

## Purpose

This resource is intended for home-based primary care (HBPC) providers and outlines the required elements of a comprehensive Advanced Primary Care Management (APCM) care plan. The APCM care plan enables care teams to align complex patient needs with coordinated, proactive management strategies and value-based care requirements. This resource was developed utilizing Center for Medicare & Medicaid Services (CMS) guidelines and requirements and can be referenced for further information.

## APCM Service Elements

Practices delivering APCM must ensure care plans are comprehensive, patient-centered, and shareable within and beyond the practice. Care plans should be structured using certified Electronic Health Record (EHR) technology and reviewed regularly. Required care plan components include<sup>1</sup>:

- Patient demographics and risk level
- Active problem list with ICD-10 codes
- Expected outcomes and prognosis
- Measurable treatment goals (clinical, functional, patient-centered)
- Medication list and reconciliation
- Cognitive, psychosocial, and functional assessments
- Symptom management strategies
- Planned interventions and timelines
- Advance care planning status
- Caregiver and support system assessment
- Environmental safety and barriers evaluation
- Assigned care team roles and communication protocols
- Interdisciplinary coordination and outside referrals
- Documentation of periodic review, reassessment, and plan updates

<sup>1</sup> <https://www.cms.gov/medicare/physician-fee-schedule/search/overview>

## To further strengthen the APCM model and ensure alignment with value-based care principles, the following additional elements should be incorporated:

- **Health Equity Assessment and Planning**
  - Identification of social determinants of health (SDOH)
  - Strategies to address disparities in access and outcomes
  - Inclusion of cultural and linguistically appropriate services (CLAS)
- **Technology-Enabled Engagement**
  - Patient and caregiver access to digital health tools
  - Telehealth integration and remote monitoring
  - Digital health literacy education
- **Care Transitions Management**
  - Protocols for transitions across care settings
  - Post-discharge medication reconciliation and follow-up
  - Communication with external providers and facilities
- **Utilization and Cost Management**
  - Monitoring of ED visits, hospitalizations, and readmissions
  - Avoidable acute care reduction strategies
  - Evaluation of plan adherence and health outcomes
- **Patient and Family Engagement and Education**
  - Shared decision-making documentation
  - Tailored health education materials
  - Feedback and experience survey collection
- **Behavioral Health Integration**
  - Screening for depression, anxiety, and substance use
  - Access to behavioral health services within care model
  - Coordination with behavioral health specialists
- **Quality Improvement and Outcome Measurement**
  - Tracking clinical quality and performance metrics
  - Continuous quality improvement (CQI) initiatives
  - Risk stratification of high-need patients
- **Workforce Development and Team-Based Care Optimization**
  - Role-specific training and skill-building
  - Defined interdisciplinary workflows
  - Strategies for staff engagement and burnout prevention
- **Emergency Preparedness and Contingency Planning**
  - Individual emergency response plans
  - Continuity planning for critical services
- **Payer and Policy Alignment**
  - Documentation for compliance with payer and CMS requirements
  - Risk adjustment support
  - Data sharing and reporting protocols


## Available APCM CPT Codes

| HCPCS Code | Description and Requirements   |
|------------|--|
| G0556      | APCM Services for Patients with One or No Chronic Condition to last 12 months or until death   |
| G0557      | APCM Services for Patients with Two or More Chronic Conditions posing significant risk of death, exacerbation or functional decline                      |
| G0558      | APCM Services for Qualified Medicare Beneficiaries with Multiple Chronic Conditions posing significant risk of death, exacerbation or functional decline |

## APCM Billing Requirements


- **Patient Consent**
  - Written or verbal consent documented in the patient’s medical record prior to initiating APCM services
  - Inform patient that only one provider can furnish and be paid for APCM services during a calendar month
  - Inform the patient that they have the right to stop services at any time and that cost sharing may apply
- **Initiating Visit**
  - Paid separately for new patients
  - No need to complete if you or another provider in your practice have seen the patient within the past three years or have provided another care management service such as Chronic Care Management (CCM), or Principal Care Management (PCM) within the past year
  - The Medicare Annual Wellness Visit (AWV) may qualify as the initiating visit if the provider that will be responsible for providing APCM care performs the AWV
- **24/7 Access and Continuity of Care**
  - Ensure 24/7 access for patients or caregivers to reach the care team
  - Enable real-time access to the patient’s medical information
  - Offer successive routine appointments with a designated care team member
  - Provide care delivery alternatives, such as home visits or extended hours
- **Comprehensive Care Management**
  - Systematic needs assessment (medical and psychosocial)
  - System-based approaches to ensure timely receipt of recommended preventative services
  - Medication reconciliation, management and oversight of self-management
- **Electronic Plan of Care**
  - Create, revise, and maintain a patient-centered care plan using certified EHR
  - Ensure care plan is available internally and externally to all involved care team members
  - Copy of the care plan must be provided to the patient or caregiver

- **Care Coordination**
  - Timely follow-up on referrals from other providers
  - Actively and timely manage transitions between care settings (ED, Hospital, SNF or other health care facility)
  - Facilitate interdisciplinary collaboration and information exchange
  - Provide ongoing coordinating communication and documentation on the patient's psychosocial strengths, functional deficits, goals, preferences and outcomes from the patient's other providers including community based social services.
  - Provide enhanced communications including non-face-to-face consultation
  - Provide patient population-level management including risk stratification tools such as HCC scores, LACE Index, EHR data, and claim history.
- **Performance Measurement**
  - Track quality indicators reflective of high quality and performing primary care
  - Use performance data to inform care improvements
  - Report the Value in Primary Care MIPS Value Pathway (MVP) OR participating CMS models.
- **Mutual Exclusivity**
  - APCM codes cannot be billed concurrently with other care management codes such as CCM, TCM or PCM for the same patient in the same month
- **Billing Frequency**
  - Each code can be billed once per calendar month per patient



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