The End of Minute-Counting

Why chronic care management stalled at 4 percent — and how APCM changes the math for independent practices

FOR PRACTICE OWNERS, ADMINISTRATORS, AND BILLING MANAGERS · JULY 2026

Executive summary

For a decade, Medicare has offered primary care practices recurring monthly revenue for managing chronic conditions between visits. Almost no one has taken it. By the government's own count, **only 4.0 percent of eligible Medicare beneficiaries received Chronic Care Management (CCM) services, and only 5.2 percent of practices billed for them**.[1] The reason was never the clinical idea — CMS's own evaluation associated CCM with meaningful reductions in hospital and emergency department use.[5] The reason was operational: minute-by-minute time logging, duplicative documentation, consent friction, and a staffing model that required a practice to enroll roughly 131 patients just to break even on one full-time nurse care manager.[9]

In January 2025, CMS replaced that model. Advanced Primary Care Management (APCM) pays one monthly code per patient, tiered by complexity rather than by minutes — a redesign CMS says was made explicitly "to reduce the administrative burden associated with current coding and billing."[12] Just as importantly, Medicare's longstanding rules allow the underlying work to be performed by auxiliary personnel under general supervision — the regulatory basis on which a practice can hand the operational load to a dedicated partner while keeping clinical ownership of its patients.[13][16]

This paper lays out the burden problem in the data, what APCM actually removes, what it does not, and the build-versus-partner arithmetic for an independent practice.

01 A good idea practices couldn't operationalize

Start with the number that defines the market. In its analysis of 100 percent of 2019 Medicare fee-for-service claims, the HHS Office of the Assistant Secretary for Planning and Evaluation found 22.6 million beneficiaries potentially eligible for CCM — and 882,728, or 4.0 percent, who actually received it. Practice participation was thinner still: 5.2 percent of practices with eligible patients billed any CCM, against 45.6 percent billing transitional care after discharges.[1] Independent analyses of claims through

2023 found the picture essentially unchanged: roughly 1.3 million recipients against a 20-million-plus eligible population.[23]

The pattern was set early. In the program's first two years, the median billing provider managed only about ten CCM patients a month, and roughly one in five enrolled beneficiaries received just a single month of service before the effort lapsed.[5] A decade in, the 4 percent figure has become a policy talking point: the bipartisan Chronic Care Management Improvement Act, introduced in April 2026 with backing from the AMA, MGMA, AHA, and AARP, cites it directly in arguing for reform.[4]

> **22.6 million eligible beneficiaries. 882,728 served. A 96% gap — sustained for a decade — is not a demand problem. It is an operations problem.**

02 The anatomy of the burden

Why did practices walk away from recurring revenue? Researchers asked them. In a peer-reviewed qualitative study spanning 50 practices, the answers were consistent: "copious documentation" requirements, duplicate data entry between the EHR and separate care-management tracking, consent conversations complicated by the patient's monthly copay, and the financial strain of hiring dedicated staff before revenue arrived. One practitioner's summary became the epigraph for the whole program: **"it takes 20 minutes to simply do the work around the work."**[6]

The mechanics bear that out. Billing CCM's base code required logging at least 20 minutes of qualifying clinical staff time per patient per month — with separate add-on codes at additional 20- and 30-minute thresholds, practitioner-time variants, and a complex-CCM tier at 60 minutes — on top of documented consent, a qualifying electronic care plan, and 24/7 access requirements.[7] Every billed month was an auditable assertion about minutes. Even practices that did the clinical work often could not sustain the accounting for it: one claims analysis found that only 77 percent of 2023 CCM claims had the required two-plus chronic conditions properly documented.[2]

03 The staffing math that never penciled

Underneath the paperwork sat a harder constraint: fixed staffing cost against uncertain enrollment. A microsimulation published in Annals of Internal Medicine found that a practice needed roughly **131 enrolled CCM patients to cover the salary and overhead of one full-time registered nurse care manager** — and that if physicians tried to do the between-visit work themselves, about a quarter of practices would lose money on the opportunity cost of displaced visits.[9] That was at 2015 wages. The median registered nurse now earns $93,600 a year before benefits and overhead.[10]

For a large system amortizing care managers across tens of thousands of patients, that math can work. For an independent practice with a few hundred eligible Medicare patients — where enrollment ramps gradually and every hire is a six-figure commitment made in advance of revenue — it rarely did. This, more than any clinical doubt, is why CCM became a program of large groups and specialized vendors rather than of the independent practices whose patients needed it most.

04 The context: primary care is out of hours

The burden question lands on a workforce that has no slack to absorb it. In the AMA-funded time-and-motion study of ambulatory physicians, doctors spent 49.2 percent of their office day on EHR and desk work versus 27.0 percent in direct clinical face time — nearly two hours of administration for every hour with patients — plus one to two additional hours of after-hours EHR work nightly.[8] A University of Chicago simulation put the structural problem in one number: a primary care physician following all guideline-recommended care for an average panel would need **26.7 hours per day** — falling to 9.3 hours only with substantial team-based delegation.[11]

The consequences show up in every survey. Forty-five percent of family physicians report at least one symptom of burnout.[17] Practice leaders rank staffing as their single biggest challenge.[18] And the independent model itself is eroding: the share of physicians in private practice fell from 60.1 percent in 2012 to 42.2 percent in 2024, with 63.6 percent of those who sold citing the need to "better manage payers' regulatory and administrative requirements" as a major reason.[19] Any program that asks an independent practice for new headcount and new workflow is, in this environment, asking for the one thing it does not have.

> **A PCP delivering all recommended care to an average panel would need 26.7 hours per day. Between-visit chronic care only happens if someone else's hours do the work.**

05 APCM's redesign, in CMS's own words

This is the problem CMS set out to solve in the CY2025 Physician Fee Schedule. APCM consolidates the functions of CCM, principal care management, and communication-technology services into a single monthly code per patient — G0556, G0557, or G0558 — tiered by patient complexity rather than by staff minutes. There are **no time thresholds to meet or log**. CMS's stated purpose: to "reduce the administrative burden associated with current coding and billing," with services furnished as clinically applicable rather than against a monthly minute quota.[12][13] The AAFP's summary was direct: CMS "has removed many of the restrictive elements of the existing services, such as meeting a time threshold to report a service."[14]

APCM billing structure (national average payment; 2026 figures are approximate — confirm against the CMS PFS lookup tool for your locality)

The program is expanding, not retrenching. In the CY2026 final rule, CMS added behavioral health integration add-on codes (G0568, G0569, G0570) billable in the same month as the APCM base code — again without the minute-counting of the legacy behavioral health codes they mirror — and extended APCM to rural health clinics and FQHCs.[15] For a typical independent panel, the arithmetic is straightforward: 200 enrolled patients at the Level 2 rate is on the order of $130,000 a year in new recurring revenue — from work the practice was never staffed to capture under CCM.

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06 What still has to happen every month

APCM did not eliminate the work; it eliminated the accounting of the work. To bill APCM, a practice must be capable of furnishing thirteen service elements, including patient consent, an initiating visit for new patients, 24/7 access for urgent needs, comprehensive care management with medication reconciliation, an electronic patient-centered care plan, management of care transitions with timely post-discharge follow-up, care coordination across settings, enhanced communication channels, population-level management, risk stratification, and performance measurement.[13] These are real operational capabilities, and a practice that signs up for APCM without a plan for them has simply traded a documentation problem for a delivery problem.

Here the regulatory design matters. CMS classifies APCM as a care management service, which means auxiliary personnel may furnish it "incident to" the billing practitioner's services under **general supervision** — the supervising physician need not be on-site while the work is performed.[1316] This is the same longstanding framework under which care-management services have been delivered by clinical staff and outside teams for a decade. Practically, it means the recurring monthly load — outreach, structured check-ins, care-plan maintenance, post-discharge contact, population tracking, and the billing file — can be carried by a dedicated partner operating under the practice's direction, while the physician remains what CMS requires: the continuing focal point for the patient's care, clinically responsible and in the loop on every escalation.

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07 The build-versus-partner arithmetic

An independent practice weighing APCM has three options. **Ignore it**, and leave both the revenue and the between-visit care gap on the table — while better-resourced competitors and consolidators capture both. **Build it**, and accept the CCM-era math: a six-figure fixed hire against gradual enrollment, with the Annals breakeven analysis suggesting a triple-digit patient count just to reach neutral, plus the ongoing management of consent, care plans, 24/7 coverage, and audit-ready records.[910] Or **partner**,

converting the fixed staffing cost into a variable per-patient cost that scales exactly with enrolled — and billable — patients from the first month.

The right answer depends on panel size and appetite for operational risk, and for very large panels an in-house program can make sense. But the decade of CCM experience is a controlled experiment in what happens when the operational load stays on the practice: 96 percent of the opportunity goes unclaimed.[1] The redesign of the billing code fixed the accounting burden. The delivery burden still has to land somewhere.

08 What to watch, honestly stated

Three caveats belong in any credible discussion. First, patient cost sharing survives: G0556 and G0557 carry standard Part B coinsurance of roughly 20 percent, and while CMS solicited comment on waiving APCM cost sharing, it declined to finalize a waiver for 2026 — so the consent conversation still includes a small monthly copay for non-QMB patients, a known source of friction from the CCM era.[620] (Congress is actively considering eliminating cost sharing for chronic care services.[4]) Second, APCM's first-year federal utilization data has not yet been published; adoption claims from any vendor, ours included, should be read accordingly. Third, only one practitioner may bill APCM per patient per month, and it cannot be billed alongside CCM, PCM, or TCM in the same month — practices with existing programs need a transition plan, not a bolt-on.[1314]

About Alli Health

Alli Health provides turnkey APCM for independent primary care practices. Alli's care team handles enrollment consent, conducts structured monthly check-ins with Medicare patients by phone, text, or email, maintains the care plan record, follows up after discharges, and delivers a compliant, billing-ready file at the end of each month — all under the practice's direction and within its existing workflow, with every escalation routed to the patient's own physician. No new hires, no new software to learn, no minute logs. A flat per-patient fee that scales only with enrolled patients. **Better care between visits. New revenue for your practice.** Learn more at allihealth.ai or write to hello@allihealth.ai.

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