COACHCARE | Boice-Willis Clinic
Coordinated, Compassionate, Comprehensive Medical Care

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

Boice-Willis Clinic, P.A.

A physician-led multispecialty group in Rocky Mount, North Carolina, for more than a century: 31 adult primary care clinicians at five sites in Rocky Mount, Nashville and Spring Hope, on one eClinicalWorks system, with a Medicare panel of about 15,000

Remote Care Service Line Optimization Report

2026 Strategy Report

A scalable, profitable remote care service line for Boice-Willis Clinic: remote monitoring and chronic care management for the heart failure and kidney disease patients its five primary care sites already know, billed under the group's own NPIs at North Carolina'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 leadership of Boice-Willis Clinic. It is the companion to the group's remote care strategy page and makes the same case at report length: why Medicare's payment rules make this the year, what the group's own Medicare claims show, how the service line runs beside the care coordinators already doing chronic care management, what it returns over 24 months at North Carolina's rates, and why CoachCare is the partner to run it.

Boice-Willis already completes about 3,600 annual wellness visits a year, bills transitional care after hospital stays from sixteen clinicians, runs its own lab and diabetes education center, has nephrology, endocrinology and pulmonology in the same group, and bills inside a two-sided Shared Savings Program ACO. Its claims show chronic care management for about 150 patients and no remote monitoring. This report shows what a program for the group's heart failure and kidney disease patients returns, to the practice and to the ACO, who does the work, and what decides how fast it grows.

Prepared by CoachCare for discussion with Boice-Willis Clinic. © 2026 CoachCare.

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Executive Summary

Boice-Willis Clinic has practiced medicine in Rocky Mount since 1914 and is still a physician-led group. Its 31 adult primary care clinicians, 15 physicians, 10 nurse practitioners and 6 physician assistants, work at five sites in Rocky Mount, Nashville and Spring Hope on one eClinicalWorks system, alongside the group's own nephrologists, endocrinologists, pulmonologists and gastroenterologists, a Medicare-certified lab, a diabetes education center, imaging and a walk-in clinic open on Saturdays.[1]

The group's own CY2024 Medicare claims describe the panel. The 34 adult primary care clinicians who billed from its five sites recorded 10,700 beneficiary-clinician relationships, with patients averaging 74.5 years old and a weighted risk score of 1.46 against a national 1.00. At least three in four carry hypertension, 41% diabetes, 44% chronic kidney disease and 22% heart failure. The group completed about 3,600 annual wellness visits and billed transitional care for about 540 patients after hospital stays. **Chronic care management runs in house for about 150 patients, and no remote monitoring program appears in the claims**.[2]

Boice-Willis bills inside **an Enhanced-track Medicare Shared Savings Program ACO**, the two-sided track, and CMS files show it there in every year since at least 2022. Patients are assigned at the end of each year from where they received most of their primary care, every admission among them counts against the ACO's spending benchmark, and the quality measures it is scored on turn on what happens between visits.[3]

The observation this report is built on

Turn the panel Boice-Willis already manages into a profit-generating service line.

The group has the panel, the conditions, the record system, the visit rhythm, the specialists and the accountable-care position, and it has already proved chronic care management works in its offices. What it lacks is daily weight and blood pressure for its heart failure and kidney disease patients, more than half the panel, and the staff to run care management for those on Medicare Advantage. This service line fills that gap: staffed by CoachCare, governed by the group's clinicians, 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	990	2,255	2,255
Contribution margin	**$258,857**	**$1,109,509**	**$1,368,366**

CoachCare Value Analysis: the heart failure and kidney disease patients in a Medicare panel of 15,000 across five primary care sites, remote monitoring on traditional Medicare and Medicare Advantage and chronic care management on Medicare Advantage, 31 referring clinicians, one CoachCare-funded on-site enrollment specialist, CY2026 North Carolina locality 00 amounts. Contribution margin is what Boice-Willis keeps from the service line.

Boice-Willis can take this two ways, and both are net-positive. CoachCare can run remote monitoring on its own and leave chronic care management with the group's coordinators: **$871,011 of contribution margin over 24**

[1] boice-willis.com, retrieved October 26, 2026: about, locations, practices, services and provider-directory pages. Adult primary care in the directory: 15 physicians (9 internal medicine, 6 family medicine), 10 nurse practitioners and 6 physician assistants. The patient portal and walk-in booking run on eClinicalWorks and healow.

[2] CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024, queried for the 34 adult primary care clinicians whose CY2024 billing address is a Boice-Willis primary care site: 10,700 beneficiary-clinician relationships (a patient seen by two clinicians counts twice); average age 74.5; risk score 1.46; diabetes 41%, CKD 44%, heart failure 22%; hypertension and high cholesterol at the 75% CMS cap; annual wellness visits about 3,620; transitional care 99495 and 99496, about 543 beneficiaries; chronic care management 99490, 149 beneficiaries.

[3] CMS Shared Savings Program ACO Participants, performance years 2022, 2023 and 2026: Enhanced track; retrospective assignment from 2025. CMS Quality Payment Program eligibility, 2026.

months, for 1,961 patients. Or CoachCare can run both, adding chronic care management for the heart failure and kidney patients on Medicare Advantage, the forecast of record above, for 2,255 unique patients.

1. **Inside the ACO, the program pays its way.** At a 30% reduction in admissions, the heart failure and kidney patients assigned to the ACO return +$416,981 to total cost of care over 24 months, net of Medicare's share of their remote monitoring. Heart failure breaks even at a 18% reduction and kidney disease at 16% (Section 7).
2. **Enrollment pace sets this forecast.** With one CoachCare enrollment specialist and 31 referring clinicians, remote monitoring reaches about 92% of the eligible heart failure and kidney patients by month 24 and chronic care management, for Medicare Advantage patients, about 92%; neither fills inside two years. A second enrollment specialist adds $420,695 of contribution margin, while across the panel sizes the claims support, 12,000 to 18,800, 24-month contribution margin moves only from $1,317,585 to $1,396,017.
3. **Medicare Advantage is the larger question.** About 62.6% of Medicare beneficiaries in Nash and Edgecombe counties are in Medicare Advantage. Medicare Advantage plans cover these Part B services and pay them on each plan's own contract terms. The forecast prices every patient at the Medicare amount; with only traditional-Medicare patients in scope, 24-month contribution margin is $830,596, so the payer mix by plan is the first thing to confirm.
4. **A staffing plan the group does not hire for.** CoachCare brings on 6 care managers by month 12 and 14 by month 24, at 165 patients each, and delivers 27,241 care-team hours over 24 months, about 13.1 full-time-equivalent years.
5. **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 climbs with the census to $121,642 in month 24, still rising.
6. **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).
7. **Transitional care and APCM stay on the stack at zero dollars.** The care team can make the two-business-day call after every discharge the group learns of, and APCM bills in place of chronic care management when the group decides which patients move.
8. **The CY2027 proposed rule takes $220,566 off 24-month contribution margin.** With enrollment held constant, a 20.6% cut to the device-supply rate reaches the remote-monitoring arm as −$196,583 and the whole line as −$220,566 over 24 months (Section 10).

The ask is a working session: confirm the Medicare chart count by payer and how the group's Medicare Advantage plans pay for care-management codes, map how CoachCare sits beside the care coordinators who run chronic care management today, scope the eClinicalWorks integration, and set the order the five primary care sites go live before the first patient enrolls.

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

Medicare is changing what it pays primary care for. Four shifts are under way at once, and each lands in the same place: the weeks between a patient's visits. For a panel that carries hypertension, diabetes and kidney disease together, those weeks decide how the year goes.

The shift	What it means for Boice-Willis
1. From visits to panels	A 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. Managing a panel means knowing which of roughly 15,000 Medicare patients across five sites 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.

The shift	What it means for Boice-Willis
2. Accountability for total cost	The group bills inside an Enhanced-track Medicare Shared Savings Program ACO. Every admission among assigned patients counts against the ACO's spending benchmark, and the Enhanced track shares the difference in both directions. Assignment follows primary care, and chronic care management counts as a primary care service in the program's assignment rules.
3. Value-based care, and a Medicare Advantage majority	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 Nash and Edgecombe counties about 62.6% of Medicare beneficiaries are in Medicare Advantage. Medicare Advantage plans cover these Part B services and pay them on each plan's own contract terms.
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 16.9% of remote-monitoring Medicare payments.[4] At North Carolina's CY2026 rates one heart failure or kidney patient on remote monitoring and chronic care management (99454, 99457 and 99490) is worth **$161.05 a month** in Medicare allowed charges.

Each shift pays for, or measures, what happens between visits. A remote care service line is how Boice-Willis covers that time for the patients most likely to be admitted, those with heart failure or kidney disease, and remote monitoring and chronic care management bill for it under Medicare fee-for-service today. The group's revenue cycle picks up new codes quickly: 21 of its primary care clinicians billed the 2024 visit-complexity add-on, G2211, about 3,800 times in its first year.

2. Boice-Willis Today: More Than a Century in Rocky Mount

Boice-Willis is a multispecialty group with primary care at its center: five adult primary care sites, one record, one lab, and specialists who see the same patients. Its Medicare panel is older and sicker than average, and the group already runs the visit rhythm a remote care program needs, from the annual wellness visit to the call after a hospital stay.

2.1 Five primary care sites, one record, specialists down the hall

Site	Service	CY2024 billing clinicians	What it means for this program
Rocky Mount Medical Park North Winstead Avenue	Internal medicine, with nephrology, endocrinology, pulmonology, gastroenterology and neurology, the lab and imaging	8	The main campus: monitored patients' readings are in the chart before the next primary care or specialist visit
Boice-Willis Primary Care the Medical Center	Internal medicine and advanced practice clinicians	11	Among the group's busiest Medicare panels and the most wellness visits
Family Practice & Walk-In Clinic	Family practice; same-day care for established patients, open Saturdays	6	A walk-in visit for swelling or breathlessness in a heart failure patient becomes an enrollment, not a one-off
Nashville and Spring Hope	Family medicine in western Nash County	9	The more rural offices, where a cellular scale and cuff save the drive

boice-willis.com, October 26, 2026, locations and practices pages. Billing clinicians: CMS CY2024 claims by billing address, the 34 adult primary care clinicians; the directory lists 31 today.

The adult primary care roster is 15 physicians, 10 nurse practitioners and 6 physician assistants. Pediatrics, dermatology, physical therapy and the endoscopy center are separate parts of the group. The group's own CLIA-

[4] CoachCare Value Analysis for Boice-Willis Clinic, 2026: 99445 and 99470 carry 16.9% of 24-month remote-monitoring Medicare payments.

certified lab served about 6,100 traditional-Medicare patients in CY2024, one count of active patients that needs no deduplication, and a psychiatric-mental-health nurse practitioner is on its provider roster.[5]

2.2 What the CY2024 claims say

The CY2024 Medicare by-provider and by-provider-and-service files were queried for the 34 adult primary care clinicians who billed from a Boice-Willis primary care site. The profile below is the traditional-Medicare panel those clinicians saw.[6]

Panel	CY2024	Condition	Share
Beneficiary-clinician relationships	10,700	**Hypertension**	**75% (a floor)**
Medicare allowed	$4,095,053	High cholesterol	75% (a floor)
Average age	**74.5**	Arthritis	50%
Weighted HCC risk score	**1.46**	**Chronic kidney disease**	**44%**
Dual-eligible, where reported	14%	**Diabetes**	**41%**
Annual wellness visits	**About 3,600**	Ischemic heart disease	33%
Depression screening	About 3,600	Depression	25%
Transitional care	**About 540, across 16 clinicians**	**Heart failure**	**22%**
Chronic care management	**About 150, 6 clinicians**	Atrial fibrillation	20%
Remote monitoring, principal care management, APCM, behavioral health integration	No program at meaningful scale	COPD	19%

CMS Medicare Physician & Other Practitioners, CY2024, the 34 adult primary care clinicians billing from Boice-Willis sites. 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: kidney disease in more than two in five patients, heart failure in more than one in five, hypertension in at least three of four, a risk score of 1.46 and an average age of 74.5. Heart failure and kidney disease together reach more than half the panel, and they are the patients whose home readings most often head off an admission. The group sees these patients on a steady rhythm and already bills chronic care management, but **the program reaches about 150 patients a year, and no remote monitoring program appears at all**.[7]

2.3 From a 1914 partnership to Nash County's multispecialty group

Year	What happened
1914	Two young surgeons from Richmond buy a controlling interest in a Rocky Mount hospital that opened that July and, with one internist, form the partnership that becomes Boice-Willis Clinic
1937	The clinic has grown to seven physicians, and specialties are developing
2006	The group opens its own licensed endoscopy center, alongside an in-house lab, imaging and physical therapy

[5] CMS Medicare Physician & Other Practitioners by Provider, CY2024, the group's clinical-laboratory NPI: 6,125 beneficiaries; CMS Doctors and Clinicians (July 2026) and PECOS reassignment (September 2026) files for the group's billing organization.

[6] Medicare Physician & Other Practitioners, CY2024, by NPI for the 34 clinicians: 10,700 beneficiary-clinician relationships, 9,731 established-visit relationships, $4,095,053 allowed. Prevalence is weighted by beneficiaries.

[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. Present: 99490 (149 beneficiaries, 707 services, 6 clinicians); 99495 and 99496 (about 543 across 16 clinicians); G0438 and G0439 (about 3,620); G0444 (about 3,585); G2211 (2,613 beneficiaries, 3,899 services). CMS suppresses lines under 11 beneficiaries.

Year	What happened
2022	CMS participant files show the group in an Enhanced-track Medicare Shared Savings Program ACO in every year since, scored on blood pressure, diabetes, depression and readmissions
Today	Five adult primary care sites in Rocky Mount, Nashville and Spring Hope, a walk-in clinic open Saturdays, a lab and diabetes education center, and specialists in the same group; about 3,600 wellness visits a year, transitional care after hospital stays and an in-house chronic care management program
Next	**Daily weight and blood pressure for every heart failure and kidney patient, with monthly care management for those on Medicare Advantage, 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 and healow	**Live at every site**	The program's host: flags, orders, readings, care documents and claims (Section 4)
Chronic care management	**In house, about 150 patients**	Credited and kept. Traditional-Medicare care management stays with them; CoachCare adds it for heart failure and kidney patients on Medicare Advantage
Annual wellness visits	**About 3,600 a year**	The enrollment moment: eligibility checked, consent taken and devices ordered the same day
Transitional care	**About 540 patients, 16 clinicians**	Credited and kept. CoachCare makes the two-business-day contact after more of the discharges and carries the patient past day 30
Lab, diabetes education center, imaging	In house	Home blood pressure tells the care team when a kidney lab is due after a dose change, and the lab draws it in house
Nephrology, endocrinology, pulmonology	In the same group	The kidney patients' own specialists; home readings reach the nephrologist in the same chart
A value-based transition and population health function	**Led by a director**	Already owns the group's accountable-care work. Monthly reporting from the care team lands in the same place
Remote monitoring	No program in the claims	Devices, daily readings and business-hours alert triage come from CoachCare

The gap is specific: daily weight and blood pressure for the 8,522 heart failure and kidney patients the forecast counts as eligible for remote monitoring, and monthly care time for the 5,336 of them on Medicare Advantage. The coordinators have shown the workflow fits the group. What they do not have is the staff to run it at that scale, or a scale and cuff in anyone's home.

2.5 The market, Medicare Advantage, and the rate basis

Rocky Mount sits across Nash and Edgecombe counties, and all five primary care sites are in Nash County. The two counties held 37,170 Medicare beneficiaries in October 2026, and about 62.6% were in a Medicare Advantage plan (Nash 60.0%, Edgecombe 67.6%). Medicare Advantage plans cover these Part B services and pay them on each plan's own contract terms. With a Medicare Advantage majority, which plans the group's patients hold and how each pays for chronic care management and remote monitoring is the second thing to confirm after the chart count.[8]

Every site sits in North Carolina's single statewide payment locality, locality 00, under the Palmetto GBA JM contractor. Every dollar in this report is priced at those CY2026 amounts.[9]

[8] CMS Medicare Advantage State/County Penetration, October 2026: Nash 24,365 eligibles, 60.01%; Edgecombe 12,805, 67.58%; weighted by eligibles. The group's patients also come from Wilson, Halifax and Franklin counties.

[9] CY2026 Physician Fee Schedule, Palmetto GBA JM carrier 11502, North Carolina locality 00: geographic indices work 1.000, practice expense 0.933, malpractice 0.639; conversion factor $33.4009.

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	Heart failure and kidney disease patients on Medicare Advantage, most with hypertension or diabetes as well
Remote physiologic monitoring (RPM)	Cellular scales and blood-pressure cuffs send readings between visits against thresholds the group's clinicians set; 99453, 99454 or 99445, 99457, 99458, 99470	Heart failure and chronic kidney disease, on traditional Medicare and Medicare Advantage
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 North Carolina locality 00
99490 · 99439	Chronic care management, first 20 minutes · each additional 20	$63.25 · $48.13
99453	Remote monitoring setup and education, once	$20.06
99454 · 99445	**Device supply, 16+ days · 2 to 15 days in 30 (99445 new in CY2026)**	**$48.52 · $48.52**
99457 · 99458	Treatment management, first 20 minutes · each additional 20	$49.28 · $39.61
99470	**Treatment management, 10 to 19 minutes (new in CY2026)**	**$24.80**
99495 · 99496	Transitional care, visit within 14 days · within 7 days	$209.72 · $284.72
G0556 · G0557 · G0558	Advanced primary care management, levels 1 to 3	$15.63 · $51.40 · $111.94
99484	Behavioral health integration, 20 minutes a month	$55.09

How the rates apply

CY2026 non-facility amounts, North Carolina locality 00 (Palmetto GBA JM, carrier 11502), ZIP 27804. 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 62.6% of the area's Medicare beneficiaries are in Medicare Advantage. Medicare Advantage plans cover these Part B services and pay them on each plan's own contract terms. The forecast prices every patient at the Medicare amount, so the plan-by-plan terms are where this forecast is most sensitive.

3.2 The care team, and the hours it keeps

CoachCare hires, trains and manages the care managers, at 165 patients each: 6 care managers for the 990 unique patients at month 12, and 14 for the 2,255 at month 24. An on-site enrollment specialist on CoachCare's payroll works the clinic schedules beside the group's medical assistants and enrolls patients during the visit, telephonic outreach reaches the rest, and the clinicians 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,

when the primary care offices are staffed. 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

Boice-Willis already bills transitional care management: about 540 traditional-Medicare patients in CY2024, across sixteen clinicians (99495 at $209.72; 99496 at $284.72). That rests on working discharge workflows, and the program builds on them. The CoachCare care team can make the two-business-day contact and the medication reconciliation after every discharge the group learns of, so more discharges meet the requirement, and the group 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.[10]

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. Boice-Willis 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.[11] It appears here at zero dollars. Moving patients from chronic care management to APCM is a program decision to make together, alongside the coordinators' own program; remote monitoring bills alongside either, and the same staff and workflow carry over.

Behavioral health integration is the adjacency. Depression appears on 25% of the panel's claims, about one patient in four, and the group screened about 3,600 Medicare patients for it in CY2024. Behavioral health integration (99484, $55.09 a month) can run on the same care-manager calls once the program is running. It carries no dollars here.

3.5 Beside the care coordinators already running CCM

Boice-Willis is not starting from nothing. Its care coordinators already run chronic care management for patients with two or more chronic conditions, and a value-based transition and population health function owns the group's accountable-care work. What the claims show is a program that works and has stayed small: about 150 patients a year, billed by 6 clinicians. The forecast leaves traditional-Medicare care management with them and adds it for the 5,336 heart failure and kidney patients on Medicare Advantage it counts as eligible. Scaling means hiring, training and keeping care-management staff, which is the part CoachCare supplies. The work is divided so that no patient is called twice.

Deployment	What CoachCare runs	What stays with the group
Remote monitoring on its own	Remote monitoring for the heart failure and kidney disease patients	Chronic care management, run by the group's coordinators as today, with home readings in the chart
Full service line, RPM + CCM (the forecast of record)	Remote monitoring for heart failure and kidney patients on both kinds of coverage, and chronic care management for those on Medicare Advantage	Traditional-Medicare care management, clinical governance, the visits, transitional care billing and quality reporting

- **The group keeps clinical governance, the patients and the revenue.** Its clinicians 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 Boice-Willis keeps $1,368,366 of contribution margin over 24 months.

[10] CMS by Provider and Service, CY2024: 99495 and 99496, about 543 beneficiaries across 16 clinicians.

[11] 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.

- **CoachCare supplies the capacity.** 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 program is a coexisting layer.** Which patients the coordinators keep, and how they and CoachCare's care team divide new enrollments, is discovery item number three.
- **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 at every site, and a flagged patient reaches the first day of service in under five days.[12] CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically.

Integration pillar	What happens in eClinicalWorks
Integrated enrollment	Flags in the chart prompt the order for patients who meet criteria the group'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), 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 clinician or specialist 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

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

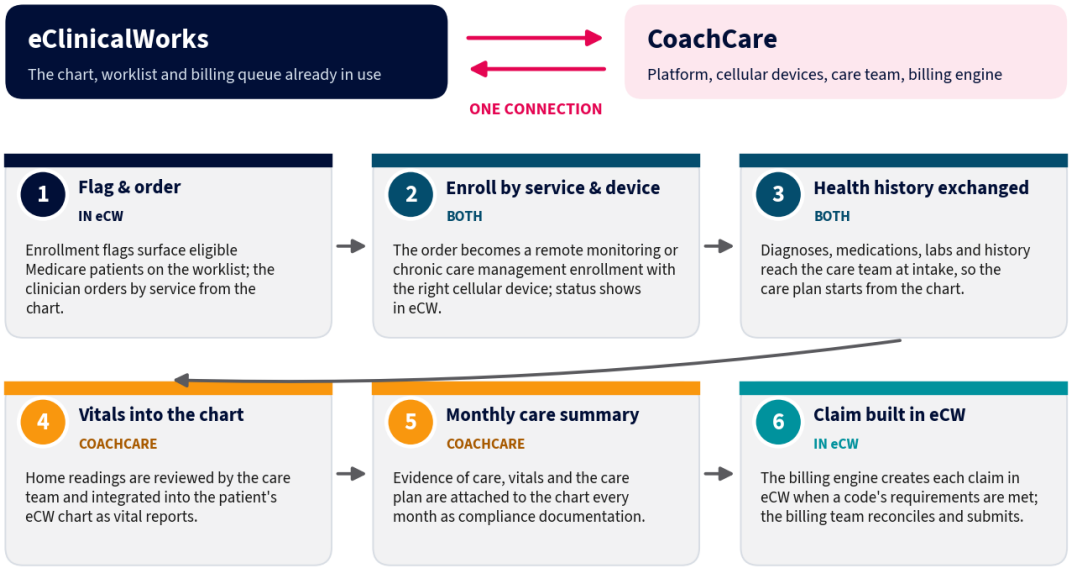


Figure 1. From a flag in the chart to a claim: the six steps CoachCare and eClinicalWorks run every month for every enrolled patient. CoachCare eClinicalWorks integration overview.

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 clinicians, for each site, before the first patient enrolls.[13]

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

[13] 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.

5.2 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 clinician or nurse each site 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 of the five sites. Care managers work readings and escalations Monday to Friday, 8 a.m. to 5 p.m. local patient time. The primary care offices close at noon on Fridays, so Friday-afternoon routing goes to the clinician or nurse the group names for it, and the walk-in clinic is a natural destination for a same-day look. 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 or observation 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 74.5 years old, and two of its offices serve the more rural part of Nash County. 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. Patients who already use the patient portal can keep using it, and nothing in the program depends on it. 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 clinicians.

6. Value Analysis: The 24-Month Forecast

6.1 The headline economics

The forecast covers remote monitoring for the heart failure and kidney disease patients in a Medicare panel of 15,000 at the five primary care sites, on traditional Medicare and Medicare Advantage, and chronic care management for those on Medicare Advantage, at the CY2026 North Carolina locality 00 amounts, with 31 referring clinicians and one CoachCare-funded on-site enrollment specialist. No transitional care, APCM, behavioral health integration or ACO payment is in these numbers.[14]

Full service line	Year 1	Year 2	24 months
Unique patients, end of period	990	2,255	2,255
Contribution margin	**$258,857**	**$1,109,509**	**$1,368,366**

Year two is about four times year one because the census climbs through both years and neither program fills: the program enters year two with 990 unique patients and ends it with 2,255. Year two returns **$1,109,509 of the $1,368,366 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 follows the same enrollment pace and reaches the same 1,961 monitored patients by month 24, with chronic care management left to the coordinators. The full line adds chronic care management for 980 patients by month 24 and $497,355 more contribution margin over 24 months.

24 months	Remote monitoring on its own	Full service line, RPM + CCM
Contribution margin	**$871,011**	**$1,368,366**
Unique patients at month 24	1,961	2,255
Hospitalizations avoided	About 237	About 237

6.3 Where the patients come from

Program	Active enrollments, month 12	Active enrollments, month 24	Share of ceiling, month 24
Remote physiologic monitoring	862	**1,961**	92%
Chronic care management	427	**980**	92%
Unique patients	**990**	**2,255**	

Remote monitoring is the larger program, 1,961 enrollments at month 24, and it produces the readings, alerts and avoided admissions. Chronic care management reaches 980 enrollments, for the heart failure and kidney patients on Medicare Advantage. The **2,941 active program enrollments at month 24 belong to 2,255 unique patients**, because most care-management patients are also monitored.

6.4 The ramp, month by month

Contribution margin runs −$5,564 in month 1 while the program ramps, on 25 enrollments. It is positive from month 2, with $2,441 on 61 enrollments, and cumulative contribution margin is above zero by the end of month

[14] CoachCare Value Analysis for Boice-Willis Clinic, 2026, the source of all Section 6 figures; sensitivity runs change one input at a time on the same workbook.

3. Referrals and on-site enrollment build to full pace by month 12, about 150 new patients a month, and the monthly contribution margin keeps climbing through month 24, when it reaches $121,642. Cumulative contribution margin passes $37,365 at month 6, $258,857 at month 12 and $1,368,366 at month 24.

Month	Active enrollments	Monthly contribution margin	Cumulative contribution margin
M1	25	**−$5,564**	−$5,564
M2	61	$2,441	−$3,123
M3	116	$4,773	$1,650
M6	389	$16,145	$37,365
M12	1,289	$53,482	$258,857
M18	2,190	$90,668	$713,201
M24	2,941	**$121,642**	**$1,368,366**

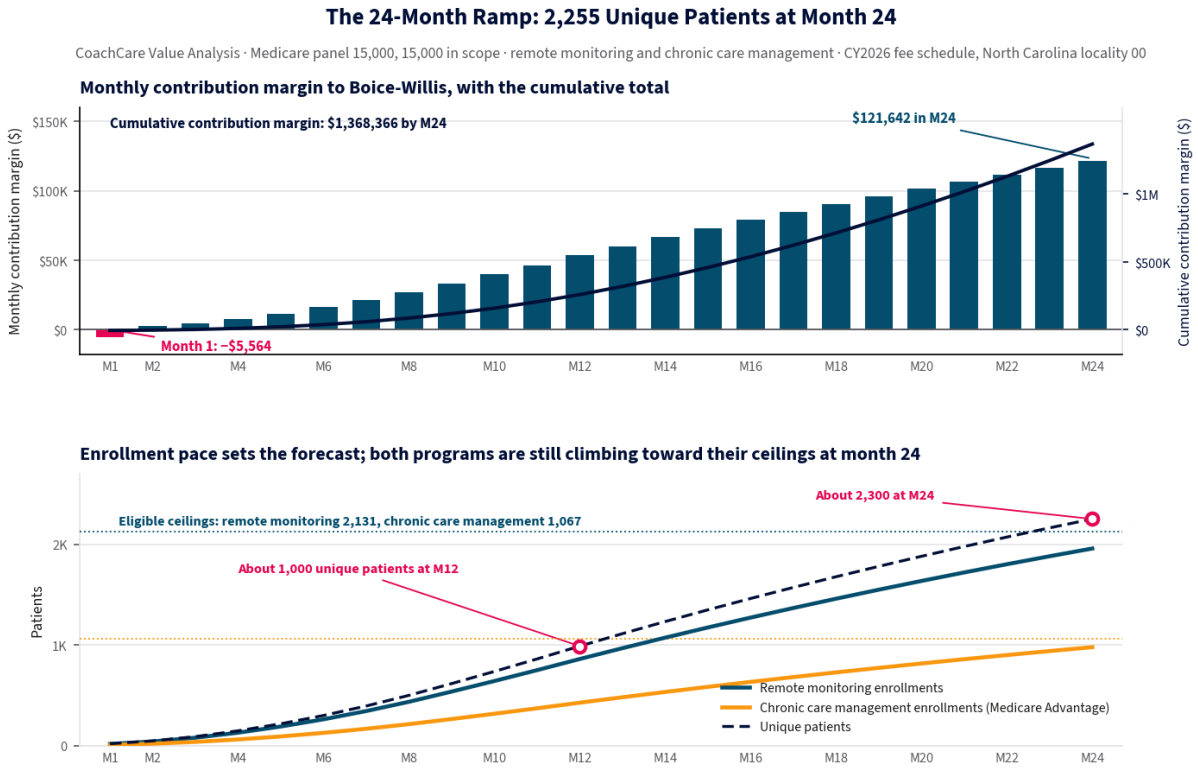


Figure 2. Monthly contribution margin, with cumulative contribution margin, and the enrollment census by program against the two eligible ceilings, with unique patients at months 12 and 24. CoachCare Value Analysis, full service line.

6.5 What sets the pace: enrollment, not the size of the pool

Program	Eligible share of the 15,000 in scope	Acceptance	Ceiling	Month 24
Remote physiologic monitoring, heart failure or kidney disease	56.8%, 8,522 patients	25%	**2,131**	**1,961 (92% of ceiling)**
Chronic care management, those on Medicare Advantage	35.6%, 5,336 patients	20%	**1,067**	**980 (92% of ceiling)**

Say the constraint out loud

At Boice-Willis enrollment pace sets the forecast. One enrollment specialist and 31 referring clinicians bring in about 150 new patients a month once referrals reach full pace in month 12; by month 24 remote monitoring holds 92% of its heart failure and kidney ceiling and chronic care management, for Medicare Advantage patients, 92%. Neither fills inside two years.

Enrollment capacity is the lever. A second CoachCare-funded enrollment specialist enrolls the same pool faster: $1,789,061 of contribution margin over 24 months against $1,368,366, $420,695 more, at no cost to the group. Without the on-site specialist contribution margin is $546,662 lower.

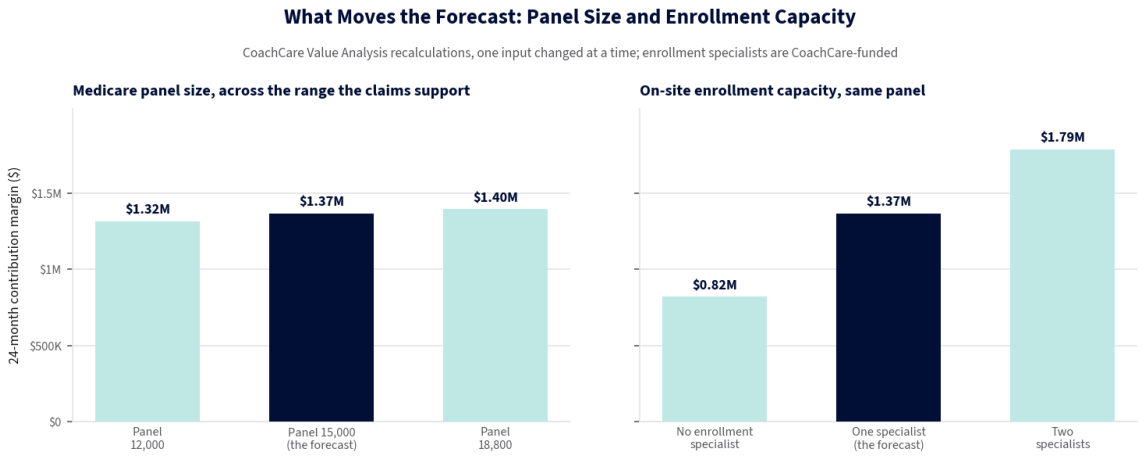


Figure 3. 24-month contribution margin across the panel sizes the claims support, and with no, one or two on-site enrollment specialists on the same panel. CoachCare Value Analysis recalculations.

Scenario	24-month contribution margin	Unique at M12	Unique at M24	Monitoring ceiling
Base: panel 15,000, heart failure and kidney patients, 31 clinicians, one enrollment specialist	**$1,368,366**	**990**	**2,255**	**92% at M24**
Panel 12,000	$1,317,585	971	1,960	M21
Panel 18,800	$1,396,017	1,014	2,297	75% at M24
Traditional-Medicare patients only in scope (5,610)	$830,596	916	916	M12
No on-site enrollment specialist	$821,704	626	1,406	59% at M24
Two on-site enrollment specialists	$1,789,061	1,355	2,451	M19
25 referring clinicians	$1,228,498	887	2,015	82% at M24
34 referring clinicians (the CY2024 claims roster)	$1,438,301	1,042	2,375	97% at M24
40, with the group's nephrology, endocrinology and pulmonology referring	$1,566,821	1,145	2,451	M23

CoachCare Value Analysis recalculations, one input changed at a time. Monitoring ceiling: the month remote monitoring reaches its eligible ceiling, or its share of the ceiling at month 24.

Enrollment capacity moves this forecast more than panel size. From 12,000 to 18,800 patients, a panel 57% larger, only $78,432 is added to 24-month contribution margin, because enrollment pace, not the size of the heart failure and kidney pool, limits how many patients join in two years. Two other things move it a great deal. Enrollment capacity: the second specialist adds $420,695. And the payer mix: if only traditional-Medicare patients were in scope contribution margin would be $830,596, which is why the Medicare Advantage plans'

terms are the second item to confirm. The group's own specialists matter too; with nephrology, endocrinology and pulmonology referring, it is $1,566,821.[15]

6.6 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	**232,888**	Weight and blood pressure values arriving between visits
Claims and billable units	**64,814**	Created in eClinicalWorks for the group's billing team
Care-management tasks	129,627	Outreach, care-plan updates and medication reviews
Patient conversations	19,444	Live contacts across 1,080 hours of call time
Care-team hours	**27,241**	**About 13.1 full-time-equivalent years of work the group does not employ**
Hospitalizations avoided	**About 237**	Admissions that never post against the ACO's spending benchmark

Reduction in admissions among enrolled patients	20%	30% (the forecast)	40%
Hospitalizations avoided over 24 months	158	**237**	316

CoachCare Value Analysis, full service line, at the enrolled patients' own admission rate: about 42.7 admissions per 100 patients a year, heart failure at 40 and kidney disease at 44.5 (Section 7).

Two ledgers, kept separate

Contribution margin funds the program. $1,368,366 to Boice-Willis over 24 months, paid claim by claim.

Avoided admissions and quality speak to the ACO. About 237 admissions avoided at a 30% reduction, plus monthly work on the measures in Section 8. Under two-sided risk the new Part B remote-monitoring spend for traditional-Medicare patients also sits on the ACO's ledger, while chronic care management for Medicare Advantage patients does not touch it. That 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; Section 7 runs the ACO's side of the ledger.

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.[16]
- **Readmissions, at the same practice.** Across 26,689 patients, the 30-day readmission rate was 7% for CoachCare patients against 15% for the rest.[17]
- **Heart failure.** Iowa Heart enrolled 450 advanced heart-failure patients and recorded zero readmissions over six months.[18]

[15] Panel sizes 12,000 to 18,800 bracket the group's CY2024 claims: a provider-based count (16 physicians × 450 and 18 advanced practice clinicians × 270) and established-visit relationships grossed up for the Medicare Advantage share; the group's own lab count (6,125 traditional-Medicare patients ÷ (1 − 0.626) = 16,385) sits inside the range.

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

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

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

7. Total Cost of Care: Remote Care Has to Pay Its Way Inside the ACO

Boice-Willis' clinicians belong to a two-sided Shared Savings Program ACO. Since 2025 its patients are assigned at the end of each year, based on where they got most of their primary care, so most of the group's traditional-Medicare patients sit inside its benchmark. Every remote monitoring claim for one of those patients is Part B spending the ACO is measured on. The spending holds up where it prevents admissions worth more than it costs. In this panel, that means **heart failure and kidney disease**, and at Boice-Willis those patients are more than half the panel.[19]

7.1 Who sits inside the benchmark

The same remote monitoring claim lands in two places depending on how the patient is covered. Medicare Advantage claims are practice revenue and nothing else. Traditional-Medicare claims for an assigned patient are practice revenue that also counts against the ACO's spending target. Of the group's 15,000-patient Medicare panel, about 9,400 are in Medicare Advantage, about 4,800 are traditional-Medicare patients assigned to the ACO, and about 800 are traditional-Medicare patients who are not.[20]

The group's ACO, PY2024	Value	Against all ACOs
Benchmark per assigned patient	**$13,363**	The spending target
Actual spending per assigned patient	$12,573	Lower than 53% of ACOs
Savings per patient	**$790 (5.9%, up from 5.7% in PY2023)**	Higher than 67% of ACOs
Admissions per 1,000 patients a year	237	**Lower than 65% of ACOs**

CMS Shared Savings Program Financial and Quality Results, PY2024; ranks against the 476 ACOs in the file.

Why it matters at a 75% sharing rate. The margin between benchmark and spending is what gets shared. A dollar of new Part B spending on an assigned patient comes straight off that margin, and about 74 cents of it would otherwise have come back as shared savings. The ACO already admits fewer patients than most ACOs do, so the admissions left to prevent are concentrated in the sickest patients: heart failure and kidney disease.

7.2 What one heart failure or kidney patient is worth to the ACO

Medicare's share of a year of remote monitoring is about $941 per patient. One avoided hospital stay is worth about $12,876, the ACO's own average for an acute admission. Whether the program pays its way depends on how often the patient would have been admitted.[21]

Assigned traditional-Medicare patients	Patients	Admissions per 100 a year	Avoided per 100 at a 30% reduction	Net to the ACO per patient-year	Reduction to break even
Heart failure	1,100	40	12	**+$604**	18%
Chronic kidney disease, without heart failure	1,600	44.5	13.4	**+$778**	16%

[19] CMS Shared Savings Program ACO Participants, 2026, and Shared Savings Program Financial and Quality Results, PY2023 and PY2024, for the group's ACO: Enhanced track, retrospective assignment from 2025, 75% sharing rate, 40% loss rate while the quality standard is met.

[20] Panel split: the Nash and Edgecombe Medicare Advantage share of 62.6% applied to the 15,000-patient panel; the assigned share of the traditional-Medicare remainder taken as 85%, the share a primary care group whose patients get most of their primary care from it would typically carry under retrospective assignment.

[21] Medicare's share: the forecast's remote-monitoring Medicare payment per patient-month, less denials and the 20% coinsurance the patient owes, which ACO expenditure does not count. Cost per admission: the ACO's PY2024 short-term acute-care spending per assigned patient divided by its short-term admission rate.

Heart failure and kidney disease patients among the group's assigned panel. Prevalence from CMS CY2024 claims for the group's adult primary care clinicians; admission rates from the USRDS 2025 Annual Data Report (44.5 per 100 at kidney disease stage 3) and 40 per 100 for heart failure. The 30% reduction is close to the 29% cut in heart failure hospitalizations that pooled telemonitoring trials report.

7.3 The 24-month ledger for this forecast

At month 24 the forecast has 1,961 patients on remote monitoring, every one with heart failure or kidney disease. About 600 of them are assigned to the ACO. The ledger below runs the forecast's own monthly census through the same arithmetic at three reductions in admissions.

Reduction in admissions	Added Part B spending	Admissions avoided	Net to total cost of care	Heart failure	Chronic kidney disease
30%	$552,575	75 ($969,556)	**+$416,981**	+$139,024	+$277,957
40%	$552,575	100 ($1,292,742)	**+$740,167**	+$257,522	+$482,645
20%	$552,575	50 ($646,371)	**+$93,796**	+$20,527	+$73,269

CoachCare Value Analysis remote-monitoring census, months 1 to 24, on the assigned share of traditional-Medicare patients. Added spending is Medicare's share of remote monitoring for those patients; admissions are priced at the ACO's own $12,876.

Both kinds of patient pay their way. At a 30% reduction the program returns +$416,981 to total cost of care over 24 months, +$740,167 at 40%, and it stays positive at 20%, +$93,796. Heart failure breaks even at a 18% reduction and kidney disease at 16%. Medicare Advantage patients on remote monitoring, about 1,200 at month 24, add nothing to the ACO's spending.

7.4 CoachCare's recommendation: heart failure and kidney disease, on both kinds of coverage

The service line enrolls the same patients whether Medicare pays through Part B or a Medicare Advantage plan. These are the patients most likely to be admitted, where a prevented stay is worth more than the program costs.

Coverage	What CoachCare runs	Why
Traditional Medicare (Part B), heart failure or kidney disease	**Remote monitoring**	Daily weight and blood pressure for about 600 assigned patients at month 24; the program pays back to the ACO at a 18% reduction in heart failure admissions and 16% in kidney disease, and chronic care management for these patients stays with the group's own coordinators
Medicare Advantage, heart failure or kidney disease	**Remote monitoring and chronic care management**	The same patients and the same daily readings, plus monthly care management; every claim is practice revenue and none of it touches the ACO's benchmark

8. Quality: The Score Sets the Sharing Rate and Caps the Losses

In a two-sided ACO the quality score does two jobs. Meeting CMS's standard keeps the ACO at the full 75% sharing rate. It also holds the share of any loss at the 40% floor, where a miss can push it as high as 75%. The ACO scored **87.5 in PY2024, up from 83.5**, higher than 71% of ACOs, against a PY2026 standard of 73.85. The measures behind that score are the ones monthly remote care moves.[22]

[22] CMS Shared Savings Program Financial and Quality Results, PY2023 and PY2024; quality reporting through the APM Performance Pathway, measures 001, 134 and 236 reported by the ACO, 479 calculated by CMS from claims. PY2026 quality performance standard: the 40th percentile, 73.85.

Measure	PY2023	PY2024	Better than	How the program moves it
Q134 Depression screening and follow-up	73.8	**75.7**	23% of ACOs	The measure with the most room. PHQ-2, then PHQ-9, on the monthly care-management call; a positive screen routed to the patient's clinician
Q001 Diabetes: A1c above 9% (lower is better)	6.2	**9.2**	38% of ACOs	The one measure that slipped. Care-management calls keep A1c tests at the group's lab and medication changes on schedule
Q236 Controlling high blood pressure	80.5	**83.2**	68% of ACOs	Home readings on 16 or more days a month and titration between visits. CMS counts readings from a device that transmits them to the clinician.
Q479 Hospital-wide 30-day readmission	15.4%	**14.7%**	69% of ACOs	A call within two business days, devices home before the follow-up visit

Q479 is a rate. Ranks against the ACOs scored on each measure in PY2024. The claims-based measure for admissions among patients with several chronic conditions (Q484) was not published for the ACO in PY2024.

Every patient now counts. CMS retired the sampled Web Interface after PY2024. ACOs that now report the electronic measures are scored on all of their eligible patients, whatever the payer. Under electronic reporting that includes the group's Medicare Advantage patients: their blood pressure, A1c and depression screening results feed the ACO's quality score, while their remote monitoring and care management add nothing to its benchmark.

What a slip would cost. Below the standard, an ACO that still passes CMS's alternative outcome test has its sharing rate scaled by its score, so a 70 would cut the rate from 75% to 52.5%. One that fails both shares in no savings and owes up to 75% of any loss. An 87.5 leaves room. Keeping it is a year-round outreach job, which is the work a care team does every month. With hypertension in at least three of four of the group's Medicare patients, Q236 covers most of the panel, and the group already screens about 3,600 patients for depression a year; monthly care management supplies the follow-up half of Q134.[23]

8.1 The same work moves Medicare Advantage Star Ratings

About 62.6% of Medicare beneficiaries in Nash and Edgecombe counties are on Medicare Advantage. Their plans are rated on a parallel set of measures, and plans pay practices for closing those gaps. For a heart failure or kidney patient on a plan, the monthly program does the same work for the plan's Star Rating that it does for the ACO's quality score.[24]

Star Ratings measure	Weight	How the program moves it
Controlling blood pressure	**Triple**	Home readings sent from a cellular cuff count toward the measure, so a controlled month at home closes the gap without waiting for an office reading
Plan all-cause readmissions	**Triple**	The same post-discharge cadence as Q479: a call within two business days, daily weight and blood pressure from day two, and a visit inside the transitional-care window
Blood sugar controlled, patients with diabetes	**Triple**	Monthly care management keeps the A1c test and the medication change after it on schedule
Medication adherence, blood pressure and diabetes drugs	**Triple**	Missed doses show up in the home readings, and the care-management call reviews refills before the patient runs out

[23] 42 CFR 425.512 and 425.610: below the quality performance standard, an ACO meeting the alternative quality standard shares savings at a rate scaled by its quality score; an ACO meeting neither shares no savings and its loss rate rises to 75%.

[24] CMS Medicare Part C and D Star Ratings technical notes, 2026: Controlling Blood Pressure, Diabetes Care – Blood Sugar Controlled and the medication adherence measures are intermediate outcomes weighted 3; Plan All-Cause Readmissions is an outcome weighted 3; Transitions of Care is a process measure weighted 1.

Star Ratings measure	Weight	How the program moves it
Transitions of care	Single	Medication reconciliation and patient engagement after discharge, documented in eClinicalWorks by the care team

CMS Medicare Part C and D Star Ratings, 2026 measure set and weights. Medicare Advantage penetration from CMS State/County Penetration, October 2026.

9. ACCESS: Paid for Results, Beside or Instead of Remote Monitoring

ACCESS is a ten-year CMS model, launched in July 2026, for technology-supported chronic care measured by results: blood pressure, A1c, cholesterol, weight and kidney labs. An approved ACCESS organization enrolls the patient and delivers the care between visits. Boice-Willis stays the patient's doctor and bills Medicare for reviewing the patient's progress. For a group inside an ACO, it covers the traditional-Medicare patients the last two sections leave out: those without heart failure or kidney disease.[25]

	Remote monitoring (fee-for-service)	ACCESS (CMS model)
What the practice bills	Remote monitoring codes each month, under the group's NPIs	Co-management codes for each review of a care update
How patients join	An office visit and a clinician's order	Patient consent; no referral or order needed
Patient cost	20% coinsurance each month	**$0**
What is measured	Days of readings and minutes of care	Blood pressure, A1c, LDL, weight and kidney labs, against targets
Effect on the ACO	Every claim counts as spending from the first month	CMS anticipates no effect from outcome payments on benchmark and spending calculations in 2026 and 2027
Coverage	Traditional Medicare and Medicare Advantage	Traditional Medicare only, for now

9.1 Other addressable chronic conditions

About 2,400 of the group's roughly 5,600 traditional-Medicare patients have neither heart failure nor kidney disease. Their conditions are the ones ACCESS pays to improve, and each maps to a track.

ACCESS track	Conditions	Share of the group's traditional-Medicare patients	Scored on
Early cardio-kidney-metabolic	Hypertension, high cholesterol, prediabetes, obesity	**Hypertension 75% or more; high cholesterol 75% or more**	Blood pressure, LDL, weight
Cardio-kidney-metabolic	Diabetes, heart disease	**Diabetes 41%; ischemic heart disease 33%**	A1c, blood pressure, LDL. Stage 3 kidney disease also qualifies, but under this plan those patients are on remote monitoring
Musculoskeletal	Chronic musculoskeletal pain	**Arthritis 50%**	Patient-reported pain and function
Behavioral health	Depression and anxiety	**Depression 25%**	PHQ-9 and GAD-7; a second track for the same patient, with its own co-management payments

[25] CMS ACCESS Model Request for Applications, version 1.1; CMS ACCESS model overview and technical FAQs; CMS co-management payment billing guidance, 2026.

CMS CY2024 claims for the group's adult primary care clinicians, share of traditional-Medicare patients with each condition. Conditions overlap, and CMS caps published prevalence at 75%, so hypertension and high cholesterol are floors. Tracks from the CMS ACCESS model overview.

One program per condition. A patient is in ACCESS or on remote monitoring for a condition, not both: CMS counts a remote monitoring setup billed for the same condition against the ACCESS organization's payment. Heart failure and kidney disease patients stay on remote monitoring, including after CMS adds a heart failure track in April 2027. The practice can run both programs on different patients, and ACCESS patients keep their Boice-Willis clinicians for everything else.

9.2 What the practice earns from ACCESS

Medicare pays the practice $30 for each review of an ACCESS care update, up to three a year, plus $10 once at onboarding, per patient per track. The review takes at least five minutes and one care-coordination step, such as a medication change or an updated problem list. There is no patient cost-sharing on these codes.

Patients in one ACCESS track	500	1,000	2,000
Co-management payments to the practice, a year at most	$50,000	$100,000	**$200,000**

Medicare-allowed co-management amounts at the maximum of three reviews plus onboarding, before sequestration and the geographic adjustment.

10. 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 North Carolina locality 00 on the forecast's own billing mix, with enrollment held constant.[26]

[26] CMS-1848-P, published July 2026. CoachCare repricing at North Carolina locality 00, conversion factor $32.8409 against $33.4009: device supply 31.5% of the remote-monitoring basket. Enrollment, and so CoachCare's per-patient program costs, are held constant, so each program's rate change reaches contribution margin dollar for dollar.

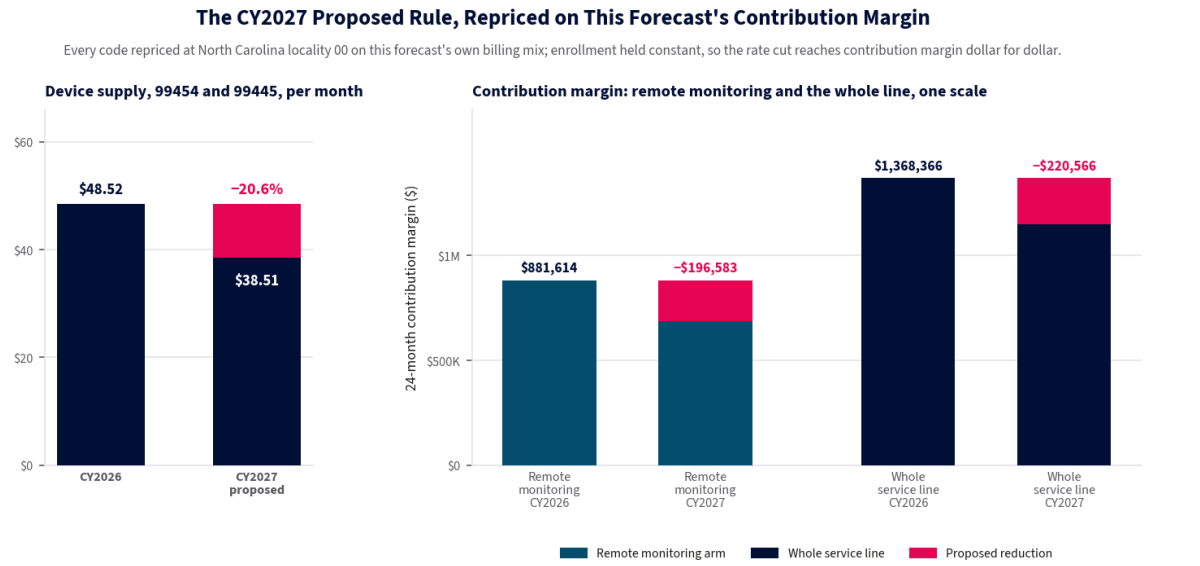


Figure 4. The CY2027 proposed rule on this forecast: the one code CMS proposes to cut, then 24-month contribution margin from the remote-monitoring arm and the whole service line under CY2026 and proposed CY2027 rates, with the reduction in coral. CoachCare repricing at the proposed CY2027 amounts.

Level	CY2026 basis	Proposed CY2027 effect	Why each step differs
Device supply, 99454 and 99445	$48.52 a month	**$38.51 a month, −20.6%**	The code CMS proposes to cut
The remote monitoring arm	$881,614 contribution margin over 24 months	**−$196,583 to contribution margin**	On this billing mix the remote monitoring rate per patient-month moves −9.5%; device supply is 31.5% of the basket
Chronic care management	$573,570 contribution margin over 24 months	−$23,982 to contribution margin	Routine rate changes only (−2.1% per patient-month); not targeted
The whole service line	$1,368,366 contribution margin over 24 months	**−$220,566, to $1,147,801**	Only the remote monitoring arm holds the code being cut

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 North Carolina locality 00 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.

11. Implementation Roadmap

11.1 Who runs what

Function	CoachCare	Boice-Willis
Identification and enrollment	Registry query in eClinicalWorks for the heart failure and kidney disease patients, recent discharges first; 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, wellness or walk-in visit
Chronic care management	Care management for heart failure and kidney patients on Medicare Advantage, at 165 patients per care manager	**Keeps its own program and its traditional-Medicare patients**
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	**Sets thresholds and routing for each site; receives escalations**
Documentation, billing, reporting	Monthly care documents in eClinicalWorks, claims created automatically, operational and clinical outcomes reports by site and clinician	**Reconciles and files under its own NPIs; keeps the revenue; names a program lead**

11.2 The model inputs

Input	Value in this forecast
Medicare panel	**15,000 patients across five primary care sites; the heart failure and kidney disease patients are in scope, all payers**
Payer mix	**About 62.6% of the area's Medicare beneficiaries are in Medicare Advantage; every patient priced at the Medicare amount. Medicare Advantage plans cover these Part B services and pay them on each plan's own contract terms.**
Referring clinicians	31: 15 physicians, 10 nurse practitioners and 6 physician assistants
Programs	Remote monitoring on traditional Medicare and Medicare Advantage; chronic care management on Medicare Advantage; transitional care, APCM and behavioral health integration at zero dollars
Eligibility and acceptance	Remote monitoring 56.8% eligible (heart failure or kidney disease), 25% accept; chronic care management 35.6% (those on Medicare Advantage), 20%; 70% of care-management patients also monitored; 3% monthly attrition
Admissions	Heart failure 40 and kidney disease 44.5 per 100 patients a year, weighted to the enrolled mix; a 30% reduction
Enrollment capacity	One CoachCare-funded on-site enrollment specialist plus telephonic outreach; 5 referrals per clinician a month, 70% accepted, building to full pace over the first 12 months. The forecast holds new enrollment to what one care team can onboard well: no more than 1,500 new patients a year.
EMR	eClinicalWorks, integrated as described in Section 4
Rates	CY2026 fee schedule, non-facility, North Carolina locality 00, ZIP 27804

11.3 The staffing plan, and the order the sites go live

CoachCare brings on care managers ahead of the census: 6 by month 12, when about 1,000 unique patients are enrolled, and 14 by month 24 at about 2,300. New patients arrive at about 150 a month at full pace, about 30 per site per month across the five sites. The on-site enrollment specialist and telephonic outreach cover the sites the schedule does not reach on a given day, and the clinicians' own orders at the visit do the rest.

The order the sites go live is a decision to make together. One sensible sequence starts at the Medical Center and Rocky Mount Medical Park, where most of the internal medicine panel and the specialists are, adds the family practice and walk-in clinic next, and brings Nashville and Spring Hope on by the end of the first quarter. Every

site uses the same flags, devices and care team, so a later start changes only when its patients join, not how the program runs.

11.4 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 by plan; the coordinators' CCM program and today's transitional care workflow mapped so nobody is called twice; thresholds, routing and the site go-live order agreed	Integration live, protocol signed, go-live order set
Weeks 6–12 **Launch the first sites**	Enrollment from the first week; remote monitoring for heart failure and kidney patients, care management for those on Medicare Advantage; the post-discharge cadence live	25 enrollments in month 1, 61 by month 2, 116 by month 3
Months 3–12 **All five sites**	Same protocols at every site; the group's nephrologists ordering for their own kidney patients; care managers added as the census grows	1,289 enrollments, 990 unique patients at month 12
Months 13–24 **Scale**	Both programs still enrolling, remote monitoring at 92% of its ceiling by month 24; the APCM mix decided together; behavioral health integration scoped; ACCESS considered for the patients outside the heart failure and kidney focus	Year 2: $1,109,509 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.

11.5 What we would confirm together

1. **The Medicare chart count, by payer and site.** Traditional Medicare against each Medicare Advantage plan, and how many patients carry heart failure or chronic kidney disease. It confirms the two eligible ceilings.
2. **The Medicare Advantage plans, one by one.** Medicare Advantage plans cover these Part B services and pay them on each plan's own contract terms. With a Medicare Advantage majority in the area, which plans the group's patients hold, and whether each pays chronic care management and remote monitoring, decides how much of this forecast is billable at the Medicare amount.
3. **The chronic care management program today.** How many patients the coordinators carry now and who staffs it, so traditional-Medicare care management stays with them and Medicare Advantage enrollments come to CoachCare's care team.
4. **Which Medicare Advantage contracts carry risk.** Which plans pay the group for quality gaps or share savings, so the Star measures in Section 8 count where they pay.
5. **Which clinicians refer, and whether the specialists join.** The 31 adult primary care clinicians from the start, and whether the group's nephrologists, endocrinologists and pulmonologists order for their own patients.
6. **Transitional care today.** Who runs the workflow for the sixteen clinicians who bill it, where discharge notices come from, and how many discharges a year reach the group in time.
7. **The eClinicalWorks configuration.** The version, the healow and care-management modules licensed, and any device connection already in place.
8. **Coinsurance at consent.** How the monthly Part B coinsurance is explained at enrollment, and who answers billing questions afterwards.
9. **The site go-live order.** Which sites launch first, and where the on-site enrollment specialist works each day.

12. Recommendations

1. **Launch the service line for heart failure and kidney disease, on both kinds of coverage.** $1,368,366 of contribution margin over 24 months ($258,857 in year one, $1,109,509 in year two), positive from month 2, with nobody hired.
2. **Pull the Medicare chart count by payer, and the Medicare Advantage plans' terms, in week one.** With a Medicare Advantage majority in the area, the plan-by-plan terms decide how much of the panel bills at the Medicare amount.
3. **Measure it on the ACO's ledger.** At a 30% reduction in admissions the program returns +$416,981 to total cost of care over 24 months; report the heart failure and kidney admissions against that line each quarter.
4. **Treat enrollment capacity as a lever.** Start with one on-site enrollment specialist and add a second when the group wants patients enrolled sooner; it adds $420,695 of contribution margin over 24 months, with CoachCare funding the specialist.
5. **Start with recent discharges and the kidney patients the nephrologists already follow.** A cellular scale and cuff for heart failure, a cuff for kidney disease, and the visit as the enrollment conversation.
6. **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.
7. **Bring the group's specialists in as referrers.** Nephrology, endocrinology and pulmonology see the same patients; readings land in the same chart.
8. **Aim the monthly work at the quality measures, the ACO's and the plans'.** Depression screening on the care-management call, A1c on schedule, home blood pressure for the control measure and the Star Rating, and each of the roughly 237 admissions avoided over 24 months kept off the ACO's benchmark.
9. **Hold APCM as the next lever, and scope behavioral health integration once running.** Both run on the same care team and the same chart.
10. **Keep clinical governance where it is.** The group's clinicians decide; CoachCare does the work and documents it.

The heart failure and kidney disease patients Boice-Willis already manages support a service line that returns $1,368,366 of contribution margin over 24 months, on staff the group does not hire and devices it does not buy, and they return +$416,981 to the ACO's total cost of care at a 30% reduction in admissions. The group has already shown chronic care management works in its offices; what remains is to add the daily readings and keep the program 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, the lab and diabetes education center, a walk-in clinic, transitional care after hospital stays and an in-house chronic care management program are already part of the week. CoachCare adds daily readings for the heart failure and kidney patients and care management for those on Medicare Advantage.
- **It runs inside the chart the group already uses.** Readings, documentation and claims live in eClinicalWorks, and enrollment status is visible at every site.

- **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 physicians and advanced practice clinicians 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 Boice-Willis' Medicare chart count by payer and how its Medicare Advantage plans pay for care-management codes, map how CoachCare sits beside the care coordinators who run chronic care management today, scope the eClinicalWorks integration, and set the order the five primary care sites go live before the first patient enrolls.

Contact

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Prepared by CoachCare for discussion with Boice-Willis Clinic. © 2026 CoachCare.

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Unique patients and program enrollments are different numbers. At month 24 the program holds 2,941 active program enrollments belonging to 2,255 unique patients, because a patient may hold both enrollments. The 15,000-patient panel covers all payers; the 10,700 beneficiary-clinician relationships in the CY2024 claims are traditional Medicare only.