



COACHCARE | SERVICE LINE STRATEGY

Family Health Center

An independent, physician-owned family-medicine practice in Sandpoint, Idaho: one site in Bonner County, six physicians with a nurse practitioner and two physician assistants, a recognized patient-centered medical home, and a Medicare panel inside a two-sided Medicare Shared Savings Program ACO

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line for the Medicare panel: remote physiologic monitoring, chronic care management and transitional care at every discharge, billed under the CY2026 rules at Idaho locality 00 amounts, run inside NextGen, staffed by CoachCare and owned by the practice

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the owners and leadership of Family Health Center. It brings together the shape of the practice's Medicare panel as the CY2024 claims files show it, the accountable-care position the practice holds in 2026, the market it serves in Bonner County, the record system the program would live in, and a 24-month financial forecast priced at the practice's own Medicare locality.

The argument is short. The practice already manages a multi-chronic Medicare panel, already convenes its diabetic patients every month, runs a recognized medical home, and already sits inside an arrangement that pays for keeping those patients out of the hospital. What the claims do not show is a monthly, staffed program between the visits. This report shows what that program returns on this panel, who does the work, and how it starts without capital or a hire.

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Executive Summary

Family Health Center is an independent, physician-owned family-medicine practice at one site in Sandpoint, Idaho, a block from the town's Critical Access Hospital. The professional limited-liability company was filed in 1996, and most of its clinicians have been with the practice a decade or more. The roster is six physicians, one nurse practitioner and two physician assistants. It is a recognized patient-centered medical home, runs open-access same-day scheduling, an on-site lab, in-office procedures, video visits and 24/7 on-call, and convenes a diabetic group visit every month. The practice runs NextGen, with Phreesia for intake, scheduling and payments.¹

The panel that matters here is the Medicare panel. The CY2024 Medicare fee-for-service claims for the clinicians now on the roster describe it: an average age of 73 to 75, a weighted risk score of 0.82, and **hypertension in 59% of beneficiaries, hyperlipidemia in 49%, diabetes in 18%, ischemic heart disease in 15%, chronic kidney disease in 14%, depression in 12%, COPD in 9% and heart failure in 9%**. Annual wellness visits and depression screens are billed in the thousands, transitional care for 45 beneficiaries, and no chronic care management, remote monitoring, principal care, advanced primary care management or behavioral-health-integration code appears at meaningful scale on any clinician in CY2024. The forecast in Section 6 covers a Medicare panel of 2,500, with 2,000 of it in scope.²

One fact sets this account apart from the usual independent-practice workup. The practice's nine clinicians are participant providers in a **two-sided Medicare Shared Savings Program ACO on the BASIC track, Level E**, verified in CMS's PY2026 participant file and in its eligibility records for every clinician; the practice joined for 2024. A two-sided track attributes beneficiaries on documented primary care and puts the practice at risk on their total cost of care. That is the same evidence a monitoring program builds: a consented, documented, monthly relationship with the panel, on the practice's own fee-for-service billing.³

The observation this report is built on

The panel is here. The conditions are here. The between-visit billing is not.

Family Health Center already does the hard part: it holds a multi-chronic Medicare panel, convenes its diabetic patients monthly, runs a recognized medical home and sits inside a two-sided arrangement. What the CY2024 claims show is that none of the between-visit work is billed as a program at meaningful scale under any practice clinician. The service line in this report is that program, supplied and staffed by a partner, governed by the practice's clinicians, billed under Family Health Center, and owned by the practice.

What the Value Analysis returns

	Year 1	Year 2	24 months
Net reimbursement	\$678,934	\$1,055,798	\$1,734,732
CoachCare fees	\$397,202	\$603,004	\$1,000,206

¹ fhcsandpoint.com home, services, appointment-information and medical-home pages, retrieved September 22, 2026: one site at 606 N Third Ave, Suite 101, Sandpoint; professional limited-liability company filed with the Idaho Secretary of State in 1996; roster of six physicians, one nurse practitioner and two physician assistants; open-access same-day scheduling; on-site lab; in-office procedures; video visits; 24/7 on-call; a monthly diabetic group visit; recognized patient-centered medical home. The patient portal self-identifies as the NextGen patient-experience portal; Phreesia handles intake, self-scheduling and payments.

² CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024, the eight roster clinicians with rows: 2,746 beneficiary-clinician pairs; \$800,509 allowed; 157 dual-eligible; weighted HCC risk 0.82; average age 73 to 75; beneficiary-weighted prevalence hypertension 59%, hyperlipidemia 49%, diabetes 18%, ischemic heart disease 15%, chronic kidney disease 14%, depression 12%, COPD 9%, heart failure 9%; 1,056 G0439 beneficiaries; 1,053 G0444 depression screens; 45 beneficiaries billed 99495; no 99490, 99439, 99491, 99487, 99453, 99454, 99457, 99458, 99091, 99445, 99470, 99424 to 99427, G0556 to G0558 or 99484 at meaningful scale on any roster clinician in CY2024.

³ CMS Quality Payment Program eligibility API, performance year 2026: apmName MEDICARE SHARED SAVINGS PROGRAM, subdivision MSSP ACO - BASIC LEVEL E, providerRelationshipCode P, advancedApmFlag true, on all nine clinicians under the practice's billing entity, with Qualifying APM Participant scores. CMS Medicare Shared Savings Program participant file, PY2026: the practice's legal business name, BASIC track Level E, two-sided, high-revenue ACO, retrospective assignment, first participant year 2024.

	Year 1	Year 2	24 months
Net to the practice	\$281,732	\$452,794	\$734,526
Practice margin	41.5%	42.9%	42.3%

CoachCare Value Analysis: 2,500 Medicare patients, 2,000 in scope, RPM + CCM, 9 referring clinicians, one CoachCare-funded on-site enrollment specialist at 80 enrollments a month, CY2026 fee schedule at the Idaho locality 00 amounts. Margin is net to the practice divided by net reimbursement. Transitional care management is recommended and is not in the forecast.

One market fact sits under every number above. Medicare Advantage covers about four in ten Bonner County beneficiaries; plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. Six in ten Bonner County beneficiaries are in Original Medicare, and the forecast is priced at the Medicare fee schedule for the whole panel.

- 1. The service line is positive from month 2.** Month 1 nets -\$1,919 on 42 enrollments, because the one-time implementation and NextGen integration setup post ahead of the ramp. Month 2 nets \$4,439, month 3 nets \$8,401, and the program holds about \$37,733 a month from month 10 once both programs are full.
- 2. Nobody at the practice is hired.** CoachCare delivers about 15,501 care-team hours over 24 months, about 7.5 full-time-equivalent years of care-management labor. The on-site enrollment specialist, the care managers and the device logistics are CoachCare's payroll, embedded in the fee, never deducted from practice margin. The nine clinicians refer and supervise; the practice's own billing staff file the claims.
- 3. The margin holds at about 42% whatever the panel turns out to be.** At a 1,700-patient panel the program returns \$527,045 to the practice over 24 months; at 3,000 it returns \$849,379. The fee scales with the census, so the margin stays between 42.2% and 42.4% whichever panel the chart count returns. Section 6.4 is the table.
- 4. The binding constraint is the eligible Medicare panel, not outreach.** Remote monitoring reaches its ceiling of 455 active enrollments in month 8 and chronic care management reaches its ceiling of 450 in month 9. From then on the program holds **905 active program enrollments across 590 unique patients**, which is every patient the two programs can take on a 2,000-patient in-scope panel. The chart count is discovery item number one.
- 5. Transitional care management belongs on the stack, and is not in the forecast.** The practice's patients are admitted at the Critical Access Hospital one block away and come back to their own medical home afterwards, and the practice already bills 99495 for 45 beneficiaries a year. The medical-home page already promises a post-discharge call; the program formalizes the cadence and makes the first one.
- 6. The program lives in NextGen.** The practice runs NextGen with a patient portal its patients already use at 82% electronic access. CoachCare integrates bi-directionally: eligibility flags and referral orders leave the chart, and monitored vitals, care documentation, enrollment status and billing-ready claims come back in. The integration is priced in the forecast at the standard NextGen integration tier, with scope confirmed in contracting. Section 4 is the path.
- 7. Advanced primary care management is the named next lever, at zero dollars.** The practice's verified value-model participation clears the eligibility gate for the advanced primary care management codes. The choice between chronic care management and advanced primary care management depends on real enrollment data, so this forecast carries the codes at zero. Section 3.2 frames it.
- 8. The CY2027 proposed rule takes 5.6% off this line and leaves the case intact.** A 20.7% cut to device supply is a 9.6% change to the remote-monitoring arm and 5.6% to the whole service line, \$97,487 over 24 months. Section 7 draws the cascade.

1. The Practice, and the Panel It Already Manages

1.1 One site in Sandpoint

Family Health Center is an independent family-medicine practice at one address in Sandpoint, the Pinegrove Medical Center building on North Third Avenue, a block from the town's Critical Access Hospital. It has run for about thirty years under its own ownership, and its physicians hold privileges at the hospital and perform endoscopy there. The practice schedules on open access, so a patient can be seen the day they call or the next; it runs an on-site lab, in-office procedures, video visits and 24/7 on-call; and it convenes a diabetic group visit on the third Wednesday of every month. It is a recognized patient-centered medical home, corroborated by the practice's CMS medical-home attestation for 2024.⁴

Two things about the practice matter to enrollment. The medical-home care team, the monthly diabetic group visit and the annual wellness visit are the enrollment moments: there is time and a reason in each to explain a cuff, sign a consent and place a referral order. And the NextGen patient portal is already in use, with 82% of the practice's patients on electronic access, so device instructions, the monthly check-in and the care plan have a channel the patient recognizes. The practice's own new-patient page says that *"if you are on Medicare there may be a longer wait to get established as the demand for these appointments has increased"*. Care management is how a nine-clinician practice adds Medicare capacity without adding exam-room slots.⁵

1.2 What the CY2024 claims say

The CY2024 Medicare by-provider and by-provider-and-service files were queried for every clinician on the practice's roster. Eight carry a CY2024 row; four of them built part of that year's volume at prior employers, a residency and out-of-state practices, before joining, and the newest physician assistant has no CY2024 row. The profile below is the fee-for-service population the clinicians now on the roster already see.⁶

CY2024 Medicare fee-for-service, the clinicians now on the roster	Value
Beneficiary-clinician pairs	2,746
Medicare allowed amount	\$800,509
Dual-eligible beneficiaries	157
Annual wellness visits, G0439 (beneficiaries)	1,056
Depression screens, G0444 (beneficiaries)	1,053
Transitional care, 99495 (beneficiaries)	45
Chronic care management, remote monitoring, principal care, advanced primary care management, behavioral health integration	no program at meaningful scale on any clinician
Average beneficiary age	73 to 75
Weighted HCC risk score	0.82
Hypertension	59%

⁴ fhcsandpoint.com, retrieved September 22, 2026: the Pinegrove Medical Center building on North Third Avenue, a block from the town's Critical Access Hospital; open-access scheduling ("you can see your doctor the day you call or the next"); a diabetic group visit on the third Wednesday of each month; endoscopy performed at the hospital; the patient portal at 82% electronic access per the practice's PY2024 promoting-interoperability attestation; and the new-patient page's statement on Medicare wait times, modified June 2026.

⁵ CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024 vintage, retrieved September 22, 2026, queried by rendering NPI for each roster clinician. Eight clinicians carry a CY2024 row; four of them billed part of that year's volume at prior employers before joining, and the newest physician assistant has no CY2024 row. The organization NPI returns no rows because the file is rendering-NPI only.

⁶ CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024, every clinician-and-code row for the roster searched for 99453, 99454, 99457, 99458, 99445, 99470, 99490, 99491, 99439, 99487, 99489, 99424 to 99427, 99484, 99091 and G0556 to G0558: none at meaningful scale. Present on most clinicians: 99213 to 99215, G0439, G0444, G2211, 99497. CMS suppresses clinician-and-code lines under 11 beneficiaries.

CY2024 Medicare fee-for-service, the clinicians now on the roster	Value
Hyperlipidemia	49%
Diabetes	18%
Ischemic heart disease	15%
Chronic kidney disease	14%
Depression	12%
COPD	9%
Heart failure	9%

CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024, the eight roster clinicians with rows. CMS suppresses counts under 11. Pairs count a patient once per clinician seen; prevalence is weighted by beneficiaries.

Read the two halves of that table together. The lower half is the profile remote care is built for: a community family-medicine panel where six in ten beneficiaries carry hypertension, half carry hyperlipidemia, and diabetes, ischemic heart disease and chronic kidney disease each sit near one in six or one in seven. The chronic care management codes require two or more chronic conditions expected to last a year, which on this panel is most patients. The remote monitoring codes want a condition whose readings change treatment between visits, and hypertension with diabetes is the largest such cohort here.

The upper half is the billing around that panel. More than a thousand annual wellness visits and more than a thousand depression screens a year mean the practice already documents a continuing relationship with these patients, and the annual wellness visit is the natural consent-and-enroll moment for care management. What the claims do not show is a monthly, staffed program between the visits: **no remote-care or care-management program at meaningful scale is visible in the CY2024 claims under any practice clinician.** Section 3.4 bounds that claim.⁷

1.3 The accountable-care position

CMS's Quality Payment Program eligibility records for 2026 place all nine clinicians, under the practice's own billing entity, inside **a two-sided Medicare Shared Savings Program ACO on the BASIC track, Level E**, as participant providers; the CMS PY2026 participant file lists the practice's legal business name in the same ACO. The practice joined for 2024. Its clinicians score as Qualifying Alternative Payment Model participants for the 2026 determination.⁸

Three consequences follow. First, a two-sided track puts the ACO at risk on the total cost of care of its assigned beneficiaries, and attribution runs on documented primary-care services, so a documented monthly care-management touch both holds the assigned panel and moves the cost the ACO is measured on. The practice's fee-for-service care-management revenue therefore also serves a two-sided ledger. Second, the practice's verified participation clears the value-model gate for the advanced primary care management codes, which Section 3.2 takes up. Third, the Value Analysis in Section 6 is fee-for-service and models no shared-savings economics; any care-management resources the ACO supplies to the practice are a co-existing layer, and whether the practice uses them is a discovery item.

⁷ CMS Quality Payment Program eligibility API, performance year 2026 (note 3), and the CMS Medicare Shared Savings Program participant file, PY2026. All nine clinicians carry the rural and Health Professional Shortage Area flags.

⁸ CMS Provider Data Catalog, PY2024 group public reporting, organisation-level: controlling high blood pressure 69% on 2,139 patients (four stars against a five-star benchmark of 90); HbA1c poor control 14% on 612 patients (four stars); patient electronic access 82%.

The quality measures the ACO is scored on are the measures a monitoring program moves. The practice's own public PY2024 group results read controlling high blood pressure at 69% on 2,139 patients, four stars against a five-star bar of 90, and HbA1c poor control at 14% on 612 patients, also four stars. Controlling blood pressure is the remote-monitoring story on this panel, and the same monthly documentation stands behind whatever quality reporting the practice carries.⁹

1.4 The county, and the rate basis

Bonner County	Value
Medicare beneficiaries, May 2026	15,851
Original Medicare (six in ten)	9,664
Medicare Advantage share, September 2026	38.6%
Population aged 65 and older	26.4%
Median household income	\$66,979
Designation	geographic primary-care HPSA

CMS Medicare Monthly Enrollment, county level, May 2026; CMS Medicare Advantage State/County Penetration, September 2026; American Community Survey 2020–2024. HPSA: Health Professional Shortage Area.

About four in ten Bonner County Medicare beneficiaries are in a Medicare Advantage plan, below the point where a market tips toward managed care; six in ten are in Original Medicare. Medicare Advantage covers about four in ten Bonner County beneficiaries; 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 in Section 6 is priced at the Medicare fee schedule for the whole panel; which plans hold the practice's members, and their terms for these code families, is the second thing to confirm after the chart count.¹⁰

The rate basis follows the geography. Idaho is a single statewide locality, locality 00 under the Noridian JF contractor, which prices the care-management codes about 5 to 8% under the national amounts: 99490 pays \$62.47, 99454 pays \$47.79 and 99457 pays \$48.66 at the CY2026 non-facility amounts, against national amounts of \$66.13, \$52.11 and \$51.77. The practice is not a health center, so the statewide locality is the only basis. Every dollar in this report is priced at the Idaho locality 00 amounts.¹¹

2. Why This Year

Three things line up for an independent Idaho family-medicine practice in 2026.

What changed	Why it matters to Family Health Center
CY2026 opened the short-window remote monitoring codes	99445 pays for device supply when a patient transmits on 2 to 15 days of a 30-day period, at the same \$47.79 as the 16-day code, and 99470 pays \$24.50 for 10 to 19 minutes of treatment management. Before 2026 a patient who transmitted on twelve days earned nothing for the month. On a panel that averages 73 to 75 years, partial-month adherence is the normal case, and on this forecast the two new codes carry about 8.8% of net reimbursement ¹²

⁹ CY2026 Medicare Physician Fee Schedule, non-facility amounts, Noridian JF carrier 02202, Idaho locality 00 (statewide), ZIP 83864; geographic indices work 1.000, practice expense 0.920, malpractice 0.473; conversion factor \$33.4009: 99490 \$62.47; 99439 \$47.52; 99453 \$19.68; 99454 and 99445 \$47.79; 99457 \$48.66; 99458 \$39.14; 99470 \$24.50; 99495 \$207.09; 99496 \$281.26; G0556 \$15.43; G0557 \$50.78; G0558 \$110.53; 99484 \$54.44. National non-facility: 99490 \$66.13; 99454 \$52.11; 99457 \$51.77. The practice is not a health center, so the statewide locality is the only basis.

¹⁰ CoachCare Value Analysis for Family Health Center, 2026: blended net reimbursement per enrolled patient-month, chronic care management \$104.49 and remote physiologic monitoring \$90.93, on the code frequencies in the forecast at the Idaho locality 00 amounts. Transitional care management is not in the forecast.

¹¹ CY2026 Medicare Physician Fee Schedule, Idaho locality 00 amounts for G0556, G0557 and G0558. CMS advanced primary care management requirements include participation in a qualifying value-based arrangement; the practice's Medicare Shared Savings Program participation (note 3) satisfies the gate in 2026. Advanced primary care management and chronic care management may not be billed for the same patient in the same month; remote physiologic monitoring may be billed alongside either.

What changed	Why it matters to Family Health Center
A two-sided ACO whose attribution runs on documented primary care	The practice is at risk on the total cost of care of its assigned beneficiaries, and assignment follows the primary-care services it documents. A monthly, documented care-management relationship holds the assigned panel and moves the cost the ACO is measured on. This service line builds that relationship under fee-for-service, on the practice's own billing, and the revenue is the practice's to keep regardless of how the ACO settles
A state policy and a payer both named remote monitoring this year	Idaho's first-year Rural Health Transformation award names remote patient monitoring for chronic conditions and after hospital discharge among the activities the state plans to fund, and the practice's largest commercial payer published a remote-monitoring administrative policy in August 2026. Idaho Medicaid covers remote monitoring for established patients. None of this is required to make the fee-for-service case, and none of it is assumed in the forecast
No capital and no headcount are required	Under the partner model the on-site enrollment specialist, the care managers, the cellular devices, the 24/7 alert triage and the claim construction are CoachCare's payroll and CoachCare's inventory, priced per active patient per month. The practice adds a referral order in NextGen and a supervising clinician. For a practice already posting open front-office and clinical positions, the program starts without a build cost and without a hiring plan

Share of 24-month net reimbursement carried by 99445 and 99470 on this forecast's billing mix: CoachCare Value Analysis.

3. The Service Line: RPM, CCM and TCM on the Medicare Panel

3.1 The clinical and billing stack

Two monthly programs and one episode code for the Medicare panel. One enrollment conversation, one care team, one billing pipeline into the practice's own billing staff through NextGen. Each answers a different clinical question and each is separately payable under the CY2026 fee schedule. The forecast in Section 6 carries the two monthly programs; transitional care management is recommended and not in the forecast.¹³

Program	What it does clinically	Who it fits on this panel	Net reimbursement per enrolled patient-month
Chronic care management (CCM)	A documented care plan for patients with two or more chronic conditions, with at least 20 minutes of clinical staff time each month; 99490 and 99439	The multi-chronic core of the panel: hypertension with hyperlipidemia, diabetes, kidney disease or COPD in one patient. The longitudinal wrapper, and the program that carries the larger share of the forecast	\$104.49
Remote physiologic monitoring (RPM)	A cellular blood pressure cuff and scale transmit readings between visits, reviewed against thresholds the practice's clinicians set; 99453 setup, 99454 or 99445 device supply, 99457, 99458 and 99470 treatment management	The hypertension, diabetes and heart-failure cohorts: six in ten of the panel carries hypertension, and the readings that change a dose are the readings a cuff sends	\$90.93

¹² fhcsandpoint.com, retrieved September 22, 2026, and CMS by Provider and Service, CY2024 (note 6). The medical-home page promises a post-discharge phone call from the care team. No care-manager, nurse-navigator or care-coordinator role is advertised on the practice's employment page.

¹³ The practice's patient portal self-identifies as the NextGen patient-experience portal, and Phreesia handles intake, self-scheduling and payments; PY2024 promoting-interoperability attestations confirm a certified record with bi-directional health-information exchange and 82% patient electronic access. The NextGen edition and interface scope are confirmed in the integration workshop. The integration is priced at the standard NextGen integration tier.

Program	What it does clinically	Who it fits on this panel	Net reimbursement per enrolled patient-month
Transitional care management (TCM)	Contact within two business days of discharge, medication reconciliation, and a face-to-face visit within 14 days (99495, moderate complexity) or 7 days (99496, high complexity); one payment per discharge	Every panel patient discharged from a hospital or observation stay at the Critical Access Hospital one block away and returning to the practice afterwards	Per discharge; not in the forecast

Blended net reimbursement per enrolled patient-month for the two monthly programs, CoachCare Value Analysis, CY2026 Idaho locality 00 amounts. Transitional care management carries no dollars in the forecast.

Code	What it pays for	CY2026 Idaho locality 00 amount
99490	Chronic care management, first 20 minutes of clinical staff time	\$62.47
99439	Each additional 20 minutes	\$47.52
99453	Remote monitoring setup and patient education, once	\$19.68
99454	Device supply with daily recording or alerts, 16 or more days in 30	\$47.79
99445	Device supply, 2 to 15 days in 30 (new in CY2026)	\$47.79
99457	Treatment management, first 20 minutes, with interactive communication	\$48.66
99458	Each additional 20 minutes	\$39.14
99470	Treatment management, 10 to 19 minutes (new in CY2026)	\$24.50
99495	Transitional care management, moderate complexity, visit within 14 days of discharge	\$207.09
99496	Transitional care management, high complexity, visit within 7 days of discharge	\$281.26
G0556	Advanced primary care management, level 1, per month	\$15.43
G0557	Advanced primary care management, level 2, two or more chronic conditions	\$50.78
G0558	Advanced primary care management, level 3, qualified Medicare beneficiary	\$110.53

CY2026 Medicare Physician Fee Schedule, non-facility amounts, Idaho locality 00 (Noridian JF, carrier 02202), ZIP 83864. Medicare Advantage covers about four in ten Bonner County beneficiaries; plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families.

A patient can hold a care-management enrollment and a monitoring enrollment in the same month, and on this panel most monitored patients qualify for both. Transitional care management is billed once per discharge and sits alongside either. Principal care management is off for this panel; advanced primary care management is a pathway decision, taken up next, and carries no dollars here.

3.2 Advanced primary care management: the next lever

Advanced primary care management (G0556, G0557 and G0558) pays a monthly per-patient amount for continuous primary-care management with no minute threshold, tiered by complexity. CMS ties the codes to participation in a value-based arrangement, and the practice's verified Medicare Shared Savings Program participation clears that gate in 2026. Few independent practices of this size can say the same.¹⁴

¹⁴ CoachCare Care Management Programs standard operating procedures, March 2026: alert and escalation decision logic, trend definitions, emergent and urgent communication protocol, escalation routing, post-discharge cadence and discharge governance, as reproduced in this section.

It appears at zero dollars. Advanced primary care management and chronic care management cannot both be billed for the same patient in the same month, so moving the multi-chronic panel from one to the other is a pathway decision: which patients, at which tier, with what documentation. Those are the practice's decisions and this forecast does not pre-empt them. Remote monitoring bills alongside either, so the monitoring arm is unchanged whichever way the decision goes. The decision belongs in months 7 to 24 of the roadmap, once the chronic care management census and the documentation workflow are real.

3.3 Behavioral health: the adjacency

The practice screened more than a thousand patients for depression in CY2024, and depression appears in 12% of the Medicare panel's claims. The monthly chronic care management touch is where a PHQ-9 gets repeated, a medication question gets asked and a referral gets made. Behavioral health integration billing (99484, \$54.44 at the Idaho locality) is an adjacency to scope once the program is running and the screening and care-management workflows have met in the chart. It carries no dollars in this report.

3.4 What exists today, stated plainly

This is the build-versus-partner section, and it starts with what the practice has already built: a recognized medical home, a care team, a monthly diabetic group visit, an annual wellness visit program billed in the thousands, a patient portal in use, and a post-discharge call the medical-home page already promises. That is more of the front end a care-management program needs than most single-site practices carry.¹⁵

Asset	Status in 2026	What it means for this program
NextGen	Live; certified record with a bi-directional integration path	The program's host. Orders and flags out, documents and claims back. Section 4
Patient portal	Live; 82% patient electronic access	The channel for device instructions, the monthly check-in and the care plan; low enrollment friction
Monthly diabetic group visit	Live; third Wednesday of each month	A ready-made enrollment channel for the diabetes cohort into monitoring and care management
Annual wellness visits and the medical-home care team	Live	The consent-and-enroll moment, and the staff who run the front end of a care-management program
Chronic care management billing	No program at meaningful scale on any clinician in CY2024	Supplied by CoachCare's care team, documented in NextGen, billed by the practice
Remote monitoring	No program at meaningful scale on any clinician in CY2024	Devices, the monitoring workflow, alert triage and the care team are supplied by CoachCare
Transitional care billing	45 beneficiaries billed 99495 in CY2024; no formal cadence	CoachCare's post-discharge cadence makes the first call; the practice bills the episode

fhcsandpoint.com, retrieved September 22, 2026; CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024.

- **What exists now is the panel, the record and the relationship.** The CY2024 claims show no remote-monitoring, care-management, principal-care or advanced primary care management code at meaningful scale under any practice clinician. CMS suppresses any clinician-and-code line

¹⁵ CoachCare Value Analysis for Family Health Center, 2026. All Section 6 figures. Inputs: 2,500 Medicare patients, 2,000 in scope; 9 referring clinicians; one on-site enrollment specialist at 80 enrollments a month; remote monitoring 65% eligible and 35% acceptance; chronic care management 75% eligible and 30% acceptance; 8 referrals per clinician per month at 80% acceptance; telephonic outreach on; 70% dual enrollment; 1.5% monthly attrition; CY2026 fee schedule at Idaho locality 00 amounts; NextGen integration at the standard tier. Sensitivity runs on the same workbook with one input changed at a time.

under 11 beneficiaries, so the supportable statement is the one this report makes, no program at meaningful scale in CY2024, rather than a claim that no patient was ever billed.

- **What the ACO may already supply is a co-existing layer.** The ACO makes care-management resources available to its practices. Whether Family Health Center uses them, who makes the post-discharge call today and whether any device is in a patient's home are the first discovery questions. Nothing in the practice's own claims shows a program, and the service line in this report is the practice's own: governed by its clinicians, billed under its name, and documented in its own chart.
- **What the partner model supplies is the program.** Devices sourced, shipped and replaced; an on-site enrollment specialist; care managers at about 160 patients each; 24/7 alert triage under a written escalation protocol; monthly documentation into NextGen; claims constructed and landed billing-ready for the practice's billing staff. None of it is the practice's headcount, inventory or software to maintain, and all of it is priced per active patient per month.
- **What the practice keeps is clinical governance, the patients and the revenue.** The clinicians set the thresholds, the routing and the discharge criteria, supervise the program, file the claims under Family Health Center and keep about 42% of net reimbursement after CoachCare's fee. Nothing about the arrangement changes who practices medicine, and nothing about it changes who owns the practice. For a thirty-year physician-owned practice a block from a hospital that employs primary care, a recurring service line the practice owns is how it adds Medicare capacity and revenue while staying independent.

4. NextGen: The Program Lives in the Chart

The practice runs NextGen, with Phreesia for intake, self-scheduling and payments and a NextGen patient portal already in use at 82% electronic access. The vendor was identified from the practice's own portal, which self-identifies as the NextGen patient-experience portal; confirming the NextGen edition and interface scope is a first-call item. CoachCare integrates bi-directionally: eligibility flags and referral orders leave the chart, and monitored vitals, care documentation, enrollment status and billing-ready claims come back into it. Phreesia stays as the intake and scheduling layer. The integration is priced in the forecast at the standard NextGen integration tier, with scope confirmed in contracting.¹⁶

Step	What happens in NextGen	Who does it
Eligibility	Patients meeting the agreed criteria are identified from the condition and encounter feeds and flagged; the flag is the enrollment prompt at the point of care	CoachCare configures the criteria the practice's clinicians approve
Referral	The clinician places a referral order the way they would order a lab. The order is the enrollment	Any of the nine clinicians, in the visit
Device	A cellular blood pressure cuff and scale ship to the patient, pre-paired; no smartphone, WiFi or app required, though the portal carries the instructions for patients who use it	CoachCare sources, ships, replaces
Outreach	The patient is reached, educated and consented; readings, alert dispositions, enrollment status and monthly care documents return to the chart	CoachCare's on-site enrollment specialist and care team
Claims	Each month's codes are constructed from logged time and transmission days and land billing-ready in the workflow the practice's billing staff already run	CoachCare generates; the practice files and keeps the revenue

¹⁶ CMS-1848-P, CY2027 Medicare Physician Fee Schedule proposed rule, published July 2026; comment period ended September 14, 2026. CoachCare repricing of this forecast at the proposed CY2027 amounts, Idaho locality 00: 99454 and 99445 \$47.79 to \$37.92 (-20.7%); remote monitoring arm -9.6% (-\$79,141) with device supply 32% of that basket; chronic care management -2.0% (-\$18,346); service line -5.6% (-\$97,487), \$1,734,732 to \$1,637,245, with remote monitoring 47% of the line. Enrollment held constant.

The NextGen integration carried in this forecast is priced at the standard integration tier: a one-time setup, a monthly interface fee and a small per-enrolled-patient charge, with scope confirmed in contracting. Together with implementation and telephonic outreach, those ancillary items total \$36,187 over 24 months, and they are inside the \$1,000,206 of CoachCare fees, not on top of it. A certified record like NextGen typically integrates in about four weeks, run in parallel with onboarding, training and care-team assignment, so the interface does not hold up the first enrollments.

5. Clinical Governance & Escalation

Section 6 shows the service line pays. This section shows it is safe. Every reading a patient takes routes through one shared escalation engine with defined thresholds, a defined trend rule, defined routing and a defined documentation standard, so the practice never carries surveillance liability it did not agree to. Thresholds and routing are set with the practice's clinicians, not by default, and signed off before the first patient enrolls.¹⁷

5.1 One shared escalation engine

Branch	The rule	Why it is written this way
Critical value	Escalate immediately, regardless of symptoms	A reading at a critical threshold escalates whether or not the patient reports symptoms. There is no wait-and-see branch on a critical value, and no client preference can suppress it
Out of range, not critical	Retake, then a structured symptom check	A non-critical out-of-range reading is worked rather than forwarded: confirm technique, request a repeat, run the symptom check. Most out-of-range readings resolve here, which is why the clinicians' inboxes stay usable
Trend	Three consecutive readings at least one hour apart for blood pressure or glucose; three readings within seven days for heart rate; a weight gain over the agreed threshold in the agreed window	A trend is a definition rather than a judgment call. A confirmed trend escalates on the same footing as a single threshold breach
Patient unreachable	Document the attempt, leave a voicemail with the callback line and advice to seek care if symptoms worsen, and escalate anyway if the reading was critical or a confirmed trend	Silence never downgrades a clinical finding. This is the branch that separates a monitoring program from a data-collection exercise
Documentation	Six fields on every escalation: vital · findings · method · contact · outcome · follow-up	The same six fields every time, so any episode can be reconstructed end to end. Parameter changes are documented in the same record

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. Any of these reported during an outreach call activates the emergent protocol immediately.

Action. 911 is called with the patient still on the line. The call is not ended and handed off. The escalation record follows the patient, and the practice is notified the same day.

If the patient refuses. The practice's care team is called with the patient still on the line and directs care. If the care team cannot be reached, CoachCare activates emergency services regardless. Either way the practice is notified and the chart records the symptoms, the 911 status, the contact made and the instructions given.

The floor. CoachCare's urgent and emergent policy supersedes any client-specific escalation preference. The practice shapes routing for everything else. It cannot lower the floor on an emergency, and neither can we.

¹⁷ CoachCare Value Analysis for Family Health Center, 2026: 99445 and 99470 together carry about 8.8% of 24-month net reimbursement on this forecast's code frequencies, about \$151,996 gross.

Recent or changing symptoms that are not actively emergent, inside a 72-hour window, route as an escalation under the practice's stated preference and are documented the same way. A patient told to seek same-day care is directed to the practice, which runs open-access same-day scheduling, so the visit, the record and the follow-up stay inside the practice.

5.3 Three-way routing

The failure mode of a monitoring program inside a busy family-medicine office is not a missed alert. It is an inbox nobody reads, because everything arrives as an alert. Escalations route three ways, and the split is agreed before the first patient enrolls.

Route	What goes there	Who sees it
Emergency	Emergent symptoms, or a critical value with clinical instability	911 activated, with the practice's care team notified
Non-critical	A confirmed out-of-range reading or trend without emergent features	The clinician or medical assistant the practice designates in its escalation matrix, within the agreed window
Stable or resolved	Worked, retaken, resolved, patient asymptomatic	Documented in the record as a note rather than pushed as an alert. This is the branch that keeps the program sustainable for a nine-clinician practice

The matrix is agreed with the practice, and the after-hours branch is defined alongside the practice's existing video-visit and 24/7 on-call arrangements, so evening and weekend readings have a route that does not depend on anyone's memory. Adding a cohort adds a row, not a redesign.

5.4 The post-discharge cadence, and the TCM episode

Triggered by any emergency visit or hospitalization in the previous 60 days. For Family Health Center the trigger usually fires from the discharge summary that arrives from the Critical Access Hospital one block away, from the patient's own call, or from a reading that changes after an admission. When the event was a hospital or observation admission the cadence is also the transitional care episode: the first touch is the two-business-day contact 99495 and 99496 require, and the confirmed follow-up is the 7- or 14-day visit with the practice. This cadence is the mechanism behind the avoided admissions in Section 6.5, and under a two-sided arrangement each one is total-cost-of-care arithmetic as well as a patient kept home.

Touch	Window	What happens
1 · Stabilize	Day 1–2	Identify what precipitated the visit; reconcile discharge medications against what is in the house; confirm a follow-up appointment exists within 7 to 14 days; symptom assessment, documented and escalated per the engine above
2 · Detect	Day 5–8	The window in which post-discharge decompensation usually declares itself. Verify medication adherence; re-evaluate the original triggers; confirm the appointment was attended; verify ordered labs were completed
3 · Secure	Day 12–14	Medication and risk review; review the outcome of the completed visit; final symptom assessment; hand the patient into the longitudinal monitoring panel so the window closes with continuity rather than a cliff

5.5 Continuity and discharge governance

1. **An unreachable patient escalates on a fixed cadence.** A monitoring patient unreachable 45 days from enrollment is escalated to the care team; non-compliance at 90 days triggers a second

escalation plus 90 more days of monitoring. Care management runs a longer clock, with the first escalation at six months.

2. **There is a hard backstop.** If no instruction comes back from the care team, discharge proceeds at 180 days for monitoring. The practice is notified in every case and discharges process in the first week of the following month, so a patient who stops transmitting is worked before a billing month is lost.
3. **The practice always decides.** Clinical discharge criteria, escalation thresholds and routing belong to the practice's clinicians. CoachCare executes them consistently and documents the execution. It does not overrule clinical judgment, with the single exception of the emergent floor in Section 5.2.
4. **Auditable by design.** Because every escalation carries the same six documented fields, any episode can be reconstructed end to end, which is what the per-code documentation rules require in any case and what an accountable-care quality review asks for.

6. Value Analysis: The 24-Month Forecast

6.1 The headline economics

The forecast covers chronic care management and remote physiologic monitoring across a Medicare panel of 2,500, with 2,000 in scope, priced at the CY2026 Idaho locality 00 amounts, with 9 referring clinicians and one CoachCare-funded on-site enrollment specialist at 80 enrollments a month. Transitional care management is recommended in Section 3 and carries no dollars here; no distribution from the accountable-care arrangement is in these numbers.¹⁸

	Year 1	Year 2	24 months
Net reimbursement	\$678,934	\$1,055,798	\$1,734,732
CoachCare fees, including the NextGen integration and implementation	\$397,202	\$603,004	\$1,000,206
Net to the practice	\$281,732	\$452,794	\$734,526
Practice margin	41.5%	42.9%	42.3%

The margin moves from 41.5% in year one to 42.9% in year two because the one-time implementation and integration setup fall out and the census is full from the first month of the year. Year two is the steady state: **\$1,055,798 of net reimbursement, \$452,794 of it kept, at 42.9%.**

6.2 Where the revenue comes from

Program	Year 1	Year 2	24 months	Per enrolled patient-month
Chronic care management	\$347,161	\$564,230	\$911,391	\$104.49
Remote physiologic monitoring	\$331,772	\$491,568	\$823,340	\$90.93
Total	\$678,934	\$1,055,798	\$1,734,732	

Net reimbursement by program and year, CoachCare Value Analysis. Year columns sum to within a dollar of the totals after rounding.

24 months	Net reimbursement	CoachCare fees	Net to the practice
Chronic care management	\$911,391	\$474,924	\$436,467

¹⁸ CoachCare Value Analysis for Family Health Center, 2026: about 60 hospitalizations avoided over 24 months on the enrolled census at the workbook's baseline admission rate, valued at \$15,000 per admission; about 121 at a 40% annual admission baseline.

24 months	Net reimbursement	CoachCare fees	Net to the practice
Remote physiologic monitoring	\$823,340	\$489,094	\$334,246
Implementation, NextGen integration setup and monthly interface, telephonic outreach		\$36,187	-\$36,187
Total	\$1,734,732	\$1,000,206	\$734,526

Fees and net to the practice by program, 24 months, CoachCare Value Analysis.

Chronic care management is the larger line, \$911,391 on 450 active enrollments at month 24, because the multi-chronic core of this panel is large and the 99439 add-on is earned in most months. That is what a multi-chronic family-medicine panel should produce. Remote monitoring carries \$823,340 on 455 enrollments and is the program that produces the readings, the alerts and the avoided admissions. The **905 active program enrollments at month 24 belong to 590 unique patients**, because most monitored patients also hold a care-management enrollment.

6.3 The ramp, month by month

Month 1 is negative, because the one-time implementation fee and the NextGen setup post in that month against 42 enrollments. Month 2 nets \$4,439 on 111 enrollments and month 3 nets \$8,401 on 207. Remote monitoring fills in month 8 and chronic care management in month 9, and the program holds about \$37,733 a month from month 10.

Month	Net reimbursement	CoachCare fees	Net to the practice
M1	\$4,476	\$6,395	-\$1,919
M2	\$11,439	\$7,000	\$4,439
M3	\$20,982	\$12,581	\$8,401
M4	\$32,334	\$19,166	\$13,168
M5	\$45,510	\$26,793	\$18,717
M6	\$58,288	\$34,102	\$24,186
M7	\$70,876	\$41,302	\$29,574
M8	\$83,096	\$48,286	\$34,810
M9	\$87,983	\$50,825	\$37,158
M10 onward	\$87,983	\$50,250	\$37,733

The commercially important number in that table is not the 24-month total. It is that the program pays its own way from its second month and every month after, with no devices purchased, no software licensed and no headcount added by the practice. Cumulative net to the practice passes \$66,992 at month 6, \$281,732 at month 12 and \$734,526 at month 24. A service line that funds itself inside two months competes with nothing else on the practice's plans.

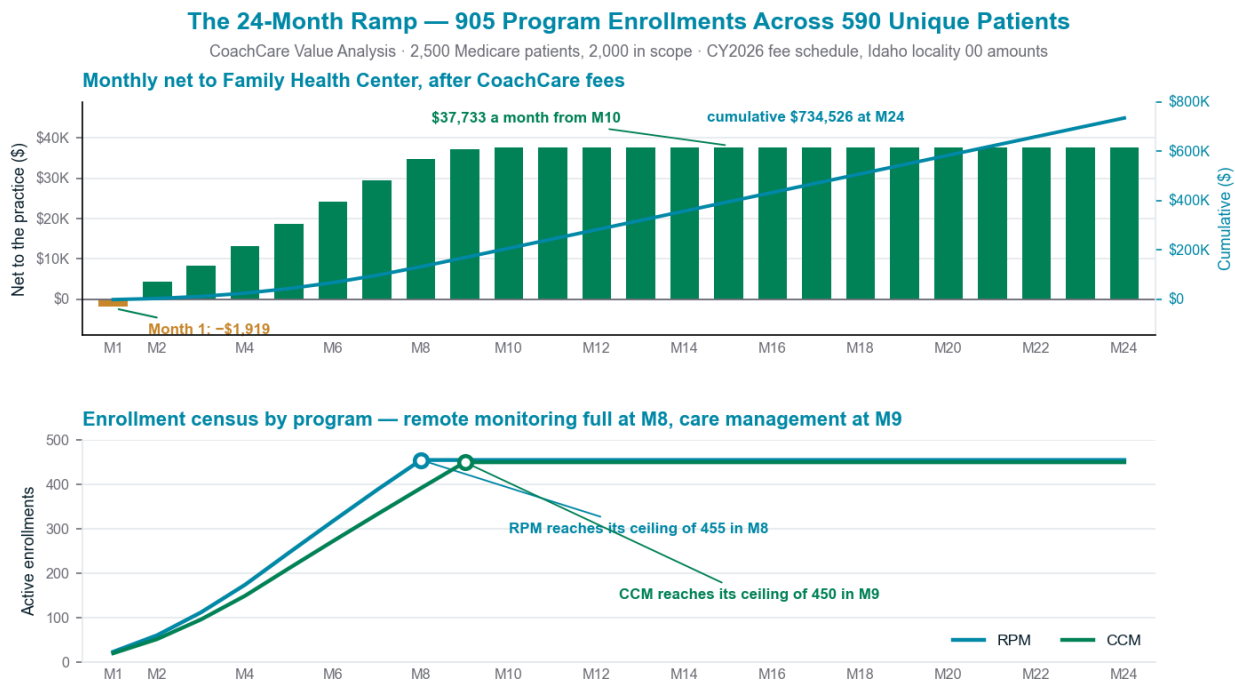


Figure 1 — monthly net to the practice after CoachCare fees, with cumulative net overlaid, and the enrollment census by program with the two ceiling months marked. CoachCare Value Analysis.

6.4 Ceilings, and what moves them

Program	Eligible share of the 2,000 in scope	Acceptance	Ceiling	Reached
Remote physiologic monitoring	65% — 1,300 patients	35%	455	M8
Chronic care management	75% — 1,500 patients	30%	450	M9

Say the constraint out loud

The binding constraint on this program is the size of the eligible Medicare panel and the eligibility definition, not outreach capacity. By month 9 every patient the two programs can take is enrolled, and the enrollment specialist has nowhere further to go on this year's panel. That is why the sensitivity table below reads the way it does: a second on-site enrollment specialist cannot raise the ceiling but reaches it sooner, in months 6 and 7, and adds \$118,068 of net reimbursement over 24 months, \$51,486 of it net to the practice; no specialist at all costs \$473,601 of net reimbursement, and remote monitoring would not fill until month 16, chronic care management month 23. The panel and the eligibility definition raise the ceiling, and nothing else does.

The chart count is discovery item number one. The 2,500 is the forecast's basis across all payers, sized from the practice's own claims and the Medicare Advantage share of Bonner County. A chart pull in week one replaces it, and every ceiling in this report moves with it.

Scenario	24-month net reimbursement	Net to the practice	Margin	Unique patients at M24	Ceilings reached
Base: panel 2,500, 2,000 in scope, 9 clinicians, one enrollment specialist	\$1,734,732	\$734,526	42.3%	590	M8 / M9
Panel 1,700, 1,360 in scope	\$1,248,468	\$527,045	42.2%	401	M6 / M7
Panel 3,000, 2,400 in scope	\$2,004,545	\$849,379	42.4%	708	M10 / M11

Scenario	24-month net reimbursement	Net to the practice	Margin	Unique patients at M24	Ceilings reached
Panel 2,500 with 100% in scope	\$2,068,887	\$876,766	42.4%	738	M10 / M11
No on-site enrollment specialist	\$1,261,131	\$525,063	41.6%	590	M16 / M23
A second on-site enrollment specialist	\$1,852,800	\$786,012	42.4%	590	M6 / M7
7 referring clinicians	\$1,701,982	\$720,483	42.3%	590	M9 / M10
11 referring clinicians	\$1,759,656	\$745,231	42.4%	590	M8 / M9

CoachCare Value Analysis sensitivity runs, one input changed at a time. Ceilings reached: remote monitoring / chronic care management.

Read across the rows. Moving the panel from 1,700 to 3,000 moves 24-month net to the practice from \$527,045 to \$849,379 at the same margin; revenue is close to linear in the panel because both programs are ceiling-limited. The in-scope share does the same work: at 100% of the panel the program reaches 738 unique patients and \$876,766. Clinician count and enrollment staffing change timing only. Two more clinicians are worth about \$25,000 over 24 months; two fewer cost about \$33,000, and the ceilings arrive a month or two later either way. The panel is the lever; everything else is timing.

6.5 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	about 95,071	Blood pressure and weight values arriving between visits from a panel where six in ten beneficiaries carry hypertension
Claims and billable units generated	about 34,755	Constructed, coded and landed billing-ready for the practice's billing staff through the NextGen integration
Care-management tasks completed	about 69,509	Outreach attempts, care-plan updates, medication reviews and follow-up actions
Patient conversations	about 10,426	Live contacts across about 579 hours of call time
Chart updates	about 17,377	Documentation returned to NextGen for the clinicians to act on
Care-team hours delivered by CoachCare	about 15,501	About 7.5 full-time-equivalent years of care-management labor the practice does not employ
Hospitalizations avoided	about 60	About \$905,000, roughly \$0.91 million, at \$15,000 per admission, cost that never lands on a payer, a patient or the ACO's total-cost-of-care ledger

CoachCare Value Analysis, 24-month totals. The avoided-admission figure is computed on a conservative baseline admission rate for the enrolled cohort; at a 40% annual admission baseline, which is realistic for a hypertension and diabetes cohort of this kind, the count is about 121.

The two layers, kept separate

Fee margin funds the program. \$734,526 to the practice over 24 months, positive from month 2, paid claim by claim by Medicare and by Medicare Advantage plans at their contracted terms.

Avoided admissions speak to the accountable-care ledger. About 60 over 24 months on this census, about \$905,000 at \$15,000 each, plus the documented monthly relationship with 590 patients that holds their assignment to the practice. Under a two-sided track those are the ACO's total-cost-of-care arithmetic. The practice's assigned-beneficiary count is the number to bring to the first working session; the ACO holds it.¹⁹

¹⁹ fhcsandpoint.com/new-patient, modified June 2026, and the practice's PY2024 promoting-interoperability attestation: the new-patient page's statement on Medicare wait times, and 82% patient electronic access on the NextGen patient portal. The monthly diabetic group visit and the annual wellness visit are the natural enrollment moments.

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

CMS published its proposed CY2027 physician fee schedule in July 2026. The comment period ended September 14, 2026; the final rule arrives in early November; the changes take effect January 1, 2027. The proposal that matters here is a reduction to the remote monitoring device-supply codes. Every code in this forecast was repriced at Idaho locality 00 on this account's own billing mix, with enrollment held constant.²⁰

The CY2027 Proposed Rule, Repriced on This Forecast — Three Numbers, One Scale

Every code repriced at Idaho locality 00 on this account's own billing mix; enrollment held constant. Device supply is 32% of the remote-monitoring basket; remote monitoring is 47% of the line.

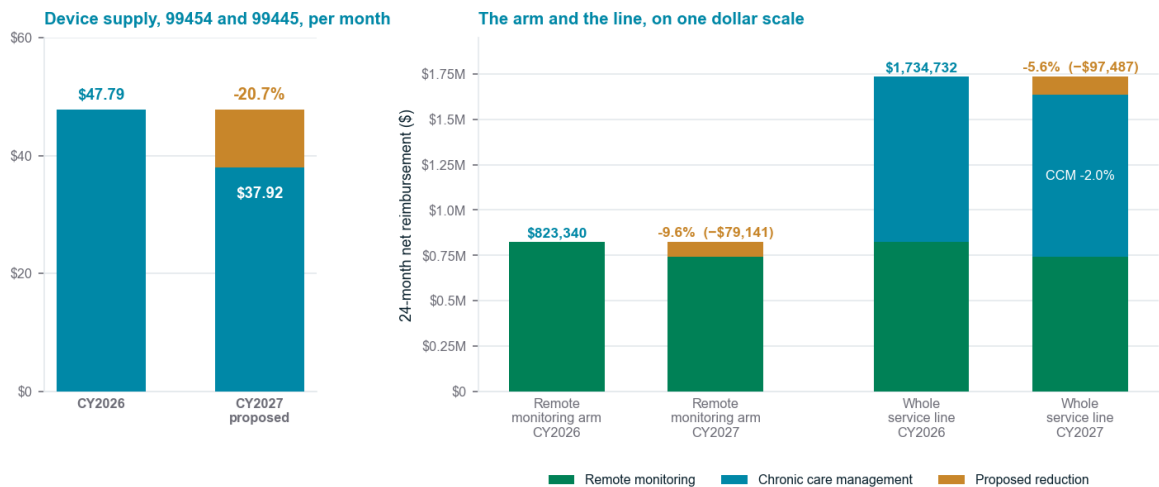


Figure 2 — the CY2027 cascade on this forecast. Left: the one code CMS proposes to cut, per month at Idaho locality 00. Right: the remote-monitoring arm and the whole service line on one dollar scale, with the proposed reduction in one colour and absolute dollars beside each percentage. CoachCare repricing of the Value Analysis at the proposed CY2027 amounts.

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
Device supply, 99454 and 99445	\$47.79 a month	\$37.92 a month, -20.7%	The code CMS proposes to cut
The remote monitoring arm	\$823,340 over 24 months	-9.6%, -\$79,141	Device supply is 32% of the remote monitoring basket; treatment management moves little
Chronic care management	\$911,391 over 24 months	-2.0%, -\$18,346	Conversion-factor and relative-value churn only; the proposal does not target these codes
The whole service line	\$1,734,732 over 24 months	-5.6%, -\$97,487, to \$1,637,245	Remote monitoring is 47% of the line; the rest moves two points

CoachCare repricing of this forecast at the CY2027 proposed amounts, Idaho locality 00, on the code frequencies in this Value Analysis.

²⁰ CMS Medicare Advantage State/County Penetration, September 2026: Bonner County 38.6% (16,162 eligibles, 6,239 enrolled). CMS Medicare Monthly Enrollment, May 2026: Bonner County 15,851 beneficiaries, 9,664 in Original Medicare. American Community Survey 2020–2024: 26.4% of the county aged 65 and older, median household income \$66,979; Bonner County is a geographic primary-care Health Professional Shortage Area.

Three numbers, each smaller than the last only because its base is larger. A 20.7% cut to one code is a 5.6% change to the service line, because this line is built on two programs of similar size and only the smaller one holds the code being repriced. CoachCare filed comments on the remote-monitoring provisions and will rerun this forecast against the final rates the week they publish. Two contingencies are already in build: an unbundled arrangement, with the software platform, device logistics and program enablement priced separately, and an arrangement in which CoachCare manages the staffing while the practice owns the clinical program and the billing. Whichever way the final rule lands, the program does not have to be rebuilt.

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%
G0556	Advanced primary care management, level 1	\$16.37	\$16.09	-1.7%
G0557	Advanced primary care management, level 2	\$53.78	\$53.20	-1.1%
G0558	Advanced primary care management, level 3	\$117.24	\$116.91	-0.3%

CY2026 Addendum B and CMS-1848-P proposed CY2027 Addendum B, national non-facility amounts. The repricing above uses Idaho locality 00 amounts and this table uses national amounts; the two bases do not reconcile to the dollar, by design. The device-supply and short-treatment codes are held to a one-year maximum reduction by section 1848(c)(7) of the Act, so CY2027 is the capped year.

8. Implementation Roadmap

8.1 Who runs what

Function	CoachCare	Family Health Center
Patient identification	Registry query in NextGen against the agreed inclusion criteria, starting from the hypertension, diabetes, kidney-disease and heart-failure cohorts on the Medicare panel	Approves the criteria and the target list
Enrollment	One on-site enrollment specialist at 80 enrollments a month, on CoachCare's payroll; the eligibility flag and referral order in NextGen	Clinician referral at the point of care, and through the monthly diabetic group visit and the annual wellness visit; nine clinicians
Transitional care	Discharge captured from the discharge summary or the patient's call; two-business-day contact and medication reconciliation completed and documented; visit scheduled inside the 7- or 14-day window	Furnishes the face-to-face visit and bills 99495 or 99496
Devices	Sourced, configured, cellular-paired, shipped, replaced	Nothing purchased, nothing stocked
Monitoring and escalation	Reading review, monthly outreach, alert triage, post-discharge cadence, protocol execution and documentation, at about 160 patients per care manager	Sets thresholds, routing and after-hours cover; receives escalations
Documentation and billing	Time logs, monthly care documents to NextGen, claims constructed and landed billing-ready	Files under its own identifiers through its own billing staff; keeps the revenue

Function	CoachCare	Family Health Center
Reporting	Monthly enrollment, engagement, escalation and revenue reporting, in a form the accountable-care arrangement can count	Standing monthly operating call with the owners; a named program lead

8.2 The model inputs

Input	Value in this forecast
Medicare panel	2,500 patients, 2,000 in scope; all payers
Referring clinicians	9: six physicians, one nurse practitioner and two physician assistants
Eligibility and acceptance	Remote monitoring 65% eligible, 35% accept; chronic care management 75% eligible, 30% accept; 8 referrals per clinician per month at 80% acceptance; 70% of monitored patients also in care management; 1.5% monthly attrition
Enrollment staffing	One CoachCare-funded on-site enrollment specialist at 80 enrollments a month, plus clinician referral and telephonic outreach; the specialist, care managers and device logistics are CoachCare's payroll, embedded in the fee
EMR	NextGen; integration per Section 4 at the standard NextGen integration tier, scope confirmed in contracting
Rates	CY2026 physician fee schedule, non-facility, Idaho locality 00 (Noridian JF), ZIP 83864. Medicare Advantage covers about four in ten Bonner County beneficiaries; plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families.
Programs	RPM + CCM in the forecast; transitional care management recommended at every hospital or observation discharge, not in the forecast; advanced primary care management named as the next lever at zero dollars; principal care management off; behavioral health integration an adjacency to scope later

8.3 The first 90 days, and after

Window	What happens	Result at the end of it
Weeks 0–4 Integrate and charter	Integration workshop with the practice's administrator and billing lead: the NextGen edition, the interface scope, orders out and documents and claims back; chart counts and the Medicare Advantage plan mix pulled; escalation thresholds, routing and after-hours cover agreed with the clinicians; billing configuration with the billing staff; protocol sign-off for the hypertension, diabetes and kidney pathways; the ACO's care-management reporting aligned so the same touch counts on both ledgers; a named program lead	Scope signed, cohorts defined, integration live, protocol signed
Weeks 4–12 Launch the first cohorts	The on-site enrollment specialist working the schedule alongside the medical assistants and the monthly diabetic group visit. Chronic care management wave across the two-plus-condition panel; remote monitoring for the hypertension and diabetes cohorts. Cellular cuffs and scales shipped and paired. Transitional care and the post-discharge cadence live from the first week	42 enrollments by month 1, 111 by month 2, 207 by month 3; positive from month 2
Months 3–9 Reach the ceilings	Both programs climb to ceiling: remote monitoring 455 in month 8 and chronic care management 450 in month 9. Monthly scorecard to the owners	905 active enrollments across 590 unique patients; about \$37,733 a month from month 10
Months 9–24 Widen the definition	Re-validate eligibility against chart data; decide the chronic care management versus advanced primary care management mix; scope behavioral health integration billing; align the program's documentation with the quality and cost measures the ACO carries	Year 2 at \$1,055,798 net reimbursement, \$452,794 to the practice, 42.9%

8.4 What we would confirm together

These are the discovery items, and every one lives in NextGen or one call away. None of them holds up the start; the first window of the roadmap collects them.

1. **The chart count and the payer split behind the 2,500.** A registry pull in week one: active patients 65 and older, traditional Medicare versus Medicare Advantage plan by plan, and how many carry hypertension, diabetes or two or more chronic conditions. This is discovery item number one, and every ceiling in Section 6 moves with it.
2. **The Medicare Advantage plan mix.** Medicare Advantage covers about four in ten Bonner County beneficiaries; 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 plan-by-plan read sets each program's target list and is the second thing to confirm after the chart count.
3. **The NextGen edition and interface scope.** NextGen was identified from the practice's own patient portal. The integration workshop confirms the edition, the interface, and whether care-plan notes, time logs and charge capture write into the chart directly or travel by document exchange. That settles the final integration scope.
4. **The ACO's care-management resources.** Whether the ACO places a care manager with the practice today, who makes the post-discharge call, whether any device is in a patient's home, and whether the ACO restricts or claims any care-management billing for its participants. The program in this report co-exists with any such layer; the working session draws the line.
5. **The assigned-beneficiary count.** The number of Medicare beneficiaries assigned to the practice under the current arrangement, which the ACO holds, bounds the panel from the accountable-care side the way the chart count bounds it from the practice side.
6. **The state and payer policy.** Whether Idaho has released the competitive solicitations under its Rural Health Transformation award and whether an independent clinic is an eligible applicant for the remote-monitoring line; and the terms of the commercial remote-monitoring policy published in August 2026. No application, award or coverage is asserted in this forecast.
7. **Hospital and observation admissions on the panel.** The count of panel patients admitted at the Critical Access Hospital or the regional medical center in the last twelve months sizes the transitional care episodes this forecast carries at zero.

9. Recommendations

1. **Launch the partner-run service line on the Medicare panel.** \$734,526 to the practice over 24 months at a 42.3% margin, positive from month 2, with nobody hired and nothing bought. The medical-home care team, the monthly diabetic group visit and the annual wellness visit are the enrollment front end the program needs.
2. **Build the integration in the workshop, on NextGen.** Orders and eligibility flags out; monitored vitals, care documents and billing-ready claims back; write-back scoped with the administrator and billing lead. Confirm the NextGen edition and interface in the same session.
3. **Point the first enrollment wave at the multi-chronic hypertensive core.** Six in ten beneficiaries carry hypertension, half carry hyperlipidemia, and diabetes and kidney disease sit near one in six. Chronic care management for the care plan, a connected cuff and scale for the readings, and the monthly diabetic group visit as the enrollment channel.
4. **Bill transitional care management at every hospital or observation discharge the practice learns of.** The practice already bills 99495 for 45 beneficiaries a year and its medical-home page already promises the post-discharge call. CoachCare makes the first call and the practice bills 99495 or 99496. Not in the forecast; sized by the panel's own admission count.

5. **Pull the chart count in week one.** The binding constraint is the eligible Medicare panel. Between 1,700 and 3,000 patients, 24-month net to the practice runs from \$527,045 to \$849,379 at the same margin; the registry, not the estimate, sets the number.
6. **Run the program as the practice's own, beside whatever the ACO supplies.** The service line is governed by the practice's clinicians, billed under Family Health Center and documented in its own chart. It co-exists with any ACO care-management layer, and its avoided admissions, about 60 over 24 months on this census, are the layer a two-sided track rewards. The fee-for-service revenue is the practice's regardless of how the ACO settles.
7. **Hold advanced primary care management as the named next lever, and decide it on real enrollment data.** The gate is cleared in 2026 by the practice's Medicare Shared Savings Program participation. The pathway choice between chronic care management and advanced primary care management is the practice's, made in months 7 to 24.
8. **Read the Medicare Advantage contracts early.** About four in ten Bonner County beneficiaries are in a plan. Medicare Advantage covers about four in ten Bonner County beneficiaries; 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 plan-by-plan read decides how far past traditional Medicare the program reaches.
9. **Scope behavioral health integration once the program is running.** Depression appears in 12% of the panel's claims and the practice screens more than a thousand patients a year. The monthly touch is the referral path; 99484 is the adjacency.
10. **Keep clinical governance where it is.** The clinicians set thresholds and routing, sign the care plans and make every clinical decision; the claims go out under Family Health Center; the revenue stays with the owners. CoachCare executes and documents. That division is the arrangement an independent practice needs, and it is how the practice adds a service line without a capital line or a hire.

The Medicare panel Family Health Center already manages supports a \$1,734,732 service line at a 42.3% practice margin inside 24 months, positive from its second month, on staff the practice does not have to hire and devices it does not have to buy. The panel is older and multi-chronic, the enrollment moments are already in the schedule, the record is certified and connected, and the practice sits inside a two-sided arrangement that pays for the same outcomes. What remains is to build the service line once, with a partner, and own it.

About CoachCare

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CoachCare operates remote care and care-management programs for more than 500,000 patients across over 400 managed conditions, with more than 10,000 clinicians on the platform. Its teams have stood up more than 1,000 programs in market, generated over 5 million claims through care-plan coding and billing, and recorded more than 100 million patient vitals.

Six reasons this partnership fits Family Health Center specifically, not remote care in general.

- **The record you already run, integrated once.** CoachCare integrates bi-directionally with NextGen: orders and eligibility flags stay in the chart; vitals, monthly care documents and billing-ready claims come back to it. There is no second system for the clinicians and no re-keying for the billing staff, and the patient portal the practice's patients already use carries the device instructions.
- **Full service, priced per patient.** The on-site enrollment specialist, care managers at about 160 patients each, device logistics, 24/7 alert triage and claim construction are CoachCare's payroll. A

practice already posting front-office and clinical positions does not add a care-management hiring cycle; the program arrives staffed, at a 42.3% margin. Fees are per active patient per month; if the census does not build, CoachCare is not paid, with implementation and integration fees the exceptions.

- **The work your accountable-care arrangement already rewards.** Fewer emergency visits and admissions among assigned patients are what a two-sided track is paid on. The monthly touches that generate care-management revenue are the same touches that produce them, and the documented care plan is what holds assignment. One program, both ledgers, with the fee-for-service margin funding it.
- **Revenue that belongs to the practice.** A recurring service line with its own margin is how an independent practice adds Medicare capacity and revenue without selling or hiring. The revenue in this report is billed under Family Health Center, governed by its clinicians and owned by its owners. CoachCare supplies staff, devices, platform and billing preparation under that governance.
- **Your clinicians stay in charge.** The clinicians set the protocols, sign the care plans and make every clinical decision; critical readings escalate through one engine whose urgent policy supersedes any preference; and every discharge the practice learns of becomes a transitional care episode with the first call already made.
- **No lock-in, no capital, paid as you enroll.** There is no capital outlay and no payroll ramp. The forecast, the workbook and the companion documents are the practice's to keep either way, and the plan is measured twice, against the chart count and the plan mix, before it goes to paper.

The ask is a working session with the owners and the practice administrator: validate the Medicare panel against a chart count, hold the integration workshop with the billing lead, confirm the ACO's care-management reporting, and set go-live for the first cohorts.

Contact

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References & Data Sources

- **Family Health Center's own published materials** (fhcsandpoint.com, retrieved September 22, 2026): the home, services, appointment-information, medical-home, diabetic-group-visit, insurance and new-patient pages, for the single site and hours, the services offered, the recognized-medical-home statement, the monthly diabetic group visit, the patient-portal link, the 24/7 on-call arrangement and the new-patient page's statement on Medicare wait times.
- **CMS Quality Payment Program eligibility records** (qpp.cms.gov API, performance year 2026, retrieved September 22, 2026), for each roster clinician's alternative payment model participation under the practice's billing entity: Medicare Shared Savings Program, BASIC track Level E, participant provider, Advanced APM flag set, on all nine clinicians, with Qualifying APM Participant scores for the 2026 determination.
- **CMS Medicare Shared Savings Program participant file, 2026** (data.cms.gov, retrieved September 2026): the practice's legal business name as a participant, BASIC track Level E, two-sided, retrospective assignment, joined for 2024.
- **CMS provider and claims files** (data.cms.gov, retrieved September 2026): NPPES records for the practice's organization and each roster clinician; the Medicare Physician & Other Practitioners by Provider file, CY2024, for beneficiary counts, allowed amounts, age, dual-eligible counts, chronic-condition prevalence and risk scores; and the by Provider and Service file, CY2024, queried for every roster clinician across the evaluation-and-management, annual wellness, remote monitoring, chronic care management, principal care, transitional care, advanced primary care management and behavioral health integration code families. CMS suppresses lines under 11 beneficiaries.

- **CMS quality reporting** (CMS Provider Data Catalog, PY2024 group public reporting, retrieved September 2026): the practice's organisation-level controlling high blood pressure and HbA1c poor-control results, and the patient-electronic-access rate.
- **Medicare payment rules:** the CY2026 Medicare Physician Fee Schedule final rule and Addendum B, for the remote monitoring family including the new 99445 and 99470, the chronic care management family, the transitional care codes and the G0556 to G0558 advanced primary care management tiers; CMS-1848-P, the CY2027 proposed rule published July 2026, for the proposed device-supply repricing and the comment deadline; and the CY2026 RVU file and geographic indices for Idaho locality 00 under the Noridian JF contractor, used for every dollar in this report.
- **Market sources:** CMS Medicare Advantage State/County Penetration, September 2026, for the Bonner County share; CMS Medicare Monthly Enrollment, county level, May 2026, for beneficiary counts; and the American Community Survey 2020–2024 for the county's age and income profile.
- **State and payer policy** (retrieved September 2026): the Idaho Department of Health and Welfare Rural Health Transformation project narrative, for the remote-patient-monitoring activity named in the state's first-year award; the Idaho Medicaid General Provider handbook, for coverage of remote monitoring for established patients; and a commercial remote-monitoring administrative policy dated August 2026 from the practice's largest commercial payer. No application, award or coverage is asserted.
- **CoachCare Care Management Programs standard operating procedures, March 2026:** the shared clinical alert and escalation decision logic, the trend definitions, the emergent and urgent communication protocol, the three-way escalation routing, the post-discharge three-touch sequence and the discharge decision flow reproduced in Section 5.
- **CoachCare Value Analysis for Family Health Center, 2026:** every financial, enrollment, clinical-output and operational figure in Sections 6, 7, 8 and 9, including the sensitivity runs, built on 2,500 Medicare patients with 2,000 in scope, 9 referring clinicians, one on-site enrollment specialist at 80 enrollments a month, and the CY2026 fee schedule at the Idaho locality 00 amounts for chronic care management and remote physiologic monitoring.

A note on how this report handles counts and names

Unique patients and program enrollments are different numbers. At month 24 the program holds 905 active program enrollments belonging to 590 unique patients, because a patient may hold a care-management enrollment and a monitoring enrollment at the same time. Wherever this report gives a patient count it says patients; wherever it gives an enrollment count it says enrollments.

The panel figure is the forecast's basis; the claims describe its shape. The 2,500 covers all payers. The 2,746 beneficiary-clinician pairs in the CY2024 claims file are fee-for-service only, count a patient once per clinician seen, and omit any clinician-and-code line under 11 beneficiaries, so the two numbers describe different things and are not in conflict.

No individual at the practice or its partners is named in this report. Clinicians, owners, administrators and accountable-care personnel are described by count and role only, and the practice's ACO by its model and track rather than by name.