COACHCARE | SERVICE LINE STRATEGY

Fountain Hills Medical Center

Fountain Hills Emergency Room & Medical Center · the flagship of Instinctive Healthcare Solutions, a physician-owned Arizona group with two 24/7 freestanding emergency rooms, an adult primary care and urgent care clinic in Fountain Hills, and Mercy Grace Pediatrics & Primary Care in Gilbert

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line for the Medicare primary care panel: remote physiologic monitoring, chronic care management and transitional care at every discharge, billed under the CY2026 rules at Arizona rates, built once on Azalea Health and installed at every clinic the group adds

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of Fountain Hills Medical Center and Instinctive Healthcare Solutions. It brings together the shape of the practice's Medicare panel as the CY2024 claims files show it, the accountable-care position the billing entity holds, the market its patients live in, the two operating models the leadership team asked to see side by side, both models run through the group's own growth plan, and a 24-month financial forecast.

The argument is short. The pieces of a remote care service line are already in place here: an older, multi-chronic panel, a 24/7 emergency room beside the clinic, a two-sided accountable-care contract that pays for fewer admissions, and an Azalea implementation under way. The service line itself is what does not yet exist. This report shows what it returns, who does the work under each model, and how it travels to the next clinic.

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Executive Summary

Fountain Hills Emergency Room & Medical Center opened on April 5, 2021 as the first 24/7 emergency facility in Fountain Hills, Arizona. It is the flagship of Instinctive Healthcare Solutions, a physician-owned group that now runs two freestanding emergency rooms (Fountain Hills, and El Mirage since November 2024), an adult primary care and urgent care clinic beside the Fountain Hills ER, and Mercy Grace Pediatrics & Primary Care in Gilbert. The Fountain Hills facility is licensed by the Arizona Department of Health Services as an outpatient treatment center providing emergency services; it is not a Medicare-certified hospital, and this report treats it as what it is: an emergency room next to a primary care practice.[1]

The panel that matters here is the adult primary care panel across the two clinics: about 4,000 to 5,000 patients in total, of whom **1,500 to 2,000 are Medicare**. The CY2024 Medicare claims files corroborate the shape of it. The two highest-volume internists at the Fountain Hills address carried 809 fee-for-service beneficiaries between them in a county where roughly half of Medicare is in Medicare Advantage. Hypertension runs at 73 to 74% of those beneficiaries, diabetes at about one in five, chronic kidney disease at 16 to 24%, and most of the panel is 75 or older.[2]

Two facts set this account apart from the usual primary care workup. The billing entity, FHMC Operating PC, is a verified PY2026 participant in an **Enhanced-track Medicare Shared Savings Program ACO**, which means the practice already carries two-sided risk on its attributed beneficiaries and is paid, through the ACO, for fewer emergency visits and admissions. And the group is moving both clinics onto **Azalea Health** now, with the implementation in progress. CoachCare is an Azalea integration partner, and the integration can be built inside the window the practice has already opened.[3]

The observation this report is built on

The pieces are in place. The service line is not.

A physician-owned group with a 24/7 emergency room beside its primary care clinic, an older panel where three in four beneficiaries carry hypertension, a two-sided accountable-care contract, a membership program that removes cost-sharing at the point of service, and an Azalea implementation under way has every component of a remote care service line except the service line. CY2024 claims show no care-management or remote-monitoring program at meaningful scale at Fountain Hills. The Gilbert clinic ran a small physician-led remote monitoring and chronic care management program in 2024, which is credit to its clinicians and also the clearest evidence that the work fits this panel. What does not exist is a practice-wide, staffed program that bills every month and travels to the next clinic.

What the Value Analysis returns

	Year 1	Year 2	24 months
Net reimbursement	**$547,561**	**$769,847**	**$1,317,408**
CoachCare fees	$318,611	$437,726	$756,337

[1] Fountain Hills Times, March 2021 (opening April 5, 2021) and November 2021; Daily Independent, November 13, 2024 (El Mirage opening November 11, 2024); Arizona Department of Health Services licensing lookup: Fountain Hills Medical Center Emergency Room, 9700 N Saguaro Blvd, licensed as an Outpatient Treatment Center; El Mirage Emergency Room & Medical Center likewise. Under A.A.C. R9-10-1019 a freestanding emergency room in Arizona is an outpatient treatment center that provides emergency room services; the AHCCCS hospital-based designation requires shared ownership with a hospital. No CMS hospital certification number exists for either facility.

[2] Discovery call, September 3, 2026, for the panel range. CMS Medicare Physician & Other Practitioners by Provider, CY2024: 476 and 333 beneficiaries for the two highest-volume internal medicine clinicians at 9700 N Saguaro Blvd; hypertension 73% and 74%; diabetes 20% and 21%; chronic kidney disease 16% and 24%; 265 of 476 aged 75 or older for the first, 150 aged 75 to 84 plus a suppressed over-84 count of 333 for the second. CMS Medicare Monthly Enrollment 2025: Maricopa County Medicare Advantage share 50.8%.

[3] CMS Medicare Shared Savings Program PY2026 participant file: FHMC OPERATING PC, ENHANCED track, low-revenue, retrospective assignment, agreement period 5, current start January 1, 2025. Azalea Health: confirmed by the patient-portal and registration links on fhmcaz.com and mgppaz.com, both resolving to Azalea's hosted portal on the same tenant; implementation status per the discovery call. CoachCare and Azalea Health marketplace partnership, January 25, 2022.

	Year 1	Year 2	24 months
Net to the practice	**$228,950**	**$332,121**	**$561,071**
Practice margin	41.8%	43.1%	**42.6%**

CoachCare Value Analysis: 1,750 Medicare patients, 1,400 in scope, RPM + CCM, seven referring clinicians, CoachCare's enrollment outreach at 80 enrollments a month, CY2026 fee schedule at the Arizona locality 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 51% of Maricopa County's beneficiaries. 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 plan-by-plan read of the 1,500 to 2,000 is the first item in Section 9.4.

1. **The service line pays for itself from its second month.** Month 1 nets −$1,985, because the one-time implementation and Azalea setup land in that month against a census of 38 enrollments. Every month from month 2 is positive: $4,245 in M2, $27,677 a month from M9 once both programs are full.
2. **Nobody is hired under the full-service model.** CoachCare delivers 11,308 care-team hours over 24 months, about 5.4 full-time-equivalent years of care-management labor. Enrollment outreach, care managers and device logistics are CoachCare's payroll, embedded in the fee, never deducted from practice margin. The practice's seven adult primary care clinicians refer and supervise; the practice's own billing team files the claims.
3. **The leadership team asked for both models, and the gap is $461,326.** Same panel, same Arizona rates. Full service returns $561,071 at 42.6% with no practice hires. Software only, with an in-house team enrolling at three-quarters of the pace and logging three-quarters of the billable minutes, collects $943,076 instead of $1,317,408 and returns $99,745 at 10.6%, with 3.0 clinical FTEs and an outreach role on the practice's payroll. Section 4 is the comparison.
4. **Through the growth plan, the gap is $1,548,531 over 36 months.** Section 5 adds a clinic every quarter from month 4, ten in all, 500 in-scope patients each. Full service returns $2,608,899 at 42.4% with 1,888 patients in care at month 36 and nobody on the practice's payroll; software only returns $1,060,367 at 29.9%, because every new clinic is a hiring cycle and three months of patients not yet reached.
5. **Transitional care management belongs on the stack, and is not in the forecast.** The ER transfers the panel's admitted patients and knows the day they come home. That is the two-business-day contact and the 7- or 14-day visit 99495 and 99496 pay for, $215.45 and $292.37 per discharge at the Arizona amounts.
6. **The binding constraint is the in-scope panel, not outreach.** Remote monitoring reaches its ceiling of 318.5 active enrollments in month 7 and chronic care management reaches 315 in month 8. At M24 the program holds 633.5 active program enrollments across 413 unique patients, which is every patient the two programs can take on a 1,400-patient in-scope panel. Every clinic the group adds is a new ceiling.
7. **The accountable-care contract turns clinical results into contract results.** Under an Enhanced-track agreement, the roughly 44 hospitalizations the program avoids over 24 months, about $657,000 at $15,000 each, are spending that never reaches the benchmark. The fee-for-service margin funds the program; the avoided admissions are the layer that speaks to the ACO.
8. **Advanced primary care management is the named next lever.** The practice's verified Shared Savings Program participation clears the eligibility gate for the APCM codes. This forecast carries them at zero dollars, because the choice between chronic care management and APCM for the multi-chronic panel is the practice's to make once the program is running. Section 3.2 frames that decision.

1. The Practice, and the Panel It Already Manages

1.1 The footprint

Instinctive Healthcare Solutions builds and operates its facilities as a physician-owned platform, and the footprint has grown every year since the Fountain Hills ER opened. The group's own published plan lists a Central Phoenix hospital, emergency room and outpatient clinic and a South Tempe emergency room and primary care clinic for Spring 2027, with a clinic at the El Mirage site to follow. On the discovery call, the leadership team described two more clinics next year and a target of 25 to 30 clinics across the Valley within about five years, by acquisition and new construction, multi-specialty and including cardiology.[4]

Facility	Role	What it means for this program
Fountain Hills ER & Medical Center **9700 N Saguaro Blvd**	24/7 freestanding emergency room; CT, X-ray, ultrasound, EKG, lab, observation up to 24 hours	The referral engine and the transitional care trigger. It transfers the panel's admitted patients, knows the receiving hospital and knows the day they come home; every ER visit fires the post-discharge cadence in Section 6.4
Fountain Hills Primary Care & Urgent Care **Suite 100, same address**	Adult primary care, Monday to Thursday 8 to 6, Friday 8 to 12; walk-in urgent care	**The billing panel. Three internists and one lead nurse practitioner; the two highest-volume internists carried 809 fee-for-service beneficiaries in CY2024**
Mercy Grace Pediatrics & Primary Care **Gilbert**	Pediatrics plus adult primary care; one internist and three family nurse practitioners on the adult side	The second clinic, on the same Azalea tenant. A small physician-led remote monitoring and chronic care management program ran here in 2024
El Mirage ER & Medical Center **12000 N El Mirage Rd**	24/7 freestanding emergency room, opened November 11, 2024	A second referral source once its clinic opens (listed for Fall 2027)
Central Phoenix and South Tempe **Spring 2027**	Hospital, ER and clinic pairs on the group's published plan	Each inherits the program as built; the Scenario Explorer on the companion microsite sizes each one

fhmcaz.com, instinctivehealthcaresolutions.com and instinctivehealthpass.com location listings; Arizona Department of Health Services licensing lookup; CMS Doctors & Clinicians file; discovery call, September 2026.

Two other pieces of the footprint matter to enrollment. The group runs **Instinctive HealthPass**, a membership program that bills the member's insurer as usual and covers the member's copay, deductible and coinsurance for eligible in-house services at participating facilities, and requires active commercial, Medicare, VA or TRICARE coverage to join. For a HealthPass member on Medicare, the 20% coinsurance conversation that slows care-management enrollment elsewhere is already settled at the point of service. And both clinics run on one Azalea Health tenant, so one integration covers both.[5]

1.2 The Medicare panel and what the claims say about it

The leadership team put the Medicare panel at 1,500 to 2,000 across the two clinics, inside a total of 4,000 to 5,000 patients. The forecast in Section 7 models the midpoint, 1,750, with 1,400 in scope, the share of a panel like this one that carries a qualifying chronic condition. The CY2024 Medicare by-provider file is the public corroboration, and it describes the panel in some detail.[6]

[4] instinctivehealthpass.com/locations/, retrieved September 2026: Central Phoenix Hospital & ER + Outpatient Clinic (Spring 2027), South Tempe ER + Primary Care Clinic (Spring 2027), El Mirage Medical Center Clinic (Fall 2027). NPPES: a Central Phoenix hospital entity enumerated June 30, 2026. Discovery call, September 3, 2026, for the five-year plan.

[5] instinctivehealthpass.com and /about/: membership from $800 a year or $80 a month; the facility bills the member's insurer as usual and the membership pays copay, deductible and coinsurance for eligible in-house services at participating facilities; requires active commercial, Medicare, VA or TRICARE coverage. The Azalea patient portal linked from fhmcaz.com and mgppaz.com carries the same tenant identifier.

[6] Discovery call, September 3, 2026. CMS Medicare Physician & Other Practitioners by Provider, CY2024 (released 2026), the two internal medicine clinicians at 9700 N Saguaro Blvd, Fountain Hills, AZ 85268. CMS suppresses beneficiary counts under 11 and caps published

CY2024 Medicare fee-for-service, the two highest-volume internists at Fountain Hills	Higher-volume internist	Second internist
Beneficiaries	**476**	**333**
Aged 75 or older	265 of 476 (56%)	150 aged 75 to 84, plus a suppressed count over 84; 122 aged 65 to 74
Hypertension	**73%**	**74%**
Hyperlipidemia	75%	75%
Diabetes	20%	21%
Chronic kidney disease	16%	24%
Ischemic heart disease	24%	27%
Heart failure	11%	14%
Atrial fibrillation	18%	20%
Average HCC risk score	0.98	1.09

CMS Medicare Physician & Other Practitioners by Provider, CY2024. CMS suppresses counts under 11. The 809 is the sum of the two rows; the two panels may overlap.

This is the profile remote care is built for. Three in four beneficiaries carry hypertension and three in four carry hyperlipidemia; a fifth are diabetic; a sixth to a quarter have chronic kidney disease. Most are 75 or older. The chronic care management codes require two or more chronic conditions expected to last a year, and the remote monitoring codes want a condition whose readings change treatment between visits. Hypertension and diabetes, the two conditions the leadership team named on the call alongside high cholesterol, are the largest such cohorts on this panel.

The same file also shows what is not there. All seven internal medicine and family practice clinicians at the Fountain Hills address, and the lead nurse practitioner, were queried against the remote monitoring, chronic care management and advanced primary care management code families for CY2024. None appears on any of them: **no remote-care or care-management program at meaningful scale is visible in CY2024 claims at Fountain Hills**. Section 3.3 bounds that claim honestly, and credits the Gilbert program that did run.[7]

1.3 The accountable-care position

FHMC Operating PC, the professional billing entity, is listed in the CMS PY2026 Medicare Shared Savings Program participant file as a participant in an **Enhanced-track ACO**: two-sided risk, low-revenue designation, retrospective beneficiary assignment, in its fifth agreement period with the current period beginning January 1, 2025, and not a participant in the prospective primary-care payment option. The ACO reports quality for its participants and holds advanced alternative payment model status.[8]

Three consequences follow for this program. First, the ACO's two-sided risk rewards exactly what remote monitoring and chronic care management produce on an older, hypertensive panel: fewer emergency visits and fewer admissions among attributed beneficiaries. Second, the practice's verified participation

chronic-condition prevalence at 75%, so the 75% hyperlipidemia figures are a ceiling. Average HCC risk scores 0.9772 and 1.0869.

[7] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024, queried per National Provider Identifier for all seven internal medicine and family practice clinicians and the lead nurse practitioner at the Fountain Hills address, for 99453, 99454, 99457, 99458, 99490, 99491, 99495, 99496 and G0556–G0558: no rows. CMS suppresses clinician-and-code lines under 11 beneficiaries. Query mechanics were validated against the Gilbert clinician's positive rows in the same file, so the nulls are absences rather than query failures.

[8] CMS Medicare Shared Savings Program PY2026 participant file, data.cms.gov, retrieved September 2026: participant legal business name FHMC OPERATING PC; ENHANCED track = 1; low-revenue ACO = 1; retrospective assignment = 1; agreement period number 5; initial start January 1, 2014; current start January 1, 2025; prospective primary-care payment option = 0. Corroborated on the ACO's public reporting page, which lists FHMC Operating PC among its participants.

clears the value-model gate for the advanced primary care management codes, which Section 3.2 takes up. Third, the remote monitoring and care-management claims this program bills are Part B spending against the ACO's benchmark for attributed beneficiaries. The Value Analysis in Section 7 is fee-for-service and does not model the ACO's shared-savings economics; Section 7.6 shows the avoided-admission layer that does speak to the contract.

1.4 The market around it

Geography	Population	Median age	Aged 65 and over	What it means here
Fountain Hills	23,789	**61.5**	**9,693 (40.7%)**	One of the oldest towns in the Valley. The Fountain Hills clinic's catchment is structurally Medicare
Gilbert	280,262	36.1	30,955 (11.0%)	A young-family market, which is why the Gilbert clinic leads with pediatrics; the 65-and-over pool is still about 31,000 people
Maricopa County Medicare	801,802 beneficiaries (2025)		394,208 in Original Medicare; 50.8% in Medicare Advantage; about 15% dually eligible	Half the county's Medicare is in a 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.

U.S. Census Bureau, American Community Survey 2024 five-year estimates; CMS Medicare Monthly Enrollment, 2025 annual, Maricopa County.

The rate basis follows the geography. ZIP 85268 and Gilbert's 85295 both fall in the Arizona statewide locality under the Noridian JF contractor, a mid-rate locality: 99490 pays $64.85, 99454 pays $50.45, 99457 pays $50.65 at the CY2026 non-facility amounts. Every dollar in this report is priced at those amounts, not at national figures.[9]

2. Why This Year

Three things line up in 2026 that did not line up before, and one of them has a calendar attached.

What changed	Why it matters to this practice
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 $50.45 as the 16-day code, and 99470 pays $25.49 for 10 to 19 minutes of treatment management. Before 2026 a patient who transmitted on twelve days earned nothing for the month. On a 75-and-older panel, partial-month adherence is the normal case, and this is the first year it is billable. Post-discharge and titration windows are now payable next to the monthly stack, and transitional care management pays for the hand-off at the discharge itself
The accountable-care contract pays for the same outcomes	The Enhanced track is two-sided: the ACO shares in savings and is accountable for spending over its benchmark. A program whose whole purpose is to catch a rising blood pressure or a gaining weight before it becomes an emergency visit is the cost half of that contract, run inside the practice
The Azalea implementation is open now	Integration work done while the practice is already configuring workflows, templates and billing costs less attention than integration work done after everything has settled. The roughly four-week CoachCare integration fits inside the window the practice has already opened

[9] CY2026 Medicare Physician Fee Schedule, non-facility amounts, MAC 03102 locality 00 (Arizona statewide, Noridian JF): 99490 $64.85; 99439 $49.41; 99453 $20.96; 99454 and 99445 $50.45; 99457 $50.65; 99458 $40.61; 99470 $25.49; G0556 $16.04; G0557 $52.72; G0558 $114.88. ZIP 85268 and ZIP 85295 both map to this locality.

What changed	Why it matters to this practice
The growth plan wants a program built once	Two more clinics next year, 25 to 30 in five. A care-management program that depends on one clinic's staff cannot be copied; a program that runs on an integration, a protocol and a staffing model can. Section 5 runs both operating models through ten new clinics; Section 8 sizes the plug-in case

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 primary care panel, and a third monthly program for the specialty clinics the group plans to add. One enrollment conversation, one care team, one billing pipeline into the practice's own in-house billing. Each answers a different clinical question and each is separately payable under the CY2026 fee schedule. The forecast in Section 7 carries the two primary care monthly programs; transitional care management and principal care management are recommended and not in the forecast.[10]

Program	What it does clinically	Who it fits on this panel	Net reimbursement per enrolled patient-month
Remote physiologic monitoring (RPM)	A cellular blood pressure cuff and scale transmit readings between visits, reviewed against thresholds the practice sets; 99453 setup, 99454 or 99445 device supply, 99457, 99458 and 99470 treatment management	The hypertension, diabetes and heart-failure cohorts: 73 to 74% of the panel carries hypertension, and the readings that change a dose are the readings a cuff sends	**$94.99**
Chronic care management (CCM)	A documented care plan for patients with two or more chronic conditions, with at least 20 minutes of care-management time each month; 99490 and 99439	The multi-chronic core of the panel: hypertension with hyperlipidemia, diabetes, kidney disease or heart failure in one patient	**$108.55**
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. The ER transferred most of them and knows the day they come home	**$215.45 / $292.37 per discharge; not in the forecast**
Principal care management (PCM)	A disease-specific care plan for a patient whose care centers on one serious condition, with at least 30 minutes a month; 99424 and 99425 when the physician does the work, 99426 and 99427 when clinical staff do	The cardiology, nephrology and pulmonology clinics the group plans to add: heart failure, chronic kidney disease stages 3b to 5, COPD. A specialty clinic cannot bill chronic care management on a primary care panel it does not own; PCM is how it bills its own monthly management, paired with RPM on the same patient	**$85.88 / $60.32 physician; $66.47 / $52.98 clinical staff; not in the forecast**

Blended net reimbursement per enrolled patient-month for the two monthly programs, CoachCare Value Analysis, CY2026 Arizona locality amounts, after the 15% program pricing applied to this forecast. Transitional care management is the CY2026 Arizona amount per discharge; principal care management is the CY2026 Arizona amount for the first 30 minutes and each additional 30 minutes. Neither carries dollars in the forecast.

[10] CoachCare Value Analysis for Fountain Hills Medical Center, 2026: blended net reimbursement per enrolled patient-month, remote physiologic monitoring $94.99 and chronic care management $108.55, on the code frequencies in the forecast at the Arizona amounts. Transitional care management 99495 $215.45 and 99496 $292.37 per discharge, CY2026 relative value units priced at the Arizona statewide locality indices (national $220.11 and $298.60); not in the forecast.

Code	What it pays for	CY2026 Arizona amount
99453	Remote monitoring setup and patient education, once	$20.96
99454	Device supply with daily recording or alerts, 16 or more days in 30	$50.45
99445	**Device supply, 2 to 15 days in 30 (new in CY2026)**	**$50.45**
99457	Treatment management, first 20 minutes, with interactive communication	$50.65
99458	Each additional 20 minutes	$40.61
99470	**Treatment management, 10 to 19 minutes (new in CY2026)**	**$25.49**
99490	Chronic care management, first 20 minutes of clinical staff time	$64.85
99439	Each additional 20 minutes	$49.41
99495	Transitional care management, moderate complexity, visit within 14 days of discharge	$215.45
99496	Transitional care management, high complexity, visit within 7 days of discharge	$292.37
99424	Principal care management, physician or other qualified professional, first 30 minutes	$85.88
99425	Each additional 30 minutes, physician or other qualified professional	$60.32
99426	Principal care management, clinical staff under physician direction, first 30 minutes	$66.47
99427	Each additional 30 minutes, clinical staff	$52.98

CY2026 Medicare Physician Fee Schedule, non-facility amounts, Arizona statewide locality (Noridian JF). National amounts for the transitional care codes are $220.11 and $298.60.

A patient can hold a monitoring enrollment and a care-management 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 the primary care panel, where chronic care management is the fitting code: three in four patients carry several chronic conditions, and the primary care clinic owns the whole plan.

Principal care management is the code the specialty clinics will bill. The growth plan adds cardiology, and the same logic reaches nephrology and pulmonology. A cardiology clinic managing a heart-failure patient, a nephrology clinic managing chronic kidney disease at stage 3b or beyond, or a pulmonology clinic managing COPD is managing one serious condition inside a panel it does not own, and chronic care management is not available to it for that patient. Principal care management is: a disease-specific care plan, 30 minutes a month, 99424 and 99425 at $85.88 and $60.32 when the physician does the work, 99426 and 99427 at $66.47 and $52.98 when clinical staff do. Paired with remote monitoring on the same patient, it is one device stack, one care team and one escalation protocol billing a different code. It is not in the forecast, which is the primary care panel; it is the reason the specialty arm of the group inherits the program with its own monthly management code already attached.

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: $16.04, $52.72 and $114.88 a month at the Arizona amounts. CMS ties the codes to participation in a value-based arrangement, and the practice's verified Shared Savings Program participation clears that gate. That is the reason APCM appears in this report at all; on most independent primary care practices it does not.[11]

[11] CY2026 Medicare Physician Fee Schedule, Arizona locality amounts for G0556, G0557 and G0558. CMS advanced primary care management requirements include participation in a qualifying value-based arrangement; the practice's Shared Savings Program participation (note 8) satisfies the gate. Advanced primary care management and chronic care management may not be billed for the

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, and how the ACO's own care-coordination arrangements interact with a participant billing APCM. Those are the practice's decisions and the ACO's, and this forecast does not pre-empt them. Remote monitoring bills alongside either, so the RPM arm of the forecast is unchanged whichever way the decision goes. The decision belongs in months 9 to 24 of the roadmap, once the chronic care management census and the documentation workflow are real.

3.3 The starting position, stated honestly

The leadership team said on the call that the practice has never billed chronic care management, remote monitoring or advanced primary care management, and the CY2024 claims file agrees for Fountain Hills. Two things bound what that absence proves, and one thing qualifies it.

- **CMS suppresses any clinician-and-code line under 11 beneficiaries.** A code billed to ten patients is invisible in the public file. The supportable statement is the one this report makes: no program at meaningful scale in CY2024, not that no patient was ever billed.
- **The Gilbert clinic did run a program.** In CY2024 one internist at the Gilbert practice billed remote monitoring device supply to 28 beneficiaries, remote monitoring treatment management to 29, and chronic care management to 12. That is a real, physician-led program, and it is evidence that this kind of work fits this kind of panel. Whether it is still running, on what platform, and how the Azalea migration affects it are discovery items in Section 9.4. This report is not a claim that the group starts from nothing; it is a plan for a practice-wide, staffed program that bills every month at both clinics and at every clinic to come.
- **The practice already has the enrollment chassis.** HealthPass settles the cost-sharing conversation for members. The ER sees the panel's sickest patients on their worst days. The Azalea implementation puts an eligibility flag and a referral order in front of every clinician. None of that needs to be built; it needs to be pointed at the program.

3.4 The emergency room: referral engine, transitional care trigger

The ER is where the panel's highest-risk patients present, with a diagnosis, a set of vitals and a reason, and it sits next to the clinic that manages them. When a panel patient needs admission, the ER transfers them. It knows the receiving hospital, it knows the diagnosis, and it learns the day the patient comes home. That is exactly the information transitional care management pays a practice to act on: contact within two business days of the hospital or observation discharge, medication reconciliation, and a face-to-face visit within 7 or 14 days, at $292.37 or $215.45 per discharge at the Arizona amounts. Most primary care practices learn of an admission days late, from a discharge summary or the patient. This one hears about it from its own ER, on the day it happens. Those episodes carry no dollars in the forecast; the practice's admission count from its own ER is the number that sizes them, and it is on the confirmation list.

Every emergency room visit, admitted or not, also fires the three-touch post-discharge cadence in Section 6.4: contact on days 1 to 2, 5 to 8 and 12 to 14, medication reconciliation, symptom assessment and a confirmed follow-up visit, then a hand-off into the longitudinal monitoring panel. For a patient not yet enrolled, the ER visit is the enrollment conversation: a hypertensive 78-year-old who just spent four hours in the ER with a blood pressure of 190 over 100 is the clearest possible candidate for a connected cuff, and the clinician who saw them can order it before they leave. For a patient already enrolled, the visit is the trigger that tightens the cadence. The El Mirage ER adds a second such source once its clinic opens.

same patient in the same month; remote physiologic monitoring may be billed alongside either.

3.5 Azalea Health: the program lives in the chart

CoachCare has been an Azalea Health marketplace partner since January 2022, described at the time as the only application on the marketplace offering remote monitoring and chronic care management together, with automated claims creation, dual enrollment and integrated cellular devices. The integration is bi-directional. The practice's implementation is in progress, both clinics share one tenant, and the CoachCare integration runs about four weeks, in parallel with the work already under way.[12]

Step	What happens in Azalea	Who does it
Eligibility	Patients meeting the agreed criteria carry a flag in the chart; the flag is the enrollment prompt at the point of care	CoachCare configures the criteria the practice approves
Referral	The clinician places a referral order the way they would order a lab. The order is the enrollment	Any of the seven adult primary care clinicians, in the visit
Device	A cellular blood pressure cuff and scale ship to the patient, pre-paired; no smartphone, WiFi or app required	CoachCare sources, ships, replaces
Outreach	The patient is reached, educated and consented; readings and monthly care documents write back to the chart	CoachCare's enrollment outreach and care team, at the ratio in Section 9.1
Claims	Each month's codes are constructed from logged time and transmission days and land billing-ready for the practice's in-house team	CoachCare generates; the practice files and keeps the revenue

The Azalea catalog pricing carried in this forecast is $1,000 for setup, $150 a month and $1.50 per enrolled patient-month, and it is confirmed in contracting. Together with implementation and telephonic outreach, those ancillary items total $28,009 over 24 months, and they are inside the $756,337 of CoachCare fees, not on top of it.

4. Two Operating Models: Full Service or Software Only

On the discovery call the leadership team said the practice prefers minimal new full-time staff, has remote staff already, and wanted to see the full-service and software-only models side by side: staffing, hours and cost. This section is that comparison. Same panel, same CY2026 Arizona rates, same 24 months, same enrollment engine. The full-service column is the forecast in Section 7. The software-only column runs the same engine with two things an in-house team carries: enrollment at three-quarters of the pace, because nobody's whole job is enrolling, and code completion a quarter lower, because time-based codes only pay when the minutes are logged every month. CoachCare's platform and device fees are at list; the practice hires the clinical minutes and an outreach role.[13]

[12] CoachCare, January 25, 2022: Azalea Health partners with CoachCare to offer integrated remote care management programs on the AzaleaApps marketplace; CoachCare described as the only Azalea application offering remote monitoring and chronic care management together, with automated claims creation, dual enrollment and integrated cellular devices. Integration duration and the parallel-build approach per the discovery call, September 3, 2026.

[13] Discovery call, September 3, 2026: the request for a full-service versus software-only comparison covering staffing, hours and cost, and the stated preference for minimal new full-time staff. CoachCare Value Analysis for Fountain Hills Medical Center, 2026, full-service and software-only cases: net reimbursement $1,317,408 versus $943,076; $561,071 versus $99,745 net to the practice over 24 months; 42.6% versus 10.6%; first positive month 2 versus 6; 0 versus 3.0 practice clinical full-time equivalents; 328,322 clinical minutes over 24 months. Software only: enrollment pace and code completion at 0.75 of full service; platform $15 and device $15 per enrolled patient-month at list; labor per CoachCare's house model, $71,510 paid and $15,844 supervision, recruiting and seat per clinical FTE-year, 71,885 billable minutes per FTE-year, $48,000 a year program management, one outreach role at $5,000 a month.

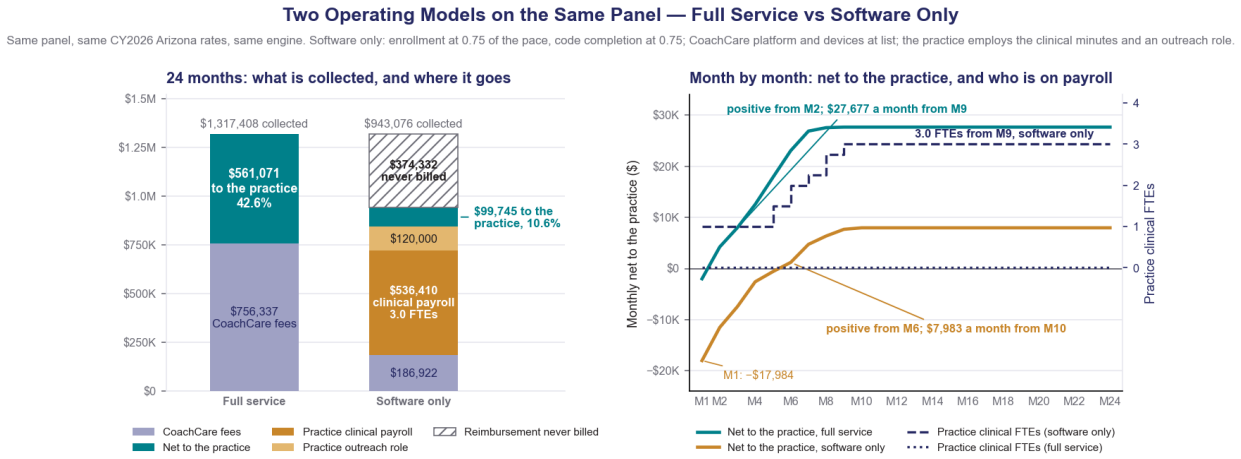

Figure 1 — the two operating models on the same panel. Left: what each model collects and where it goes over 24 months; the hatched block is reimbursement the in-house team never bills. Right: monthly net to the practice under each model, and the clinical full-time equivalents the practice employs, month by month. CoachCare Value Analysis.

4.1 The comparison

24 months, same panel and rates	Full service	Software only
Net reimbursement	**$1,317,408**	**$943,076** −$374,332: a quarter of the billable minutes never logged
CoachCare fees	$756,337	$186,922 platform and device at list, Azalea integration, implementation
Practice clinical payroll	$0	$536,410 3.0 clinical full-time equivalents
Practice outreach role	$0	$120,000
Net to the practice	**$561,071**	**$99,745**
Practice margin	**42.6%**	**10.6%**
Year 1 / Year 2 net to the practice	$228,950 / $332,121	$3,944 / $95,801
First positive month	**M2**	M6
Enrollments at month 6	**533**	400
Ceilings reached	M7 and M8	M9 and M10
Who is on the practice's payroll	**Nobody**	**3.0 clinical FTEs, hired in quarter-FTE steps from a one-FTE floor, plus an outreach role at $5,000 a month**
Devices, logistics, escalation coverage, documentation, claim construction	CoachCare	Platform and devices from CoachCare; the practice's own staff run the clinical minutes, escalations and documentation

CoachCare Value Analysis, full-service and software-only cases. Software only prices the CoachCare platform at $15 and the remote monitoring device at $15 per enrolled patient-month at list, plus Azalea integration and implementation, and runs enrollment and code completion at three-quarters of the full-service pace.

The gap is **$461,326 over 24 months**, and the whole of it is execution: slower enrollment, missed minutes, and payroll that starts before the census does. Under software only the practice pays CoachCare $569,415 less, then spends $656,410 employing the clinical minutes and the outreach role that earn the reimbursement, and collects $374,332 less of it. The minutes are not optional: 99490

requires 20 documented minutes of clinical staff time in the month, 99457 requires 20 minutes including live interaction, and the add-on codes require 20 more each. The revenue is the labor, priced by the fee schedule, and a minute nobody logs is a code nobody bills.

4.2 What the software-only case carries

The labor basis is CoachCare's own house model. A clinical full-time equivalent costs $71,510 a year in pay and about $15,844 a year in supervision, recruiting and a seat, and delivers 71,885 billable minutes a year: 124,800 paid minutes, less 20% for paid time off, holidays and training, less 4% for turnover ramp, of which three-quarters is billable. Program management is $48,000 a year. Hiring runs in quarter-FTE steps from a one-FTE floor, and one outreach role costs $5,000 a month. The in-house team reaches 3.0 clinical FTEs to deliver about 328,300 clinical minutes over 24 months.

- **Enrollment at three-quarters of the pace.** Nobody's whole job is enrolling. The census reaches 400 enrollments at month 6 against 533 in full service, and the two ceilings arrive in months 9 and 10 instead of 7 and 8. Every month of the ramp shifts right and the first positive month moves from M2 to M6.
- **Code completion a quarter lower.** The time-based and device codes only pay when the minutes are logged and the transmission days are counted, every month, for every patient. In-house teams that also cover a clinic and an emergency room miss some of both. That is where the $374,332 of reimbursement goes: it is earned in principle and never billed.
- **Payroll ahead of the census.** One FTE from month 1 against a census of 28.5 enrollments, three by month 9, held through turnover, coverage and after-hours escalation. Year 1 nets $3,944.

Where software only wins is control, and long-run unit cost at very large scale. Where it loses is the first two years: enrollment nobody owns, minutes nobody logs, hiring ahead of the census, and program management nobody budgeted. The two handicaps in this column are modest by industry experience; in-house programs more often stall between 100 and 200 patients than reach the ceiling at all.

4.3 The recommendation

> **Launch full service. Prove the census and the workflow. Then revisit staffing across several clinics.**
>
> This is what CoachCare said on the call, and the arithmetic supports it. Full service returns $461,326 more over 24 months, is positive four months sooner, and puts nobody on the practice's payroll while the program is being proven at two clinics. The software-only economics improve as the census grows across clinics, because program management and supervision spread over more patients; Section 5 tests exactly that claim across ten new clinics. The platform, the Azalea integration and the devices are the same in both models, so the switch, if the practice ever makes it, is a staffing decision rather than a rebuild, made with two years of the practice's own enrollment, adherence and escalation data in hand.

5. The Scale-Out: Ten New Clinics, Both Models, 36 Months

The group's plan is more clinics, fast. This section runs both operating models through that plan over 36 months: the two clinics today, then one new location every quarter from month 4, each bringing 500 in-scope Medicare patients and three referring clinicians, until ten are open at month 31. That is 5,000 new in-scope patients on top of the 1,400 the forecast starts with. Under full service every site runs the engine at full pace from the month it opens, and CoachCare adds care team as the census grows. Under software only each new site carries what an in-house program carries at scale: it waits three months for a trained lead before enrolling; the team hires one care manager at a time, opening a requisition at 85% of staffed capacity and landing the hire three months later; each in-house care manager carries 250

patients; one in four care managers turns over every year and takes three months to replace; and the enrollment and completion handicaps from Section 4 apply everywhere.[14]

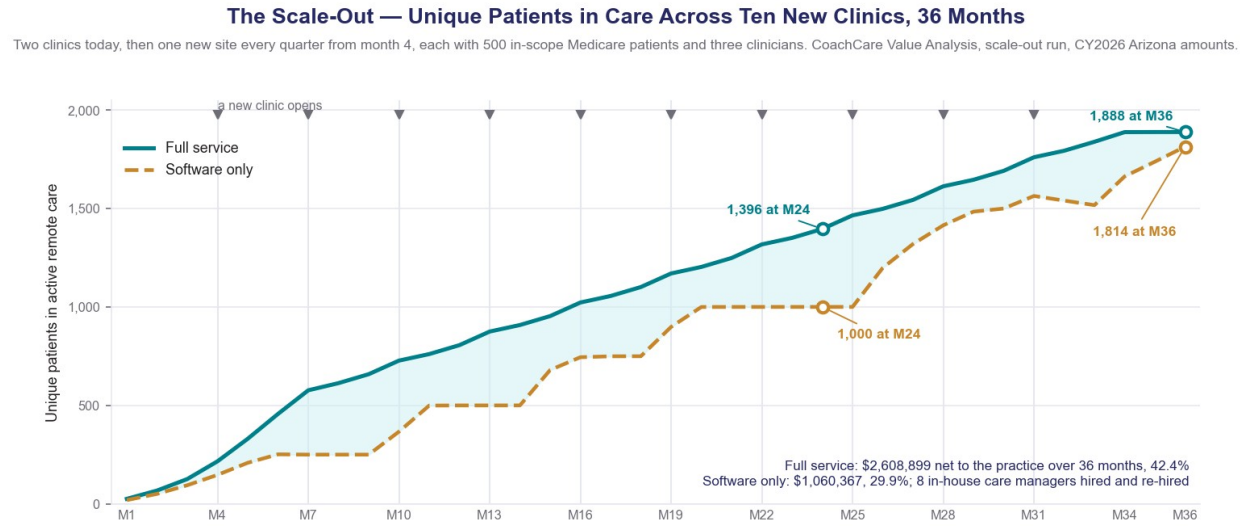

Figure 2 — unique patients in active remote care over 36 months, full service against software only, as ten new clinics open one a quarter from month 4. Each rise in the full-service line is a clinic coming online with the program already running; the software-only line flattens each time the in-house team reaches its staffed capacity and waits for the next hire. CoachCare Value Analysis, scale-out run.

5.1 The two models through the growth plan

36 months, twelve sites by month 31	Full service	Software only
Net reimbursement	**$6,148,511**	$3,544,612
Net to the practice	**$2,608,899**	**$1,060,367**
Practice margin	**42.4%**	29.9%
Cumulative net at month 12	$341,608	−$11,406
Cumulative net at month 24	$1,240,718	$330,957
Unique patients in care, month 24	**1,396**	1,000
Unique patients in care, month 36	**1,888**	1,814
Staffing at month 36	About 11.8 CoachCare care managers at 160 patients each; none on the practice's payroll	8 in-house care managers, hired and re-hired through turnover
Gap		**$1,548,531 over 36 months**

CoachCare Value Analysis, scale-out run: the 1,400-patient in-scope panel from month 1 plus ten sites of 500 in-scope patients and three clinicians opening in months 4, 7, 10, 13, 16, 19, 22, 25, 28 and 31, at the CY2026 Arizona amounts.

Read the unique-patient rows against each other. Software only ends month 36 at 1,814 patients, within 74 of full service, and that is the flattering way to read it. At month 24 it is at 1,000 against 1,396, and its

[14] CoachCare Value Analysis for Fountain Hills Medical Center, 2026, scale-out run, 36 months: the 1,400-patient in-scope panel with 7 clinicians from month 1, plus one site of 500 in-scope patients and 3 clinicians opening in each of months 4, 7, 10, 13, 16, 19, 22, 25, 28 and 31. Full service: net reimbursement $6,148,511, net to the practice $2,608,899, 42.4%, 1,888 unique patients at month 36, about 11.8 CoachCare care managers at 160 patients each. Software only: $3,544,612, $1,060,367, 29.9%, 1,814 unique patients, 8 in-house care managers; 3-month lead time per new site; 250 patients per care manager; requisition at 85% of capacity with a 3-month hire lag, one hire at a time from 1 FTE; 25% annual turnover with 3-month backfills; enrollment and completion at 0.75 of full service. Site cadence per the group's stated growth plan.

cumulative net is $330,957 against $1,240,718, because every one of the intervening months had patients the program had not reached and minutes the team had not logged. The full-service line rises the month each clinic opens. The software-only line rises when a hire lands, flattens at 250 patients per care manager until the next one does, and dips each time somebody leaves. By month 36 the in-house program has hired eight care managers to hold a census CoachCare covers with about 11.8 at a 160-to-1 ratio, and the practice has paid for every requisition, every three-month vacancy and every backfill.

5.2 What the scale-out says about the plan

In full service the program is part of the acquisition playbook

It is switched on the month a site opens, with the margin intact at 42.4%, and the care team behind it grows by census rather than by requisition. Nobody at the new clinic is hired for it, trained for it or replaced when they leave. In software only, every new clinic is another hiring cycle, another lead to train, and another three months of patients the program has not reached. The plan the leadership team described, 25 to 30 clinics in five years, is the case for the model that scales without the practice hiring for it.

The software-only margin does improve with scale, from 10.6% at two clinics to 29.9% at twelve, which is the effect Section 4.3 anticipated: program management and supervision spread over more patients. It improves to a level that is still 12.5 points below full service, and it gets there by hiring eight people.

6. Clinical Governance & Escalation

Section 7 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 clinical leadership, not by default, and signed off before the first patient enrolls.[15]

6.1 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

[15] 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.

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. 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 practice's own emergency room is minutes from most of the Fountain Hills panel, and the escalation record follows the patient there.

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 clinic 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.

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.

6.3 Three-way routing

The failure mode of a monitoring program inside a busy clinic 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 care team notified
Non-critical	A confirmed out-of-range reading or trend without emergent features	The defined care-team member named in the 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 seven clinicians who also cover an emergency room**

The matrix is agreed per clinic, because the covering clinician in Fountain Hills is not the covering clinician in Gilbert, and the after-hours branch is defined alongside the practice's existing on-call arrangement, so night and weekend readings have a route that does not depend on anyone's memory. Each new clinic adds a row, not a redesign.

6.4 The post-discharge three-touch cadence, and the TCM episode

Triggered by any emergency room visit or hospitalization in the previous 60 days. For a practice with its own 24/7 emergency room the trigger fires the same day, and when the visit ended in 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. On this account the trigger fires most often from the practice's own ER, which is why Section 3.4 calls the ER the transitional care trigger. This cadence is the mechanism behind the avoided admissions in Sections 7.5 and 7.6.

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

Touch	Window	What happens
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

6.5 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 clinic is notified in every case and discharges process in the first week of the following month.
3. **The practice always decides.** Clinical discharge criteria, escalation thresholds and routing belong to Fountain Hills Medical Center. CoachCare executes them consistently and documents the execution. It does not overrule clinical judgment, with the single exception of the emergent floor in Section 6.2.
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 ACO quality review asks for.

7. Value Analysis: The 24-Month Forecast

7.1 The headline economics

The forecast covers remote physiologic monitoring and chronic care management across a Medicare panel of 1,750, the midpoint of the 1,500 to 2,000 the leadership team gave, with 1,400 in scope, priced at the CY2026 Arizona locality amounts, with seven referring adult primary care clinicians (three physicians and four advanced practice providers across the two clinics) and CoachCare's enrollment outreach at 80 enrollments a month. Transitional care management is recommended in Section 3 and carries no dollars here.[16]

	Year 1	Year 2	24 months
Net reimbursement	**$547,561**	**$769,847**	**$1,317,408**
CoachCare fees, including Azalea and implementation	$318,611	$437,726	$756,337
Net to the practice	**$228,950**	**$332,121**	**$561,071**
Practice margin	41.8%	43.1%	**42.6%**

The margin moves from 41.8% in year one to 43.1% in year two because the one-time implementation and Azalea setup fall out and the census is full from the first month of the year. Year two is the steady state: **$769,847 of net reimbursement, $332,121 of it kept, at 43.1%**.

[16] CoachCare Value Analysis for Fountain Hills Medical Center, 2026. All Section 7 figures. Inputs: 1,750 Medicare patients, 1,400 in scope; 7 referring clinicians; CoachCare enrollment outreach at 80 enrollments a month; remote monitoring 65% eligible and 35% acceptance; chronic care management 75% eligible and 30% acceptance; 15% program pricing; CY2026 fee schedule at Arizona locality amounts.

7.2 Where the revenue comes from

Program	Year 1	Year 2	24 months	Per enrolled patient-month
Remote physiologic monitoring	$264,274	$359,525	**$623,799**	$94.99
Chronic care management	$283,287	$410,322	**$693,609**	$108.55
Total	**$547,561**	**$769,847**	**$1,317,408**	

Net reimbursement by program and year, CoachCare Value Analysis.

24 months	Net reimbursement	CoachCare fees	Net to the practice
Remote physiologic monitoring	$623,799	$367,692	**$256,107**
Chronic care management	$693,609	$360,636	**$332,973**
Implementation, Azalea setup and monthly, per-patient EMR, telephonic outreach		$28,009	−$28,009
Total	**$1,317,408**	**$756,337**	**$561,071**

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

Chronic care management is the larger line, $693,609 on 315 active enrollments at M24, because the multi-chronic core of this panel is large and the 99439 add-on is earned in most months. Remote monitoring carries $623,799 on 318.5 enrollments and is the program that produces the readings, the alerts and the avoided admissions. The **633.5 active program enrollments at M24 belong to 413 unique patients**, because most monitored patients also hold a care-management enrollment.

7.3 The ramp, month by month

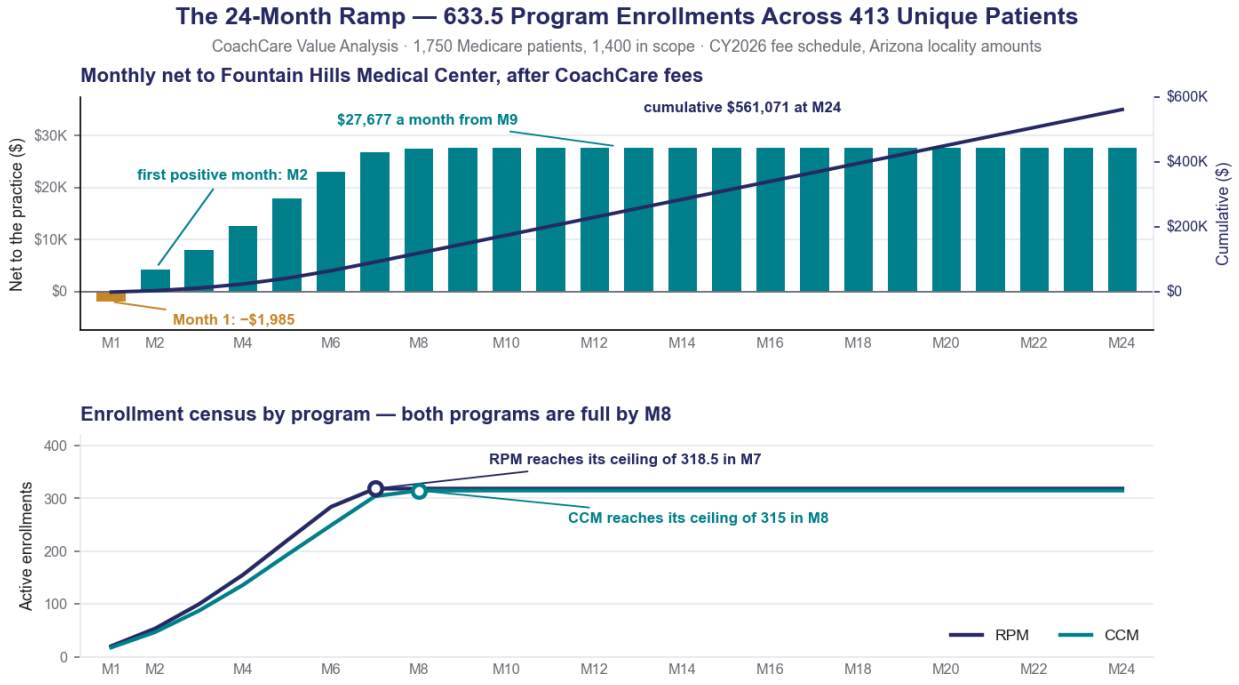

Figure 3 — monthly net to the practice after CoachCare fees, with cumulative net overlaid, and the enrollment census by program with the two ceiling months marked. CoachCare Value Analysis.

Month 1 nets **−$1,985**, because the one-time implementation fee and the Azalea setup land in that month against 38 enrollments. The first positive month is **M2**, at $4,245 on 101 enrollments, and M2 more than repays month 1. The census reaches 187 enrollments in M3, remote monitoring fills in M7, chronic care management fills in M8, and the program holds $27,677 a month from M9.

Month	Net reimbursement	CoachCare fees	Net to the practice
M1	$4,219	$6,204	**−$1,985**
M2	$10,783	$6,538	**$4,245**
M3	$19,782	$11,756	$8,026
M4	$30,487	$17,917	$12,570
M6	$54,971	$31,907	$23,064
M7	$63,633	$36,739	$26,894
M8	$64,154	$36,584	$27,570
M9 onward	**$64,154**	$36,477	**$27,677**

The commercially important number in that table is not the 24-month total. It is that the program is cash-positive in its second month and self-funding from then on, with no devices purchased, no software licensed and no headcount added by the practice. A service line that pays its own way from M2 competes with nothing else on a growth budget that is building hospitals.

7.4 Ceilings, and what moves them

Program	Eligible share of the 1,400 in scope	Acceptance	Ceiling	Reached
Remote physiologic monitoring	65% — 910 patients	35%	**318.5**	**M7**
Chronic care management	75% — 1,050 patients	30%	**315**	**M8**

Say the constraint out loud

The binding constraint on this program is the eligibility definition and the in-scope panel, not outreach capacity. By M8 every patient the two programs can take is enrolled, and CoachCare's outreach has nowhere further to go on this year's panel. That is why the sensitivity table below reads the way it does: doubling the outreach cannot raise the ceiling, only reach it sooner.

Chart counts are discovery item number one. The 1,750 is the midpoint of the range the leadership team gave on the call. The practice's own registry, pulled in week one, replaces it, and every ceiling in this report moves with it.

Scenario	24-month net reimbursement	Net to the practice	Margin	Ceilings reached
Base: panel 1,750, 1,400 in scope, 7 clinicians, outreach at 80 a month	**$1,317,408**	**$561,071**	**42.6%**	M7 / M8
Outreach doubled to 160 enrollments a month	$1,391,101	$593,344	42.7%	M5 / M5
Nine referring clinicians, once the two listed internists carry a panel	$1,334,458	$568,395	42.6%	M6 / M7
Panel 2,000, 1,600 in scope (top of the range)	$1,476,956	$629,743	42.6%	M8 / M8

Scenario	24-month net reimbursement	Net to the practice	Margin	Ceilings reached
Panel 1,500, 1,200 in scope (bottom of the range)	$1,151,512	$489,610	42.5%	M6 / M7

CoachCare Value Analysis sensitivity runs. Ceilings reached: remote monitoring / chronic care management.

Read across the rows. Doubling the outreach is worth about $32,000 over 24 months because it reaches the same ceilings two to three months sooner. Two more referring clinicians add about $17,000 for the same reason. Moving the panel itself from 1,500 to 2,000 moves 24-month net to the practice from $489,610 to $629,743, at the same margin. The panel is the lever; everything else is timing.

7.5 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	**68,950**	Blood pressure and weight values arriving between visits from a panel where three in four beneficiaries carry hypertension
Claims and billable units generated	**25,327**	Constructed, coded and landed billing-ready for the practice's in-house team through the Azalea integration
Care-management tasks completed	50,653	Outreach attempts, care-plan updates, medication reviews and follow-up actions
Patient conversations	7,598	Live contacts across 422 hours of call time
Chart updates	12,663	Documentation written back for the care team to act on
Care-team hours delivered by CoachCare	**11,308**	**About 5.4 full-time-equivalent years of care-management labor the practice does not employ**
Hospitalizations avoided	**43.8**	About $657,000 at $15,000 per admission, cost that never lands on a payer, a patient or the ACO's benchmark

CoachCare Value Analysis, 24-month totals.

7.6 What the accountable-care contract sees

The forecast above is fee-for-service. It does not include shared-savings distributions or loss allocations under the ACO agreement; those settle at the ACO level, on the ACO's benchmark. Under an Enhanced-track agreement the distinction cuts in a specific direction. The program bills $1,317,408 of Part B reimbursement over 24 months on attributed and non-attributed patients alike, and that spending counts toward total cost of care for the attributed ones. The roughly 44 admissions it avoids are worth about $657,000 against the same benchmark, before counting the emergency visits that a rising blood pressure caught on a Tuesday never becomes.

The two layers, kept separate

Fee margin funds the program. $561,071 to the practice over 24 months, positive from M2, paid claim by claim by Medicare and by Medicare Advantage plans at their contracted terms.

Avoided admissions speak to the ACO. About 44 over 24 months on this census, about $657,000 at $15,000 each, plus the documented monthly relationship with 413 patients that retrospective assignment reads as primary care delivered here. The practice's assigned-beneficiary count and its distribution history under the current agreement are the numbers to bring to the first working session; the ACO holds both.

8. Growth: Plug-In Economics Across the Valley

The leadership team's plan is two more clinics next year, a fifth by the end of 2027, and 25 to 30 clinics across the Valley in about five years, multi-specialty and including cardiology, by acquisition and new construction. Instinctive Healthcare Solutions' published footprint already lists the Central Phoenix hospital, emergency room and clinic and the South Tempe emergency room and clinic for Spring 2027. A care-management program that lives in one clinic's staff cannot follow that plan. One that lives in an integration, a protocol and a staffing model can.[17]

What is built once	What each new clinic inherits
The Azalea integration	Both clinics share one tenant today. A clinic added to the tenant inherits the eligibility flag, the referral order, the write-back and the claim construction from the first day
The clinical protocol	Thresholds, trend rules, the emergent floor and the three-touch cadence are the same everywhere. Each clinic adds a routing row naming its covering clinician and its after-hours path
The staffing model	The care team scales by census at the same care-manager ratio, and CoachCare's enrollment outreach works each clinic's launch. Under full service, none of it is the clinic's headcount; Section 5 shows what that is worth across ten clinics
The economics	Every clinic is a new ceiling. An acquired internal medicine practice with a 1,000-patient Medicare panel is sized in the Scenario Explorer on the companion microsite in about a minute, at the Arizona amounts, before the letter of intent is signed
The specialty extension	When cardiology, nephrology or pulmonology joins the group, the same monitoring infrastructure carries the heart-failure, kidney-disease and COPD cohorts, and principal care management (99424 to 99427, $85.88 / $60.32 physician and $66.47 / $52.98 clinical staff at the Arizona amounts) is the monthly management code the specialty clinic bills on its own patients, paired with RPM. The platform does not change; the code mix does

Each acquired specialty practice brings a principal care management panel with it. A cardiology group's heart-failure patients, a nephrology group's stage 3b to 5 kidney patients and a pulmonology group's COPD patients are already identified in that practice's own chart, already seen monthly or quarterly, and already candidates for a connected scale or cuff. Under full service the same CoachCare care team enrolls them, monitors them and logs the 30 minutes against 99426 or 99427, and the practice's own physicians bill 99424 and 99425 when they do the work themselves. Nothing about the integration, the protocol or the staffing model changes; a specialty clinic simply adds a row to the code table. Those dollars are not in this forecast; the Scenario Explorer sizes them the day the practice is identified.

The order matters. Fountain Hills first, because its panel is the oldest and its ER is next door; Gilbert in parallel, because it shares the tenant and has already shown the work fits; then each new clinic as it opens or closes, with the program part of the integration plan rather than an afterthought to it.

9. Implementation Roadmap

9.1 Who runs what

Function	CoachCare	Fountain Hills Medical Center
Patient identification	Registry query against the agreed inclusion criteria, starting from the hypertension, diabetes and hyperlipidemia cohorts on the Medicare panel	Approves the criteria and the target list
Enrollment	**Enrollment outreach at 80 enrollments a month, on CoachCare's payroll; Azalea eligibility flag and referral order**	Clinician referral at the point of care and at the ER discharge; seven adult primary care clinicians

[17] Discovery call, September 3, 2026; instinctivehealthpass.com/locations/ and instinctivehealthcaresolutions.com, retrieved September 2026.

Function	CoachCare	Fountain Hills Medical Center
Transitional care	Discharge notification from the ER captured; 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 150 to 160 patients per care manager	**Sets thresholds, routing and after-hours cover per clinic; receives escalations**
Documentation and billing	Time logs, monthly care documents to the chart, claims constructed and landed billing-ready	**Files under its own enrollments through its in-house billing team; keeps the revenue**
Reporting	Monthly enrollment, engagement, escalation and revenue reporting, including the view the ACO needs	Standing monthly operating call; a named program lead

9.2 The model inputs

Input	Value in this forecast
Medicare panel	**1,750 patients, 1,400 in scope**; the midpoint of the 1,500 to 2,000 the leadership team gave for the two clinics
Referring clinicians	7 in adult primary care: 3 physicians and 4 advanced practice providers across Fountain Hills and Gilbert
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
Enrollment staffing	CoachCare's enrollment outreach at 80 enrollments a month, plus clinician referral and telephonic outreach; outreach, care managers and device logistics are CoachCare's payroll, embedded in the fee
EMR	Azalea Health; integration per Section 3.5 at $1,000 setup, $150 a month and $1.50 per enrolled patient-month
Rates	CY2026 physician fee schedule, non-facility, Arizona statewide locality (Noridian JF). 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.
Program pricing	15% program pricing, reflected in the per-patient-month fees: **RPM $55.99 · CCM $56.44**
Programs	RPM + CCM in the forecast; transitional care management recommended at every hospital or observation discharge, not in the forecast; principal care management recommended for the specialty clinics the group adds, not in the forecast; advanced primary care management named as the next lever at zero dollars

9.3 The roadmap

Window	What happens	Result at the end of it
Weeks 0–4 Integrate and charter	Azalea integration built alongside the practice's own implementation, on the shared tenant. Chart counts and the MA/FFS split pulled from the registry. Escalation thresholds, per-clinic routing and after-hours cover agreed. Billing configuration with the in-house team. Protocol sign-off for the hypertension, diabetes and lipid pathways. A named program lead at the practice	Scope signed, cohorts defined, integration live, protocol signed

Window	What happens	Result at the end of it
Weeks 4–12 Launch the first cohorts	CoachCare's enrollment outreach working both clinics. Chronic care management wave across the multi-chronic panel; remote monitoring for the hypertension and diabetes cohorts. Cellular cuffs and scales shipped and paired. Transitional care, the ER-visit trigger and the three-touch cadence live from the first week	38 enrollments by month 1, 101 by month 2, 187 by month 3; month 2 positive
Months 3–9 Reach the ceilings	Gilbert launches in parallel on the same tenant. Both programs climb to ceiling: remote monitoring 318.5 in M7, chronic care management 315 in M8. Monthly operating and ACO reporting views live	633.5 active enrollments across 413 unique patients; $27,677 a month from M9
Months 9–24 Widen and replicate	Chart-data eligibility widens the in-scope panel. The chronic care management versus advanced primary care management decision, with the ACO. Quality alignment with the ACO's measure set. Each new clinic added to the tenant with its routing row	Year 2 at $769,847 net reimbursement, $332,121 to the practice, 43.1%

9.4 What we would confirm together

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

1. **Chart counts and the payer split behind the 1,500 to 2,000.** A registry pull in week one: traditional Medicare versus Medicare Advantage, plan by plan, and how many carry hypertension, diabetes or two or more chronic conditions. 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 plan mix sets each program's target list.
2. **HealthPass members on the Medicare panel.** The share of Medicare patients who are members decides how much of the enrollment conversation is already settled at the point of service.
3. **The Gilbert program's platform and status.** Whether the 2024 remote monitoring and chronic care management program is still running, on what platform, and whether the Azalea migration retires it or migrates it.
4. **The accountable-care arrangements.** Whether the ACO places a care coordinator in either clinic, whether it restricts or claims chronic care management or advanced primary care management billing for participants, and the practice's assigned-beneficiary count and distribution history.
5. **Azalea go-live dates at each clinic, and the prior record system.** So the integration is scheduled against the tenant as it will actually run, and any historical data the program should carry forward is identified.
6. **The two listed internists' start dates and panels.** Two internists listed at Fountain Hills carry no Medicare panel in the CY2024 file. Once they do, the referring-clinician count moves from seven to nine, per the sensitivity table in Section 7.4.
7. **Any Medicare Advantage delegated-risk arrangement.** None was found in the public record. If any part of the panel sits under capitation, the fee-for-service forecast is scoped to the part that does not.
8. **The Azalea integration fee, in contracting.** The forecast carries catalog pricing of $1,000 setup, $150 a month and $1.50 per enrolled patient-month.
9. **Hospital and observation admissions from the practice's own ER.** The count of panel patients the Fountain Hills and El Mirage ERs transferred in the last twelve months sizes the transitional care episodes, which this forecast carries at zero.

10. The CY2027 Proposed Rule, Repriced on This Forecast

CMS published its proposed CY2027 physician fee schedule in July 2026. Comments are due September 14, 2026; the final rule arrives in early November; the changes take effect January 1, 2027, and a statutory phase-in caps how far any code's payment can fall in a single year. The proposal that matters

here is a reduction to the remote monitoring device-supply codes. Every code in this forecast was repriced at the Arizona locality on this practice's own billing mix, with enrollment held constant.[18]

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
Device supply, 99454 and 99445	$50.45 a month	**$40.06 a month, −20.6%**	The code CMS proposes to cut
The remote monitoring arm	$623,799 over 24 months	**−9.5%, about −$59,300**	Device supply is 32% of the remote monitoring basket; treatment management moves little
Chronic care management	$693,609 over 24 months	−2.1%, about −$14,600	Conversion-factor and relative-value churn only; the proposal does not target these codes
The whole service line	$1,317,408 over 24 months	**−5.6%, −$73,949, to $1,243,459**	Remote monitoring is 47% of the line; the rest is untouched

CoachCare repricing of this forecast at the CY2027 proposed amounts, Arizona locality, on the code frequencies in this Value Analysis. The final rule may differ.

Three numbers, each smaller than the last only because its base is larger. A 20.6% cut to one code is a 5.6% change to the service line, because this line is built on two programs and the larger of them is not the one being repriced. The comment window is open until September 14, and CoachCare is filing.

11. Recommendations

1. **Launch full service at Fountain Hills, with Gilbert in parallel.** $561,071 to the practice over 24 months at a 42.6% margin, positive from month 2, with no practice hires, against $99,745 at 10.6% with three clinical hires and an outreach role under software only. Prove the census and the workflow at two clinics before reopening the staffing question across several.
2. **Carry the program into the growth plan as built.** Run through ten new clinics over 36 months, full service returns $2,608,899 at 42.4% with 1,888 patients in care at month 36 and nobody on the practice's payroll; software only returns $1,060,367 at 29.9% after hiring eight care managers. Switch the program on the month each site opens.
3. **Bill transitional care management at every hospital or observation discharge the ER transferred or learns of.** The two-business-day contact and the 7- or 14-day visit are the cadence the program already runs; 99495 and 99496 pay $215.45 and $292.37 per discharge for them at the Arizona amounts. Not in the forecast, and sized by the ER's own admission count.
4. **Bill principal care management at every specialty clinic the group adds.** Heart failure in cardiology, stage 3b to 5 kidney disease in nephrology, COPD in pulmonology: one serious condition, a disease-specific plan, 30 minutes a month, paired with remote monitoring on the same patient. 99424 and 99425 pay $85.88 and $60.32 when the physician does the work; 99426 and 99427 pay $66.47 and $52.98 when clinical staff do, at the Arizona amounts. Not in the forecast; the primary care panel stays on chronic care management.
5. **Build the integration inside the Azalea window that is already open.** About four weeks, on the shared tenant, in parallel with the implementation under way. Every later clinic inherits it.
6. **Point the first enrollment wave at the multi-chronic hypertensive core.** Three in four beneficiaries carry hypertension and three in four carry hyperlipidemia; a fifth are diabetic. Chronic

[18] CMS-1848-P, CY2027 Medicare Physician Fee Schedule proposed rule, published July 2026; comment deadline September 14, 2026. CoachCare repricing of this forecast at the proposed CY2027 amounts, Arizona locality (conversion factor $32.8409 versus $33.4009): 99454 and 99445 $50.45 to $40.06 (−20.6%); remote monitoring arm −9.5% (−$59,308) with device supply 32.1% of that basket; chronic care management −2.1% (−$14,641); service line −5.6% (−$73,949), $1,317,408 to $1,243,459, with remote monitoring 47.4% of the line. Enrollment held constant.

care management for the care plan, a connected cuff and scale for the readings, and the ER-visit trigger for the cadence.

7. **Make the ER the referral engine it already is.** Any ER visit or hospitalization in the last 60 days fires the three-touch cadence. Order the device before the patient leaves the emergency room; hand the enrolled patient back to the clinic with a plan; when the ER transfers a patient, start the transitional care clock the day the hospital sends them home.
8. **Pull the chart counts in week one.** The binding constraint is the in-scope panel. Between 1,500 and 2,000 Medicare patients, 24-month net to the practice runs from $489,610 to $629,743 at the same margin; the registry, not the estimate, sets the number.
9. **Bring the ACO into the first working session.** The avoided admissions, about 44 over 24 months and about $657,000, are the layer the two-sided contract rewards. The practice's assigned-beneficiary count, its distribution history and any coordinator or billing arrangement the ACO runs shape how the program is drawn.
10. **Hold advanced primary care management as the named next lever, and decide it in months 9 to 24.** The gate is cleared. The pathway choice between chronic care management and APCM is the practice's, made with the ACO, once the care-management census and documentation workflow are real.
11. **Read the Medicare Advantage contracts early.** About half of Maricopa County's Medicare is in a 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 plan-by-plan read decides how far past traditional Medicare the program reaches.
12. **Treat every new clinic as a new ceiling, and size it before the deal closes.** The Scenario Explorer on the companion microsite prices an acquired panel at the Arizona amounts in a minute. The program should be part of the integration plan for each clinic, not an afterthought to it.

The Medicare panel this group already manages supports a $1,317,408 service line at a 42.6% practice margin inside 24 months, positive from its second month, on staff the practice does not have to hire, and $2,608,899 over 36 months once the growth plan is under it. The panel is old and multi-chronic, the emergency room next door sees its sickest patients first and knows the day they come home, the accountable-care contract pays for the same outcomes the program produces, and the record system is being installed right now. The pieces are in place. What remains is to build the service line once, and carry it to every clinic that follows.

12. Why CoachCare for Fountain Hills Medical Center

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

12.1 Built for the way this group is growing

Six reasons this partnership fits Fountain Hills Medical Center specifically, not remote care in general.

- **Azalea.** CoachCare is the Azalea integration partner that carries remote monitoring and chronic care management together, with automated claim creation. Eligibility flags and referral orders leave the chart; vitals, documentation and billing-ready claims come back into it. The integration is built

inside the implementation already under way, so there is no second system for the clinicians and no re-keying for the billing team.

- **Full service.** Enrollment outreach, care managers at about 160 patients each, device logistics, 24/7 alert triage and billing preparation are CoachCare's payroll. Every clinic the group opens or acquires inherits a running program the month it opens, at a 42.6% margin, without a hiring cycle. Section 5 is the arithmetic.
- **The ER.** Every ER visit by an enrolled patient fires the three-touch cadence the same day, and every hospital transfer becomes a transitional care episode. Critical readings escalate through one engine whose urgent policy supersedes any preference. A 24/7 emergency room beside a primary care clinic is the ideal shape for this program.
- **Two-sided risk.** Under the Enhanced track, fewer ED visits and admissions among attributed patients are shared savings. The same monthly touches produce both ledgers: the fee-for-service margin funds the program while the risk-side benefit accrues to the ACO contract.
- **Specialty ready.** When the cardiology, nephrology and pulmonology clinics arrive, the program keeps its shape: remote monitoring plus principal care management for heart failure, chronic kidney disease and COPD, on the same devices, the same care team and the same Azalea tenant. CoachCare already runs this for one of the largest cardiology groups in the Valley.
- **Aligned.** Fees are per active patient per month. There is no capital outlay and no payroll ramp; if the census does not build, CoachCare is not paid, with implementation and integration fees the exceptions. The forecast, the workbook and the companion documents are the practice's to keep.

12.2 The ask

A working session with the executive team: validate the panel against chart counts, confirm the Azalea timeline with the implementation contact, and set go-live for the Fountain Hills and Gilbert cohorts.

References & Data Sources

- **The practice's own published materials** (retrieved September 2026): fhmcaz.com, instinctivehealthcaresolutions.com, instinctivehealthpass.com and mgppaz.com, for the facility listings, hours, services, the membership program's terms, the published expansion plan, and the Azalea Health patient-portal links that confirm both clinics run on one tenant.
- **Discovery call, September 3, 2026:** the panel range (4,000 to 5,000 patients, 1,500 to 2,000 Medicare), the record system and implementation status, the billing arrangement, the conditions to model, the preference on staffing and the request for a full-service versus software-only comparison, and the growth plan. Prospect-stated facts take precedence over public inference throughout.
- **Arizona Department of Health Services licensing lookup:** the Fountain Hills and El Mirage facilities as licensed outpatient treatment centers providing emergency services; Arizona Administrative Code R9-10-1019 and the AHCCCS freestanding emergency department guidance for the distinction from a hospital-based department.
- **CMS provider and claims files** (data.cms.gov, retrieved September 2026): NPPES organization and individual records; the CMS Doctors & Clinicians file for the two organization records at the Fountain Hills address; the Medicare Physician & Other Practitioners by Provider file, CY2024, for beneficiary counts, age distribution, chronic-condition prevalence and risk scores of the two highest-volume internists; and the by Provider and Service file, CY2024, queried per clinician across the eight-clinician Fountain Hills roster and the Gilbert internist for the remote monitoring, chronic care management and advanced primary care management code families. CMS suppresses lines under 11 beneficiaries and caps published chronic-condition prevalence at 75%.

- **Medicare Shared Savings Program PY2026 participant file** (data.cms.gov, retrieved September 2026): FHMC Operating PC as a participant in an Enhanced-track ACO; low-revenue; retrospective assignment; agreement period five, current period beginning January 1, 2025; not a participant in the prospective primary-care payment option. Corroborated on the ACO's public reporting page.
- **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 and the G0556–G0558 advanced primary care management tiers; CMS-1848-P, the CY2027 proposed rule published July 2026, for the proposed device-supply repricing, the comment deadline and the statutory phase-in; and the Noridian JF Arizona statewide locality amounts used for every dollar in this report.
- **Market and population sources:** CMS Medicare Monthly Enrollment, 2025 annual, Maricopa County, for beneficiary counts, the Original Medicare and Medicare Advantage split and the dual-eligibility share; U.S. Census Bureau American Community Survey 2024 five-year estimates, profile DP05, for Fountain Hills and Gilbert population, median age and the 65-and-over share.
- **Azalea Health:** the CoachCare and Azalea Health marketplace partnership announcement, January 25, 2022, for the integration's scope (remote monitoring and chronic care management together, automated claims creation, dual enrollment, integrated cellular devices); azaleahealth.com for the vendor profile.
- **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 6.
- **CoachCare Value Analysis for Fountain Hills Medical Center, 2026:** every financial, enrollment, clinical-output and operational figure in Sections 4, 5, 7, 8, 9 and 10, including the software-only case, the scale-out run and the sensitivity runs, built on 1,750 Medicare patients with 1,400 in scope, seven referring clinicians, CoachCare's enrollment outreach at 80 enrollments a month, and the CY2026 fee schedule at the Arizona locality amounts for remote physiologic monitoring and chronic care management. The software-only labor basis is CoachCare's house staffing model; the scale-out run adds ten sites of 500 in-scope patients and three clinicians, one a quarter from month 4.
- **Transitional care management amounts:** CY2026 Medicare Physician Fee Schedule relative value units (PPRRVU2026) for 99495 and 99496, priced with the Addendum E geographic indices for the Arizona statewide locality: $215.45 and $292.37 per discharge (national $220.11 and $298.60). Transitional care management carries no dollars in the Value Analysis.

A note on how this report handles counts and names

Unique patients and program enrollments are different numbers. At M24 the program holds 633.5 active program enrollments belonging to 413 unique patients, because a patient may hold a monitoring enrollment and a care-management 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 comes from the practice, corroborated by claims. The 1,500 to 2,000 Medicare figure is the leadership team's, covers both clinics and all payers, and is the basis of the forecast at its midpoint. The 809 fee-for-service beneficiaries in the CY2024 claims file belong to two clinicians at one clinic and exclude Medicare Advantage, so the two numbers describe different things and are not in conflict.

No individual is named anywhere in this report. Clinicians, executives and ACO personnel are described by count and role only, and the practice's ACO is described by its program track rather than by name.