

The Clinical Case for Between-Visit Care

What a decade of Medicare care-management evidence tells us about Advanced Primary Care Management (APCM)

FOR PHYSICIANS AND CLINICAL LEADERS AT INDEPENDENT PRIMARY CARE PRACTICES • JULY 2026

Executive summary

Medicare's Advanced Primary Care Management program (APCM), launched in January 2025, pays primary care practices a monthly, per-patient fee to manage chronic conditions between office visits. It is not a new idea. It is the redesign of a decade-old one — Chronic Care Management (CCM) — whose evidence base is now mature enough to evaluate honestly.

That evidence says three things. First, when Medicare paid for structured between-visit care, its own commissioned evaluation found the program was **associated with \$74 per patient per month in slower spending growth at 18 months — roughly \$888 per patient per year** — driven by fewer hospital, skilled nursing, and emergency department services.³ Second, the benefit is not automatic: across the broader literature, the programs that work share specific ingredients — frequent contact, medication management, support for care transitions, and a close link back to the treating physician — while low-touch telephone programs without those ingredients have repeatedly failed.¹⁴¹⁵ Third, almost nobody got this care: in the government's own claims analysis, only about 4 percent of eligible Medicare beneficiaries received CCM in a year.⁵

APCM is CMS's attempt to close that gap by removing the administrative barriers that kept practices out. This paper reviews what the clinical evidence actually shows — including where it is mixed and where it is silent — so that physicians can judge the model on its merits.

01 The gap between visits

Chronic disease is the core business of Medicare. In CMS's most recent comprehensive chartbook, about two-thirds of Medicare fee-for-service beneficiaries had two or more chronic conditions, and the sickest 14 percent — those with six or more — accounted for 46 percent of program spending.¹ Yet the delivery system built around this population still runs almost entirely on episodic office visits. A patient with heart failure, diabetes, and hypertension may see her primary care physician for a handful of visits

a year, totaling perhaps an hour of contact — and spend the other 8,700 hours managing three conditions on her own.

The cost of what happens in those unobserved hours is visible in the utilization data. In 2020, Medicare patients were readmitted within 30 days at a rate of 17 per 100 admissions, at an average cost of \$18,100 per readmission.² Much of the deterioration behind those numbers — missed medications, unrecognized symptom changes, failed follow-up after discharge — is exactly the kind of problem that surfaces in a routine check-in conversation, if anyone is having one.

≈2 in 3 Medicare beneficiaries have two or more chronic conditions. The 14% with six or more drive 46% of program spending.

02 What Medicare found when it paid for between-visit care

In 2015, Medicare began paying for CCM: structured, non-face-to-face care management for beneficiaries with two or more chronic conditions. CMS commissioned Mathematica Policy Research to evaluate the program's first two years using claims from more than 270,000 CCM recipients matched against comparison beneficiaries.³

The headline finding: CCM was associated with progressively slower growth in total Medicare spending — no significant difference at 6 months, **\$28 per beneficiary per month lower at 12 months, and \$74 per beneficiary per month lower at 18 months**, the figure behind the widely cited estimate of roughly \$888 per patient per year.³⁴ The savings came from the places clinicians would predict: reduced spending on inpatient hospital care, skilled nursing facilities, and outpatient and emergency department services. The evaluation also found a tenfold difference in advance care planning (10 percent of CCM recipients versus about 1 percent of comparable beneficiaries), with the largest expenditure reductions among patients near the end of life — a signal that between-visit conversations change more than utilization curves.³

Two honest caveats. The design was a matched difference-in-differences comparison, not a randomized trial, so the correct phrasing is "associated with," not "caused." And the effect took time to appear — a program evaluated at six months would have looked like a failure. Between-visit care is a compounding intervention, not an acute one.

CMS's commissioned evaluation: CCM was associated with \$74 per patient per month in slower Medicare spending growth at 18 months — driven by fewer hospital, SNF, and ED services.

03 The transitions evidence

The single most dangerous between-visit window is the weeks after a hospital discharge. Here the evidence for structured follow-up — Medicare's Transitional Care Management (TCM) benefit, whose functions APCM folds into its monthly service — is unusually consistent across independent analyses.

A JAMA Internal Medicine study of 18.8 million Medicare discharges found that beneficiaries who received TCM had about 10 percent lower adjusted costs in the following month than those who did not.⁶ A more rigorous federal replication by NORC for the HHS Office of the Assistant Secretary for Planning and Evaluation, using 8.4 million episodes from 2018–2019, found TCM associated with a 5.6 percent relative reduction in rehospitalization, \$236 (7.8 percent) lower spending per episode, and more healthy days at home.⁷ A 2025 Health Affairs analysis confirmed the pattern — and found the effects were larger for patients attributed to accountable care organizations.⁸ Among dual-eligible beneficiaries, one of Medicare's most vulnerable populations, TCM receipt was associated with a **13 percent relative reduction in 30-day readmissions and a 9 percent reduction in emergency department visits.**⁹

One discipline note: an early study also reported lower mortality with TCM, but the federal replication did not confirm a mortality benefit.^{6,7} The defensible claim is about readmissions, spending, and days at home — and that claim has now been replicated three times.

04 The active ingredients: frequency and support

Condition-level research explains why monthly contact matters — and what has to travel with it.

Diabetes. A meta-analysis of 41 randomized trials covering 7,013 patients found that chronic disease management programs reduced A1c by about half a point on average. The more striking finding was the dose-response: programs with **high-frequency patient contact showed nearly double the effect** of low-frequency programs, and programs whose care managers could act on medications outperformed those that could not.¹⁰ Contact frequency is not a convenience feature; in the trial data, it is the active ingredient.

Hypertension. An individual-patient-data meta-analysis of 25 randomized trials (10,487 patients) found that blood pressure self-monitoring **alone** produced essentially no benefit — about 1 mmHg — while self-monitoring **paired with individualized support** lowered systolic pressure by 6.1 mmHg at twelve months.¹¹ Devices and portals do not manage blood pressure. The support layer wrapped around them does.

Heart failure. A Cochrane review of 41 trials found structured telephone support was associated with a 15 percent reduction in heart-failure hospitalizations and a 13 percent reduction in all-cause mortality, with telemonitoring showing stronger effects still.¹²

Depression. Chronic physical disease rarely travels alone. In the landmark IMPACT trial of collaborative care for depression in 1,801 older primary care patients, systematic between-visit follow-up roughly **doubled the treatment response rate (45 percent versus 19 percent)** — and a four-year cost analysis found net savings of about \$3,363 per patient.¹³ This evidence is newly relevant: in 2026, CMS added behavioral health integration add-on codes to APCM, funding exactly this kind of systematic follow-up alongside medical care management.²⁰

The evidence is not uniform across conditions, and it is worth saying so. In COPD, results are genuinely mixed — one well-run trial of a simple education-plus-monthly-call program reduced COPD-related hospitalizations and ED visits substantially, but another comprehensive care-management trial was stopped early for excess mortality, and a third was retracted and republished after its claimed benefit reversed on reanalysis. Responsible programs treat COPD patients within a physician-supervised escalation framework rather than promising condition-specific results. In chronic kidney disease, the care-management literature is similarly thin. A credible between-visit program should claim what the evidence supports — no more.

05 What separates programs that work from programs that don't

The strongest cautionary evidence in this field is also its most useful design document. Medicare's Coordinated Care Demonstration randomized more than 18,000 beneficiaries across 15 different care-coordination programs in the early 2000s. The aggregate result was sobering: most programs did not reduce hospitalizations, and none generated net savings after fees.¹⁴

But the follow-up analysis of the demonstration is where the lesson lives. The programs that **did** cut hospitalizations — by 8 to 33 percent among higher-risk enrollees — shared a specific anatomy: frequent contact with patients, rigorous medication management, teaching patients self-management skills, a strong transitional-care component after hospital discharge, and — critically — care coordinators who functioned as a communications hub with the treating physicians rather than as a detached call center.¹⁵

That anatomy is the design brief for modern between-visit care, and it is the standard against which any APCM program — including ours — should be judged: monthly contact at minimum, medication review built into every check-in, structured post-discharge follow-up, and a closed escalation loop that puts findings in front of the patient's own physician, in the practice's own workflow.

In Medicare's 15-program randomized demonstration, detached, low-touch telephone coordination failed. The programs that cut hospitalizations 8–33% shared frequent contact, medication management, transition support, and a tight link to the treating physician.

06 Continuity: the quiet compounder

One more line of evidence deserves attention because it favors precisely the practices APCM was designed for. In an analysis of 1.45 million Medicare beneficiaries, patients whose care showed the highest continuity with their primary care physician had **14.1 percent lower total Medicare spending and 16.1 percent lower odds of hospitalization** than those with the lowest continuity.¹⁶ A systematic review found that in 9 of 12 studies examining the question, higher continuity was associated with lower all-cause mortality.¹⁷

Between-visit care management, done correctly, is continuity infrastructure: it keeps the patient's relationship anchored to their own physician rather than to whichever urgent care or emergency department is open. That is a clinical argument, and — as Paper 2 in this series details — an economic one for the practice.

07 APCM: scaling what worked

This is the context in which to read APCM. CMS folded the functions of CCM, principal care management, and communication-technology services into a single monthly payment, stratified by patient complexity, with no minute-counting — explicitly to remove the administrative burden that held CCM participation to a small fraction of the eligible population.⁵¹⁸¹⁹ (Paper 3 in this series examines that redesign in detail.)

A transparency note that we believe belongs in any honest treatment of this subject: **APCM is new, and no APCM-specific outcome data has yet been published.** Medicare claims data lags roughly two years; the first rigorous analyses of the program's 2025 launch cohort are expected in late 2026 and 2027. The clinical case for APCM today rests on the CCM, TCM, and care-management evidence reviewed above — the same evidence CMS cites as the program's foundation. We will update this series as first-party APCM data emerges.

A note on reading this evidence

Most of the Medicare-scale studies cited here are observational analyses with matched comparisons, not randomized trials; patients who receive care management may differ from those who do not in ways statistical adjustment cannot fully capture. Where randomized evidence exists — the condition-level meta-analyses, the IMPACT trial, the Coordinated Care Demonstration — we have said so. Throughout, we use "associated with" deliberately. The consistent direction of the evidence across designs, populations, and decades is what makes the case; no single study does.

About Alli Health

Alli Health provides turnkey APCM for independent primary care practices. Alli's care team conducts structured monthly check-ins with Medicare patients between visits — by phone, text, or email — reviews medications, screens for the warning signs the evidence says matter, and routes every escalation back to the patient's own physician through the practice's existing workflow. Practices add a new Medicare revenue line and the between-visit layer their patients need, with no new staff and no operational change. **Better care between visits. New revenue for your practice.** Learn more at allihealth.ai or write to hello@allihealth.ai.

REFERENCES

1. Centers for Medicare & Medicaid Services. Chronic Conditions Among Medicare Beneficiaries, Chartbook (2012 edition; 2010 claims data). <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/chronic-conditions/downloads/2012chartbook.pdf>
2. Jiang HJ, Barrett ML. Overview of Hospital Readmissions, 2020. HCUP Statistical Brief #307. Agency for Healthcare Research and Quality; April 2024. <https://hcup-us.ahrq.gov/reports/statbriefs/sb307-readmissions-2020.jsp>
3. Schurrer J, O'Malley A, Wilson C, McCall N, Jain N. Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report. Mathematica Policy Research for CMS; November 2017. <https://www.cms.gov/priorities/innovation/files/reports/chronic-care-mngmt-finalevalrpt.pdf>
4. Galewitz P, Hacker A. Medicare's Push To Improve Chronic Care Attracts Businesses, but Not Many Doctors. KFF Health News; April 2024. <https://kffhealthnews.org/aging/medicare-chronic-care-management-monitoring-business/>
5. Colligan E, et al. Utilization of Chronic Care Management and Transitional Care Management Services: A Descriptive Analysis (2019 Medicare claims). Office of the Assistant Secretary for Planning and Evaluation (ASPE), HHS; March 2022. <https://aspe.hhs.gov/sites/default/files/documents/31b7d0eeb7decf52f95d569ada0733b4/CCM-TCM-Descriptive-Analysis.pdf>
6. Bindman AB, Cox DF. Changes in Health Care Costs and Mortality Associated With Transitional Care Management Services After a Discharge Among Medicare Beneficiaries. *JAMA Internal Medicine*. 2018;178(9):1165–1171. <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2687989>
7. NORC at the University of Chicago. Impact of Transitional Care Management: Findings (2018–2019 Medicare claims). Prepared for ASPE/PTAC; June 2023. <https://aspe.hhs.gov/sites/default/files/documents/7efe5a4755b8c3aee4779a9371ab021b/PTAC-Jun-12-TCM-Findings.pdf>
8. Hughes A, Hu M, Soo J, et al. Transitional Care Management Associated With More Healthy Days at Home, Lower Spending After Hospital Discharge. *Health Affairs*. 2025;44(6). <https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.01287>
9. Akiyama J, Batsis JA, et al. Transitional Care Management and Readmissions Among Dual-Eligible Medicare Beneficiaries. *Journal of General Internal Medicine*. 2025–2026. <https://link.springer.com/article/10.1007/s11606-025-09969-7>
10. Pimouguet C, Le Goff M, Thiébaud R, Dartigues JF, Helmer C. Effectiveness of disease-management programs for improving diabetes care: a meta-analysis. *CMAJ*. 2011;183(2):E115–E127. <https://www.cmaj.ca/content/183/2/E115>
11. Tucker KL, Sheppard JP, Stevens R, et al. Self-monitoring of blood pressure in hypertension: A systematic review and individual patient data meta-analysis. *PLOS Medicine*. 2017;14(9):e1002389. <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002389>
12. Inglis SC, Clark RA, Dierckx R, Prieto-Merino D, Cleland JGF. Structured telephone support or non-invasive telemonitoring for patients with heart failure. *Cochrane Database of Systematic Reviews*. 2015;(10):CD007228. <https://www.cochrane.org/CD007228>
13. Unützer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting (IMPACT). *JAMA*. 2002;288(22):2836–2845; and Unützer J, et al. Long-term cost effects of collaborative care for late-life depression. *American Journal of Managed Care*. 2008;14(2):95–100. <https://jamanetwork.com/journals/jama/fullarticle/195599> · <https://www.ajmc.com/view/feb08-2835p095-100>
14. Peikes D, Chen A, Schore J, Brown R. Effects of care coordination on hospitalization, quality of care, and health care expenditures among Medicare beneficiaries: 15 randomized trials. *JAMA*. 2009;301(6):603–618. <https://jamanetwork.com/journals/jama/fullarticle/183370>

15. **15.** Brown RS, Peikes D, Peterson G, Schore J, Razafindrakoto CM. Six features of Medicare Coordinated Care Demonstration programs that cut hospital admissions of high-risk patients. *Health Affairs*. 2012;31(6):1156–1166. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.0393>
16. **16.** Bazemore A, Petterson S, Peterson LE, Bruno R, Chung Y, Phillips RL. Higher primary care physician continuity is associated with lower costs and hospitalizations. *Annals of Family Medicine*. 2018;16(6):492–497. <https://www.annfammed.org/content/16/6/492>
17. **17.** Baker R, Freeman GK, Haggerty JL, Bankart MJ, Nockels KH. Primary medical care continuity and patient mortality: a systematic review. *British Journal of General Practice*. 2020;70(698):e600–e611. <https://bjgp.org/content/70/698/e600>
18. **18.** Centers for Medicare & Medicaid Services. Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule — fact sheet. November 2024. <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule>
19. **19.** Centers for Medicare & Medicaid Services. Advanced Primary Care Management Services. <https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services>
20. **20.** Centers for Medicare & Medicaid Services. Medicare Physician Fee Schedule Final Rule Summary: CY 2026 (MLN MM14315). <https://www.cms.gov/files/document/mm14315-medicare-physician-fee-schedule-final-rule-summary-cy-2026.pdf>

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