# APCM Summary: what Medicare actually requires.

Advanced Primary Care Management (APCM) is a set of monthly Medicare payments for between-visit primary care, in effect since January 1, 2025. This page summarizes the rules in plain English. It is not billing or legal advice; confirm specifics with your Medicare Administrative Contractor or billing advisor. Last checked October 2026.

## What it is

Traditional Medicare (Part B) pays a primary care practice a flat monthly fee per enrolled patient for the work that happens between visits: care plans, follow-up, coordination, patient communication. No minutes are counted. For an enrolled patient it replaces the time-tracked chronic care management (CCM), principal care management (PCM), and transitional care management (TCM) codes. Medicare Advantage plans are not required to pay these codes; check each plan.

## Why it was introduced

Medicare has paid for between-visit care since 2015 through CCM and related codes, but each one is billed by the minute: at least 20 minutes of documented clinical staff time per month for CCM, more for the complex versions, with a separate code for each category of work. CMS found that the minute-tracking kept most practices from billing at all, that the separate codes fragmented the work, and that practices in its primary care models (Comprehensive Primary Care Plus, Primary Care First) were delivering this care without a matching payment in regular Medicare. APCM, finalized in the 2025 Physician Fee Schedule, replaces the time-based codes with one monthly payment per patient. The test moves from "how many minutes did you log" to "can your practice provide these services, and did it when the patient needed them."

## The three codes

One code per patient per calendar month, chosen by the patient's chronic conditions and Medicaid status. 2026 national average payment, non-facility; actual amounts vary by locality, and hospital-outpatient rates are lower.

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| **G0556** | one chronic condition, or none. | About **$16** per month. |
| **G0557** | two or more chronic conditions expected to last at least 12 months. | About **$54** per month. |
| **G0558** | two or more chronic conditions, and the patient is a Qualified Medicare Beneficiary (QMB), a low-income Medicare patient whose cost sharing Medicaid covers. | About **$117** per month. |

## What the change makes possible

Because the payment is for capability rather than minutes, most of what qualifies a practice is systems: identifying eligible patients and their tier, keeping the care plan current, tracking discharges, handling routine outreach and messaging in the practice's name, and keeping documentation an auditor would accept. Systems can be automated far more completely than minute-logged phone calls. A practice can therefore enroll a much larger share of its Medicare panel without adding to its staff's day, and bill every month a patient is enrolled rather than only the months minimum time limits were logged or sufficient readings were received back from patients.

That changes who can run a program at all. Under CCM, a program needed a dedicated person logging time, so it only paid for itself above a certain panel size, and the outside companies that run it for practices generally need a large enough panel to make their own staffing work. When the work is systems, the fixed cost falls. A five-physician practice, a two-physician practice, and a solo practitioner can run a program that was previously realistic only for large groups.

The payment does not depend on patient behavior the way remote patient monitoring does, where reimbursement requires the patient to keep transmitting device readings. APCM depends on what the practice can provide.

The cost-sharing problem is also smaller than it looks. QMB patients cannot be charged any cost sharing, and most other traditional Medicare patients have Medigap, employer retiree, or Medicaid coverage that pays the 20% for them. Which patients those are can usually be worked out from the practice's own Medicare remittance records (the electronic remittance advice shows when a claim was forwarded to a supplemental insurer, and names it) for every patient the practice has billed, before anyone is asked to consent. That makes the consent conversation short and honest.

If the between-visit work actually gets done, patients get more consistent follow-up, which is what the payment was designed to buy.

## What the patient pays

Standard Part B cost sharing applies: the annual deductible and 20% coinsurance, roughly $3 to $23 a month depending on the code. QMB patients (code G0558) cannot be billed any cost sharing. Medigap Plans F, G, and N and most employer retiree plans pay the 20% in full, and about three in four traditional Medicare patients have coverage of this kind (KFF analysis of 2023 CMS data). Routinely waiving the coinsurance is not permitted.

## What your practice has to be able to do

APCM pays for capability, not minutes. CMS requires that these service elements be available to every enrolled patient and provided when the patient needs them, not that each one is performed every month.

1. **Consent:** written or verbal, documented in the record, obtained once. The patient must be told that only one practitioner can bill APCM for them in a month, that they can stop at any time, and that cost sharing may apply.
2. **An initiating visit for new patients.** Not needed if your practice has seen the patient in the last 3 years or provided CCM, PCM, or APCM in the last year. An Annual Wellness Visit counts.
3. **24/7 access** for urgent needs to a member of the care team with real-time access to the patient's record; the ability to book successive appointments with the same team member; and some way to deliver care other than an office visit (phone, video, expanded hours, home visits). A recording that says "call 911 or go to urgent care" does not meet this.
4. **Comprehensive care management:** assessment of medical and psychosocial needs, preventive services, medication reconciliation.
5. **An electronic, patient-centered care plan** the care team can update and that can be shared outside the practice.
6. **Management of care transitions:** follow-up after hospital, emergency department, or facility discharge, with timely exchange of records.
7. **Coordination** with other practitioners and with home- and community-based services.
8. **Enhanced communication:** secure messaging, patient portal, email, patient-initiated digital contact.
9. **Population-level management:** identify care gaps and risk-stratify the practice's patients.
10. **Performance measurement:** report quality, total cost of care, and use of certified EHR technology, either through the Value in Primary Care MIPS Value Pathway (MVP) or by participating in an ACO (Medicare Shared Savings Program or ACO REACH). Two other qualifying models, Primary Care First and Making Care Primary, ended in 2025.

Clinical staff can do most of this under the billing practitioner's general supervision ("incident to"); the practitioner does not have to be present.

### Plan the billing before you enroll anyone

APCM creates one claim per enrolled patient per month, a 20% patient statement where no supplemental coverage pays it, and secondary billing where one does. A billing plan is part of a successful implementation, not an afterthought: without one, the practice does the between-visit work and has no process in place to make sure it is paid for it.

## Who can bill it

Physicians, nurse practitioners, physician assistants, clinical nurse specialists and certified nurse midwives who are, or intend to be, responsible for all of the patient's primary care and serve as the continuing focal point for all their health care. CMS does not restrict it by specialty, but that condition means it is in practice family medicine, internal medicine, general practice and geriatrics. The work itself can be done by clinical staff under general supervision. One billing practitioner per patient per month. Practitioners subject to MIPS must also report the Value in Primary Care MIPS Value Pathway or be in a Medicare Shared Savings Program ACO, an ACO REACH or another qualifying CMS primary care model. Federally Qualified Health Centers and Rural Health Clinics can also bill APCM.

## What you cannot bill in the same month

The practitioner billing APCM cannot also bill, for that patient in that month: CCM, PCM, TCM, virtual check-ins, e-visits, remote evaluation of patient-submitted images or video, and interprofessional consults. They are inside the bundle. The restriction is on the billing practitioner, not the patient: a different practitioner, including one in the same practice, can still bill these for the same patient when medically necessary.

**What you can:** office visits, including telehealth visits, and the Annual Wellness Visit; the separately paid initiating visit for new patients; remote patient monitoring (RPM) and remote therapeutic monitoring; Community Health Integration and Principal Illness Navigation; and, from 2026, the optional behavioral health add-on codes G0568 to G0570 for behavioral health integration and collaborative care, billed on top of the APCM base code.

### What an auditor looks for

Documented consent. The care plan in the record. Evidence that the practice could actually provide each element (an after-hours arrangement, a transitions process, a way to risk-stratify) and that it did so when a patient needed it. The performance-reporting pathway in place. The common failure is not too few minutes. It is a service the practice said it offered and could not show it had.

Sources: CMS, "Advanced Primary Care Management Services," Physician Fee Schedule (page updated January 2026); CY 2025 and CY 2026 Physician Fee Schedule final rules; KFF analysis of 2023 CMS data on supplemental coverage. Prepared by Leslie Dickson-Tetteh and Ji Tang as part of an independent study of between-visit care in independent primary care. Questions: leslie@seraphmed.io · apcmstudy.com