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New Revenue Opportunities

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Diversifying Income Streams Beyond Traditional Fee-for-Service

Executive Summary

As traditional fee-for-service reimbursement continues to decline—with CMS implementing its fifth consecutive year of payment reductions in 2025—forward-thinking physician organizations are helping member practices diversify revenue streams through innovative care delivery models and value-added services.[1]

The opportunities are substantial and growing:

- **Chronic Care Management (CCM):** National average reimbursement of $60.49 per patient per month for the base service, with combined CCM and Remote Patient Monitoring (RPM) programs generating $140-210 per patient monthly[2][3]
- **Continuous Glucose Monitoring (CGM):** North American market expanding from $8.78 billion in 2025 to $20.97 billion by 2030 (19.01% CAGR), with substantial practice revenue opportunities[4]
- **Direct Primary Care (DPC) Contracting:** Market projected to grow from $59.5 billion in 2024 to $92.9 billion by 2034, with 57% of DPC practices now contracting with employers[5][6]

This white paper provides physician organizations with a comprehensive framework for implementing new revenue opportunities that enhance patient care while creating sustainable, diversified income streams for member practices.

The Imperative for Revenue Diversification

The Fee-For-Service Squeeze

Independent physician practices cannot rely solely on traditional fee-for-service revenue:

Medicare Payment Declines:

- 2025 conversion factor reduced to $32.35 (down 2.83% from 2024)[7]
- Fifth consecutive year of physician payment reductions
- No adjustment for inflation despite 20%+ increase in operating costs since 2020
- Cumulative 29% decline in real physician payments since 2001 (adjusted for inflation) [8]

Commercial Payer Pressures:

- Flat or declining reimbursement rates across most markets
- Increasing administrative burden and prior authorization requirements
- Movement toward narrow networks excluding independent practices
- Shift of financial risk to providers through value-based contracts

Patient Affordability Crisis:

- High-deductible health plans shifting 22.9% of costs to patients[9]
- Growing bad debt from patient portions
- Delayed or foregone care due to cost concerns
- Price transparency requirements pressuring provider margins

The Strategic Response: Revenue Diversification

Leading physician organizations are guiding member practices toward diversified revenue portfolios that combine:

1. **Optimized fee-for-service billing** (traditional revenue base)
2. **Care management services** (CCM, RPM, TCM, PCM, BWI)
3. **Advanced diagnostic and monitoring programs** (CGM, cardiovascular testing, sleep studies)
4. **Direct contracting arrangements** (DPC with employers, direct specialty care)
5. **Ancillary services** (labs, imaging, physical therapy, infusion)
6. **Value-based payments** (shared savings, quality incentives, risk-based contracts)

This diversified approach provides:

- **Revenue stability** during fee-for-service decline
- **Margin improvement** from higher-margin services
- **Enhanced patient care** through comprehensive service offerings
- **Competitive differentiation** versus hospital-employed practices
- **Practice sustainability** supporting long-term independence

High-Impact Revenue Opportunities

1. Chronic Care Management (CCM) Programs

The Opportunity: Approximately 60% of Medicare beneficiaries have two or more chronic conditions, yet CCM enrollment rates remain below 15% nationally.[10] This represents massive untapped revenue potential for practices willing to implement structured CCM programs.

2025 Reimbursement Rates:

- **99490** (20 minutes non-complex CCM by clinical staff): $60.49 national average[11]
- **99439** (each additional 20 minutes): $45.93 national average[12]

- **99491** (30 minutes physician/NP-provided CCM): $82.16 national average[13]
- **99437** (each additional 30 minutes physician/NP): $57.58 national average[14]
- **Complex CCM (99487/99489):** Higher rates for patients with moderate/high medical complexity

Revenue Example: A practice with 1,000 Medicare patients (typical for 3-4 primary care physicians):

- 600 patients have 2+ chronic conditions (eligible for CCM)
- 30% enrollment rate = 180 enrolled CCM patients
- Average reimbursement: $60/patient/month × 180 patients = $10,800/month
- **Annual revenue: $129,600** (conservative scenario with base code only)

With 50% enrollment and additional time units: **$250,000-350,000 annually**

Implementation Requirements:

- **Care coordination staff:** RNs, medical assistants, or health coaches trained in CCM protocols
- **Technology platform:** CCM-specific software for care planning, patient outreach, and time tracking
- **Provider engagement:** Physician/NP participation in complex care plan development
- **Patient education:** Clear communication of CCM benefits and consent process
- **Documentation standards:** Comprehensive care plans meeting CMS requirements

Key Success Factors:

- Target patients with multiple chronic conditions and recent utilization
- Establish systematic patient outreach and engagement protocols
- Track time meticulously to capture all billable activities
- Focus on medication management and care gap closure
- Integrate with care coordination for hospitalized patients
- Report outcomes (A1C improvement, BP control, patient satisfaction)

Expected Outcomes:

- Revenue increase of $100,000-350,000 per practice annually
- Improved chronic disease control and quality metrics
- Reduced hospitalizations and ED visits
- Enhanced patient satisfaction and engagement
- Better performance in value-based contracts

2. Remote Patient Monitoring (RPM) Programs

The Opportunity: Remote Patient Monitoring complements CCM by adding physiologic data monitoring for chronic conditions. RPM can be billed concurrently with CCM, creating combined revenue of $140-210 per patient per month.[15]

2025 Reimbursement Rates:

- **99453** (initial device setup and patient education): $20.57[16]
- **99454** (device supply with data transmission): $64.93 per month[17]
- **99457** (first 20 minutes of clinical staff time reviewing data): $54.71[18]
- **99458** (each additional 20 minutes): $42.18[19]

Applicable Conditions:

- Hypertension (blood pressure monitoring)
- Diabetes (continuous glucose monitoring)
- Heart failure (weight scales, pulse oximetry)
- COPD (pulse oximetry, spirometry)
- Chronic kidney disease (blood pressure, weight)

Revenue Example: A practice enrolling 200 patients in RPM programs:

- Device/setup codes: $20.57 + $64.93 = $85.50 per patient = $17,100 initial
- Monthly monitoring: $54.71 per patient × 200 = $10,942/month
- **Annual revenue: $17,100 (initial) + $131,304 (ongoing) = $148,404**

Combined CCM + RPM: Practices enrolling patients in both programs can generate $140-210 per patient per month, or **$1,680-2,520 annually per enrolled patient**.[20]

Implementation Requirements:

- **Device procurement:** Cellular-enabled monitoring devices (BP cuffs, scales, glucometers, pulse oximeters)
- **Technology platform:** RPM software with real-time data transmission and alerts
- **Clinical protocols:** Evidence-based thresholds for clinical staff intervention
- **Staff training:** Clinical staff competency in remote monitoring and patient coaching
- **Patient selection:** Identify high-risk patients most likely to benefit
- **Workflow integration:** Embed RPM review into daily clinical workflows

Expected Outcomes:

- Additional $100,000-200,000 annual revenue per practice
- Proactive identification of clinical deterioration
- Reduced hospital admissions and ED visits
- Improved patient engagement and self-management
- Enhanced value-based care performance

3. Continuous Glucose Monitoring (CGM) Programs

The Opportunity: The CGM market is experiencing explosive growth, with the North American market expanding from $8.78 billion in 2025 to a projected $20.97 billion by 2030 (19.01% CAGR).[21] Medicare coverage expansion and improved reimbursement have made CGM accessible to a much broader patient population beyond Type 1 diabetes.

Eligible Patient Populations:

- Type 1 diabetes (traditional CGM population)
- Type 2 diabetes on insulin therapy
- Type 2 diabetes on non-insulin medications (expanding coverage)
- Prediabetes in high-risk populations (emerging opportunity)
- Gestational diabetes

Revenue Streams:

- **Professional CGM interpretation:** Physicians bill for downloading and interpreting CGM data
- **Patient education and training:** Initial CGM setup and training sessions
- **Ongoing management:** Regular review of CGM data and treatment adjustments
- **Device markup** (if dispensed directly from practice)
- **Enhanced diabetes management fees** from value-based contracts

Revenue Example: A primary care practice managing 400 diabetic patients:

- 150 patients eligible for CGM (Type 1, insulin-dependent Type 2)
- 60% adoption rate = 90 CGM patients
- Average professional fee per patient: $150-250 quarterly
- **Annual revenue: $54,000-90,000** (professional fees only)

Additional revenue from improved diabetes quality metrics in value-based contracts: $25,000-50,000 annually.

Implementation Requirements:

- **Provider training:** CGM device options, data interpretation, treatment algorithms
- **Staff competency:** Patient education on device insertion and app usage
- **Technology integration:** CGM data platforms connected to EHR
- **Patient identification:** Systematic review of diabetic patients for CGM eligibility
- **Prior authorization support:** Staff dedicated to obtaining payer approvals
- **Ongoing support:** Patient troubleshooting and device replacement protocols

Key Success Factors:

- Partner with all major CGM manufacturers (Dexcom, Abbott, Medtronic)
- Develop standardized patient education materials
- Create efficient workflows for CGM data review
- Track clinical outcomes (A1C reduction, hypoglycemia episodes)

- Bill appropriately for professional interpretation
- Integrate CGM data into care management programs

Expected Outcomes:

- Direct revenue of $50,000-100,000 per practice annually
- Improved diabetes control (0.5-1.0% A1C reduction)
- Reduced hypoglycemic episodes
- Enhanced patient satisfaction
- Better performance on diabetes quality metrics
- Reduced diabetes-related complications and costs

4. Direct Primary Care (DPC) Contracting

The Opportunity: The DPC market is projected to grow from $59.5 billion in 2024 to $92.9 billion by 2034, driven by employer demand for alternatives to traditional insurance.[22] Currently, 57% of DPC practices contract with employers to provide primary care services for employees.[23]

DPC Revenue Model: Practices receive a monthly membership fee per enrolled patient (typically $50-150/month per member) in exchange for comprehensive primary care services without copays or deductibles. This creates predictable, insurance-independent revenue.

Revenue Example: A practice contracting with local employers:

- 3 employer contracts totaling 500 covered employees
- Average membership fee: $75/employee/month
- Monthly revenue: $37,500
- **Annual revenue: $450,000** (independent of insurance reimbursement)

Hybrid Models: Many practices adopt hybrid approaches:

- **DPC for employers** + traditional insurance for other patients
- **Concierge primary care** for complex patients + standard care for others
- **Direct specialty care** (orthopedics, cardiology, dermatology) with episodic fees

Implementation Requirements:

- **Legal structure:** Compliance with state DPC laws and insurance regulations
- **Employer outreach:** Business development to identify potential employer partners
- **Service definition:** Clear scope of included services and exclusions
- **Contract negotiations:** Legal review of employer agreements
- **Billing systems:** Separate billing for DPC vs. insurance-based patients
- **Enhanced access:** Extended hours, same-day appointments, telemedicine
- **Practice capacity:** Panel size management (typically 600-800 DPC patients per provider vs. 2,000+ in traditional practice)

Key Success Factors:

- Focus on self-insured employers with 100-500 employees
- Emphasize total cost savings from reduced specialist referrals and hospitalization
- Provide clear ROI projections for employers
- Offer on-site or near-site clinic options for larger employers
- Integrate with employer wellness and benefits programs
- Track and report utilization and cost savings data

Expected Outcomes:

- Predictable revenue independent of insurance reimbursement
- Reduced administrative burden (no insurance billing for DPC services)
- Enhanced physician satisfaction and reduced burnout
- Improved patient relationships with longer visit times
- Lower patient panel sizes but higher per-patient revenue
- Competitive advantage in recruiting and retaining physicians

5. Advanced Cardiovascular and Diagnostic Testing

The Opportunity: Cardiovascular disease remains the leading cause of death in the United States, yet many primary care practices lack access to advanced diagnostic testing. Offering in-office or coordinated cardiovascular testing creates clinical value and revenue opportunities.

High-Value Testing Programs:

- **Coronary calcium scoring (CT):** Early detection of coronary artery disease
- **Carotid intima-media thickness (CIMT) ultrasound:** Stroke risk assessment
- **Peripheral arterial disease (PAD) screening:** ABI testing with reimbursement
- **Echocardiography:** In-office cardiac function assessment
- **Ambulatory blood pressure monitoring:** 24-hour BP profiles
- **Holter monitoring:** Extended cardiac rhythm monitoring
- **Sleep apnea testing:** Home sleep studies

Revenue Example: A practice implementing a cardiovascular risk program:

- 200 high-risk patients annually receive calcium scoring + CIMT
- Professional interpretation fee: $150 per study
- Technical fee (if equipment owned): $300-500 per study
- **Annual revenue: $90,000-130,000** (professional fees + technical if applicable)

Implementation Models:

- **Mobile service partnerships:** Companies bring equipment to practice
- **Equipment ownership:** Purchase or lease echo, vascular ultrasound, sleep study equipment
- **Referral partnerships:** Coordinate with imaging centers, share professional fees
- **Physician training:** Invest in advanced imaging certification for practice physicians

Expected Outcomes:

- Enhanced cardiovascular risk management

- Earlier detection of subclinical disease
- Improved patient outcomes and reduced events
- Revenue diversification beyond E/M services
- Competitive differentiation in market

6. Transitional Care Management (TCM) and Principal Care Management (PCM)

The Opportunity: Hospital discharges and complex chronic disease management represent high-risk, high-cost periods that are under-addressed and under-billed by most practices.

Transitional Care Management (TCM): Post-discharge care coordination within 30 days of hospital or SNF discharge.

2025 Reimbursement:

- **99495** (moderate complexity, phone contact within 2 days, visit within 14 days): $182.99[24]
- **99496** (high complexity, phone contact within 2 days, visit within 7 days): $257.11[25]

Revenue Example: Practice with 2,000 Medicare patients experiences ~200 hospitalizations annually:

- 70% TCM capture rate = 140 TCM services
- Average reimbursement: $220 per discharge
- **Annual revenue: $30,800**

Principal Care Management (PCM): New in 2024, PCM codes reimburse ongoing management of a single high-risk chronic condition.

2025 Reimbursement:

- **99424** (first 30 minutes): $85.44[26]
- **99425** (each additional 30 minutes): $70.21[27]

Revenue Example: 100 patients with complex single conditions (CHF, COPD, CKD) enrolled in PCM:

- Average time: 45 minutes per month
- Average reimbursement: $120 per patient per month
- **Annual revenue: $144,000**

Implementation Requirements:

- **Hospital discharge notification:** Real-time alerts when patients are discharged
- **Outreach protocols:** Systematic phone contact within 2 business days
- **Visit scheduling:** Prioritized appointment slots for TCM patients
- **Care coordination:** Medication reconciliation, follow-up scheduling, DME/home health
- **Documentation:** Comprehensive TCM note requirements
- **Time tracking:** Meticulous time logs for PCM services

Expected Outcomes:

- Additional $50,000-200,000 annual revenue depending on patient volume
- Reduced 30-day readmissions (10-25% reduction)
- Improved medication adherence
- Better care coordination across settings
- Enhanced HEDIS/quality measure performance

Implementation Framework for Physician Organizations

Phase 1: Assessment and Prioritization (Months 1-2)

Opportunity Analysis:

- Patient population analysis identifying eligible patients for each program
- Current billing analysis to identify missed opportunities
- Competitive landscape review of other practices' offerings

- Staff capacity assessment for program implementation
- Technology infrastructure evaluation

Financial Modeling:

- Revenue projections for each opportunity based on practice patient volumes
- Implementation cost estimates (staff, technology, training, marketing)
- Break-even analysis and ROI timelines
- Cash flow implications during ramp-up period

Prioritization: Rank opportunities based on:

- Revenue potential relative to implementation cost
- Fit with practice patient population and capabilities
- Staff interest and physician champion availability
- Time to revenue (quick wins vs. longer-term investments)
- Strategic importance to practice sustainability

Recommended Sequence:

1. **Quick wins** (3-6 months to revenue): CCM, TCM, RPM
2. **Medium-term** (6-12 months): CGM programs, advanced testing
3. **Longer-term** (12-24 months): DPC contracting, ancillary services

Phase 2: Infrastructure Development (Months 3-6)

Technology Procurement:

- Care management platform (CCM, RPM, PCM)
- Remote monitoring devices and patient apps
- CGM data integration platforms
- Billing software upgrades for new CPT codes
- Patient portal enhancements for program enrollment

Team Development:

- Hire care coordinators and health coaches
- Train existing clinical staff on new programs
- Identify physician champions for each initiative
- Create program management roles

Protocol Development:

- Clinical protocols for each program
- Patient enrollment and consent workflows
- Billing and documentation standards
- Quality monitoring and reporting

Contracting:

- Device vendor agreements (RPM, CGM)
- Employer outreach for DPC (if applicable)
- Mobile diagnostic service partnerships
- Legal review of all new service agreements

Phase 3: Pilot Launch (Months 7-9)

Pilot Programs: Launch each program with 1-2 practices and limited patient cohorts:

- CCM: 50-100 patients per practice
- RPM: 25-50 patients per practice
- CGM: Systematic review of all diabetic patients
- TCM: 100% of hospital discharges
- PCM: 25-50 complex patients per practice

Staff Training:

- Comprehensive training on program protocols
- Technology system training
- Billing and documentation training

- Role-playing and scenario-based practice

Patient Enrollment:

- Systematic outreach to eligible patients
- Clear communication of program benefits
- Simplified consent processes
- Regular enrollment tracking

Quality Monitoring:

- Weekly program metrics review
- Staff feedback and workflow refinement
- Patient satisfaction monitoring
- Early win identification and celebration

Phase 4: Scale and Optimize (Months 10-24)

Expansion:

- Roll out successful programs to all member practices
- Increase patient enrollment targets
- Add additional program components (e.g., complex CCM, additional RPM devices)
- Launch next phase opportunities (DPC, ancillary services)

Optimization:

- Refine workflows based on pilot learnings
- Implement automation where possible
- Address billing and documentation issues
- Improve patient engagement strategies

Performance Management:

- Regular program performance dashboards
- Practice-level benchmarking and feedback

- Financial and clinical outcome tracking
- Best practice sharing across practices

Sustainability:

- Incorporate programs into routine practice operations
- Embed quality improvement processes
- Plan for staff growth as programs scale
- Develop long-term financial sustainability models

Key Performance Indicators

Financial Metrics

- **Revenue per program:** Track monthly/annual revenue for each new service line
- **Enrollment rates:** Percentage of eligible patients enrolled in each program
- **Reimbursement per patient:** Average monthly revenue per enrolled patient
- **Program margins:** Revenue minus direct costs (staff, technology, devices)
- **Practice-level revenue diversification:** Percentage of total revenue from new programs vs. traditional E/M

Clinical Quality Metrics

- **CCM outcomes:** Chronic disease control (A1C, BP, LDL), hospitalizations, ED visits
- **RPM outcomes:** Clinical parameter improvements, alert response times
- **CGM outcomes:** A1C reduction, hypoglycemia episodes, time in range
- **TCM outcomes:** 30-day readmission rates, medication adherence
- **PCM outcomes:** Disease-specific metrics for primary condition

Operational Metrics

- **Patient satisfaction:** Net Promoter Score for each program

- **Staff utilization:** Care coordinator FTE productivity
- **Billing compliance:** Clean claim rate for new CPT codes
- **Enrollment velocity:** New patients enrolled per month
- **Retention rate:** Patients remaining enrolled after 6 months

New Revenue Opportunities Checklist for Physician Organizations

- [ ] **Patient Population Analysis:** Review member practice patient populations to quantify eligible patients for CCM, RPM, CGM, TCM, and PCM programs
- [ ] **Revenue Opportunity Quantification:** Calculate potential annual revenue from each program based on realistic enrollment and billing assumptions
- [ ] **Technology Platform Selection:** Evaluate and select care management platforms with CCM, RPM, and PCM capabilities
- [ ] **Device Procurement:** Establish vendor relationships for RPM devices (BP cuffs, scales, pulse oximeters, glucometers)
- [ ] **CGM Partnerships:** Create agreements with Dexcom, Abbott, and Medtronic for CGM device supply and data integration
- [ ] **Staff Recruitment:** Hire care coordinators, health coaches, and program managers to support new revenue programs
- [ ] **Provider Training:** Educate physicians and advanced practice providers on clinical protocols, billing requirements, and documentation standards
- [ ] **Billing System Updates:** Ensure billing software can handle new CPT codes and track time-based services appropriately
- [ ] **Patient Enrollment Workflows:** Develop systematic processes for identifying, educating, and enrolling eligible patients

- [ ] **Documentation Templates:** Create EHR templates for care plans, TCM notes, and time tracking documentation
- [ ] **Hospital Discharge Notifications:** Establish real-time alerts when patients are admitted or discharged from hospitals
- [ ] **DPC Employer Outreach:** If pursuing direct contracting, develop business development strategy and financial modeling tools
- [ ] **Cardiovascular Testing Partnerships:** Explore mobile service partnerships or equipment ownership for advanced diagnostic testing
- [ ] **Compliance Review:** Ensure all new programs comply with federal and state regulations, including billing requirements
- [ ] **Quality Monitoring:** Establish dashboards tracking clinical outcomes, patient satisfaction, and financial performance for each program

Conclusion

The era of exclusive reliance on fee-for-service reimbursement is ending for independent physician practices. As traditional Medicare and commercial payments decline, practices must diversify revenue streams to remain financially viable and clinically independent.

The opportunities outlined in this white paper represent proven, scalable revenue sources that enhance patient care while generating substantial new income:

- Chronic Care Management and Remote Patient Monitoring programs can generate $100,000-350,000 annually per practice
- Continuous Glucose Monitoring programs expand diabetes care while adding $50,000-100,000 in revenue

- Direct Primary Care contracting creates insurance-independent revenue streams of $300,000-500,000+ annually
- Advanced cardiovascular testing and transitional care management add $50,000-150,000 in diversified income

Combined, a comprehensive new revenue strategy can increase practice revenue by 15-30% while improving patient outcomes and satisfaction.

Physician organizations play a critical role by providing the infrastructure, expertise, and scale needed to successfully launch these programs. By centralizing technology, training, and program management, physician organizations enable individual practices to access opportunities that would be impossible to implement alone.

Joyn Health partners with physician organizations to implement comprehensive new revenue programs across all member practices. Our proven implementation frameworks, turnkey technology platforms, and expert program management teams have helped numerous physician organizations successfully launch CCM, RPM, CGM, and DPC programs that generate millions in new annual revenue while enhancing patient care.

This white paper is provided by Joyn Health as an educational resource for physician organizations and their member practices. The information contained herein is for informational purposes only and does not constitute legal, financial, or medical advice. Physician organizations should consult with appropriate professionals before implementing new service lines and revenue programs.

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