SERVICE LINE STRATEGY · **Connected Care, by CoachCare.**

Associated Physicians Group

An independent Metro East practice bringing interventional pain care, physical therapy and primary care together in O'Fallon, Alton, Edwardsville and Swansea, Illinois, with 4 primary care clinicians caring for a Medicare panel of about 1,950

Remote Care Service Line Optimization Report

2026 Strategy Report

A scalable, profitable remote care service line for Associated Physicians Group: remote monitoring and chronic care management for the Medicare primary care panel, run inside eClinicalWorks from the day the move is complete and billed under APG's own NPIs at the East St. Louis locality's CY2026 Medicare rates

Purpose of this document

Prepared by CoachCare, November 2026, as a discussion document for the leadership of Associated Physicians Group. It is the companion to APG's remote care strategy page and makes the same case at report length: why Medicare's payment rules favor care between visits, what APG's own Medicare claims show, how the work can be divided between APG's team and CoachCare's once the practice is on eClinicalWorks, and what the service line returns over 24 months at the East St. Louis locality's rates.

APG already runs remote care with its own staff. The move to eClinicalWorks is the natural point to decide how that work runs from here: by APG's team on a platform built into the new chart, by CoachCare's care team, or split between the two. This report models the fully staffed option and describes the other two.

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Executive Summary

Associated Physicians Group is an independent Metro East practice, not owned by a hospital system, that brings interventional pain care, physical therapy and primary care under one roof. Its four offices sit in O'Fallon, where the practice is headquartered, Alton, Edwardsville and Swansea, and its primary care line offers both insurance-based care and a concierge relationship. APG is moving the practice onto eClinicalWorks now.[1]

This report covers the part of APG that carries the Medicare chronic-care panel: 4 primary care clinicians, an internist, a family physician and two primary care nurse practitioners. Their CY2024 traditional-Medicare patients averaged 74.3 years old with a weighted risk score of 1.13 against a national 1.00. About three in four have hypertension, one in three diabetes and 32% chronic kidney disease. The same clinicians completed about 500 annual wellness visits that year, billed transitional care for about 50 patients after a hospital stay, and billed telephone visits for about 240, on codes Medicare deleted for 2025. APG also runs remote care today, with its own staff on another vendor's platform. That program started after CY2024, the latest year CMS has published, so it does not show in the claims.[2]

Medicare Advantage is more than half of this market. About 55.7% of Medicare beneficiaries in Madison and St. Clair counties, where APG's primary care offices sit, are in a Medicare Advantage plan. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The forecast prices every patient at the Medicare amount, so how each plan APG contracts with covers these codes is the second thing to confirm, after the chart count.[3]

> **The observation this report is built on**
>
> **Turn the panel APG already manages into a profit-generating service line.**
>
> APG has the patients, the conditions, the wellness-visit habit, a team that already does remote care and a new record system arriving now. The question the move to eClinicalWorks raises is who does the monthly work from here and how it lives in the chart. Fully staffed by CoachCare, governed by APG's clinicians and billed under APG's NPIs, the service line returns the figures below without adding APG headcount.

What the Value Analysis returns

Full service line, CoachCare-staffed	Year 1	Year 2	24 months
Unique patients, end of period	324	324	324
Contribution margin	**$115,322**	**$259,801**	**$375,123**

CoachCare Value Analysis (illustrative, modeled — verify against practice data): Medicare panel of 1,950, 1,560 in scope, remote monitoring and chronic care management, 4 referring clinicians, one CoachCare-funded on-site enrollment specialist, CY2026 East St. Louis locality amounts. Contribution margin is what APG keeps from the service line.

1. **The panel is the limit, and it is reached in year one.** Remote monitoring and chronic care management both reach their eligible ceilings in month 11. From then on about 324 unique patients stay enrolled, new patients replace those who leave, and year two runs at the ceiling. Year two returns 2.3 times year one for that reason.

[1] associatedphysicians.com, retrieved November 3, 2026: About, Locations, Primary Care, Concierge Primary Care, Our Services and provider pages. The eClinicalWorks move is as stated by APG.

[2] CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024, queried November 3, 2026 for every NPI enrolled under APG's billing organizations. In scope: 1 internal medicine physician, 1 family physician and 2 primary care nurse practitioners. Average age 74.3; HCC risk 1.131; hypertension 74.1% (two clinicians at CMS's 75% top-code, so a floor); diabetes 33.9%; CKD 31.9%. Annual wellness visits 502 beneficiaries; transitional care 49; telephone visits 99441 to 99443, 242. CMS suppresses lines under 11 beneficiaries.

[3] CMS Medicare Advantage State/County Penetration, October 2026: Madison County 55.69%, St. Clair County 55.71%. Cross-checked against CMS Medicare Monthly Enrollment, July 2026 (55.4% and 55.9%).

2. **So the chart count is the first number to confirm.** Without the concierge physician's insurance panel the forecast is $257,095; with two more nurse practitioners referring it is $430,702.
3. **The enrollment specialist is CoachCare's cost and APG's biggest lever.** Without an on-site enrollment specialist neither program reaches its ceiling inside two years and the forecast falls by $274,380. CoachCare pays for the specialist; none of that cost comes out of APG's contribution margin.
4. **Positive from month 2, and $21,650 a month from month 12.** Contribution margin runs slightly negative in month 1 while the program ramps; every month after is positive.
5. **APG chooses who does the work.** Its own team on CoachCare's platform, CoachCare's care team, or a split between them. The forecast models the fully staffed option; Section 4 sets out the other two.
6. **The program lives in eClinicalWorks.** CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically, and building the integration alongside the move means one cutover instead of two (Section 5).
7. **Transitional care at every discharge; APCM named for later, at zero dollars.** Which of APG's billing entities primary care bills under after the move decides how well advanced primary care management fits.
8. **The CY2027 proposed rule takes $47,551 off the 24-month contribution margin.** A 20.4% cut to device supply leaves $327,572 over 24 months instead of $375,123, with enrollment held constant (Section 9).

The ask is a working session to confirm APG's Medicare chart count by payer and by office, check how each Medicare Advantage contract covers the care-management codes, decide how much of the care team APG staffs itself, and scope the eClinicalWorks integration alongside the move, before the first patient enrolls.

1. Why Now: Medicare Pays for the Time Between Visits

Medicare is changing what it pays primary care for, and the changes land in the weeks between a patient's visits. For a panel that carries hypertension, diabetes, kidney disease and heart disease together, those weeks decide how the year goes.

The shift	What it means for APG
1. The panel is the unit of care, not the appointment	An APG primary care patient on a chronic medication sees a clinician a few times a year. Blood pressure drifts in the months between, glucose climbs in them, and the admission that follows starts in them. Population health means knowing which of roughly 1,950 Medicare patients in APG's primary care panel are trending the wrong way before they reach an emergency department. That takes data from home and a team assigned to act on it every month.
2. The between-visit codes APG used are gone	In CY2024 APG's primary care clinicians billed telephone visits (99441 to 99443) for about 240 traditional-Medicare patients. Medicare deleted those codes for 2025, so that between-visit contact no longer has a code of its own. Remote monitoring and chronic care management pay for the same kind of contact on a monthly schedule, with a care plan and a reading behind each month.
3. Value-based care, with Medicare Advantage at 55.7%	CMS wants every Traditional Medicare beneficiary in an accountable care relationship by 2030, and since 2025 advanced primary care management has paid a monthly amount for running the whole panel. In Madison and St. Clair counties about 55.7% of Medicare beneficiaries are in Medicare Advantage. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families.
4. Codes for the work between visits	Remote monitoring pays when a patient takes readings on 16 or more days in a month, and two codes new in 2026, 99445 and 99470, pay for shorter months; in this forecast they carry 17% of remote-monitoring Medicare payments.[4] At the East St. Louis locality's CY2026 rates one hypertensive patient on remote monitoring and chronic care management (99454, 99457 and 99490) is worth **$165.09 a month** in Medicare allowed charges.

[4] CoachCare Value Analysis for Associated Physicians Group, 2026: 99445 and 99470 together, 16.7% of 24-month remote-monitoring Medicare payments.

Each shift pays for, or measures, what happens between visits. APG's revenue cycle already picks up new codes: its primary care clinicians billed the visit-complexity add-on, G2211, 413 times for 225 patients in CY2024, its first year.

2. APG Today: Pain, Therapy and Primary Care Under One Roof

Associated Physicians Group is an independent Metro East practice, not owned by a hospital system, that brings interventional pain care, physical therapy and primary care under one roof in O'Fallon, Alton, Edwardsville and Swansea. Its insurance-based primary care line is small and old in the way that makes remote care pay: the traditional-Medicare patients of its four primary care clinicians average 74 years old, about three in four have hypertension and one in three has diabetes. APG is moving the practice onto eClinicalWorks, which sets the moment to decide how care between visits runs from here.

2.1 Four offices, one record

Office	What APG runs there	Primary care
O'Fallon (headquarters)	Interventional pain care, physical therapy and MedX, central scheduling	Family medicine, insurance-based
Alton	Pain care and physical therapy, and APG's internal medicine office	Internal medicine, insurance-based and concierge
Edwardsville	Pain care and physical therapy	Limited primary care
Swansea	APG's newest office	Growing

associatedphysicians.com, locations and primary care pages, November 2026. APG also runs two pain clinics on hospital campuses further out, outside this program's scope.

The 4 clinicians in scope are an internist, a family physician and two primary care nurse practitioners. APG's pain clinicians and physical therapists see many of the same older patients and carry their own Medicare billing, which sits outside this forecast; their role in the program is as a referral source, flagging a patient with uncontrolled blood pressure or diabetes for primary care. Every office moves onto one eClinicalWorks system, so a program built into that chart reaches every office at once.[5]

2.2 What the CY2024 claims say

The CY2024 Medicare by-provider and by-provider-and-service files were queried for every clinician enrolled under APG's billing organizations. The profile below is the traditional-Medicare panel of the 4 primary care clinicians in scope.

Panel	CY2024	Condition	Share
Beneficiary-clinician relationships	1,332	**Hypertension**	**74%, a floor**
Established-visit relationships	1,231	High cholesterol	75%, a floor
Medicare allowed	$503,430	Arthritis	64%
Average age	**74.3**	**Diabetes**	**34%**
Weighted HCC risk score	**1.13**	Ischemic heart disease	33%
Dual-eligible, where reported	6%	**Chronic kidney disease**	**32%**
Annual wellness visits	**About 500**	Depression	21%
Depression screening	About 90	Atrial fibrillation	20%

[5] CMS Doctors and Clinicians (July 2026), PECOS reassignment (September 2026) and Quality Payment Program eligibility (2026) files for APG's billing organizations: 29 NPIs across the roster, 24 with a CY2024 claims profile; 4 classified as primary care by billed codes and the practice website.

Panel	CY2024	Condition	Share
Telephone visits, codes deleted for 2025	**About 240**	**Heart failure**	**17%**
Transitional care	**About 50**	**COPD**	**17%**
Remote monitoring, chronic or principal care management, APCM, behavioral health integration	No program at meaningful scale	Asthma	10%

CMS Medicare Physician & Other Practitioners, CY2024, the 4 primary care clinicians in scope. Program rows are beneficiaries; relationships count a patient once per clinician seen. CMS caps published prevalence at 75% per clinician, so the two most common conditions are floors, and suppresses lines under 11 beneficiaries.

This is the panel remote care is built for: hypertension in three of four patients or more, diabetes in one in three, kidney and heart disease in about a third each, and an average age of 74.3. Most patients qualify for chronic care management, and hypertension with diabetes or kidney disease is the largest group whose home readings would change treatment. In CY2024 **APG's primary care clinicians billed no remote monitoring or chronic care management at a volume CMS publishes**. That year predates the program APG runs today, so the claims describe the panel, not what APG does for it now.[6]

2.3 How the practice got here

Stage	What happened
Where APG is known	Interventional pain care without opioids first. APG built its name on non-opioid interventional pain care across the Metro East, with satellite pain clinics on two hospital campuses further out.
Function	Physical therapy and MedX in the same building. Physical therapists and MedX strength equipment sit next to the pain clinicians, so treatment and rehabilitation run on one plan.
Whole-person care	Internal and family medicine join the practice. Insurance-based primary care in Alton and O'Fallon, with a focus on hypertension, diabetes, cholesterol and follow-up after hospital stays.
Beyond the visit	Diabetes education and an enhanced wellness option. A diabetes boot camp, an enhanced wellness program and a concierge primary care relationship give patients more time with the care team than a standard visit allows.
Growth	A fourth office. APG opens in Swansea, joining O'Fallon, Alton and Edwardsville, and keeps recruiting primary care clinicians.
One record	The move to eClinicalWorks. APG is moving the practice onto eClinicalWorks. Orders, readings, care plans and claims for any remote care program can live in that one chart from the first day.
Next: between visits	**A remote care service line for the Medicare panel. The next step puts daily readings and monthly care management behind every eligible Medicare patient in primary care, inside eClinicalWorks and billed under APG's NPIs.**

2.4 The market, and the rate basis

Madison County held 59,827 Medicare beneficiaries in July 2026 and St. Clair County 54,503. About 55.7% of them were in a Medicare Advantage plan on CMS's October 2026 penetration file; the rural counties where APG's outlying pain clinics sit run lower, from 41% to 47%. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. With more than half the market on Medicare Advantage, APG's own payer mix and each plan's coverage of remote

[6] CMS by Provider and Service, CY2024, searched code by code for the remote monitoring, chronic care management, principal care management, APCM, transitional care and behavioral health integration codes for every APG clinician with a claims profile. In primary care: transitional care 99495 and 99496, 49 beneficiaries; no other code in these families at 11 or more beneficiaries. CY2025 claims, the first year APG's current program could appear, are not yet published.

monitoring and chronic care management decide how much of this forecast bills as modeled. At about 1.7% of the two counties' Medicare beneficiaries, the modeled panel is a credible share for a practice this size.[7]

Every APG office sits in the East St. Louis payment locality (carrier 06102, locality 12), and every dollar in this report is priced at that locality's CY2026 amounts.[8]

3. The Service Line: Remote Monitoring and Chronic Care Management

3.1 The clinical and billing stack

Two monthly programs and one episode code, with one enrollment conversation, one care team and one billing pipeline into APG's own billing through eClinicalWorks. The forecast carries the two monthly programs; transitional care, which APG already bills, stays on the stack and carries no dollars.

Program	What it does clinically	Who it fits on this panel
Chronic care management (CCM)	A documented care plan and at least 20 minutes of clinical staff time a month for patients with two or more chronic conditions; 99490, 99439	The multi-chronic core: hypertension with diabetes, kidney disease, heart disease or COPD
Remote physiologic monitoring (RPM)	Cellular cuffs, glucometers, scales and pulse oximeters send readings between visits against thresholds APG's clinicians set; 99453, 99454 or 99445, 99457, 99458, 99470	Hypertension and diabetes first, then heart failure, kidney disease, COPD and atrial fibrillation
Transitional care management (TCM)	Contact within two business days of discharge, medication reconciliation, a visit within 14 days (99495) or 7 days (99496)	Every panel patient discharged from a hospital or observation stay; already billed, not in the forecast

Codes	What they pay for	CY2026 East St. Louis
99490 · 99439	Chronic care management, first 20 minutes · each additional 20	$66.07 · $50.10
99453	Remote monitoring setup and education, once	$20.70
99454 · 99445	**Device supply, 16+ days · 2 to 15 days in 30 (99445 new in CY2026)**	**$48.30 · $48.30**
99457 · 99458	Treatment management, first 20 minutes · each additional 20	$50.72 · $41.20
99470	**Treatment management, 10 to 19 minutes (new in CY2026)**	**$25.53**
99495 · 99496	Transitional care, visit within 14 days · within 7 days	$216.87 · $293.61
G0556 · G0557 · G0558	Advanced primary care management, levels 1 to 3	$16.46 · $53.36 · $116.71
99484	Behavioral health integration, 20 minutes a month	$57.53

[7] CMS Medicare Monthly Enrollment, July 2026, and CMS Medicare Advantage State/County Penetration, October 2026: Madison 55.69%, St. Clair 55.71%, Jersey 46.24%, Montgomery 40.33%, Clinton 39.45%.

[8] CY2026 Physician Fee Schedule, carrier 06102, locality 12 (East St. Louis): geographic indices work 1.000, practice expense 0.920, malpractice 2.014; conversion factor $33.4009. All six APG ZIP codes map to this locality.

How the rates apply

CY2026 non-facility amounts, East St. Louis locality (carrier 06102, locality 12), ZIP 62269. One device code, one first-tier management code and one care-management program (chronic care management or advanced primary care management) bill for a patient in a given month; transitional care bills once per discharge alongside either.

About 55.7% of Madison and St. Clair county Medicare beneficiaries are in Medicare Advantage. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The forecast prices every patient at the Medicare amount.

3.2 Transitional care at every discharge

APG's primary care clinicians already bill transitional care management: about 50 traditional-Medicare patients in CY2024 at the volumes CMS publishes, at $216.87 for the 14-day level and $293.61 for the 7-day level. A care team that makes the two-business-day contact and the medication reconciliation after every discharge APG learns of means more discharges meet the requirement, and APG furnishes the visit and bills the code. Remote monitoring and chronic care management then carry the patient past day 30, when most readmissions happen. The forecast carries no transitional care dollars.

3.3 The next levers: APCM and behavioral health integration

Advanced primary care management (G0556 to G0558) pays a monthly amount per patient, in place of chronic care management, to a practice that takes on the whole-panel primary care elements, tiered by complexity. It fits best where a practice is already accountable for the total cost of its patients' care. APG bills Medicare through two organizations, one of which takes part in a Medicare Shared Savings Program ACO, so which organization primary care bills under after the move decides how strong that fit is.[9] It appears here at zero dollars, as a named later option. Moving patients from chronic care management to APCM is a program decision to make together; remote monitoring bills alongside either, and the same staff and workflow carry over.

Behavioral health integration is the adjacency. Depression appears on 21% of the panel's claims, about one in five, and APG's primary care clinicians screened about 90 Medicare patients for it in CY2024. Behavioral health integration (99484, $57.53 a month) can run on the same care-manager calls once the program is running. It carries no dollars here.

4. Who Runs It: APG's Team, CoachCare's, or Both

APG is not starting a remote care program. It runs one today, with its own staff doing the monthly work on another vendor's platform, and the practice's services page lists remote patient monitoring and chronic care management. What changes now is the chart. Once every office is on eClinicalWorks, the program either moves with it or runs beside it, and that makes this the time to decide how the work should be staffed and how much of it should live inside the new record.

4.1 Three ways to run between-visit care on eClinicalWorks

	APG's team (self-service)	Shared (hybrid)	CoachCare's team (full service, modeled)
Who does the monthly work	APG staff enroll, review readings, make the care-management calls and document	Divided by program, by office or by task: APG keeps the work its team does well and CoachCare takes the rest	**CoachCare care managers, at 165 patients each, plus a CoachCare-funded on-site enrollment specialist**
Who carries the headcount	APG, including cover for leave and turnover	Split, by agreement	**CoachCare; none of it is APG headcount**

[9] CY2025 and CY2026 Physician Fee Schedule final rules: APCM (G0556 to G0558) effective January 1, 2025, billed in place of chronic care management for the same patient and month. CMS Shared Savings Program participant file, performance year 2026, and Quality Payment Program eligibility, 2026.

	APG's team (self-service)	Shared (hybrid)	CoachCare's team (full service, modeled)
What CoachCare supplies	The platform, cellular devices and logistics, the eClinicalWorks integration and automated claims	The platform and integration, plus the share of the care-team work APG hands over	All of it, from enrollment to the claim
Enrollment pace	Set by how much staff time APG can give it	Set by who owns enrollment	The on-site enrollment specialist works the clinic schedules; both programs reach their ceilings in month 11
Fits a practice that	Has care staff with capacity and wants to keep every patient contact in house	Wants to keep its current team's relationships while growing the census	Wants the service line at full scale without hiring

All three run on the same eClinicalWorks integration, devices and escalation rules. Only the fully staffed option is modeled in Section 7; CoachCare will set the self-service and hybrid options against APG's own staffing costs in the working session.

The models differ in who carries the staffing, and that is where most of the economics sit. In the fully staffed model CoachCare pays for the on-site enrollment specialist, the single input that moves this forecast most (Section 7.4), and hires care managers ahead of the census. In a self-service model APG keeps more of each claim and carries the people instead. A hybrid often makes sense for a practice that already has a working team: APG's staff keep the patients they know, and CoachCare adds enrollment capacity and covers the rest of the panel.

4.2 What stays with APG in every model

- **Clinical governance, the patients and the revenue.** APG's clinicians set thresholds, routing and discharge criteria and sign the care plans; claims go out under APG's NPIs. In the fully staffed model APG keeps $375,123 of contribution margin over 24 months.
- **One program across every office.** The same flags, devices and escalation rules at O'Fallon, Alton, Edwardsville and Swansea, whoever does the work, because the program runs from the chart rather than the building.
- **Independence.** A recurring service line with its own contribution margin funds the practice's next decisions from its own panel, which matters to a practice that describes itself as not owned by a hospital system.

5. eClinicalWorks: The Program Lives in the Chart

CoachCare works inside eClinicalWorks' own workflows, so APG's clinicians and staff learn one system, not two. Evidence of care, vitals and care plans are attached to each chart every month, enrollment status is visible at every office, and a flagged patient reaches the first day of service in under five days.[10] CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically. Because APG is configuring eClinicalWorks now, the remote care workflow can be built into the setup rather than added after go-live.

Integration pillar	What happens in eClinicalWorks
Integrated enrollment	Flags in the chart prompt the order for patients who meet criteria APG's clinicians approve, at a chronic-care visit, a wellness visit or on an outreach list
Enrollment by services and devices	The clinician orders by service and by device (cuff, glucometer, scale, pulse oximeter), the way a lab is ordered

[10] CoachCare eClinicalWorks integration overview, 2026: the six integration pillars; patients begin chronic care management and remote monitoring in less than five days.

Integration pillar	What happens in eClinicalWorks
Exchange of health history	Diagnoses, medications, vitals and lab results pass to the care team at intake; the care plan comes back
Integrated vital reports	Home readings land in the chart, so the clinician sees home averages at the next visit
Compliance documentation and care summary	Evidence of care, vitals and the care plan attached monthly for every enrolled patient
Automated claim generation	Claims built for every patient, every month, once a code's requirements are met; APG's billing team reconciles and files them

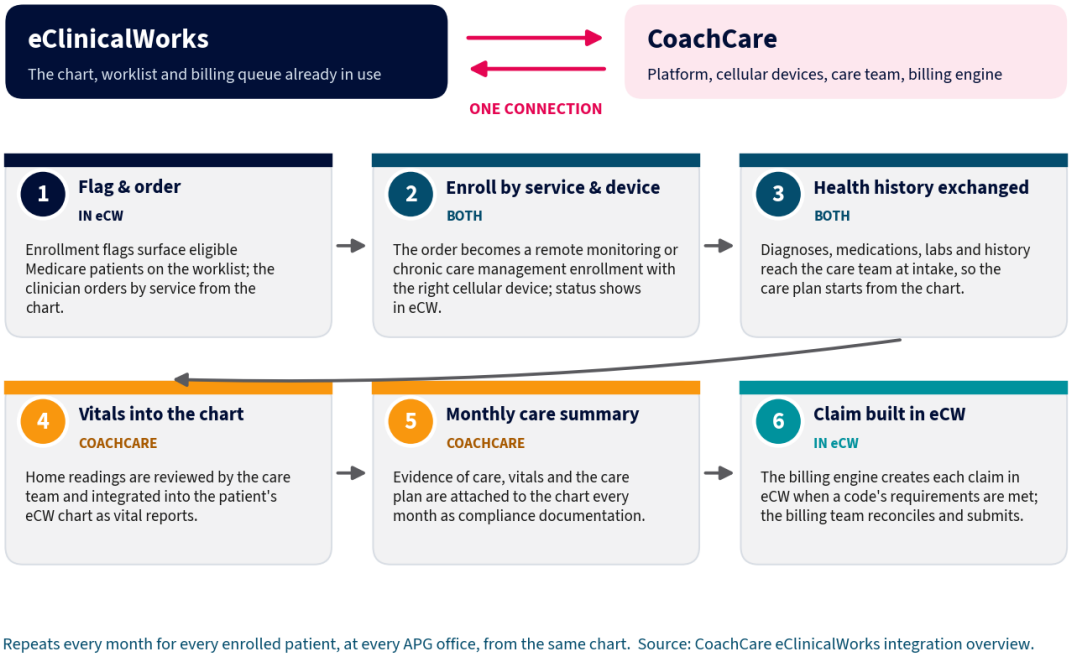


Figure 1. From a flag in the chart to a claim: the six steps CoachCare and eClinicalWorks run every month for every enrolled patient. CoachCare eClinicalWorks integration overview.

The integration is the same in all three staffing models in Section 4, so the decision about who does the work can follow the build rather than hold it up.

6. Clinical Governance & Escalation

Every reading routes through one escalation engine with defined thresholds, trend rules, routing and documentation, so the practice never carries surveillance liability it did not agree to. Thresholds and routing are set with APG's clinicians, for each office, before the first patient enrolls.[11]

6.1 One shared escalation engine

Branch	The rule	Why
Critical value	**Escalate to the practice, regardless of symptoms**	No practice preference can suppress it. A critical reading on its own goes to the clinic, not to 911

[11] CoachCare Care Management Programs standard operating procedures, March 2026: escalation logic, trend definitions, emergent protocol, care-management hours (Monday to Friday, 8:00 a.m. to 5:00 p.m. local patient time), post-discharge sequence and discharge governance.

Branch	The rule	Why
Out of range, not critical	Retake, then a structured symptom check	Most out-of-range readings resolve here, which keeps inboxes usable
Trend	**Three consecutive readings an hour or more apart for blood pressure, glucose or oxygen saturation; three within seven days for heart rate; weight gain past the agreed threshold**	A confirmed trend escalates like a single threshold breach
Patient unreachable	Document, leave a callback message, and escalate anyway if the reading was critical or a confirmed trend	Silence never downgrades a clinical finding
Documentation	**Six fields: vital · findings · method · contact · outcome · follow-up**	Any episode can be reconstructed end to end

6.2 The emergent pathway

Non-negotiable, and stated as such

Triggers. Chest pain · new shortness of breath · signs of stroke · syncope · worst-ever headache · sudden swelling, reported by the patient on a call.

Action. The care team calls 911 with the patient on the line, then notifies the patient's clinic the same day. A critical reading alone, without those symptoms, goes to the clinic instead.

If the patient refuses. The clinic is called with the patient still on the line and directs care; if the clinic cannot be reached, CoachCare activates emergency services.

The floor. CoachCare's emergent policy supersedes any practice escalation preference. This cannot be configured away. APG shapes routing for everything else.

6.3 Routing, the post-discharge cadence and an older panel

Route	What goes there	Who sees it
Emergency	Active emergent symptoms reported on a call	911 with the patient on the line; the clinic notified
Needs the practice	A critical reading, or an out-of-range reading or trend confirmed after a retake	The clinician or nurse each office designates, in eClinicalWorks, with readings and a recommended next step
Stable or resolved	**Worked, retaken and resolved**	**Documented as an FYI in the chart, without paging anyone**

Care managers work readings and escalations on business hours, Monday to Friday, 8 a.m. to 5 p.m. local patient time, which matches the hours APG's offices keep, so every escalation lands while a clinician is in the building. A reading that arrives on a weekend or overnight is worked the next business day, and the patient's standing instruction for anything urgent is the office's own line or 911.

Any emergency visit or hospitalization in the previous 60 days triggers a three-touch cadence: stabilize on days 1 to 2 (what led to the visit, discharge medications reconciled, a follow-up visit confirmed within 7 to 14 days), detect on days 5 to 8 (adherence, triggers, appointments and labs), and secure on days 12 to 14 (medication and risk review, then a handoff into monthly monitoring). After a hospital or observation stay it is also the transitional care episode APG already bills.

APG's traditional-Medicare patients average 74.3 years old, and the program is set up for them. Devices are cellular and arrive ready to use, with no home internet, smartphone or pairing. The welcome call, the monthly care-management call and every escalation call are made by phone, so no patient has to learn an app. A monitoring patient unreachable 45 days from enrollment is escalated to the clinic; without an instruction from

the clinic, discharge from monitoring follows at 180 days, and discharge criteria always belong to APG's clinicians.

7. Value Analysis: The 24-Month Forecast

7.1 The headline economics

The forecast covers remote monitoring and chronic care management across a Medicare panel of 1,950, 1,560 in scope, at the CY2026 East St. Louis locality amounts, with 4 referring clinicians and one CoachCare-funded on-site enrollment specialist, in the fully staffed model. No transitional care, APCM, behavioral health integration or shared-savings payment is in these numbers. Every figure in this section is illustrative, modeled — verify against practice data.[12]

Full service line	Year 1	Year 2	24 months
Unique patients, end of period	324	324	324
Contribution margin	**$115,322**	**$259,801**	**$375,123**

Year two returns 2.3 times year one because both programs reach their ceilings in month 11: the program enters year two full and stays there. Year two returns **$259,801 of the $375,123 contribution margin**, and from month 12 the line runs at $21,650 a month to APG, about $259,801 a year if the census holds.

7.2 Two scopes, side by side

Remote monitoring on its own is shown beside the full service line. Both run on the same enrollment plan, so remote monitoring reaches the same 254 patients in both, by month 11. The full line adds chronic care management for 234 patients and $193,973 more contribution margin over 24 months.

24 months	Remote monitoring on its own	Full service line, RPM + CCM
Contribution margin	**$181,150**	**$375,123**
Unique patients at month 24	254	324
Active program enrollments at month 24	254	488
Hospitalizations avoided	About 30	About 30

The 488 active program enrollments at month 24 belong to 324 unique patients, because most care-management patients are also monitored.

7.3 The ramp, month by month

Contribution margin runs −$6,202 in month 1 while the program ramps, on 10 enrollments. It is positive from month 2, with $954 on 25 enrollments, and cumulative contribution margin is above zero by the end of month 4. New patients join at a rising pace, about 60 a month at the peak; remote monitoring and chronic care management both reach their ceilings in month 11, after which new enrollments replace attrition and the monthly contribution margin holds at $21,650. Cumulative contribution margin passes $13,096 at month 6, $115,322 at month 12 and $375,123 at month 24.

Month	Active enrollments	Monthly contribution margin	Cumulative contribution margin
M1	10	**−$6,202**	−$6,202
M2	25	$954	−$5,248

[12] CoachCare Value Analysis for Associated Physicians Group, 2026, the source of all Section 7 figures; sensitivity runs change one input at a time on the same workbook. The forecast counts every enrollment as new; patients already in APG's current program would move across rather than add.

Month	Active enrollments	Monthly contribution margin	Cumulative contribution margin
M3	49	$2,018	−$3,230
M6	172	$7,525	$13,096
M9	366	$16,232	$52,406
M12	488	$21,650	$115,322
M18	488	$21,650	$245,222
M24	488	**$21,650**	**$375,123**

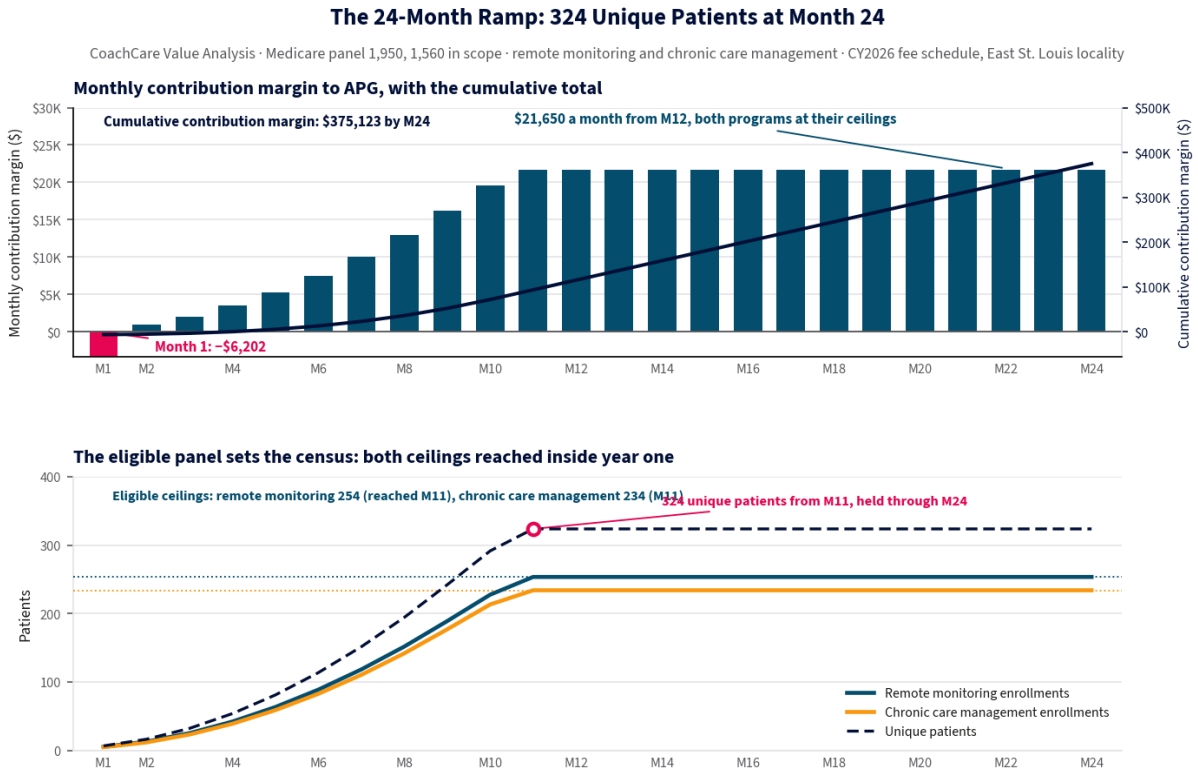


Figure 2. Monthly contribution margin, with cumulative contribution margin, and the enrollment census by program against the two eligible ceilings. CoachCare Value Analysis, full service line.

7.4 The limit is the panel

Program	Eligible share of the 1,560 in scope	Acceptance	Ceiling	Reached
Remote physiologic monitoring	65%, 1,014 patients	25%	**254**	**Month 11**
Chronic care management	75%, 1,170 patients	20%	**234**	**Month 11**

Say the constraint out loud

One limit sets this forecast: the eligible panel. Referrals from 4 clinicians and the on-site enrollment specialist fill both programs by month 11, so year two runs at the ceiling with about 324 unique patients. More enrollment effort after that adds nothing; only a larger panel, or a larger share of it in scope, does.

Read it as a chart-count question. APG's own Medicare chart count, by payer and by office, is the first number to confirm. A smaller panel lowers the forecast directly; a larger one raises it. 2 CoachCare care managers, at 165 patients each, cover the census from month 12. A second on-site enrollment specialist would fill the panel by month 8 and add $41,476 by getting there sooner.

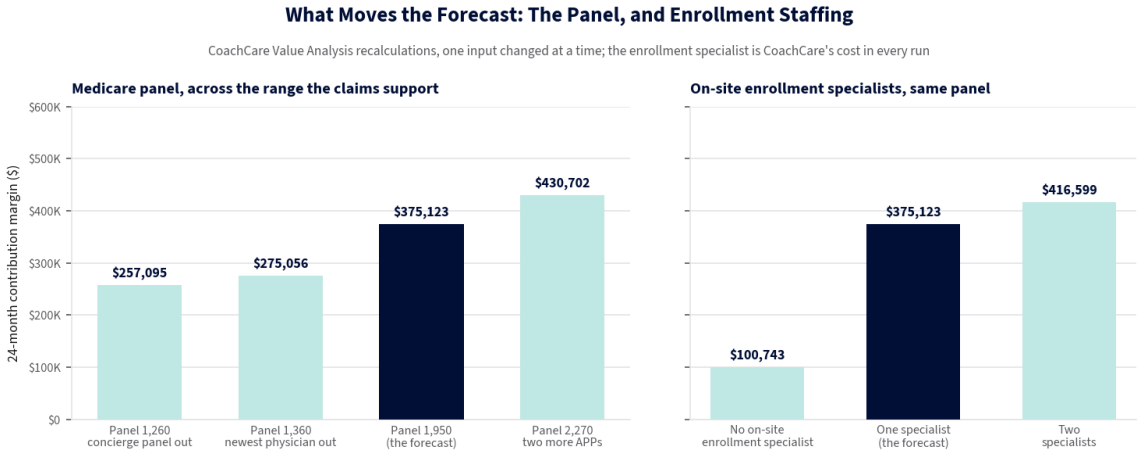


Figure 3. 24-month contribution margin across the panel sizes the claims support, and with none, one or two on-site enrollment specialists on the same panel. CoachCare Value Analysis recalculations.

Scenario	24-month contribution margin	Unique at M24	Ceilings reached (RPM / CCM)
Base: panel 1,950, 1,560 in scope, 4 clinicians, one enrollment specialist	**$375,123**	**324**	**M11 / M11**
Panel 1,260: the concierge physician's insurance panel left out	$257,095	209	M9 / M9
Panel 1,360: the newest physician's CY2024 patients left out	$275,056	226	M9 / M9
Panel 2,270: two more nurse practitioners referring	$430,702	377	M12 / M12
Panel 1,950 with 60% in scope	$295,091	243	M10 / M9
Panel 1,950 with all of it in scope	$447,836	405	M13 / M12
No on-site enrollment specialist	$100,743	161	not by M24 / not by M24
A second on-site enrollment specialist	$416,599	324	M8 / M8

CoachCare Value Analysis recalculations, one input changed at a time; panel runs keep 80% in scope.

The on-site enrollment specialist and the panel move this forecast most. Without the specialist, contribution margin falls by $274,380, because neither program reaches its ceiling inside two years. Leaving out the concierge physician's insurance panel lowers it by $118,028, to $257,095; adding two more referring nurse practitioners raises it to $430,702. A second specialist adds $41,476, less than either panel change, because it only fills the same ceiling sooner.[13]

[13] Panel method: 1,231 established-visit relationships in CY2024 (each clinician's 99212 to 99215 patients, capped at that clinician's total) × 0.70 for patients seen by more than one clinician ÷ (1 − 55.7% Medicare Advantage) = 1,945, modeled as 1,950. One physician joined APG in 2025, and that

7.5 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	**46,971**	Blood pressure, glucose, weight and oxygen saturation values arriving between visits
Claims and billable units	**16,910**	Created in eClinicalWorks for APG's billing team
Care-management tasks	33,819	Outreach, care-plan updates and medication reviews
Patient conversations	5,073	Live contacts across 282 hours of call time
Care-team hours	**7,482**	**About 3.6 full-time-equivalent years of work APG does not employ**
Hospitalizations avoided	**About 30**	Admissions, emergency visits and the follow-up they bring that never happen

Annual admission rate among enrolled patients	20% (the workbook's baseline)	30%	40%	50%
Hospitalizations avoided over 24 months	30	45	**60**	75

CoachCare Value Analysis, full service line. The workbook prices avoided admissions at a 20% annual admission rate; the first patients enrolled, uncontrolled hypertension with diabetes, kidney disease or heart failure, run closer to 40%, which puts the figure near 60.

7.6 Published results from CoachCare programs

- **Blood pressure.** Cardiac Solutions, a physician-owned cardiology practice with three West Phoenix offices, put 2,738 patients on CoachCare remote monitoring. Stage 2 hypertension patients saw a 29.1 mmHg average systolic drop, and 94.8% improved. Patients who took readings consistently dropped 8.53 mmHg against 3.54 mmHg for those who did not.[14]
- **Readmissions, at the same practice.** Across 26,689 patients, the 30-day readmission rate was 7% for CoachCare patients against 15% for the rest.[15]
- **Heart failure.** Iowa Heart enrolled 450 advanced heart-failure patients and recorded zero readmissions over six months.[16]

8. Quality: The Measures Primary Care Is Scored On

Primary care is scored every year on quality measures, through MIPS or through accountable-care reporting depending on the billing organization, and the same handful of measures carry most of the weight for a chronic-care panel. Three move directly with this program's monthly work, and APG's patients count in all three.[17]

Measure	What it counts	What the program does each month
Q236 Controlling high blood pressure	Hypertensive patients whose latest blood pressure is under 140/90	Home averages give an accurate reading of control and a monthly chance to act
Q001 Diabetes: A1c poor control (> 9%)	Patients with diabetes whose latest A1c is above 9%; lower is better	Care management keeps A1c testing and medication changes on schedule; home glucose shows slippage early

physician's CY2024 patients were billed under a prior practice; the forecast assumes they followed. The range 1,260–2,270 brackets these assumptions.

[14] Cardiac Solutions case study, April 2026: 2,738 remote-monitoring patients enrolled 12 months or more.

[15] Cardiac Solutions readmissions case study: 7% against 15% across 26,689 patients.

[16] Iowa Heart case study, 2026: 450 NYHA class III to IV patients over six months.

[17] CMS Quality Payment Program measure specifications, 2026: Q236 Controlling High Blood Pressure; Q001 Diabetes: Hemoglobin A1c Poor Control (> 9%); Q134 Screening for Depression and Follow-Up Plan.

Measure	What it counts	What the program does each month
Q134 Depression screening and follow-up	Patients screened, with a follow-up plan when the screen is positive	PHQ-2 and PHQ-9 in monthly care management; positives routed to the clinician

With hypertension in at least three of four of APG's Medicare patients, Q236 covers most of the panel, and a month of home readings is a better basis for it than one office reading. The primary care clinicians already screen about 90 Medicare patients a year for depression, and monthly care management supplies the follow-up half of Q134. Readmissions and avoidable admissions, which CMS calculates from claims, improve the same way: an admission that does not happen does not count.

9. Policy Watch: The CY2027 Proposed Rule, Repriced on This Forecast

CMS published its proposed CY2027 physician fee schedule in July 2026. The comment period closed September 14, 2026, the final rule is expected in early November 2026, and the changes take effect January 1, 2027. The proposal cuts the remote-monitoring device-supply codes. Every code in this forecast was repriced at the East St. Louis locality on the forecast's own billing mix, with enrollment held constant.[18]

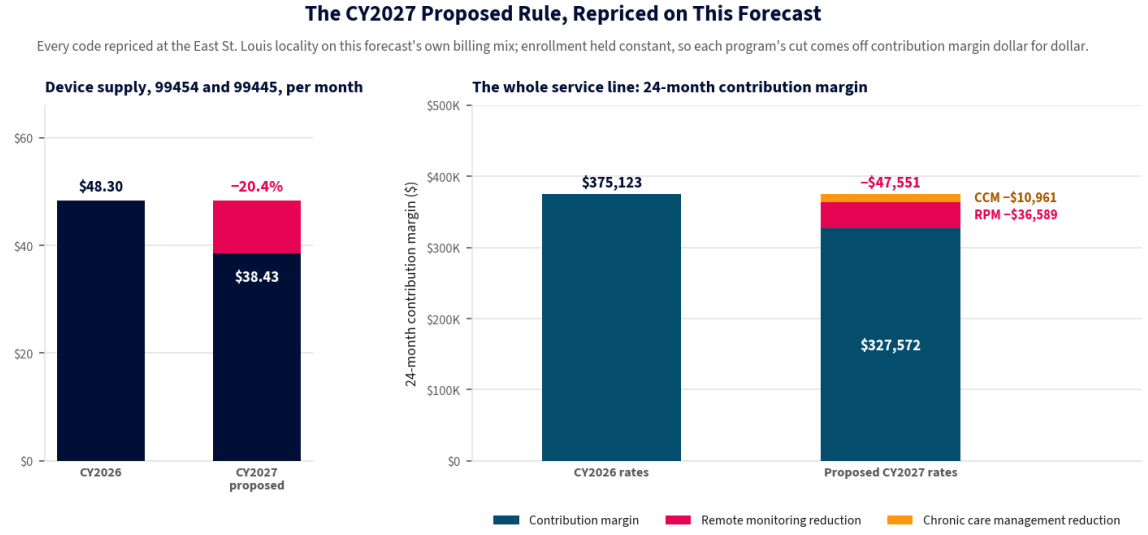


Figure 4. The CY2027 cascade on this forecast: the one code CMS proposes to cut, then the 24-month contribution margin of the whole service line at CY2026 and proposed CY2027 rates, with the reduction from each program shown. Enrollment held constant.

Level	CY2026 rates	Proposed CY2027 rates	What changes
Device supply, 99454 and 99445	$48.30 a month	**$38.43 a month, −20.4%**	The code CMS proposes to cut
Remote monitoring, change in contribution margin		**−$36,589**	Device supply is 30.9% of the remote monitoring basket
Chronic care management, change in contribution margin		−$10,961	Routine rate changes only (−2.4%); not targeted

[18] CMS-1848-P, published July 2026. CoachCare repricing at carrier 06102, locality 12, conversion factor $32.8409 against $33.4009: device supply 30.9% of the remote-monitoring basket; remote monitoring 48.1% of the line.

Level	CY2026 rates	Proposed CY2027 rates	What changes
Whole service line, 24-month contribution margin	**$375,123**	**$327,572 (−$47,551)**	Enrollment held constant, so the repricing passes through dollar for dollar

With enrollment held constant, every dollar of repricing comes off contribution margin: $36,589 from remote monitoring and $10,961 from chronic care management, which leaves $327,572 over 24 months. CoachCare will rerun the forecast at the final rates. The proposal falls hardest on device supply, which is also where a self-service or hybrid model changes least, since the devices and their logistics come from CoachCare in all three.

Code	What it pays for	CY2026 national	Proposed CY2027 national	Change
99453	Remote monitoring setup	$21.71	$20.03	−7.7%
99454 / 99445	**Device supply, 16+ days / 2–15 days**	**$52.11**	**$41.38**	**−20.6%**
99457	Treatment management, first 20 minutes	$51.77	$49.59	−4.2%
99458	Each additional 20 minutes	$41.42	$40.39	−2.5%
99470	Treatment management, 10–19 minutes	$26.05	$20.69	−20.6%
99490	Chronic care management, first 20 minutes	$66.13	$64.04	−3.2%
99439	Each additional 20 minutes	$50.44	$49.92	−1.0%

CY2026 Addendum B and CMS-1848-P proposed CY2027 Addendum B, national non-facility amounts; the repricing above uses East St. Louis locality amounts, and the two bases do not reconcile to the dollar, by design. Section 1848(c)(7) of the Act limits how far a code's relative value can fall in one year.

10. Implementation Roadmap

10.1 Who runs what

Function	CoachCare (fully staffed model)	APG
Identification and enrollment	Registry query in eClinicalWorks starting with the hypertension, diabetes, heart-failure and kidney patients; an on-site enrollment specialist; telephonic outreach; devices shipped, cellular-paired and replaced	Approves the criteria and target list; clinicians order at the chronic-care or wellness visit
Patients in today's program	Moves each patient onto the new program and devices without a gap in monitoring	Decides the cutover date and which patients move first
Transitional care	Two-business-day contact and medication reconciliation after each discharge APG learns of; visit booked inside the 7- or 14-day window	Furnishes the visit and bills 99495 or 99496, as today
Monitoring and escalation	Reading review, monthly outreach, business-hours alert triage and the post-discharge cadence, at 165 patients per care manager	**Sets thresholds and routing for each office; receives escalations**
Documentation, billing, reporting	Monthly care documents in eClinicalWorks, claims created automatically, operational and clinical outcomes reports by office and clinician	**Reconciles and files under its own NPIs; keeps the revenue; names a program lead**

10.2 The model inputs

Input	Value in this forecast
Medicare panel	**1,950 patients in the primary care panel, 1,560 in scope; all payers**

Input	Value in this forecast
Medicare Advantage	About 55.7% in Madison and St. Clair counties; every patient priced at the Medicare amount. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families.
Referring clinicians	4: an internist, a family physician and two primary care nurse practitioners
Programs	Remote monitoring and chronic care management; transitional care, APCM and behavioral health integration at zero dollars
Eligibility and acceptance	Remote monitoring 65% eligible, 25% accept; chronic care management 75%, 20%; 70% of care-management patients also monitored; 3% monthly attrition
Enrollment plan	5 referrals per clinician a month, 70% accepted; one CoachCare-funded on-site enrollment specialist plus telephonic outreach; both programs at their ceilings by month 11
Staffing model	Fully staffed by CoachCare; self-service and hybrid described in Section 4, not modeled
EMR	eClinicalWorks, integrated as described in Section 5
Rates	CY2026 fee schedule, non-facility, East St. Louis locality, ZIP 62269

10.3 The first 90 days, and after

Window	What happens	Result
Weeks 0–6 **Integrate and charter**	eClinicalWorks workshop with APG's IT and billing leads, timed with the move; chart counts and payer mix, plan by plan; the staffing model chosen; today's program and transitional care workflow mapped; thresholds and routing agreed	Integration live, protocol signed, cutover plan for current patients
Weeks 6–12 **Launch**	Enrollment from the first week at O'Fallon and Alton; remote monitoring for hypertension and diabetes, care management for two-plus conditions; the post-discharge cadence live	10 enrollments in month 1, 25 by month 2, 49 by month 3
Months 3–11 **Fill the panel**	Same protocols at Edwardsville and Swansea; heart failure, kidney disease and atrial fibrillation cohorts added; pain and therapy referrals flowing	Both programs at their ceilings in month 11, 324 unique patients
Months 12–24 **At the ceilings**	Census held; the APCM decision made once the billing organization is settled; behavioral health integration scoped; the panel re-counted as clinicians join	Year 2: $259,801 of contribution margin

Remote monitoring and chronic care management carry Part B coinsurance, so the consent conversation explains the monthly cost plainly before the device ships.

10.4 What we would confirm together

1. **The Medicare chart count, by payer and office.** Traditional Medicare against each Medicare Advantage plan, and how many patients carry hypertension, diabetes or two or more conditions. The panel sets the ceiling, so this is the first number to confirm.
2. **The Medicare Advantage contracts.** Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. Which plans APG's patients hold, and whether each pays chronic care management and remote monitoring, is confirmed plan by plan.
3. **Today's program.** How many patients it carries, which codes it bills, who does the work, and how it moves to eClinicalWorks.
4. **The staffing model.** Self-service, hybrid or fully staffed, set against what APG's own care staff cost and how much time they have.
5. **Which billing organization primary care uses after the move.** It decides how well APCM fits and how the quality measures are reported.

6. **The concierge membership.** What the membership covers and how many members are Medicare patients, so the monthly care-management codes are billed only for work the membership does not already include.
7. **Which clinicians are in scope.** The four modeled, any primary care clinicians joining, and how the newest physician's Medicare patients have followed.
8. **Coinsurance at consent.** How the monthly Part B coinsurance is explained at enrollment, and who answers billing questions afterwards.

11. Recommendations

1. **Build remote care into eClinicalWorks as part of the move.** One cutover for the chart and the program, with flags, orders, readings and claims in the new record from the first day.
2. **Choose the staffing model before go-live.** Fully staffed, the service line returns $375,123 of contribution margin over 24 months ($115,322 in year one, $259,801 in year two), positive from month 2, with nobody hired.
3. **Pull the Medicare chart count by payer and office in week one.** The panel in scope sets the ceiling the program reaches in month 11.
4. **Confirm Medicare Advantage coverage plan by plan before launch.** With more than half the market on Medicare Advantage, each contract's terms for the care-management codes decide how much of the forecast bills as modeled.
5. **Start with hypertension and diabetes at chronic-care and wellness visits.** Care management for the plan, a cellular cuff or glucometer for the readings, the visit as the enrollment conversation.
6. **Use the pain and therapy clinics as referral sources.** A high reading or an unmanaged condition at a pain or therapy visit becomes a primary care referral.
7. **Take the call after every discharge.** Transitional care APG already bills, extended to more of the discharges it learns of.
8. **Hold APCM as the next lever, and scope behavioral health integration once running.** Both run on the same care team and the same chart.

The Medicare panel APG already manages supports a service line that returns $375,123 of contribution margin over 24 months on CoachCare's staffing, and APG already knows how to run remote care. What the move to eClinicalWorks adds is the chance to put that work inside the chart, at the scale the panel supports, with the staffing model APG chooses.

About CoachCare

> **The experience to get it right**
>
> CoachCare manages more than 500,000 patients across over 400 conditions, with more than 10,000 clinicians running remote care programs on its platform day to day. Its teams have stood up more than 1,000 programs, built the care-plan coding and billing behind more than 5 million claims, and recorded over 100 million vitals.

- **It runs inside the chart APG is moving to.** Readings, documentation and claims live in eClinicalWorks, and enrollment status is visible at every office.
- **Staffed the way APG chooses.** Self-service on CoachCare's platform, a hybrid, or fully staffed: care managers at 165 patients each, enrollment, devices, business-hours alert triage and billing preparation on CoachCare's payroll.
- **Clinicians stay in charge.** APG's physicians and nurse practitioners set the protocols, sign the care plans and make every clinical decision.

- **Designed for an older panel.** Cellular devices with nothing to pair, and outreach by phone, so no patient has to learn an app.
- **Published results.** A 29.1 mmHg drop in Stage 2 hypertension across 2,738 patients at Cardiac Solutions, half the 30-day readmission rate across 26,689 patients at the same practice, and zero readmissions among 450 advanced heart-failure patients at Iowa Heart.

The ask is a working session to confirm APG's Medicare chart count by payer and by office, check how each Medicare Advantage contract covers the care-management codes, decide how much of the care team APG staffs itself, and scope the eClinicalWorks integration alongside the move, before the first patient enrolls.

Contact

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- **Medicare payment rules:** the CY2026 Physician Fee Schedule final rule, Addendum B, RVU file and East St. Louis locality geographic indices; CMS-1848-P, the CY2027 proposed rule.
- **Market:** CMS Medicare Advantage State/County Penetration, October 2026; CMS Medicare Monthly Enrollment, July 2026, by county.
- **CoachCare:** eClinicalWorks integration overview, 2026; Care Management Programs standard operating procedures, March 2026; Cardiac Solutions and Iowa Heart case studies; and the Value Analysis for Associated Physicians Group, 2026, the source of every financial, enrollment, clinical-output and operational figure in Sections 7 to 11.

Unique patients and program enrollments are different numbers. At month 24 the program holds 488 active program enrollments belonging to 324 unique patients, because a patient may hold both enrollments. The 1,950-patient panel covers all payers; the 1,332 beneficiary-clinician relationships in the CY2024 claims are traditional Medicare only.