal point clinician. CMS could align this designation with voluntary alignment in MSSP, so the relationship persists when a practice joins an accountable arrangement.
- Allow APCM to convert to prospective payment within ACOs. For ACO participants, CMS could permit APCM revenue to be paid as a prospective per-beneficiary amount rather than billed code-by-code each month. This would reduce the billing burden, remove the monthly cost-sharing trigger and give practices direct experience with the prospective payment that accountable care requires.
- Equip APCM practices with the data accountable care requires. APCM's population health management element asks practices to stratify and manage risk, but most non-ACO practices lack the claims-based utilization and cost data ACOs receive. Artificial intelligence (AI) applications will likely improve current tools. Extending comparable data access and digital tools to APCM practices would build the analytic capacity needed to take on primary care capitation or total cost of care.
- Track progression, not just adoption. CMS should monitor whether APCM adopters later enter ACOs or other alternative payment models, alongside uptake and retention. This progression is the clearest test of whether APCM is working as an on-ramp.

To motivate greater clinician participation in VBP models such as MSSP, provide more regulatory flexibility and payment differentials for participating clinicians. CMS is exercising its limited authority to lower beneficiary financial burden.

In the proposed 2027 MPFS rule, Medicare proposes a major step that could reduce the financial burden of beneficiary cost-sharing for those served by ACOs by permitting ACOs and their participating clinicians to waive beneficiary coinsurance for certain Part B services. This would require ACOs to create written policies, have them preapproved by CMS and assume the costs (using shared savings or other revenues/savings) of waiving coinsurance.

We encourage CMS to prioritize high-value services such as APCM where cost-sharing is likely to be a barrier to needed care. This option for MSSP ACOs is also an opportunity for research to evaluate the uptake of waivers and the impact on the utilization of APCM and other services.

Conclusion

Medicare's introduction of APCM in 2025 represents a significant investment in strengthening comprehensive, longitudinal primary care. By supporting the important work that occurs between visits, APCM gives practices a practical starting point for building the team-based, longitudinal capabilities that whole-person care requires. It is an on-ramp for many: a way for practices still operating largely in FFS to build the foundations for accountable care. And for those with VBP experience, it provides additional financial support to expand their teams and provide a more comprehensive set of services, or perhaps for others to keep the lights on.

The quantitative and qualitative evidence introduced in this report, together with uptake patterns of other Medicare care management and preventive services, suggests that APCM adoption is likely to follow a modest trajectory unless additional steps are taken to support practices. The uptake of CCM and TCM demonstrates that new payment opportunities and new forms of payment alone are not sufficient to spur widespread adoption. The evolution of the AWV, which does not require beneficiary coinsurance, has been steadier, its path also highlights the many factors that affect the adoption and delivery of a covered service to an eligible beneficiary.

While early data on clinician and practice adoption of APCM shows encouraging increases in new adopters each quarter, it also indicates that a portion of clinicians fail to sustain participation over multiple quarters. It is difficult to determine what factors may be affecting this turnover among clinicians based on limited early claims-based data. Surveys of beneficiaries and clinicians are needed to supplement claims data. Data from EHRs could also provide insight into other important aspects of APCM adoption.

Findings from the PCC survey and qualitative interviews reveal enthusiasm for APCM services within the primary care community. The early adopters interviewed for our case studies consistently described APCM services as an opportunity to secure sustainable resources for care coordination, population health management, BHI and interdisciplinary teams required to manage complex patient populations. For many organizations, APCM services provide more predictable and administratively feasible support than previous care management programs.

As APCM enters its third year in 2027, policymakers have an opportunity to strengthen it on two fronts.

The first is removing the barriers that slow adoption: beneficiary affordability, administrative complexity, multipayer misalignment and ambiguity about how interdisciplinary teams participate.

The second, and ultimately more consequential, is connecting APCM to what comes next. The capabilities required to participate in APCM are the same capabilities required for success in accountable care or VBP models. However, APCM on its own as part of the fee schedule does not unleash the full value of primary care to transform care delivery.

Deliberate action from Congress and CMS to link APCM to attribution, data, prospective payments and accountable arrangements—including hybrid payment—that create a pathway for primary care at various stages of readiness to make the journey to primary care that is accountable for the health of the people and communities it serves.

Glossary

Accountable Care Organization (ACO): Organized group of doctors, hospitals and other health care professionals that work together to give patients high-quality, coordinated health care services, improve health outcomes and manage costs.

Advanced Primary Care Management (APCM): APCM is a monthly activity-based Medicare payment launched by the **Centers for Medicare & Medicaid Services (CMS)** that bundles continuous, coordinated primary care services without requiring minute-by-minute time tracking.

Annual Wellness Visit (AWV): A Medicare-covered visit (once every 12 months) to develop or update a personalized prevention plan and perform a health risk assessment. There is no patient cost-sharing (if the clinician accepts Medicare assignment).

Behavioral Health Integration (BHI): is integrating behavioral health with primary care or other care. It is a proven strategy to improve mental and behavioral health. Collaborative Care Model (CoCM): Psychiatric CoCM is a BHI model delivered by a primary care team. Medicare covers collaborate care delivered by teams that include a primary or other specialty care clinician and a care manager who work in collaboration with a psychiatric consultant, such as a psychiatrist.

Centers for Medicare and Medicaid Services (CMS): CMS is the federal agency that provides health coverage to more than 160 million people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.

Center for Medicare and Medicaid Innovation (CMMI): Also known as the CMS Innovation Center, CMMI develops and tests new health care payment and service delivery models to improve care, lower costs and better align payment systems to promote patient-centered, equitable practices.

Comprehensive Primary Care Plus (CPC+): Comprehensive Primary Care was an advanced primary care medical home model developed and tested by CMMI. It was designed to strengthen primary care through regionally based multipayer payment reform and care delivery transformation. Similar primary care models were also developed and tested by CMMI.

Chronic Care Management (CCM): Medicare covers **CCM**, which is for a doctor or other clinician who is managing a patient's multiple (2 or more) chronic conditions expected to last at least 12 months, or until their death. Chronic conditions place the patient at significant risk of death, acute exacerbation or decompensation or functional decline.

Clinically-integrated Network (CIN): An organization that unites independent practices and providers to share clinical infrastructure and guidelines to improve care and care coordination. If it meets specific legal criteria. a CIN can negotiate or enter payer contracts, such as a Medicare ACO agreement, on behalf of the members.

Dual-Eligible Beneficiary (DE): A low-income Medicare beneficiary who is also enrolled in Medicaid. Some categories of dual-eligible beneficiaries receive support from state Medicaid programs for their Medicare premiums or services not covered by Medicare.

Evaluation and Management Services (E/M): Visit with physician or other clinician to assess, diagnose and manage a patient's health.

Medicare Shared Savings Program (MSSP): The MSSP is a voluntary program for physicians and other clinicians who form accountable care organizations (ACOs) to work together to coordinate beneficiaries' care and earn shared savings with Medicare. As a group, ACOs are held accountable for the quality, costs and patient experience of care for beneficiaries attributed to the ACO based on their primary care utilization.

Patient-Centered Medial Home (PCMH): a model of primary care that meets standards to provide primary care that is comprehensive, patient-centered, coordinated and continuous, accessible and demonstrates high quality. The CMMI has sponsored and evaluated primary care payment models based on PCMH, including Primary Care First (PCF) and Comprehensive Primary Care Plus (CPC+).

Principal Care Management (PCM): Medicare covers PCM services that include disease-specific services a doctor or other clinician delivers for a single, complex chronic condition expected to last at least three months that puts the beneficiary at risk of hospitalization, physical or cognitive decline or death. A disease-specific care plan is created, and ongoing monitoring is conducted.

Qualified Medicare Beneficiary (QMB): A category of dually eligible low-income Medicare beneficiaries who qualify for state Medicaid benefits and have no legal obligation to pay Part A or Part B deductibles, coinsurance or copayments for any Medicare-covered items and services. Under Medicare APCM rules, QMBs who receive APCM services are not charged for cost-sharing for APCM or any Medicare services.

Transitional Care Management (TCM): Services to support a beneficiary transition from an inpatient setting back to a community setting (30-day period), includes medication management, getting referrals, appointments or other follow-up care, supporting caregivers and other coordination activities.

Value-based care and value-based payment (VBC; VBP): Value-based care is a term used to describe health care organized to focus on improving quality and other domains of care while managing resources effectively. VBP pays health care organizations based on meeting performance goals that include quality, patient experience of care and managing resources effectively.

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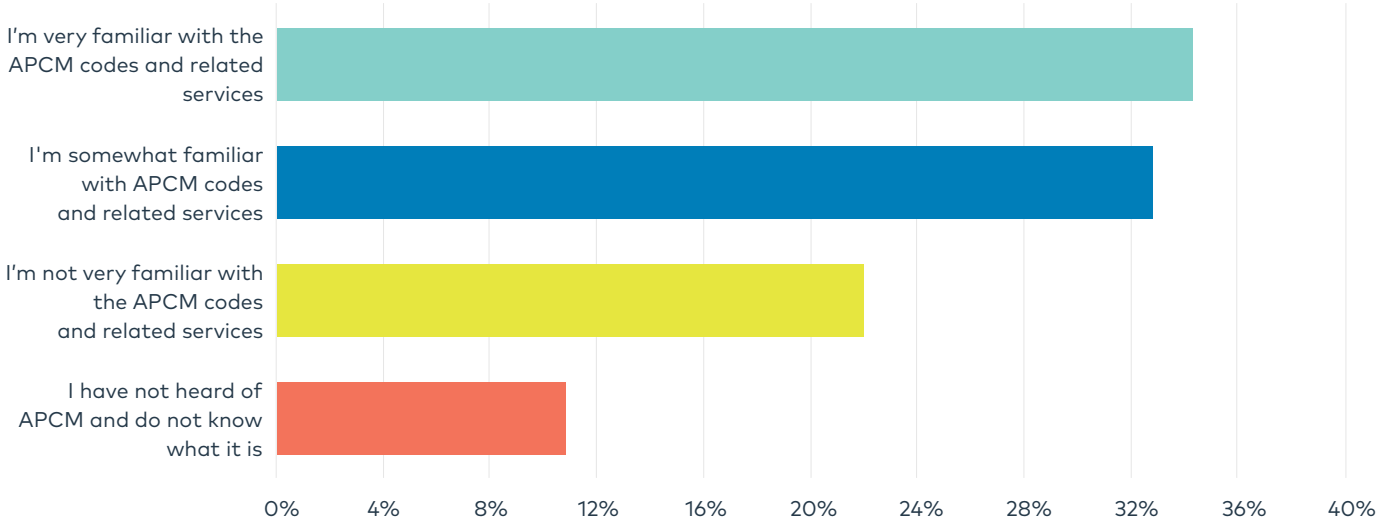
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Appendix

How Primary Care is Leveraging APCM — SurveyMonkey Repsonses

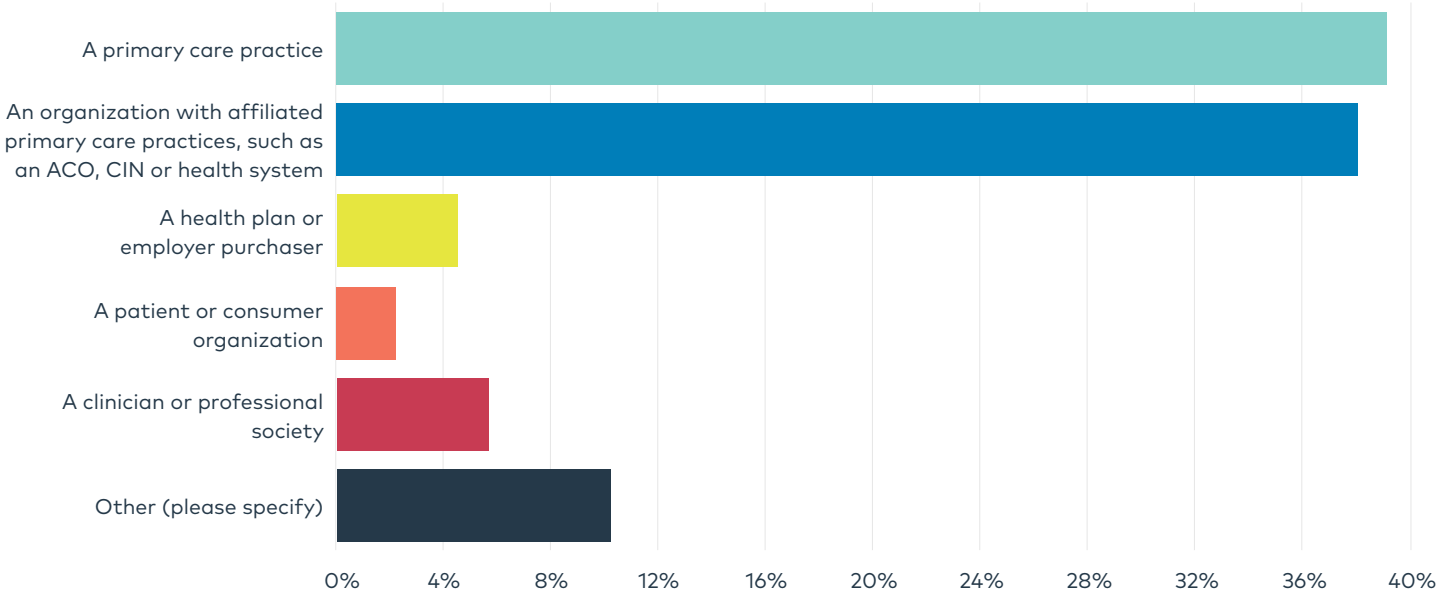
Q1 268 responses

In 2025, Medicare rolled out new codes for Advanced Primary Care Management. How much have you heard about these APCM codes? Pick the response that best fits you.



Q2 176 responses

Which type of organization are you affiliated/associated with?

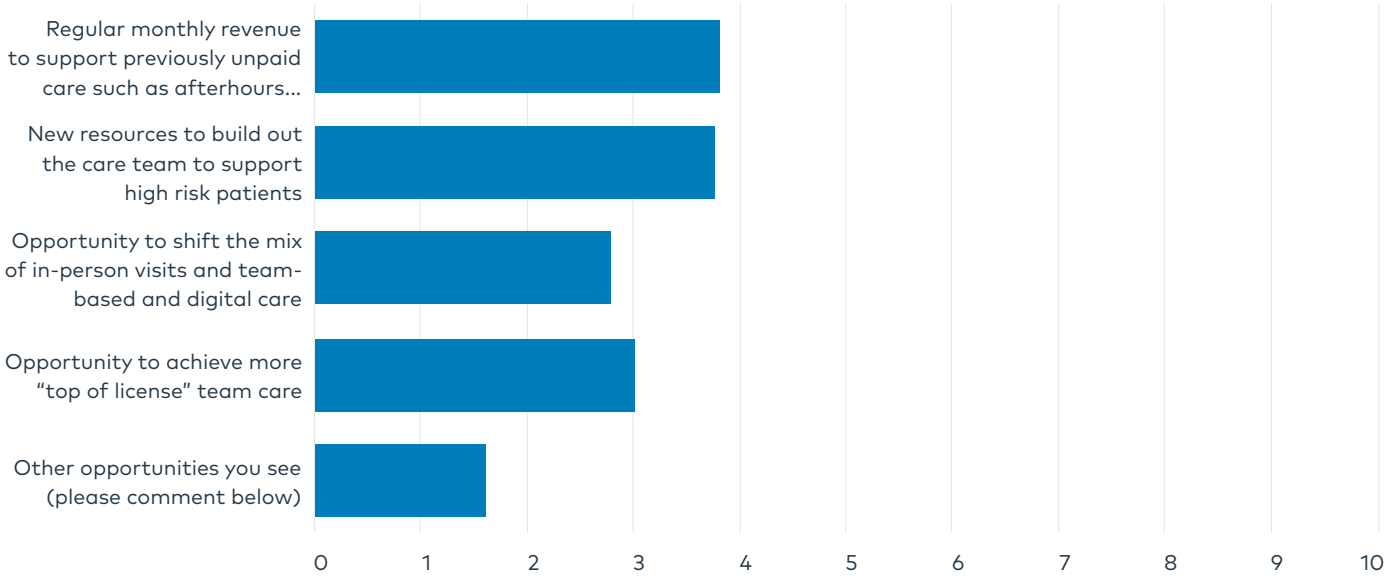


Answer Choices	Percentage	Responses
A primary care practice	39.20%	69
An organization with affiliated primary care practices, such as an ACO, CIN or health system	38.07%	67
A health plan or employer purchaser	4.55%	8
A patient or consumer organization	2.27%	4
A clinician or professional society	5.68%	10
Other (please specify)	10.23%	18
Total		**176**

#	OTHER (PLEASE SPECIFY)	DATE
1	I am a retired PCP with teaching experience now on our board of health which provides some women's services. I also helped write a Medicaid reform bill in Ohio that will include advanced PCP management. It copies reforms in Connecticut that are saving money and improving care.	8/5/2026 12:00 PM
2	Military	8/4/2026 8:13 AM
3	College of Pharmacy	8/2/2026 1:18 PM
4	Government	7/30/2026 12:42 PM
5	Practice advisor/consultant	7/30/2026 12:20 PM
6	community FP retired due to private capital seizure of healthcare	7/30/2026 11:45 AM
7	Consulting Firm	7/30/2026 10:53 AM
8	Consulting	7/30/2026 9:36 AM
9	federal government	7/29/2026 2:31 PM
10	Non-profit dental organization	7/21/2026 3:31 PM
11	Unaffiliated	7/21/2026 9:45 AM
12	Purchaser led coalition	7/20/2026 1:12 PM
13	Integrated behavioral health training and support team	7/20/2026 12:37 PM
14	Financial Institution	7/20/2026 12:35 PM
15	Consultant	7/16/2026 12:21 PM
16	consulting	7/16/2026 10:14 AM
17	Non-profit multistakeholder primary care convener	7/16/2026 9:43 AM
18	I'm a medical practice consultant	7/16/2026 9:18 AM

Q3 176 responses

Considering the following potential benefits of APCM, which do you see as the biggest opportunity? Rank them 1-5, with 1 being the most promising and 5 being the least promising.



Q4 Answered: 67 Skipped: 201

Please list any "other opportunities" below.

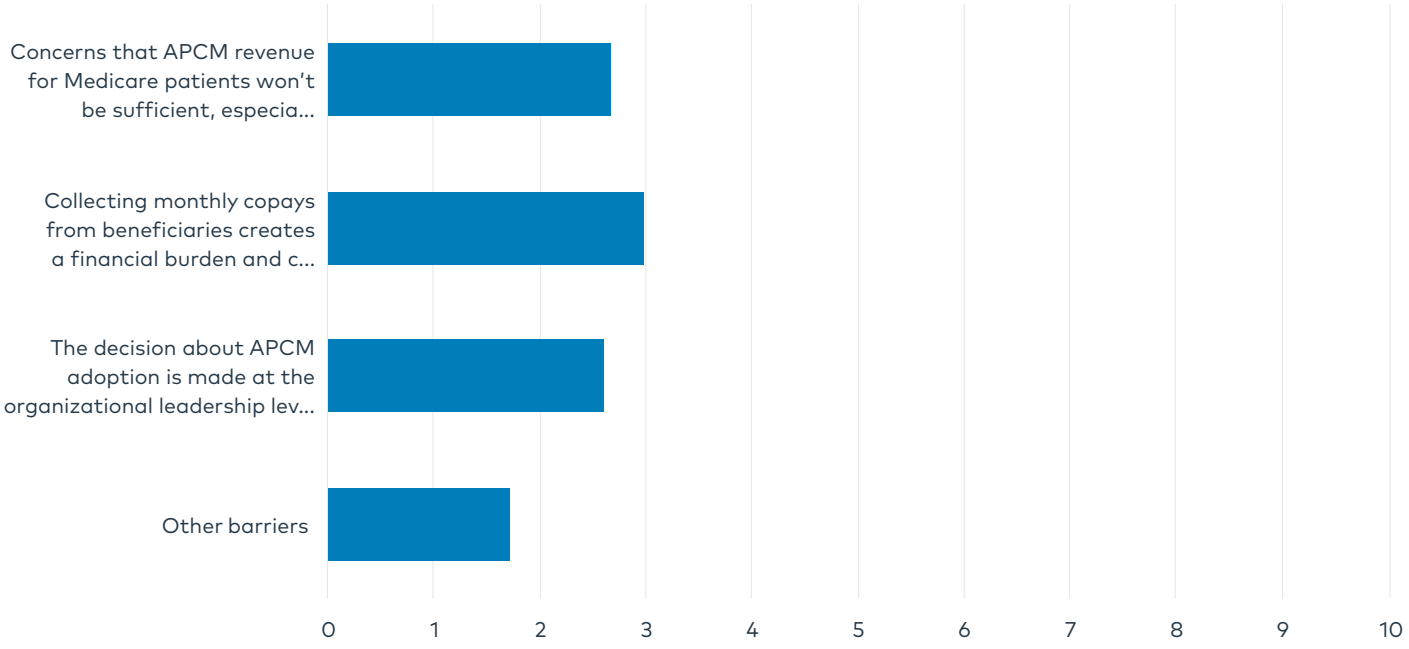
#	RESPONSES	DATE
1	Network does not provide for a team and if they were willing to use these codes, and if reimbursed correctly, they might be able to	8/5/2026 2:04 PM
2	Opportunity to have the resources to focus on preventative care, patient education, and general health support resulting in better overall outcomes for patients who are not yet at risk.	8/5/2026 12:16 PM
3	Expanded, integrated services - SDOH	8/5/2026 12:12 PM
4	The ability to attract more residents into primary care by reducing moral injury and burn out and increasing pay.	8/5/2026 12:00 PM
5	Enhance population health	8/5/2026 11:54 AM
6	provide wrap around services to patients that need it.	8/5/2026 11:39 AM
7	maybe eventually also help support non-primary care activities	8/4/2026 2:47 PM
8	Na	8/3/2026 9:29 AM
9	Ability to bill monthly but separately from regular visits including at FQHC's and only under general supervision.	8/2/2026 1:18 PM
10	Opportunity for health coaches to support care plans with whole health, patient-centered partnership and team collaboration	7/31/2026 4:15 PM
11	NA	7/31/2026 4:06 PM
12	General sustainability for clinic support staff the does population health work.	7/30/2026 5:01 PM
13	Support for patients to help further our value based care priorities (decreased ER utilization, avoiding hospitalization for chronic disease exacerbations)	7/30/2026 4:33 PM
14	Currently there is little benefit to board certified clinical pharmacists who provide comprehensive medication management services and are restricted to "incident to" billing	7/30/2026 12:52 PM
15	Getting closer to value-based care	7/30/2026 12:20 PM
16	I do not see opportunities to support independent practice with adequate staffing	7/30/2026 11:45 AM
17	Opportunity to support integrated behavioral health in primary care.	7/30/2026 11:35 AM
18	Possible mechanism to fund CHWS but Medicare copyaments are a barriers.	7/30/2026 10:22 AM
19	Promoting what patients desire through new models of care - group visits, weight management, lifestyle medicine, chronic disease self management, move toward screening for factors that lead to psychological distress.	7/30/2026 10:17 AM
20	We do not drop codes simply because patients say they can't afford it. If we charge for Medicare, we have to charge for all and most often the patients that can't afford it need care management the most. We claim our ROI through cost avoidance and Value based contracts.	7/30/2026 10:05 AM
21	Lower total cost of care through more appropriate utilization, transitional care visits, and medicine reconciliation.	7/30/2026 9:42 AM
22	Opportunities to lower losses on primary care for high risk patients and create care models to support them	7/30/2026 9:41 AM

#	RESPONSES	DATE
23	Introduce additional disciplines into primary care. Nutrition, stress mgmt, sleep studies, exercise programs (yoga, trainers, Chiro), groups to fight social isolation	7/30/2026 9:36 AM
24	using apcm as one of the tools to provide high value care	7/30/2026 9:29 AM
25	Ability to shift the conversation about expectations on the multiple ways that effective care can be delivered. Start changing societal expectations that it's in person 1:1 or nothing	7/30/2026 9:26 AM
26	Ensuring that team based payments are linked to the clinical primary care team and not to corporate support services	7/30/2026 9:21 AM
27	More sustainable reimbursement, improved care coordination/transitions of care including addressing SDOH, stronger patient engagement, enhanced chronic disease management, reduced risk of hospitalizations and ED utilization, support for team-based care, improved quality performance and patient experience, supports value-based care transformation, and better population health management	7/29/2026 7:52 PM
28	financial sustainabiity for care teams we have already built over past decade. Otherwise we might be regressing from CPC+ and PCF, loss of which has caused significant revenue shortage.	7/29/2026 1:48 PM
29	Ability to be innovative in care, such as paying for transportation, improved medication reconciliation, providing frequent contact in between patient visits.	7/29/2026 1:46 PM
30	I don't see any care benefit to the patient only revenue gain-	7/21/2026 5:43 PM
31	Allows us to hire support staff for un-funded services that patients rely on in the primary care setting (such as navigating insurance plan restrictions/denials, and tracking outside referrals or tests)	7/21/2026 4:09 PM
32	N/A	7/21/2026 1:26 PM
33	Waste of time!	7/20/2026 9:56 PM
34	Primary care is first and foremost trying just to survive. These monthly APCM payments will help allow practices to stay in business. Ultimately, it would be great for this money to support team based care, etc., but we are so far behind that I don't think that is possible yet.	7/20/2026 7:23 PM
35	Opportunity to offer services without a fee to APCM participants	7/20/2026 5:09 PM
36	To have the opportunity to providebest possible care according to patients medical conditions and needs	7/20/2026 1:12 PM
37	Coordinate care team across multiple disciplines	7/20/2026 1:12 PM
38	Expand pop health team	7/20/2026 1:07 PM
39	All of the above. But biggest is the resources to build out the care team.	7/20/2026 12:39 PM
40	To do the "payments" Faster and do them electronically for Remittance and Payments.	7/20/2026 12:35 PM
41	Other opportunities: encourage use of Collaborative Care and waive co-pays to reduce barriers to use of this model of care.	7/20/2026 12:06 PM
42	Would like to further optimize the new codes for collaborative care but they are not optimized or designed to be utilized	7/20/2026 11:28 AM
43	add pharmacists to care team	7/20/2026 10:59 AM
44	I'm not excited about these changes. They are fighting the wrong battles, for the most part.	7/20/2026 10:50 AM
45	NA	7/20/2026 10:24 AM
46	Enhance multidisciplinary care with RN support	7/20/2026 10:12 AM
47	Support infrastructure de elopement for CBOs to support care coordination activities rendered by non physician employed staff (CHW, LMSW, dietitians)	7/20/2026 10:07 AM

#	RESPONSES	DATE
48	If you already have the services is it worth it to bui8ld this model.	7/16/2026 2:50 PM
49	In house care management	7/16/2026 1:49 PM
50	Moves US a step closer toward hybrid payments and value based care.	7/16/2026 12:21 PM
51	To focus on WHOLE population care and not focus so much on who is "eligible" or ineligible.	7/16/2026 11:24 AM
52	im trying to better understand the opportunities.	7/16/2026 10:34 AM
53	NA	7/16/2026 10:14 AM
54	Reduction in fee for service administrative burdent.	7/16/2026 10:11 AM
55	None	7/16/2026 10:04 AM
56	Other = ability to meet patient needs without the constraints of CCM billing requirements	7/16/2026 9:44 AM
57	Opportunity for patients to truly feel that they have a quarterback who is coordinating their care and advancing their ability to get the right care at the right place at the right time (vs. working up a patient vs. reflexive referrals)	7/16/2026 9:43 AM
58	Offsets continued declining reimbursement for primary care	7/16/2026 9:39 AM
59	Add more BH support .improve MD and np compensation.	7/16/2026 9:35 AM
60	Begin utilizing group visits. Rely on "trained" community health workers.	7/16/2026 9:31 AM
61	Provide better care to patients specifically in better coordinating their care and establishing a clear care plan.	7/16/2026 9:27 AM
62	Convenience to consumer of having both their medical and behavioral issues addressed in one visit leading to more effective care and better health	7/16/2026 9:25 AM
63	NA	7/16/2026 9:18 AM
64	Regular monthly revenue to support non-visit work or panel management for both the PCP and the care team needed to take care of patients.	7/16/2026 9:17 AM
65	Opportunity to reduce the total cost of care and thereby qualify for increased shared savings.	7/16/2026 9:16 AM
66	Financial stabilization as reimbursement shifts from FFS to VBC payment models	7/16/2026 9:14 AM
67	awareness of unique role of primary care	7/16/2026 9:11 AM

Q5 176 responses

Consider the following potential barriers to adoption of APCM; which do you see posing the biggest hurdle? Rank them 1-4, with 1 being the biggest barrier and 4 being the smallest barrier.



Q4 Answered: 72 Skipped: 196

Please list any “other barriers” below.

#	RESPONSES	DATE
1	Existing CCM and TCM workflows/Complexities of implementing this process, including new consent process for more patients	8/5/2026 9:36 PM
2	won't reduce the desire of patients for "doctor" face to face visits so this time to manage is going to be on top of all other things all ready happening	8/5/2026 8:21 PM
3	Some insurers - including government programs, do not support the APCM program.	8/5/2026 1:49 PM
4	Getting IT and administrative support	8/5/2026 12:33 PM
5	Lack of synchronicity among federal payors on coverage for this program as a 2ndary payor. Specifically federal payors.	8/5/2026 12:16 PM
6	Time - Workload for care teams	8/5/2026 12:12 PM
7	Insurers and employers seem wedded to copays despite the fact that we have the highest in the world without evidence of cost savings. All the evidence says that access to well trained PCP care improves quality, saves money and saves lives.	8/5/2026 12:00 PM
8	EHR does not support automated billing of APCM. Patients have no familiarity with APCM, being billed for a "service" when the patient did not have contact with the office is confusing.	8/5/2026 11:54 AM
9	obtaining patient consent--rules say this must be done by the billing provider, which is inconsistent with typical workflows, where outreach for this type of care will be performed by the non-billing care provider.	8/4/2026 10:34 AM
10	I work at a facility-owned clinic, so the underlying assumptions about payment in this system really don't apply. For example, if Medicare pays something like $15 for someone from the clinic to call a recently discharged patient to see how they're doing, then Medicare is saying "we expect the LVN or MA to do this." These types of employees are not paid from the general revenue billed by the physicians. They are paid through the facility fee that Medicare also pays for the clinic visits. Therefore, the doctor gets ZERO payment for the extra work for managing this clinic work. And even for the private practices where there is no facility fee, this level of payment takes no account of the work the doctors do to manage the issues that arise during the phone calls: review meds, change meds, reorder tests that didn't happen, and so on.	8/3/2026 10:12 AM
11	Na	8/3/2026 9:29 AM
12	Documentation burdens and satisfying requirements to meet criteria to bill this code	7/31/2026 9:18 PM
13	Requiring additional documentation maybe problematic	7/31/2026 4:06 PM
14	Main barrier continues to be organizational leadership driven of not pursuing pharmacist billing for this service, as our ambulatory pharmacy leadership has asked and was told no. Another consideration is barrier to credentialing of pharmacists at our institution.	7/31/2026 12:32 PM
15	health system unwilling to bill for incident to visits	7/31/2026 10:47 AM
16	Our heath system does not allow incident to billing.	7/31/2026 10:30 AM
17	We are short-staffed already...how do we find affordable staffing for the position	7/30/2026 4:33 PM
18	Patient not understanding why they are being charged for monthly visits and not “seeing the doctor”	7/30/2026 2:18 PM
19	Currently there are substantial barriers for me as a board certified psychiatric pharmacist to provide interprofessional comprehensive medication management services to patients with difficult-to-treat mental health conditions.	7/30/2026 12:52 PM

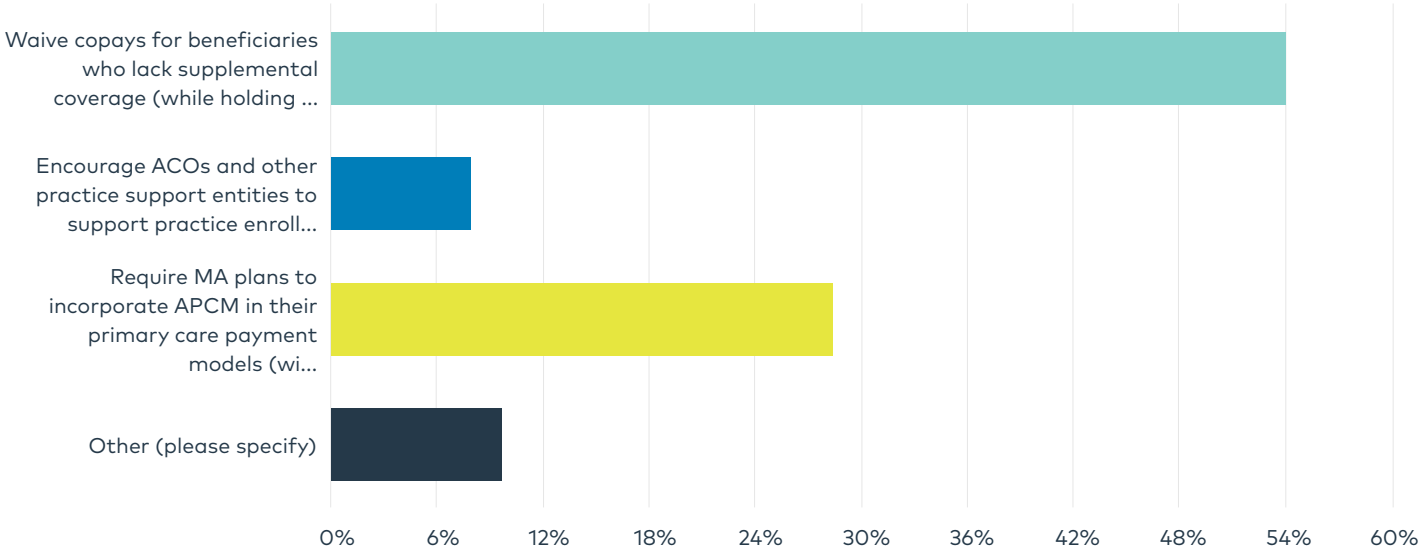
#	RESPONSES	DATE
20	I do not see any change in the underlying payment system due to theft by private capital. These financial structures of theft are not going away compared to other advanced countries, which do not permit ownership by private equity	7/30/2026 11:45 AM
21	While much simpler to document required components for billing compared to traditional CCM, operationalizing this across a large medical group requires significant infrastructure and support from multiple stakeholders (billing, coding, revenue cycle, IS, informatics, administration, physician leadership, etc.). In a single site primary care clinic, rolling out APCM would be pretty easy, but in a multisite medical group, rollout is an 8–12-month endeavor, if not longer.	7/30/2026 11:33 AM
22	I am affiliated with the two organizations. APCM decision are made at the top at the AMC. But I also work at FQHCs. Copayments are huge issue possibly bigger at the FQHC.	7/30/2026 10:22 AM
23	Again- charging for Medicare means we have to charge everyone. Patients that need it the most can't afford the cost.	7/30/2026 10:05 AM
24	EHR's incompatibility and lack of data feeds on ADT	7/30/2026 9:42 AM
25	Getting the money from systems to providers	7/30/2026 9:41 AM
26	Behavior modification of providers to team	7/30/2026 9:36 AM
27	patients acceptance of apcm. we already have a few 'complaints' and questions form patients. so that has led to a clinic wide effort to help explain apcm to all of our senior care pts .	7/30/2026 9:29 AM
28	This does not apply to Pediatrics and disenfranchises an already under resourced primary care group	7/30/2026 9:26 AM
29	Informatics resources, compliance, etc. needed to set this up; not relevant across payers	7/30/2026 9:21 AM
30	Workflow redesign with team members with the appropriate licensure/ skill set/ knowledge, EHR optimization, provider and staff adoption, upfront costs to implement, lack of dedicated and skilled care management resources, and risk to reduce continuity of care with a primary care provider if set up with a "clinic" versus PCP to build long-term relationships	7/29/2026 7:52 PM
31	We have developed an adequate workflow and care coordination team, but we see the complexity of enrolling patients individually, and the cost sharing potential , are significantly limiting us in getting patient buy-in. THey will potentially getting the same services we have been providing for past years in PCF for free.	7/29/2026 1:48 PM
32	Getting consent.	7/29/2026 1:46 PM
33	I don't see benefit for patient- why would we not adopt CCM	7/21/2026 5:43 PM
34	Commercial Medicare Advantage payer's tactics to avoid paying for APCM services (such as claim denials, excessive audits, demands for repayment of 'overpayment', legal threats) .	7/21/2026 4:09 PM
35	Need to include inter-professional care that impacts health outcomes such as dental services.	7/21/2026 3:31 PM
36	Waste of time!	7/20/2026 9:56 PM
37	Going through the process of enrolling patients is a barrier	7/20/2026 7:23 PM
38	Patient agreement	7/20/2026 5:09 PM
39	"Practices must report performance metrics, including primary care quality, total cost of care, and meaningful use of certified EHR technology, often through ACO participation or MIPS Value Pathway" = how can or are the PCPs determining meaningful use of EHR technology? (especially when multiple portals are involved)	7/20/2026 1:12 PM
40	Cost share is the largest obstacle. Lack of familiarity with the program, and few resources for patients to gain a better understanding of.	7/20/2026 1:07 PM
41	Our health system uses Epic and is trying to figure out how to bill for this. We've not been able to start the program due to the technical issues of this. Monthly co-pays is a problem.	7/20/2026 12:39 PM

#	RESPONSES	DATE
42	From those who shall be "disintermediated" by "Faster Payments". No "float" for them!	7/20/2026 12:35 PM
43	Lack of awareness that this exists and how to go about implementing it.	7/20/2026 11:40 AM
44	the co pays for collaborative care are a barrier as are others	7/20/2026 11:28 AM
45	insufficient Medicare data to measure outcomes	7/20/2026 10:59 AM
46	I work at a FM residency and our clinics are hospital-owned, so it also charges a facility fee to patients/ Medicare/Medicaid. I don't think any of this APCM discussion and reform has factored in how this is supposed to work in this environment. For example, if some of the monthly "check in with the patient by phone" codes essentially are priced for a LVN or MA to do the work, then there time is actually covered in the facility fee for the clinic visits. I have no incentive as the doctor to bill for these services, because the money will probably go to the host organization and I'll never see it. Plus, this kind of work absolutely generates work for me to do as the "team" has questions for me to answer, but I can't bill separately for that time unless I call the patient and then generate a bill for the patient. And the huge difference in payment between a phone visit and a visual visit is ridiculous discrimination, especially for someone like me who cares for a lot of poor elderly people and recent immigrants who don't have either the knowledge/ comfort or technology at home to do the video work.	7/20/2026 10:50 AM
47	We do not have the man-power to initiate this type program. There are too many requirements for us to be successful and compliant.	7/20/2026 10:25 AM
48	NA	7/20/2026 10:24 AM
49	Registry functionality is questionable at our organization. We would need to upgrade.	7/20/2026 10:12 AM
50	Any extra coding efforts (or added build in EMR to capture the codes) makes APCM a burden. Consent and copays are a huge barrier. A good number of high risk disengaged patients won't readily consent even though they need and use care management.	7/18/2026 6:58 PM
51	deductibles have to be reached first. if not reached the entire balance goes to the patient	7/17/2026 3:14 PM
52	Differentiating between the services you do / don't get if patient sign up.	7/16/2026 2:50 PM
53	separate consenting from general medical and other care mgmt.	7/16/2026 1:49 PM
54	System issues to be able to track and bill appropriately. Explaining to the patient the program and their lack of understanding because when they think of a "billed service" they see it as in person- not something we can bill monthly.	7/16/2026 12:48 PM
55	The required documentation is burdensome given the EHR platform that we utilize (NextGen).	7/16/2026 12:25 PM
56	The too frequent (monthly) panel submission and audit requirements represent another administrative burden and will cause some practices to not use the codes.	7/16/2026 12:21 PM
57	3rd party vendor for CCM, In House for APCM. Causing disagreement in value.	7/16/2026 11:24 AM
58	more work documenting just to document	7/16/2026 10:15 AM
59	NA	7/16/2026 10:14 AM
60	Having to create new administrative procedures to support how many patients are within this environment versus fee for service. Creates a burden of supporting two types of patients from an administrative perspective versus streamlining standards uniformly for all patients.	7/16/2026 10:11 AM
61	NA	7/16/2026 10:04 AM
62	Other = Medicare only; does not apply to Medicaid or uninsured patients	7/16/2026 9:44 AM
63	Really operationalizing APCM and meeting compliance obligations; truly having the systems and processes in place for APCM delivery every time for patients when they would benefit from it	7/16/2026 9:43 AM
64	Cost sharing to beneficiaries	7/16/2026 9:39 AM

#	RESPONSES	DATE
65	IT workflows and implementation. difficulty accurately, identifying qualified Medicare beneficiaries	7/16/2026 9:35 AM
66	Commercial payers and Medicaid are slow to adopt the payment methodology. Currently it's not a true "population health" approach.	7/16/2026 9:31 AM
67	Significant technology barriers, staff training in best techniques to build and maintain a care plan in scale.	7/16/2026 9:27 AM
68	Patient copays is a significant barrier in the current economic environment (of high inflation, stagnant wages etc)	7/16/2026 9:25 AM
69	Lack of time for clinician to patient communication regarding APCM benefits that would increase patient engagement.	7/16/2026 9:18 AM
70	The need to consent the patient to provide the care we're already providing to them to receive the monthly payment. Of course, this is tied to the patient financial share. My suggestion would be to eliminate the patient financial share so all Medicare patients can benefit (equity issue) and in so doing eliminate the administrative burden for Primary Care.	7/16/2026 9:17 AM
71	Resistance among MDs to relying more heavily on advanced practice clincians (non-MDs)	7/16/2026 9:16 AM
72	patient awareness of the value	7/16/2026 9:11 AM

Q7 176 responses

If Medicare were to make the following changes, which would make the biggest difference in helping scale APCM adoption?

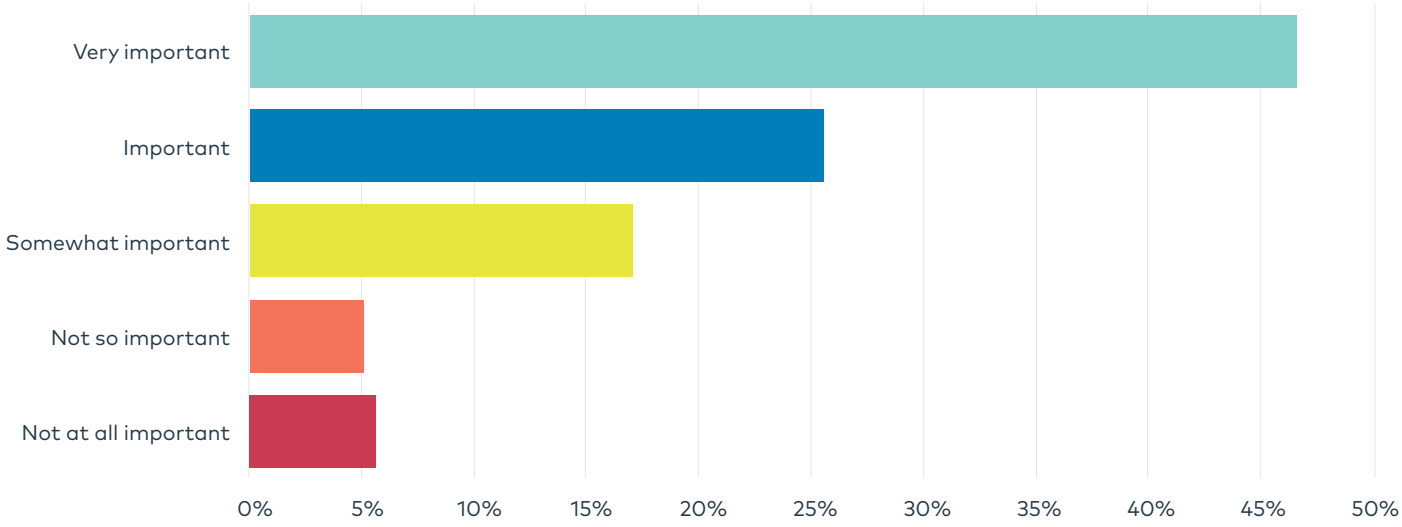


Answer Choices	Percentage	Responses
Waive copays for beneficiaries who lack supplemental coverage (while holding billing clinicians harmless)	53.98%	95
Encourage ACOs and other practice support entities to support practice enrollment activities such as patient education materials and engagement tactics	7.95%	14
Require MA plans to incorporate APCM in their primary care payment models (with no cost-share)	28.41%	50
Other (please specify)	9.66%	17
Total		**176**

#	OTHER (PLEASE SPECIFY)	DATE
1	Require secondary plans to cover the cost share / deductible or waive the cost share or cover it 100% as preventative.	8/5/2026 12:16 PM
2	Complicated problem! We need national health insurance that supports PCPs and makes acces to them free of copays. A demonstration of success with this idea at the state level would help with moving the national changes needed along. We need USA healthcare-Universal Simple and Affordable. A state based version of an improved expanded Medicare for all could be the platform. See the CBO report form 12/2020 on this subject.	8/5/2026 12:00 PM
3	Recognize pharmacists as providers - this will allow more billing opportunities to make and thus make it easier to integrate into pharmacists primary care clinics	7/31/2026 9:44 AM
4	Expand credentialling to board-certified pharmacists who are experienced in providing interprofessional comprehensive medication management services.	7/30/2026 12:52 PM
5	These criteria do not reflect reality, nor the loss of community practices throughout the US.	7/30/2026 11:45 AM
6	APCM and Commercial plans cover the cost along with Medicare	7/30/2026 10:05 AM
7	Imit it to programs that we can show help patients	7/30/2026 9:41 AM
8	I'm not sure	7/30/2026 9:39 AM
9	Make this apply to Medicaid as well	7/30/2026 9:26 AM
10	all of the above, plus allow a standard opt in, with option for opt out, if beneficiary chooses.	7/29/2026 1:48 PM
11	Total waste of time!	7/20/2026 9:56 PM
12	Faster Payments.	7/20/2026 12:35 PM
13	Abandon these efforts and pivot to paying family docs for dealing with multiple issues in one visit, eliminate the bigotry of the phone vs. video payment, and incentivize family docs to practice slow less is more medicine.	7/20/2026 10:50 AM
14	remove this going to deductible	7/17/2026 3:14 PM
15	we need to make PC a first dollar system PERIOD	7/16/2026 10:15 AM
16	Higher APCM monthly payments	7/16/2026 9:43 AM
17	Consider this a preventative service so that no plans have cost sharing	7/16/2026 9:39 AM

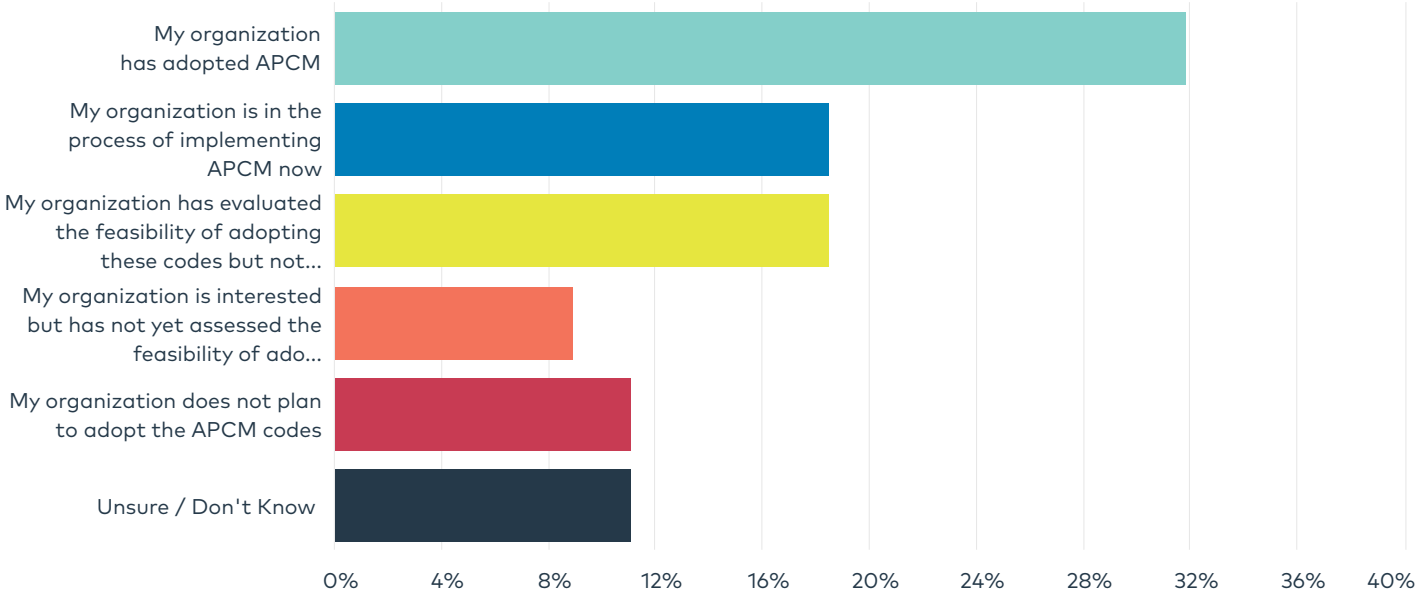
Q8 176 responses

How important is it to you that Medicare include integrated behavioral health in APCM (not just as an add-on code)?



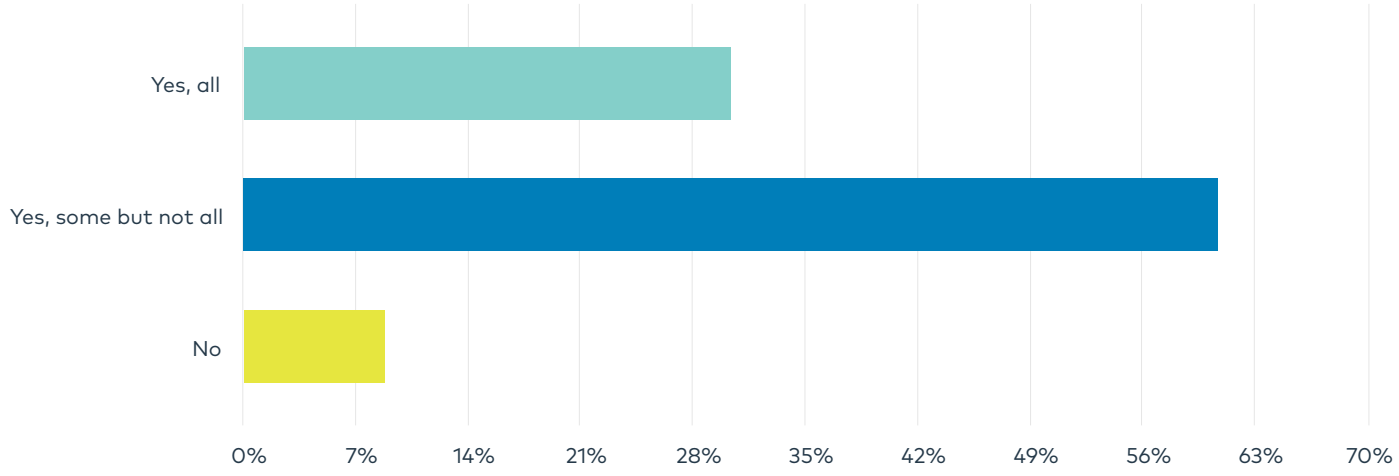
Q9 135 responses

Where is your organization in the process of of deciding whether or not to adopt APCM?



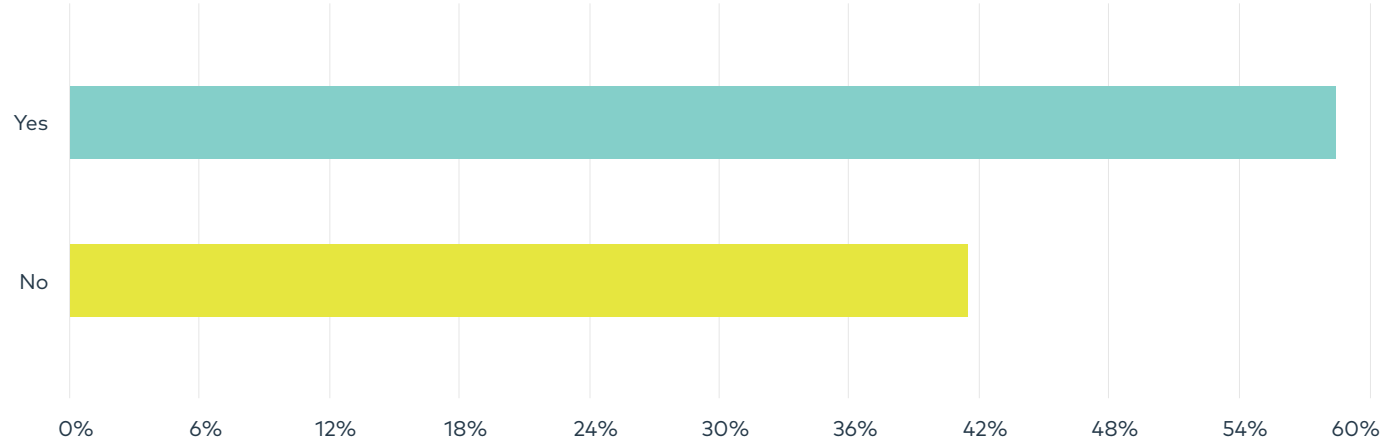
Q10 135 responses

Does your organization already provide and bill for CCM, TCM, and PCM services?



Q11 135 responses

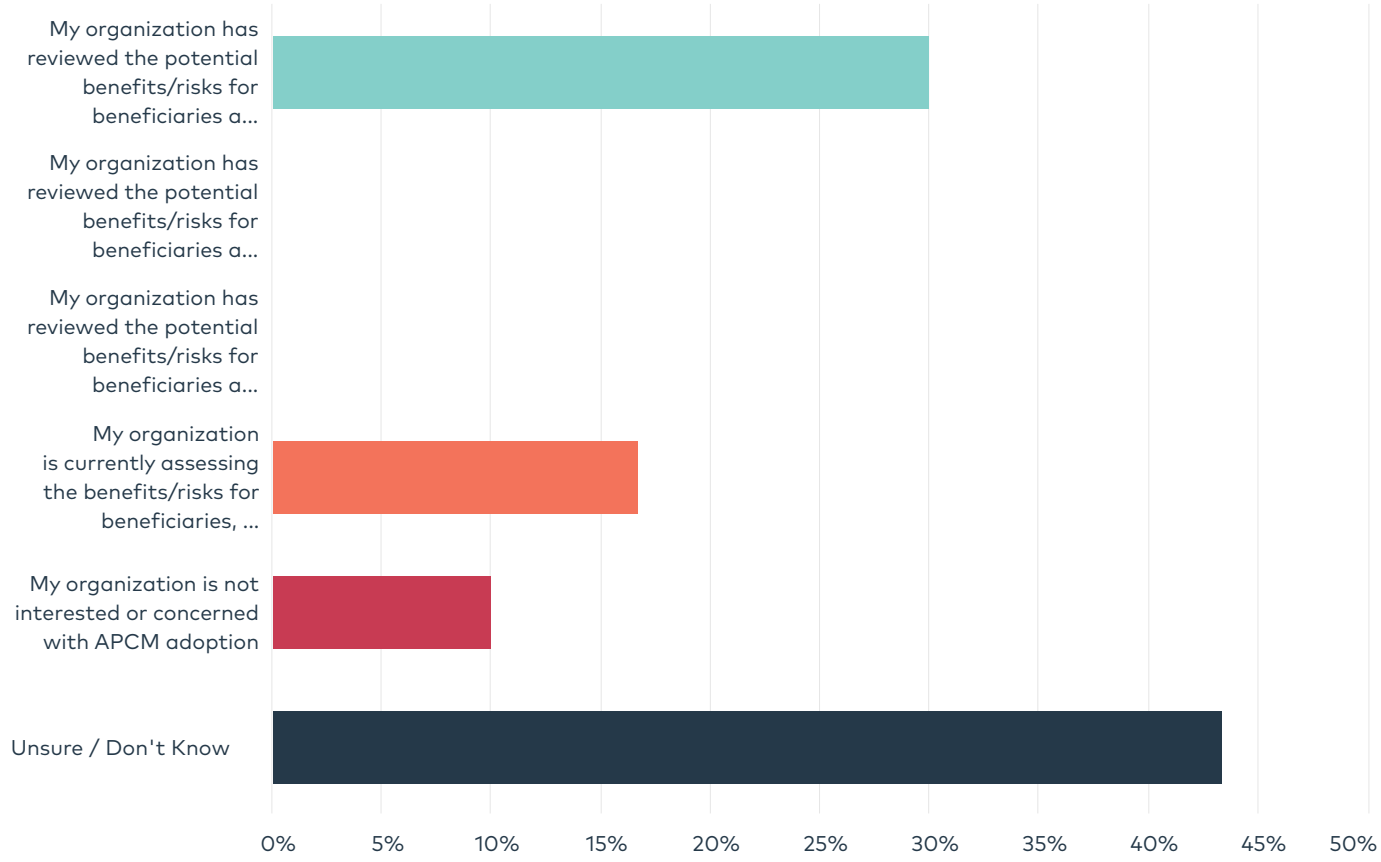
Does your organization provide and bill for behavioral health integration?



Answer Choices	Percentage	Responses
Yes	58.52%	79
No	41.48%	56
Total		**135**

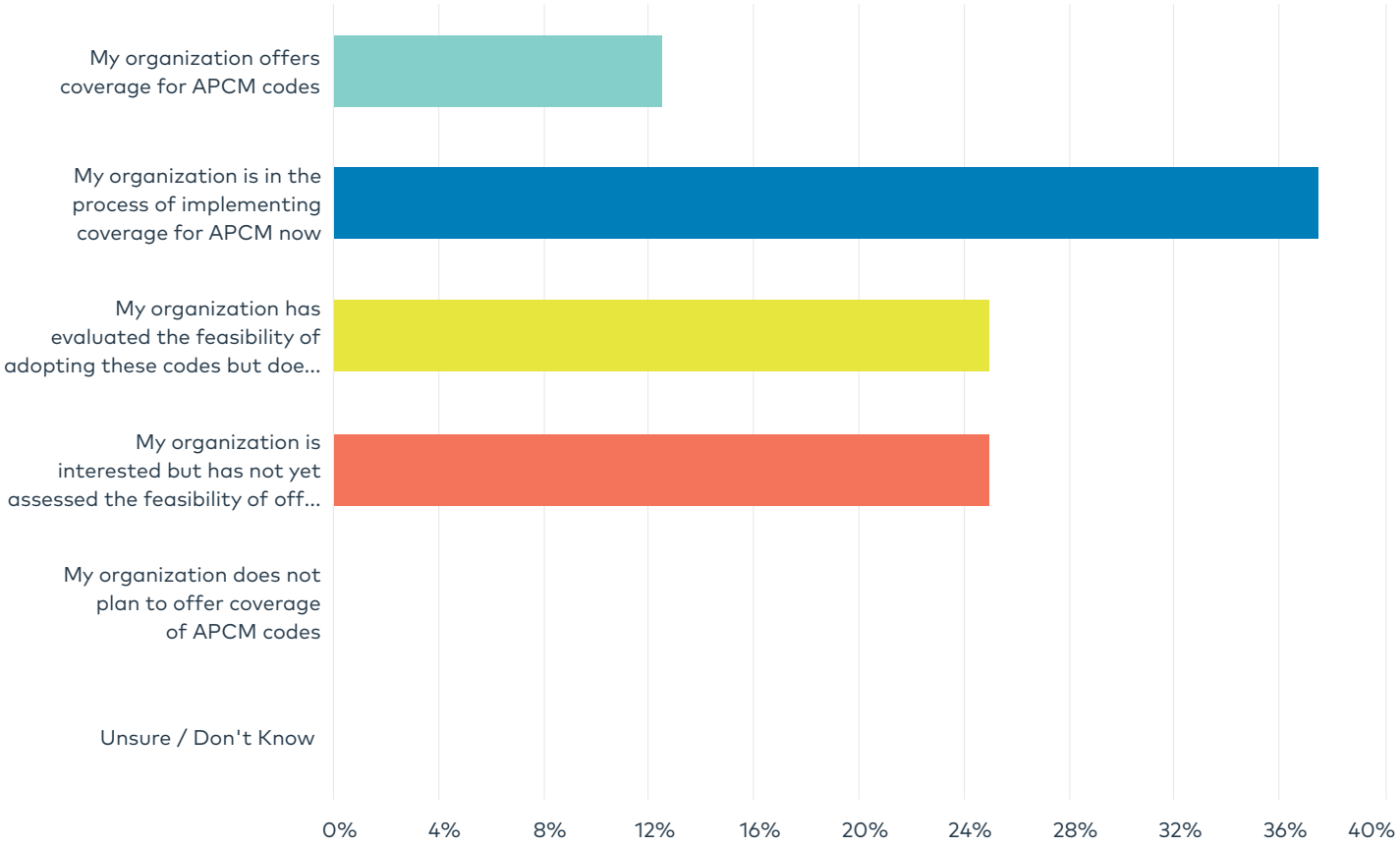
Q12 30 responses

Where is your organization in the process of assessing APCM codes?



Q13 8 responses

Where is your organization in the process of of deciding whether or not to offer coverage for APCM codes?



Endnotes

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Primary Care Collaborative

The Primary Care Collaborative (PCC) is the leading national, nonpartisan and multi-stakeholder voice advocating for better health and wellbeing for all Americans by strengthening primary care. The PCC unifies and engages diverse stakeholders in promoting policies and sharing best practices that encourage the growth of comprehensive, whole-person primary care.

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