

Coury Family Medicine

An independent, physician-owned family practice in the East Valley of Maricopa County, Arizona: offices in Gilbert and Mesa, nine clinicians, and a large, older Medicare panel inside an Enhanced-track Medicare Shared Savings Program ACO

Remote Care Service Line Optimization Report

2026 Strategy Report

A scalable, profitable remote care service line for Coury Family Medicine: remote monitoring and chronic care management for the Medicare panel its nine clinicians already know, billed under Coury's own NPIs at Arizona'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 leadership of Coury Family Medicine. It is the companion to Coury's remote care strategy page and makes the same case at report length: why Medicare's payment rules make this the year, what Coury's own Medicare claims show, how the service line runs, what it returns over 24 months at Arizona's locality rates, and why CoachCare is the partner to run it.

Coury already sees every patient on a chronic medication twice a year, completes about 1,810 wellness visits, runs transitional care after hospital stays, and has billed for at least five years inside an ACO scored on what happens between visits. What its claims do not show is daily readings for the hypertension and diabetes patients, or monthly care management for anyone. This report shows what that program returns, who does the work, and how fast it can be enrolled.

Prepared by CoachCare for discussion with Coury Family Medicine. © 2026 CoachCare.

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Executive Summary

Coury Family Medicine is an independent, physician-owned family practice in the East Valley, with offices in Gilbert and Mesa, each open weekdays from 8 to 5 with lab draws on site. Nine clinicians, two family physicians, six physician assistants and a nurse practitioner, see patients of every age. The practice runs eClinicalWorks.¹

Coury's own CY2024 Medicare claims describe the panel. Its physicians billed for **more than 2,900 traditional-Medicare patients, averaging 77 years old**, with a weighted risk score of 1.08 against a national 1.00. Hypertension appears in 73% of them, high cholesterol sits at CMS's 75% reporting cap, and chronic kidney disease runs at 26%, diabetes 25%, heart failure 14% and COPD 13%. Coury already completes about 1,810 annual wellness visits, screens about 2,000 patients for depression and bills transitional care after about 80 hospital stays a year. **No remote monitoring, chronic care management, APCM or behavioral health integration program appears at meaningful scale.**²

For at least five performance years Coury has billed inside **an Enhanced-track Medicare Shared Savings Program ACO**, the two-sided track, with patients assigned at the start of each year since January 2025; its clinicians are Qualifying APM Participants. Every admission avoided among the ACO's assigned patients is spending that never posts against the ACO's benchmark, and the quality measures it is scored on turn on what happens between visits.³

The observation this report is built on

Turn the panel Coury already manages into a profit-generating service line.

Coury has the panel, the conditions, the record system, the visit rhythm and the accountable-care position. What it does not have is daily readings between the six-month checkups, or monthly care management for the thousands of patients with two or more chronic conditions. This service line fills that gap: staffed by CoachCare, governed by Coury's clinicians, billed under Coury's NPIs from inside eClinicalWorks.

What the Value Analysis returns

Full service line	Year 1	Year 2	24 months
Net reimbursement	\$828,041	\$2,387,591	\$3,215,632
CoachCare fees	\$485,312	\$1,361,760	\$1,847,072
Net to Coury	\$342,729	\$1,025,831	\$1,368,560
Practice margin	41.4%	43.0%	42.6%

CoachCare Value Analysis: 6,000 Medicare patients across two offices, 4,800 in scope, remote monitoring and chronic care management, 9 referring clinicians, one CoachCare-funded on-site enrollment specialist, CY2026 Arizona locality 00 amounts. Margin is net to Coury divided by net reimbursement.

Coury can take this two ways, and both are net-positive. CoachCare can run remote monitoring on its own, with care coordination left to Coury's team and the ACO: **\$1,587,887 of net reimbursement and**

¹ couryfamilymedicine.com, retrieved October 23, 2026: offices at 1520 W Guadalupe Rd, Suite 108, Gilbert, and 5424 E Southern Ave, Suite 101, Mesa, Monday to Friday 8:00 a.m. to 5:00 p.m.; two physicians (family medicine), six physician assistants, one nurse practitioner. The patient portal is hosted on eClinicalWorks' domain under the healow name.

² CMS Medicare Physician & Other Practitioners, CY2024, the two physicians who carry the practice's billing: 3,432 beneficiary-physician pairs, 2,906 distinct beneficiaries under the larger of the two; average age 77; HCC risk 1.08; hypertension 72.7%, high cholesterol 75% (cap), CKD 26.4%, diabetes 25.2%, heart failure 13.5%, COPD 12.8%; annual wellness visits 1,806; depression screening 2,003; transitional care 82 beneficiaries.

³ CMS Shared Savings Program ACO Participants, 2022 to 2026 (2026 dataset 9767cb68): Enhanced track, prospective assignment from January 1, 2025. CMS Quality Payment Program eligibility, 2024 to 2026: Advanced APM, Qualifying APM Participant status.

\$672,624 to Coury over 24 months, for 1,092 patients. Or CoachCare can run both programs across the panel, the forecast of record above, for 1,416 unique patients.

1. **Positive from month 2, with nobody hired.** Implementation and the eClinicalWorks setup post in month 1; every month after is positive, and the monthly net climbs with the census to \$95,256 a month from month 22. CoachCare delivers 27,427 care-team hours over 24 months, about 13.2 full-time-equivalent years, with six care managers at month 12 and nine at month 24, at 165 patients each.
2. **The binding constraint is enrollment capacity, not the size of the panel.** At a Medicare panel of about 6,000, remote monitoring reaches its ceiling of 1,092 in month 18 and chronic care management its ceiling of 1,080 in month 21. Across every panel size Coury's claims support, 3,700 to 7,100, 24-month net reimbursement moves only from \$2,440,032 to \$3,372,301.
3. **A second on-site enrollment specialist is the largest lever.** It cannot raise the ceiling, but reaches it sooner, in months 12 and 13, and lifts 24-month net reimbursement from \$3,215,632 to \$3,932,856 (+\$717,224, +22%). We recommend scoping it; the forecast of record keeps one (Section 6.5).
4. **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).
5. **Transitional care already runs at Coury; CoachCare extends it.** The care team can make the two-business-day contact after every discharge, so more discharges qualify for 99495 (\$215.45) or 99496 (\$292.37), and remote monitoring and chronic care management carry the patient past day 30. The forecast carries no transitional care dollars.
6. **Advanced primary care management is the named next lever, at zero dollars.** Coury's Shared Savings Program participation qualifies it. APCM bills in place of chronic care management, and which patients move is a program decision to make together.
7. **The CY2027 proposed rule takes 5.8% off this line.** A 20.6% cut to device supply is 9.5% on the remote-monitoring arm and \$185,222 over 24 months on the whole line. Section 8 draws the cascade.

The ask is a working session: confirm the Medicare chart count by payer, map how chronic care management sits beside the ACO's care coordination, scope the eClinicalWorks integration, and set enrollment staffing for the Gilbert and Mesa offices before the first patient enrolls.

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

Medicare is changing what it pays primary care for. Four shifts are under way at once, and each lands in the same place: the weeks between a patient's visits. For a panel that carries hypertension, diabetes and kidney disease together, those weeks decide how the year goes.

The shift	What it means for Coury
1. From visits to panels	Coury asks every patient on a chronic medication to come in every six months: two visits a year, and 363 days without a reading. Managing a panel means knowing which of Coury's roughly 6,000 Medicare patients are trending the wrong way before they reach an emergency department, and that takes home data and a team assigned to act on it every month.
2. Accountability for total cost	Coury has billed inside an Enhanced-track Medicare Shared Savings Program ACO for at least five performance years, and since January 2025 its patients are assigned at the start of each year. Every admission among them counts against the ACO's spending benchmark, and the Enhanced track shares the difference in both directions.
3. Value-based care, with Medicare Advantage at 51%	CMS wants every Traditional Medicare beneficiary in an accountable care relationship by 2030, and since 2025 advanced primary care management has paid a monthly amount for running the whole panel. In Maricopa County 51.47% of Medicare beneficiaries are in Medicare Advantage.

The shift	What it means for Coury
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 17% of remote-monitoring reimbursement. ⁴ At Arizona's CY2026 rates one hypertensive patient on remote monitoring and chronic care management (99454, 99457 and 99490) is worth \$165.95 a month in Medicare allowed charges.

Each shift pays for, or measures, what happens between visits. A remote care service line is how Coury covers that time for every eligible patient, and remote monitoring and chronic care management bill for it under Medicare fee-for-service today.

2. Coury Today: A Practice Built Around Its Patients

Coury has cared for East Valley families for more than twenty years. Its Medicare panel is large and older than most, and the practice already runs the visit rhythm a remote care program needs: a checkup every six months for every patient on a chronic medication, a wellness visit every year, and a call after a hospital stay.

2.1 Two offices, nine clinicians

Office	Hours	What it means for this program
Gilbert 1520 W Guadalupe Rd	Weekdays 8 to 5; lab draws from 7 a.m.	One of two launch sites. Blood pressure and glucose are checked at the visit and then go unseen until the next one; patients flagged here go home with cellular devices
Mesa 5424 E Southern Ave	Weekdays 8 to 5; lab draws from 7 a.m.	The second launch site. Its ZIP, 85206, is 32% age 65 or older, twice the county share, and runs adult high blood pressure at 36.9%, coronary heart disease at 8.1% and COPD at 7.6%, each above Maricopa County ⁵

couryfamilymedicine.com, October 23, 2026; American Community Survey 2020–2024; CDC PLACES 2025, ZIP 85206 against Maricopa County.

The roster is two family physicians, six physician assistants and a nurse practitioner. Both offices draw labs on site, run EKGs and joint injections, and monitor INR in the office for patients on warfarin, so the heart and rhythm patients this program targets are already being seen and tested in the building.⁶

2.2 What the CY2024 claims say

The CY2024 Medicare by-provider and by-provider-and-service files were queried for every clinician linked to Coury's billing organization. Two physicians carry essentially all of the practice's Medicare billing, so the profile below is the traditional-Medicare panel the whole practice sees, recorded under their two names.⁷

Panel	CY2024	Condition	Share
Beneficiary-physician pairs	3,432	Hypertension	73%
Medicare allowed	\$1,654,967	High cholesterol	75% (at the cap)
Average age	77	Arthritis	54%

⁴ CoachCare Value Analysis for Coury Family Medicine, 2026: 99445 and 99470 carry 17.2% of 24-month remote-monitoring gross reimbursement.

⁵ American Community Survey 2020–2024, ZCTA 85206: 32.2% age 65 or older, median age 47.2; ZCTA 85233: 16.1%. CDC PLACES 2025, ZCTA 85206 against Maricopa County (crude): high blood pressure 36.9% against 30.8%, coronary heart disease 8.1% against 5.7%, COPD 7.6% against 5.7%.

⁶ couryfamilymedicine.com services and providers pages, retrieved October 23, 2026; CMS Doctors and Clinicians, October 2026.

⁷ CMS by Provider (8889d81e) and by Provider and Service (92396110), CY2024, queried by NPI for every clinician linked to the practice's billing organization: 3,432 beneficiary-physician pairs, 4,156 established-visit pairs, \$1,654,967 allowed.

Panel	CY2024	Condition	Share
Weighted HCC risk score	1.08	Ischemic heart disease	29%
Annual wellness visits	About 1,810	Chronic kidney disease	26%
Depression screening	About 2,000	Diabetes	25%
Transitional care	About 80, mostly high complexity	Depression	22%
EKGs · INR checks · home-health certification	About 300 · 56 · 120	Atrial fibrillation	20%
Remote monitoring, chronic care management, APCM, behavioral health integration	No program at meaningful scale	Heart failure · COPD	14% · 13%

CMS Medicare Physician & Other Practitioners, CY2024, the two physicians billing for Coury Family Medicine. Program rows are beneficiaries; pairs count a patient once per physician seen. CMS caps published prevalence at 75%, so high cholesterol is a floor, and suppresses lines under 11 beneficiaries.

This is the panel remote care is built for: hypertension in nearly three of four patients, kidney disease and diabetes in about one in four each, heart disease common, and an average age of 77. Most patients qualify for chronic care management, and hypertension with diabetes or kidney disease is the largest group whose home readings would change treatment. Coury already sees these patients on a fixed rhythm, but **no remote monitoring, chronic care management, APCM or behavioral health integration program appears at meaningful scale under either physician.**⁸

2.3 Two decades in the East Valley, five years in an ACO

Year	What happened
2001	The practice's founding physician, an Arizona native, finishes family medicine residency in Scottsdale and starts caring for East Valley families, with added experience in geriatric medicine
2004	Medicare enrollment follows, and the practice opens near Southern Avenue and Higley Road in Mesa; patients still write about knowing it since its first office ⁹
2007	Coury Family Medicine organizes as a group with its own group NPI, and physicians and advanced practice clinicians work as one team under it
2022	By 2022 Coury is a participant in an Enhanced-track Medicare Shared Savings Program ACO, the two-sided track, scored every year on blood pressure, diabetes, depression and admissions; its clinicians are Qualifying APM Participants. Prospective assignment begins in January 2025
Today	Two offices, nine clinicians, onsite labs, EKGs, joint injections and in-office INR monitoring, about 1,810 wellness visits a year and transitional care after hospital stays
Next	Daily readings and monthly care management for every eligible Medicare patient, run by a CoachCare care team inside eClinicalWorks

2.4 What Coury already runs, and the gap

What exists	Status	What it means for this program
eClinicalWorks and its healow-branded portal	Live	The program's host: flags, orders, readings, care documents and claims (Section 4)

⁸ CMS by Provider and Service, CY2024, searched for the remote monitoring, chronic care management, APCM, transitional care and behavioral health integration codes. Present: 99496 (57 beneficiaries) and 99495 (25); G0439 and G0438 (1,806); G0444 (2,003); G0180 (124); 93000 (295); 85610 (56). CMS suppresses lines under 11 beneficiaries.

⁹ CMS Quality Payment Program: Medicare enrollment first approved in 2004. NPPEs: the group's organization record enumerated March 14, 2007. Residency year from the practice website.

What exists	Status	What it means for this program
Six-month chronic checkups	Required to keep refills	The enrollment moment for anyone above goal; the months between visits stop being blank
Annual wellness visits and depression screening	About 1,810 and 2,000	Where eligibility is checked, consent is taken and devices are ordered
Transitional care	About 80 patients, mostly 99496	Credited and kept. CoachCare makes the two-business-day contact after more of the discharges and carries the patient past day 30
In-office INR, EKG and home-health oversight	About 56, 300 and 120 patients	Home weight and blood pressure fill the months between office tests
The ACO's care-coordination resources	Offered for assigned patients	Nurse care managers and a nurse line for patients with serious or chronic conditions. The program coexists with them ¹⁰
Remote monitoring, chronic care management, APCM	No program at meaningful scale	Devices, daily readings, monthly care management and business-hours alert triage come from CoachCare

The gap is specific: daily readings for the hypertension, diabetes and heart patients, and monthly billable care management for every patient with two or more chronic conditions, across both offices and all nine clinicians.

2.5 The market, and the rate basis

Maricopa County had 823,407 Medicare-eligible residents in October 2026, and 51.47% were in a Medicare Advantage plan; 399,822 remain in Original Medicare, and 14.4% are dual-eligible county-wide. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. Coury's own payer mix is not public, so it is the second thing to confirm after the chart count.¹¹

Both offices sit in Arizona's single statewide payment locality, locality 00, under the Noridian JF contractor. Every dollar in this report is priced at those CY2026 amounts.¹²

3. The Service Line: Remote Monitoring and Chronic Care Management

3.1 The clinical and billing stack

Two monthly programs and one episode code, with one enrollment conversation, one care team and one billing pipeline into Coury's own billing through eClinicalWorks. The forecast carries the two monthly programs; transitional care, which Coury already bills, stays on the stack and carries no dollars.

Program	What it does clinically	Who it fits on this panel	Net reimbursement per patient-month
Chronic care management (CCM)	A documented care plan and at least 20 minutes of clinical staff time a month for patients with two or more chronic conditions; 99490, 99439	The multi-chronic core: hypertension with kidney disease, diabetes, heart disease or COPD	\$108.55

¹⁰ The ACO's published materials for Shared Savings Program patients of participating physicians, retrieved October 23, 2026.

¹¹ CMS Medicare Advantage State/County Penetration, October 2026: Maricopa 51.47% (423,846 of 823,407). CMS Medicare Monthly Enrollment, July 2026: 399,822 in Original Medicare; 118,008 dual-eligible (14.4%).

¹² CY2026 Physician Fee Schedule, Noridian JF carrier 03102, Arizona locality 00: geographic indices work 1.000, practice expense 0.969, malpractice 0.856; conversion factor \$33.4009.

Program	What it does clinically	Who it fits on this panel	Net reimbursement per patient-month
Remote physiologic monitoring (RPM)	Cellular cuffs, glucometers and scales send readings between visits against thresholds Coury's clinicians set; 99453, 99454 or 99445, 99457, 99458, 99470	Hypertension and diabetes first, then kidney disease, heart failure and atrial fibrillation	\$95.32
Transitional care management (TCM)	Contact within two business days of discharge, medication reconciliation, a visit within 14 days (99495) or 7 days (99496)	Every panel patient discharged from a hospital or observation stay	Already billed; not in the forecast

Codes	What they pay for	CY2026 Arizona locality 00
99490 · 99439	Chronic care management, first 20 minutes · each additional 20	\$64.85 · \$49.41
99453	Remote monitoring setup and education, once	\$20.96
99454 · 99445	Device supply, 16+ days · 2 to 15 days in 30 (99445 new in CY2026)	\$50.45 · \$50.45
99457 · 99458	Treatment management, first 20 minutes · each additional 20	\$50.65 · \$40.61
99470	Treatment management, 10 to 19 minutes (new in CY2026)	\$25.49
99495 · 99496	Transitional care, visit within 14 days · within 7 days	\$215.45 · \$292.37
G0556 · G0557 · G0558	Advanced primary care management, levels 1 to 3	\$16.04 · \$52.72 · \$114.88
99484	Behavioral health integration, 20 minutes a month	\$56.41

How the rates apply

CY2026 non-facility amounts, Arizona locality 00 (Noridian JF, carrier 03102), ZIP 85233. One device code, one first-tier management code and one care-management program (chronic care management or advanced primary care management) bill per patient per month; transitional care bills once per discharge alongside either.

Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The forecast prices every patient at the Medicare amount.

3.2 The care team, and the hours it keeps

CoachCare hires, trains and manages the care managers, at 165 patients each: six care managers for the 926 unique patients at month 12, and nine for the 1,416 at month 24. An on-site enrollment specialist on CoachCare's payroll works the Gilbert and Mesa schedules beside Coury'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, the same hours both offices keep. Patients are told at consent to call 911 for an emergency and Coury for anything urgent.

3.3 Transitional care: more discharges that qualify

Coury already bills transitional care management: about 82 traditional-Medicare patients in CY2024, most at high complexity (99496 at \$292.37; 99495 at \$215.45). That rests on a working discharge workflow, and the program builds on it rather than replacing it. The CoachCare care team can make the two-business-day contact and the medication reconciliation after every discharge Coury learns of, so more discharges meet the requirement, and Coury furnishes the visit and bills the code. Remote monitoring and chronic care management then carry the patient past day 30, when most readmissions happen. The forecast carries no transitional care dollars. Who runs today's workflow, and where discharge notices come from the hospitals where Coury's patients are admitted, is discovery item number five.¹³

3.4 The next levers: APCM and behavioral health integration

Advanced primary care management (G0556 to G0558) pays a monthly amount per patient, in place of chronic care management, to a practice that runs the whole panel, tiered by complexity. Coury can bill it today, and its Shared Savings Program participation fits the accountable-care model APCM was built around.¹⁴ It appears here at zero dollars. Moving patients from chronic care management to APCM is a program decision to make together; remote monitoring bills alongside either, and the same staff and workflow carry over.

Behavioral health integration is the adjacency. Depression appears on 22% of the panel's claims and anxiety on about 20%, and Coury already screens about 2,000 Medicare patients for depression each year. Behavioral health integration (99484, \$56.41 a month) can run on the same care-manager calls once the program is running. It carries no dollars here.

3.5 Two deployments, and what Coury keeps

Coury has already built part of the answer to build-versus-partner: it runs the visit rhythm, the wellness visits, in-office INR and EKG, and transitional care, and its ACO offers nurse care managers and a nurse line for assigned patients. What none of it supplies is daily readings or monthly billable care management across the whole eligible panel. CoachCare adds those, alongside the ACO's resources.

Deployment	What CoachCare runs	What stays with Coury and the ACO
Remote monitoring on its own	Remote monitoring for the hypertension, diabetes, kidney and heart patients	Care coordination, as Coury's team and the ACO run it today, with home readings in the chart
Full service line, RPM + CCM (the forecast of record)	Both programs, enrolling every eligible patient into chronic care management as well as monitoring	Clinical governance, the visits, transitional care billing and the patients

- **Coury 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 Coury's NPIs, and in the full service line Coury keeps 42.6% of net reimbursement after CoachCare's fee.
- **CoachCare supplies the program.** Devices, an on-site enrollment specialist, care managers, business-hours alert triage, monthly documentation and automated claims, all priced per active patient per month. None of it is Coury's headcount, inventory or software.
- **The ACO's care managers are a coexisting layer.** How they and a CoachCare chronic care management program divide the work, so that no patient is called twice, is discovery item number three.

¹³ CMS by Provider and Service, CY2024: 99496, 57 beneficiaries and 59 services; 99495, 25 beneficiaries and 25 services; 82 beneficiaries in all.

¹⁴ CY2025 and CY2026 Physician Fee Schedule final rules: APCM (G0556 to G0558) effective January 1, 2025, billed in place of chronic care management for the same patient and month.

- **Independence is part of the return.** A recurring service line with its own margin is an alternative to selling the practice to fund the next hire.

4. eClinicalWorks: The Program Lives in the Chart

CoachCare works inside eClinicalWorks' own workflows, so Coury's 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 both offices, and a flagged patient reaches the first day of service in under five days.¹⁵ 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 patients who meet criteria Coury's clinicians approve, at a six-month checkup, a wellness visit or on an outreach list
Enrollment by services and devices	The clinician orders by service and by device (cuff, glucometer, scale), the way a lab is ordered
Exchange of health history	Diagnoses, medications, vitals and labs, INR results included, pass to the care team at intake; the care plan comes back
Integrated vital reports	Home readings land in the chart, so the clinician sees home averages at the next checkup
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; Coury's billing team reconciles and files them

The integration costs \$4,000 for setup, \$150 a month and \$1.50 per enrolled patient-month. With implementation and telephonic outreach the ancillary items total \$67,978 over 24 months, inside the \$1,847,072 of CoachCare fees. The 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 Coury never carries surveillance liability it did not agree to. Thresholds and routing are set with Coury's clinicians, for each office, before the first patient enrolls.¹⁶

5.1 One shared escalation engine

Branch	The rule	Why
Critical value	Escalate to the practice, regardless of symptoms	No client preference can suppress it. A critical reading on its own goes to the office, not to 911
Out of range, not critical	Retake, then a structured symptom check	Most out-of-range readings resolve here, which keeps inboxes usable
Trend	Three consecutive readings an hour or more apart for blood pressure or glucose; three within seven days for heart rate; weight gain past the agreed threshold	A confirmed trend escalates like a single threshold breach

¹⁵ CoachCare eClinicalWorks integration overview, 2026: the six pillars; patients begin chronic care management and remote monitoring in less than five days.

¹⁶ 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.

Branch	The rule	Why
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

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 Cory office the same day. A critical reading alone, without those symptoms, goes to the office instead.

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

The floor. CoachCare's emergent policy supersedes any client escalation preference. Cory 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 office notified
Needs the practice	A critical reading, or an out-of-range reading or trend confirmed after a retake	The clinician or nurse each office 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 Gilbert and Mesa separately. Care managers work readings and escalations Monday to Friday, 8 a.m. to 5 p.m. local patient time, which matches the hours both offices are open, so every escalation lands while a Cory clinician is in the building. A reading that arrives on a weekend or overnight is worked the next business day, and the patient's standing instruction for anything urgent is Cory's own line, covered after hours by its answering service, or 911.

5.4 The post-discharge cadence

Any emergency visit or hospitalization in the previous 60 days triggers the cadence. After a hospital or observation stay it is also the transitional care episode Cory already bills, and inside the ACO each admission it prevents is spending that never posts against the benchmark.

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

5.5 Built for an older, phone-first panel

Coury's traditional-Medicare patients average 77 years old, and the Mesa office sits in a ZIP where a third of residents are 65 or older. The program is set up for them. Devices are cellular and arrive ready to use, with no home internet, smartphone or pairing. The welcome call, the monthly care-management call and every escalation call are made by phone, so no patient has to learn an app. Patients who already use the eClinicalWorks portal can keep using it, and nothing in the program depends on it. The routine is set on the welcome call to fit the patient's day, and a missed run of readings prompts a call, not a portal message.

5.6 Continuity and discharge governance

1. **Unreachable patients escalate on a fixed clock.** A monitoring patient unreachable 45 days from enrollment goes to the office; non-compliance at 90 days triggers a second escalation; chronic care management's first escalation comes at six months.
2. **There is a hard backstop.** Without an instruction from the office, discharge from monitoring proceeds at 180 days, with the office notified.
3. **Coury always decides.** Discharge criteria, thresholds and routing belong to Coury's clinicians, with the single exception of the emergent floor in Section 5.2.

6. Value Analysis: The 24-Month Forecast

6.1 The headline economics

The forecast covers remote monitoring and chronic care management across a Medicare panel of 6,000 at the two offices, 4,800 in scope, at the CY2026 Arizona locality 00 amounts, with 9 referring clinicians and one CoachCare-funded on-site enrollment specialist at 80 enrollments a month. No transitional care, APCM, behavioral health integration or ACO payment is in these numbers.¹⁷

Full service line	Year 1	Year 2	24 months
Chronic care management	\$403,263	\$1,224,483	\$1,627,745
Remote physiologic monitoring	\$424,778	\$1,163,109	\$1,587,887
Net reimbursement	\$828,041	\$2,387,591	\$3,215,632
CoachCare fees, including eClinicalWorks integration and implementation	\$485,312	\$1,361,760	\$1,847,072
Net to Coury	\$342,729	\$1,025,831	\$1,368,560
Practice margin	41.4%	43.0%	42.6%

Year two is nearly three times year one because the census is still climbing through most of it: the program enters year two with 926 unique patients and ends it with 1,416. The margin rises from 41.4% to 43.0% as the one-time setup falls away. Year two returns **\$2,387,591 of net reimbursement, \$1,025,831 of it kept by Coury.**

6.2 Two deployments, side by side

Each deployment is priced on its own, and the full service line is the forecast of record. The avoided admissions are the same in both because they come from the monitoring. The full line adds chronic care management for 1,080 patients, 324 of them patients the monitoring does not reach, and \$695,936 more to Coury over 24 months.

¹⁷ CoachCare Value Analysis for Coury Family Medicine, 2026, the source of all Section 6 figures; sensitivity runs change one input at a time on the same workbook.

24 months	Remote monitoring on its own	Full service line, RPM + CCM
Net reimbursement	\$1,587,887	\$3,215,632
Net to Coury after fees	\$672,624	\$1,368,560
Unique patients at month 24	1,092	1,416
Hospitalizations avoided	About 111	About 111

6.3 Where the revenue comes from

24 months	Net reimbursement	CoachCare fees	Net to Coury
Chronic care management	\$1,627,745	\$846,332	\$781,413
Remote physiologic monitoring	\$1,587,887	\$932,762	\$655,124
Implementation, eClinicalWorks integration, per-patient EMR fee, telephonic outreach		\$67,978	-\$67,978
Total	\$3,215,632	\$1,847,072	\$1,368,560

The two programs are close in size. Chronic care management carries \$1,627,745 on 1,080 enrollments at month 24, because the multi-chronic core of the panel is large and the 99439 add-on is earned in most months. Remote monitoring carries \$1,587,887 on 1,092 enrollments and produces the readings, alerts and avoided admissions. The **2,172 active program enrollments at month 24 belong to 1,416 unique patients**, because most monitored patients also hold a care-management enrollment. The two codes new in 2026 carry 17% of remote-monitoring gross reimbursement on this mix.¹⁸

6.4 The ramp, month by month

Month 1 nets -\$4,756, because the one-time implementation fee and the eClinicalWorks setup post against 43 enrollments. The program is positive from month 2, with \$4,828 on 114 enrollments, and cumulative net to Coury is above zero by the end of month 2. New patients join at about 96 a month once the launch is running, so the monthly net climbs every month until both ceilings are reached and holds \$95,256 a month from month 22. At month 12 the program holds 1,366 active program enrollments across 926 unique patients, and cumulative net to Coury passes \$69,419 at month 6, \$342,729 at month 12 and \$1,368,560 at month 24.

Month	Active enrollments	Net reimbursement	CoachCare fees	Net to Coury
M1	43	\$4,798	\$9,554	-\$4,756
M2	114	\$12,218	\$7,390	\$4,828
M3	212	\$22,355	\$13,271	\$9,084
M6	600	\$61,871	\$35,922	\$25,949
M12	1,366	\$138,849	\$79,714	\$59,135
M18	2,042	\$206,540	\$118,151	\$88,389
M21	2,172	\$219,956	\$124,989	\$94,968
M22 onward	2,172	\$219,956	\$124,700	\$95,256

¹⁸ CoachCare Value Analysis: 99445 \$252,124 and 99470 \$42,462 of \$1,714,318 remote-monitoring gross reimbursement over 24 months.

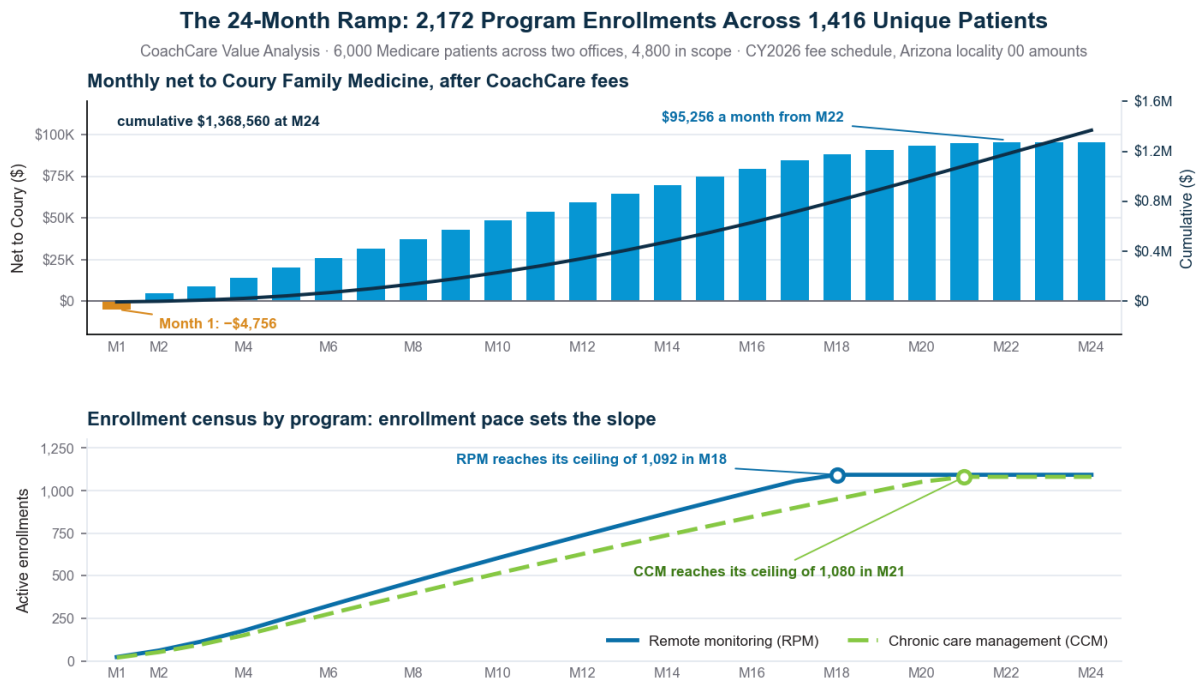


Figure 1. Monthly net to Coury after CoachCare fees, with cumulative net, and the enrollment census by program with the two ceiling months marked. CoachCare Value Analysis, full service line.

6.5 Enrollment capacity sets the pace

Program	Eligible share of the 4,800 in scope	Acceptance	Ceiling	Reached
Remote physiologic monitoring	65%, 3,120 patients	35%	1,092	M18
Chronic care management	75%, 3,600 patients	30%	1,080	M21

Say the constraint out loud

At a Medicare panel of about 6,000, enrollment capacity sets the pace, not panel size. One on-site specialist, nine referring clinicians and telephonic outreach take remote monitoring to its ceiling of 1,092 in month 18 and chronic care management to its ceiling of 1,080 in month 21, so most of the first 18 months is spent enrolling. A second on-site enrollment specialist cannot raise the ceiling, but reaches it sooner, in months 12 and 13, and adds \$717,224 of net reimbursement over 24 months (\$3,932,856 against \$3,215,632, +22%) and \$315,227 to Coury. With no on-site specialist the forecast falls to \$1,466,980 and neither ceiling is reached.

The second specialist is a recommendation to scope. The forecast of record keeps one. The Medicare chart count is still discovery item number one, because it sets the two ceilings.

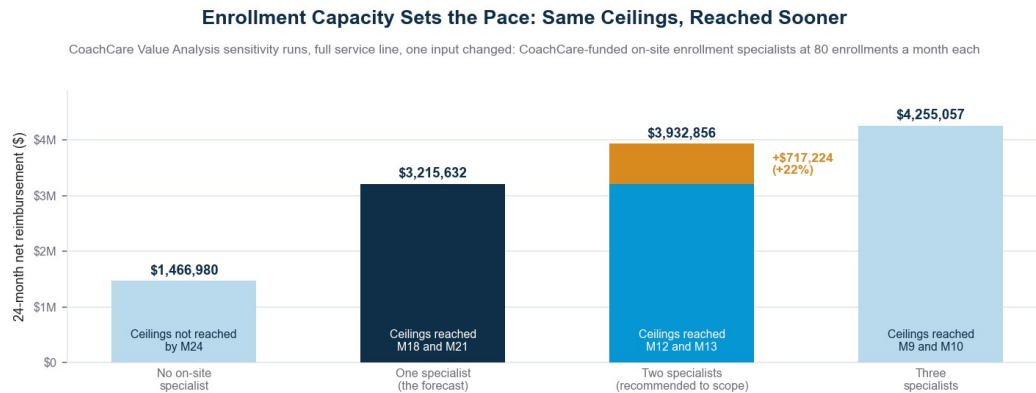


Figure 2. 24-month net reimbursement with zero to three CoachCare-funded on-site enrollment specialists, the months each ceiling is reached, and the second specialist's addition in gold. CoachCare Value Analysis sensitivity runs.

Scenario	24-month net reimbursement	Net to Coury	Unique patients at M24	Ceilings reached
Base: panel 6,000, 4,800 in scope, nine clinicians, one enrollment specialist	\$3,215,632	\$1,368,560	1,416	M18 / M21
No on-site enrollment specialist	\$1,466,980	\$610,725	840	Not by M24
A second on-site enrollment specialist	\$3,932,856	\$1,683,787	1,416	M12 / M13
A third on-site enrollment specialist	\$4,255,057	\$1,824,654	1,416	M9 / M10
Panel 3,700, 2,960 in scope	\$2,440,032	\$1,040,053	873	M12 / M13
Panel 5,000, 4,000 in scope	\$2,951,594	\$1,257,803	1,180	M15 / M17
Panel 6,200, 4,960 in scope	\$3,254,998	\$1,384,812	1,463	M19 / M22
Panel 7,100, 5,680 in scope	\$3,372,301	\$1,432,020	1,667	M21 / after M24
Panel 6,000 with 60% in scope (3,600)	\$2,776,324	\$1,183,459	1,062	M14 / M16
Panel 6,000 with all of it in scope	\$3,399,845	\$1,443,017	1,740	M22 / after M24
Seven referring clinicians	\$3,017,135	\$1,282,630	1,416	M20 / M23
Eleven referring clinicians	\$3,380,260	\$1,439,946	1,416	M16 / M19
The two physicians referring alone	\$2,326,391	\$988,102	1,224	Not by M24

CoachCare Value Analysis sensitivity runs, one input changed at a time; panel runs keep 80% in scope. Ceilings reached: remote monitoring / chronic care management.

Panel size moves this forecast far less than enrollment capacity does. From 3,700 to 7,100 patients, a panel almost twice as large, 24-month net reimbursement rises 38%, because at one specialist's pace the larger panel's ceilings are not reached inside 24 months; a second specialist adds 22% at the same 6,000. Referring clinicians are the other pace lever: seven return \$3,017,135, eleven \$3,380,260, and the two physicians alone \$2,326,391. The margin barely moves in any run, because the fee scales with the census.¹⁹

6.6 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	174,912	Blood pressure, glucose and weight values arriving between visits

¹⁹ Panel sizes 3,700 to 7,100 bracket Coury's CY2024 claims: the wellness-visit count and the total-beneficiary count, each grossed up for Maricopa County's Medicare Advantage share; 6,000 follows the established-visit count.

Output over 24 months	Volume	What it represents
Claims and billable units	62,009	Created in eClinicalWorks for Coury's billing team
Care-management tasks	124,018	Outreach, care-plan updates and medication reviews
Patient conversations	18,603	Live contacts across 1,033 hours of call time
Care-team hours	27,427	About 13.2 full-time-equivalent years of work Coury does not employ
Hospitalizations avoided	About 111	Admissions that never post against the ACO's spending benchmark

CoachCare Value Analysis, 24-month totals, full service line. The avoided-admission count uses the workbook's baseline admission rate of 20% a year; at a 40% annual admission baseline, realistic for a multi-morbid panel averaging 77, it is about 222.

Two ledgers, kept separate

Fee margin funds the program. \$1,368,560 to Coury over 24 months, paid claim by claim.

Avoided admissions and quality speak to the ACO. About 111 admissions avoided, plus monthly work on the five measures in Section 7. Under two-sided risk the new Part B care-management spend also sits on the ACO's ledger, which is why the avoided admissions and the quality measures carry the argument there, more than the fee revenue does.²⁰

6.7 Published results from CoachCare programs

- **Blood pressure, in West Phoenix.** 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.²¹
- **Readmissions, at the same practice.** Across 26,689 patients, the 30-day readmission rate was 7% for CoachCare patients against 15% for the rest.²²
- **Heart failure, in Iowa.** Iowa Heart enrolled 450 advanced heart-failure patients and recorded zero readmissions over six months.²³

The result followed the patients who kept taking readings, so the care team's monthly work is outreach and engagement, and clinician time goes to the escalations that need it.

7. Quality: The Measures the ACO Is Scored On

The Shared Savings Program scores every ACO each year on a fixed set of quality measures, and the score decides whether the ACO meets the program's quality standard. Five move with this program's monthly work, and Coury's patients count in all five.²⁴

Measure	What it counts	What the program does each month
Q236 Controlling high blood pressure	Hypertensive patients whose latest blood pressure is under 140/90	Home averages give an accurate reading of control and a monthly chance to act

²⁰ CoachCare Value Analysis: 111.1 hospitalizations avoided over 24 months at the workbook's baseline admission rate.

²¹ Cardiac Solutions case study, April 2026: 2,738 remote-monitoring patients enrolled 12 months or more.

²² Cardiac Solutions readmissions case study: 7% against 15% across 26,689 patients.

²³ Iowa Heart case study, 2026: 450 NYHA class III to IV patients over six months.

²⁴ Shared Savings Program quality reporting through the APM Performance Pathway: measures 001, 134 and 236 reported by the ACO; 479 and 484 calculated by CMS from claims.

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

Two of the five come from claims, so an admission that does not happen does not count. With hypertension in nearly three of four Coury Medicare patients, Q236 covers most of the panel; Coury already screens about 2,000 patients for depression a year, and monthly care management supplies the follow-up half of Q134.

8. 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 Arizona locality 00 on Coury's own billing mix, with enrollment held constant.²⁵

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

Every code repriced at Arizona locality 00 on Coury's own billing mix, enrollment held constant. Device supply is 32.0% of the remote-monitoring basket; remote monitoring is 49.4% of the line.

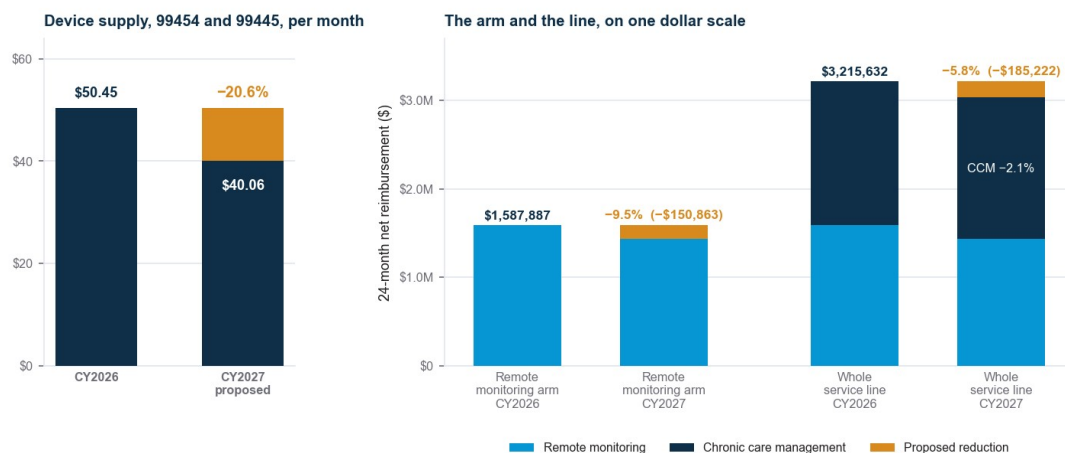


Figure 3. The CY2027 cascade on this forecast: the one code CMS proposes to cut, then the remote-monitoring arm and the whole service line on one dollar scale, with the proposed reduction in gold. CoachCare repricing at the proposed CY2027 amounts.

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
Device supply, 99454 and 99445	\$50.45 a month	\$40.06 a month, -20.6%	The code CMS proposes to cut

²⁵ CMS-1848-P, published July 2026. CoachCare repricing at Arizona locality 00, conversion factor \$32.8409 against \$33.4009: device supply 32.0% of the remote monitoring basket; remote monitoring 49.4% of the line.

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
The remote monitoring arm	\$1,587,887 over 24 months	-9.5%, -\$150,863	Device supply is 32.0% of the remote monitoring basket
Chronic care management	\$1,627,745 over 24 months	-2.1%, -\$34,359	Routine rate changes only; not targeted
The whole service line	\$3,215,632 over 24 months	-5.8%, -\$185,222, to \$3,030,410	Remote monitoring is 49.4% of the line

Each number is smaller than the last only because its base is larger: this line rests on two programs of nearly equal size, and only one holds the code being repriced. CoachCare will rerun the forecast at the final rates. Two contingencies are already in build: an unbundled arrangement, with the software platform, device logistics and program enablement priced separately, and one in which CoachCare manages the staffing while Coury 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%
99457	Treatment management, first 20 minutes	\$51.77	\$49.59	-4.2%
99458	Each additional 20 minutes	\$41.42	\$40.39	-2.5%
99470	Treatment management, 10–19 minutes	\$26.05	\$20.69	-20.6%
99490	Chronic care management, first 20 minutes	\$66.13	\$64.04	-3.2%
99439	Each additional 20 minutes	\$50.44	\$49.92	-1.0%

CY2026 Addendum B and CMS-1848-P proposed CY2027 Addendum B, national non-facility amounts; the repricing above uses Arizona locality 00 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.

9. Implementation Roadmap

9.1 Who runs what

Function	CoachCare	Coury Family Medicine
Identification and enrollment	Registry query in eClinicalWorks starting with the hypertension, diabetes, kidney and heart-failure patients; an on-site enrollment specialist at 80 enrollments a month; telephonic outreach; devices shipped, cellular-paired and replaced	Approves the criteria and target list; clinicians order at the six-month checkup or the wellness visit
Transitional care	Two-business-day contact and medication reconciliation after each discharge Coury learns of; visit booked inside the 7- or 14-day window	Furnishes the visit and bills 99495 or 99496, as today
Monitoring and escalation	Reading review, monthly outreach, business-hours alert triage and the post-discharge cadence, at 165 patients per care manager	Sets thresholds and routing for each office; receives escalations
Coordination with the ACO	Works beside the ACO's nurse care managers so that no patient is called twice	Decides with the ACO how the work divides
Documentation, billing, reporting	Monthly care documents in eClinicalWorks, claims created automatically, operational and clinical outcomes reports	Reconciles and files under its own NPIs; keeps the revenue; names a program lead

9.2 The model inputs

Input	Value in this forecast
Medicare panel	6,000 patients across the two offices, 4,800 in scope; all payers
Referring clinicians	9: two physicians, six physician assistants, one nurse practitioner
Programs	Remote monitoring and chronic care management; transitional care, APCM and behavioral health integration at zero dollars
Eligibility and acceptance	Remote monitoring 65% eligible, 35% accept; chronic care management 75%, 30%; 8 referrals per clinician a month at 80% acceptance; 70% of monitored patients also in care management; 1.5% monthly attrition
Enrollment staffing	One CoachCare-funded on-site enrollment specialist at 80 a month, plus telephonic outreach
EMR	eClinicalWorks: \$4,000 setup, \$150 a month, \$1.50 per patient-month
Rates	CY2026 fee schedule, non-facility, Arizona locality 00, ZIP 85233; every patient priced at the Medicare amount

9.3 Enrollment staffing for two offices

The forecast puts one CoachCare-funded enrollment specialist across both offices, working the Gilbert and Mesa schedules on alternating days alongside telephonic outreach and the clinicians' own orders at the visit. That pace fills the two ceilings in months 18 and 21. The option worth scoping is a second specialist, one stationed in each office, so every six-month checkup and wellness visit at both sites has someone in the building to enroll the patient that day. It costs Coury nothing in staff, reaches the same ceilings in months 12 and 13, and adds \$717,224 of net reimbursement and \$315,227 to Coury over 24 months. The census it fills is the same, so the care-management staffing at 165 patients each simply arrives sooner.

9.4 The first 90 days, and after

Window	What happens	Result
Weeks 0–6 Integrate and charter	eClinicalWorks workshop with the practice and billing leads; chart counts and payer mix; the ACO's care coordination and today's transitional care workflow mapped so nobody is called twice; thresholds, routing and the enrollment staffing plan agreed	Integration live, protocol signed, staffing decided
Weeks 6–12 Launch in Gilbert and Mesa	Enrollment at both offices from the first week; remote monitoring for hypertension and diabetes, care management for two-plus conditions; the post-discharge cadence live	43 enrollments in month 1, 114 by month 2, 212 by month 3
Months 3–12 Build the census	Same protocols; heart failure, kidney disease and atrial fibrillation cohorts added; care managers added as the census grows	1,366 enrollments, 926 unique patients at month 12
Months 13–24 Reach the ceilings	Remote monitoring reaches 1,092 in month 18 and chronic care management 1,080 in month 21; the APCM mix decided together; behavioral health integration scoped	Year 2: \$1,025,831 to Coury at 43.0%

Remote monitoring and chronic care management carry Part B coinsurance, so the consent conversation explains the monthly cost plainly before the device ships.

9.5 What we would confirm together

- 1. The Medicare chart count, by payer and office.** Traditional Medicare against each Medicare Advantage plan, and how many patients carry hypertension, diabetes or two or more conditions. It sets both ceilings in Section 6.
- 2. The Medicare Advantage mix.** Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code

families. Which plans Coury's patients hold, and whether those plans pay chronic care management and remote monitoring, is confirmed plan by plan.

3. **The ACO's care coordination and a chronic care management program.** Which assigned patients the ACO's nurse care managers support today, and how they and CoachCare's care team divide the work.
4. **The billing practitioner.** Who bills remote monitoring and chronic care management for patients the physician assistants and nurse practitioner manage, and the supervision workflow that goes with it.
5. **Transitional care today.** Who runs the workflow, where discharge notices come from, and how many discharges a year reach the practice in time.
6. **The eClinicalWorks version and modules.** The version, the healow and care-management modules licensed, and any device connection already in place.
7. **Coinsurance at consent.** How the monthly Part B coinsurance is explained at enrollment, and who answers billing questions afterwards.

10. Recommendations

1. **Launch the full service line in Gilbert and Mesa together.** \$1,368,560 to Coury over 24 months at a 42.6% margin, positive from month 2, with nobody hired.
2. **Scope a second on-site enrollment specialist.** Enrollment capacity sets the pace at this panel size: a specialist in each office reaches the same ceilings in months 12 and 13 and adds \$717,224 of net reimbursement.
3. **Pull the Medicare chart count by payer in week one.** It sets both ceilings.
4. **Start with the hypertension and diabetes patients at the six-month checkup.** Care management for the plan, a cellular cuff and glucometer for the readings, the checkup or the wellness visit as the enrollment conversation.
5. **Extend the transitional care Coury already bills.** CoachCare makes the two-business-day call after every discharge Coury learns of; Coury bills 99495 or 99496.
6. **Settle the division of work with the ACO's care managers before launch.** Or begin with remote monitoring on its own; both deployments are net-positive.
7. **Aim the monthly work at the ACO's quality measures.** Each of the roughly 111 admissions avoided over 24 months is spending that never posts against the ACO's benchmark.
8. **Hold APCM as the next lever, and scope behavioral health integration once running.** Both run on the same care team and the same chart.
9. **Keep clinical governance where it is.** Coury's clinicians decide; CoachCare does the work and documents it.

The Medicare panel Coury already manages supports a \$3,215,632 service line at a 42.6% practice margin over 24 months, on staff Coury does not hire and devices it does not buy. How fast it gets there depends on enrollment capacity, which is CoachCare's to supply. What remains is to build it once, with a partner, and run it as Coury'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 Coury already does.** Six-month checkups, wellness visits, in-office INR and EKG, and transitional care after hospital stays are already part of Coury's week. Remote monitoring and chronic care management fill the months between them.
- **It runs inside the chart Coury already uses.** Readings, documentation and claims live in eClinicalWorks, and enrollment status is visible at both offices.
- **Fully staffed, no hiring.** Care managers at 165 patients each, enrollment, devices, business-hours alert triage and billing preparation on CoachCare's payroll, with fees per active patient per month.
- **Clinicians stay in charge.** Coury'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, nearby.** A 29.1 mmHg drop in Stage 2 hypertension at Cardiac Solutions in West Phoenix, half the 30-day readmission rate at the same practice, and zero readmissions among 450 advanced heart-failure patients at Iowa Heart.

The ask is a working session to confirm Coury's Medicare chart count by payer, map how chronic care management sits beside the ACO's care coordination, scope the eClinicalWorks integration, and set enrollment staffing for the Gilbert and Mesa offices before the first patient enrolls.

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- **CoachCare:** eClinicalWorks integration overview, 2026; Care Management Programs standard operating procedures, March 2026; Cardiac Solutions and Iowa Heart case studies; and the Value Analysis for Coury Family Medicine, 2026, the source of every financial, enrollment, clinical-output and operational figure in Sections 6 to 10.

Unique patients and program enrollments are different numbers. At month 24 the program holds 2,172 active program enrollments belonging to 1,416 unique patients, because a patient may hold both a care-management and a monitoring enrollment. The 6,000-patient panel covers both offices and all payers; the 3,432 beneficiary-physician pairs in the CY2024 claims are fee-for-service only and count a patient once per physician seen.