APCM and the ACO: Built to Work Together

How between-visit care management compounds value-based care performance

FOR ACO-PARTICIPATING PRACTICES, ACO ADMINISTRATORS, MSOS, AND IPAS · JULY 2026

Executive summary

Practices in accountable care organizations sometimes hesitate before adding a new fee-for-service program, and reasonably so: in a total-cost-of-care model, new billing is not automatically good news. Advanced Primary Care Management (APCM) is the exception that CMS designed on purpose. **ACO participation automatically satisfies APCM's performance-measurement requirement** — CMS's rules state that practitioners in a Shared Savings Program ACO, REACH ACO, Primary Care First, or Making Care Primary may meet the requirement "by virtue of" their participation.[1] **APCM billing counts as a primary care service for MSSP beneficiary attribution**, reinforcing the practice's claim to its own attributed lives.[3] And the clinical activity APCM funds — monthly contact, medication follow-up, transitions management — maps directly onto the quality measures and utilization results ACOs are scored on.

The evidence and the economics point the same direction. CMS's evaluation of Chronic Care Management, the program APCM scales, associated it with $74 per beneficiary per month in slower total-cost growth at 18 months — accruing to exactly the benchmark an ACO is measured against.[9] And in the most recent Shared Savings Program results, the ACOs that look most like APCM's natural adopters — physician-led, primary-care-dominant, low-revenue — generated **$403 in net per capita savings, roughly 1.8 times** their hospital-centric counterparts.[11] This paper walks through the regulatory mechanics, the measure map, the economics, and — because credibility requires it — the entries on the other side of the ledger.

01 Where CMS is taking primary care payment

APCM is best understood as a waypoint on a path CMS has described publicly for years. The agency has set a goal of having all Traditional Medicare beneficiaries in accountable care relationships by 2030, and has called advanced primary care "a core mechanism" for getting there.[5] In the rule that created APCM, CMS described the new codes as "a step towards paying for primary care services with hybrid payments" — a mix of encounter-based and population-based payment — and opened a formal request for information on that hybrid future.[16] By the CY2026 cycle, CMS was soliciting comment on going further still: bundling preventive services into APCM and **paying ACOs capitated amounts for APCM services**.[7]

In other words: APCM is not a side program that happens to coexist with accountable care. It is the fee-for-service on-ramp CMS built toward the payment model ACOs already operate under. Practices that stand up APCM capabilities now are building the exact machinery — monthly population contact, risk stratification, documented care management — that the next stage of primary care payment assumes.

02 The regulatory handshake

Two provisions make the APCM–ACO fit explicit rather than incidental.

ACO participation satisfies the hardest APCM requirement. APCM's thirteenth service element requires the billing practitioner to be assessed on performance. For practices outside value-based arrangements, that means registering for the Value in Primary Care MIPS Value Pathway. For ACO participants, CMS resolved it cleanly: membership in an MSSP ACO, REACH ACO, Primary Care First, or Making Care Primary satisfies the requirement outright.[12] An ACO practice can adopt APCM with one less obligation than its non-ACO peers — a deliberate nudge, as CMS put it, expected to "help grow participation in the Shared Savings Program."[3]

APCM protects attribution. Beginning with performance year 2025, CMS added APCM codes to the definition of primary care services used for MSSP beneficiary assignment; the 2026 rule extended the same treatment to APCM's new behavioral-health add-on codes.[34] Assignment runs on the plurality of primary care allowed charges, so every APCM month billed adds weight to the billing practice's claim on that patient. For an independent practice competing for attribution against hospital outpatient departments and consolidating groups, twelve additional primary care claims per patient per year is not a rounding error — it is a structural reinforcement of the panel the practice's shared savings are computed on. A patient receiving monthly contact from their own practice is also, practically speaking, less likely to drift to other providers in ways that fragment care and reassign attribution.

> **ACO participation satisfies APCM's performance-measurement requirement outright — and every APCM claim adds primary-care billing weight that anchors the beneficiary's attribution to your practice.**

03 The quality-measure map

MSSP ACOs are phasing into the APP Plus measure set. Between-visit care management touches most of it. The table below states the mechanism honestly — where randomized or program-level evidence supports the link, it is cited; where the connection is workflow logic, it is labeled as such.

APP Plus measures and the between-visit mechanism

Program-level data reinforce the pattern: MSSP ACOs collectively improved on blood pressure control and glycemic control measures in the most recent performance year and outperformed comparable non-ACO physician groups on depression screening (53.5 versus 44.4 percent) and blood pressure control (71.2 versus 67.8 percent).[11] That is improvement evidence, not causal attribution to care management specifically — but the direction of every arrow is the same.

04 The economics: a stack, not a trade-off

For an ACO-participating practice, APCM revenue arrives on top of — not instead of — the value-based upside. The components stack. **Fee-for-service revenue:** roughly $16, $54, or $117 per patient per month at the three APCM tiers (2026 national averages), plus behavioral-health add-ons of roughly $57 to $162 where clinically indicated.[24] Two hundred enrolled Level 2 patients is on the order of $130,000 a year. **Shared savings:** in performance year 2024, three-quarters of MSSP ACOs earned performance payments totaling $4.1 billion.[11] **A better conversion factor:** qualifying APM participants received a 3.77 percent payment update for 2026 versus 3.26 percent for everyone else — a small structural bonus on every APCM dollar an ACO practice bills.[8]

The distribution of ACO results should embolden exactly the practices reading this paper. In PY2024, **low-revenue ACOs — predominantly physician-led — generated $319 in net per capita savings versus $180 for high-revenue ACOs, and**

primary-care-dominant ACOs generated $403 versus $224 for those with fewer primary care clinicians.[11] MedPAC's independent analysis reached the same conclusion years earlier: physician-only ACOs outperform hospital-affiliated ones.[12] The savings engine of accountable care is primary care doing more primary care — which is precisely the activity APCM pays for.

> **PY2024 MSSP: primary-care-dominant ACOs generated $403 net per capita savings — 1.8x their hospital-centric counterparts. The savings engine of accountable care is primary care doing more primary care.**

05 The evidence the offset case rests on

An ACO's rational concern about any new fee-for-service program is that its cost lands inside total cost of care. So it matters that the care-management evidence is a total-cost story, not a gross-revenue story. CMS's commissioned evaluation of CCM found the program associated with $28 per beneficiary per month in slower spending growth at 12 months and **$74 at 18 months** — net movement in exactly the number an ACO defends, driven by reduced inpatient, skilled nursing, and outpatient/ED spending.[9] The transitions evidence points the same way: federal analyses associate timely post-discharge management with 5.6 to 13 percent relative reductions in readmissions and about 8 percent lower episode spending — and a 2025 Health Affairs study found the healthy-days and spending effects were **larger for patients in ACOs and other population-based payment models**.[10] A monthly APCM fee measured in tens of dollars sits against a Medicare readmission that averages $18,100.[16]

The honest framing for an ACO board: APCM is a funded mechanism for the utilization work the ACO already needs done — with the cost of the mechanism visible in the benchmark and the offsetting utilization evidence documented at Medicare scale over a decade.

06 The honest ledger

Three entries belong on the other side, and sophisticated ACO audiences will respect a vendor that states them. **First, APCM spending counts.** APCM payments are Part B expenditures inside the ACO's performance-year total; no CMS provision excludes them, and ACO trade groups are actively seeking clarity on benchmark treatment. In the short run, APCM billing raises measured spend; the offset case is the utilization evidence above, which accrues over 12 to 18 months — ACOs should model both timelines.[7] **Second, beneficiary cost sharing persists.** G0556 and G0557 carry standard Part B coinsurance; CMS considered but declined to finalize a cost-sharing waiver for 2026, so patient consent conversations include a small monthly copay for non-QMB patients.[17] **Third, billing exclusivity applies.** Only one practitioner may bill APCM per patient per month, and it cannot be billed in the same month as CCM, PCM, or TCM — ACOs with existing care-management vendors need a coordinated transition, not parallel programs.[2]

07 Sidebar: the same workflows, Medicare Advantage Stars

APCM itself is a Traditional Medicare benefit — G0556 is not billed to Medicare Advantage plans. But the workflows it funds transfer directly to a practice's MA panel, where the 2026 Star Ratings weight the same clinical territory: blood pressure control, glycemic status, plan all-cause readmissions, and three triple-weighted medication-adherence measures. Published analysis finds plans achieving 5 stars on adherence measures were 3.5 to 4.7 times more likely to achieve 5 stars on the paired control measures.[18] A practice that builds monthly between-visit contact for its Traditional Medicare patients acquires, as a byproduct, the operating muscle its MA contracts increasingly pay for.

08 The early-mover logic

CMS has signaled where this goes: RFIs on hybrid primary care payment, on bundling preventive services into APCM, and on capitating APCM payments to ACOs.[67] Each step rewards organizations that already run population-scale between-visit operations — enrolled panels, monthly contact rates, documented care plans, transition workflows, and clean data. Practices and ACOs that build that machinery under today's fee-for-service APCM will meet tomorrow's hybrid payment as incumbents. Those that wait will be standing up operations under deadline pressure, inside payment models that assume the operations already exist.

One transparency note, consistent with the rest of this series: APCM launched in January 2025, and no APCM-specific outcome or utilization data has yet been published. The regulatory facts cited here are current through the CY2026 final rule; the outcome evidence is the CCM, TCM, and care-management record on which CMS built the program. We will update this paper as first-year APCM data emerges.

About Alli Health

Alli Health provides turnkey APCM for independent primary care practices, including practices in ACOs, MSOs, and IPAs. Alli's care team conducts structured monthly check-ins with Medicare patients by phone, text, or email, manages post-discharge follow-up, maintains care-plan records, and routes every escalation to the patient's own physician through the practice's existing workflow — generating the documentation, contact cadence, and billing-ready monthly file that both APCM and ACO reporting reward. No new staff, no operational change, a flat per-patient fee. **Better care between visits. New revenue for your practice.** Learn more at allihealth.ai or write to hello@allihealth.ai.

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