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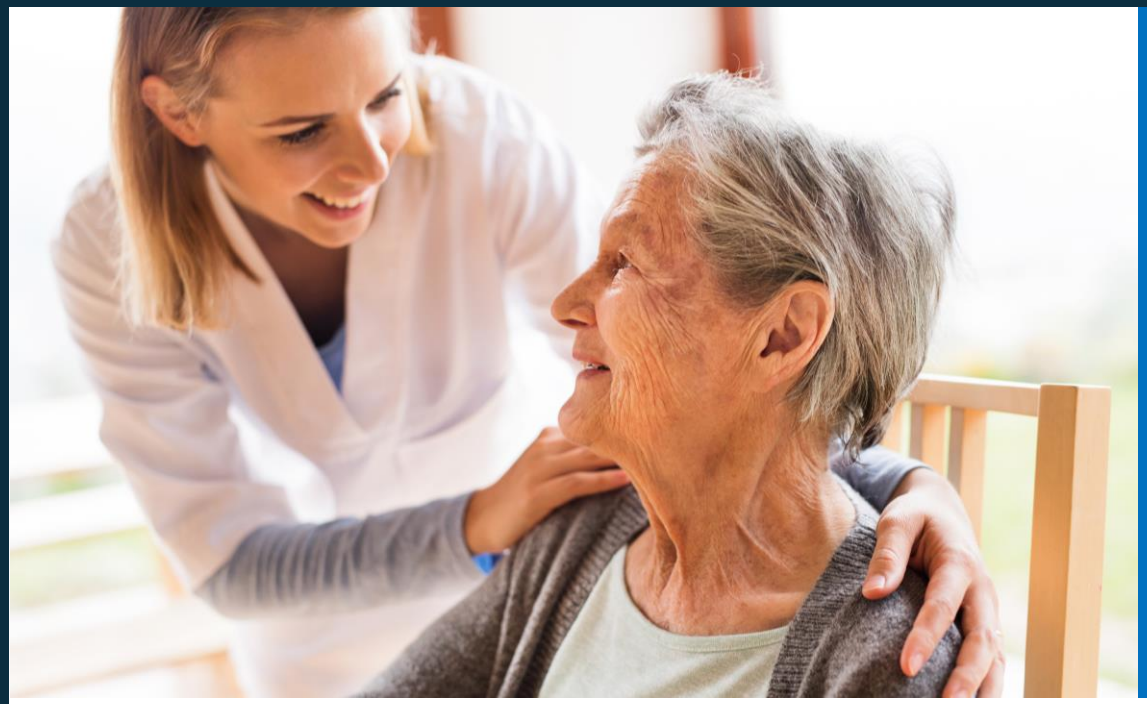

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Revolutionizing Home-Based Care: Unveiling the Power of Advanced Primary Care Management

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July 29, 2025

Agenda

1. Objectives
2. Introduction
3. Overview
4. Improving Patient Outcomes
5. Overcoming Challenges
6. Billing and Coding Practices
7. Next Steps
8. Q/A

Objectives

- **Overview:** Provide an introduction to Advanced Primary Care Management (APCM), highlighting key principles, benefits, and strategies for implementation in home-based settings.
- **Improving Patient Outcomes:** Explore how APCM enhances patient care through personalized plans, proactive health management, and integrated care coordination.
- **Overcoming Challenges:** Discuss common obstacles in adopting APCM in home-based care and present practical solutions and best practices to address these issues.
- **Billing and Coding Practices**: Review accurate billing and coding practices specific to APCM in home-based primary care to ensure compliance and efficiency.

Presenters

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Overview

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What is Advanced Primary Care Management (APCM)

- Advanced Primary Care Management (APCM) is a comprehensive, team-based approach to delivering coordinated care for patients with chronic and complex conditions. It is designed for individuals with multiple ongoing health issues who may benefit from longitudinal support outside traditional face-to-face encounters. CMS introduced dedicated billing codes in 2025 (G0556, G0557, and G0558) to reimburse practices offering these advanced care management services.

- The model focuses on addressing care gaps, promoting health equity, improving patient satisfaction, and reducing total cost of care. APCM is most often delivered in home-based or post-acute settings for patients who may not benefit from traditional in-office models of care.

Eligibility Criteria

- Patients eligible for separately payable APCM services include Medicare beneficiaries and dually eligible individuals (Medicare and Medicaid) who have medically complex needs and are at high-risk of acute exacerbation, functional decline, decompensation or risk of death.

- Examples of chronic or complex conditions that may qualify include but are not limited to: Alzheimer's disease and related dementias, arthritis, asthma, atrial fibrillation, autism spectrum disorders, cancer, cardiovascular disease, chronic obstructive pulmonary disease (COPD), depression, substance use disorders, diabetes, hypertension, and infectious diseases such as HIV/AIDS.

Key Components of APCM

Initiating Visit

- New patients & Annual Wellness Visit may qualify

24/7 Access and Continuity of Care

- Real-time access for urgent needs

Comprehensive Care Management

- Systematic needs assessments, prevention services and medication reconciliation

Individualized Care Planning

- Developing, updating and monitoring

Key Components of APCM

Comprehensive Care Coordination

- Care transitions and specialist referrals including SDoH

Enhanced Communication

- Asynchronous, non-face-to-face

Patient Population-Level Management

- Risk stratification and gaps in care to identify and target services

Measurement and Reporting

- Primary care quality, total cost of care and meaningful CEHRT use via either ACO participation or the Value in Primary Care MIPS Pathway

Improving Patient Outcomes

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Improving Patient Outcomes

Advanced Primary Care Management

- Transforms primary care from a reactive, episodic model to a proactive, continuous, and patient-centered approach

Enhancing Care Delivery and Results

Proactive and Preventive Care

- APCM helps patients stay healthier and manage complex conditions more effectively

Enhanced Care Coordination and Communication

- APCM promotes better communication, coordination and transitions of care

Increased Patient Engagement and Satisfaction

- APCM strengthens provider / patient relationship and adherence to care plan

Enhancing Care Delivery and Results

Reduced Healthcare Costs

- APCM prevents hospitalization, ER visits, and costly unnecessary treatments

Integration with Technology

- APCM incorporates technologies for continuous monitoring, real-time adjustments and increased access

APCM Challenges and Strategies to Overcome

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Common Obstacles

Challenges that can impact implementation and scalability:

- Practical
- Operational
- Regulatory

Common Challenges and Strategies to Overcome

Infrastructure and Workflow Reform

- APCM requires significant changes in workflows and investments in resources
- Invest, Commit and Plan!

Technology – Interoperability and Gabs

- Not all CEHRT systems are interoperable across care settings – limits real-time information
- Investing in and ensuring inoperability and reporting capabilities

Common Challenges and Strategies to Overcome

Payment Model Misalignment

- With Commercial payers, Medicare Advantage and Medicaid programs
- Leverage and engage payer relationships!

Digital Competency and Aversion

- Technology based interventions can be challenging
- Educate, commit to access and equity including language support and forming community relationships!

Billing and Coding Practices

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APCM Billing Practices

As of January 1, 2025, a physician or a non-physician practitioner including Nurse Practitioners, Physician Assistants or Certified Nurse Specialists who are responsible for all the patient's primary care services, is the focal point for all the patient's needed health care services and has obtained either written of verbal consent from the patient.

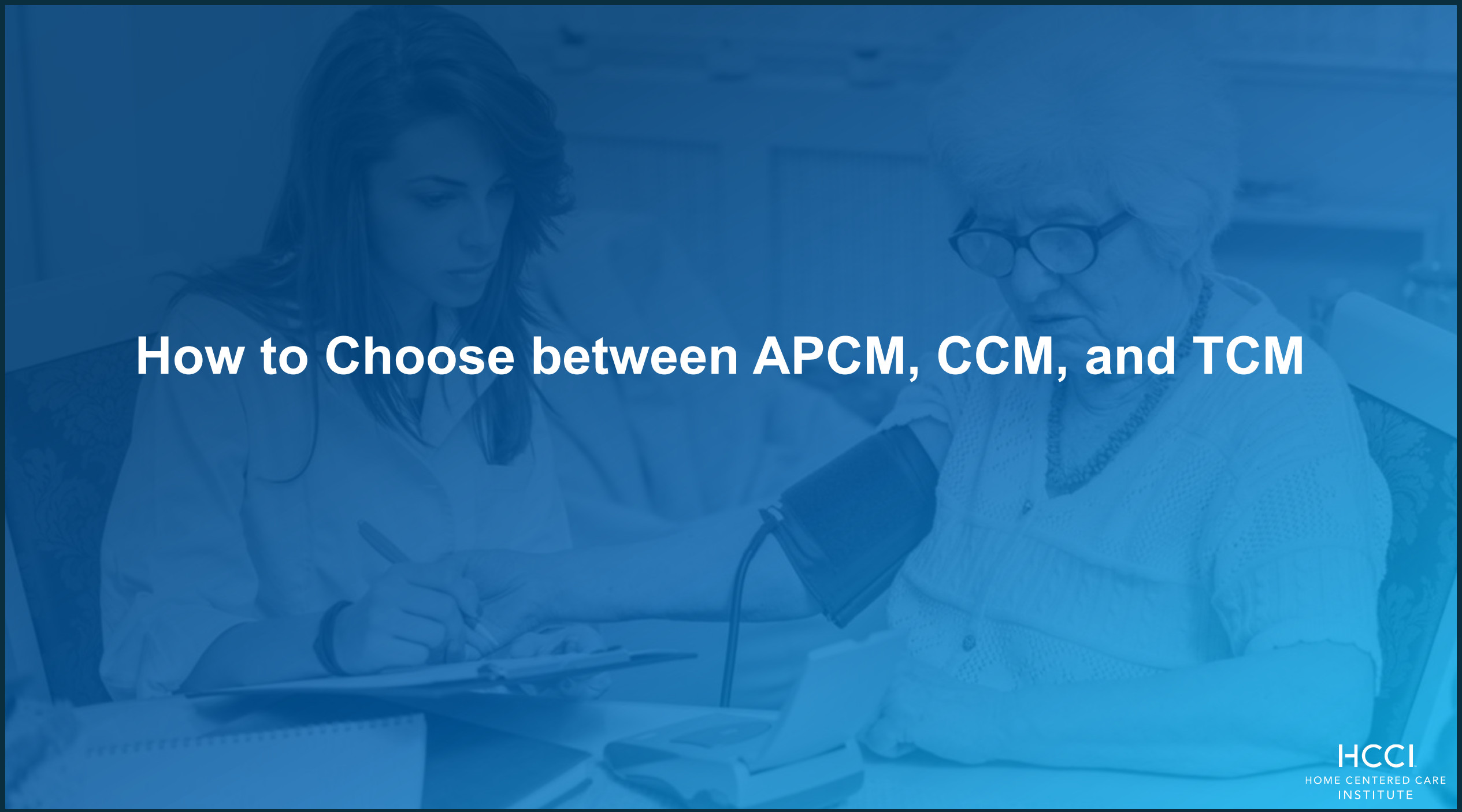
- Can be billed once per patient per calendar month
- Cannot be billed concurrently with other care management codes

Billing and Coding Requirements

- Obtain and document verbal or written consent
- Conduct an initiating visit
- Ensure around-the-clock access
- Provide ongoing medical and psychosocial assessments
- Maintain and share an electronic care plan
- Support care transitions
- Maintain continuous documentation
- Use secure digital tools
- Use data to identify care gaps and stratify patient risk

APCM Coding

HCPCS Code	Description and Requirements
G0556	ACPM services for patients with one chronic condition to last 12 months or until death
G0557	ACPM services for patients with two or more chronic conditions posing significant risk of death, exacerbation, or functional decline
G0558	ACPM services for qualified Medicaid beneficiaries with multiple chronic conditions posing significant risk of death, exacerbation, or functional decline



How to Choose between APCM, CCM, and TCM

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Choosing Between APCM, CCM, and TCM

- **APCM (Advanced Primary Care Management)** focuses on long-term, preventive care and population health, often within value-based care models.
- **CCM (Chronic Care Management)** supports patients with multiple chronic conditions through monthly, structured care coordination to improve outcomes.
- **TCM (Transitional Care Management)** provides short-term, high-touch support for patients recently discharged from inpatient settings to reduce readmissions.
  - Each model differs in patient eligibility, care goals, billing codes, documentation, and staffing needs.
  - The right choice depends on your organization's clinical priorities, infrastructure, and strategic goals.

Additional APCM Resources

HCCIntelligence™ Premier Resources

- Advanced Primary Care Management Care Plan Requirements – 2025
- Advanced Primary Care Management Care Plan Template - 2025
- Advanced Primary Care Management Providers Checklist – 2025
- Advanced Primary Care Plan Toolkit - 2025
- Navigating Care Models: Comparing APCM & CCM for Optimal Practice Benefits

HCCI Online Courses

- Optimizing Revenue for House Calls: Coding, Billing, and Documentation
- Mastering APCM: Strategies & Tools for Sustainable Success - **Coming Soon!**

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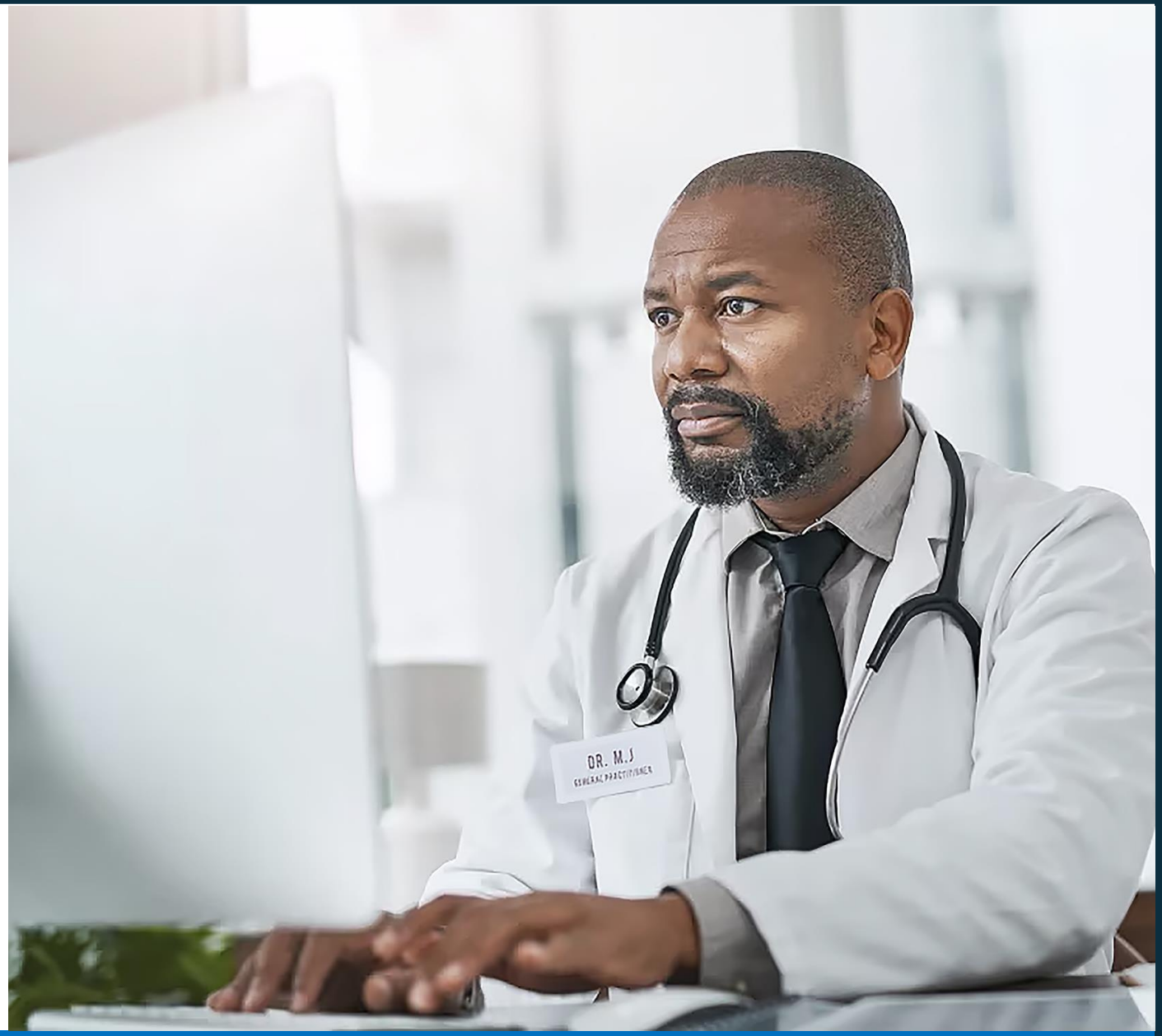

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