

Advanced Primary Care Management Program Reference Guide

Introduction to Advanced Primary Care Management (APCM)

Advanced Primary Care Management (APCM) is Medicare's latest initiative to help primary care providers deliver continuous, proactive care to patients. This program is a significant step by the Centers for Medicare & Medicaid Services (CMS) in bridging traditional fee-for-service (FFS) care with value-based, population-focused care elements. For primary care practices accustomed to the FFS model, APCM offers a unique opportunity to explore population-based care management without the downside risk that can often come with value-based initiatives.

Unlike past pilot programs — such as Primary Care First and Comprehensive Primary Care Plus (CPC+) — APCM integrates population-based elements directly into the FFS structure. This makes it a low-risk, voluntary program that enhances care without requiring a full commitment to a new payment model. Such a blend of FFS and value-based care makes APCM a win-win for practices: primary care providers can broaden their approach to patient care while simultaneously benefitting from stable, recurring revenue streams.

In this comprehensive guide, we'll explore everything you need to know about APCM, including its benefits, CMS requirements, implementation steps, and tips for integrating APCM with remote patient monitoring (RPM). Whether you're considering APCM to improve patient outcomes, enhance engagement, or diversify revenue, this guide will equip you with the knowledge and tools to make APCM a seamless addition to your practice.

Definition of APCM

Advanced Primary Care Management (APCM) is a Medicare-funded service designed to provide structured, continuous care for patients. Unlike traditional chronic care management (CCM), APCM offers flexibility, allowing providers to tailor care for a wide range of patient needs — from low to high complexity. This service is exclusively available to primary care providers (PCPs), who can bill for APCM services monthly based on the complexity of managing each patient's care.

For many Medicare beneficiaries, APCM offers vital support that helps them stay connected to their healthcare providers, remain adherent to treatment plans, and address health issues early to prevent complications. This ongoing connection enhances patient engagement and builds trust between the provider and patient, leading to better health outcomes and satisfaction.

How APCM Differs From Traditional Chronic Care Management

While APCM and chronic care management (CCM) are both designed to support patients with chronic conditions, there are key differences between the two services. CCM provides general support for patients with multiple chronic conditions, but APCM is more adaptable to a wider range of patient needs, including those with stable conditions and those requiring more complex management. Additionally, APCM offers more targeted billing codes, allowing providers to capture accurate reimbursement based on patient complexity.

- **Service scope:** APCM caters to patients with varying levels of need, offering tailored billing codes for zero- or single-chronic condition patients, multiple chronic conditions, and high-complexity patients with Qualified Medicare Beneficiary (QMB) status.
- **Billing and reimbursement:** APCM provides billing codes (i.e., G0556, G0557, G0558) that reflect the intensity of care required, rewarding providers for managing both simpler cases and more complex patient needs.
- **Multidisciplinary approach:** While only primary care providers can bill for APCM, this service encourages the involvement of interdisciplinary care teams, including nurses and care coordinators, to deliver well-rounded care.

Key Benefits of APCM for Medicare Providers

Advanced Primary Care Management offers substantial benefits to both patients and providers. For patients, APCM translates to more personalized, continuous care, and regular contact with their healthcare team. For providers, APCM represents an opportunity to enhance patient outcomes while generating new revenue streams through monthly Medicare reimbursements.

Top benefits of APCM:

- 1. Improved patient outcomes:** With regular follow-ups and a structured care plan, patients enrolled in APCM often experience better disease management, fewer hospitalizations, and improved adherence to treatment plans.
- 2. Enhanced patient engagement:** By fostering a proactive care model, APCM keeps patients connected to their providers, increasing trust and satisfaction.
- 3. Financial benefits for providers:** APCM offers monthly reimbursement codes that allow practices to generate stable income from care management activities. This reimbursement structure also allows providers to invest in staff and resources that improve care delivery.
- 4. Efficiency and workflow optimization:** APCM often integrates well with technology like RPM and care management software, allowing providers to monitor patients remotely, document efficiently, and maintain compliance.

How APCM Can Enhance Revenue

Implementing APCM offers primary care practices a significant revenue opportunity. By billing Medicare monthly for APCM services, practices can create a steady revenue stream, which can be increased by offering additional services like RPM. Many providers find that APCM is an effective way to expand their care offerings, increase patient satisfaction, and enhance revenue.



Understand the APCM codes, including eligibility requirements and reimbursement rates

- **G0556:** APCM services for a patient with **one chronic condition** [expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation / decompensation, or functional decline], **or fewer**, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month.
- **G0557:** APCM services for a patient with **multiple (two or more) chronic conditions** expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation / decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month.
- **G0558:** APCM services for a patient that is a **Qualified Medicare Beneficiary with multiple (two or more) chronic conditions** expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation / decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month.

Eligibility Requirements for APCM

The Centers for Medicare & Medicaid Services (CMS) guidelines have set specific eligibility criteria for APCM services. To ensure compliance, it's essential that practices verify which patients qualify for APCM and document patient consent before services begin. The CMS requirements for APCM eligibility are designed to ensure that the service targets patients who would benefit most from continuous, managed care.

- **Providers acting as primary point of care only:** While the proposed rule stated that only PCPs are eligible to bill for APCM services, the final rule expanded this wording to include providers acting as the primary point of care services for a patient. This allows for a range of providers to bill for APCM, as long as they provide the patient with primary care services and act as the focal point for all of your patient's needed health care services.
- **Medicare beneficiaries** Patients must be Medicare enrollees to qualify for APCM. There are specific billing codes based on the level of patient complexity, including codes for patients with multiple chronic conditions and those with QMB status.
- **Patient consent:** CMS mandates that practices obtain and document patient consent for APCM. This consent must be documented in the patient's record to confirm that the patient understands the nature of the service and any associated codes.

APCM Billing Requirements

Each code also requires that the physician or qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all health care services (i.e. the individual providing APCM services) make available the following elements as appropriate:

1. **Patient consent:** Inform the patient of the availability of the service, that only one practitioner can furnish and be paid for the service during a calendar month, of the right to stop the services at any time (effective at the end of the calendar month), and that cost sharing may apply.
2. **Initiating visit:** Initiation during a qualifying visit for new patients or patients not seen within 3 years.

APCM Billing Requirements Continued:

3. **24/7 access to care:** Provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week.
4. **Continuity of care:** Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.
5. **Alternative care delivery:** Deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours.
6. **Comprehensive care management:** Overall comprehensive care management, including:
 - Systematic needs assessment (medical and psychosocial)
 - System-based approaches to ensure receipt of preventive services
 - Medication reconciliation, management and oversight of self-management.
7. **Patient-centered care plan:** Development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan with typical care plan elements when clinically relevant:
 - Care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver.
8. **Coordination of care transitions:** Coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable:
 - Ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care.
 - Ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated.

APCM Billing Requirements Continued:

9. **Ongoing communication:** Ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record.
10. **Enhanced communication opportunities:** Enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication-technology-based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/EHR referral service(s), to maintain ongoing communication with patients, as appropriate:
 - Ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and E/M visits (or e-visits).
11. **Population data analysis:** Analyze patient population data to identify gaps in care and offer additional interventions, as appropriate;
12. **Risk stratification:** Risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients;
13. **Performance measurement:** Be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of Certified EHR Technology.

APCM Compliance Best Practices

Ensuring compliance with APCM requirements is critical for maximizing revenue and reducing the risk of claim denials or audits. CMS expects practices to meet high standards for documentation, patient engagement, and care plan management.

Best practices for APCM compliance:

- **Use APCM-compliant software:** APCM-compliant software simplifies the documentation and billing process by automating coding and sending compliance reminders for routine tasks.
- **Regular staff training:** Conduct regular training sessions for your care team to stay updated on APCM requirements, CMS guidelines, and best practices in documentation.
- **Monthly compliance checks:** Monthly checks of APCM documentation, billing, and care plan updates can help ensure that all activities align with CMS standards, minimizing the risk of compliance issues.

These compliance practices not only support APCM billing accuracy but also improve overall patient care by ensuring each patient's needs are continuously monitored and addressed.

Assessing Patient Eligibility

Implementing APCM effectively begins with assessing your patient population to identify those who could benefit most from this service. The criteria set by CMS primarily focuses on chronic conditions, and APCM services are tailored to patients with varying degrees of care needs, from stable chronic conditions to those requiring complex, multidisciplinary management.

Medicare patients with zero, one, or multiple chronic condition(s) may qualify for APCM, making the program essentially available to all Medicare enrollees. More specific billing codes are available for patients with two or more chronic conditions or Qualified Medicare Beneficiary status.

Assessing Patient Care Needs

Use of EHR and screening tools: Many practices use electronic health records (EHRs) to identify APCM-eligible patients automatically, particularly those who may benefit from ongoing care management, including frequent hospital visits or medication adherence challenges.

Understanding billing codes for different levels of care: Different APCM billing codes (G0556, G0557, G0558) support varying levels of care, so be sure to match each patient's needs to the correct code for accurate billing and compliance.

Creating a Comprehensive Care Plan

Each APCM patient must have a personalized care plan that addresses their specific health needs, goals, and treatment priorities. An effective APCM care plan includes elements designed to guide the care team in delivering consistent, goal-oriented support.

Key components of an APCM care plan:

- **Individualized health goals:** Set clear, measurable goals for the patient, focusing on chronic condition management, preventive measures, and functional improvement.
- **Patient assessment and ongoing evaluation:** Begin with a thorough assessment of the patient's physical, mental, and social needs, and include routine reassessments to update the care plan based on progress or new challenges.
- **Multidisciplinary team collaboration:** Identify the roles of each care team member (e.g., nurses, social workers) to ensure that all aspects of the patient's care are coordinated effectively. Documentation of these roles also aids compliance and keeps team communication efficient.

Patient Education and Engagement Strategies

A successful APCM program relies heavily on patient engagement. Educating patients about the benefits of APCM and setting clear expectations for participation help to create an open line of communication and build trust.

Best practices for APCM compliance:

- **Explain APCM benefits and responsibilities:** Patients should understand the benefits of APCM, such as improved access to their care team, more structured care, and proactive health management.
- **Use accessible communication methods:** Consider using secure patient portals, email, or text reminders to engage patients effectively. Regular reminders keep patients connected to their care plans, helping them stay adherent to treatment instructions and routine check-ins.
- **Encourage patient feedback:** Feedback can provide valuable insights into the patient's experience with APCM, helping practices refine their engagement strategies. Regular feedback loops also improve patient satisfaction and strengthen the patient-provider relationship.

Why APCM Software Is Important for Effective Program Management

For practices running programs, APCM software is crucial in streamlining workflows, helping ensure compliance, and supporting seamless billing. Without software, manually tracking time spent on patient care, documenting interactions, and meeting CMS compliance standards can be overwhelming for staff to manage alongside other responsibilities.

Key Features to Look for in APCM Software

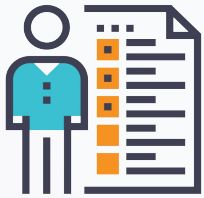
The right APCM software should not only streamline workflows but also help ensure compliance with CMS requirements. Look for the following key features when selecting a software solution for APCM:

1. **Comprehensive care plan management:** APCM software should support care plan customization, enabling providers to tailor care to each patient's unique health needs.
2. **Compliance alerts and reminders:** Built-in compliance reminders ensure that providers complete required documentation, such as patient consent and regular care plan updates, keeping practices aligned with CMS guidelines.
3. **Patient communication tools:** Effective APCM includes regular patient follow-up. Choose software that offers secure communication options, like patient portals or SMS reminders, to keep patients engaged in their care.
4. **Billing support:** Software with automated billing capabilities helps streamline end-of-month activities for enrolled patients.
5. **Data integration with EHR and RPM systems:** Look for software that integrates seamlessly with your existing EHR system and RPM solutions to consolidate patient information, making it easier to monitor patients and document care in one location.

Choosing a Comprehensive Remote Care Platform

While APCM software may initially serve a single purpose, selecting a platform that supports additional care management services like chronic care management and remote patient monitoring offers long-term benefits. A comprehensive platform allows your practice to expand its services over time, future-proofing your investment in software.

- **Scalability:** By supporting additional care management services, comprehensive software enables your practice to expand remote care options without needing multiple platforms.
- **Unified workflow management:** Consolidating various care programs under one software streamlines operations, saving your staff time and reducing administrative burden.
- **Enhanced patient care:** Offering a full suite of care management services allows you to address a broader range of patient needs, creating a more holistic approach to patient care.



Practical Tips for Maximizing APCM Benefits in Your Practice

Regular Staff Training and Compliance Updates

To maximize the benefits of APCM, it's essential to keep your staff updated on CMS requirements and best practices for documentation, patient engagement, and billing. Scheduling regular training sessions ensures that everyone on the team is aligned with APCM goals and understands how to use APCM software effectively. Partnering with a software and service vendor who deeply understands operational best practices and changing compliance standards can help ensure less of the burden falls on your team.

Conducting Monthly Compliance Checks

Monthly compliance audits help ensure that documentation and billing align with CMS standards. By reviewing APCM records regularly, practices can identify any discrepancies, confirm that all activities are fully documented, and reduce the risk of compliance issues.

Tips for conducting checks:

- **Focus on key documentation:** Verify that patient interactions, time spent, and care plans are fully documented and up-to-date.
- **Check billing codes and time tracking:** Ensure that the appropriate billing codes are used and that time-tracking records align with CMS requirements.
- **Engage the entire team:** Involve your care team in audit reviews to ensure everyone understands CMS expectations and can contribute to compliance.

Engaging Patients and Measuring Program Success

APCM is designed to be patient-centered, so it's important to measure both patient engagement and program outcomes. Patient feedback can offer insights into areas for improvement, while tracking patient outcomes and program metrics helps practices assess the effectiveness of their APCM services.

- **Collect patient feedback:** Use surveys or follow-up calls to gather patient input on the APCM experience, and use feedback to refine your engagement strategies.
- **Monitor key metrics:** Track metrics such as patient outcomes, readmission rates, and billing accuracy. These data points can help practices identify trends and areas for improvement.
- **Continuous improvement:** Use patient and performance data to continuously refine APCM workflows and enhance the quality of care provided.

The Role of RPM in Supporting APCM

Remote patient monitoring (RPM) is a valuable tool for practices offering APCM, as it provides real-time data on patient health metrics and can be billed alongside APCM services. By integrating RPM with APCM, providers can deliver more proactive, data-driven care, further improving patient outcomes and engagement.

Integrating remote patient monitoring (RPM) with APCM allows providers to monitor patients between visits, catching potential issues early and reducing the likelihood of acute complications. RPM is especially useful for patients with chronic conditions like hypertension, diabetes, or heart disease, as it enables continuous tracking of vital health data.

How RPM complements APCM:

- **Data-driven insights:** RPM provides up-to-date information on patient health metrics, allowing providers to make timely adjustments to care plans.
- **Improved patient outcomes:** By monitoring health data in real time, providers can intervene early, reducing hospitalizations and improving long-term health outcomes.
- **Increased patient engagement:** RPM encourages patients to take an active role in their health, which can lead to greater adherence to care plans and improved satisfaction.

Embracing APCM for a New Era in Care Management

Advanced Primary Care Management (APCM) represents a pivotal shift in Medicare's approach to care management, introducing population-based care elements into the traditional fee-for-service (FFS) framework. This change aligns with the Centers for Medicare & Medicaid Services' (CMS) broader goal to encourage practices, especially those deeply rooted in FFS models, to adopt more value-based care practices. Over recent years, CMS has piloted similar models like Primary Care First and Comprehensive Primary Care Plus (CPC+), but APCM is unique in that it incorporates elements of these models directly into the FFS system, creating new opportunities for providers within a familiar framework.

One of APCM's most attractive features is that it's entirely voluntary and free from any downside financial risk to providers. Primary care practices can engage with APCM without fearing potential financial loss, giving them a supportive, low-risk environment to explore population-based care management. This makes APCM an ideal entry point for providers who may be hesitant to adopt value-based care models but are interested in expanding their patient care strategies beyond traditional FFS structures.

As the healthcare landscape continues to shift towards preventive and population-focused care, APCM offers a flexible, supportive way for primary care providers to adopt elements of value-based care. Through APCM, practices can enhance patient outcomes, increase engagement, and capture consistent revenue, all while positioning themselves as leaders in proactive, patient-centered care. For practices ready to take the next step, APCM provides a pathway to a future in healthcare that balances patient and financial well-being, bridging the best of traditional and innovative care management.

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