

Advanced Family Medical Center

An independent, certified Rural Health Clinic in Middleton, Tennessee, with same-day and walk-in access, in-house laboratory and X-ray, and a sliding-fee scale

Remote Care Service Line Performance & Optimization

2026 Strategy Report

Remote physiologic monitoring, chronic care management and advanced primary care management for a one-provider clinic's Medicare panel, billed under the CY2026 rules that pay a Rural Health Clinic for each code at national amounts, on top of the all-inclusive rate, and staffed by CoachCare

Purpose of this document

Prepared by CoachCare in October 2026 as a discussion document for Advanced Family Medical Center. It covers the clinic and its county, the CY2026 billing rules for Rural Health Clinics, the chronic care management the clinic already runs, a 24-month Value Analysis for a remote care service line, the accountable-care track the clinic now sits on, the eClinicalWorks integration, the clinical governance that would run the program, and a plan for the first 90 days.

The short version: the clinic has the patients, the chart and the reason. What a one-provider clinic does not have is a second pair of hands for the work between visits. Since January, Medicare pays for that work code by code. CoachCare does the enrollment and the monthly work.

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Executive Summary

Advanced Family Medical Center is an independent, freestanding Rural Health Clinic at 101 North Main Street in Middleton, Hardeman County, Tennessee, certified by CMS in November 2019.¹ It is a one-provider clinic: a single full-time practitioner carries the whole panel, with same-day appointments, walk-ins, in-house laboratory and X-ray, and a sliding-fee scale for patients who cannot pay.² The chart, the patient portal and the healow app run on eClinicalWorks. The clinic already runs chronic care management inside eClinicalWorks, counts about 600 Medicare patients, and names hypertension and diabetes as its clinical focus.³

Three things changed around the clinic at once. In January, Medicare started paying Rural Health Clinics for chronic care management, remote physiologic monitoring and advanced primary care management as individual codes at national amounts, on top of each visit. In 2026 the clinic's Medicare Shared Savings Program ACO moved to the two-sided ENHANCED track, so the cost and quality of the clinic's attributed patients now carry downside as well as upside. And the county's need did not change: nearly half of Hardeman County adults have high blood pressure and one in six has diagnosed diabetes.⁴

The observation this report is built on

A one-provider rural clinic already doing chronic care management for 600 Medicare patients, 15 miles from the nearest hospital, now on a two-sided accountable-care track. The clinic has the panel, the eClinicalWorks workflow and the reason. What it does not have is a second pair of hands.

Since January Medicare pays a Rural Health Clinic for every month of remote monitoring and care management as its own codes, at national amounts, on top of each visit. The enrollment and the monthly work are ours.

What the Value Analysis returns

The forecast prices a service line for the clinic's 600 Medicare patients, traditional Medicare and Medicare Advantage together, referred by the clinic's one provider and worked by a CoachCare-funded on-site enrollment specialist, at the national amounts a rural health clinic is paid for these codes. Over 24 months it returns **42.77% to the clinic**: 40.73% in Year 1 and 44.29% in Year 2.⁵

	Year 1	Year 2	24 months
Net reimbursement	\$216,076	\$292,610	\$508,687
CoachCare fees	\$128,077	\$163,024	\$291,101
Net to the clinic	\$88,000	\$129,586	\$217,586
Margin to the clinic	40.73%	44.29%	42.77%

CoachCare Value Analysis. CY2026 national non-facility Physician Fee Schedule amounts, the rail a Rural Health Clinic bills these codes on. 600 Medicare patients in scope; RPM + CCM + APCM. Margin is net to the clinic divided by net reimbursement. CoachCare fees include \$20,531 of implementation, eClinicalWorks integration and telephonic outreach.

¹ CMS Rural Health Clinic Enrollments (July 2026) and CMS Provider of Services file (April 2026 release): Advanced Family Medical Center, CCN 883807, independent Rural Health Clinic (not hospital-based), certified November 12, 2019, active, rural.

² CMS Medicare cost report (HCRIS, CMS-222-17), FY2025: 1.0 practitioner FTE. Services, hours and the sliding-fee policy from the clinic's own website, retrieved October 6, 2026.

³ eClinicalWorks confirmed from the clinic's website (eClinicalWeb patient portal, healow practice page, healowpay). Chronic care management in eClinicalWorks, the ~600 Medicare patient count and the hypertension and diabetes focus are the clinic's own description to CoachCare, 2026.

⁴ CMS MLN006398, Information for Rural Health Clinics, January 2026; CMS Medicare Shared Savings Program Participants, PY2026, and the CMS Quality Payment Program eligibility record for the clinic, 2026; CDC PLACES county data, 2025 release (BRFSS 2023).

⁵ CoachCare Value Analysis for Advanced Family Medical Center, 2026: CY2026 national non-facility Physician Fee Schedule amounts; 600 Medicare patients in scope; 1 referring clinician; one CoachCare-funded on-site enrollment specialist; RPM, CCM and APCM.

1. **The program pays for itself from month 2.** Month 1 nets -\$5,858 because implementation lands before the first billing months. Month 2 turns positive at \$2,074. From M10 the line runs at \$24,384 of monthly net reimbursement and \$10,799 net to the clinic.
2. **The panel fills inside the first year.** APCM reaches its ceiling in M3, CCM in M6 and RPM in M9. At M24 the program holds 271 active program enrollments across 177 unique patients. After month 9 the limit is the size of the Medicare panel, not enrollment pace.
3. **The enrollment specialist is the program.** One provider can refer about six patients a month between visits. On referrals alone the same forecast returns \$130,517 over 24 months. The CoachCare-funded specialist adds \$378,170 of net reimbursement and \$169,726 net to the clinic, at no cost to the clinic.
4. **Nobody is hired.** CoachCare delivers 3,531 care-team hours over 24 months, about 1.7 FTE-years, for a clinic whose entire practitioner staff is one full-time position.
5. **It works for the two-sided track as well as the fee schedule.** Daily blood-pressure and glucose readings and a documented monthly touch are how hypertension and diabetes control move. The forecast projects 18.0 avoided hospitalizations over 24 months, about \$270,000 of avoided cost at \$15,000 each.
6. **Medicare Advantage is most of the county.** 56% of Hardeman County's Medicare beneficiaries are in Medicare Advantage. Plans pay these code families at a floor of the Medicare amount and set their own contract terms, so the plan terms are the first thing to confirm together.

1. The Clinic and Its County

1.1 A one-provider Rural Health Clinic in Middleton

Advanced Family Medical Center is a for-profit, independent Rural Health Clinic, not owned by a hospital or a health system, with no management company and no outside investor. It has operated from one site in Middleton since its CMS certification in November 2019, and its ownership has not changed.⁶ It covers the range of family medicine: annual checkups, preventive and chronic-condition care, women's and men's health, and DOT, sports and pre-employment physicals.⁷

What the clinic has	Why it matters for this service line
Certified Rural Health Clinic since 2019, with its own primary-care and mental-health shortage-area designations	Bills care management and monitoring on the Rural Health Clinic claim at national amounts
Same-day appointments and walk-ins	Patients are seen when a reading says they should be
In-house laboratory and X-ray	A1c, glucose and urinalysis results land in the same chart as the home readings
Chronic care management in eClinicalWorks	Consent, care-plan and documentation habits already exist (Section 3)
Medicare Shared Savings Program participant, ENHANCED track in 2026	Cost and quality for attributed patients now carry two-sided risk (Section 6)
One full-time practitioner	Every between-visit task competes with the visit schedule (Section 4)

CMS Provider of Services file; HRSA shortage-designation files; the clinic's website; CMS Medicare Shared Savings Program Participants, PY2026.

One fact shapes everything else in this report. The clinic runs on a single practitioner. Your provider sees every scheduled patient, every walk-in and every same-day add-on, and the between-visit work of a 600-patient Medicare panel has to fit around that schedule. That is not a weakness. It is the design constraint the service line is built around.

1.2 Hypertension and diabetes: the county's burden and the clinic's focus

Hardeman County's cardiometabolic load is heavy. Among adults, 45.9% have high blood pressure, 17.2% have diagnosed diabetes and 43.7% are obese; one in four reports depression.⁸ The clinic's own Medicare patients run higher. Among the fee-for-service beneficiaries with laboratory or ECG claims billed under the clinic's provider in CY2024, at least three in four had hypertension and 28% had diabetes.⁹

Hardeman County	Value
Adults with high blood pressure	45.9%
Adults with diagnosed diabetes	17.2%
Adult obesity	43.7%
Adult depression	25.8%

⁶ CMS Provider of Services file (April 2026): provider category 12 (Rural Health Clinic), hospital-based indicator N, no change of ownership recorded. CMS Rural Health Clinic All Owners file (July 2026): a single direct owner since 2018, no private-equity, holding, management or MSO flags.

⁷ Service list from the clinic's website, retrieved October 6, 2026.

⁸ CDC PLACES county data, 2025 release (BRFSS 2023 model-based estimates), Hardeman County, Tennessee (FIPS 47069), crude prevalence among adults 18 and over: high blood pressure 45.9%; diagnosed diabetes 17.2%; obesity 43.7%; depression 25.8%.

⁹ CMS Medicare Physician & Other Practitioners by Provider, CY2024: chronic-condition prevalence among the fee-for-service beneficiaries with Part B laboratory, ECG or X-ray lines under the clinic's provider. CMS caps published prevalence at 75%, so the hypertension figure is a floor ("at least three in four"), not a measurement. Diabetes 28%.

Hardeman County	Value
Clinic's CY2024 fee-for-service patients with hypertension	at least three in four
Population / aged 65 and over	25,433 / 18.7%
Poverty rate / median household income	19.0% / \$46,069
Households with a broadband subscription	81.7%
Primary-care Health Professional Shortage Area and Medically Underserved Area	Yes, both

CDC PLACES 2025 release (BRFSS 2023); CMS Medicare Physician & Other Practitioners, CY2024 (hypertension prevalence is CMS top-coded at 75%); U.S. Census Bureau ACS 2020–2024 five-year estimates; HRSA shortage-designation files, October 2026.

Those two conditions are the core of the forecast. Blood-pressure cuffs and glucometers are the devices this panel needs, and blood-pressure and diabetes control are the outcomes a primary-care practice is measured on. The program starts where the clinic already concentrates.

1.3 Medicare Advantage covers most of the county's Medicare

Hardeman County has 6,220 Medicare beneficiaries. In the September 2026 CMS penetration file, **56% of them are in Medicare Advantage**, and 23% are dual-eligible for Medicaid, well above Tennessee's 15%.¹⁰ The clinic's 600 Medicare patients include both, and the forecast prices all of them at the national Medicare amounts. Medicare Advantage plans, which cover most of the Medicare population in Hardeman County, reimburse the care-management and remote-monitoring code families at a floor of the Medicare amount; individual plan contracts set their own terms.

What a 56% Medicare Advantage county means for the revenue line

Most of the county's Medicare beneficiaries carry a plan card rather than the red-white-and-blue one. The care-management and monitoring code families are paid by the plans at a floor of the Medicare amount, and each plan's contract with the clinic sets its own terms, including any authorization or billing rules.

The practical step is early and small: pull the clinic's payer mix out of eClinicalWorks and confirm RPM, CCM and APCM terms with the two or three plans that carry most of it, in the first weeks (Recommendation 5). Section 11 shows the traditional-Medicare-only case.

The dual-eligible share matters too. Advanced primary care management pays its highest tier, G0558, for Qualified Medicare Beneficiaries, and at least 12.4% of the county's Medicare beneficiaries are in that group. The forecast weights the APCM blend toward it.¹¹

1.4 Fifteen miles from the nearest hospital

Middleton sits about 15 miles from the nearest hospital, a critical access hospital, and more than 40 miles from the region's tertiary center. The county is a geographic primary-care shortage area and a medically underserved area, and the clinic holds its own Rural Health Clinic shortage designation.¹² For a patient whose blood pressure has been climbing for a week, the choice today is a drive to the clinic, a drive to an emergency department, or nothing. A cellular cuff that sends a reading the moment it is used puts that

¹⁰ CMS Medicare Monthly Enrollment, June 2026 (6,220 beneficiaries; 1,430 dual-eligible, 23.0%; Tennessee 15.2%) and CMS Medicare Advantage State/County Penetration, September 2026 (Hardeman County 56.14%).

¹¹ CMS Medicare Monthly Enrollment, June 2026: QMB-plus beneficiaries 772 (12.4% of the county's Medicare beneficiaries; the QMB-only count is suppressed, so 12.4% is a floor).

¹² CMS Care Compare Hospital General Information and Provider of Services file: the nearest hospital is a critical access hospital; distances are straight-line from the clinic's location. HRSA: Hardeman County geographic primary-care HPSA (score 15) and MUA; the clinic's own Rural Health Clinic primary-care HPSA (score 19) and mental-health HPSA (score 17).

week in front of a nurse before it becomes an emergency visit. The devices do not need home broadband or a smartphone, which matters in a county where one household in five has no broadband subscription.

2. The CY2026 Billing Change for Rural Health Clinics

2.1 G0511 is gone; each code now pays on top of the all-inclusive rate

A Rural Health Clinic is paid an all-inclusive rate per qualifying visit. For years, the care-management work between visits was compressed into one flat monthly code, G0511, whatever the patient needed. G0511 stopped being payable on October 1, 2025. Since then Rural Health Clinics bill the individual codes (the CCM, RPM, APCM, PCM, BHI and TCM families among them) and Medicare pays each at the **national non-facility Physician Fee Schedule amount, on top of the all-inclusive rate**.¹³ TCM can be billed in the same month as CCM and remote physiologic monitoring.

CY2026 also added two short-window remote-monitoring codes. 99445 pays the device-supply month when a patient sends 2 to 15 days of readings rather than 16 or more, and 99470 pays the first 10 minutes of monthly management time. A patient enrolled on the 20th of the month used to produce an unbillable partial month; now it bills. In this forecast the two codes carry \$49,343 of gross reimbursement over 24 months, about 9.7% of net reimbursement, revenue that did not exist two years ago.¹⁴

The consequence is structural. Between-visit care stops being one flat payment and becomes a per-service revenue line that grows with enrollment and delivered work. That is what makes a staffed, managed program worth running at a one-provider clinic. Tennessee's \$206.9 million first-year Rural Health Transformation Program award names remote monitoring in its technology pillar; the billing change is the nearer lever.¹⁵

2.2 What the codes pay

The Value Analysis prices every code at the CY2026 national non-facility amounts, the rate a rural health clinic is paid on for these codes.¹⁶

Code	What it pays for	Cadence	CY2026 national
99453	RPM setup and patient education	One-time	\$21.71
99454	Device supply, 16–30 days of readings	Monthly	\$52.11
99445	Device supply, 2–15 days of readings (new 2026)	Monthly	\$52.11
99457	RPM management, first 20 minutes	Monthly	\$51.77
99470	RPM management, first 10 minutes (new 2026)	Monthly	\$26.05
99458	RPM management, each additional 20 minutes	Monthly	\$41.42
99490	CCM, first 20 minutes of clinical staff time	Monthly	\$66.13
99439	CCM, each additional 20 minutes	Monthly	\$50.44
G0556	APCM, level 1: one chronic condition	Monthly	\$16.37
G0557	APCM, level 2: two or more chronic conditions	Monthly	\$53.78
G0558	APCM, level 3: Qualified Medicare Beneficiary	Monthly	\$117.24

¹³ CMS MLN006398, Information for Rural Health Clinics, January 2026, pp. 10–11 (care coordination services RHCs bill; payment and coinsurance at the national non-facility rate; TCM billable with CCM and remote physiologic monitoring); 42 CFR 405.2464(c). G0511 retirement effective October 1, 2025.

¹⁴ CoachCare Value Analysis, Financial Value detail (99445 \$42,294 and 99470 \$7,049 gross over 24 months) against \$508,687 of net reimbursement.

¹⁵ Tennessee Department of Health, Rural Health Transformation Program: FY2026 award \$206,888,882; the state plan lists remote monitoring under Tech Innovation.

¹⁶ CY2026 Physician Fee Schedule national non-facility amounts (conversion factor \$33.4009), as carried in the Value Analysis and CoachCare's rate tables.

Code	What it pays for	Cadence	CY2026 national
99495	Transitional care, moderate complexity	Per discharge	\$220.11 (named, \$0 in the forecast)
99496	Transitional care, high complexity	Per discharge	\$298.60 (named, \$0 in the forecast)
99484	Behavioral health integration, 20 minutes	Monthly	\$57.45 (named, \$0 in the forecast)

CY2026 national non-facility Physician Fee Schedule amounts. The APCM blend in the forecast is 17% level 1, 70% level 2 and 13% level 3, weighted to the county's Qualified Medicare Beneficiary share.

These are the Medicare amounts. Medicare Advantage plans, which cover most of the Medicare population in Hardeman County, reimburse the care-management and remote-monitoring code families at a floor of the Medicare amount; individual plan contracts set their own terms. The forecast prices every patient at these amounts and leaves no rate cushion on top.

3. What the Clinic Already Runs: Chronic Care Management in eClinicalWorks

3.1 Credit where it is due

This is not a greenfield program. The clinic already bills chronic care management for its Medicare patients inside eClinicalWorks.¹⁷ That means the hard habits exist: consent conversations, care plans, monthly documentation and a billing workflow that has already lived through the move off G0511. It also means the clinic knows what the monthly work costs in time.

3.2 Build or partner: what the program adds

The question for this clinic is whether to grow its in-house program or partner, and the answer depends on what in-house care management cannot do alone at a one-provider clinic. There are four gaps, and each is specific.

- **No physiologic signal between visits.** Remote monitoring needs a device fleet, shipping and replacement, and someone reading and triaging every transmission every day. That is a different operation from a monthly call.
- **No advanced primary care management.** APCM pays a monthly bundle without minute tracking, and its third tier pays most for exactly the dual-eligible patients this county has in numbers.
- **No enrollment engine.** Enrolling at the pace the panel allows takes dedicated outreach time. In a one-provider clinic that time comes out of the visit schedule.
- **The monthly logs depend on the provider's hours.** Every 20-minute block of CCM time and every month of RPM management needs a clinician's oversight and a documented record. Without more hands, growth means more evenings.

The upgrade, plainly

CoachCare runs remote monitoring, APCM, enrollment and the monthly time logs as the clinic's extension, inside eClinicalWorks, under the clinic's clinical direction. The clinic keeps its patients, its care plans and its claims. The existing CCM patients fold into one program rather than running beside a second one. How many patients the clinic carries in CCM today, and whether they sit inside the forecast's 72-enrollment CCM ceiling or add to it, is the second question in Section 13.

¹⁷ The clinic's own description to CoachCare, 2026. Rural Health Clinic care management bills on the institutional claim, which has no public line-level file, so the program's volume is not visible in CMS public data.

4. One Provider, One Panel: The Staffing Argument

4.1 Where the between-visit work goes today

In a one-provider clinic, every between-visit task lands on the same calendar: the enrollment call, the device question, the reading that needs a look, the care-plan update, the time log that has to be complete before the claim goes out. Each one competes with the next patient in the waiting room. The panel is there and the codes pay, but the hours do not exist inside a full visit schedule.

Your provider can flag patients during visits. At the forecast's referral rate that is about six enrollments a month, and on referrals alone the program reaches about half of its possible enrollments by month 24.¹⁸

4.2 The enrollment specialist is the program

This is the account where the enrollment specialist does most of the work. A CoachCare-funded specialist works the panel directly, in the clinic and by phone, at up to 80 enrollments a month. The comparison is stark:

Over 24 months	Referrals only	With the CoachCare enrollment specialist	Difference
Net reimbursement	\$130,517	\$508,687	+\$378,170
Net to the clinic	\$47,860	\$217,586	+\$169,726
Margin	36.67%	42.77%	
Ceilings reached (RPM / CCM / APCM)	none in 24 months	M9 / M6 / M3	

CoachCare Value Analysis recalculations, same panel and pricing. The enrollment specialist is CoachCare's expense; it is not a cost to the clinic.

The specialist cannot raise a ceiling; the panel sets those. What it does is fill them by month 9 instead of leaving three-quarters of the 24-month revenue on the table. A second specialist would reach the ceilings sooner, months 5, 4 and 2, for another \$32,485 of net reimbursement, which is not needed at this panel size. Once the ceilings are full, the binding constraint is the size of the Medicare panel, not enrollment pace.

4.3 Nobody is hired

Over 24 months CoachCare delivers **3,531 care-team hours, about 1.7 FTE-years**, to a clinic whose whole practitioner staff is one full-time position.¹⁹ That is the labor a clinic like this would otherwise have to recruit, in a county that is a federal primary-care shortage area. The enrollment specialist is CoachCare's expense, not a program cost.

The split of work is the design. CoachCare's staff carry the recurring load: enrollment, device logistics, reading review, outreach, documentation and escalation handling. Your provider contributes the two things only a clinician can, the referral flag that starts an enrollment and clinical judgment at the escalation points.

¹⁸ CoachCare Value Analysis sensitivity, no on-site enrollment specialist: 8 referrals a month at 80% acceptance; active enrollments at M24 of 39.0 RPM, 32.9 CCM and 59.7 APCM against ceilings of 136.5, 72 and 63; no program reaches its ceiling inside 24 months.

¹⁹ CoachCare Value Analysis operational outputs: 3,531 care-team hours over 24 months; FTE equivalent 1.7. Practitioner staffing from the clinic's FY2025 Medicare cost report (1.0 FTE).

5. The Service Line: RPM, CCM and APCM

5.1 The clinical and billing stack

Three programs run on one infrastructure. Remote physiologic monitoring supplies the daily signal; chronic care management and advanced primary care management supply the monthly coordination. Enrollment, devices, monitoring, escalation, documentation and claims run on the same CoachCare engine for all three. Principal care management is not in the forecast: in a primary-care panel CCM and APCM cover what PCM would, and PCM stays available for single-condition patients.

Program	Who qualifies	What it is	Billing
RPM	390 of the 600 Medicare patients (65%): hypertension, diabetes and other conditions that produce readings	Cellular blood-pressure cuffs and glucometers; readings reviewed against clinical thresholds; monthly management time	99453 setup; 99454/99445 supply; 99457/99470/99458 management
CCM	240 (40%): two or more chronic conditions expected to last 12 months or more	Monthly non-face-to-face coordination: care plan, medication reconciliation, referrals, outreach	99490 + 99439
APCM	210 (35%): an ongoing primary-care relationship; tier set by condition count and Qualified Medicare Beneficiary status	Monthly bundle of practice-capability elements; no minute tracking	G0556 / G0557 / G0558
TCM	A hospital or skilled nursing facility discharge home	Contact within two business days, medication reconciliation, a visit within 7 or 14 days	99495 / 99496, named, \$0 in the forecast
BHI	Patients with a behavioral health condition	Monthly behavioral care management	99484, named, \$0 in the forecast

Eligible-pool counts from the Value Analysis eligibility model. The pools overlap; the billing does not.

One coordination rule, set at enrollment

APCM and CCM never bill for the same patient in the same month; each patient carries one care-management wrapper. RPM stacks with either. A transitional care episode runs for 30 days after a discharge and does not overlap APCM for that patient in that month. The enrollment workflow assigns the wrapper once, so the code families never collide on a claim.

5.2 Four ways the service line pays

1. **Additive revenue.** Every care-management and monitoring dollar lands on top of the all-inclusive rate: \$508,687 of net reimbursement and \$217,586 net to the clinic over 24 months, a 42.77% margin.
2. **An answer to geography.** A reading from a kitchen table reaches a nurse the same morning, with no 15-mile drive for the patient. Cellular devices work without home internet.
3. **Fewer admissions.** A blood pressure that climbs for a week gets a medication change by phone and a same-day visit if needed, instead of an emergency visit. That is where the forecast's 18.0 avoided hospitalizations come from.
4. **Staffing that does not depend on recruiting.** CoachCare's clinical staff deliver the monitoring and monthly work, so growth does not wait on a hire the clinic would struggle to make.

A fifth layer sits on top of these: the clinic's two-sided accountable-care track, covered in Section 6.

5.3 Transitional care and behavioral health, named at zero

When a clinic patient goes home from a hospital or skilled nursing facility, a transitional care episode opens: an interactive contact within two business days, medication reconciliation, and a visit within 14 days (99495, \$220.11 national) or 7 days (99496, \$298.60). A Rural Health Clinic bills TCM in the same month as CCM and RPM. The area's hospitals discharge the clinic's patients, and the discharge is the highest-yield moment to start monitoring.²⁰ TCM carries no dollars in this forecast because discharge volume and discharge notification are discovery items. Every episode billed is upside.

Behavioral health integration (99484, \$57.45 national) is the natural next arm. The clinic holds a mental-health shortage designation and one in four county adults reports depression. It runs on the same care-management engine and is also at \$0 here.²¹

6. The Accountable-Care Layer: A Two-Sided Track

Advanced Family Medical Center participates in the Medicare Shared Savings Program. For 2026 the ACO it participates in moved onto the two-sided ENHANCED track with retrospective assignment, after two years in a one-sided BASIC-track ACO.²² On a two-sided track, the total cost of care and the quality scores of the clinic's attributed traditional-Medicare patients carry downside as well as upside.

The service line works on both sides of that ledger.

- **Quality.** Blood-pressure control and diabetes control are among the measures a primary-care ACO is graded on. Daily readings, a documented monthly touch and medication changes between visits are how those numbers move, for a panel where hypertension is close to universal.
- **Cost.** The 18.0 avoided hospitalizations in the forecast, about \$270,000 of avoided cost, are total-cost-of-care dollars. Admissions are the largest line in any attributed population's spending.
- **Attribution.** Assignment runs on primary-care services, and CCM and APCM are primary-care services. Documented monthly care management for the clinic's own patients helps keep them attributed to the clinic.

None of this changes the fee-for-service math. RPM, CCM and APCM bill per claim for every enrolled patient, and the Value Analysis counts only those claims. Whether the ACO already supplies care coordinators or care management to its participants, and how that fits with this program, is a question for the working session (Section 13).

7. eClinicalWorks Integration: The Program Lives in the Chart

The clinic's chart, its eClinicalWeb patient portal and its healow app run on eClinicalWorks. CoachCare integrates with eClinicalWorks directly, priced in the forecast at \$4,000 setup, \$150 a month and \$1.50 per patient-month.²³ Clinicians stay in the chart they already use.

- **Flag and order.** Your provider flags an eligible patient and places the order inside eClinicalWorks, the way a lab order is placed. CoachCare picks it up, ships the device and reaches the patient.
- **Monitor.** Readings arrive from cellular devices and are worked against the escalation protocol in Section 9.

²⁰ CPT 99495 and 99496 requirements; CY2026 national non-facility amounts \$220.11 and \$298.60; CMS MLN006398 (TCM billable with CCM and remote physiologic monitoring). TCM is carried at \$0 in every figure in this report.

²¹ HRSA: the clinic's Rural Health Clinic mental-health HPSA (score 17). CDC PLACES 2025: adult depression 25.8%. CY2026 national non-facility amount for 99484: \$57.45.

²² CMS Medicare Shared Savings Program Participants, PY2026 (ENHANCED track, retrospective assignment) and PY2025 (BASIC Level A), matched to the clinic through the CMS Quality Payment Program eligibility record for 2026 and 2025.

²³ CoachCare integration catalog for eClinicalWorks as carried in the Value Analysis: \$4,000 setup, \$150 a month, \$1.50 per patient-month. Included in the \$20,531 of 24-month ancillary fees with implementation (\$2,500) and telephonic outreach.

- **Post to the chart.** Every month, vitals land as discrete values, and the care documentation, care plan and enrollment status post to the eClinicalWorks chart. There is no second system to log into.
- **Bill in-house.** Claims are created in the eClinicalWorks billing module with the care-management codes on them, and the clinic's own billing staff file them on the Rural Health Clinic claim. Over 24 months that is about 8,185 claims, none of them re-keyed.

The clinic's current CCM documentation lives in the same chart, so existing enrollees move onto the program's workflow without a records migration.

8. Value Analysis: The 24-Month Forecast

8.1 Headline economics

Over 24 months the service line produces **\$508,687 in net reimbursement** for Advanced Family Medical Center. CoachCare's fees total \$291,101, including \$20,531 for implementation, the eClinicalWorks integration and telephonic outreach. Net to the clinic is **\$217,586, a 42.77% margin**: 40.73% in Year 1 and 44.29% in Year 2.²⁴

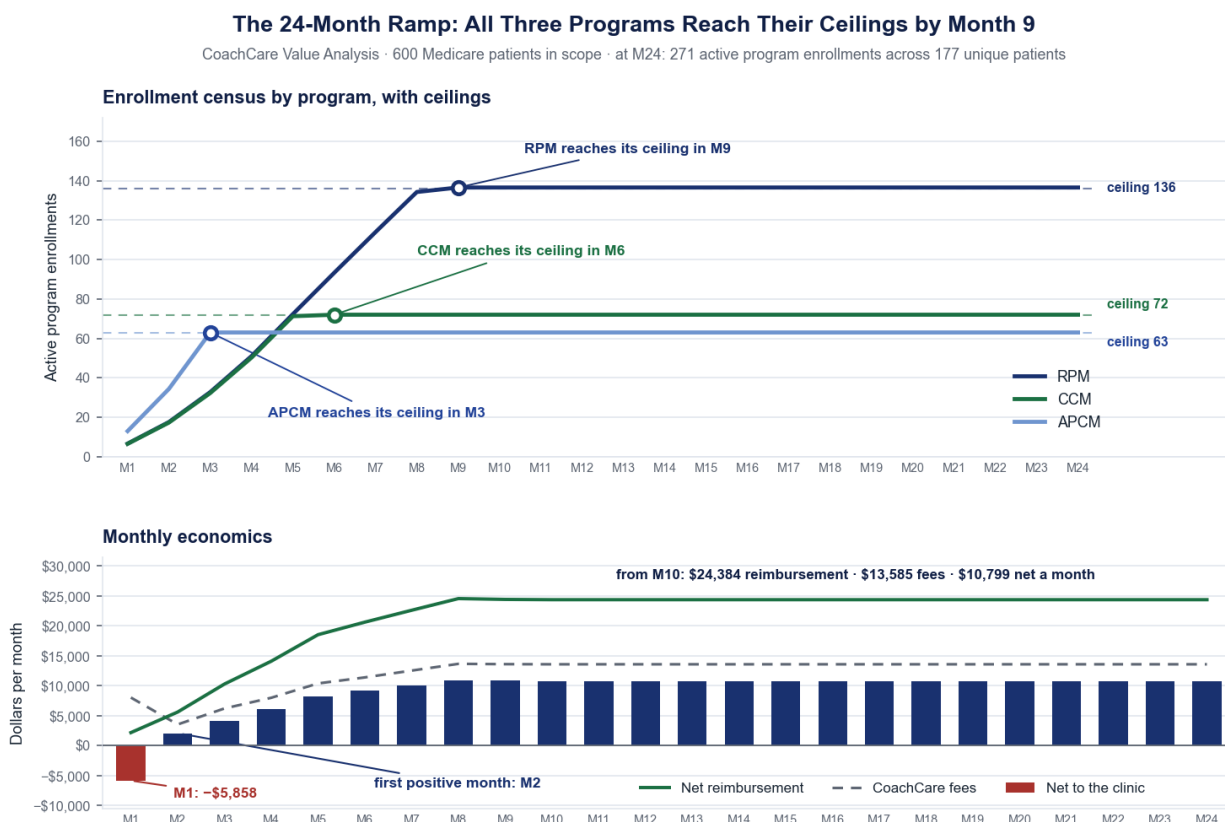


Figure 1. The 24-month ramp: enrollment census by program with ceilings (above) and monthly net reimbursement, CoachCare fees and net to the clinic (below). Month 1 nets -\$5,858; the first positive month is M2; from M10 the line holds at \$10,799 net a month.

Month 1 is negative, -\$5,858, because implementation lands before the first full billing months. Month 2 turns positive at \$2,074, month 3 nets \$4,081, and the line climbs as the programs fill. Net reimbursement peaks at \$24,568 in month 8 while RPM setup codes are still billing, then settles from month 10 at \$24,384 of net reimbursement, \$13,585 of fees and \$10,799 net to the clinic each month.

²⁴ CoachCare Value Analysis, 24-month forecast. Margin is net to the clinic divided by net reimbursement: Year 1 40.73% (\$88,000 of \$216,076), Year 2 44.29% (\$129,586 of \$292,610).

8.2 Program economics by year

Program	Line	Year 1	Year 2	24 months
RPM	Net reimbursement	\$105,654	\$157,944	\$263,598
	CoachCare fees	\$57,673	\$88,481	\$146,154
	Net to the clinic	\$47,981	\$69,463	\$117,444
CCM	Net reimbursement	\$75,496	\$95,687	\$171,183
	CoachCare fees	\$37,116	\$47,043	\$84,160
	Net to the clinic	\$38,380	\$48,644	\$87,023
APCM	Net reimbursement	\$34,926	\$38,980	\$73,906
	CoachCare fees	\$19,024	\$21,232	\$40,257
	Net to the clinic	\$15,902	\$17,748	\$33,649
Ancillary	Implementation, eClinicalWorks integration, outreach	\$14,263	\$6,268	\$20,531
All programs	Net reimbursement	\$216,076	\$292,610	\$508,687
	CoachCare fees	\$128,077	\$163,024	\$291,101
	Net to the clinic	\$88,000	\$129,586	\$217,586
	Margin	40.73%	44.29%	42.77%

CoachCare Value Analysis, per-program economics by contract year. Ancillary: implementation \$2,500; eClinicalWorks integration \$4,000 setup, \$150 a month and \$1.50 per patient-month; telephonic outreach. Rows round to the dollar, so program nets less ancillary sum to \$1 under the total.

RPM is the volume engine at 2,706 patient-months and \$263,598 of net reimbursement. CCM is the yield engine at \$110.75 of net reimbursement per patient-month, against \$97.42 for RPM and \$51.56 for APCM. APCM earns its place differently: a monthly bundle with no minute tracking, weighted toward the two-condition tier where a primary-care panel sits. Year 2 outruns Year 1 by \$76,534 because Year 1 carries the ramp and Year 2 runs at ceiling from its first month.

Service-Line Composition: RPM \$263,598 · CCM \$171,183 · APCM \$73,906

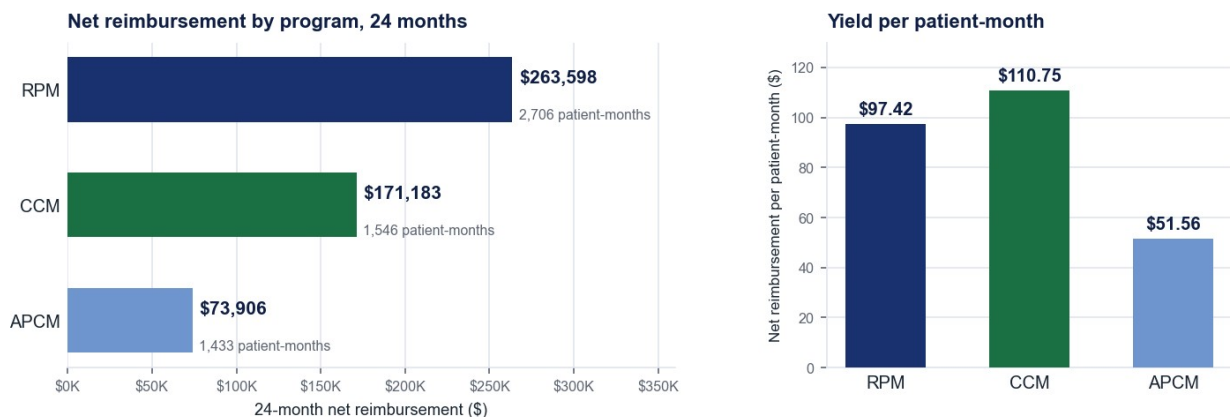


Figure 2. Service-line composition: 24-month net reimbursement by program and net reimbursement per patient-month.

8.3 The ramp: every ceiling reached by month 9

All three programs are ceiling-limited inside year one. APCM reaches its ceiling of 63 enrollments in month 3, CCM its 72 in month 6 and RPM its 136 in month 9. From month 9 the panel is full, which is why the month-12 census and the month-24 census are the same.²⁵ The first 90 days move fast: 26 active enrollments in month 1, 69 by month 2 and 128 by month 3.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
RPM	390	136	Month 9	136
CCM	240	72	Month 6	72
APCM	210	63	Month 3	63
All programs		271		271 enrollments · 177 unique patients

Enrollments are program enrollments, not patients: the 271 active program enrollments at M24 belong to 177 unique patients, because a patient may carry a monitoring enrollment and a care-management enrollment at the same time.

The constraint is worth saying out loud. After month 9 what limits this program is the size of the Medicare panel, not enrollment pace. That caps the forecast and it also de-risks it: the forecast asks for no heroic enrollment performance, only a panel that exists. The ways the number grows are the panel itself, Medicare Advantage plan terms, and the adjacent arms, TCM and BHI.

8.4 Clinical and operational value

24-month output	Volume
Claims generated, billing-ready	8,185
Device readings reviewed	28,410
Care-management tasks completed	16,370
Chart updates written to eClinicalWorks	4,092
Patient conversations held	2,455 (136 hours of call time)
Care-team hours delivered	3,531 (≈ 1.7 FTE-years)
Hospitalizations avoided	18.0 · ≈ \$270,000 at \$15,000 per admission

CoachCare Value Analysis operational and clinical outputs, 24 months.

18.0 avoided hospitalizations over 24 months is about \$270,000 of cost that never lands on Medicare, on the plans or on the clinic's attributed-patient ledger. For the patient it is a week at home instead of a ward 15 or 40 miles away.²⁶

9. Clinical Governance and Escalation

A monitoring program is a clinical operation before it is a revenue line. The clinic inherits CoachCare's care-management standard operating procedures at signing, covering qualification, monitoring, escalation

²⁵ CoachCare Value Analysis enrollment model: ceilings 136.5 (RPM), 72 (CCM), 63 (APCM), reached in months 9, 6 and 3; 271 active program enrollments across 177 unique patients at M12 and M24 (care-management set 135, plus RPM-only patients).

²⁶ CoachCare Value Analysis clinical-outcomes module: 18.0 avoided hospitalizations over 24 months, valued at \$15,000 per avoided admission.

and program discharge for RPM, CCM and APCM.²⁷ Your provider sets the escalation preferences and signs off on care plans; CoachCare runs the protocol.

9.1 One shared escalation engine

Every program routes through one alert-and-escalation logic. A critical value escalates immediately, whatever the symptoms. An out-of-range reading that is not critical is worked first: the patient retakes the reading and answers a symptom check, so the clinic hears clinical signal rather than cuff artifacts. Trend rules are explicit. Three consecutive out-of-range blood-pressure or glucose readings at least an hour apart count as a trend and draw clinical review even when no single reading is critical.

9.2 The emergent pathway

An active emergent symptom reported during any contact triggers the 911 pathway. That rule overrides any clinic-specific escalation preference; the emergent floor does not move. Every emergent event is documented and the clinic is notified the same day.

9.3 Qualification, device assignment and routing

Enrollment starts with the panel, not the device inventory. Patients are screened by ICD-10 code and routed to the right program and device, and device assignment follows a fixed order in which the highest-priority qualifying diagnosis wins: a patient with hypertension and diabetes gets the device the higher-acuity condition needs, and both where indicated. Once monitoring runs, escalations route three ways: emergencies to the emergent pathway, non-critical clinical items to your provider for direction, and informational items documented to the chart.

9.4 The post-discharge cadence and program discharge

An emergency visit or hospitalization in the last 60 days starts a fixed three-touch follow-up: a first contact on day 1 or 2, a second on days 5 to 8, and a third on days 12 to 14. Each touch is documented, and any alert raised during a touch escalates under the same logic. For a hospital discharge, the first touch is also the interactive contact a transitional care episode requires, and the day-12-to-14 touch lands inside the 14-day visit window.

Leaving the program is governed too. Discharge criteria and unreachable-patient timelines are defined per program, and the clinic is told in every case. For monitoring patients a recommended discharge first goes to your provider for instructions, re-escalates every 30 days, and proceeds at 180 days if no instruction comes. Nobody quietly falls out of the program, and nobody quietly stays in it.

10. The CY2027 Proposed Rule, Repriced on This Forecast

CMS published its proposed CY2027 Physician Fee Schedule in July 2026. Comments on CMS-1848-P closed September 14, 2026; the final rule is expected in early November, and the changes take effect January 1, 2027, with a statutory phase-in that caps how far a code's payment can fall in one year. The proposal that matters here is a cut to the remote-monitoring device-supply codes. Every code in this forecast was repriced at the proposed national amounts on the clinic's own billing mix, with enrollment held constant.²⁸

²⁷ CoachCare Care Management Programs standard operating procedures and the derived process maps: qualification and device assignment; the RPM patient lifecycle; the care-management lifecycle; alert-and-escalation decision logic; the emergent communication protocol; the post-discharge follow-up sequence; the discharge decision flow.

²⁸ CMS-1848-P, proposed CY2027 Physician Fee Schedule (July 2026). CoachCare repricing at national amounts on this forecast's code frequencies and APCM tier weights: 99454 and 99445 \$52.11 → \$41.38 (−20.6%); remote monitoring arm −9.5% (−\$25,092); CCM −2.15% (−\$3,680); APCM −0.89% (−\$659); service line −5.8% (−\$29,431, from \$508,687 to \$479,256). Enrollment held constant.

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
Device supply, 99454 and 99445	\$52.11 a month	\$41.38 a month, -20.6%	The code CMS proposes to cut
The remote monitoring arm	\$263,598 over 24 months	-9.5%, -\$25,092	Device supply is 32% of the RPM basket; management time moves little
Chronic care management	\$171,183 over 24 months	-2.15%, -\$3,680	Conversion-factor and relative-value churn; the proposal does not target these codes
Advanced primary care management	\$73,906 over 24 months	-0.89%, -\$659	Same churn; the bundle's values barely move
The whole service line	\$508,687 over 24 months	-5.8%, -\$29,431, to \$479,256	RPM is 52% of the line; care management is \$4,339 of the total

CoachCare repricing of this forecast at the CY2027 proposed national amounts, on the code frequencies and APCM tier weights in this Value Analysis.

The CY2027 Proposal on This Forecast: -20.6% on One Code, -5.8% on the Line

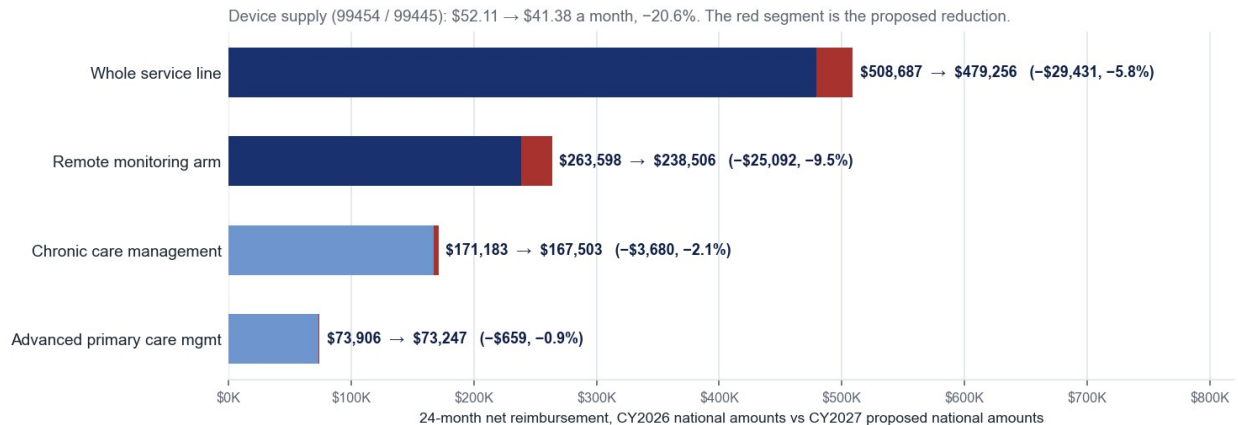


Figure 3. The proposal on one shared dollar scale: CY2026 national amounts against CY2027 proposed national amounts, with the reduction in red.

Code	CY2026 national	CY2027 proposed national
99453	\$21.71	\$20.03
99454	\$52.11	\$41.38
99445	\$52.11	\$41.38
99457	\$51.77	\$49.59
99470	\$26.05	\$20.69
99458	\$41.42	\$40.39
99490	\$66.13	\$64.04
99439	\$50.44	\$49.92
G0556	\$16.37	\$16.09
G0557	\$53.78	\$53.20
G0558	\$117.24	\$116.91

CY2026 national non-facility amounts and CMS-1848-P proposed CY2027 national non-facility amounts. A Rural Health Clinic bills these codes at the national amounts in both years.

A 20.6% cut to one code is a 5.8% change to the service line, because the line rests on three programs and two of them are not the one being repriced. Care management, the part of the line the clinic already knows, moves by \$4,339 across 24 months.

11. Recommendations

1. **Start the service line on the national rail now.** The individual-code rules have been live since January, and the ramp is the same whenever it starts. Each month of delay pushes \$217,586 of 24-month net one month further out.
2. **Fold the existing CCM program in.** Keep the clinic's consent and care-plan habits, and add what in-house CCM lacks: monitoring, APCM, an enrollment engine and the monthly time logs. Count existing CCM patients at the start so nobody is enrolled twice.
3. **Keep the CoachCare-funded enrollment specialist in the plan.** It is worth \$378,170 of 24-month net reimbursement and \$169,726 net to the clinic against referrals alone, and it is how a one-provider clinic fills the panel by month 9.
4. **Lead with hypertension and diabetes.** Start the RPM cohort with blood-pressure cuffs and glucometers for the patients the clinic already manages for those conditions, where the readings change decisions fastest.
5. **Confirm Medicare Advantage terms in the first weeks.** Medicare Advantage plans, which cover most of the Medicare population in Hardeman County, reimburse the care-management and remote-monitoring code families at a floor of the Medicare amount; individual plan contracts set their own terms. Pull the payer mix from eClinicalWorks and confirm RPM, CCM and APCM terms with the plans that carry most of it.
6. **Use the program for the two-sided track.** Report blood-pressure and diabetes control from the program's readings each quarter, and keep monthly care management documented for every attributed patient.
7. **Add TCM at discharge, then BHI.** Ask the area's hospitals for discharge notifications, enroll at discharge, and bill TCM on every eligible episode. Behavioral health integration is the next arm on the same engine.
8. **Set the attribution rule at enrollment.** One wrapper per patient per month, CCM or APCM, plus RPM where indicated and a TCM episode after a discharge. One rule, set once, prevents every collision the code families allow.

What moves the number

Scenario	24-month net reimbursement	Net to the clinic	Margin	Ceiling reached RPM / CCM / APCM
Base: 600 panel, 1 clinician, 1 enrollment specialist	\$508,687	\$217,586	42.77%	M9 / M6 / M3
No on-site enrollment specialist	\$130,517	\$47,860	36.67%	none reach ceiling
Second on-site enrollment specialist	\$541,172	\$231,976	42.87%	M5 / M4 / M2
Two referring clinicians	\$513,269	\$219,599	42.78%	M8 / M5 / M3
Traditional Medicare only (about 263 patients)	\$239,752	\$97,144	40.52%	M5 / M3 / M2
Panel 450	\$393,933	\$166,152	42.18%	M7 / M5 / M3
Panel 800	\$649,434	\$280,743	43.23%	M11 / M7 / M4

CoachCare Value Analysis recalculations at the same national rates and pricing. The traditional-Medicare-only row prices the 44% of the panel outside Medicare Advantage and counts no plan revenue at all.

Two readings matter. The enrollment specialist is the largest single lever in the table, larger than any change in panel size in the table. And the margin holds between about 40% and 43% across every staffed scenario, because CoachCare's fees scale with the enrollments that produce the revenue.

12. Implementation Roadmap and the First 90 Days

12.1 Who runs what

CoachCare delivers	Advanced Family Medical Center keeps
On-site and telephonic enrollment; the enrollment specialist is CoachCare's expense	Referral flags in eClinicalWorks; clinical direction of the program
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans and escalation preferences
Reading review, documentation and the escalation protocol in Section 9	Responses to provider-routed escalations; same-day visits when a reading calls for one
Billing-ready claims in the eClinicalWorks billing module	Filing the Rural Health Clinic claims; billing review; the revenue
Monthly operating reports against the dashboard in 12.3	Program governance

12.2 Model inputs

Input	Value
Medicare panel in scope	600 patients, the clinic's own count, traditional Medicare and Medicare Advantage together
Referring clinicians	1
Programs	RPM + CCM + APCM; TCM and BHI named at \$0; PCM not in the forecast
Program-eligible pools	RPM 390 · CCM 240 · APCM 210
Enrollment ceilings	RPM 136 (M9) · CCM 72 (M6) · APCM 63 (M3)
Acceptance	RPM 35% · CCM and APCM 30% of the eligible pool
Enrollment engine	8 referrals per clinician per month at 80% acceptance; one CoachCare-funded on-site enrollment specialist at 80 enrollments a month; telephonic outreach on; 1.5% monthly attrition
Rate basis	CY2026 national non-facility Physician Fee Schedule, the amounts a rural health clinic is paid for these codes
APCM tier blend	17% level 1 · 70% level 2 · 13% level 3
Medicare Advantage	56% of Hardeman County's Medicare (September 2026). Plans pay at a floor of the Medicare amount; contracts set their own terms
EMR	eClinicalWorks; CoachCare integration at \$4,000 setup, \$150 a month, \$1.50 per patient-month

12.3 The 90-day plan and the operating dashboard

Days 0–30: foundation. Program agreement and the eClinicalWorks integration plan. Reconcile the 600-patient panel by payer and fold in the current CCM roster. ICD-10 screening of the Medicare panel, devices staged, escalation preferences set with your provider, and the Medicare Advantage plan check started in week one.

Days 31–60: enrollment live. The enrollment specialist in the clinic and on the phone; first devices in homes; first billable months. Month 1 nets –\$5,858 as implementation lands, and month 2 turns positive. The forecast carries 26 active enrollments in month 1 and 69 by month 2.

Days 61–90: scale. 128 active enrollments by month 3, with APCM at its ceiling and CCM close behind. First monthly operating report against the dashboard, and a discharge-notification conversation with the area's hospitals to open TCM.

The operating dashboard from month one:

- Enrollment census by program against ceiling (136 / 72 / 63)
- Time from referral flag to first billable month
- Reading days per patient-month against the 16-day 99454 threshold, with 99445 covering 2- to 15-day months
- Blood-pressure and glucose control across the enrolled cohort, quarter by quarter
- Escalations by pathway: emergent, provider-routed, documented
- Claims generated against expected claims, and claims filed
- Net to the clinic per month against the \$10,799 steady-state line

13. Questions for a Working Session

These are the questions we would bring to a working session with the clinic, in the order they move the plan.

1. **How was the 600 counted, and how does it split?** Unique Medicare patients seen in the last year or two, traditional Medicare against Medicare Advantage, and which plans carry most of the Medicare Advantage side.
2. **What does CCM look like today?** Who on the staff runs it, how many patients are enrolled in a typical month, and how it is billed on the Rural Health Clinic claim since G0511 ended.
3. **What does the ACO provide?** Whether the ACO supplies care coordinators, care management or analytics to participants, and how the clinic would want this program to sit alongside them.
4. **Where do your patients go when they are admitted?** Which hospitals and skilled nursing facilities discharge them, and whether discharge notifications reach the clinic today. That sizes TCM.
5. **What are the Medicare Advantage plan terms?** Any authorization, billing or rate terms the clinic's plan contracts set for RPM, CCM and APCM.
6. **How is eClinicalWorks configured?** The care-management and billing modules in use, and who handles claims on the clinic side.
7. **Where would the enrollment specialist sit?** A desk or room in the clinic, the days that fit the patient flow, and who on the staff is the program's day-to-day contact.
8. **Is behavioral health integration of interest?** Whether the clinic wants BHI in the first year or after the core programs are full.

14. About CoachCare

CoachCare runs remote care programs for practices and health systems, from enrollment and devices to monitoring, documentation and billing-ready claims, under the practice's own clinical direction.²⁹

²⁹ CoachCare company statistics, 2026: patients managed, managed conditions, providers on the platform, implementations, claims generated, vitals recorded and care actions enabled.

Measure	CoachCare in market
Patients managed	500,000+ patients across more than 400 managed conditions
Clinicians on the platform	10,000+ providers running remote care programs day to day
Implementations	1,000+ programs stood up and running in market
Claims generated	Care-plan coding and billing behind more than 5 million claims
Vitals recorded	Over 100 million vitals recorded; 4 million+ care actions enabled

Contact

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Prepared by CoachCare for discussion with Advanced Family Medical Center. © 2026 CoachCare.

References and Data Sources

- **CMS Rural Health Clinic Enrollments and Rural Health Clinic All Owners (July 2026); CMS Provider of Services file (April 2026):** Advanced Family Medical Center, CCN 883807, independent Rural Health Clinic, certified November 12, 2019, single site, Middleton, Tennessee.
- **CMS Medicare cost report (HCRIS CMS-222-17), FY2025:** practitioner staffing (1.0 FTE).
- **CMS MLN006398, Information for Rural Health Clinics (January 2026), and 42 CFR 405.2464(c):** individual-code billing for care coordination services at national non-facility amounts on top of the all-inclusive rate; G0511 retirement; TCM with CCM and RPM.
- **CMS Medicare Shared Savings Program Participants, PY2025 and PY2026, and the CMS Quality Payment Program eligibility record:** the clinic's ACO participation, track and assignment method.
- **CMS Medicare Monthly Enrollment (June 2026) and Medicare Advantage State/County Penetration (September 2026):** Hardeman County's 6,220 beneficiaries, 56.14% Medicare Advantage, 23.0% dual-eligible, QMB-plus 12.4%.
- **CMS Medicare Physician & Other Practitioners by Provider, CY2024:** chronic-condition prevalence among the clinic's fee-for-service beneficiaries with Part B laboratory and ECG lines (hypertension top-coded at 75%; diabetes 28%).
- **CDC PLACES county data, 2025 release (BRFSS 2023):** Hardeman County adult high blood pressure, diabetes, obesity and depression.
- **U.S. Census Bureau ACS 2020–2024 five-year estimates (DP02, DP03, DP05):** population, age, poverty, income and broadband subscription.
- **HRSA shortage-designation and MUA files (October 2026):** county geographic primary-care HPSA, MUA, and the clinic's own primary-care and mental-health HPSAs.
- **CMS Care Compare Hospital General Information:** type and location of the nearest hospitals.
- **CY2026 Physician Fee Schedule and CMS-1848-P (proposed CY2027):** national non-facility amounts for every code in the forecast and the CY2027 repricing.
- **Tennessee Department of Health, Rural Health Transformation Program:** FY2026 award and state plan.
- **The clinic's website, retrieved October 6, 2026:** services, access policy, and the eClinicalWorks patient portal and healow links.
- **CoachCare Care Management Programs standard operating procedures and integration standards:** Section 9 governance and the Section 7 eClinicalWorks workflow.

- **CoachCare Value Analysis for Advanced Family Medical Center, 2026, its sensitivity recalculations and the CY2027 repricing:** every financial, enrollment, clinical-output and operational figure in this report.

How this report counts

Patients and program enrollments are different numbers. At M24 the program holds 271 active program enrollments belonging to 177 unique patients, because a patient may carry a monitoring enrollment and a care-management enrollment at the same time. Where this report gives a patient count it says patients; where it gives an enrollment count it says enrollments.

No individual is named anywhere in this report. The clinic and its care team are described by role and count only.