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

Medical Associates of Rhode Island, Inc.

A physician-owned internal medicine group in Bristol and East Providence: 20 clinicians on one eClinicalWorks system, with a Medicare panel of about 5,200

Remote Care Service Line Optimization Report

2026 Strategy Report

A scalable, profitable remote care service line for Medical Associates of Rhode Island: remote monitoring and chronic care management for the Medicare panel its internists already know, billed under the group's own NPIs at Rhode Island's CY2026 Medicare rates, staffed by CoachCare and run inside eClinicalWorks

Purpose of this document

Prepared by CoachCare, October 2026, as a discussion document for the physician leadership of Medical Associates of Rhode Island. It is the companion to the group's remote care strategy page and makes the same case at report length: why 2026 is the year, what the group's own Medicare claims show, how the service line runs across both offices, what it returns over 24 months at Rhode Island's rates, and why CoachCare is the partner to run it.

Medical Associates completes about 1,540 annual wellness visits a year, follows its patients into nursing facilities, manages patients by phone, and bills inside an Enhanced-track Shared Savings Program ACO. Until the end of 2025 it was a Primary Care First practice, and that model kept chronic care management off the table for the patients attributed to it. The model is gone. This report shows what the work between visits now returns, who does it, and how fast the group reaches its whole eligible panel.

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Executive Summary

Medical Associates of Rhode Island is a physician-owned internal medicine group with offices on Hope Street in Bristol and Warren Avenue in East Providence. Its 20 clinicians, 17 physicians and 3 nurse practitioners, share one eClinicalWorks system. The Bristol office also runs a walk-in center staffed by the internists, a lab, x-ray, ultrasound, mammography and bone-density scanning, with dermatology and podiatry under the same billing entity.[1]

The group's CY2024 Medicare claims describe the panel. Its 19 internal medicine clinicians recorded 3,653 beneficiary-clinician relationships, with patients averaging 76 years old and a weighted risk score of 1.07 against a national 1.00. Hypertension appears in seven of ten, diabetes in nearly one in four, chronic kidney disease in 19% and heart failure in 13%. The internists completed about 1,540 annual wellness visits. **Neither remote monitoring nor chronic care management appears at meaningful scale**.[2]

There is a reason for that. Through 2025 the group was a **Primary Care First** practice, and that model's claims rules did not allow chronic care management for the patients attributed to it. CMS ended Primary Care First on December 31, 2025. In 2026 the group still bills inside **an Enhanced-track Medicare Shared Savings Program ACO**, the two-sided track, and every patient with two or more chronic conditions can be billed for monthly care management.[3]

The observation this report is built on

Turn the panel Medical Associates already manages into a profit-generating service line.

The group has the panel, the conditions, the record system, the visit rhythm and the accountable-care position. What it has not had, until this year, is a payment rule that let it bill monthly care management for its own patients. This service line fills the time between visits with daily readings and a care team, staffed by CoachCare, governed by the group's internists and billed under its NPIs from inside eClinicalWorks.

What the Value Analysis returns

Full service line	Year 1	Year 2	24 months
Unique patients, end of period	659	863	863
Contribution margin	**$206,872**	**$696,358**	**$903,231**

CoachCare Value Analysis: Medicare panel of 5,200 across both offices, 4,160 in scope, remote monitoring and chronic care management, 20 referring clinicians, one CoachCare-funded on-site enrollment specialist, CY2026 Rhode Island locality 01 amounts. Contribution margin is what Medical Associates keeps from the service line.

Medical Associates can take this two ways, and both are net-positive. CoachCare can run remote monitoring on its own, with care coordination left where it sits today: **$449,672 of contribution margin over 24 months**, for 676 patients. Or CoachCare can run both programs across the panel, the forecast of record above, for 863 unique patients.

[1] medassociatesofri.com, retrieved October 26, 2026: offices, services, internal medicine roster (17 physicians and 3 nurse practitioners), walk-in center, patient portal on eClinicalWorks. CMS Doctors and Clinicians national file, July 2026, and PECOS reassignment file, September 2026, for the group's billing entity; Rhode Island Secretary of State annual reports, 2014 to 2024.

[2] CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024, queried for the 19 internal medicine and family medicine clinicians billing under the group in CY2024: 3,653 beneficiary-clinician relationships (a patient seen by two clinicians counts twice); average age 76; HCC risk 1.07; hypertension 70.9%, diabetes 22.8%, CKD 19.3%, heart failure 12.7%; annual wellness visits 1,537. CMS suppresses lines under 11 beneficiaries.

[3] CMS Quality Payment Program eligibility records for the group's physicians, performance years 2022, 2025 and 2026: Primary Care First (general practice) in 2022 and 2025; Shared Savings Program, Enhanced, in every year. CMS Shared Savings Program ACO Participants, PY2026: the group's billing entity is a participant, Enhanced track, retrospective assignment. CMS guidance of May 15, 2020 directed contractors to deny chronic care management codes for the Primary Care First model; CMS Innovation Center announcement, 2025: Primary Care First ends December 31, 2025.

1. **Enrollment pace sets year one; the eligible panel sets year two.** Referrals build to full pace over the first 12 months. Remote monitoring reaches its eligible ceiling of 676 patients in month 15 and chronic care management its ceiling of 624 in month 16, and the program runs at full census from there. A second enrollment specialist would reach both ceilings sooner and add $118,832; the group's own Medicare chart count decides how high the ceilings sit.
2. **Medicare Advantage carries more than half of it.** About 58% of Medicare beneficiaries around the two offices are in Medicare Advantage, and the forecast prices every patient 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. Priced on traditional Medicare patients alone, the line returns $471,129 of contribution margin.
3. **A small, fully staffed team.** CoachCare brings on 4 care managers by month 12 at 165 patients each and delivers 17,309 care-team hours over 24 months, about 8.3 full-time-equivalent years. None of it is the group's headcount.
4. **Positive from month 2.** Contribution margin runs slightly negative in month 1 while the program ramps; every month after is positive, and the monthly contribution margin levels off at $59,332 once both programs are full.
5. **The program lives in eClinicalWorks.** CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically, and a flagged patient reaches the first day of service in under five days (Section 4).
6. **Advanced primary care management is the named next lever, at zero dollars.** APCM bills in place of chronic care management, and which patients move is a program decision to make together.
7. **The CY2027 proposed rule takes $125,004 off 24-month contribution margin.** A 20.6% cut to the device supply rate is a 9.6% rate cut on the remote-monitoring arm's codes and 5.9% across the service line's codes (Section 8).

The ask is a working session: confirm the Medicare chart count by payer, map how chronic care management sits beside the value-based support the group already has, scope the eClinicalWorks integration, and set which office goes live first before the first patient enrolls.

1. Why Now: The Model Ended, the Codes Remain

Medicare is changing what it pays primary care for, and for this group one of the changes has already happened. Four shifts land in the same place: the weeks between a patient's visits. For internists whose Medicare patients carry hypertension, diabetes and kidney disease together, those weeks decide how the year goes.

The shift	What it means for Medical Associates
1. From visits to panels	A patient on a chronic medication sees an internist a few times a year. Blood pressure drifts in the months between, glucose climbs in them, and the admission that follows starts in them. Managing a panel means knowing which of roughly 5,200 Medicare patients are trending the wrong way before they reach an emergency department, and that takes home data and a team assigned to act on it every month.
2. Accountability for total cost	The group bills inside an Enhanced-track Medicare Shared Savings Program ACO, whose current two-sided agreement began in 2024. Patients are assigned after the year closes, on the primary care they actually received, and every admission among them counts against the ACO's spending benchmark.
3. The model that paid for the panel has ended	Primary Care First paid the group a monthly population-based amount, and its claims rules did not allow chronic care management for attributed patients. CMS ended it on December 31, 2025. In 2026 the work between visits bills patient by patient, and since 2025 advanced primary care management has paid a monthly amount per patient for running the whole panel.
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 17.3% of remote-monitoring Medicare payments.[4] At Rhode Island's CY2026 rates one hypertensive patient on remote monitoring and chronic care management (99454, 99457 and 99490) is worth **$174.31 a month** in Medicare allowed charges.

Each shift pays for, or measures, what happens between visits. A remote care service line is how Medical Associates covers that time for every eligible patient, and remote monitoring and chronic care management bill for it under Medicare fee-for-service today, under the group's own NPIs.

2. Medical Associates Today: Internal Medicine for the East Bay

Medical Associates is an internal medicine group first: two offices, one record, one billing entity and physician leadership that has stayed in place for more than a decade. Its Medicare panel is older than average, and the group already runs the visit rhythm a remote care program needs, from the annual wellness visit to the nursing-facility round.

2.1 Two offices, 20 clinicians, one record

Office	Clinicians	What else is there	What it means for this program
Bristol **1180 Hope Street**	14 internists and family physicians, 3 nurse practitioners	A walk-in center staffed by the internists, lab, x-ray, ultrasound, mammography and bone density; dermatology and podiatry	Most of the group's established Medicare patients; the first office to go live
East Providence **950 Warren Avenue**	5 internists and 1 nurse practitioner; two of the internists and the nurse practitioner also see patients in Bristol	Internal medicine, lab and podiatry	The same flags, devices and care team; a smaller schedule for the on-site enrollment specialist

medassociatesofri.com, October 26, 2026: 20 internal medicine clinicians across the two offices, three of them at both. The group's billing entity also carries radiology, dermatology, pediatric and podiatry clinicians outside this program.

Both offices run on one eClinicalWorks system, with the patient portal and bill pay on the same platform. Several internists and a nurse practitioner follow the group's patients into nursing facilities, at least 200 traditional-Medicare patients in CY2024, and the internists manage patients by phone: about 150 had telephone visits that year. Bone-density scanning runs in the Bristol office.[5]

2.2 What the CY2024 claims say

The CY2024 Medicare by-provider and by-provider-and-service files were queried for the 19 internal medicine and family medicine clinicians who billed under the group. The profile below is the traditional-Medicare panel those clinicians saw.[6]

Panel	CY2024	Condition	Share
Beneficiary-clinician relationships	3,653	**Hypertension**	**71% (a floor)**
Medicare allowed	$639,238	High cholesterol	74% (a floor)
Average age	**76**	Arthritis	45%
Weighted HCC risk score	**1.07**	**Diabetes**	**23%**

[4] CoachCare Value Analysis for Medical Associates of Rhode Island, 2026: 99445 and 99470 carry 17.3% of 24-month remote-monitoring Medicare payments.

[5] CMS by Provider and Service, CY2024: nursing-facility visit codes 99304 to 99310 for three clinicians (the largest single code per clinician, summed: 209 beneficiaries); telephone visit codes 99442 and 99443 for five clinicians (148, same method); bone densitometry 77080 for 214 beneficiaries under one internist.

[6] Medicare Physician & Other Practitioners, CY2024, by NPI for the 19 clinicians: 3,653 beneficiary-clinician relationships, 3,205 established-visit relationships (99212 to 99215), $639,238 allowed. Prevalence is weighted by beneficiaries.

Panel	CY2024	Condition	Share
Dual-eligible, where reported	10%	Ischemic heart disease	23%
Annual wellness visits	**About 1,540**	**Chronic kidney disease**	**19%**
Nursing-facility visits	At least 200 patients	Depression	21%
Telephone visits	About 150 patients	Atrial fibrillation	18%
Transitional care	Below 11 per clinician	COPD	13%
Remote monitoring, chronic care management, principal care management, APCM	No program at meaningful scale	**Heart failure**	**13%**

CMS Medicare Physician & Other Practitioners, CY2024, the 19 internal medicine and family medicine clinicians billing under the group. Program rows are beneficiaries; relationships count a patient once per clinician seen. CMS caps published prevalence at 75% per clinician, so hypertension and high cholesterol are floors, and suppresses lines under 11 beneficiaries.

This is the panel remote care is built for: hypertension in at least seven of ten patients, diabetes in nearly one in four, kidney disease, heart disease and atrial fibrillation common, and an average age of 76. Most patients qualify for chronic care management, and hypertension with diabetes or kidney disease is the largest group whose home readings would change treatment. The group sees these patients on a steady rhythm, but **neither remote monitoring nor chronic care management appears at meaningful scale in CY2024**, the last full year under Primary Care First.[7]

2.3 How the group got here

Year	What happened
2013	State filings show the same internists serving as the corporation's officers from at least 2013 to today, with the principal office at 1180 Hope Street in Bristol
2022	CMS lists the group as a Primary Care First practice, paid in part by a monthly population-based amount, while it also bills inside a Shared Savings Program ACO
2024	The group's ACO begins its current agreement in the Enhanced, two-sided track, scored every year on blood pressure, diabetes, depression and readmissions
2025	CMS ends Primary Care First a year early, on December 31. Its population-based payment ends with it, and so does the claims rule that kept chronic care management off the table for attributed patients
Today	Two offices, 17 physicians and 3 nurse practitioners, one eClinicalWorks system, a walk-in center, imaging and bone-density scanning in Bristol, about 1,540 wellness visits a year, nursing-facility rounds and care by phone
Next	**Daily readings and monthly care management for every eligible Medicare patient, run by a CoachCare care team inside eClinicalWorks and billed under the group's NPIs**

2.4 What the group already runs, and the gap

What exists	Status	What it means for this program
eClinicalWorks	**Live at both offices**	The program's host: flags, orders, readings, care documents and claims (Section 4)
Annual wellness visits	**About 1,540 a year**	The enrollment moment: eligibility checked, consent taken and devices ordered the same day
Walk-in center	**Weekdays and Saturday mornings**	Staffed by the internists, with lab and x-ray on site; a walk-in visit for blood pressure or sugar becomes an enrollment

[7] CMS by Provider and Service, CY2024, searched for the remote monitoring, chronic care management, principal care management, APCM, transitional care and behavioral health integration codes for all 19 clinicians: no line reaches the 11-beneficiary publication threshold. CMS Part B claims, 2019 to 2024, by NPI: remote monitoring $0; under $2,000 of chronic care management and about $21,000 of transitional care in six years.

What exists	Status	What it means for this program
Nursing-facility rounds	**Three clinicians**	When a patient goes home from a facility stay, devices and the care-management call pick up the first weeks
Care by phone	About 150 patients in CY2024	Monthly care-management calls make that contact routine, documented and billable
Transitional care	**Small volume**	Credited and kept. CoachCare makes the two-business-day contact after more of the discharges and carries the patient past day 30
Value-based support	Through the group's ACO and its physician network	Quality reporting and payer contracting. The program coexists with it
Chronic care management	No program at meaningful scale	Open since January 2026; CoachCare runs it for every eligible patient
Remote monitoring	No program in the claims	Devices, daily readings and business-hours alert triage come from CoachCare

The gap is specific: daily readings for the hypertension, diabetes and heart patients, and monthly billable care time for every patient with two or more chronic conditions, across both offices and all 20 clinicians. The value-based support the group already has works on quality reporting and contracts; none of it is billable monthly care management delivered in the practice.

2.5 The market, Medicare Advantage, and the rate basis

Bristol County held 13,286 Medicare beneficiaries in July 2026, and East Providence sits in Providence County. Weighted by where the group's established Medicare patients are seen, about 58% are in a Medicare Advantage plan (Bristol County 55.3%, Providence County 64.5%). **Most of this panel is paid under 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 the group's patients hold, and how each pays these codes, is the second thing to confirm after the chart count.[8]

Both offices sit in Rhode Island's single statewide payment locality, locality 01, under the National Government Services JK contractor. Every dollar in this report is priced at those CY2026 amounts.[9]

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 the group's own billing through eClinicalWorks. The forecast carries the two monthly programs; transitional care, which the group 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 and scales send readings between visits against thresholds the group's internists set; 99453, 99454 or 99445, 99457, 99458, 99470	Hypertension and diabetes first, then kidney disease, heart failure and atrial fibrillation

[8] CMS Medicare Monthly Enrollment, July 2026: Bristol County 13,286 beneficiaries, 7,348 in Medicare Advantage and other health plans; Providence County 133,741 and 86,204. Weighted by CY2024 established-visit relationships, about three quarters at the Bristol office.

[9] CY2026 Physician Fee Schedule, National Government Services carrier 14412, Rhode Island locality 01: geographic indices work 1.019, practice expense 1.033, malpractice 0.892; conversion factor $33.4009.

Program	What it does clinically	Who it fits on this panel
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, observation or facility stay; already billed, not in the forecast

Codes	What they pay for	CY2026 Rhode Island locality 01
99490 · 99439	Chronic care management, first 20 minutes · each additional 20	$67.52 · $51.54
99453	Remote monitoring setup and education, once	$22.33
99454 · 99445	**Device supply, 16+ days · 2 to 15 days in 30 (99445 new in CY2026)**	**$53.78 · $53.78**
99457 · 99458	Treatment management, first 20 minutes · each additional 20	$53.01 · $42.31
99470	**Treatment management, 10 to 19 minutes (new in CY2026)**	**$26.67**
99495 · 99496	Transitional care, visit within 14 days · within 7 days	$225.18 · $305.56
G0556 · G0557 · G0558	Advanced primary care management, levels 1 to 3	$16.70 · $54.95 · $119.76
99484	Behavioral health integration, 20 minutes a month	$58.63

How the rates apply

CY2026 non-facility amounts, Rhode Island locality 01 (National Government Services JK, carrier 14412), ZIP 02809. 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 58% of the panel is 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; the traditional-Medicare share alone is $471,129 of the 24-month contribution margin (Section 6.5).

3.2 The care team, and the hours it keeps

CoachCare hires, trains and manages the care managers, at 165 patients each: 4 care managers for the 659 unique patients at month 12, and 5 for about 863 at month 24. An on-site enrollment specialist on CoachCare's payroll works the office schedules beside the group's medical assistants and enrolls patients during the visit, telephonic outreach reaches the rest, and the internists order from the chart. Devices are cellular, with no Wi-Fi, smartphone or pairing needed. Monitoring runs on business hours: devices transmit daily, and care managers review readings, run outreach and send escalations Monday to Friday, 8 a.m. to 5 p.m. in the patient's time zone, the hours the offices keep. Patients are told at consent to call 911 for an emergency and their office for anything urgent.

3.3 Transitional care: more discharges that qualify

Medical Associates already bills transitional care management, at small volume: no clinician reached CMS's 11-beneficiary publication threshold in CY2024. The working discharge workflow is there, and the program builds on it. The CoachCare care team can make the two-business-day contact and the medication reconciliation after every hospital, observation or facility discharge the group learns of, so more discharges meet the requirement, and the group furnishes the visit and bills the code (99495 at $225.18; 99496 at $305.56). Remote monitoring and chronic care management then carry the patient past day 30, when most readmissions happen. The forecast carries no transitional care dollars.

3.4 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. With Primary Care First over, Medical Associates can bill it as a primary care practice, and for a group already accountable for total cost it fits the way the group is measured.[10] It appears here at zero dollars. 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 patient in five, and depression screening with follow-up is one of the measures the group's ACO reports. Behavioral health integration (99484, $58.63 a month) can run on the same care-manager calls once the program is running. It carries no dollars here.

3.5 Alongside the value-based support already in place

Medical Associates is not starting from nothing on value-based care. Its physicians take part in an Enhanced-track Shared Savings Program ACO and its quality reporting, and the group contracts with health plans through a physician network that shares responsibility for cost and quality. That support works on contracts, measures and incentives. It does not deliver billable, monthly care time inside the practice for every eligible patient, and it does not put a cuff in anyone's home. CoachCare adds those pieces, and the work is divided so that no patient is called twice.

Deployment	What CoachCare runs	What stays with the group and its partners
Remote monitoring on its own	Remote monitoring for the hypertension, diabetes, kidney and heart patients	Care coordination, as the group's team and its value-based support run it today, with home readings in the chart
Full service line, RPM + CCM (the forecast of record)	Both programs, enrolling every eligible patient into chronic care management as well as monitoring	Clinical governance, the visits, transitional care billing, quality reporting and the patients

- **The group keeps clinical governance, the patients and the revenue.** Its internists set thresholds, routing and discharge criteria and sign the care plans; claims go out under the group's NPIs, and in the full service line Medical Associates keeps $903,231 of contribution margin over 24 months.
- **CoachCare supplies the program.** Devices, an on-site enrollment specialist, care managers, business-hours alert triage, monthly documentation and automated claims. None of it is the group's headcount, inventory or software.
- **The existing support is a coexisting layer.** How the ACO's work and a CoachCare care-management program divide the outreach is a discovery item (Section 9.5).
- **Independence is part of the return.** A recurring service line with its own contribution margin funds the group's next decisions from its own panel.

4. eClinicalWorks: The Program Lives in the Chart

CoachCare works inside eClinicalWorks' own workflows, so the group's clinicians and staff do not learn a second system. Evidence of care, vitals and care plans are attached to each chart every month, enrollment status is visible in both offices, and a flagged patient reaches the first day of service in under five days.[11] CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically.

[10] 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.

[11] 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
Integrated enrollment	Flags in the chart prompt the order for patients who meet criteria the group's internists approve, at a chronic-care visit, a wellness visit or on an outreach list
Enrollment by services and devices	The internist orders by service and by device (cuff, glucometer, scale), the way a lab is ordered
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 internist 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; the group's billing team reconciles and files them

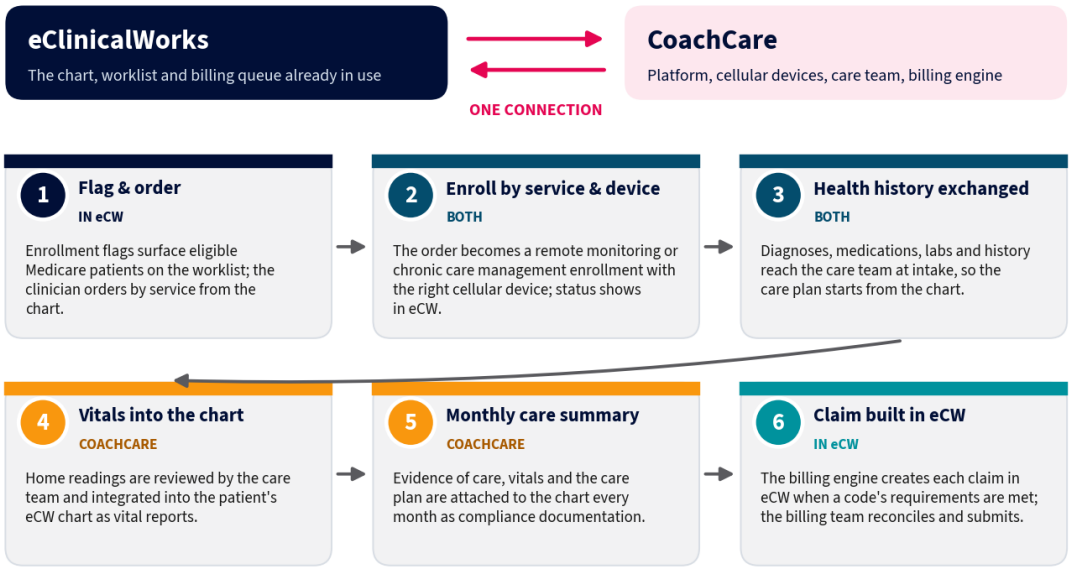


Figure 1. From a flag in the chart to a claim: the six steps CoachCare and eClinicalWorks run every month for every enrolled patient. CoachCare eClinicalWorks integration overview.

The build runs alongside onboarding, so it does not hold up the first enrollments.

5. Clinical Governance & Escalation

Every reading routes through one escalation engine with defined thresholds, trend rules, routing and documentation, so the group never carries surveillance liability it did not agree to. Thresholds and routing are set with the group's internists, for each office, before the first patient enrolls.[12]

[12] 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.

5.1 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 office, not to 911
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 or glucose; 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

5.2 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 office the same day. A critical reading alone, without those symptoms, goes to the office instead.

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

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

5.3 Three-way routing, on business hours

Route	What goes there	Who sees it
Emergency	Active emergent symptoms reported on a call	911 with the patient on the line; the office notified
Needs the practice	A critical reading, or an out-of-range reading or trend confirmed after a retake	The internist 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**

The matrix is agreed for each office. Care managers work readings and escalations Monday to Friday, 8 a.m. to 5 p.m. local patient time, which matches the hours the offices are open, so every escalation lands while an internist 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.

5.4 The post-discharge cadence

Any emergency visit or hospitalization in the previous 60 days triggers the cadence. After a hospital, observation or facility stay it is also the transitional care episode the group already bills, and inside the ACO each admission it prevents is spending that never posts against the benchmark.

Touch	Window	What happens
1 · Stabilize	**Day 1–2**	What led to the visit; discharge medications reconciled against what is in the house; a follow-up visit confirmed within 7 to 14 days
2 · Detect	**Day 5–8**	Adherence verified, triggers re-checked, appointment and ordered labs confirmed
3 · Secure	**Day 12–14**	Medication and risk review, visit outcome, and a handoff into monthly monitoring

5.5 Built for an older, phone-first panel

The group's traditional-Medicare patients average 76 years old, and some live in nursing facilities part of the year. 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, which the internists already use for care, so no patient has to learn an app. A monitoring patient unreachable 45 days from enrollment is escalated to the office; without an instruction from the office, discharge from monitoring follows at 180 days, and discharge criteria always belong to the group's internists.

6. Value Analysis: The 24-Month Forecast

6.1 The headline economics

The forecast covers remote monitoring and chronic care management across a Medicare panel of 5,200 at the two offices, 4,160 in scope, at the CY2026 Rhode Island locality 01 amounts, with 20 referring clinicians and one CoachCare-funded on-site enrollment specialist. No transitional care, APCM, behavioral health integration or ACO payment is in these numbers.[13]

Full service line	Year 1	Year 2	24 months
Unique patients, end of period	659	863	863
Contribution margin	**$206,872**	**$696,358**	**$903,231**

Year two is about three times year one because the program spends year one ramping up: it enters year two with 659 unique patients, both programs reach their eligible ceilings in months 15 and 16, and it closes year two with 863. Year two returns **$696,358 of the $903,231 contribution margin**.

6.2 Two deployments, side by side

Each deployment is shown on its own, and the full service line is the forecast of record. Remote monitoring on its own reaches the same 676 patients in month 15 and avoids the same admissions, because the readings drive both. The full line adds chronic care management for 624 patients by month 24 and adds $453,559 more contribution margin over 24 months.

24 months	Remote monitoring on its own	Full service line, RPM + CCM
Contribution margin	**$449,672**	**$903,231**
Unique patients at month 24	676	863
Hospitalizations avoided	About 71	About 71

[13] CoachCare Value Analysis for Medical Associates of Rhode Island, 2026, the source of all Section 6 figures; sensitivity runs change one input at a time on the same workbook.

6.3 Where the patients come from

Program	Active enrollments, month 12	Active enrollments, month 24	Ceiling reached
Remote physiologic monitoring	527	**676**	M15
Chronic care management	440	**624**	M16
Unique patients	**659**	**863**	

Chronic care management reaches 624 enrollments at month 24, because the multi-chronic core of the panel is large. Remote monitoring reaches 676 and produces the readings, alerts and avoided admissions. The **1,300 active program enrollments at month 24 belong to 863 unique patients**, because most care-management patients are also monitored.

6.4 The ramp, month by month

Contribution margin runs −$5,872 in month 1 while the program ramps, on 17 enrollments. It is positive from month 2, with $1,740 on 41 enrollments, and cumulative contribution margin is above zero by the end of month 4. New patients join faster each month as referrals build, reaching about 100 a month by month 12; once both programs are full, the monthly contribution margin holds at about $59,332. Cumulative contribution margin passes $27,047 at month 6, $206,872 at month 12 and $903,231 at month 24.

Month	Active enrollments	Monthly contribution margin	Cumulative contribution margin
M1	17	**−$5,872**	−$5,872
M2	41	$1,740	−$4,132
M3	80	$3,531	−$601
M6	280	$12,657	$27,047
M12	967	$43,897	$206,872
M18	1,300	$59,332	$547,241
M24	1,300	**$59,332**	**$903,231**

CoachCare Value Analysis, full service line. Cumulative contribution margin is the running total from month 1; the monthly figure holds once both programs reach their eligible ceilings.

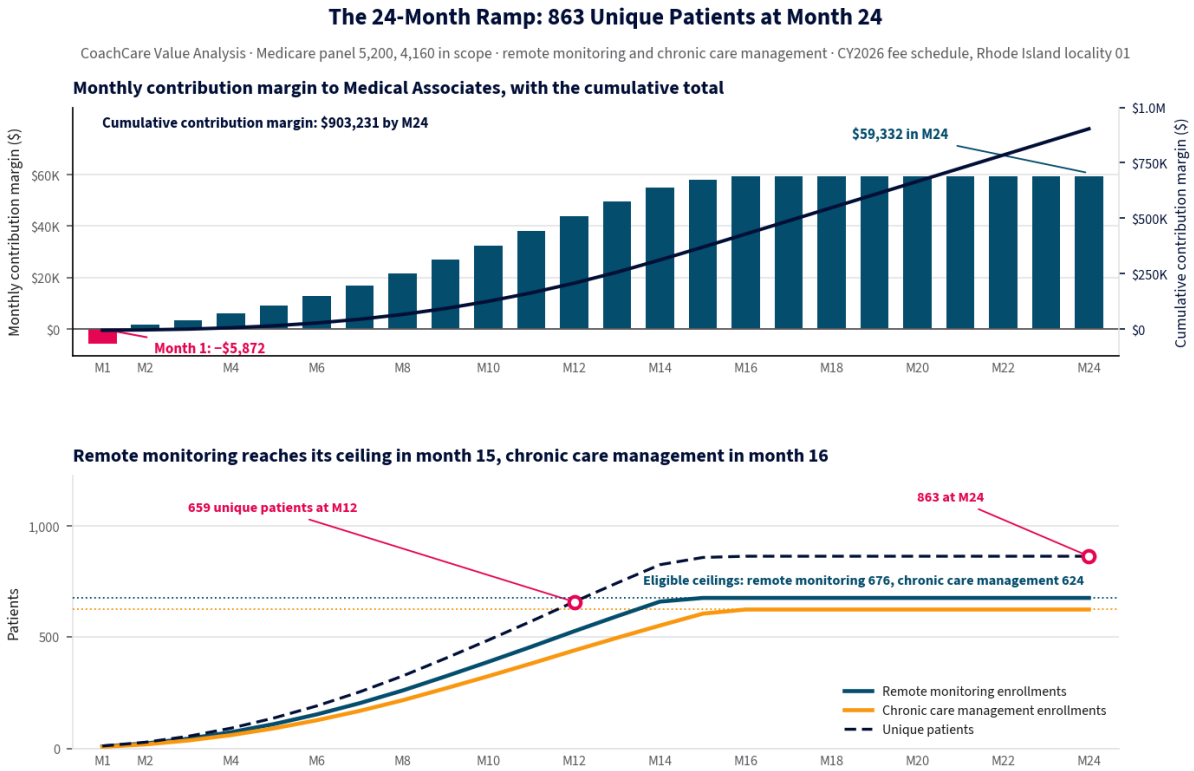


Figure 2. Monthly contribution margin, with cumulative contribution margin, and the enrollment census by program against the two eligible ceilings, with unique patients at months 12 and 24. CoachCare Value Analysis, full service line.

6.5 The eligible panel sets the ceiling

Program	Eligible share of the 4,160 in scope	Acceptance	Ceiling	Reached
Remote physiologic monitoring	65%, 2,704 patients	25%	**676**	**Month 15**
Chronic care management	75%, 3,120 patients	20%	**624**	**Month 16**

Say the constraint out loud

At Medical Associates, enrollment pace sets year one and the eligible panel sets year two. With one CoachCare enrollment specialist and the internists referring, remote monitoring reaches its ceiling in month 15 and chronic care management in month 16. From then on the program runs at full census, and the forecast grows only with a larger confirmed panel or a higher share of it in scope.

A second enrollment specialist cannot raise either ceiling, but reaches both sooner. On the same panel it brings the ceilings forward to months 11 and 12 and adds $118,832 of contribution margin over 24 months, from patient-months that would otherwise come later. Without the on-site specialist neither program reaches its ceiling inside 24 months, and the line gives up $370,979.

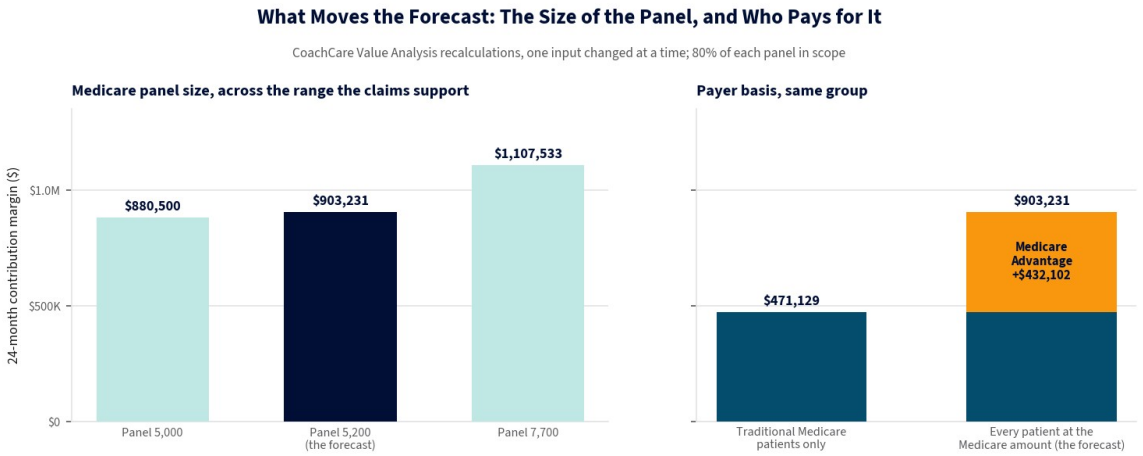


Figure 3. 24-month contribution margin across the panel sizes the claims support, and the same forecast priced on traditional Medicare patients alone. CoachCare Value Analysis recalculations.

Scenario	24-month contribution margin	Unique at M12	Unique at M24	Monitoring ceiling
Base: panel 5,200, 4,160 in scope, 20 clinicians, one enrollment specialist	**$903,231**	**659**	**863**	**M15**
Panel 5,000, 4,000 in scope	$880,500	658	830	M14
Panel 7,700, 6,160 in scope	$1,107,533	670	1,278	M20
Panel 5,200 with all of it in scope	$1,029,434	665	1,079	M17
Traditional Medicare patients only (2,244, 1,795 in scope)	$471,129	373	373	M9
A second on-site enrollment specialist	$1,022,063	863	863	M11
No on-site enrollment specialist	$532,252	334	766	Not by M24
The 17 physicians referring alone	$879,506	612	863	M15

CoachCare Value Analysis recalculations, one input changed at a time; panel runs keep 80% in scope. Monitoring ceiling: the month remote monitoring reaches its eligible ceiling.

Two facts about the group move this forecast more than any other. The first is the panel: at 7,700 patients the line is $1,107,533, at 5,000 it is $880,500, and the chart count settles which. The second is who pays. **Priced on its traditional-Medicare patients alone, the group's line returns $471,129 of contribution margin**; the Medicare Advantage patients carry the other $432,102, and each plan's contract decides how that part pays.[14]

6.6 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	**111,161**	Blood pressure, glucose and weight values arriving between visits
Claims and billable units	**39,296**	Created in eClinicalWorks for the group's billing team
Care-management tasks	78,593	Outreach, care-plan updates and medication reviews
Patient conversations	11,789	Live contacts across 655 hours of call time
Care-team hours	**17,309**	**About 8.3 full-time-equivalent years of work the group does not employ**

[14] Panel sizes 5,000 to 7,700 bracket the group's CY2024 claims: established-visit relationships × 0.70 grossed up for the Medicare Advantage share of Bristol County alone (5,021) and of both offices weighted (5,285), and the provider method (17 physicians × 450); the 5,200 forecast sits between the first two. Traditional Medicare only: 2,244 patients (established-visit relationships × 0.70).

Output over 24 months	Volume	What it represents
Hospitalizations avoided	**About 71**	Admissions that never post against the ACO's spending benchmark

Annual admission rate among enrolled patients	20% (the workbook's baseline)	30%	40%	50%
Hospitalizations avoided over 24 months	71	106	**141**	176

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 141.

Two ledgers, kept separate

Contribution margin funds the program. $903,231 to Medical Associates over 24 months, paid claim by claim.

Avoided admissions and quality speak to the ACO. About 71 admissions avoided at the workbook's baseline, plus monthly work on the five measures in Section 7. Under two-sided risk the new Part B care-management spend also sits on the ACO's ledger, which is why the avoided admissions and the quality measures carry the argument there, more than the contribution margin does. The Value Analysis is fee-for-service and does not model shared savings.

6.7 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.[15]
- **Readmissions, at the same practice.** Across 26,689 patients, the 30-day readmission rate was 7% for CoachCare patients against 15% for the rest.[16]
- **Heart failure.** Iowa Heart enrolled 450 advanced heart-failure patients and recorded zero readmissions over six months.[17]

7. Quality: The Measures the ACO Is Scored On

The Shared Savings Program scores every ACO each year on a fixed set of quality measures, and the score decides whether the ACO meets the program's quality standard. Five move with this program's monthly work, and Medical Associates' patients count in all five. Two of the group's physicians sit on the ACO's governing body, so these are measures the group already watches.[18]

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

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

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

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

[18] Shared Savings Program quality reporting through the APM Performance Pathway: measures 001, 134 and 236 reported by the ACO; 479 and 484 calculated by CMS from claims. ACO public reporting page, 2026: governing-body seats by participant.

Measure	What it counts	What the program does each month
Q484 Admissions, multiple chronic conditions	Unplanned admissions among patients with several chronic conditions, from claims	Daily readings, outreach on a confirmed trend, a fixed cadence after any admission
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 group
Q479 Hospital-wide 30-day readmission	Unplanned readmissions within 30 days of discharge, from claims	A call within two business days, devices home before the follow-up visit

Two of the five come from claims, so an admission that does not happen does not count. With hypertension in at least seven of ten of the group's Medicare patients, Q236 covers most of the panel, and monthly care management supplies the follow-up half of Q134.

8. 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 Rhode Island locality 01 on the forecast's own billing mix, with enrollment held constant.[19]

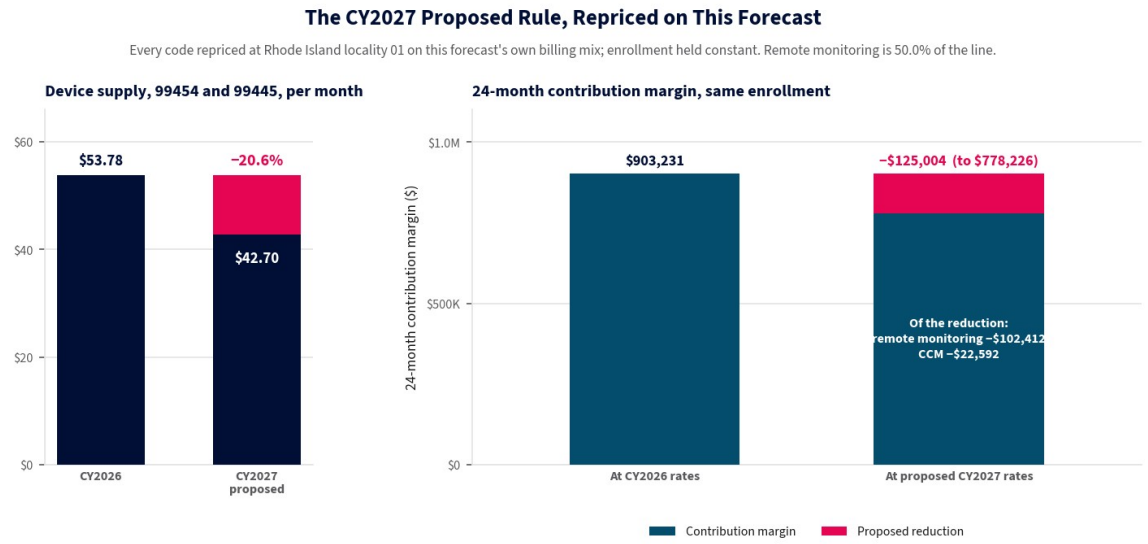


Figure 4. The CY2027 proposal on this forecast: the one code CMS proposes to cut, then 24-month contribution margin under CY2026 and proposed CY2027 rates, with the reduction in coral. CoachCare repricing at the proposed CY2027 amounts.

Level	Proposed CY2027 rate change	Effect on 24-month contribution margin	Why each step is smaller
Device supply, 99454 and 99445	**$53.78 to $42.70 a month, −20.6%**		The code CMS proposes to cut
The remote monitoring arm	−9.6% across its codes	**−$102,412**	Device supply is 32.4% of the remote monitoring basket

[19] CMS-1848-P, published July 2026. CoachCare repricing at Rhode Island locality 01, conversion factor $32.8409 against $33.4009: device supply 32.4% of the remote-monitoring basket; remote monitoring 50.0% of the line.

Level	Proposed CY2027 rate change	Effect on 24-month contribution margin	Why each step is smaller
Chronic care management	−2.1%	−$22,592	Routine rate changes only; not targeted
The whole service line	−5.9% across its codes	**−$125,004: $903,231 under CY2026 rates, $778,226 under CY2027**	Remote monitoring is 50.0% of the line's Medicare payments

CoachCare repricing on this forecast's own billing mix, with enrollment held constant.

Each number is smaller than the last only because its base is larger: this line rests on two programs, and only one holds the code being repriced. CoachCare will rerun the forecast at the final rates. A contingency is already in build in which CoachCare manages the staffing while the group owns the clinical program and the billing.

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 Rhode Island locality 01 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.

9. Implementation Roadmap

9.1 Who runs what

Function	CoachCare	Medical Associates
Identification and enrollment	Registry query in eClinicalWorks starting with the hypertension, diabetes, kidney and heart-failure patients; an on-site enrollment specialist; telephonic outreach; devices shipped, cellular-paired and replaced	Approves the criteria and target list; internists order at the chronic-care or wellness visit
Transitional care	Two-business-day contact and medication reconciliation after each discharge the group 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**
Coordination with existing support	Works beside the ACO's programs so that no patient is called twice	Decides how the work divides
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**

9.2 The model inputs

Input	Value in this forecast
Medicare panel	**5,200 patients across both offices, 4,160 in scope; all payers**
Payer mix	**About 58% Medicare Advantage around the two offices.** 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. Every patient is priced at the Medicare amount.
Referring clinicians	20: 17 physicians and 3 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	One CoachCare-funded on-site enrollment specialist plus telephonic outreach; five referrals per clinician a month, 70% accepted; referrals and on-site enrollment build to full pace over the first 12 months
EMR	eClinicalWorks, integrated as described in Section 4
Rates	CY2026 fee schedule, non-facility, Rhode Island locality 01, ZIP 02809

9.3 The staffing plan, and which office goes first

CoachCare brings on care managers ahead of the census: 4 by month 12, when about 659 unique patients are enrolled, and 5 once both programs reach full census in month 16. New patients arrive faster each month in year one, about 100 a month by month 12. The on-site enrollment specialist works the Bristol schedule most days and East Providence on the days its clinicians see their chronic-care patients; telephonic outreach and the internists' own orders at the visit do the rest.

Which office goes first is a decision to make together. One sensible sequence starts in Bristol, where most of the group's established Medicare patients are seen, and brings East Providence on within the first quarter. Both offices use the same flags, devices and care team, so a later start changes only when its patients join, not how the program runs.

9.4 The first 90 days, and after

Window	What happens	Result
Weeks 0–6 Integrate and charter	eClinicalWorks workshop with the EHR administrator and billing leads; chart counts and payer mix; the ACO's outreach and today's transitional care workflow mapped so nobody is called twice; thresholds, routing and the office order agreed	Integration live, protocol signed, go-live order set
Weeks 6–12 Launch in Bristol	Enrollment from the first week; remote monitoring for hypertension and diabetes, care management for two-plus conditions; the post-discharge cadence live	17 enrollments in month 1, 41 by month 2, 80 by month 3
Months 3–12 Both offices, building the census	Same protocols in East Providence; heart failure, kidney disease and atrial fibrillation cohorts added; care managers added as the census grows	967 enrollments, 659 unique patients at month 12
Months 13–24 Reach full census	Both programs reach their eligible ceilings by month 16; the APCM mix decided together; behavioral health integration scoped	Year 2: $696,358 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.

9.5 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. It sets both eligible ceilings, and with them what year two is worth.
2. **The Medicare Advantage plans, one by one.** 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 the group's patients hold, whether each pays chronic care management and remote monitoring, and whether any arrangement already pays the group for this work, is confirmed plan by plan.
3. **The ACO's outreach and a chronic care management program.** Which patients the ACO's programs reach today, and how they and CoachCare's care team divide the work.
4. **Which clinicians and panels are in scope.** Whether any panels, such as long-stay nursing-facility patients, sit outside the program, and who refers from the start.
5. **Transitional care today.** Who runs the workflow at each office, where discharge notices come from, and how many discharges a year reach the group in time.
6. **The eClinicalWorks configuration.** The version, the modules licensed, who hosts it, and any device connection already in place.
7. **Coinsurance at consent.** How the monthly Part B coinsurance is explained at enrollment, and who answers billing questions afterwards.

10. Recommendations

1. **Launch the full service line in 2026, the first year chronic care management is open to the group.** $903,231 of contribution margin over 24 months ($206,872 in year one, $696,358 in year two), positive from month 2, with nobody hired.
2. **Pull the Medicare chart count by payer in week one.** It sets both ceilings, which the program reaches in year two, so it decides what year two is worth.
3. **Confirm the Medicare Advantage plans before counting their patients.** More than half of the panel is paid under plan contracts; the traditional-Medicare share alone is $471,129 of contribution margin.
4. **Start in Bristol with the hypertension and diabetes patients at the chronic-care and wellness visits.** Care management for the plan, a cellular cuff and glucometer for the readings, the visit as the enrollment conversation.
5. **Extend the transitional care the group already bills.** CoachCare makes the two-business-day call after every discharge the group learns of; the group bills 99495 or 99496.
6. **Settle the division of work with the ACO's outreach before launch.** Or begin with remote monitoring on its own; both deployments are net-positive.
7. **Aim the monthly work at the ACO's quality measures.** Each of the roughly 71 admissions avoided over 24 months is spending that never posts against the ACO's benchmark.
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.
9. **Keep clinical governance where it is.** The group's internists decide; CoachCare does the work and documents it.

The Medicare panel Medical Associates already manages supports a service line that returns $903,231 of contribution margin over 24 months, on staff the group does not hire and devices it does not buy. The payment rule that kept this work off the claim ended with 2025. What remains is to build it once, with a partner, and run it as the group's own.

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 builds on what the group already does.** Wellness visits, bone-density scanning, nursing-facility rounds, care by phone and transitional care after hospital stays are already part of the week. Remote monitoring and chronic care management fill the months between them.
- **It runs inside the chart the group already uses.** Readings, documentation and claims live in eClinicalWorks, and enrollment status is visible in Bristol and East Providence alike.
- **Fully staffed, no hiring.** Care managers at 165 patients each, enrollment, devices, business-hours alert triage and billing preparation on CoachCare's payroll.
- **Clinicians stay in charge.** The group's internists 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 Medical Associates' Medicare chart count by payer, map how chronic care management sits beside the value-based support the group already has, scope the eClinicalWorks integration, and set which office goes live first 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 Rhode Island locality 01 geographic indices; CMS-1848-P, the CY2027 proposed rule.
- **Market:** CMS Medicare Monthly Enrollment, July 2026, Bristol and Providence counties.
- **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 Medical Associates of Rhode Island, 2026, the source of every financial, enrollment, clinical-output and operational figure in Sections 6 to 10.

Unique patients and program enrollments are different numbers. At month 24 the program holds 1,300 active program enrollments belonging to 863 unique patients, because a patient may hold both enrollments. The 5,200-patient panel covers all payers; the 3,653 beneficiary-clinician relationships in the CY2024 claims are traditional Medicare only.