COACHCARE | Arkansas Family Care Network

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

Arkansas Family Care Network, P.A.

An independent, physician-led network in central Arkansas, incorporated in 1970: 26 primary care clinicians at seven clinics in Little Rock, Bryant and Hensley, on one eClinicalWorks system, with a Medicare panel of about 15,000

Remote Care Service Line Optimization Report

2026 Strategy Report

A scalable, profitable remote care service line for Arkansas Family Care Network: remote monitoring for the heart failure and kidney disease patients its seven primary care clinics already know, billed under the network's own group enrollment at Arkansas's CY2026 Medicare rates, staffed by CoachCare and run inside eClinicalWorks

Purpose of this document

Prepared by CoachCare, October 2026, as a discussion document for the physician leadership of Arkansas Family Care Network. It is the companion to the network's remote care strategy page and makes the same case at report length. It starts from the network's own Medicare claims, explains why remote monitoring is the program that pays here, and shows how it runs beside the care coordinators already at work. Then it prices the program over 24 months at Arkansas's rates and runs the ACO's side of the ledger.

AFCN completes about 5,450 annual wellness visits a year, bills transitional care after hospital stays from twelve clinicians, and took part in CMS's Comprehensive Primary Care initiative from 2012. Its claims show no remote monitoring. This report shows what a program for the network's heart failure and kidney disease patients returns, to the clinics and to the ACO, who does the work, and what decides how large it gets.

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Executive Summary

Arkansas Family Care Network (AFCN) is an independent, physician-led network, incorporated in 1970, that bills Medicare as one group. Its 26 primary care clinicians practice at seven clinics in Little Rock, Bryant and Hensley, in Pulaski and Saline counties. Every clinic runs on one shared eClinicalWorks system, and the two Little Rock Family Practice clinics, with 14 of the 26 clinicians, have their own care coordinators, a registered dietitian and a clinical pharmacist.[1]

The network's own CY2024 Medicare claims describe the panel. The 26 clinicians who billed from its seven primary care clinics recorded 10,160 beneficiary-clinician relationships, with patients averaging 73.7 years old and a weighted risk score of 1.02 against a national 1.00. About three in four carry hypertension, 25% diabetes, 19% chronic kidney disease and 13% heart failure. The clinics completed about 5,450 annual wellness visits, screened about 3,510 patients for depression and billed transitional care for about 500 patients after hospital stays. **No remote monitoring program appears in the claims**.[2]

AFCN bills inside **an Enhanced-track Medicare Shared Savings Program ACO**, the two-sided track, with patients assigned at the end of each year from where they received most of their primary care. Every admission among assigned patients counts against the ACO's spending benchmark. The ACO also takes part in a CMS model that pays it a monthly prospective primary-care payment in place of claims for most primary-care services for its assigned patients. Remote physiologic monitoring is not among those services, so it bills claim by claim for every Medicare patient, assigned or not. That is why this service line leads with remote monitoring.[3]

The observation this report is built on

Turn the panel AFCN already manages into a profit-generating service line, powered by CoachCare.

The network has the panel, the record system, the visit rhythm, the care coordinators and the accountable-care position. What it lacks is daily weight and blood pressure for its heart failure and kidney disease patients, about one in four of the panel, and a staff to watch those readings every business day. This service line adds both. CoachCare staffs it. AFCN's clinicians govern it, and the network bills for it under its own group enrollment from inside eClinicalWorks.

What the Value Analysis returns

Remote monitoring service line	Year 1	Year 2	24 months
Patients enrolled, end of period	994	994	994
Contribution margin	**$208,136**	**$440,548**	**$648,684**

CoachCare Value Analysis: the heart failure and kidney disease patients in a Medicare panel of 15,000 across seven primary care clinics, remote monitoring on traditional Medicare and Medicare Advantage, 26 referring clinicians, one CoachCare-funded on-site enrollment specialist, CY2026 Arkansas locality 13 amounts. Contribution margin is what AFCN keeps from the service line.

[1] arkansasfamilycarenetwork.com and the member clinics' own sites, retrieved October 28, 2026: locations, services and provider pages; Arkansas Secretary of State corporate record for Arkansas Family Care Network, P.A., filed 1970. The network's dermatology, fertility and physical therapy clinics sit outside this program.

[2] CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024, queried for the 26 primary care clinicians whose CY2024 billing address is an AFCN primary care clinic: 10,160 beneficiary-clinician relationships (a patient seen by two clinicians counts twice); average age 73.7; risk score 1.02; diabetes 25%, chronic kidney disease 19%, heart failure 13%; hypertension and high cholesterol at the 75% CMS cap; annual wellness visits 5,452 beneficiaries; depression screening 3,513; transitional care 99495 and 99496, 502 beneficiaries across 12 clinicians.

[3] CMS Shared Savings Program ACO Participants, performance years 2023 to 2026: the network has participated since PY2023 and in its current ACO since PY2024; Enhanced track and retrospective assignment in PY2026. The CMS model's PY2026 participant list (January 2026) and its financial methodology (version 3, May 2026, Appendix B): no remote physiologic monitoring code (99453, 99454, 99445, 99457, 99458, 99470) appears in the primary-care code table.

1. **Inside the ACO, the program pays its way.** At a 30% reduction in admissions, the heart failure and kidney patients assigned to the ACO return $664,625 to total cost of care over 24 months, net of Medicare's share of their remote monitoring. Heart failure breaks even at a 15% reduction and kidney disease at 13% (Section 7).
2. **Remote monitoring pays claim by claim for every Medicare patient.** The ACO's monthly primary-care payment replaces claims for office visits and care management on assigned patients; it does not cover remote monitoring, so each month of readings bills under AFCN's group enrollment (Section 3.2).
3. **The heart failure and kidney pool sets the ceiling, and the program reaches it in month 11.** One enrollment specialist and 26 referring clinicians enroll all 994 patients the forecast counts as reachable by month 11. A second specialist gets there by month 9 and adds $43,678 of contribution margin. Across the panel sizes the claims support, 10,300 to 18,800, 24-month contribution margin runs from $471,771 to $777,413.
4. **A staffing plan the network does not hire for.** CoachCare brings on 6 care managers as the census fills, at 165 patients each, and delivers 12,529 care-team hours over 24 months, about 6.0 full-time-equivalent years.
5. **Positive from month 2.** Contribution margin runs slightly negative in month 1 while the program ramps; every month after is positive, and from month 12 contribution margin is $36,712 a month.
6. **The program lives in eClinicalWorks.** CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically, and a flagged patient reaches the first day of service in under five days (Section 4).
7. **Transitional care stays as it is, at zero dollars.** AFCN already bills it from twelve clinicians. Remote monitoring picks the patient up after the transitional care visit and carries the daily readings past day 30.
8. **The CY2027 proposed rule takes $143,869 off this line's 24-month contribution margin.** A 20.6% cut to the device-supply codes, on a line that is all remote monitoring, moves contribution margin from $648,684 to $504,815 over 24 months (Section 10).

The ask is a working session: confirm the Medicare chart count by payer and clinic, map how CoachCare's care team sits beside the coordinators already following patients after hospital stays, scope the eClinicalWorks integration, and set the order the seven clinics go live before the first patient enrolls.

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

Medicare has changed what it pays primary care for, and the changes point at the same place: the weeks between a patient's visits. For a heart failure patient, those weeks are where fluid builds and an admission starts. For a kidney patient, they are where blood pressure drifts after a dose change.

The shift	What it means for AFCN
1. From visits to panels	A patient on a chronic medication sees a clinician a few times a year. Weight climbs between those visits, blood pressure drifts, and the admission that follows starts there. Managing a panel means knowing which of roughly 15,000 Medicare patients across seven clinics are trending the wrong way before they reach an emergency department, and that takes home data and a team assigned to act on it.
2. Accountability for total cost	AFCN bills inside an Enhanced-track Medicare Shared Savings Program ACO. Every admission among assigned patients counts against the ACO's spending benchmark, and the Enhanced track shares the difference in both directions.
3. A monthly payment for primary care	Since 2025 the ACO has received a monthly prospective payment from CMS in place of most primary-care claims for its assigned patients. Remote monitoring sits outside that payment and still bills per claim. About 45.9% of Medicare beneficiaries in Pulaski and Saline counties are in Medicare Advantage. Medicare Advantage plans cover these Part B services and pay them on each plan's own contract terms.

The shift	What it means for AFCN
4. Codes for the work between visits	Remote monitoring pays when a patient takes readings on 16 or more days in a month, and two codes new in 2026, 99445 and 99470, pay for shorter months; in this forecast they carry 16.7% of remote-monitoring Medicare payments.[4] At Arkansas's CY2026 rates one heart failure or kidney patient on remote monitoring (99454 and 99457) is worth **$91.52 a month** in Medicare allowed charges.

Each shift pays for, or measures, what happens between visits. For AFCN the arithmetic is unusual: the ACO's monthly payment already covers the visit and care-management work on assigned patients, so the one program that adds claims revenue for every patient is remote monitoring. The network's billing team adopts new codes quickly. Seventeen of its primary care clinicians billed the visit-complexity add-on, G2211, about 8,100 times in CY2024, the code's first year.

2. Arkansas Family Care Network Today: Seven Clinics, One Record

AFCN is a network of family practices that bills as one group: seven primary care clinics, 26 clinicians and one eClinicalWorks system. Its traditional-Medicare patients average 73.7 years old, with a risk score close to the national 1.00, and at least three in four carry hypertension. The clinics already run the visit rhythm a remote care program needs, from the annual wellness visit to the visit after a hospital stay.

2.1 Seven primary care clinics in Pulaski and Saline counties

Clinic	Service	CY2024 billing clinicians	What it means for this program
Little Rock Family Practice, Central **University Avenue, Little Rock**	Family medicine; on-site lab, X-ray and bone densitometry; care coordinators, a registered dietitian and a clinical pharmacist	6	A CMS Comprehensive Primary Care clinic in 2012 to 2016, with coordinators who already follow patients after hospital stays
Little Rock Family Practice, West **Rodney Parham Road, Little Rock**	The same service menu as Central	8	The network's largest group of billing clinicians and its busiest Medicare schedules
A family clinic in west Little Rock **Executive Center Drive**	Family and internal medicine; X-ray, EKG and lab on site; same-day slots for acute visits	5	A same-day visit for swelling or breathlessness in a heart failure patient becomes an enrollment
Bryant Family Clinic **Bryant, Saline County**	Family medicine; disease management for hypertension, diabetes and heart failure; in-house A1c and INR testing	2	Already manages heart failure by name; also a Comprehensive Primary Care clinic
Maple Creek Medical Clinic **Hensley, southern Pulaski County**	Family medicine	3	The most rural of the seven, where a cellular scale and cuff save a drive
Two single-physician offices **Central Little Rock**	Family medicine and internal medicine	1 each	The same flags, devices and care team work in a one-clinician office

arkansasfamilycarenetwork.com and the clinics' own sites, October 28, 2026. Billing clinicians: CMS CY2024 claims by billing address, the 26 primary care clinicians. Comprehensive Primary Care: CMS participating-practice list.

[4] CoachCare Value Analysis for Arkansas Family Care Network, 2026: 99445 and 99470 together, as a share of 24-month remote-monitoring Medicare payments on this forecast's billing mix.

The primary care roster is 18 physicians (16 family medicine, 2 internal medicine), 7 nurse practitioners and 1 physician assistant, with no pediatric-only clinicians. All seven clinics bill Medicare under AFCN's single group enrollment, and one management team handles billing and the shared record for all of them.[5]

2.2 What the CY2024 claims say

The CY2024 Medicare by-provider and by-provider-and-service files were queried for the 26 primary care clinicians who billed from an AFCN primary care clinic. The profile below is the traditional-Medicare panel those clinicians saw.[6]

Panel	CY2024	Condition	Share
Beneficiary-clinician relationships	10,160	**Hypertension**	**74% (a floor)**
Medicare allowed	$2,854,404	High cholesterol	73% (a floor)
Average age	**73.7**	Arthritis	46%
Weighted HCC risk score	**1.02**	Ischemic heart disease	29%
Annual wellness visits	**About 5,450**	Diabetes	25%
Depression screening	About 3,510	Depression	25%
Transitional care	**About 500, across 12 clinicians**	**Chronic kidney disease**	**19%**
Visit-complexity add-on, G2211	About 8,100 services	Atrial fibrillation	16%
Remote monitoring	**No program at meaningful scale**	**Heart failure**	**13%**
Chronic or principal care management	No program at meaningful scale	COPD	12%

CMS Medicare Physician & Other Practitioners, CY2024, the 26 primary care clinicians billing from AFCN clinics. Program rows are beneficiaries or services; relationships count a patient once per clinician seen. CMS caps published prevalence at 75% per clinician, so hypertension and high cholesterol are floors, and suppresses lines under 11 beneficiaries.

Heart failure reaches about one patient in eight and chronic kidney disease about one in five. Together, once patients with both are counted once, they make up 26.5% of the panel, and they are the patients whose home readings most often head off an admission. Hypertension, in at least three of four patients, runs through both groups. The clinics see these patients on a steady rhythm, but **no remote monitoring program reaches them between visits**.[7]

2.3 From a 1963 family practice to an accountable-care network

Year	What happened
1963	Little Rock Family Practice opens on University Avenue
1970	Arkansas Family Care Network, P.A. is incorporated as an Arkansas medical corporation, the billing entity its member clinics still share
2012–2016	Little Rock Family Practice Central and West and the Bryant clinic take part in CMS's Comprehensive Primary Care initiative

[5] CMS Doctors and Clinicians and the Medicare revalidation reassignment list (October 2026) for AFCN's group enrollment; NPPES. Two more primary care clinicians joined in 2026 and are not in the CY2024 claims.

[6] Medicare Physician & Other Practitioners, CY2024, by NPI for the 26 clinicians: 10,160 beneficiary-clinician relationships, 12,846 established-visit relationships, $2,854,404 allowed. Prevalence is weighted by beneficiaries.

[7] CMS by Provider and Service, CY2024, searched for the remote monitoring, chronic and principal care management, advanced primary care management, transitional care and behavioral health integration codes. Present: 99495 and 99496 (502 beneficiaries, 535 services, 12 clinicians); G0438 and G0439 (5,452); G0444 (3,513); G2211 (4,892 beneficiaries, 8,137 services). CMS suppresses lines under 11 beneficiaries.

Year	What happened
2020–2021	AFCN is named among Arkansas practices in Comprehensive Primary Care Plus and Primary Care First, the CMS models that followed
2023	AFCN joins the Medicare Shared Savings Program
2024–2026	In its current ACO from 2024; the ACO moves to the Enhanced two-sided track in 2025 and begins receiving a monthly prospective primary-care payment from CMS for assigned patients
Today	Seven primary care clinics and 26 clinicians on one eClinicalWorks system; about 5,450 wellness visits a year, transitional care after hospital stays, and care coordinators at Little Rock Family Practice
Next	**Daily weight and blood pressure for every heart failure and kidney patient who accepts, run by a CoachCare care team inside eClinicalWorks and billed under AFCN's group enrollment**

lrfpc.com history page; Arkansas Secretary of State; CMS Comprehensive Primary Care participating practices; public CPC+ and Primary Care First award announcements for 2020 and 2021 performance; CMS ACO participant files, 2023 to 2026.

2.4 What the network already runs, and the gap

What exists	Status	What it means for this program
eClinicalWorks and healow	**One shared system, every clinic**	The program's host: flags, orders, readings, care documents and claims (Section 4)
Care coordinators, a dietitian and a clinical pharmacist	**At Little Rock Family Practice**	Credited and kept. Home readings land in the chart they already work from, and the pharmacist's medication changes get daily feedback
Annual wellness visits	**About 5,450 a year**	The enrollment moment: eligibility checked, consent taken and devices ordered the same day
Transitional care	**About 500 patients, 12 clinicians**	Credited and kept. Remote monitoring starts or resumes after the transitional care visit
Depression screening	About 3,510 patients	Feeds the ACO's quality score (Section 8)
CMS primary care models	Comprehensive Primary Care from 2012; the Shared Savings Program since 2023	The network already knows panel management, quality reporting and accountable care
Remote monitoring	No program in the claims	Devices, daily readings and business-hours alert triage come from CoachCare

The gap is specific: daily weight and blood pressure for the 3,976 heart failure and kidney patients the forecast counts as eligible, and the staff to read them every business day. The coordinators have shown that follow-up after a hospital stay fits the network's clinics. What they do not have is a scale and cuff in each patient's home, or the hours to review a month of readings for well over a thousand patients.

2.5 The market, Medicare Advantage, and the rate basis

The seven clinics sit in Pulaski and Saline counties, which held 113,775 Medicare beneficiaries in July 2026. About 45.9% of Medicare beneficiaries in the two counties are in a Medicare Advantage plan (Pulaski 46.0%, Saline 44.2%). Medicare Advantage plans cover these Part B services and pay them on each plan's own contract terms. Which plans AFCN's patients hold, and how each pays for remote monitoring, is the second thing to confirm after the chart count.[8]

Every clinic sits in Arkansas's single statewide payment locality, locality 13, under the Novitas Solutions JH contractor. Every dollar in this report is priced at those CY2026 amounts.[9]

[8] CMS Medicare Monthly Enrollment, July 2026: Pulaski 85,125 and Saline 28,650 beneficiaries. CMS Medicare Advantage State/County Penetration, October 2026: Pulaski 46.0%, Saline 44.2%; weighted by the network's CY2024 established visits in each county, 45.9%.

3. The Service Line: Remote Monitoring for Heart Failure and Kidney Disease

3.1 The clinical and billing stack

The service line is one monthly program, with one enrollment conversation, one care team and one billing pipeline into AFCN's own billing through eClinicalWorks. Transitional care, which the clinics already bill, stays on the stack and carries no dollars in the forecast.

Program	What it does clinically	Who it fits on this panel
Remote physiologic monitoring (RPM)	Cellular scales and blood-pressure cuffs send readings between visits against thresholds AFCN's clinicians set; 99453, 99454 or 99445, 99457, 99458, 99470	Heart failure and chronic kidney disease, on traditional Medicare and Medicare Advantage
Transitional care management (TCM)	Contact within two business days of discharge, medication reconciliation, a visit within 14 days (99495) or 7 days (99496)	Panel patients discharged from a hospital or observation stay; already billed, not in the forecast

Codes	What they pay for	CY2026 Arkansas locality 13
99453	Remote monitoring setup and education, once	$18.42
99454 · 99445	**Device supply, 16+ days · 2 to 15 days in 30 (99445 new in CY2026)**	**$44.64 · $44.64**
99457 · 99458	Treatment management, first 20 minutes · each additional 20	$46.88 · $37.99
99470	**Treatment management, 10 to 19 minutes (new in CY2026)**	**$23.61**

How the rates apply

CY2026 non-facility amounts, Arkansas locality 13 (Novitas Solutions JH, carrier 07102), ZIP 72205. One device code and one first-tier management code bill for a patient in a given month, with 99458 for each further 20 minutes; setup bills once.

About 45.9% of the area's Medicare beneficiaries are in Medicare Advantage. Medicare Advantage plans cover these Part B services and pay them on each plan's own contract terms. The forecast prices every patient at the Medicare amount, so the plan-by-plan terms are worth confirming early.

3.2 Why remote monitoring leads

AFCN's Enhanced-track Medicare Shared Savings Program ACO takes part in a CMS model under which the ACO receives a monthly prospective primary-care payment in place of claims for most primary-care services for its assigned patients: office visits, chronic and principal care management, transitional care, behavioral health integration and advanced primary care management. Remote physiologic monitoring is not among those services, so it is billed and paid claim by claim for every Medicare patient, assigned or not.[10]

[9] CY2026 Physician Fee Schedule, Novitas Solutions JH carrier 07102, Arkansas locality 13: geographic indices work 1.000, practice expense 0.859, malpractice 0.515; conversion factor $33.4009.

[10] CMS financial methodology and rate book for the model the ACO participates in, version 3, May 2026, section 4.6 and Appendix B (the primary-care code table); CMS participant list, PY2026.

How Medicare pays for an assigned traditional-Medicare patient

Office visits, chronic and principal care management, transitional care, behavioral health integration and advanced primary care management: through the ACO's monthly prospective primary-care payment, in place of the claim.

Remote physiologic monitoring (99453, 99454, 99445, 99457, 99458, 99470): claim by claim, under AFCN's group enrollment, as for every other Medicare patient.

That is why this service line leads with remote monitoring. It is the one program that adds claims revenue on every Medicare patient, whether assigned to the ACO, not assigned, or on a Medicare Advantage plan. It also leaves the follow-up work the network's own care coordinators already do exactly where it is.

3.3 The care team, and the hours it keeps

CoachCare hires, trains and manages the care managers, at 165 patients each: 6 care managers once the census reaches its 994-patient ceiling in month 11. An on-site enrollment specialist on CoachCare's payroll works the clinic schedules beside AFCN's medical assistants and enrolls patients during the visit, telephonic outreach reaches the rest, and the clinicians order from the chart. Devices are cellular, with no Wi-Fi, smartphone or pairing needed. Monitoring runs on business hours: devices transmit daily, and care managers review readings, run outreach and send escalations Monday to Friday, 8 a.m. to 5 p.m. in the patient's time zone, when the clinics are staffed. Patients are told at consent to call 911 for an emergency and their clinic for anything urgent.

3.4 After discharge: where transitional care hands off

AFCN already bills transitional care management: about 500 traditional-Medicare patients in CY2024, across twelve clinicians. At Little Rock Family Practice and the west Little Rock clinic, hospitalists manage the inpatient stay and the patient returns to the clinic at discharge, and Little Rock Family Practice's coordinators help schedule the follow-up. The forecast carries no transitional care dollars, and nothing in this program changes how the clinics furnish or bill it.[11]

Remote monitoring is what happens next. For a heart failure or kidney patient who is not yet enrolled, the transitional care visit is the natural enrollment conversation, and the scale or cuff can be home before the 30 days that follow a discharge, when most readmissions happen. For a patient already enrolled, the discharge triggers CoachCare's three-touch post-discharge cadence (Section 5.4) alongside the clinic's own visit.

3.5 Beside the care coordinators already at work

AFCN is not starting from nothing. Little Rock Family Practice's care coordinators follow patients after hospital stays and emergency visits and through chronic problems, its dietitian builds plans for chronic conditions, and its pharmacist manages warfarin, diabetes medications and inhalers. What the network does not run is daily home monitoring, or a team whose job is to review those readings. That is the part CoachCare supplies, and the work is divided so that no patient is called twice.[12]

Work	What CoachCare runs	What stays with AFCN
Daily monitoring	Devices, daily readings, the monthly treatment-management time behind 99457 and 99458, and business-hours triage	Thresholds, routing and every clinical decision
Care coordination	Readings and trends in the chart the coordinators already use	**The coordinators' follow-up after hospital stays and emergency visits, as today**
Medication changes	A week of home readings after each change, flagged when out of range	The pharmacist's and clinicians' titration

[11] CMS by Provider and Service, CY2024: 99495 and 99496, 502 beneficiaries across 12 clinicians. lrfpc.com policies page, October 2026, for the hospitalist handoff.

[12] lrfpc.com services page, October 28, 2026: care coordinators, registered dietitian and clinical pharmacist.

- **AFCN keeps clinical governance, the patients and the revenue.** Its clinicians set thresholds, routing and discharge criteria and sign the care plans; claims go out under the network's group enrollment, and AFCN keeps $648,684 of contribution margin over 24 months.
- **CoachCare supplies the capacity.** It brings the devices, an on-site enrollment specialist, care managers, business-hours alert triage, monthly documentation and automated claims. None of it is the network's headcount, inventory or software.
- **Independence is part of the return.** A recurring service line with its own margin, built on AFCN's own panel, adds a revenue line the network's physicians control, and helps pay for the network's next decisions on its own terms.

4. eClinicalWorks: The Program Lives in the Chart

AFCN's clinics share one eClinicalWorks system, and CoachCare works inside eClinicalWorks' own workflows, so clinicians and staff do not learn a second system. Evidence of care, vitals and care plans are attached to each chart every month, enrollment status is visible at every clinic, and a flagged patient reaches the first day of service in under five days.[13] CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically.

Integration pillar	What happens in eClinicalWorks
Integrated enrollment	Flags in the chart prompt the order for heart failure and kidney patients who meet criteria AFCN's clinicians approve, at a chronic-care visit, a wellness visit, a transitional care visit or on an outreach list
Enrollment by services and devices	The clinician orders by service and by device (scale, cuff), the way a lab is ordered
Exchange of health history	Diagnoses, medications, vitals and lab results pass to the care team at intake; the care plan comes back
Integrated vital reports	Home readings land in the chart, so the clinician, coordinator or pharmacist sees home averages at the next visit
Compliance documentation and care summary	Evidence of care, vitals and the care plan attached monthly for every enrolled patient
Automated claim generation	Claims built for every patient, every month, once a code's requirements are met; AFCN's billing team reconciles and files them

[13] CoachCare eClinicalWorks integration overview, 2026: the six integration pillars; patients begin remote monitoring in less than five days. The shared system: the healow portal linked from the network's and the clinics' sites resolves to one eClinicalWorks cloud instance.

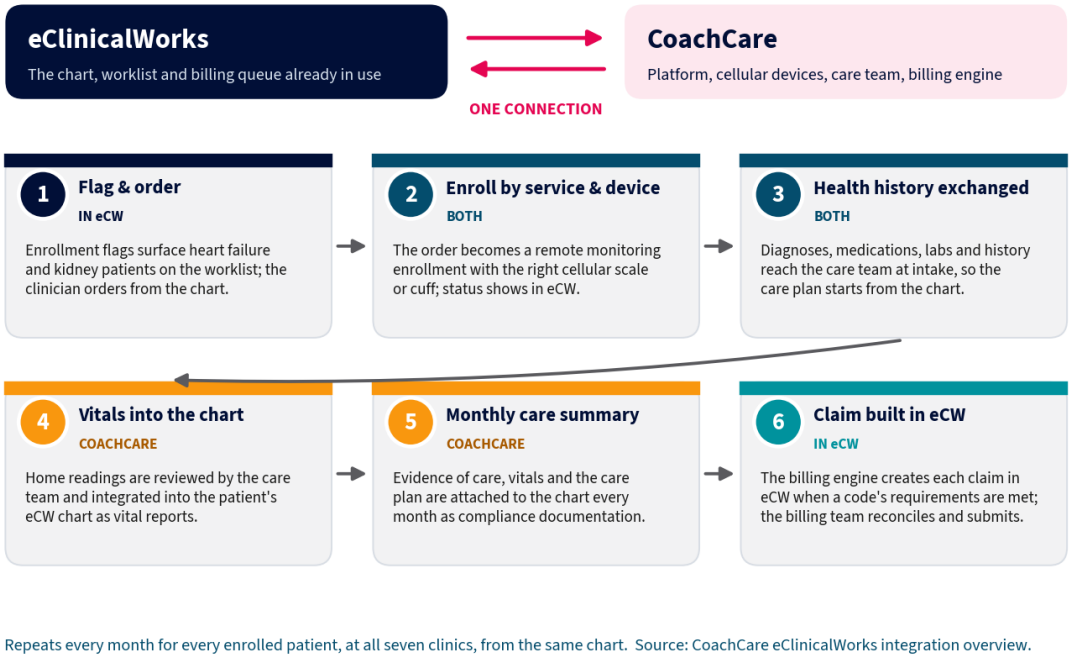


Figure 1. From a flag in the chart to a claim: the six steps CoachCare and eClinicalWorks run every month for every enrolled patient. CoachCare eClinicalWorks integration overview.

The integration build runs alongside onboarding, so it does not hold up the first enrollments.

5. Clinical Governance & Escalation

Every reading routes through one escalation engine with defined thresholds, trend rules, routing and documentation, so AFCN never carries surveillance liability it did not agree to. Thresholds and routing are set with the network's clinicians, clinic by clinic, before the first patient enrolls.[14]

5.1 One shared escalation engine

Branch	The rule	Why
Critical value	**Escalate to the practice, regardless of symptoms**	No practice preference can suppress it. A critical reading on its own goes to the clinic, not to 911
Out of range, not critical	Retake, then a structured symptom check	Most out-of-range readings resolve here, which keeps inboxes usable
Trend	**Three consecutive blood pressure readings an hour or more apart; three heart-rate readings within seven days; weight gain past the agreed threshold**	A confirmed trend escalates like a single reading past the threshold
Patient unreachable	Document, leave a callback message, and escalate anyway if the reading was critical or a confirmed trend	Silence never downgrades a clinical finding
Documentation	**Six fields: vital · findings · method · contact · outcome · follow-up**	Any episode can be reconstructed end to end

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

5.2 The emergent pathway

Non-negotiable, and stated as such

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

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

If the patient refuses. The clinic is called with the patient still on the line and directs care; if the clinic cannot be reached, CoachCare activates emergency services.

The floor. CoachCare's emergent policy supersedes any practice escalation preference. This cannot be configured away. AFCN shapes routing for everything else.

5.3 Three-way routing, on business hours

Route	What goes there	Who sees it
Emergency	Active emergent symptoms reported on a call	911 with the patient on the line; the clinic notified
Needs the practice	A critical reading, or an out-of-range reading or trend confirmed after a retake	The clinician or nurse each clinic designates, in eClinicalWorks, with readings and a recommended next step
Stable or resolved	**Worked, retaken and resolved**	**Documented as an FYI in the chart, without paging anyone**

The matrix is agreed for each of the seven clinics. Care managers work readings and escalations Monday to Friday, 8 a.m. to 5 p.m. local patient time. The clinics' exam schedules end between 4:15 and 4:30 p.m., so the matrix names who takes an escalation in the last half hour of the care team's day; the same-day slots several clinics already hold are the natural place for a next-morning look. A reading that arrives on a weekend or overnight is worked the next business day, and the patient's standing instruction for anything urgent is the clinic's own line, or 911.

5.4 The post-discharge cadence

Any emergency visit or hospitalization in the previous 60 days triggers the cadence for an enrolled patient. It runs beside the transitional care the clinics already furnish, and inside the ACO each admission it prevents is spending that never posts against the benchmark.

Touch	Window	What happens
1 · Stabilize	**Day 1–2**	What led to the visit; discharge medications reconciled against what is in the house; a follow-up visit confirmed within 7 to 14 days
2 · Detect	**Day 5–8**	Adherence verified, weight and blood pressure trends re-checked, appointment and ordered labs confirmed
3 · Secure	**Day 12–14**	Medication and risk review, visit outcome, and a handoff into monthly monitoring

5.5 Built for an older, phone-first panel

AFCN's traditional-Medicare patients average 73.7 years old, and the Hensley clinic serves the more rural south end of Pulaski County. The program is set up for them. Devices are cellular and arrive ready to use, with no home internet, smartphone or pairing. The welcome call, the monthly call and every escalation call are made by phone, so no patient has to learn an app. Patients who already use the healow portal can keep using it, and nothing in the program depends on it. A monitoring patient unreachable 45 days from enrollment is escalated to the clinic; without an instruction from the clinic, discharge from monitoring follows at 180 days, and discharge criteria always belong to AFCN's clinicians.

6. Value Analysis: The 24-Month Forecast

6.1 The headline economics

The forecast covers remote monitoring for the heart failure and kidney disease patients in a Medicare panel of 15,000 at the seven primary care clinics, on traditional Medicare and Medicare Advantage, at the CY2026 Arkansas locality 13 amounts, with 26 referring clinicians and one CoachCare-funded on-site enrollment specialist. No transitional care, ACO payment or shared savings is in these numbers.[15]

Remote monitoring service line	Year 1	Year 2	24 months
Patients enrolled, end of period	994	994	994
Contribution margin	**$208,136**	**$440,548**	**$648,684**

Year two is larger than year one because the census is full for all twelve months of it: the program reaches its 994-patient ceiling in month 11 and holds it, replacing about 30 patients a month who leave. Year two returns **$440,548 of the $648,684 contribution margin**.

6.2 Where the patients come from

Program	Patients enrolled, month 12	Patients enrolled, month 24	Patient-months	Ceiling reached
Remote physiologic monitoring	994	**994**	17,585	M11

All of the contribution margin is remote monitoring, across 17,585 patient-months. The two codes new in 2026, 99445 for months with 2 to 15 days of readings and 99470 for 10 to 19 minutes of treatment management, carry 16.7% of remote-monitoring Medicare payments on this mix. They pay for short or partial months that did not bill two years ago.

6.3 The ramp, month by month

Contribution margin runs −$5,635 in month 1 while the program ramps, on 23 enrollments. It is positive from month 2, with $2,172 on 56 enrollments, and cumulative contribution margin is above zero by the end of month 3. New patients join at up to about 170 a month in months 9 and 10, the census reaches its ceiling in month 11, and from month 12 contribution margin is $36,712 a month. Cumulative contribution margin passes $31,456 at month 6, $208,136 at month 12 and $648,684 at month 24.

Month	Patients on monitoring	Monthly contribution margin	Cumulative contribution margin
M1	23	**−$5,635**	−$5,635
M2	56	$2,172	−$3,464
M3	108	$4,195	$731
M6	358	$13,805	$31,456
M8	597	$22,840	$72,365
M12	994	$36,712	$208,136
M24	994	**$36,712**	**$648,684**

[15] CoachCare Value Analysis for Arkansas Family Care Network, 2026, the source of all Section 6 figures; sensitivity runs change one input at a time on the same workbook.

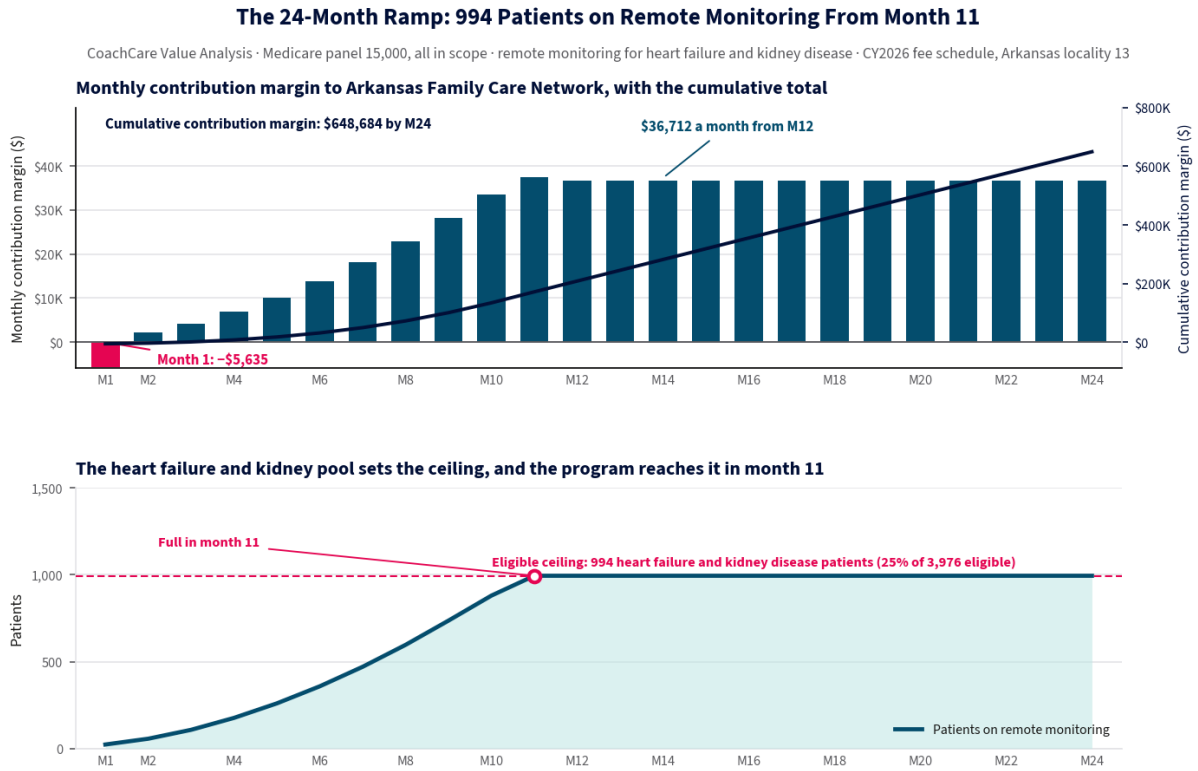


Figure 2. Monthly contribution margin, with cumulative contribution margin, and the remote monitoring census against its eligible ceiling. CoachCare Value Analysis.

6.4 What sets the ceiling: the heart failure and kidney pool

Program	Eligible share of the 15,000 in scope	Acceptance	Ceiling	Month 24
Remote physiologic monitoring, heart failure or chronic kidney disease	26.5%, 3,976 patients	25%	**994**	**994 (full in M11)**

Eligibility is the panel's heart failure share (12.8%) plus its chronic kidney disease share (19.4%), with patients who have both counted once, from the CY2024 claims profile.

Say the constraint out loud

At AFCN the eligibility definition is the constraint, not outreach. One enrollment specialist and 26 referring clinicians bring in up to about 170 new patients a month, and the program enrolls every heart failure and kidney patient the forecast counts as reachable by month 11. From then on the census holds at 994.

Enrollment capacity cannot raise the ceiling, but it reaches it sooner. A second CoachCare-funded enrollment specialist fills the pool by month 9: $692,362 of contribution margin over 24 months against $648,684, $43,678 more, at no cost to AFCN. Without the on-site specialist the pool fills in month 16 and contribution margin is $97,872 lower.

Panel size moves the ceiling itself. A larger Medicare panel holds a larger heart failure and kidney pool, so the chart count is the number that sets this forecast.

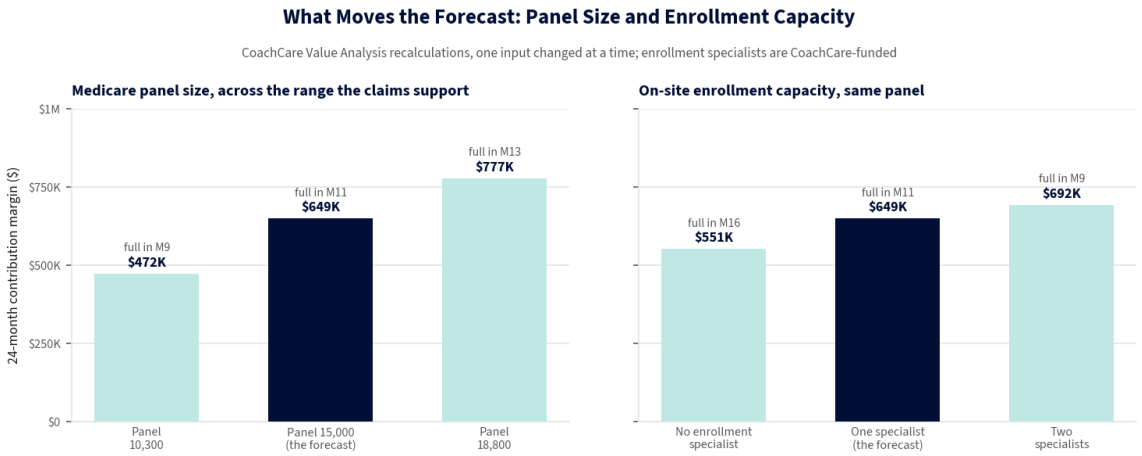


Figure 3. 24-month contribution margin across the panel sizes the claims support, and with no, one or two on-site enrollment specialists on the same panel, with the month remote monitoring fills its pool. CoachCare Value Analysis recalculations.

Scenario	24-month contribution margin	Patients at M24	Ceiling reached
Base: panel 15,000, heart failure and kidney patients, 26 clinicians, one enrollment specialist	**$648,684**	**994**	**M11**
Panel 10,300	$471,771	683	M9
Panel 18,800	$777,413	1,246	M13
Traditional-Medicare patients only in scope (8,120)	$382,443	538	M8
No on-site enrollment specialist	$550,811	994	M16
Two on-site enrollment specialists	$692,362	994	M9
20 referring clinicians	$631,368	994	M12
28 referring clinicians, with the two who joined in 2026	$653,473	994	M11

CoachCare Value Analysis recalculations, one input changed at a time. Ceiling reached: the month remote monitoring enrolls every heart failure and kidney patient the forecast counts as reachable.

Panel size moves this forecast more than anything else. From 10,300 to 18,800 patients, the panel adds $305,642 of 24-month contribution margin, because every panel size fills its pool by month 13 and a larger panel holds a larger pool. The payer mix matters too: with only traditional-Medicare patients in scope contribution margin would be $382,443, which is why the Medicare Advantage plans' terms are the second item to confirm. Enrollment capacity and the referring roster move the 24-month figure by $4,790 to $97,872, because they change how fast the pool fills rather than how large it is.[16]

6.5 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	**184,643**	Weight and blood pressure values arriving between visits
Claims and billable units	**32,705**	Created in eClinicalWorks for AFCN's billing team
Care-management tasks	65,411	Outreach, reading reviews, chart updates and medication checks
Patient conversations	9,812	Live contacts across 545 hours of call time

[16] Panel sizes 10,300 to 18,800 bracket the network's CY2024 claims: a provider-based count (18 physicians × 450 and 8 advanced practice clinicians × 270 = 10,260) and the CY2024 beneficiary-clinician relationships grossed up for the Medicare Advantage share (10,160 ÷ (1 − 0.459) = 18,768). Established-visit relationships, deduplicated and grossed up the same way, give 16,611.

Output over 24 months	Volume	What it represents
Care-team hours	**12,529**	**About 6.0 full-time-equivalent years of work the network does not employ**
Hospitalizations avoided	**About 186**	Across every enrolled patient, whatever the coverage; Section 7 counts the ones that land on the ACO's ledger

Reduction in admissions among enrolled patients	20%	30% (the forecast)	40%
Hospitalizations avoided over 24 months	124	**186**	248

CoachCare Value Analysis, at the enrolled patients' own admission rate: about 42.3 admissions per 100 patients a year, heart failure at 40 and kidney disease at 44.5 (Section 7).

Two ledgers, kept separate

Contribution margin funds the program. $648,684 to AFCN over 24 months, paid claim by claim.

Avoided admissions and quality speak to the ACO. About 186 admissions avoided at a 30% reduction, plus monthly work on the measures in Section 8. Under two-sided risk the new Part B remote-monitoring spend for assigned patients also sits on the ACO's ledger, while remote monitoring for Medicare Advantage patients does not touch it. That is why the avoided admissions and the quality measures carry the argument there, more than the contribution margin does. The Value Analysis is fee-for-service and does not model shared savings; Section 7 runs the ACO's side of the ledger.

6.6 Published results from CoachCare programs

- **Blood pressure.** Cardiac Solutions, a physician-owned cardiology practice with three West Phoenix offices, put 2,738 patients on CoachCare remote monitoring. Stage 2 hypertension patients saw a 29.1 mmHg average systolic drop, and 94.8% improved. Patients who took readings consistently dropped 8.53 mmHg against 3.54 mmHg for those who did not.[17]
- **Readmissions, at the same practice.** Across 26,689 patients, the 30-day readmission rate was 7% for CoachCare patients against 15% for the rest.[18]
- **Heart failure.** Iowa Heart enrolled 450 advanced heart-failure patients and recorded zero readmissions over six months.[19]

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

AFCN's clinicians belong to a two-sided Shared Savings Program ACO with retrospective assignment: patients are assigned at the end of each year, based on where they got most of their primary care, so most of the network's traditional-Medicare patients sit inside its benchmark. Every remote monitoring claim for one of those patients is Part B spending the ACO is measured on. The spending holds up where it prevents admissions worth more than it costs. In this panel, that means **heart failure and kidney disease**.[20]

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

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

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

[20] CMS Shared Savings Program ACO Participants, PY2026, for the network's ACO: Enhanced track, retrospective assignment. Enhanced-track terms: a 75% sharing rate and a 40% loss rate while the quality standard is met. Shared Savings Program Financial and Quality Results, PY2024, for the results below.

7.1 Who sits inside the benchmark

The same remote monitoring claim lands in different places depending on how the patient is covered. Medicare Advantage claims are practice revenue and nothing else. Traditional-Medicare claims for a patient who is not assigned are the same. Traditional-Medicare claims for an assigned patient are practice revenue that also counts against the ACO's spending target. Of AFCN's 15,000-patient Medicare panel, about 6,900 are in Medicare Advantage, about 6,900 are traditional-Medicare patients assigned to the ACO, and about 1,200 are traditional-Medicare patients who are not.[21]

The ACO, PY2024	Value	Against all ACOs
Benchmark per assigned patient	**$14,406**	The spending target
Actual spending per assigned patient	$13,287	Lower than 37% of ACOs
Savings per patient	**$1,119 (7.8% of benchmark)**	**Higher than 79% of ACOs**
Admissions per 1,000 patients a year	244	Lower than 57% of ACOs

CMS Shared Savings Program Financial and Quality Results, PY2024, the network's first year in this ACO; ranks against the 476 ACOs in the file. The ACO spans practices in several states, and CMS does not publish a participant's own results.

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

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

Medicare's share of a year of remote monitoring is about $882 per patient. One avoided hospital stay is worth about $14,703, the ACO's own average for an acute admission. Whether the program pays its way depends on how often the patient would have been admitted.[22]

Assigned traditional-Medicare patients	Patients	Admissions per 100 a year	Avoided per 100 at a 30% reduction	Net to the ACO per patient-year	Reduction to break even
Heart failure	900	40	12	**+$883**	15%
Chronic kidney disease, without heart failure	900	44.5	13.4	**+$1,081**	13%

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

7.3 The 24-month ledger for this forecast

At month 24 the forecast has 994 patients on remote monitoring, every one with heart failure or kidney disease. About 500 of them are assigned to the ACO. The ledger below runs the forecast's own monthly census through the same arithmetic at three reductions in admissions.

[21] Panel split: the Pulaski and Saline Medicare Advantage share of 45.9% applied to the 15,000-patient panel; the assigned share of the traditional-Medicare remainder taken as 85%, the share a primary care network whose patients get most of their primary care from it would typically carry under retrospective assignment.

[22] Medicare's share: the forecast's remote-monitoring reimbursement per patient-month ($94.19), less denials and the 20% coinsurance the patient owes, which ACO expenditure does not count. Cost per admission: the ACO's PY2024 short-term acute-care spending per assigned patient divided by its short-term admission rate.

Reduction in admissions	Added Part B spending	Admissions avoided	Net to total cost of care	Heart failure	Chronic kidney disease
30%	$594,453	86 ($1,259,078)	**+$664,625**	+$286,747	+$377,877
40%	$594,453	114 ($1,678,771)	**+$1,084,318**	+$477,783	+$606,534
20%	$594,453	57 ($839,385)	**+$244,932**	+$95,712	+$149,221

CoachCare Value Analysis remote-monitoring census, months 1 to 24, on the assigned share of traditional-Medicare patients. Added spending is Medicare's share of remote monitoring for those patients; admissions are priced at the ACO's own $14,703.

Both kinds of patient pay their way. At a 30% reduction the program returns $664,625 to total cost of care over 24 months, $1,084,318 at 40%, and it stays positive at 20%, at $244,932. Heart failure breaks even at a 15% reduction and kidney disease at 13%. Medicare Advantage patients on remote monitoring, about 500 at month 24, add nothing to the ACO's spending.

7.4 CoachCare's recommendation: heart failure and kidney disease, on every kind of coverage

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

Coverage	What CoachCare runs	Why
Traditional Medicare, assigned to the ACO	**Remote monitoring**	Daily weight and blood pressure for about 500 assigned patients at month 24; the program pays back to the ACO at a 15% reduction in heart failure admissions and 13% in kidney disease
Traditional Medicare, not assigned	**Remote monitoring**	About 100 patients at month 24; every claim is practice revenue and none of it touches the ACO's benchmark
Medicare Advantage	**Remote monitoring**	About 500 patients at month 24, on the same daily readings; claims are paid on each plan's terms and stay off the ACO's benchmark

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

In a two-sided ACO the quality score does two jobs. Meeting CMS's standard keeps the ACO at the full 75% sharing rate. It also holds the share of any loss at the 40% floor, where a miss can push it as high as 75%. The ACO scored **80.3 in PY2024**, against a PY2026 standard of 73.85; 64% of ACOs scored higher. The measures with the most room are the ones monthly remote care moves.[23]

Measure	PY2024	Better than	How the program moves it
Q484 Admissions for patients with several chronic conditions, per 100 patient-years (lower is better)	**43.2**	**14% of ACOs**	The measure with the most room, and the one this program aims at: heart failure and kidney patients are most of the patients it counts. Daily weight and blood pressure catch fluid gain and drift before an admission
Q479 Hospital-wide 30-day readmission (lower is better)	**15.9%**	**22% of ACOs**	Devices home before the follow-up visit, readings from the day after discharge, and the three-touch cadence

[23] CMS Shared Savings Program Financial and Quality Results, PY2024; quality reporting through the APM Performance Pathway, measure 236 reported by the ACO, 479 and 484 calculated by CMS from claims. PY2026 quality performance standard: the 40th percentile, 73.85.

Measure	PY2024	Better than	How the program moves it
Q236 **Controlling high blood pressure**	81.2	56% of ACOs	Home readings on 16 or more days a month and titration between visits. CMS counts readings from a device that transmits them to the clinician.

Q479 is a rate. Ranks against the ACOs scored on each measure in PY2024. The ACO also reports depression screening and follow-up (Q134, 88.3, better than 69% of ACOs) and poorly controlled diabetes (Q001, 8.7, better than 47%); this program does not target either directly.

Every patient now counts. CMS retired the sampled Web Interface after PY2024. ACOs that now report the electronic measures are scored on every eligible patient, of every payer. Under electronic reporting that includes AFCN's Medicare Advantage patients: their blood pressure results feed the ACO's quality score, while their remote monitoring adds nothing to its benchmark.

What a slip would cost. Below the standard, an ACO that still passes CMS's alternative outcome test has its sharing rate scaled by its score, so a 70 would cut the rate from 75% to 52.5%. One that fails both shares in no savings and owes up to 75% of any loss. An 80.3 leaves room above the 73.85 standard, and keeping it is a year-round outreach job, the work a care team does every month. With hypertension in at least three of four of AFCN's Medicare patients, Q236 covers most of the panel.[24]

8.1 The same work moves Medicare Advantage Star Ratings

About 45.9% of Medicare beneficiaries in Pulaski and Saline counties are on Medicare Advantage. Their plans are rated on a parallel set of measures, and plans pay practices for closing those gaps. For a heart failure or kidney patient on a plan, the monthly program does the same work for the plan's Star Rating that it does for the ACO's quality score.[25]

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

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

9. ACCESS: Paid for Results, Beside Remote Monitoring

ACCESS is a ten-year CMS model, launched in July 2026, for technology-supported chronic care measured by results: blood pressure, A1c, cholesterol, weight and kidney labs. An approved ACCESS organization enrolls the patient and delivers the care between visits. AFCN stays the patient's doctor and bills Medicare for reviewing the patient's progress. For a network inside an ACO, it covers the traditional-Medicare patients the last two sections leave out: those without heart failure or kidney disease.[26]

[24] 42 CFR 425.512 and 425.610: below the quality performance standard, an ACO meeting the alternative quality standard shares savings at a rate scaled by its quality score; an ACO meeting neither shares no savings and its loss rate rises to 75%.

[25] CMS Medicare Part C and D Star Ratings technical notes, 2026: Controlling Blood Pressure and the medication adherence measures are intermediate outcomes weighted 3; Plan All-Cause Readmissions is an outcome weighted 3.

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

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

9.1 Other addressable chronic conditions

About 6,000 of AFCN's roughly 8,100 traditional-Medicare patients have neither heart failure nor kidney disease. Their conditions are the ones ACCESS pays to improve, and each maps to a track.

ACCESS track	Conditions	Share of AFCN's traditional-Medicare patients	Scored on
Early cardio-kidney-metabolic	Hypertension, high cholesterol, prediabetes, obesity	**Hypertension 74% or more; high cholesterol 73% or more**	Blood pressure, LDL, weight
Cardio-kidney-metabolic	Diabetes, heart disease	**Diabetes 25%; ischemic heart disease 29%**	A1c, blood pressure, LDL. Stage 3 kidney disease also qualifies, but under this plan those patients are on remote monitoring
Musculoskeletal	Chronic musculoskeletal pain	**Arthritis 46%**	Patient-reported pain and function
Behavioral health	Depression and anxiety	**Depression 25%**	PHQ-9 and GAD-7; a second track for the same patient, with its own co-management payments

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

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

9.2 What the network earns from ACCESS

Medicare pays the practice $30 for each review of an ACCESS care update, up to three a year, plus $10 once at onboarding, per patient per track. The review takes at least five minutes and one care-coordination step, such as a medication change or an updated problem list. There is no patient cost-sharing on these codes.[27]

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

[27] CMS ACCESS co-management payment billing guidance, 2026: G0676 to G0678. None of the three appears in the May 2026 primary-care code table of the model the ACO participates in.

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

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

CMS published its proposed CY2027 physician fee schedule in July 2026. The comment period closed September 14, 2026, the final rule is expected in early November 2026, and the changes take effect January 1, 2027. The proposal cuts the remote-monitoring device-supply codes. Every code in this forecast was repriced at Arkansas locality 13 on the forecast's own billing mix, with enrollment held constant.[28]

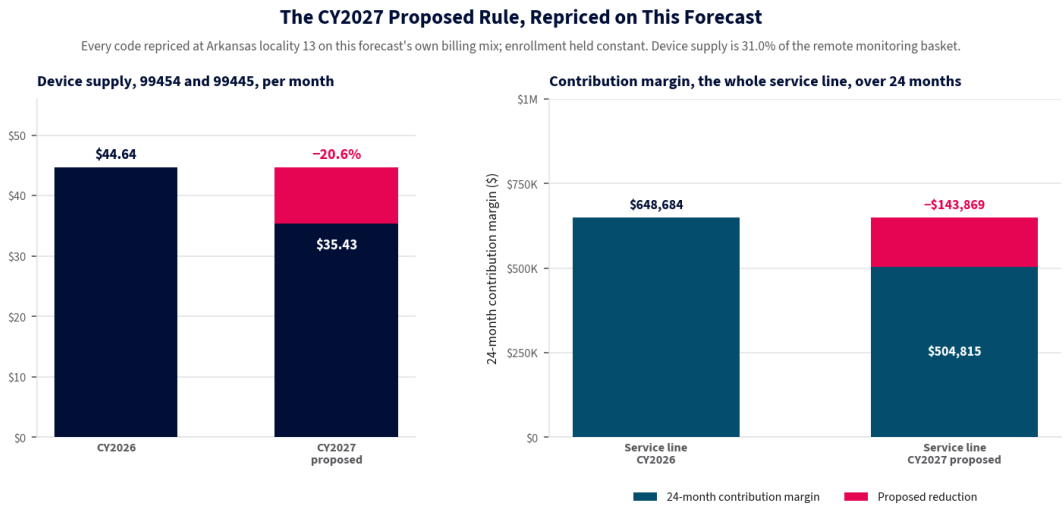


Figure 4. The CY2027 cascade on this forecast: the code family CMS proposes to cut, then the whole service line over 24 months, with the proposed reduction in coral. CoachCare repricing at the proposed CY2027 amounts.

Level	CY2026 basis	Proposed CY2027 effect	How it flows through
Device supply, 99454 and 99445	$44.64 a month	**$35.43 a month, −20.6%**	The code family CMS proposes to cut
The whole service line, contribution margin	$648,684 over 24 months	**−$143,869, to $504,815**	Device supply is 31.0% of the remote monitoring basket; management time and setup move a few points through routine rate changes, and the cut reaches contribution margin dollar for dollar

Device supply is under a third of what each patient-month bills, so most of each patient-month is untouched by the cut. CoachCare will rerun the forecast at the final rates. A contingency is already in build in which CoachCare manages the staffing while AFCN owns the clinical program and the billing.

Code	What it pays for	CY2026 national	Proposed CY2027 national	Change
99453	Remote monitoring setup	$21.71	$20.03	−7.7%
99454 / 99445	**Device supply, 16+ days / 2–15 days**	**$52.11**	**$41.38**	**−20.6%**

[28] CMS-1848-P, published July 2026. CoachCare repricing at Arkansas locality 13, conversion factor $32.8409 against $33.4009: device supply 31.0% of the remote-monitoring basket; remote monitoring 100.0% of the line.

Code	What it pays for	CY2026 national	Proposed CY2027 national	Change
99457	Treatment management, first 20 minutes	$51.77	$49.59	−4.2%
99458	Each additional 20 minutes	$41.42	$40.39	−2.5%
99470	Treatment management, 10–19 minutes	$26.05	$20.69	−20.6%

CY2026 Addendum B and CMS-1848-P proposed CY2027 Addendum B, national non-facility amounts; the repricing above uses Arkansas locality 13 amounts, and the two bases do not reconcile to the dollar, by design. Section 1848(c)(7) of the Act limits how far a code's relative value can fall in one year.

11. Implementation Roadmap

11.1 Who runs what

Function	CoachCare	AFCN
Identification and enrollment	Registry query in eClinicalWorks for the heart failure and kidney disease patients, recent discharges first; an on-site enrollment specialist; telephonic outreach; devices shipped, cellular-paired and replaced	Approves the criteria and target list; clinicians order at the chronic-care, wellness or transitional care visit
Monitoring and escalation	Reading review, the monthly treatment-management time, business-hours alert triage and the post-discharge cadence	**Sets thresholds and routing for each clinic; receives escalations**
Care coordination	Readings and trends in the chart; no separate care-management program	**The coordinators, dietitian and pharmacist keep their work, as today**
Transitional care	Starts or resumes monitoring after the visit; the three-touch cadence for enrolled patients	Furnishes the visit and bills it, as today
Documentation, billing, reporting	Monthly care documents in eClinicalWorks, claims created automatically, operational and clinical outcomes reports by clinic and clinician	**Reconciles and files under its group enrollment; keeps the revenue; names a program lead**

11.2 The model inputs

Input	Value in this forecast
Medicare panel	**15,000 patients across seven primary care clinics; the heart failure and kidney disease patients are in scope, all payers**
Payer mix	**About 45.9% of the area's Medicare beneficiaries are in Medicare Advantage; every patient priced at the Medicare amount. Medicare Advantage plans cover these Part B services and pay them on each plan's own contract terms.**
Referring clinicians	26: 18 physicians (16 family medicine, 2 internal medicine), 7 nurse practitioners and 1 physician assistant
Program	Remote monitoring on traditional Medicare and Medicare Advantage; transitional care credited at zero dollars
Eligibility and acceptance	26.5% eligible (heart failure 12.8%, chronic kidney disease 19.4%, patients with both counted once); 25% accept; 3% monthly attrition
Admissions	Heart failure 40 and kidney disease 44.5 per 100 patients a year, weighted to the enrolled mix; a 30% reduction
Enrollment capacity	One CoachCare-funded on-site enrollment specialist plus telephonic outreach
EMR	eClinicalWorks, integrated as described in Section 4
Rates	CY2026 fee schedule, non-facility, Arkansas locality 13, ZIP 72205

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

CoachCare brings on care managers ahead of the census, reaching 6 by month 11, when the program holds about 1,000 patients. New patients arrive at up to about 170 a month in months 9 and 10, about 24 per clinic per month across the seven clinics, and about 30 a month after that to replace patients who leave. The on-site enrollment specialist and telephonic outreach cover the clinics the schedule does not reach on a given day, and the clinicians' own orders at the visit do the rest.

The order the clinics go live is a decision to make together. One sensible sequence starts at the two Little Rock Family Practice clinics, with 14 of the 26 clinicians and the care coordinators, adds the west Little Rock clinic and Bryant next, and brings Hensley and the two single-physician offices on by the end of the first quarter. Every clinic uses the same flags, devices and care team, so a later start changes only when its patients join, not how the program runs.

11.4 The first 90 days, and after

Window	What happens	Result
Weeks 0–6 Integrate and charter	eClinicalWorks workshop with the EHR administrator and billing leads; chart counts and payer mix by plan; the coordinators' post-hospital workflow mapped so nobody is called twice; thresholds, routing and the clinic go-live order agreed	Integration live, protocol signed, go-live order set
Weeks 6–12 Launch the first clinics	Enrollment from the first week, recent discharges first; the post-discharge cadence live	23 patients in month 1, 56 by month 2, 108 by month 3
Months 3–11 All seven clinics	Same protocols at every clinic; care managers added as the census grows	994 patients by month 11, the eligible ceiling
Months 12–24 Hold and report	Attrition replaced each month; heart failure and kidney admissions reported against the ACO ledger each quarter; ACCESS considered for the patients outside the heart failure and kidney focus	Year 2: $440,548 of contribution margin

Remote monitoring carries Part B coinsurance, so the consent conversation explains the monthly cost plainly before the device ships.

11.5 What we would confirm together

1. **The Medicare chart count, by payer and clinic.** Traditional Medicare against each Medicare Advantage plan, and how many patients carry heart failure or chronic kidney disease. It confirms the eligible ceiling, the number this forecast turns on.
2. **Which patients the ACO's monthly primary-care payment covers.** Which AFCN clinicians and assigned patients it applies to, so the ACO ledger in Section 7 runs on the network's real assigned count.
3. **The Medicare Advantage plans, one by one.** Medicare Advantage plans cover these Part B services and pay them on each plan's own contract terms. Which plans AFCN's patients hold, and how each pays for remote monitoring, decides how much of the Medicare Advantage share bills at the Medicare amount.
4. **Care coordination today.** How many coordinators the clinics carry, at which clinics, and what they do after a discharge, so CoachCare's care team adds readings without repeating a call.
5. **Transitional care today.** Who runs the workflow for the twelve clinicians who bill it, where discharge notices come from, and whether they arrive in eClinicalWorks in time.
6. **Which Medicare Advantage contracts pay for quality.** Which plans pay the network for closing gaps, so the Star measures in Section 8 count where they pay.
7. **Which clinicians refer.** The 26 primary care clinicians from the start, and the two who joined in 2026.
8. **The eClinicalWorks configuration.** The version, the healow modules licensed, and any device connection already in place.

9. **Coinsurance at consent, and the go-live order.** How the monthly Part B coinsurance is explained at enrollment, which clinics launch first, and where the on-site enrollment specialist works each day.

12. Recommendations

1. **Launch remote monitoring for heart failure and kidney disease, on every kind of coverage.** $648,684 of contribution margin over 24 months ($208,136 in year one, $440,548 in year two), positive from month 2, with nobody hired.
2. **Keep the service line to remote monitoring.** It is the one program that bills claim by claim for every Medicare patient, assigned to the ACO or not.
3. **Measure it on the ACO's ledger.** At a 30% reduction in admissions the program returns $664,625 to total cost of care over 24 months; report the heart failure and kidney admissions against that line each quarter.
4. **Pull the Medicare chart count by payer and clinic in week one.** The heart failure and kidney pool sets the ceiling, and the Medicare Advantage plans' terms decide how much of it bills at the Medicare amount.
5. **Treat enrollment capacity as a lever.** Start with one on-site enrollment specialist and add a second if AFCN wants the pool full by month 9; it adds $43,678 of contribution margin over 24 months at CoachCare's cost.
6. **Start with patients just home from the hospital.** The transitional care visit is the enrollment conversation; a scale and cuff for heart failure, a cuff for kidney disease.
7. **Put the coordinators' work and CoachCare's on one map.** The coordinators, dietitian and pharmacist keep what they do; the readings land in the chart they already use.
8. **Aim the monthly work at the ACO's two admission measures.** Q484 and Q479 have the most room, and both count the admissions this program is built to prevent among assigned patients. The daily blood pressure readings feed Q236 and the plans' Star measures.
9. **Keep clinical governance where it is.** AFCN's clinicians decide; CoachCare does the work and documents it.

The heart failure and kidney disease patients AFCN already manages support a service line that returns $648,684 of contribution margin over 24 months, on staff the network does not hire and devices it does not buy, and they return $664,625 to the ACO's total cost of care at a 30% reduction in admissions. Remote monitoring is the one program here that pays per claim for every patient. What remains is to put a scale and cuff in those homes and keep the program as the network's own.

About CoachCare

> **The experience to get it right**
>
> CoachCare manages more than 500,000 patients across over 400 conditions, with more than 10,000 clinicians running remote care programs on its platform day to day. Its teams have stood up more than 1,000 programs, built the care-plan coding and billing behind more than 5 million claims, and recorded over 100 million vitals.

- **It builds on what the network already does.** Wellness visits, transitional care after hospital stays, care coordinators, a dietitian and a pharmacist are already part of the week. CoachCare adds daily readings for the heart failure and kidney patients and the team to watch them.
- **It runs inside the chart the network already uses.** Readings, documentation and claims live in eClinicalWorks, and enrollment status is visible at every clinic.
- **Fully staffed, no hiring.** Care managers at 165 patients each, enrollment, devices, business-hours alert triage and billing preparation on CoachCare's payroll.

- **Clinicians stay in charge.** AFCN's physicians and advanced practice clinicians set the protocols, sign the care plans and make every clinical decision.
- **Designed for an older panel.** Cellular devices with nothing to pair, and outreach by phone, so no patient has to learn an app.
- **Published results.** A 29.1 mmHg drop in Stage 2 hypertension across 2,738 patients at Cardiac Solutions, half the 30-day readmission rate across 26,689 patients at the same practice, and zero readmissions among 450 advanced heart-failure patients at Iowa Heart.

The ask is a working session to confirm AFCN's Medicare chart count by payer and clinic, map how CoachCare's care team sits beside the coordinators who follow patients after hospital stays today, scope the eClinicalWorks integration, and set the order the seven clinics go live before the first patient enrolls.

Contact

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References & Data Sources

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Patients, panel and claims are different counts. At month 24 the program holds 994 patients on remote monitoring, each enrolled once. The 15,000-patient panel covers all payers; the 10,160 beneficiary-clinician relationships in the CY2024 claims are traditional Medicare only.