Advanced Primary Care Management: what Medicare requires, in plain English.

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.

In any month it is billed, it replaces for that patient 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 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 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.

From 2026, optional behavioral health add-on codes (G0568 to G0570) can be billed on top of the base code. The 2027 fee schedule, due in November, proposed no change to the base codes, the consent rules or the care plan.

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, patient communication in the practice's name, and documentation an auditor would accept. Systems can be automated far more completely than minute-logged phone calls, so a practice can enroll a much larger share of its traditional Medicare panel with the staff it has, and bill every month a patient is enrolled.

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 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 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 question can be answered before anyone is asked. 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 have secondary coverage for the Medicare patient share can usually be worked out from the practice's own Medicare remittance records, which show when a claim was forwarded to a supplemental insurer and name it, for every patient the practice has billed. That makes the consent conversation short and honest.

If the between-visit work 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 ($283 in 2026) and 20% coinsurance. Once the deductible is met, the patient share is about $3 a month on the $16 code and about $11 on the $54 code. The $117 code applies only to QMB patients, who cannot be billed any cost sharing.

Until the deductible is met, the whole monthly amount, up to about $54, counts toward it and falls to the patient or their supplemental plan. APCM does not add to the deductible, which is the same $283 whatever services a patient uses, but it can change which bill the deductible lands on: for a patient whose first services of the year are APCM months, those months can appear on a statement from the practice.

Medigap Plans C and F cover the Part B deductible. Plans G and N, which between them cover more than half of Medigap holders, do not. Plans K and L pay only part of the coinsurance. About three in four traditional Medicare patients have Medigap or employer retiree coverage that pays the 20% for them, and more have Medicaid (KFF analysis of 2023 data); about one in eight have no supplemental coverage and are billed the share.

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.

01 Consent. Written or verbal, documented in the record, obtained once. The patient must be told that the service is available, 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. Consent names the billing practitioner and is obtained again if that practitioner changes; a CCM consent does not carry over.

02 An initiating visit for new patients. Not needed if the patient has been seen in the last three years or had CCM, PCM or APCM from the practice in the last year. CMS's own documents differ on whether "seen" means by the practice or by the billing practitioner, so plan on the stricter reading. An Annual Wellness Visit counts when a physician, nurse practitioner, physician assistant, clinical nurse specialist or certified nurse midwife furnishes it.

03 24/7 access for urgent needs to a member of the care team, with each after-hours contact documented and passed to the care team; 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.

04 Comprehensive care management: assessment of medical and psychosocial needs, preventive services, medication reconciliation.

05 An electronic, patient-centered care plan the care team can update and that can be shared outside the practice, with a copy for the patient.

06 Management of care transitions: follow-up after a hospital, emergency department or facility discharge, within seven days where clinically indicated, with timely exchange of records.

07 Coordination with other practitioners and with home- and community-based services.

08 Enhanced communication: secure messaging, patient portal, email, patient-initiated digital contact.

09 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 or by participating in a Medicare Shared Savings Program ACO or ACO REACH. Practitioners not subject to MIPS, for example those below its low-volume threshold, are not required to report it. ACO REACH ends in December 2026; whether its successor model qualifies has not been stated.

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 patient statement where no supplemental coverage pays the share, and secondary billing where one does. It also needs a check each month of what else was billed for that patient, because some codes cannot be billed in the same month.

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. 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. A transitional care month is worth about four APCM months, so the choice matters.

The rule names the billing practitioner. Whether another practitioner in the same practice can bill these codes for the same patient in the same month is not settled in CMS's guidance, so confirm with your Medicare contractor before relying on it.

What you can bill alongside APCM:

- office visits, including telehealth visits, and the Annual Wellness Visit
- the separately paid initiating visit for new patients
- remote patient monitoring and remote therapeutic monitoring
- Community Health Integration and Principal Illness Navigation
- from 2026, the behavioral health add-on codes G0568 to G0570, 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; CY 2027 proposed rule (July 2026); KFF analysis of 2023 CMS data on supplemental coverage.

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