MARYLAND
Health Care
Commission

Maryland Health Care Commission
LEARNING NETWORK

Using Advanced Primary Care Management Services and Designing Team-Based Models Tailored to Patient Demographics

An MHCC Learning Network Event

SEPTEMBER 19, 2025

CME Disclosure, Accreditation and Designation Statement

- **Accreditation Statement**

  This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint providership of MedChi, The Maryland State Medical Society (MedChi) and MHCC. MedChi is accredited by the ACCME to provide continuing medical education for physicians.

- **Designation Statement**

  MedChi designates this enduring activity for a maximum of 1 AMA PRA Category 1 Credits. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

- **Disclosure Statement**

  The planners and reviewers for this activity have reported no relevant financial relationships to disclose.

Learning Objectives

- Discuss use of Advanced Primary Care Management Services G0556, GO557, and GO558 to provide payment for the resources used to deliver comprehensive care to patients with chronic conditions
- Understand how primary care teams can be tailored to serve the diverse needs of specific populations; learn how team-based care promotes proactive, well-coordinated care delivery, and receive actionable tips for culturally sensitive care

AGENDA

I. **Gene Ransom**, CEO, *MedChi*

II. **Melanie Cavaliere**, *MHCC*

III. **Douglas Jacobs, MD, MPH, Executive Director,** *MHCC*

IV. **Ken Buczynski, MD, Founder,** *Wellspring Family Medicine*

V. **Joe Weidner, MD,** *Stone Run Family Medicine*

VI. Q&A

Gene Ransom

CEO

MedChi

Learning Network Events

- The MHCC convenes peer learning network events in collaboration with local and national health care leaders on topics such as health equity, advanced care delivery, and practice transformation
- More information on learning network events is available at: mhcc.maryland.gov/mhcc/Pages/apc/apc_icd/apc_icd_learning_networks.aspx

Advanced Care Delivery Events

- Prior events available on the **Learning Network** include:

IMPROVING ACCESS THROUGH A DIGITAL FRONT DOOR STRATEGY

June 2025

An IT expert and a practice manager discuss the importance of a digital front door to improve patient access, engagement, and experience; and the role of telehealth in increasing accessibility and convenience, reducing costs, and improving management of chronic conditions. They provide actionable tips for use of patient portals to facilitate convenient and secure access to health information, enhance patient-provider communication, and empower patients to participate fully in their care.

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OPTIMIZING THE ROLE OF PATIENT AND FAMILY ADVISORY COUNCILS (PFACs)

March 2025

Representatives from two physician practices and two subject matter experts discuss the role of Patient and Family Advisory Councils, overview their potential benefits, and highlight success stories and actionable strategies for effective implementation.

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New for 2025


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MARYLAND PRIMARY CARE PROGRAM
Beyond the Textbook: Real-World Medicine and Case Studies Webinars
Welcome to MHCC's Beyond the Textbook (BTT): Real-World Medicine and Case Studies Webinars. Innovative care delivery is focused on improving how care is coordinated, accessed, and delivered - especially for patients with complex, chronic, or serious health conditions. Shifting from traditional fee-service models may require providers to adjust payment structures, technology, workflows, staffing, ar organizational culture. The presentations that follow feature a distinguished group of health care professionals discussing key opportunities and challenges in innovative care delivery.

Douglas Jacobs, MD, MPH,

Executive Director

MHCC

Today's agenda

- Why were Advanced Primary Care Management (APCM) codes created?
- Describe Advanced Primary Care Management (APCM) Services
- Requirements to bill for the codes
- How the payments work
- Looking forward

Pre-2025

How do clinicians get paid for time spent doing care management, patient portal messaging?

- Chronic Care Management, Principal Care Management Codes
- Communication technology-based services (virtual check-ins)

- However, significant burden associated with time-based billing, barrier to clinician uptake

Advanced Primary Care Management Services

- Started in 2025
- Combines several existing elements of care management, communication-technology based services, into a single monthly payment
- **Not time-based**
- 3 levels, based on medical & social complexity
- Requirements to have practice-level capabilities indicative of advanced primary care
- Paid for by Medicare, but other payors may decide to adopt the codes

What are the codes? 3 levels

G0556

0-1 chronic Condition

$12 (facility)* per month

$15 (non-facility)* per month

G0557

2 or more chronic conditions

$36 (facility)* per month

$49 (non-facility)* per month

G0558

2 or more chronic conditions

Qualified Medicare Beneficiary (QMB): low-income Medicare beneficiary, **exempt from cost sharing**

$80 (facility)* per month

$107 (non-facility)* per month

* These are approximations in what Traditional Medicare pays, and the actual payment amount may vary depending on geographic distribution and annual updates made to RVUs

Billing requirements

- Patient consent
- Initiating visit for new patients (if hasn't been seen in last 3 years)
- 24/7 access and continuity of care
- Comprehensive care management
- Care plan
- Coordinate care transitions and across practitioners
- Enhanced communication opportunities (patient portal)
- Population-level management*
- Measure and report performance*

Notes:

* Satisfied if participating in an ACO

All requirements can be performed by "auxiliary personnel" under general supervision from the billing practitioner

All requirements do not need to be fulfilled every month, but are dependent on patient need

Who can bill?

- Physicians or non-physician practitioners (NPP), including a nurse practitioners (NP), physician assistant (PA), or clinical nurse specialist (CNS)
- You are responsible for all of your patient's primary care services
- You are the focal point for all needed health care services
- Primarily for primary care specialties, like general internal medicine, family medicine, geriatric medicine, or pediatrics

Looking forward

- CMS recently published the 2026 Physician Fee Schedule Rule
- Proposed add-ons to the APCM codes for Behavioral Health Integration (BHI) and the Collaborative Care Model (CoCM)
- Also not time-based
- Request for information about whether APCM should count as prevention in Medicare, and eliminating cost-sharing for APCM services
- Proposed efficiency adjustment for procedures, tests, and radiology services
- Finalized rule published before or on November 1st.

Discussion

Where can I get more information?

CMS.gov website on APCM:
https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services

2025 Physician Fee Schedule Final Rule:
https://www.federalregister.gov/documents/2024/12/09/2024-25382/medicare-and-medicaid-programs-cy-2025-payment-policies-under-the-physician-fee-schedule-and-other

2026 Physician Fee Schedule Proposed Rule:
https://www.federalregister.gov/documents/2025/07/16/2025-13271/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other

Ken Buczynski, MD

Founder

Wellspring Family Medicine

No One Is an Island

BUILDING TEAMS IN PRIMARY CARE,

LEVERAGING RESOURCES TO RAISE OUTCOMES

KEN R. BUCZYNSKI MD, WELLSPRING FAMILY MEDICINE

My Context

Founder, owner, physician of Wellspring Family Medicine since 2004

Currently 2 MDs, 4 PAs, 2 NPs, 1 PMHNP

Rural Garrett County, MD

- 3 current sites

Clinic, hospital, obstetrics, Emergency Department

Expanding to Cumberland, MD as part of EQUIP-PC grant

- Co-locating with Union Rescue Mission residential workforce re-entry program

Joined Privia Medical Group in 2021

Participated in MDPCP since 2020

Team Based Care

Before MDPCP

- No direct funding of Advanced Primary Care in private practice
- Strategies including leveraging internal resources to connect patients
  - Clinical Assistants
  - Phone nurse
- Connect patients to consultants and community resources
- Facilitate in office productivity

After MDPCP

Care Management Funding and HEART funding available.

- Nurse care manager for qualifying Medicare patients
  - Collaborate with hospital and payor care managers
- Additional “Float Clinical” to connect patients with community resources and coach patients toward optimizing screening, wellness and chronic disease management
- Float also available in office for same day nurse visits.

Question:

For those who participated MDPCP, how has it impacted your journey towards providing Advanced Primary Care?

Community Team Building

Developed relationships with Primary Care aligned community organizations

- GRMC daily interdisciplinary meetings and collaborate with discharge planners and transitional care coordinators
- Leverage hospital privileges to maintain open access and communication about high complexity patients.
- Close coordination with physicians, imbedded care manager, clinical assistants
- Leverage Privia Care management and quality resources
- Partner with Health Dept. on Adolescent health initiatives
- Partner with Health Dept., FQHC and other independent primary care providers in our community for various care initiatives
- Participate in Health Dept. cancer screening program
- MAP and AERS utilizations
- Local pregnancy resource center
- Garrett Transit Services
- Cindy's fund cancer care support network

Question:

What community partners or resources have surprised you the most in their value or efficacy in helping patients?

Team Based Healthcare

Fundamentally we leverage our position in our healthcare community to connect patients with existing healthcare resources and help facilitate them connecting with those resources

Analogy – just as CRISP links healthcare entities to health information outside their organization, we as primary care help link patients to beneficial resources outside our practice

Majority of wellness care, chronic disease management and low acuity acute care provided in house	Connect patients to appropriate healthcare and community resources

Question:

What negative impacts have you seen from the volume of information generated for each patient?

Team Based Care

Static tamers

- It seems sometimes that the volume of medical information that is produced for each patient can become like a drowning static.
- It takes a team to sort through the static and get the salient information to the right members of the care team.
- Healthcare occurs upon a bizarre three-legged platform of competing interests – patient, provider and payor
  - Beyond those foundational relationships, there is a medusa's head of competing interests trying to affect those parties to align with their interests.
  - Many patients are disempowered when attempting to navigate toward their best interests
  - Primary care can empower and facilitate their goals – people need people face to face

Question:

What or who are some of the outside influences affecting that 3 legged platform?

Team based care

One of the last components of our team revolves around our full-time referral specialist supported by our inhouse billing expert.

It takes a full-time person to help patients navigate their payor network and associated funding limitation

Fundamentally our healthcare non-system has become so multifaceted and listless without overarching leadership, the majority of patients require professional assistance to navigate healthcare to achieve their health goals

Advance Primary Care has become that essential resource to not only provide the majority of care patients need, but also help patients access care beyond the scope of their primary care provider.

Primary Care is the only health care resource where more of it results in better health outcomes

Team based care

I believe those of us who are called to primary care seek to provide whole person care and to facilitate our patients to enjoy life and life abundantly.

No one of us is an island of care in this sea of healthcare, we require an armada of aligned people and organizations to help our patients navigate toward safer, healthier shores

As primary care is resourced, we will continue to use those resources to help our patients navigate toward healthier lives, healthier families and healthier communities!

Joe Weidner, MD

Stone Run Family Medicine

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1. Office Staffing
2. Workflow features
3. Morning Huddle
4. Patient Family Advisory Council
5. Network Table project
6. Office Systems Manager role

Joe Weidner, Jr. MD drweidner@jkwmd.com

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Office Staff

1 MD, 1 DO, 2 PA-Cs
1 LPN / Nurse Manager / Care Manager
1 MA-C / Care Manager / AWVs
4.5 additional MA-C
4 Clerical/Front Desk
2 Billing / Referral
1 Office Manager
0.5 Office Systems Manager

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Workflow Features

- Care Managers are trained in Hopkins Guided Care program
- All MA-Cs following protocols give vaccinations, point of care testing, perform cognitive testing (MoCA or SLUMS)
- AWVs are preloaded before provider sees patient, either prior to visit day, or by staff at point of care
- AWVs need identified with front desk
- Paper Fee slips have up to 6 quality measures identified

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Morning Huddle

15 minutes prior to the first patient scheduled

All staff, except two – one front and one back

Agenda:

- HIE review of transitions of care and ED visits
- Patient schedule review – TOC
- Network Table, those with barriers to care identified
- Staffing, meetings, vendors, lunches
- Kudos – encouragement. For above & beyond
- Prayer

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Patient Family Advocacy Council PFAC

June 2019 initiated

Existing staff member - Certified Patient Experience Professional

Beryl Institute (online course)

Meets Quarterly+

Volunteers - six – fed dinner and dessert
selection by staff and mailed invitation
6/20 positive response patients/caregivers
diverse: culture, age, gender, insurer

Practice provides follow-up on every decision/ recommendation

Joe Weidner, Jr. MD drweidner@jkwmd.com

PFAC Topics for Meetings

Physical Plant
- New front door
- Security measures
- Walk through
- Drive through COVID clinics
- Public wifi

Website/Social media review

Policies
Workflow
Introduction of new processes

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PFAC Topics for Meetings

Policies
- Handout development – over 18
- SDOH screening handout
- No – show letters
- Late for appt policy

CAHPS survey

Workflow
- Phone tree implementation
- New provider

Introduction of new processes
- workflow with new provider

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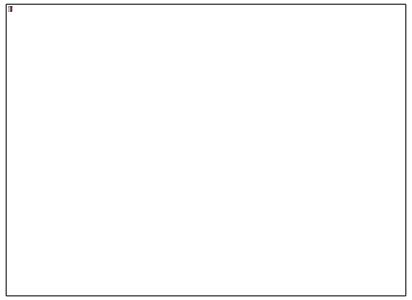
Network Table

Address Primary Support Need - those with barriers to care / adverse SDOH

Community Health Worker (CHW):

- Part time
- Recruits / reaches out to patients identified by practice
- Manages a group of volunteers who meet every few weeks
- Reviews cases and meets the primary need of each individual



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Network Table – Results

Of those with Medicare (not with MA):

- 37% decrease in ED utilization
- 18% reduction in expenditures
- Total cost reduction of $154,246.44
- $2235 cost reduction per person

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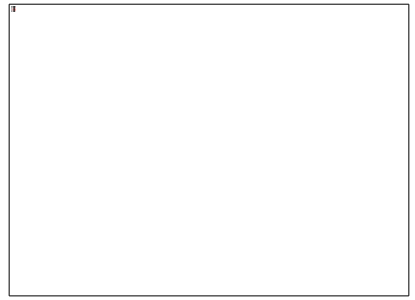

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Office Systems Manager

- Support and troubleshooting for all the systems that make an office work
- Managing computer, phones, electronic systems, subscriptions
- Data mining, analysis and reporting from EMR, other sources, data for quality measures
- Customization and maintenance of EMR and third parties
- Point person to interact with ACOs, HIEs, Immunet
- Managing social media and website

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THANK YOU

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