



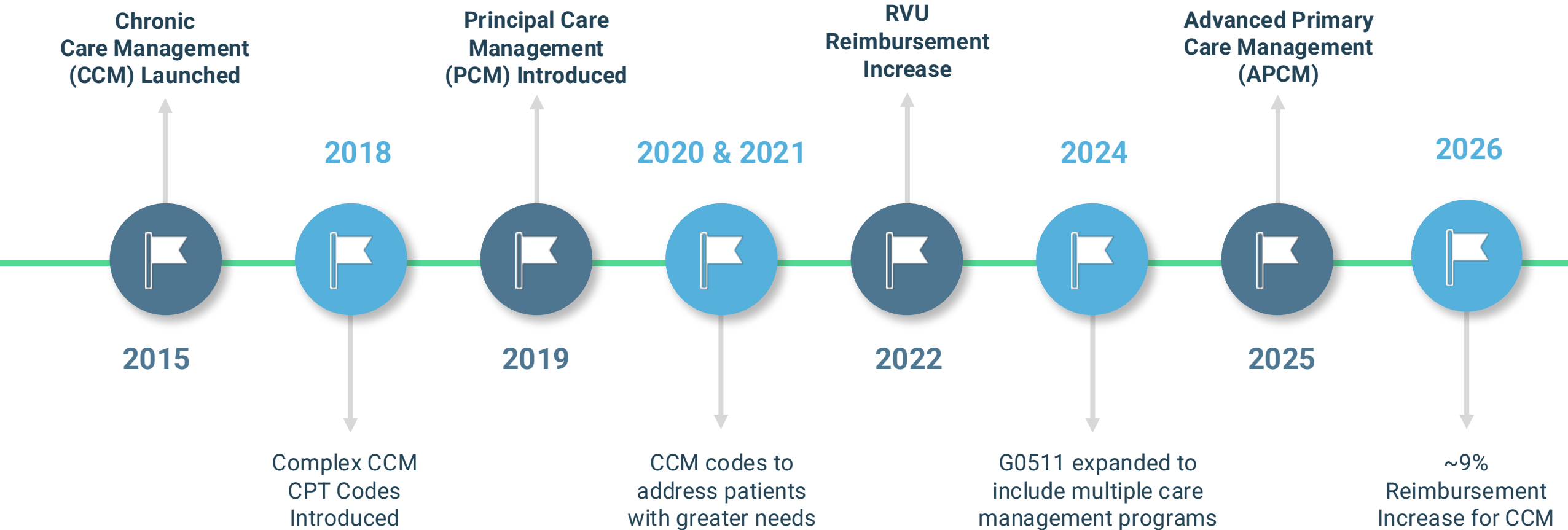
Thriving in the 2026 Care Management Landscape – Maximizing Revenue Through CCM & APCM



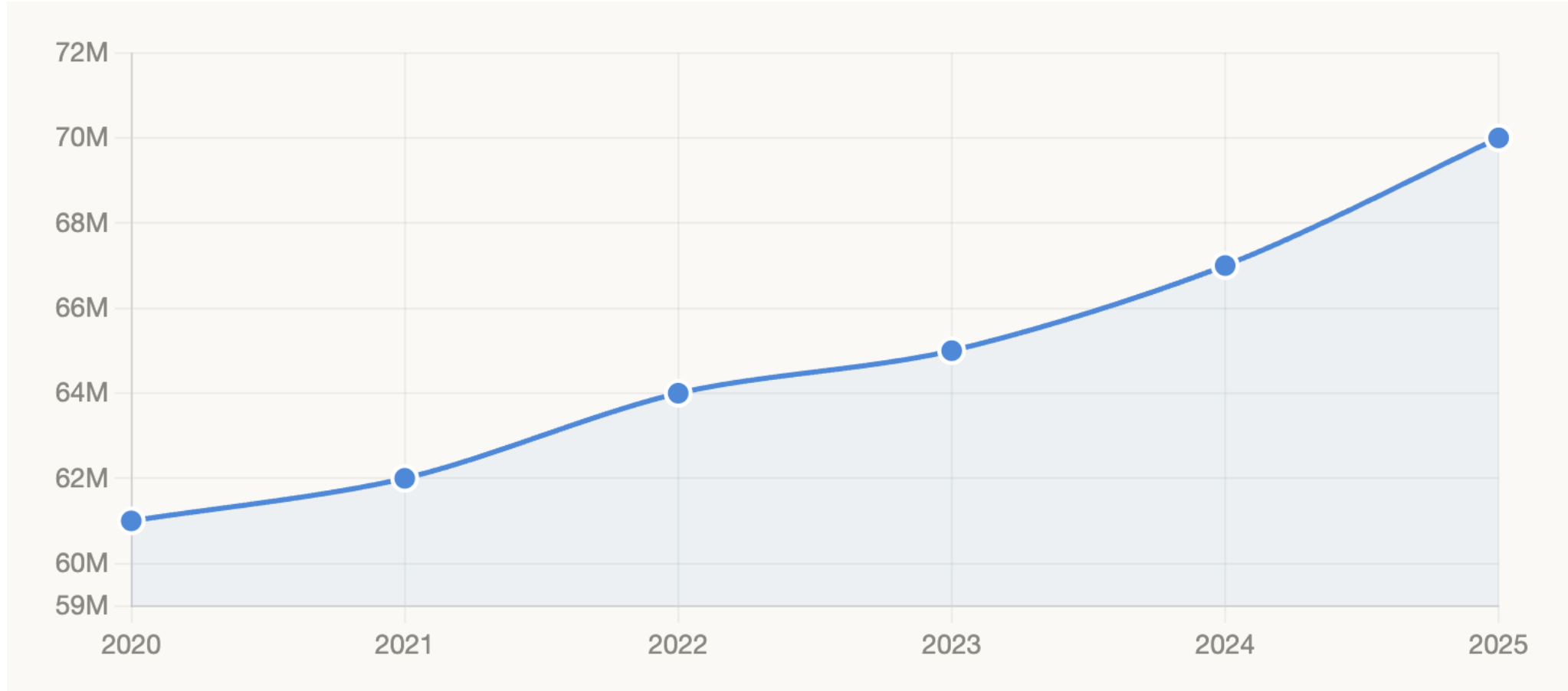
CARE MANAGEMENT KEY MILESTONES

RAPID CMS EXPANSION FOR MORE THAN A DECADE

Since 2013, CMS has evolved care management programs

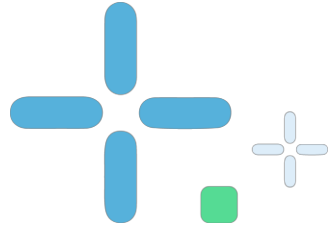


TOTAL MEDICARE BENEFICIARIES BY YEAR



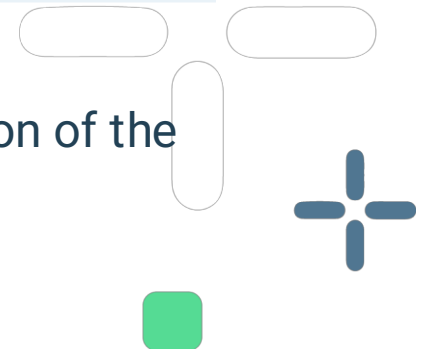
2026 ~1.2m Total Medicare Beneficiaries in Minnesota
 13% Dual Eligible ~ 156k

2026 MINNESOTA: CCM-99490 & 99439 (non QPs)



CPT Code	2025 National Average Payment	2026 National Average Payment	Approximate Increase
99490 (First 20 min)	~ \$59.78	~ \$65.37	+9.34%
99439 (Each Add'l 20 min)	~ \$45.58	~ \$50.00	+9.71%

Note: The percentage increase for 99439 is higher due to a combination of the CF increase and a minor, positive RVU adjustment for the code.



Search the Physician Fee Schedule

Data Updated: 03/10/2026

Use this search to view adjusted pricing amounts that reflect variations in pricing costs from area to area.

CHRONIC CARE MANAGEMENT

PREVENTATIVE CARE PROGRAM FOR MEDICARE PATIENTS



Patient must have **TWO** or more chronic conditions

Patient must have **24/7** access to care management

ADVANCED PRIMARY CARE MANAGEMENT

PREVENTATIVE CARE BASED ON ACUITY

Available for

ALL

Medicare beneficiaries



Focused on

COMPLEX

service capabilities



Patients stratified into

3 Levels based on ACUITY

CARE MANAGEMENT : DIFFERENTIATORS

CHOOSE THE PROGRAM THAT WORKS BEST FOR YOU

Standard Chronic Care Management (CCM) No Stratification

- 99490 & 99439
- 2 or more chronic conditions
- Seen in past 12 months
- \$65 pppm – national average
- 82% of Medicare cohort

Enhanced Advanced Primary Care Management (APCM) Stratification (and Re-Stratification)

Level One G0556	Level Two G0557	Level Three G0558
<ul style="list-style-type: none"> • 0-1 chronic conditions • Seen in past three years • \$16 pppm • 18% of Medicare cohort 	<ul style="list-style-type: none"> • 2 or more chronic conditions • Seen in past three years • \$53 pppm • 70% of Medicare cohort 	<ul style="list-style-type: none"> • QMB Patients - 2 or more chronic conditions • Seen in past three years • \$116 pppm • 12% of Medicare cohort

CARE MANAGEMENT: SERVICE REQUIREMENTS

HOW WILL APCM DIFFER FROM CCM?

Standard Chronic Care Management (CCM)

- Patient consent
- 24/7/365 access to clinical care
- Care coordination (**Time-based thresholds**)
- Management of comprehensive care plan

vs

Enhanced Advanced Primary Care Management (APCM)

- Patient consent
- 24/7/365 access to clinical care
- Comprehensive care management (**Performance-based**)
- Management of comprehensive care plan
- **Eligibility stratification, including QMB confirmation**
- **Hospital discharge management**
- **In-home & community-based resource referrals**
- **Two-way, digital communication capability**
- **Risk stratification and population health analytics utilizing clinical data**