

APCM on one page: 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

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.

- **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 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.

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.

Who can bill it

Physicians, nurse practitioners, physician assistants, and clinical nurse specialists who are responsible for all of the patient’s primary care and serve as the continuing focal point for their care: in practice, family medicine, internal medicine, general practice, and geriatrics. One billing practitioner per patient per month. Federally Qualified Health Centers and Rural Health Clinics can also bill APCM.

What you cannot bill in the same month

For the same patient: CCM, PCM, TCM, virtual check-ins, e-visits, and interprofessional consults. They are inside the bundle.

What you can: office visits, the Annual Wellness Visit, remote patient monitoring (RPM) and remote therapeutic monitoring, and, from 2026, the behavioral health add-on codes G0568 to G0570 for collaborative care and behavioral health integration.

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