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Navigating Care Models: Comparing APCM & CCM for Optimal Practice Benefits

Purpose

This resource serves as a comparative guide to support healthcare providers in evaluating and selecting between Advanced Primary Care Management (APCM) and Chronic Care Management (CCM). It outlines structural, operational, and reimbursement differences while helping organizations determine which model aligns best with their goals for home-based primary care (HBPC), care coordination, and patient outcomes. This resource was developed utilizing Centers for Medicare & Medicaid Services (CMS) guidelines and requirements and can be referenced for further details.

Intent of Resource

This guide is intended to:

- Clarify the definitions and core elements of APCM and CCM.
- Illustrate their respective workflows, billing requirements, and eligibility criteria.
- Provide strategic insight into when and how each model may be best applied.
- Assist practices in optimizing care delivery and reimbursement in a value-based care environment.

Understanding the Foundations: Key Differences Between APCM and CCM

Strategic Alignment: Choosing the Right Model for Your HBPC Practice

Selecting between APCM and CCM should be guided by clinical and operational priorities:

Choose APCM when:

- You serve high-risk, medically complex patients requiring frequent touchpoints.
- Your practice is structured around interdisciplinary care teams.
- You aim to reduce the total cost of care and achieve quality metrics across multiple domains.
- You have the ability to implement 24/7 access and proactive care workflows.
- Your practice has the infrastructure to gather and report quality measures to CMS.

Choose CCM when:

- You want to implement care coordination services for patients with chronic conditions but have fewer resources for team-based care.
- You're piloting care management efforts with limited staff.
- You seek additional revenue streams through structured chronic care documentation.

Best Practice Tip: Some practices implement both models strategically leveraging CCM for less complex cases while using APCM for their highest-need patients.

Feature	Advanced Primary Care Management (APCM)	Chronic Care Management (CCM)
Focus	Comprehensive, longitudinal, team-based primary care	Coordination of services for patients with ≥2 chronic conditions
Patient Eligibility	Typically complex, high-need populations (e.g., dual eligible, home-limited)	≥2 chronic conditions expected to last ≥12 months
Initiating Visit	Required for new patients; Annual Wellness Visit may qualify	Required unless billed within last year
Care Plan	Multidisciplinary, integrated care plan shared across care team	Comprehensive care plan with specific elements (goals, problems, interventions)
Care Coordination	Includes 24/7 access, scheduling, real-time EHR sharing, multidisciplinary care and focuses on proactive, on-going care vs. time-based thresholds	Focused on communication with specialists and community services
Staffing	Involves primary care provider, care manager, behavioral health, pharmacist, etc.	May involve clinical staff under general supervision
Billing Codes (2025)	G0556, G0557, G0558	99490, 99439, 99487, 99489, 99491, 99437
Reimbursement Structure	G-codes; monthly; based on complexity; is not time-based; instead, it uses a monthly prospective payment based on patient risk stratification, regardless of time spent, as long	CPT, Time-based; per determined minutes of clinical staff time per month
Technology Requirements	Certified EHR, real-time access, team-based documentation, quality reporting and data gathering capabilities for CMS	Certified EHR, structured documentation of care plan

References

Centers for Medicare & Medicaid Services. (2025, January). Advanced Primary Care Management Services. U.S. Department of Health & Human Services. https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services

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