



VENDOR EVALUATION GUIDE • 2026

# Choosing an APCM partner

Seven dimensions, the 2026 vendor landscape, and the exact questions to ask, reviewed against the CMS CY2025 and CY2026 Final Rules.

ABOUT THIS GUIDE

# Choosing an APCM vendor comes down to seven things.

Features are rarely the deciding factor. What matters most is how much of the work your practice actually has the capacity to carry, every month, across a whole panel.

Advanced Primary Care Management is the biggest shift in primary care reimbursement in a decade. This guide gives you the criteria, the vendor landscape, and the exact questions to ask, reviewed against the CMS CY2025 and CY2026 Physician Fee Schedule Final Rules. It is vendor neutral in method: the framework applies to any partner you consider, including Vivo Care.

**WHO THIS IS FOR**

- Practice owners and administrators choosing how to run APCM
- Clinical operations leaders standing up or consolidating a program
- Medical directors accountable for documentation and audit readiness

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## SECTION 01 · CONTEXT

# What APCM is, and why vendor choice matters.

## APCM AT A GLANCE

**Live since Jan 1, 2025** • **3 codes:** G0556, G0557, G0558 •

**\$16 to \$117** per patient, per month • **No time tracking**, a monthly bundle

**A**PCM pays a primary care practice a monthly, per-patient fee to manage its whole panel, with no minute-by-minute time tracking. It rolls elements of Chronic Care Management (CCM), Principal Care Management (PCM), Transitional Care Management (TCM), and communication-technology services into one bundled payment, tiered by patient complexity. For CY2026, CMS raised all three tiers and added optional behavioral-health add-on codes (G0568, G0569, G0570).

The catch is the service bar: 24/7 access, documented consent, an initiating visit, a maintained care plan, care-transition follow-up, population health management, and performance reporting. Meeting that every month, across a panel, is an operational commitment. The vendor or internal model you choose decides whether it is sustainable.

**The codes reward a documented, retained relationship, not logged activity. So should your shortlist.**

### EVALUATION PRINCIPLE

Derived from CMS APCM service elements, 2025

SECTION 02 · CODES AND REIMBURSEMENT

# APCM codes and 2026 reimbursement.

APCM uses three HCPCS codes, billed monthly per enrolled patient and tiered by complexity. Figures below are 2026 national benchmarks (CY2026 Physician Fee Schedule, non-facility); actual rates vary by CMS locality.

CODE	COMPLEXITY	PATIENT PROFILE	2026 BENCHMARK	YOY
G0556	Level 1 (low)	0 to 1 chronic conditions expected to last at least 12 months	~\$16	+7.7%
G0557	Level 2 (moderate)	2 or more chronic conditions placing the patient at significant risk	~\$54	+10.0%
G0558	Level 3 (high)	Meets Level 2 criteria and holds Qualified Medicare Beneficiary (QMB) status	~\$117	+9.6%

Source: CY2026 Medicare Physician Fee Schedule, non-facility rates; locality-specific rates at cms.gov. RHCs and FQHCs bill these codes at national non-facility PFS rates.

### WHAT DRIVES APCM YIELD

Two things: complexity mix and geography. The rate scales sharply with complexity, so accurate G0558 identification at intake captures a disproportionate share of revenue. Rates are also locality-specific, with more than 37% dispersion between the highest and lowest markets. Alaska and California localities pay the most; Arkansas, Mississippi, Alabama, much of Missouri, and Kansas pay the least. Multi-state groups should model with CMS locality rates, not national medians.

SECTION 02 · BILLING RULES

# What you can and cannot bill with APCM.

The same practitioner cannot bill APCM and CCM, PCM, or TCM in the same month. APCM does stack with monitoring and behavioral-health services, as long as clinical effort is not double-counted.

SERVICE	WITH APCM?
Chronic Care Management (CCM)	Not allowed
Principal Care Management (PCM)	Not allowed
Transitional Care Management (TCM)	Not allowed
Virtual check-ins / digital E/M	Not allowed
Remote Patient Monitoring (RPM)	Allowed
Remote Therapeutic Monitoring (RTM)	Allowed
Behavioral Health Integration (BHI)	Allowed
Principal Illness Navigation (PIN)	Allowed

## APCM vs CCM, in practice

DIMENSION	APCM	CCM
Time tracking	Not required	Required (20-min min.)
Eligibility	Tiered by complexity	2+ chronic conditions
Billing	Monthly bundle by tier	Per 20-min unit
Best fit	Whole-panel management	Time-tracked engagement

### THE CAPABILITY THIS REVEALS

Most panels have patients suited to each program, which is why mapping the panel across APCM, CCM, and RPM is now a standard first step, and a capability worth testing in any vendor.

## SECTION 03 · THE DECISION

# Why practices evaluate APCM partners.

APCM solves a reimbursement problem and creates an operations problem. Most practices hit the same four pressures.

**01 Staffing capacity**

Few teams have spare clinical headcount for monthly outreach, care plans, and 24/7 access.

**02 The false binary**

Buy software and staff it yourself, or hand it to a call center. Neither extreme fits everyone.

**03 Compliance exposure**

Consent, the initiating visit, the care plan, and quality reporting are real audit risks.

**04 Switching cost from CCM**

A practice on CCM must re-map its panel and cannot bill both for one patient in a month.

## THE CORE IDEA

## A capability-versus-capacity decision, not a good-versus-bad one.

The question is not whether you can run APCM. It is whether you have the capacity to run it consistently, every month, without the program quietly degrading the first time the front office gets busy. That is what the seven dimensions on the next pages are built to test.

## SECTION 04 • THE SCORECARD

# Seven dimensions for evaluating any vendor.

Use these as a scorecard, ordered by how often they separate a good fit from a bad one.

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## 01 Model fit: in-house, fully managed, or elastic

A strong partner offers a real choice, software you staff yourself, a fully managed program, or an elastic model in between, rather than forcing the one model they sell.

**ASK** Can we start self-managed and shift clinical work to your team as we grow, on the same platform, without re-implementing?

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## 02 Clinical staffing: who does the work, and where?

This is a compliance fact, not a preference. Under 42 CFR 411.9, Medicare care-management services cannot be billed if the clinical work is performed outside the United States. General supervision rules did not change that.

**ASK** Are the people who speak with our patients U.S.-based and state-licensed? Employees or subcontractors?

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## 03 Patient experience and continuity of care

APCM is a relationship product. Disjointed, anonymous outreach is the most common complaint about managed programs run by an outside team, and it directly hits enrollment and retention.

**ASK** Will our patients reach the same care team members over time, and will the program feel like it comes from us?

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## 04 Compliance and documentation

The service bar is specific: consent, an initiating visit, a maintained care plan, 24/7 access, care-transition follow-up, population health, and MVP performance reporting. A capable vendor produces audit-ready documentation automatically.

**ASK** Show me how consent, the care plan, and the monthly service elements are captured, and how you would defend a claim in an audit.

## SECTION 04 • THE SCORECARD, CONTINUED

# Where the program scales, or stalls.

The first four dimensions decide whether a program is defensible. The last three decide whether it grows.

## 05 RPM and CCM stacking, and panel mapping

The highest-value 2026 programs layer APCM with RPM. A partner already running RPM at scale can stack both on one team and one platform, and help map which patients belong where.

**ASK** Can you run APCM and RPM on the same platform and team, and help us map our panel across APCM, CCM, and RPM?

## 06 Evidence: what data can they actually show?

Every vendor claims to improve outcomes. Ask for specifics: engagement consistency, billing-threshold attainment, enrollment conversion, clinical movement. Be wary of adjectives without numbers, and numbers without a reporting period.

**ASK** What percentage of enrolled patients hit the monthly billing threshold, and what results can you document, with dates?

## 07 Commercial model and transparency

Know exactly how the vendor is paid and what is included versus billed separately. Overpromised revenue and onboarding complexity are the two most common sources of buyer regret.

**ASK** Walk me through total cost at 100 and at 500 patients, and tell me what is not included.

### HOW TO SCORE IT

Rate each dimension 1 to 5 for every vendor. The lowest scores, not the average, are usually what you live with day to day.

SECTION 05 · THE MARKET

# The 2026 APCM vendor landscape.

The market sorts into four archetypes. The archetype, more than any single feature, is what you are choosing between. All vendors listed carry explicit, published APCM offerings as of 2026; this orients your evaluation, it is not a ranking.

ARCHETYPE	WHAT YOU GET	REPRESENTATIVE VENDORS	THE TRADE-OFF
<b>Self-Managed</b>	Run APCM, CCM, and RPM with your own staff	ThoroughCare, HealthArc	Most control and lowest cost; staffing stays with you
<b>Managed Clinical</b>	An outside team runs the program end to end	CareHarmony, Wellbox, ChartSpan†	Lowest lift; watch continuity and patient-experience risk
<b>Platform + elastic staffing</b>	One platform; you choose how much to hand off	<b>Vivo Care</b> , Prevounce, TimeDoc Health, HealthSnap, CoachCare / MD Revolution	Flexibility; needs an upfront design conversation
<b>In-house enablement</b>	Tech that makes your own staff more productive	Phamily	Retains revenue and relationship; needs internal bandwidth

*Vendor categories reflect each company's published APCM positioning as of 2026 and may change. Always confirm current scope, staffing, and integrations directly.  
 † ChartSpan is primarily a CCM provider; confirm current APCM scope directly.*

**READING THE LANDSCAPE**

The two outer archetypes optimize for control or for lift. The middle one, **platform plus elastic staffing**, exists because most practices want to start one way and shift as the panel grows. If that describes you, weight dimension 01 heavily.

## SECTION 06 • DILIGENCE

# Questions to ask any APCM vendor.

Twelve questions that surface the answers that matter. Bring them to every shortlist conversation.

- 01** Can we run self-managed, fully managed, or hybrid, and shift between them without re-implementing?
- 02** Are the clinical staff who speak with our patients U.S.-based and state-licensed? Employees or subcontractors?
- 03** How do you preserve continuity so patients reach consistent care team members?
- 04** How are consent, the initiating visit, and the care plan documented and made audit-ready?
- 05** How do you support 24/7 access and care-transition follow-up?
- 06** How do you handle MVP / Value in Primary Care performance reporting?
- 07** Can you run APCM and RPM on the same platform and care team?
- 08** Will you help map our panel across APCM, CCM, and RPM to avoid concurrent-billing errors?
- 09** What share of enrolled patients meet the monthly billing threshold, with a reporting period?
- 10** What clinical or engagement outcomes can you document, and over what window?
- 11** Exactly how are you paid, and what is the total cost at 100 and 500 patients?
- 12** What is included versus billed separately: devices, staffing, onboarding, EHR integration?

## SECTION 06 · IMPLEMENTATION

# APCM implementation checklist.

Ten requirements every billed month has to satisfy. Use it to pressure-test a vendor's workflow, or your own.

- ✓ **Eligibility and stratification:** assign each patient the correct tier (G0556, G0557, G0558).
- ✓ **Consent:** document it, with the one-biller and opt-out disclosures.
- ✓ **Initiating visit:** for new patients or any not seen in three years (an Annual Wellness Visit qualifies).
- ✓ **Care plan:** maintain a patient-centered plan, accessible to outside providers.
- ✓ **24/7 access:** round-the-clock access to a care team member with real-time record access.
- ✓ **Care transitions:** follow up after hospital, ED, or SNF discharge (target within seven days).
- ✓ **Population health:** risk-stratify the panel and find care gaps.
- ✓ **Performance measurement:** report on the Value in Primary Care MVP if MIPS-eligible.
- ✓ **Concurrent-billing guardrails:** no CCM, PCM, or TCM for the same patient in the same month.
- ✓ **Monthly billing review:** confirm each patient met the service bar before submitting.

## THE TEST THAT MATTERS

Ask a prospective partner to walk one patient through all ten, for a single recent billed month, start to finish. The gap between what a platform can capture and what it actually produces is where audit risk lives.

## SECTION 06 • FAQ

# Frequently asked questions.

**Q How is APCM different from CCM?**

APCM is a monthly bundle with no time tracking; CCM requires at least 20 minutes of documented care coordination per month. The same practitioner cannot bill both for the same patient in the same month.

**Q Can you bill APCM and RPM together?**

Yes, for the same patient by the same practitioner, as long as clinical effort is not double-counted. This stacking is one of the most valuable 2026 program designs.

**Q What are the 2026 APCM reimbursement rates?**

National proxies are about \$16/month for G0556, \$54 for G0557, and \$117 for G0558. Actual reimbursement varies by CMS payment locality.

**Q Can RHCs and FQHCs bill APCM?**

Yes. They bill the APCM codes at national non-facility PFS rates, and the same concurrent-billing prohibitions apply.

**Q Should we run APCM in-house or use a vendor?**

It depends on capacity, not capability. With clinical bandwidth, a software platform works in-house; without spare headcount, a managed or elastic model keeps the program running consistently.

**SOURCES & DISCLAIMER**

CMS Advanced Primary Care Management Services; CMS CY2025 and CY2026 Physician Fee Schedule Final Rules; AAFP APCM coding guidance (G0556, G0557, G0558); 42 CFR 411.9. Reimbursement figures are national proxies and vary by CMS payment locality. *This guide is educational and does not constitute billing, legal, or financial advice.*

SECTION 07 · THE VIVO CARE APPROACH

# How Vivo Care approaches APCM.

Vivo Care is model-agnostic by design. A practice can run APCM Self-Managed, or hand the clinical work to Vivo Care's Managed Clinical team on the same platform, staffed by U.S.-based, state-licensed care navigators who act as an extension of the provider team, not an offshore or third-party call center.

The APCM program launches later in 2026 alongside the existing RPM and CCM programs, so practices already running RPM can layer APCM on top with the same team. Mapping a panel across RPM, APCM, and CCM, so each patient lands in the program that fits, is the first thing we do in a Vivo Care panel consult.



THE PROOF, WITH REPORTING PERIODS

**2.3x**

the documented output gap versus Self-Managed, matched 2025 cohort

**350+**

active healthcare organizations

**120K+**

patients supported on the platform

**25.9M+**

documented engagement minutes, 2023 to 2025

LIMITED-TIME OFFER

## Sign by June 30, 2026 for a head start on APCM.

Sign an RPM, CCM, or PCM agreement on or before June 30, 2026 and the Pillar 2 clinical program fee is waived for the first four months at APCM activation. Care navigator services, if elected, bill normally. Existing Vivo Care customers are eligible.

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