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Advanced Primary Care Management (APCM) Toolkit



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This resource was developed utilizing Centers for Medicare & Medicaid Services (CMS) guidelines and requirements and can be referenced for further details.

What is Advanced Primary Care Management (APCM)?

Advanced Primary Care Management (APCM) is an essential model of care home-based medical care that enhances patient outcomes, increases access, and support the shift from fee-for-service to value-based care. The Centers for Medicare & Medicaid Services (CMS) acknowledges the time and effort required to deliver APCM services and has established dedicated billing codes to compensate providers for the additional support they offer between appointments. These services combine elements of several existing care management and communication technology-based services that reflect the essential elements of advanced primary care including:

- Principal care management (PCM) – disease-specific services to help manage a patient’s care for a single, complex chronic condition that puts them at risk of hospitalization, physical or cognitive decline, or death.
- Transitional care management (TCM) – transitional care services during the 30-day period that begins when a physician discharges a Medicare patient from an inpatient stay and continues for the next 29 days.
- Chronic Care Management (CCM) – time-based care management services for patients with two or more chronic conditions that pose a significant risk of death, acute exacerbation, decompensation, or functional decline.

APCM services allow practices to provide patients with a care plan to meet their patients’ needs based on complexity. APCM services are billed using a monthly bundle instead of billing for each individual service or recording time by minutes. With over two-thirds of Medicare beneficiaries managing multiple chronic or complex conditions, many patients can benefit from APCM, including the ongoing support provided between visits.

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.

By implementing APCM, providers can offer more coordinated, patient-centered care that improves health outcomes and enhances patient engagement and satisfaction. This toolkit offers resources for healthcare professionals, patients and professional organizations, and community groups. It includes guidance on getting started, fact sheets outlining APCM requirements, and educational materials to share with patients.

According to the Centers for Medicare & Medicaid Services (CMS), one in four adults, including 70% of Medicare beneficiaries, have complex or multiple chronic conditions, making them eligible for APCM services. Medicare began reimbursing APCM separately under the Physician Fee Schedule (PFS) in 2025. Practitioners can bill APCM services once per patient per calendar month, which eliminates some of the burden of billing with individual, time-based care management codes.

Starting Your Practice with APCM

APCM offers a proactive, team-based approach that emphasizes care coordination, population health, and quality improvement over volume-driven services. This model supports better outcomes by aligning provider incentives with preventive care, chronic disease management, and patient engagement. Ultimately, APCM helps reduce avoidable hospitalizations and supports practice sustainability through value-based reimbursement.

Eligibility

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.

APCM services may be billed by*:

- Physicians and certain Non-Physician Practitioners (Physician Assistants, Clinical Nurse Specialists, and Nurse Practitioners)
 - Who is responsible for all of the patient's primary care services
 - Who is the focal point for all of the patient's needed health care services
 - Who has received either written or verbal consent from the patient

*Only one physician or NPP can bill APCM for a patient during a calendar month..

APCM involves providing patient care outside of in-person visits, such as telehealth, remote patient monitoring, and secure communication platforms. . It includes care coordination activities that go beyond traditional face-to-face encounters, such as telephone communication, reviewing medical records and test results, offering self-management education and support, and exchanging health information with other healthcare professionals and community resource providers.

Key components and requirements of APCM include:

Conducting an initiating visit:

- New patients.
- Annual Wellness Visit may qualify.

Not needed if another provider in the practice has:

- Seen the patient within the past 3 years
- Provided another care management service (APCM, CCM, or PCM) to the patient within the past year

Providing 24/7 access and continuity of care:

- 24/7 access for your patients or their caregivers with urgent needs to contact you or another member of the care team
- Real-time access to the patient's medical information
- The ability for the patient to schedule successive routine appointments with a designated member of the care team
- Care delivery in alternative ways to traditional office visits, like home visits or expanded hours

Comprehensive care management:

- Systemic needs assessments (medical and psychosocial)
- System-based approaches to ensure receipt of preventive services
- Medication reconciliation, management, and oversight of self-management

Developing, implementing, revising and maintaining an electronic patient-centered comprehensive care plan:

- Must be available within and outside of practice to individuals involved in patient's care, accessible and updated and copy given to patient.

Coordinating care transitions:

- Timely exchange of electronic health information and timely follow-up communication.

Coordinating practitioner, home and community-based care:

- Ongoing coordinating communication and documentation of patient's psychosocial strengths, functional deficits, goals, preferences and desired preferences from practitioners, home and community-based service providers, hospitals, Skilled Nursing Facilities, and others.

Enhanced communication opportunities:

- Must offer asynchronous, non-face-to-face consultation methods, have ability to conduct remote evaluation of pre-recorded patient information and use patient initiated digital communications.

Patient population-level management:

- Analyze population data to identify gaps in care and risk stratify practice population based on defined diagnoses, claims, or other electronic data to identify and target services.

Measuring and reporting performance:

- Including assessment of primary care quality, total cost of care, and meaningful use of Certified Electronic Health Records Technology (CEHRT)

Note: Advanced Primary Care Management (APCM), Chronic Care Management (CCM), and Transitional Care Management (TCM) services cannot be billed during the same month.

Speaking With Staff About APCM

The following information is intended to help healthcare providers and practices educate their staff about APCM services. It does not replace official guidance on delivering APCM services or seeking reimbursement.

What Is 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..

What do we need to do to furnish and bill for APCM?

To be eligible to bill for APCM services, the clinician's practice must meet specific requirements. While it may take time and effort to fully implement these changes, they will help improve the care you provide.

By offering APCM services, practices can deliver comprehensive care management that focuses on managing chronic conditions and ensuring patients receive all recommended preventive services, helping them better manage their health.

For each patient receiving APCM services, the clinician will create a comprehensive assessment and care plan that addresses all health issues, including medical and psychosocial aspects, with a special emphasis on chronic conditions. The practice will also:

- **Engage and educate the patient:** Develop and share the care plan with the patient (and any caregivers).
- **Review and update the care plan:** Periodically assess and revise the plan as needed.
- **Provide person-centered care:** Tailor care to the individual's specific needs.
- **Collaborate with home- and community-based services:** Work with providers such as adult day health programs, personal care workers, home-delivered meal services, etc..

- **Educate the patient:** Provide tools to help patients manage their complex conditions, social determinants of health and medications.
- **Medication reconciliation:** Ensure the patient's medication list is accurate, especially when prescribed by other healthcare providers, and ensure the patient has access to medications after care transitions.
- **Manage care transitions:** Share relevant information with the practice and other providers and follow up with the patient after referrals or hospital discharges..
- **Use standardized technology:** Employ certified EHR systems to document patient information (demographics, medical conditions, medications, allergies) and share information in a timely manner with other healthcare providers
- **Provide continuous care:**
 - 24/7 access to a qualified healthcare professional who can address urgent needs outside of regular office hours.
- **Enhanced communication methods,** such as secure email portals, allow patients to contact the practice at any time.

What is required of patients?

Patients must provide advance consent to ensure they are actively involved in their treatment plan and fully aware of any applicable cost sharing. They must understand that only one primary care practitioner can provide these services each month, meaning they cannot receive APCM from multiple providers. Patients should not give consent for these services to anyone else. Additionally, they should be informed that they can request to discontinue APCM at any time. Informed consent may be given verbally, but you may also choose to use electronic or paper forms.

Note: Standard cost-sharing rules may apply to APCM services, meaning many patients will be responsible for the usual Medicare Part B cost-sharing (deductible and coinsurance) if they do not have supplemental ("wraparound") insurance. However, most dually eligible individuals (those with both Medicare and Medicaid) are not responsible for cost-sharing. Medigap plans cover cost-sharing for APCM, and many individuals have Medigap or other supplemental insurance to assist with this.

Technology Barriers and Alternative Communication Methods

Home-based primary care (HBPC) providers often face significant challenges when it comes to technology barriers, which can impact the delivery of care to patients. Many HBPC patients, particularly those in rural or underserved areas, may have limited access to reliable internet, which hinders the use of telehealth and other digital communication tools. Additionally, some patients may struggle with using technology due to age, cognitive impairment, or lack of digital literacy. To overcome these barriers, HBPC providers can explore alternative communication methods such as phone calls, text messages, or even in-person visits when feasible. These alternatives help ensure that patients receive the necessary care and maintain consistent communication with their providers, while minimizing the digital divide. Adapting communication strategies to meet patients' needs is essential for improving care delivery and fostering better patient-provider relationships in home-based settings.

Emergency And Safety Protocols in Home-Based APCM

Emergency and safety protocols in home-based Advanced Primary Care Management (APCM) are crucial for ensuring patient safety and timely intervention in case of health crises. Home-based care providers must have clear, well-defined procedures for handling medical emergencies, such as sudden health deterioration, falls, or complications related to chronic conditions. This includes ensuring that patients and caregivers are aware of the steps to take during an emergency, such as how to contact emergency services, when to seek immediate medical attention, and how to manage chronic conditions that may lead to acute events. Providers should also maintain up-to-date medical records and have emergency contact information readily available, including nearby hospitals or urgent care centers. Additionally, safety protocols should include regular check-ins with patients, especially those with cognitive or mobility impairments, to identify risks before they lead to emergencies. Using technology, such as remote monitoring tools or emergency alert systems, can enhance real-time tracking of patient health and facilitate quick response in critical situations. By establishing and reinforcing emergency and safety protocols, HBPC providers can minimize risks and ensure a rapid, coordinated response when urgent care is needed.

Remote Monitoring and Telehealth Integration

Remote monitoring and telehealth integration in Advanced Primary Care Management (APCM) are essential components for delivering continuous, high-quality care to patients with chronic conditions. These technologies allow healthcare providers to track patient health metrics, such as blood pressure, glucose levels, or weight, in real-time, without requiring patients to visit the clinic. This ongoing monitoring helps detect early signs of deterioration or complications, enabling timely interventions and reducing the need for emergency visits or hospitalizations. Telehealth integration facilitates virtual consultations, offering patients greater access to care from the comfort of their homes, particularly for those with mobility issues or living in remote areas. For HBPC providers, incorporating remote monitoring and telehealth tools enhances communication with patients and allows for more frequent check-ins, improving the management of chronic conditions. However, successful integration requires ensuring that patients are comfortable with the technology and have access to the necessary devices and internet connectivity. Additionally, providers must ensure compliance with privacy and security regulations, such as HIPAA, to protect sensitive health information. Overall, remote monitoring and telehealth integration improve care efficiency, increase patient engagement, and support better health outcomes for patients managing chronic conditions at home.

Benefits

The benefits of offering APCM services in your practice:

- Improved patient care and enhanced patient satisfaction.
- Increased reimbursement for the practice by providing coordinated APCM services.

By offering APCM services and billing through Medicare, eligible patients benefit from having dedicated interdisciplinary team members who manage their care and regularly interact with them. These team members help patients plan for better health, stay on track with treatments, medications, referrals, and appointments, and provide regular check-ins and reminders.

Encouraging patients to participate in APCM services provides valuable support between visits, ensuring they stay on top of their care.

Explaining APCM to Patients

The following information is intended to help healthcare professionals explain APCM services to patients and caregivers, outlining the benefits to the patient and their caregiver, and their role in coordinating these services.

What is APCM?

If you have Medicare or both Medicare and Medicaid, are managing complex health conditions, and have high needs for additional care management, Medicare offers Advanced Primary Care Management (APCM) services to help you better manage your health and spend more time enjoying life in good health.

If you have chronic or complex conditions such as Alzheimer's disease and related dementia, arthritis, asthma, atrial fibrillation, autism spectrum disorders, cancer, cardiovascular disease, chronic obstructive pulmonary disease (COPD), depression, diabetes, hypertension, substance use disorder, or infectious diseases like HIV/AIDS, APCM is an essential part of the care we can provide to support your health and well-being.

What Are the Benefits of APCM?

Regular participation in APCM allows you to better manage your care and focus on your health. It helps you work toward your health and quality of life goals, while reducing the risk of health setbacks like hospitalization, emergency department visits, or worsening conditions.

Coordinated care means you will receive personalized attention and support from a healthcare provider who knows you and your health conditions, helping you stay healthy

Informed Consent Notification

Patients must provide consent to receive APCM services. This consent can be given verbally or in writing and must be documented in the medical record. Informed consent is required only once unless the patient switches to a different APCM practitioner.

The following language is a guide for having conversations seeking verbal consent for APCM services. Please ensure you cover the key points below:

- Your care team will review your medical records and may contact you if needed. They will also check in with you to keep you informed about how they are working to support your health.

Questions to ask:

- Do you have any questions about APCM services?
- Do you agree to receive APCM services?
- Do you understand that a monthly fee could apply to APCM services?
- How would you prefer to be contacted?
- What is the best time for us to contact you?

Additionally, the care team in your practice will share relevant health information to make sure we can discuss everything when we meet again.

Please note: Standard cost-sharing rules apply to APCM services, meaning many patients will be responsible for the usual Medicare Part B cost-sharing (deductible and coinsurance) if they do not have supplemental (“wrap-around”) insurance. However, most dually eligible individuals (those with both Medicare and Medicaid) are not responsible for cost-sharing. Medigap plans also provide wrap-around coverage for APCM cost-sharing, and many individuals have Medigap or other supplemental insurance to assist with this.

How Will We Be Paid for Providing APCM Services to Individuals with Medicare Fee-for-Service?

Payment Information

HCPCS Code	Description	Monthly Reimbursement
G0556	One or no chronic conditions; team-based longitudinal support	\$16.45
G0557	Two or more chronic conditions; increased service complexity	\$54.04
G0558	QMB patients with high complexity; includes additional social needs	\$117.82

*National Non-Facility reimbursement rate

Advanced Primary Care Management (APCM) Script for Talking to Patients

Good morning/afternoon, [PATIENT'S NAME],

My name is [YOUR NAME], and I'm a clinical coordinator with [ORGANIZATION NAME], working alongside your provider, [PROVIDER NAME, if known]. I'm reaching out to share information about a valuable program available to you called Advanced Primary Care Management, or APCM.

APCM is like having a dedicated health coach. It connects you with a trained healthcare professional who will regularly check in with you to support your health needs. This can include help with medication refills, arranging specialist referrals, coordinating transportation, community resources or ordering medical equipment.

You'll also have access to a 24/7 phone line to speak with a healthcare provider or nurse whenever you need assistance. We'll schedule regular check-ins to ensure the program continues to meet your needs.

Please let me know if you have any questions or would like to learn more about enrolling in APCM.

Best regards,

[YOUR NAME]

[ORGANIZATION NAME]

[CONTACT INFORMATION, if applicable]

Frequently Asked Questions (By Patients):

1. What is Advanced Primary Care Management?

Advanced Primary Care Management (APCM) is a Medicare program designed to provide coordinated care for patients with complex medical conditions. It offers support outside of regular office visits, including personalized care plans, 24/7 access to a care team, and assistance with managing medications, appointments, community resources and health goals. APCM aims to improve your quality of life and help you manage your conditions more effectively.

2. Who is eligible for APCM?

You are eligible for APCM if you are a Medicare beneficiary with complex medical needs, such as diabetes, hypertension, arthritis, heart disease, or others. These conditions could place you at risk of worsening health or functional decline. Your healthcare provider can confirm if your conditions qualify.

3. What kind of services will I receive through APCM?

APCM services include:

- A dedicated care coordinator who contacts you at least monthly to check on your health and goals.
- A personalized care plan outlining your health conditions, medications, and care needs.
- 24/7 access to a care team for urgent needs.
- Help with scheduling appointments, refilling prescriptions, and coordinating care between your doctors, specialists, and pharmacies.
- Support for social needs, such as finding community resources for food, housing, or emotional support.

These services are mostly provided remotely via phone or online, though in-person visits may occur if needed.

4. Will APCM cost me anything?

APCM may involve a monthly copay. Medicare Part B covers 80% of the cost after you meet your deductible, leaving you responsible for about a 20% copay. If you have secondary insurance (like Medigap), it may cover the remaining cost. Dual-eligible Medicare and Medicaid patients may be exempt from copays. Always check with your provider for specific costs.

5. Do I need to consent to participate in APCM?

Yes, you must give informed consent to enroll in APCM, which can be verbal or written. Your provider will explain the program, including services, costs, that only one provider can bill for APCM per month, and your right to stop the program at any time. Consent ensures you understand and agree to participate.

6. Can I stop participating in APCM if I change my mind?

Yes, you can opt out of APCM at any time by notifying your provider or care coordinator via phone or in writing. There is no long-term commitment, and you can re-enroll later if needed.

7. How is APCM different from my regular doctor visits?

APCM provides ongoing support between office visits. While regular doctor visits focus on in-person exams and treatment, APCM offers non-face-to-face care, such as monthly check-ins, care coordination, and help with managing your medical conditions. It ensures continuous support to prevent health issues and keep your care on track.

8. Will I still need to see my doctor in person?

Yes, APCM complements but does not replace in-person visits. You'll still need regular check-ups, such as annual wellness visits, to monitor your health. APCM helps ensure you follow your care plan and prepares you for those visits by coordinating care and addressing issues early.

9. Can I enroll in APCM with more than one doctor?

No, only one primary care provider can bill Medicare for APCM services per month. If you're enrolled with one provider, another cannot bill for APCM unless you switch providers. Your care coordinator will confirm you're not enrolled elsewhere before starting.

10. How will APCM benefit me?

APCM improves your health by:

- Helping you stick to your treatment plan, reducing the risk of complications.
- Providing regular support to manage symptoms and prevent hospital visits.
- Coordinating care between your doctors to avoid gaps or errors.
- Offering access to resources for better self-management and quality of life.

Patients in APCM often have better health outcomes and fewer emergency room visits or hospitalizations.

11. What are complex conditions that would qualify for APCM?

Common conditions that may qualify include, but are not limited to:

- Diabetes
- Hypertension (high blood pressure)
- Heart disease
- Arthritis
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Cancer
- Alzheimer's disease or dementia
- Asthma

12. How do I enroll in APCM?

To enroll, talk to your primary care provider. They will confirm your eligibility, explain the program, and obtain your consent. Enrollment can often be done over the phone or during an office visit, sometimes in less than five minutes. An initiating visit (like an annual wellness visit or evaluation) may be required if you're a new patient or haven't seen the provider in over a year.

13. What is a comprehensive care plan, and will I get a copy?

A comprehensive care plan is a personalized document listing your health conditions, medications, goals, other providers, and community resources. It's created by your care team to guide your care. You or your caregiver can access or receive a copy of this plan to stay informed about your treatment.

14. How often will I hear from my care coordinator?

Your care coordinator will contact you at least once a month to review your health, care plan, and needs. These check-ins are usually by phone or online, but you can also reach out to them anytime, including 24/7 for urgent issues.

15. Can APCM be provided by specialists, or is it only for primary care?

APCM can be provided by primary care providers only.

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