



PAAs and Advanced Primary Care Management (APCM)

What is Advanced Primary Care Management? (APCM)

The Centers for Medicare & Medicaid Services (CMS) established Advanced Primary Care Management (APCM) services to simplify and strengthen reimbursement for the ongoing, relationship-based care that primary care clinicians provide. APCM was first finalized in the 2025 Physician Fee Schedule (PFS) final rule as a consolidated monthly payment intended to replace multiple overlapping care-management codes and better reflect the longitudinal work involved in caring for patients with chronic and behavioral health needs.¹

For physician associates (PAs), APCM offers new opportunities to deliver and lead whole-person primary care while receiving more predictable reimbursement for the between-visit work that is central to managing chronic and behavioral health needs.

This Reimbursement Brief introduces the APCM structure, explains how the codes work, outlines billing and documentation requirements, and highlights refinements finalized in the 2026 PFS that further support integrated primary care.

How APCM Works

APCM consists of three G-codes that reflect varying levels of patient complexity and the intensity of care coordination needed. These codes may be billed once per beneficiary, per month, by the clinician providing longitudinal primary care.²

- G0556 – Level 1 APCM: Monthly primary care management for beneficiaries requiring ongoing, longitudinal care with one or fewer chronic conditions.
- G0557 – Level 2 APCM: Beneficiaries with two or more chronic conditions requiring more intensive coordination, outreach, and follow-up.
- G0558 – Level 3 APCM: Beneficiaries with two or more chronic conditions who also qualify as Qualified Medicare Beneficiaries (QMBs) (The QMB program covers Part A and B premiums for low-income individuals and prohibits providers from billing these patients for Medicare cost sharing).

These codes are not time-based. Billing is tied to the number of chronic conditions and a practitioner's responsibility for the patient's ongoing care, not minutes of staff activity.

What APCM Covers

APCM consolidates a wide range of primary care coordination and management services that previously required multiple codes and rules.³

APCM may include:

Chronic Care Management (CCM), Principal Care Management (PCM), Transitional Care Management (TCM), digital communication and virtual follow up, population health management, care-plan development and coordination, medication and diagnostic follow up, between-visit outreach led by clinical or auxiliary staff, coordination with specialists, behavioral health, and community resources.

By bundling these elements into a single payment, APCM seeks to reduce administrative complexity and support continuous care.

Eligible Clinicians and Billing Requirements

Eligible billing practitioners include PAs, physicians, NPs, CNSs, and CNMs. The billing clinician must be the patient's **primary longitudinal clinician** for that month. Supervision: most activities may be performed by clinical or auxiliary staff under general supervision, consistent with other care-management services.

Documentation Expectations

Practices should be able to show:

- A valid initiating visit (when required)
- Beneficiary consent for APCM participation
- A comprehensive, up-to-date care plan
- Evidence of ongoing care coordination, follow-up, and communication
- Evidence that only one provider is serving as the primary point of care for that month

Mutually Exclusive Billing

When APCM is billed for a patient in a given month, the following services generally cannot be billed for the same patient in the same month:

- Chronic Care Management (99490, 99439, 99491, 99437, 99487, 99489)
- Principal Care Management (G2064/G2065)
- Transitional Care Management (99495/99496)

These services are considered included in APCM because to deliver APCM, a PA must already be performing the core activities covered by CCM, PCM, and TCM. Care planning, coordination, and follow-up are inherent to the ongoing relationship-based care that APCM is intended to cover.

Behavioral Health Integration with APCM

Behavioral health services are an integral part of primary care management, and CMS updated the APCM structure in the 2026 PFS final rule to reflect that.

New Behavioral Health Add-On Codes (Effective 2026)

APCM may be paired with newly finalized behavioral health integration (BHI) and Collaborative Care Model (CoCM) add-on codes when practices deliver these services in the same month. Providers no longer need to choose between APCM and BHI/CoCM as these new add-on codes allow additional reimbursement on top of the monthly APCM payment:

- **G0568 – Initial Behavioral Health Add-On (BHI/CoCM):** Add-on to an APCM monthly service in the *first calendar month* during which a behavioral health care manager’s activities begin.
- **G0569 – Subsequent Behavioral Health Add-On (CoCM):** Add-on to APCM for the *subsequent calendar months* of behavioral health care manager activities after the initial month.
- **G0570 – Behavioral Health Care Management Add-On (BHI):** Add-on to APCM for general behavioral health integration services.

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Policies

CMS aligned APCM-related structures with FQHC and RHC payment policies beginning in 2026. Key updates include:

- Behavioral health add-ons may be billed in FQHCs/RHCs
- CMS requires reporting of the underlying CoCM and digital communications codes rather than composite codes (e.g., G0512, G0071).
- Payment aligns more closely with PFS-based rates.

These changes are intended to create clearer reimbursement pathways for PAs and other providers practicing in FQHC and RHC settings.

APCM and Accountable Care Organization (ACO) Assignment

Beginning in 2026, APCM and the behavioral health add-ons are included in the list of primary care services that can be used to determine which ACO a beneficiary should be assigned to under the Medicare Shared Savings Program (MSSP).

Additional Information

[CMS Advanced Primary Care Management Services](#) | [2026 Physician Fee Schedule Final Rule Fact Sheet](#)

References

1. Centers for Medicare & Medicaid Services. Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule Summary (MM13887). Published November 21, 2024. Accessed December 3, 2025. <https://www.cms.gov/files/document/mm13887-medicare-physician-fee-schedule-final-rule-summary-cy-2025.pdf>
2. Centers for Medicare & Medicaid Services. Advanced Primary Care Management Services. Updated April 21, 2025. Accessed December 3, 2025. <https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services>
3. Centers for Medicare & Medicaid Services. Care Management. Updated April 21, 2025. Accessed December 3, 2025. <https://www.cms.gov/medicare/payment/fee-schedules/physician/care-management>
4. Centers for Medicare & Medicaid Services. CY 2026 PFS Final Rule (CMS-1832-F). Published October 31, 2025. Accessed December 3, 2025. <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-final-rule-cms-1832-f>

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