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

Consolidated Medical Practices of Memphis, PLLC

A physician-owned group formed in 2008 to keep primary care in Memphis independent: 22 locations, primary care and eight specialties on one eClinicalWorks system, with chronic and principal care management already running across its clinicians

Remote Care Service Line Optimization Report

2026 Strategy Report

One care-management program CMPM can stand behind in an audit: the chronic and principal care management its clinicians already run, moved to a CoachCare care team inside eClinicalWorks with every billed month documented in the chart, and remote monitoring added for primary care, endocrinology and cardiology patients, billed under the group's own NPIs at Tennessee's CY2026 Medicare rates

Purpose of this document

Prepared by CoachCare, October 2026, as a discussion document for the physician owners and leadership of Consolidated Medical Practices of Memphis (CMPM). It is the companion to the group's remote care strategy page and makes the same case at report length: what Medicare requires behind every care-management claim, how the program the group already runs moves into eClinicalWorks without starting over, how it grows into remote monitoring and new care management across primary care, endocrinology and cardiology, and what that returns over 24 months at Tennessee's rates.

CMPM is not starting from zero. Its clinicians bill chronic and principal care management today, its endocrinology practices have run remote monitoring for part of their diabetes panel, and thirteen of its clinicians bill transitional care after hospital stays. This report takes that program as the starting point.

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Executive Summary

Consolidated Medical Practices of Memphis began in 2008, when six small internal medicine practices combined to stay independent, and it is still owned by its physicians. It now runs 22 locations across Memphis, Germantown, Collierville, Bartlett and Cordova, with nearly 40 physicians and more than 50 nurse practitioners, physician assistants and other clinicians, in primary care and eight specialties, on one eClinicalWorks system. In 2026 its clinicians bill inside an Enhanced-track Medicare Shared Savings Program ACO, the two-sided track.[1]

CMPM already runs care management between visits. Its clinicians bill chronic care management and principal care management across the group today, with an outside service doing the monthly work. A program at that scale is only as strong as the record behind each claim, so the question this report answers is how the group moves that program into eClinicalWorks, with every billed month documented where a reviewer would look for it, and what it can grow into once it is there.

> **The observation this report is built on**
>
> **One program, documented in the chart, that the group can stand behind in an audit.**
>
> Medicare pays for care management when the work is done and documented: consent on file, a care plan in the chart, and clinical-staff time that meets each code's threshold, every month a claim goes out. CoachCare moves the patients CMPM has already enrolled to a care team working inside eClinicalWorks, documents every month before it is billed, and adds remote monitoring and new care management for the primary care, endocrinology and cardiology patients who qualify.

What the Value Analysis returns

Full program	Year 1	Year 2	24 months
Unique patients, end of period	3,251	4,457	4,457
Contribution margin	**$1,121,982**	**$2,359,167**	**$3,481,149**

CoachCare Value Analysis: about 2,000 patients moved from today's program in six monthly waves, plus new remote monitoring and chronic care management in primary care (49 clinicians, panel 24,500) and new remote monitoring and principal care management in endocrinology and cardiology (18 clinicians, panel 12,800), CY2026 Tennessee locality 35 amounts. Contribution margin is what CMPM keeps from the program.

CMPM can take this two ways, and both return a positive contribution margin. CoachCare can move the program the group runs today and stop there: **$1,528,586 of contribution margin over 24 months**, for the patients already enrolled. Or CoachCare can move it and grow it, the forecast of record above, reaching 4,457 unique patients by month 24.

1. **Today's patients move first, without starting over.** About 2,000 patients (an estimate; the claims support 900 to 3,000) move in six monthly waves of about 333. Their consent is recorded to the CMPM clinician who bills for them, so a change in who staffs the program does not by itself require new consent. The moved patients carry $1,456,815 of contribution margin over 24 months.
2. **Every billed month is documented before it is billed.** Consent, the care plan and the clinical-staff time each code requires are recorded in eClinicalWorks, and the claim is built there only when the month is complete, for the clinician to sign (Section 3).
3. **Growth follows a staffing plan.** The forecast holds new enrollment to what one care team can onboard well: no more than 1,500 new patients a year. New enrollment from 67 referring clinicians and two

[1] medicalofmemphis.com, retrieved October 26, 2026: about-us, providers, services and locations pages. CMS Shared Savings Program ACO Participants, PY2026 (Enhanced track) and PY2022 (BASIC track, level D).

enrollment specialists reaches 1,492 new patients at month 12 and 2,989 at month 24, alongside the moved patients.

4. **A staffing plan the group does not hire.** About 20 CoachCare care managers by month 12 and 27 by month 24, at 165 patients each. None of it is CMPM headcount.
5. **Positive from month 1.** The moved patients bill from the first wave, so contribution margin is $8,333 in month 1 and climbs to $228,159 in month 24.
6. **The CY2027 proposed rule takes $345,239 off the 24-month contribution margin.** With enrollment held constant it leaves $3,135,910 instead of $3,481,149. The cut lands on remote-monitoring device supply; chronic and principal care management rates move −2.0% and −0.4% (Section 9).

The ask is a working session: confirm how many patients are enrolled today and under which codes, review a month of the program's documentation together, scope the eClinicalWorks integration, and choose the practices whose patients move first.

1. Why Now: Medicare Pays for Documented 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 group whose Medicare patients carry hypertension, diabetes and heart disease together, across primary care and its own specialty practices, those weeks decide how the year goes.

The shift	What it means for CMPM
1. From visits to panels	Blood pressure drifts in the months between visits, glucose climbs in them, and the admission that follows starts in them. Managing a panel means knowing which of roughly 37,300 Medicare patients in primary care, endocrinology and cardiology are trending the wrong way before they reach an emergency department.
2. Two-sided accountability, starting this year	In 2026 the group's clinicians bill inside an Enhanced-track Medicare Shared Savings Program ACO, sharing savings and losses against a spending benchmark; in 2022 they were on the one-sided BASIC track.
3. Value-based care, with Medicare Advantage at 48.2%	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 Shelby County about 48.2% of Medicare beneficiaries are in Medicare Advantage. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families.
4. Documented time between visits	Chronic and principal care management pay for clinical-staff time in a calendar month, under consent and a care plan; remote monitoring pays when a patient takes readings on 16 or more days, and two codes new in 2026, 99445 and 99470, pay for shorter months. At Tennessee's CY2026 rates, 99490 pays $62.29, and one hypertensive patient on remote monitoring and chronic care management is worth **$157.95 a month** in Medicare allowed charges. What Medicare checks is the record behind each month.

2. CMPM Today: Independent Primary Care Since 2008

CMPM is an internal medicine group at its core that grew a specialty bench around it: one record, one billing number and one physician ownership across 22 locations. Its primary care Medicare panel is large and older than average, and the group already runs the visit rhythm a care-management program needs, from the annual wellness visit to the call after a hospital stay.

2.1 Twenty-two locations, one record

Part of the group	Locations	What it means for this program
Primary care	Nine practices: Cresthaven Internal Medicine and Collierville Medical Specialists at the Great Oaks and Collierville campuses, East Memphis Internal Medicine, Complete Health Care Center, Memphis Internal Medicine and Pediatrics, Mid City Medical Associates, and three practices that carry a physician's name	The primary care arm: 49 clinicians, a Medicare panel of about 24,500, remote monitoring and chronic care management
Endocrinology and diabetes	Seven practices across Memphis, Germantown, Bartlett and Cordova	Half of the specialty arm: remote monitoring and principal care management for the patient whose diabetes drives the risk
Cardiology	Two practices at the Great Oaks campus	The other half: daily weight and blood pressure, and principal care management for heart failure and resistant hypertension (18 specialty clinicians, panel about 12,800)
Other specialties and services	Infectious disease, rheumatology, allergy, OB-GYN, hematology-oncology, pediatrics and an imaging center	Patients already enrolled from these practices move with the rest; new enrollment here is not in the forecast

medicalofmemphis.com, October 26, 2026. Clinician counts from CMS CY2024 claims and the 2026 Doctors and Clinicians and PECOS files.

2.2 What the CY2024 claims say

The CY2024 Medicare files were queried for every clinician on the group's billing number. The profile below is the traditional-Medicare panel its primary care clinicians saw; chronic condition shares are weighted across the 19 highest-volume primary care clinicians (11,196 traditional-Medicare patients).[2]

Panel	CY2024	Condition	Share
Average age	**75.4**	**Hypertension**	**74% (a floor)**
Weighted HCC risk score	**0.95**	High cholesterol	75% (a floor)
Dual-eligible, where reported	3%	Arthritis	49%
Established-patient office visits	**About 26,700**	Ischemic heart disease	31%
Annual wellness visits	**About 6,800**	**Diabetes**	**25%**
Depression screening	About 2,600	**Chronic kidney disease**	**17%**
Transitional care	**About 390 patients, 13 clinicians**	Depression	17%
Specialty office visits (endocrinology, cardiology)	About 9,500 patient relationships, 18 clinicians	**Heart failure**	**11%**
Atrial fibrillation	16%	COPD	10%

CMS Medicare Physician & Other Practitioners, CY2024. Visit and wellness rows are the primary care clinicians; the specialty row counts established-patient office-visit relationships (99213 and 99214). CMS suppresses lines under 11 beneficiaries.

This is the panel care management is built for: hypertension in at least three of four patients, diabetes in one in four, kidney disease, heart disease and atrial fibrillation common, and an average age of 75.4. Most primary care patients qualify for chronic care management; in endocrinology and cardiology, the patient whose one condition drives the risk fits principal care management.

[2] Medicare Physician & Other Practitioners, CY2024: by Provider and Service for the primary care candidates on the roster (49 classified as primary care) and for the endocrinology, cardiology, rheumatology and oncology physicians; by Provider for the 19 highest-volume primary care clinicians. Prevalence weighted by beneficiaries; CMS caps each clinician's published prevalence at 75%.

2.3 The care management CMPM already runs

CMPM's clinicians bill chronic and principal care management today, with an outside service doing the monthly work, by the group's own description across about 120 providers. The latest claims CMS has published are for CY2024: that year, 8 clinicians billed 99490 for about 940 traditional-Medicare patients (about 430 billed patient-months a month), one endocrinology practice also billed remote monitoring, and no principal care management line appears. A program described today as running across the group and including principal care management is larger than the CY2024 file shows, which is why the enrolled count is the first thing to confirm.[3]

Estimate of patients enrolled today	Patients	How it is built
Low	900	The CY2024 traditional-Medicare billing rate (430 billed patient-months a month), grossed up for Medicare Advantage (about 840 a month) and for months not billed
The forecast	**2,000**	**The CY2024 count of distinct traditional-Medicare patients billed for 99490, grossed up for Medicare Advantage (about 1,800); about 30 per office clinician modeled here**
High	3,000	The CY2024 primary care billing clinicians' monthly rate per clinician, applied to the 67 office clinicians in the two arms

CoachCare estimate from CMS CY2024 claims. The group's own enrollment report replaces it in the first week.

2.4 The market, and the rate basis

Shelby County held 168,074 Medicare beneficiaries in July 2026, and 48.2% of them were in a Medicare Advantage plan. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The group's own payer mix, for the patients enrolled today and for the panel, is the second thing to confirm.[4]

Every practice sits in Tennessee's single statewide payment locality, locality 35, under the Palmetto GBA contractor. Every dollar in this report is priced at those CY2026 amounts.[5]

3. What Medicare Requires Behind Every Billed Month

A care-management claim is a statement that specific work was done for a specific patient in a specific calendar month. What follows is what CMS requires behind each claim in this program, from CMS's own guidance and Physician Fee Schedule rules. Two points shape everything else. CMS does not require an office visit, or a phone call, every month for chronic or principal care management: most of the work is non-face-to-face. It does require that each billed month carry documented consent, a care plan and clinical-staff time that meets the code's threshold.[6]

3.1 Chronic care management

Requirement	What CMS says
Who qualifies	Two or more chronic conditions expected to last at least 12 months, or until death, that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline

[3] CMS by Provider and Service, CY2024, and the CMS Part B remote-care extract for the roster: 99490 billed by 8 clinicians for 939 beneficiaries and 5,203 services; no 99424 to 99427 line; CMS suppresses lines under 11 beneficiaries. Medicare paid the roster $313,926 for care-management, monitoring and transitional-care codes in CY2024. Claims for CY2025 are not yet published.

[4] CMS Medicare Monthly Enrollment, Shelby County, Tennessee, July 2026: 168,074 beneficiaries, 81,043 in Medicare Advantage and other health plans.

[5] CY2026 Physician Fee Schedule (CMS-1832-F), Palmetto GBA carrier 10312, Tennessee locality 35: geographic indices work 1.000, practice expense 0.909, malpractice 0.537; conversion factor $33.4009.

[6] CMS, Chronic Care Management Services, MLN909188, June 2025 (eligibility, consent, initiating visit, time thresholds, care plan, access and certified EHR requirements for 99490, 99439, 99487, 99489, 99491; principal care management 99424 to 99427).

Requirement	What CMS says
Consent	Verbal or written, documented before services begin. The patient is told the service is available, that cost-sharing applies, that only one practitioner can bill it in a month, and that they can stop at any time. Consent is needed once, unless the patient changes to a different billing practitioner
Initiating visit	A comprehensive office visit, annual wellness visit or initial preventive exam for a new patient or one not seen in the past year, with care management discussed at that visit
Time	99490: at least 20 minutes of clinical-staff time in the calendar month, directed by the billing practitioner; 99439 each additional 20; 99487 and 99489 for complex care (60 minutes, then each 30); 99491 for 30 minutes of the practitioner's own time. Time counted for one code cannot be counted for another
Care plan	An electronic, comprehensive care plan, established, implemented, revised or monitored, available inside and outside the practice, with a copy to the patient
Access and record	Access at any hour, for urgent needs, to someone who can reach the record (the practice's after-hours coverage), a designated care-team member for continuity, and certified EHR technology for the core clinical record

CMS MLN909188, Chronic Care Management Services, June 2025; CY2026 Physician Fee Schedule final rule (CMS-1832-F).

3.2 Principal care management

Principal care management (99424 to 99427) is the single-condition counterpart: one complex chronic condition expected to last at least three months that places the patient at significant risk of hospitalization, acute exacerbation or decompensation, functional decline or death, managed under a disease-specific care plan, typically because it needs frequent medication changes or its management is complicated by other conditions. 99426 pays for the first 30 minutes of clinical-staff time in a calendar month ($63.80 in Tennessee) and 99427 for each additional 30 ($50.72); 99424 and 99425 are the practitioner-time versions. Less than 30 minutes in a month is not billable. Consent and the initiating visit work as they do for chronic care management. In this program it is the specialty arm's care-management code: the endocrinology patient whose diabetes drives the risk, the cardiology patient with heart failure.[7]

3.3 Remote monitoring and advanced primary care management

Remote physiologic monitoring has two requirements a care-management month does not. The device code (99454) needs readings on at least 16 days in a 30-day period, or 2 to 15 days for 99445, new in CY2026; and the management code (99457, or 99470 for 10 to 19 minutes, also new in CY2026) needs at least one real-time, interactive conversation with the patient or caregiver in the month. That is the one place in this program where Medicare requires a live exchange every month. Remote monitoring can be billed alongside chronic or principal care management for the same patient, as long as no minute is counted twice.[8]

Advanced primary care management (G0556 to G0558) pays a monthly amount, tiered by complexity, with no minute threshold, to a practice that furnishes the whole-panel primary care elements under consent. It bills in place of chronic and principal care management for the same patient and month. It is named here at zero dollars.[9]

3.4 What CoachCare documents, every month

Every billed month carries	Where it lives	Who does it
Consent, with the date and the notice CMS requires	The patient's chart in eClinicalWorks	Checked for every patient in the move; taken at enrollment for new patients

[7] CMS MLN909188 (principal care management, 99424 to 99427); CY2022 Physician Fee Schedule final rule (CMS-1751-F), which replaced G2064 and G2065 with 99424 to 99427.

[8] CY2021 Physician Fee Schedule final rule (CMS-1734-F): 'interactive communication' for 99457 means real-time synchronous, two-way audio interaction that can be enhanced with video. CY2026 final rule (CMS-1832-F): 99445 and 99470. CMS MLN909188: RPM may be billed with CCM or TCM.

[9] CY2025 Physician Fee Schedule final rule (CMS-1807-F): APCM G0556 to G0558, effective January 1, 2025.

Every billed month carries	Where it lives	Who does it
A care plan, current	eClinicalWorks, shared with the patient	Reviewed in the patient's first month with CoachCare, revised as the condition changes, signed by the clinician
Time that meets the code	A time log by person, date and activity	CoachCare care managers; 20 minutes for 99490, 30 for 99426, each add-on only when its full increment is met
A conversation with the patient	The care-management note	A monthly call as the care team's standard; for remote monitoring, the real-time exchange 99457 requires
The claim	eClinicalWorks claim queue	Built only when the month is complete; reconciled and filed by CMPM under its own NPIs

A month that does not meet its code is not billed. That rule costs some months, and the forecast assumes it: chronic and principal care management bill in 95% of enrolled months, the first add-on in a share of them, and remote monitoring device supply only when the reading days are there.

4. The Program: Move It, Then Grow It

4.1 The clinical and billing stack

Program	Who it fits on this panel
Chronic care management (CCM, 99490, 99439)	Primary care patients with two or more chronic conditions: hypertension with diabetes, kidney disease, heart disease or COPD
Principal care management (PCM, 99426, 99427)	Endocrinology and cardiology patients whose one condition drives the risk: uncontrolled diabetes, heart failure
Remote physiologic monitoring (RPM, 99453, 99454 or 99445, 99457, 99458, 99470)	Hypertension and diabetes first in primary care; glucose, weight and blood pressure in the specialty practices
Transitional care management (TCM, 99495, 99496)	Every panel patient discharged from a hospital or observation stay; already billed, not in the forecast

Codes	What they pay for	CY2026 Tennessee locality 35
99490 · 99439	Chronic care management, first 20 minutes · each additional 20	$62.29 · $47.35
99426 · 99427	**Principal care management, first 30 minutes · each additional 30**	**$63.80 · $50.72**
99453	Remote monitoring setup and education, once	$19.49
99454 · 99445	Device supply, 16+ days · 2 to 15 days in 30 (99445 new in CY2026)	$47.24 · $47.24
99457 · 99458 · 99470	Treatment management, first 20 minutes · each additional 20 · 10 to 19 minutes (new)	$48.42 · $39.01 · $24.38
99495 · 99496	Transitional care, visit within 14 days · within 7 days	$206.17 · $279.97
G0556 · G0557 · G0558	Advanced primary care management, levels 1 to 3	$15.39 · $50.60 · $110.15
99484	Behavioral health integration, 20 minutes a month	$54.30

CY2026 non-facility amounts, Tennessee locality 35 (Palmetto GBA, carrier 10312), ZIP 38138. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The forecast prices every patient at the Medicare amount.

4.2 Moving the patients already enrolled

The patients CMPM has already enrolled are the program's first patients. They are not re-enrolled: the forecast counts them once, in the move, and new enrollment draws only on eligible patients who are not yet in the program. Of the about 2,000 modeled, about 1,316 are primary care patients on chronic care management and about 684 are specialty patients on principal care management, split by each arm's share of office visits until the group's own report replaces the split.

Window	What happens
Weeks 1–4: inventory	Every enrolled patient exported from eClinicalWorks with the code billed, the consent date, the care plan and the last documented contact; practices ordered into six waves
Month 1: integration live	The eClinicalWorks interface, worklist and claim queue; care managers assigned by practice; clinician sign-off routed in the chart
Months 1–6: six waves	About 333 patients a month: consent confirmed, care plan reviewed and updated, a first call from the assigned care manager, a first documented month, then the claim
Month 7 on: one program	New enrollments from primary care, endocrinology and cardiology join the same monthly loop and the same report

Moved patients leave the program at 1.5% a month, the rate of a book that is already established, so about 1,759 remain at month 12 and 1,468 at month 24; replacement comes from new enrollment. Each moved patient bills the same codes, at the same rates, as a new patient in the same program.

4.3 The care team, and the hours it keeps

CoachCare hires, trains and manages the care managers, at 165 patients each: about 20 for the 3,300 unique patients at month 12 and about 27 for the 4,500 at month 24. Two on-site enrollment specialists on CoachCare's payroll, one for primary care and one for the specialty practices, work the schedules beside the group's medical assistants; telephonic outreach reaches the rest. Devices are cellular, with no Wi-Fi, smartphone or pairing needed. Monitoring runs on business hours: devices transmit daily, and care managers review readings, run outreach and send escalations Monday to Friday, 8 a.m. to 5 p.m. in the patient's time zone, the hours the practices keep. Patients are told at consent to call 911 for an emergency and their practice for anything urgent.

4.4 Transitional care, APCM and behavioral health

Transitional care. CMPM already bills it, for about 390 traditional-Medicare patients in CY2024 across thirteen clinicians. The CoachCare care team can make the two-business-day contact and medication reconciliation after every discharge the group learns of, the group furnishes the visit and bills the code, and care management carries the patient past day 30. **Advanced primary care management** is the named next lever for the primary care arm, at zero dollars; which patients move to it is a program decision to make together. **Behavioral health integration** (99484, $54.30 a month) can run on the same care-manager calls once the program is running; depression appears on 17% of the primary care panel's claims.

5. 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. The evidence behind every billed month (time logs, care plans, vitals and the monthly care summary) is attached to each chart every month, enrollment status is visible at every location, and a flagged patient reaches the first day of service in under five days.[10] CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically.

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

Integration pillar	What happens in eClinicalWorks
Integrated enrollment	Flags in the chart prompt the order for patients who meet criteria the group's clinicians approve
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 sees home averages at the next visit
Compliance documentation and care summary	Time logs, the care plan and the care summary attached monthly for every enrolled patient
Automated claim generation	Claims built once a code's requirements are met and documented; the group's billing team reconciles and files them

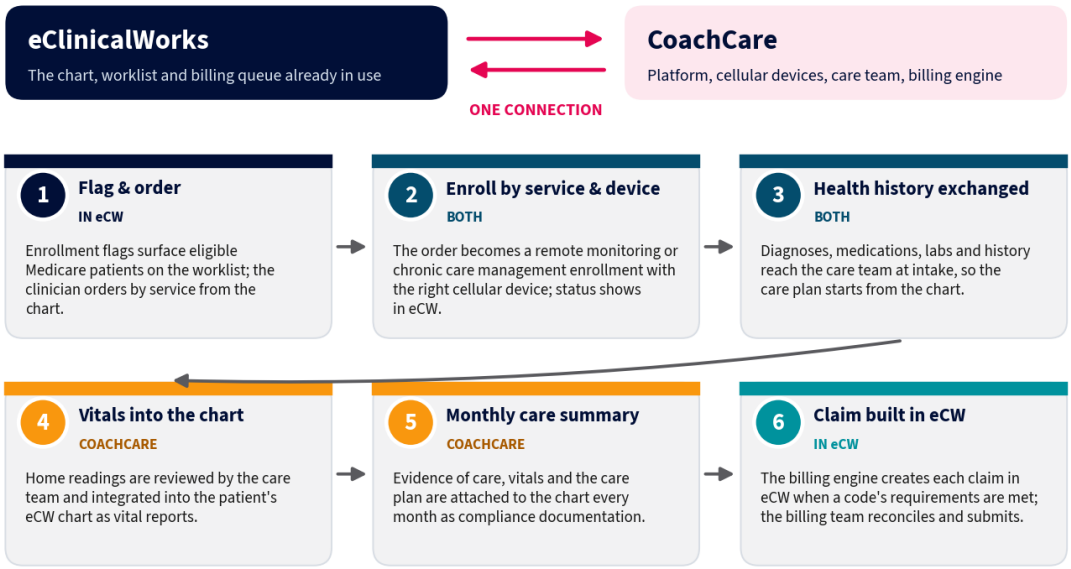


Figure 1. From a flag in the chart to a claim: the six steps CoachCare and eClinicalWorks run every month for every enrolled patient. CoachCare eClinicalWorks integration overview.

The build runs alongside the inventory, so the first wave moves in month 1.

6. 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 practice, before the first patient enrolls.[11]

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

6.1 One shared escalation engine

Branch	The rule	Why
Critical value	**Escalate to the practice, regardless of symptoms**	No practice preference can suppress it. A critical reading on its own goes to the practice, 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

6.2 The emergent pathway

Non-negotiable, and stated as such

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

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

If the patient refuses. The practice is called with the patient still on the line and directs care; if the practice 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.

6.3 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 practice notified
Needs the practice	A critical reading, or an out-of-range reading or trend confirmed after a retake	The clinician or nurse each practice 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 practice. Care managers work readings and escalations Monday to Friday, 8 a.m. to 5 p.m. local patient time, which matches the hours the practices are open, so every escalation lands while a clinician is in the building. A reading that arrives on a weekend or overnight is worked the next business day, and the patient's standing instruction for anything urgent is the practice's own line, or 911.

6.4 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

6.5 Built for an older, phone-first panel

The group's traditional-Medicare primary care patients average 75.4 years old. 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 group's 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 practice; without an instruction from the practice, discharge from monitoring follows at 180 days, and discharge criteria always belong to the group's clinicians.

7. Value Analysis: The 24-Month Forecast

7.1 The headline economics

The forecast has three layers: the patients moved from today's program (about 2,000, in six monthly waves), new remote monitoring and chronic care management in primary care (49 clinicians, a Medicare panel of 24,500), and new remote monitoring and principal care management in endocrinology and cardiology (18 clinicians, a panel of 12,800), at the CY2026 Tennessee locality 35 amounts. No transitional care, APCM, behavioral health integration or ACO payment is in these numbers.[12]

Full program	Year 1	Year 2	24 months
Patients moved from today's program, active at period end	1,759	1,468	1,468
New patients, unique, at period end	1,492	2,989	2,989
Unique patients, end of period	3,251	4,457	4,457
Contribution margin	**$1,121,982**	**$2,359,167**	**$3,481,149**

Year one is anchored by the moved patients, who bill from the first wave; year two is larger because new enrollment keeps climbing, from 1,492 new patients active at month 12 to 2,989 at month 24. Year two returns **$2,359,167 of the $3,481,149 contribution margin**.

7.2 Two deployments, side by side

Each deployment is shown on its own, and the full program is the forecast of record. Moving today's program alone keeps the patients the group has already enrolled, documented in the chart, with no new enrollment. Growing it adds remote monitoring and new care management across primary care, endocrinology and cardiology, and adds $1,952,563 of contribution margin over 24 months.

24 months	Move today's program	Move it, then grow it
Contribution margin	**$1,528,586**	**$3,481,149**
Unique patients at month 24	1,468	4,457

[12] CoachCare Value Analysis for CMPM, 2026 (two workbooks, primary care and specialty, and the program-move layer), the source of all Section 7 figures; sensitivity runs change one input at a time.

24 months	Move today's program	Move it, then grow it
Care managers at month 24	9	27
Hospitalizations avoided	Not modeled (no remote monitoring)	About 201

7.3 Where the patients come from

Program	Active enrollments, month 12	Active enrollments, month 24
Chronic care management, moved	1,158	**966**
Principal care management, moved	602	**502**
Remote physiologic monitoring, new	1,259	**2,514**
Chronic care management, new	542	**1,080**
Principal care management, new	234	**503**
Unique patients	**3,251**	**4,457**

Remote monitoring is the program that grows fastest and produces the readings, alerts and avoided admissions. The moved patients carry the program from the first month, and the rest is new chronic and principal care management. At month 24 the program holds 5,565 active program enrollments belonging to 4,457 unique patients, because most care-management patients enrolled from now on are also monitored.

7.4 The ramp, month by month

Contribution margin is $8,333 in month 1, because the first wave of moved patients bills from the start. The moved patients are all in by month 6, and new enrollment builds on the staffing plan, so the monthly contribution margin climbs every month of the forecast, to $228,159 in month 24. Cumulative contribution margin passes $335,847 at month 6, $1,121,982 at month 12 and $3,481,149 at month 24.

Month	Patients moved, active	New enrollments, active	Monthly contribution margin	Cumulative contribution margin
M1	333	43	**$8,333**	$8,333
M2	662	105	$30,359	$38,693
M3	985	197	$46,977	$85,670
M6	1,926	636	$102,411	$335,847
M12	1,759	2,035	$154,106	$1,121,982
M18	1,607	3,160	$194,738	$2,192,535
M24	1,468	4,097	**$228,159**	$3,481,149

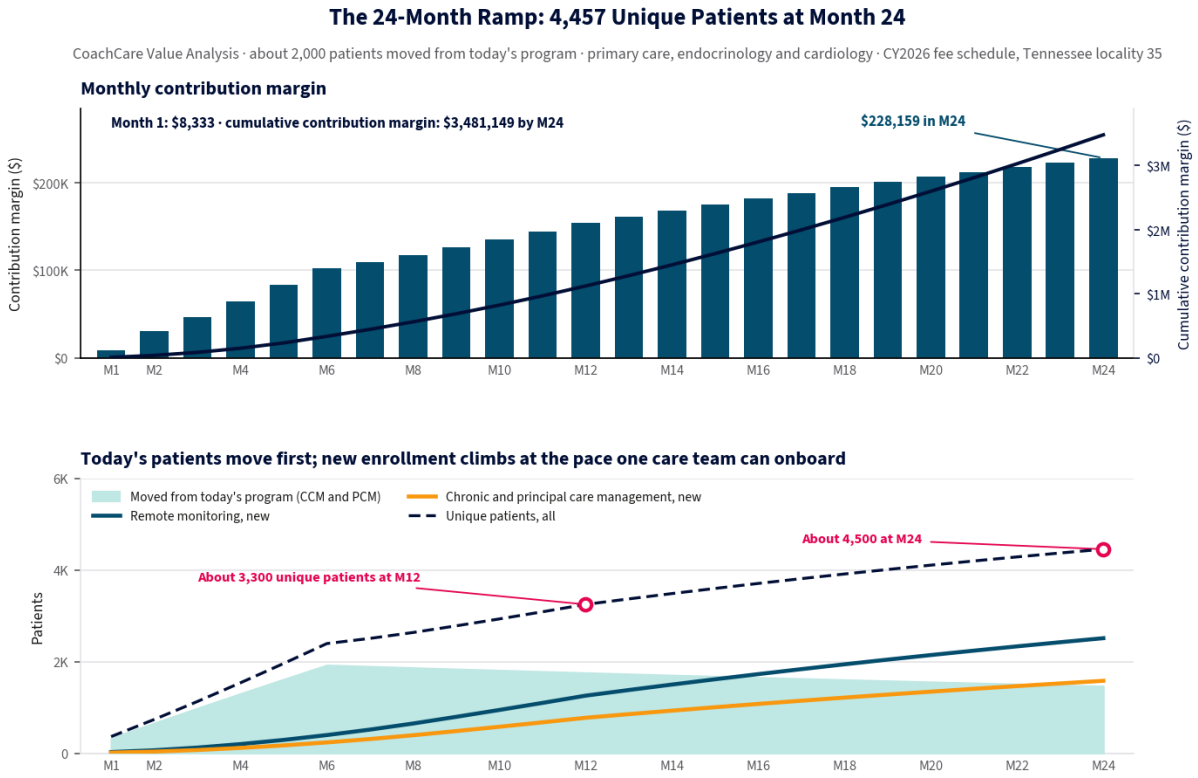


Figure 2. Monthly and cumulative contribution margin, and the census: patients moved from today's program, new remote monitoring, new chronic and principal care management, and unique patients at months 12 and 24. CoachCare Value Analysis, full program.

7.5 A staffing plan sets the pace of growth

Say the constraint out loud

The forecast holds new enrollment to what one care team can onboard well: no more than 1,500 new patients a year. At CMPM that plan, not the size of the panel or the number of referring clinicians, sets the pace of growth. With 67 clinicians referring and two enrollment specialists, demand for new enrollment runs above it in both years, so the forecast holds new enrollment to the plan: 1,492 new patients at month 12 and 2,989 at month 24. The moved patients come on top, in their own six waves.

Read it as a staffing plan. More referring clinicians or a larger panel fill the plan, not exceed it; the number that moves the forecast most is how many patients are enrolled today.

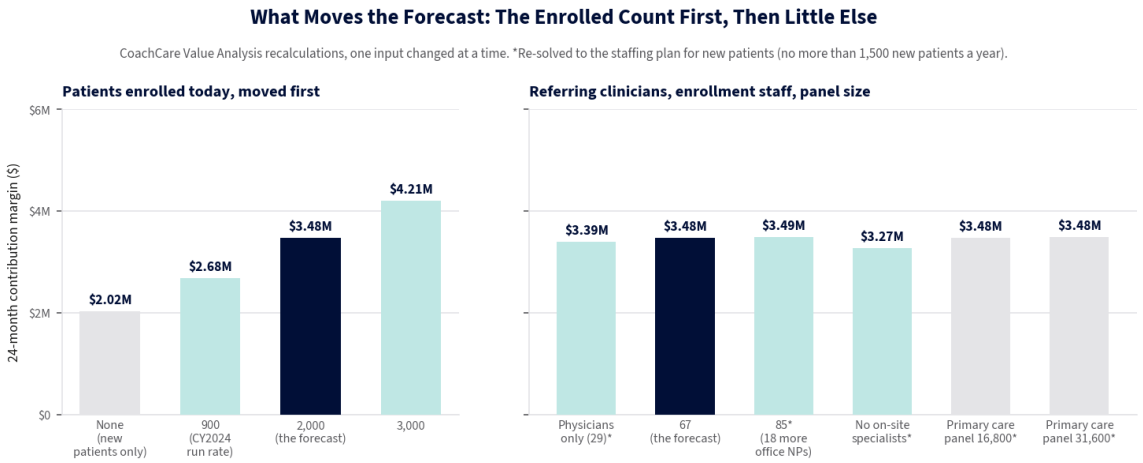


Figure 3. 24-month contribution margin by the number of patients moved from today's program, then by referring clinicians, enrollment staff and panel size. CoachCare Value Analysis recalculations.

Scenario	24-month contribution margin	Unique at M12	Unique at M24
Base: about 2,000 moved; 67 referring clinicians; two enrollment specialists	**$3,481,149**	**3,251**	**4,457**
900 moved (the CY2024 billing rate)	$2,679,857	2,284	3,649
3,000 moved	$4,209,557	4,131	5,190
Nothing moved (new patients only)	$2,024,333	1,492	2,989
The 29 physicians referring alone	$3,389,732	3,165	4,365
85 clinicians (18 more office nurse practitioners)	$3,491,401	3,252	4,453
No on-site enrollment specialists	$3,268,686	3,073	4,274
Primary care panel 16,800	$3,475,785	3,252	4,453
Primary care panel 31,600	$3,483,721	3,252	4,453
Specialty panel halved (patients shared with primary care)	$3,487,469	3,252	4,453

CoachCare Value Analysis recalculations, one input changed at a time. Runs that change new enrollment are re-solved to the same staffing plan for new patients.

The enrolled count is the swing: from 900 to 3,000 moved patients, 24-month contribution margin runs from $2,679,857 to $4,209,557. Everything else moves it less, because new enrollment is already at the staffing plan: with the 29 physicians referring alone the forecast is $3,389,732, and adding 18 more office nurse practitioners changes it by $10,252.[13]

7.6 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	**316,100**	Blood pressure, glucose and weight values arriving between visits
Claims and billable units, new enrollment	**92,741**	Created in eClinicalWorks for the group's billing team
Care-management tasks, new enrollment	185,482	Outreach, care-plan updates and medication reviews

[13] Panel sizes from the group's CY2024 claims: primary care 18,207 established-visit relationships × 0.70 ÷ (1 − 0.482) = 24,613 (modeled 24,500; range 16,800 to 31,600); specialty 9,461 relationships × 0.70 ÷ (1 − 0.482) = 12,790 (modeled 12,800). Patients seen in both arms are not deduplicated; the halved specialty panel bounds that overlap.

Output over 24 months	Volume	What it represents
Patient conversations, new enrollment	27,822	Live contacts across 1,546 hours of call time
Care-team hours, new enrollment	**40,958**	**About 19.7 full-time-equivalent years of work the group does not employ, before the moved patients' hours**
Hospitalizations avoided	**About 201**	Admissions that never post against the ACO's spending benchmark

Annual admission rate among monitored patients	20% (the workbook's baseline)	30%	40%	50%
Hospitalizations avoided over 24 months	201	301	**401**	502

CoachCare Value Analysis, full program, remote-monitoring patient-months only. The first patients enrolled, uncontrolled hypertension with diabetes, kidney disease or heart failure, run closer to a 40% admission rate, which puts the figure near 401.

7.7 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.[14]
- **Readmissions, at the same practice.** Across 26,689 patients, the 30-day readmission rate was 7% for CoachCare patients against 15% for the rest.[15]
- **Heart failure.** Iowa Heart enrolled 450 advanced heart-failure patients and recorded zero readmissions over six months.[16]

8. Quality: The Measures the ACO Is Scored On

The Shared Savings Program scores every ACO each year on a fixed set of quality measures, and the score decides whether the ACO meets the program's quality standard. Five move with this program's monthly work, and CMPM's patients count in all five.[17]

Measure	What it counts	What the program does each month
Q236 Controlling high blood pressure	Hypertensive patients whose latest blood pressure is under 140/90	Home averages give an accurate reading of control and a monthly chance to act
Q001 Diabetes: A1c poor control (> 9%)	Patients with diabetes whose latest A1c is above 9%; lower is better	Care management keeps A1c testing and medication changes on schedule; home glucose shows slippage early
Q484 Admissions, multiple chronic conditions	Unplanned admissions among patients with several chronic conditions, from claims	Daily readings, outreach on a confirmed trend, a fixed cadence after any admission
Q134 Depression screening and follow-up	Patients screened, with a follow-up plan when the screen is positive	PHQ-2 and PHQ-9 in monthly care management; positives routed to the group
Q479 Hospital-wide 30-day readmission	Unplanned readmissions within 30 days of discharge, from claims	A call within two business days, devices home before the follow-up visit

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

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

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

[17] Shared Savings Program quality reporting through the APM Performance Pathway: measures 001, 134 and 236 reported by the ACO; 479 and 484 calculated by CMS from claims.

Two of the five come from claims, so an admission that does not happen does not count. With hypertension in at least three of four of the group's Medicare patients, Q236 covers most of the panel; the primary care clinicians already screen about 2,600 patients for depression a year, and monthly care management supplies the follow-up half of Q134.

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

CMS published its proposed CY2027 physician fee schedule in July 2026. The comment period closed September 14, 2026; the final rule is expected in early November 2026 and takes effect January 1, 2027. Until it is final, every figure in this report uses CY2026 rates. The proposal cuts the remote-monitoring device-supply codes. Every code in this forecast was repriced at Tennessee locality 35 on the forecast's own billing mix, with enrollment held constant.[18]

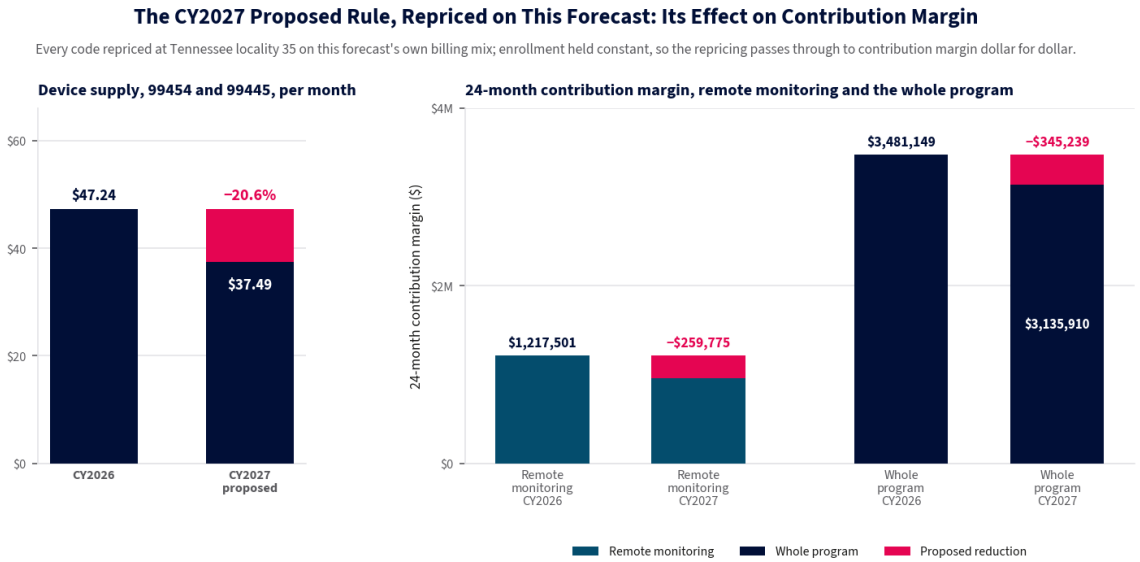


Figure 4. The CY2027 cascade on this forecast: the one code CMS proposes to cut, then the 24-month contribution margin of remote monitoring and of the whole program at CY2026 and proposed CY2027 rates, with the reduction in coral. Enrollment held constant.

Level	CY2026 rates	Proposed CY2027 rates	What changes
Device supply, 99454 and 99445	$47.24 a month	**$37.49 a month, −20.6%**	The code CMS proposes to cut
Remote monitoring, change in contribution margin	—	**−$259,775**	Device supply is about a third of the monitoring basket
Chronic and principal care management, change in contribution margin	—	−$85,463	Routine rate changes only (−2.0% and −0.4%); not targeted
The whole program, 24-month contribution margin	**$3,481,149**	**$3,135,910 (−$345,239)**	Enrollment held constant, so the repricing passes through dollar for dollar

With enrollment held constant, every dollar of repricing comes off contribution margin: −$259,775 from remote monitoring and −$85,463 from chronic and principal care management, which leaves $3,135,910 over 24 months. The care-management codes that carry the moved patients are barely touched. CoachCare will rerun the forecast at the final rates.

[18] CMS-1848-P, published July 2026. CoachCare repricing at Tennessee locality 35, conversion factor $32.8409 against $33.4009.

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%
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%
99426	Principal care management, first 30 minutes	$67.80	$67.00	−1.2%

CY2026 Addendum B and CMS-1848-P proposed CY2027 Addendum B, national non-facility amounts; the repricing above uses Tennessee locality 35 amounts, and the two bases do not reconcile to the dollar, by design.

10. Implementation Roadmap

10.1 Who runs what

Function	CoachCare	CMPM
Moving today's program	Inventory from eClinicalWorks; consent check; care-plan review; first call and first documented month for every moved patient, in six waves	Shares the enrolled list and the program's records; sets the wave order; manages notice on today's arrangement
New enrollment	Registry flags in eClinicalWorks; two on-site enrollment specialists; telephonic outreach; devices shipped, cellular-paired and replaced	Approves criteria and target lists; clinicians order at the visit
Monitoring, care management and escalation	Reading review, monthly care-management calls, business-hours alert triage and the post-discharge cadence, at 165 patients per care manager	**Sets thresholds and routing for each practice; receives escalations; signs care plans**
Documentation, billing, reporting	Time logs, care plans and the monthly care summary in eClinicalWorks; claims built only for complete months; operational and clinical outcomes reports by practice	**Reconciles and files under its own NPIs; keeps the revenue; names a program lead**

10.2 The model inputs

Input	Value in this forecast
Patients moved	**About 2,000 (estimate; range 900 to 3,000), six monthly waves; 1,316 on chronic care management, 684 on principal care management; 1.5% monthly attrition**
Primary care arm	Medicare panel 24,500, all payers; 49 clinicians (20 physicians, 29 nurse practitioners and physician assistants); remote monitoring 65% eligible and 25% accept; chronic care management 75%, 20%, less the patients already enrolled; 3% monthly attrition on new enrollment
Specialty arm	Medicare panel 12,800; 18 clinicians in endocrinology and cardiology (9 physicians, 9 nurse practitioners and physician assistants); remote monitoring 75%, 25%; principal care management 85%, 20%, less the patients already enrolled
Enrollment	Five referrals per clinician a month at 70% follow-through, one CoachCare-funded on-site enrollment specialist per arm and telephonic outreach, building to full pace over the first year; new enrollment held to the staffing plan of no more than 1,500 new patients a year
Billing	99490 and 99426 in 95% of enrolled months; add-ons only when their full increment is met; Medicare's collection waterfall (denials, coinsurance, bad debt)
EMR	eClinicalWorks integration, built during the inventory so the first wave moves in month 1
Rates	CY2026 fee schedule, non-facility, Tennessee locality 35, ZIP 38138; every patient priced at the Medicare amount

10.3 The first 90 days, and after

Window	What happens	Result
Weeks 0–4 **Inventory and charter**	eClinicalWorks workshop with the IT and billing leads; the enrolled list, codes, consent dates and care plans exported; thresholds, routing and the wave order agreed	Integration scoped, protocol signed, waves set
Months 1–6 **Move, and launch**	Six waves of about 333 moved patients; new enrollment starts in primary care and the specialty practices	About 1,926 moved patients active by month 6; 2,563 enrollments overall
Months 7–12 **One program**	All practices on the same protocols; care managers added as the census grows	3,251 unique patients at month 12
Months 13–24 **Scale**	New enrollment at the year-two plan; the APCM mix decided together; behavioral health integration scoped	Year 2: $2,359,167 of contribution margin

10.4 What we would confirm together

1. **How many patients are enrolled today, by practice, code and payer.** It replaces the estimate of about 2,000 and sets the size of each wave.
2. **A month of the program's documentation and billing, reviewed together.** Consent dates, care plans, time logs and billed months for a sample of patients, so the first CoachCare month starts from a known record.
3. **The notice on today's arrangement.** It sets when the first wave can move.
4. **The Medicare chart count by payer, and the Medicare Advantage plans.** Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. Which plans pay chronic and principal care management and remote monitoring is confirmed plan by plan.
5. **Which clinicians refer from the start.** The forecast counts 67; the website lists fewer and the billing roster more.
6. **The eClinicalWorks configuration.** The version, the portal and care-management modules licensed, and any device connection already in place.
7. **Coinsurance at consent.** How the monthly Part B coinsurance is explained, for moved patients and new ones, and who answers billing questions.

11. Recommendations

1. **Move today's program into eClinicalWorks first.** Every billed month documented in the chart before it is billed, starting with the first wave in month 1.
2. **Then grow it across primary care, endocrinology and cardiology.** $3,481,149 of contribution margin over 24 months ($1,121,982 in year one, $2,359,167 in year two), positive from month 1, with nobody hired.
3. **Confirm the enrolled count in week one.** It is the number that moves this forecast most.
4. **Start new enrollment with the hypertension and diabetes patients.** Chronic care management and a cellular cuff in primary care; principal care management and home glucose or weight in the specialty practices.
5. **Extend the transitional care the group already bills.** CoachCare makes the two-business-day call after every discharge the group learns of; the group bills 99495 or 99496.
6. **Aim the monthly work at the ACO's quality measures.** Each of the roughly 201 admissions avoided over 24 months is spending that never posts against the ACO's benchmark.

7. **Keep clinical governance where it is.** The group's clinicians decide; CoachCare does the work and documents it.

CMPM already runs care management across its clinicians. Moved into eClinicalWorks and grown into remote monitoring and new care management, it returns $3,481,149 of contribution margin over 24 months, every month of it documented in the group's own chart.

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.** Chronic and principal care management already run across CMPM's clinicians. CoachCare moves that program into the chart, documents every month of it, and adds remote monitoring where it helps.
- **It runs inside the chart the group already uses.** Consent, care plans, time logs, readings and claims live in eClinicalWorks, where a reviewer would look for them.
- **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, and the revenue stays with a physician-owned group.
- **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 how many patients are enrolled today and under which codes, review a month of the program's documentation together, scope the eClinicalWorks integration, and choose the practices whose patients move first.

Contact

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Prepared by CoachCare for discussion with Consolidated Medical Practices of Memphis. © 2026 CoachCare.

References & Data Sources

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- **CMS care-management rules:** Chronic Care Management Services, MLN909188, June 2025; CY2021 (CMS-1734-F), CY2022 (CMS-1751-F), CY2025 (CMS-1807-F) and CY2026 (CMS-1832-F) Physician Fee Schedule final rules; CMS-1848-P, the CY2027 proposed rule.
- **CMS accountable-care files:** Medicare Shared Savings Program ACO Participants, 2022 and 2026.
- **CMS provider and claims files:** Doctors and Clinicians, July 2026; PECOS reassignment, September 2026; Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024; CMS Part B remote-care codes, CY2019 to CY2024.
- **Medicare payment amounts:** CY2026 Addendum B, RVU file and Tennessee locality 35 geographic indices; proposed CY2027 Addendum B.
- **Market:** CMS Medicare Monthly Enrollment, Shelby County, July 2026.

- **CoachCare:** eClinicalWorks integration overview, 2026; Care Management Programs standard operating procedures, March 2026; Cardiac Solutions and Iowa Heart case studies; and the Value Analysis for CMPM, 2026, the source of every financial, enrollment, clinical-output and operational figure in Sections 7 to 11.

Unique patients and program enrollments are different numbers. At month 24 the program holds 5,565 active program enrollments belonging to 4,457 unique patients, because a newly enrolled patient may hold both a care-management and a monitoring enrollment. Panels cover all payers; the CY2024 claims figures are traditional Medicare only.