



SERVICE LINE STRATEGY • Connected Care, by CoachCare.

Virginia Physicians, Inc.

A physician-owned, physician-governed primary care group serving Central Virginia since 1923: 79 primary care clinicians in ten offices across Chesterfield, Henrico, Hanover and Powhatan counties, on one eClinicalWorks system, with a Medicare panel of about 32,000

Remote Care Service Line Optimization Report

2026 Strategy Report

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

Virginia Physicians already completes about 9,100 annual wellness visits a year, runs transitional care after hospital stays from nineteen clinicians, has its own core lab and dietitians, and has carried two-sided risk in the Shared Savings Program since 2023. What its claims do not show is daily readings for the hypertension and diabetes patients, or monthly care management beyond a single clinician's patients. This report shows what that program returns, who does the work, and how fast a group this size can responsibly enroll it.

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Table of Contents

Executive Summary.....	3
1. Why Now: Medicare Pays for the Time Between Visits.....	4
2. Virginia Physicians Today: A Century of Primary Care.....	5
2.1 Ten offices, 79 clinicians, one record.....	5
2.2 What the CY2024 claims say.....	5
2.3 From one Richmond clinic to four counties.....	6
2.4 What the group already runs, and the gap.....	7
2.5 The market, and the rate basis.....	7
3. The Service Line: Remote Monitoring and Chronic Care Management.....	8
3.1 The clinical and billing stack.....	8
3.2 The care team, and the hours it keeps.....	8
3.3 Transitional care: more discharges that qualify.....	9
3.4 The next levers: APCM and behavioral health integration.....	9
3.5 Alongside the value-based support already in place.....	9
4. eClinicalWorks: The Program Lives in the Chart.....	10
5. Clinical Governance & Escalation.....	11
5.1 One shared escalation engine.....	11
5.2 The emergent pathway.....	11
5.3 Three-way routing, on business hours.....	11
5.4 The post-discharge cadence.....	12
5.5 Built for an older, phone-first panel.....	12
6. Value Analysis: The 24-Month Forecast.....	12
6.1 The headline economics.....	12
6.2 Two deployments, side by side.....	13
6.3 Where the revenue comes from.....	13
6.4 The ramp, month by month.....	13
6.5 Onboarding capacity sets the pace.....	14
6.6 What the program produces clinically and operationally.....	15
6.7 Published results from CoachCare programs.....	16
7. Quality: The Measures the ACO Is Scored On.....	16
8. Policy Watch: The CY2027 Proposed Rule, Repriced on This Forecast.....	17
9. Implementation Roadmap.....	18
9.1 Who runs what.....	18
9.2 The model inputs.....	18
9.3 The staffing plan, and the order the offices go live.....	19
9.4 The first 90 days, and after.....	19
9.5 What we would confirm together.....	19
10. Recommendations.....	20
About CoachCare.....	20
References & Data Sources.....	21

Executive Summary

Virginia Physicians has practiced primary care in Central Virginia since 1923 and is still owned and governed by its physicians. Its 79 primary care clinicians, 52 physicians, 20 nurse practitioners and 7 physician assistants, work across ten offices in Chesterfield, Henrico, Hanover and Powhatan counties on one eClinicalWorks system, backed by the group's own CLIA core lab with eleven draw sites, imaging at Westchester Commons, two registered dietitians, a lipid clinic and Saturday hours at one office.¹

The group's own CY2024 Medicare claims describe the panel. Its 69 primary care clinicians who billed from Virginia Physicians offices recorded 24,962 beneficiary-clinician relationships, with patients averaging 74.5 years old and a weighted risk score of 0.91 against a national 1.00. Hypertension appears in seven of ten, diabetes in one in four, chronic kidney disease in 17% and heart failure in 10%. The group completed about 9,100 annual wellness visits and billed transitional care for about 500 patients after hospital stays. **No remote monitoring program appears in the claims, and chronic care management appears for one clinician's patients only, about 55 of them.**²

Since 2023 Virginia Physicians has billed inside **an Enhanced-track Medicare Shared Savings Program ACO**, the two-sided track, with patients assigned at the start of each year. Every admission avoided among 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 Virginia Physicians already manages into a profit-generating service line.

The group has the panel, the conditions, the record system, the visit rhythm and the accountable-care position. It also has more referring clinicians than any new program can absorb at once. What it lacks is daily readings between visits and monthly billable care management for the thousands of patients with two or more chronic conditions. This service line fills that gap: staffed by CoachCare, governed by the group's clinicians, billed under its NPIs from inside eClinicalWorks.

What the Value Analysis returns

Full service line	Year 1	Year 2	24 months
Net reimbursement	\$2,592,569	\$9,032,779	\$11,625,348
CoachCare fees	\$1,501,448	\$5,172,408	\$6,673,855
Net to Virginia Physicians	\$1,091,121	\$3,860,372	\$4,951,493
Practice margin	42.1%	42.7%	42.6%

CoachCare Value Analysis: Medicare panel of 32,000 across ten offices, 25,600 in scope, remote monitoring and chronic care management, 79 referring clinicians, one CoachCare-funded on-site enrollment specialist, CY2026 Virginia locality 00 amounts. Practice margin is net to Virginia Physicians divided by net reimbursement.

¹ vaphysicians.com, retrieved October 25, 2026: company history, providers by location, office, laboratory, imaging and dietitian pages. Primary care roster: 52 physicians, 20 nurse practitioners, 7 physician assistants in ten offices. The patient portal runs on eClinicalWorks under the healow name.

² CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024, queried for the 69 primary care clinicians whose CY2024 address is a Virginia Physicians office: 24,962 beneficiary-clinician relationships (a patient seen by two clinicians counts twice); average age 74.5; HCC risk 0.91; hypertension 69.7%, diabetes 25.3%, CKD 17.2%, heart failure 10.2%; annual wellness visits 9,058; transitional care 99495 and 99496, about 497 beneficiaries; chronic care management 99490, 55 beneficiaries under one clinician.

³ CMS Shared Savings Program ACO Participants, performance years 2022 to 2026: Enhanced track from 2023, prospective assignment; an earlier BASIC-track year in 2022.

Virginia Physicians can take this two ways, and both are net-positive. CoachCare can run remote monitoring on its own, with care coordination left where it sits today: **\$7,256,287 of net reimbursement and \$3,088,795 to the group over 24 months**, for 5,824 patients. Or CoachCare can run both programs across the panel, the forecast of record above, for 6,998 unique patients.

1. **The binding constraint is onboarding capacity, not the panel or the referrals.** Seventy-nine clinicians can refer more patients than one care team should take on at once, so the forecast holds enrollment to about 3,000 unique patients at month 12 and 7,000 at month 24. Neither program reaches its eligible ceiling inside two years. Across the panel sizes the claims support, 27,400 to 40,500, 24-month net reimbursement moves only from \$11,406,626 to \$11,761,842.
2. **That makes it a staffing plan.** CoachCare brings on 18 care managers by month 12 and 42 by month 24, at 165 patients each, and delivers 97,273 care-team hours over 24 months, about 46.8 full-time-equivalent years. None of it is Virginia Physicians headcount.
3. **Positive from month 2.** Implementation and the eClinicalWorks setup post in month 1; every month after is positive, and the monthly net climbs with the census to \$430,350 in month 24.
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. **Nineteen clinicians already bill transitional care; CoachCare extends it.** The care team can make the two-business-day contact after every discharge the group learns of, 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.** 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 6.2% off this line.** A 20.6% cut to device supply is 9.6% on the remote-monitoring arm and \$721,255 over 24 months on the whole line (Section 8).

The ask is a working session: confirm the Medicare chart count by payer, map how chronic care management sits beside the value-based support the group already has, scope the eClinicalWorks integration, and set the order the ten offices go live 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 Virginia Physicians
1. From visits to panels	A patient on a chronic medication sees a clinician a few times a year. Blood pressure drifts in the months between, glucose climbs in them, and the admission that follows starts in them. Managing a panel means knowing which of roughly 32,000 Medicare patients across ten offices 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	The group has billed inside an Enhanced-track Medicare Shared Savings Program ACO since 2023, after an earlier year in the program's one-sided track. Every admission among assigned patients 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 38.4%	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. Across the four counties about 38.4% of Medicare beneficiaries are in Medicare Advantage, and those plans pay at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families.

The shift	What it means for Virginia Physicians
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 17.2% of remote-monitoring reimbursement. ⁴ At Virginia's CY2026 rates one hypertensive patient on remote monitoring and chronic care management (99454, 99457 and 99490) is worth \$166.93 a month in Medicare allowed charges.

Each shift pays for, or measures, what happens between visits. A remote care service line is how Virginia Physicians covers that time for every eligible patient, and remote monitoring and chronic care management bill for it under Medicare fee-for-service today. The group's revenue cycle already picks up new codes quickly: it billed the 2024 visit-complexity add-on, G2211, more than 23,000 times in its first year.

2. Virginia Physicians Today: A Century of Primary Care

Virginia Physicians is a primary care group by design: ten offices, one record, one lab and one governance structure. Its Medicare panel is large and older than average, and the group already runs the visit rhythm a remote care program needs, from the annual wellness visit to the call after a hospital stay.

2.1 Ten offices, 79 clinicians, one record

County	Offices	Clinicians	What it means for this program
Chesterfield	Midlothian Family Practice at Village, Waterford and Westchester Commons; Midlothian Medical Care on Wadsworth Drive	33	About half of the group's established Medicare patients. Westchester Commons holds imaging and the Saturday clinic
Henrico	Reynolds Primary Care; Innsbrook Primary Care	18	EKG and Holter monitoring, a lipid clinic and an on-site lab at Reynolds; the core lab and a dietitian at Innsbrook
Hanover	Cold Harbor Family Medicine; Hanover Family Physicians; Ashland Medical Center	21	Cold Harbor also follows nursing-home patients; Hanover Family Physicians has trained family-medicine residents since 1987
Powhatan	Midlothian Family Practice, Powhatan	7	The most rural office, where a cellular cuff saves the drive

vaphysicians.com, October 25, 2026: 79 primary care clinicians by office. Established Medicare visit relationships by county from CMS CY2024 claims.

The roster is 52 physicians, about 40 in family medicine and 12 in internal medicine, with 20 nurse practitioners and 7 physician assistants. A psychiatric-mental-health nurse practitioner joined in 2026. The group's rheumatology division sits outside this program. Every office runs on one eClinicalWorks system with healow booking and TeleVisits, and the group's own CLIA lab runs chemistries, hematology and coagulation 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 69 primary care clinicians who billed from a Virginia Physicians office. The profile below is the traditional-Medicare panel those clinicians saw.⁶

⁴ CoachCare Value Analysis for Virginia Physicians, 2026: 99445 \$1,011,355 and 99470 \$168,790 of \$6,860,562 remote-monitoring gross reimbursement over 24 months.

⁵ vaphysicians.com providers-by-location, laboratory and telemedicine pages, retrieved October 25, 2026; CMS Doctors and Clinicians and PECOS reassignment files, July to September 2026.

Panel	CY2024	Condition	Share
Beneficiary-clinician relationships	24,962	Hypertension	70%
Medicare allowed	\$15,298,578	High cholesterol	74% (a floor)
Average age	74.5	Arthritis	42%
Weighted HCC risk score	0.91	Diabetes	25%
Dual-eligible, where reported	4%	Ischemic heart disease	23%
Annual wellness visits	About 9,100	Chronic kidney disease	17%
Depression screening	About 5,600	Atrial fibrillation	15%
Transitional care	About 500, across 19 clinicians	Depression	15%
Chronic care management	About 55, one clinician	COPD	11%
Remote monitoring, principal care management, APCM, behavioral health integration	No program at meaningful scale	Heart failure	10%

CMS Medicare Physician & Other Practitioners, CY2024, the 69 primary care clinicians billing from Virginia Physicians offices. Program rows are beneficiaries; relationships count a patient once per clinician seen. CMS caps published prevalence at 75% per clinician, so high cholesterol is a floor, and suppresses lines under 11 beneficiaries.

This is the panel remote care is built for: hypertension in seven of ten patients, diabetes in one in four, kidney disease, heart disease and atrial fibrillation common, and an average age of 74.5. Most patients qualify for chronic care management, and hypertension with diabetes or kidney disease is the largest group whose home readings would change treatment. The group sees these patients on a steady rhythm, but **no remote monitoring program appears at all, and chronic care management runs for about 55 patients of one clinician.**⁷

2.3 From one Richmond clinic to four counties

Year	What happened
1923	A physician group opens in Richmond: fifteen specialists in seven departments, organized on the Mayo Clinic model of physicians practicing as one group, in what they called the first medical clinic in Virginia
1975	Twenty-six physicians move the clinic to the West End, and satellites follow through the late 1970s and 1980s, from Patterson Avenue to Mechanicsville
1996	After Midlothian Family Practice joins, the group passes 110 physicians, and the clinic becomes Virginia Physicians, Inc. Ashland Medical Center joins the same year
2012	Every office moves onto one eClinicalWorks system for the record, practice management, the patient portal and analytics, with a patient-centered medical home as the stated goal
2019	Hanover Family Physicians, founded in 1987 as a teaching practice, joins, giving the group three offices in Hanover County
2023	The group moves into an Enhanced-track Medicare Shared Savings Program ACO, scored every year on blood pressure, diabetes, depression and admissions
Today	Ten primary care offices from Powhatan to Ashland, a CLIA core lab with eleven draw sites, imaging, dietitians, a lipid clinic and Saturday hours; about 9,100 wellness visits a year and transitional care after hospital stays

⁶ Medicare Physician & Other Practitioners, CY2024, by NPI for the 69 clinicians: 24,962 beneficiary-clinician relationships, 28,113 established-visit relationships, \$15,298,578 allowed. Prevalence is weighted by beneficiaries.

⁷ CMS by Provider and Service, CY2024, searched for the remote monitoring, chronic care management, principal care management, APCM, transitional care and behavioral health integration codes. Present: 99490 (55 beneficiaries) and 99439 (34), both under one nurse practitioner; 99495 (about 460) and 99496 (37) across 19 clinicians; G0438 and G0439 (9,058); G0444 (5,601); G2211 (13,730 beneficiaries, 23,124 services). CMS suppresses lines under 11 beneficiaries.

Year	What happened
Next	Daily readings and monthly care management for every eligible Medicare patient, run by a CoachCare care team inside eClinicalWorks and billed under the group's NPIs

2.4 What the group already runs, and the gap

What exists	Status	What it means for this program
eClinicalWorks and the healow portal	Live at every office	The program's host: flags, orders, readings, care documents and claims (Section 4)
Annual wellness visits	About 9,100 a year	The enrollment moment: eligibility checked, consent taken and devices ordered the same day
Transitional care	About 500 patients, 19 clinicians	Credited and kept. CoachCare makes the two-business-day contact after more of the discharges and carries the patient past day 30
Core lab, dietitians, lipid clinic, EKG and Holter	In house	Home readings tell the care team when a lab is due, and weight and glucose trends reach the dietitian between appointments
A value-based care programs function	RN-led	Already tracks quality and the ACO's measures. Monthly reporting from the care team lands in the same place
Nurse outreach and quality support	Through the group's health-system partners	Practice support and calls after an emergency visit or hospital stay. The program coexists with it
Chronic care management	About 55 patients, one clinician	Proof the workflow fits the group; CoachCare extends it to every eligible patient
Remote monitoring	No program in the claims	Devices, daily readings 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 time for every patient with two or more chronic conditions, across all ten offices and all 79 clinicians. The value-based support the group already has is quality-focused and outreach-focused; none of it is billable monthly care management delivered in the practice.

2.5 The market, and the rate basis

The four counties held 178,932 Medicare beneficiaries in July 2026. Weighted by where the group's established Medicare patients are seen, about 38.4% are in a Medicare Advantage plan (Chesterfield 38.5%, Henrico 41.6%, Hanover 36.3%, Powhatan 31.4%). Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The group's own payer mix is the second thing to confirm after the chart count.⁸

Every office sits in Virginia's single statewide payment locality, locality 00, under the Palmetto GBA JM contractor. Every dollar in this report is priced at those CY2026 amounts.⁹

⁸ CMS Medicare Advantage State/County Penetration, October 2026, weighted by CY2024 established-visit relationships per county (Chesterfield 13,339, Henrico 7,585, Hanover 4,883, Powhatan 2,306). CMS Medicare Monthly Enrollment, July 2026: 178,932 beneficiaries in the four counties.

⁹ CY2026 Physician Fee Schedule, Palmetto GBA JM carrier 11302, Virginia locality 00: geographic indices work 1.000, practice expense 0.983, malpractice 0.706; conversion factor \$33.4009.

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 the group's own billing through eClinicalWorks. The forecast carries the two monthly programs; transitional care, which the group 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 diabetes, kidney disease, heart disease or COPD	\$108.73
Remote physiologic monitoring (RPM)	Cellular cuffs, glucometers and scales send readings between visits against thresholds the group's clinicians set; 99453, 99454 or 99445, 99457, 99458, 99470	Hypertension and diabetes first, then kidney disease, heart failure and atrial fibrillation	\$96.38
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 Virginia locality 00
99490 • 99439	Chronic care management, first 20 minutes • each additional 20	\$64.93 • \$49.51
99453	Remote monitoring setup and education, once	\$21.16
99454 • 99445	Device supply, 16+ days • 2 to 15 days in 30 (99445 new in CY2026)	\$51.13 • \$51.13
99457 • 99458	Treatment management, first 20 minutes • each additional 20	\$50.87 • \$40.69
99470	Treatment management, 10 to 19 minutes (new in CY2026)	\$25.60
99495 • 99496	Transitional care, visit within 14 days • within 7 days	\$216.19 • \$293.46
G0556 • G0557 • G0558	Advanced primary care management, levels 1 to 3	\$16.05 • \$52.84 • \$115.08
99484	Behavioral health integration, 20 minutes a month	\$56.45

How the rates apply

CY2026 non-facility amounts, Virginia locality 00 (Palmetto GBA JM, carrier 11302), ZIP 23113. 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: 18 care managers for the 3,000 unique patients at month 12, and 42 for the 7,000 at month 24. An on-site enrollment specialist on CoachCare's payroll works the office schedules beside the group'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 hours the offices keep. Patients are told at consent to call 911 for an emergency and their office for anything urgent.

3.3 Transitional care: more discharges that qualify

Virginia Physicians already bills transitional care management: about 500 traditional-Medicare patients in CY2024, across nineteen clinicians, most at the 14-day level (99495 at \$216.19; 99496 at \$293.46). That rests on working discharge workflows, and the program builds on them. The CoachCare care team can make the two-business-day contact and the medication reconciliation after every discharge the group learns of, so more discharges meet the requirement, and the group 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.¹⁰

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 takes on the whole-panel primary care elements, tiered by complexity. Virginia Physicians can bill it as a primary care practice, and for a group already accountable for total cost it fits the way the group is measured.¹¹ 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 15% of the panel's claims, about one patient in six, and the group screened about 5,600 Medicare patients for it in CY2024, with a psychiatric-mental-health nurse practitioner now on staff. Behavioral health integration (99484, \$56.45 a month) can run on the same care-manager calls once the program is running. It carries no dollars here.

3.5 Alongside the value-based support already in place

Virginia Physicians is not starting from nothing on value-based care. An RN-led value-based care programs function already tracks quality and the ACO's measures, and the group's health-system partners supply nurse practice support and outreach after an emergency visit or hospital stay. That support works on quality and follow-up. It does not deliver billable, monthly care time inside the practice for every eligible patient, and it does not put a cuff in anyone's home. CoachCare adds those pieces, and the work is divided so that no patient is called twice.

Deployment	What CoachCare runs	What stays with the group and its partners
Remote monitoring on its own	Remote monitoring for the hypertension, diabetes, kidney and heart patients	Care coordination, as the group's team and its value-based support 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, quality reporting and the patients

- **The group 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 group's NPIs, and in the full service line Virginia Physicians 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 the group's headcount, inventory or software.

¹⁰ CMS by Provider and Service, CY2024: 99495, about 460 beneficiaries; 99496, 37; about 497 in all across 19 clinicians.

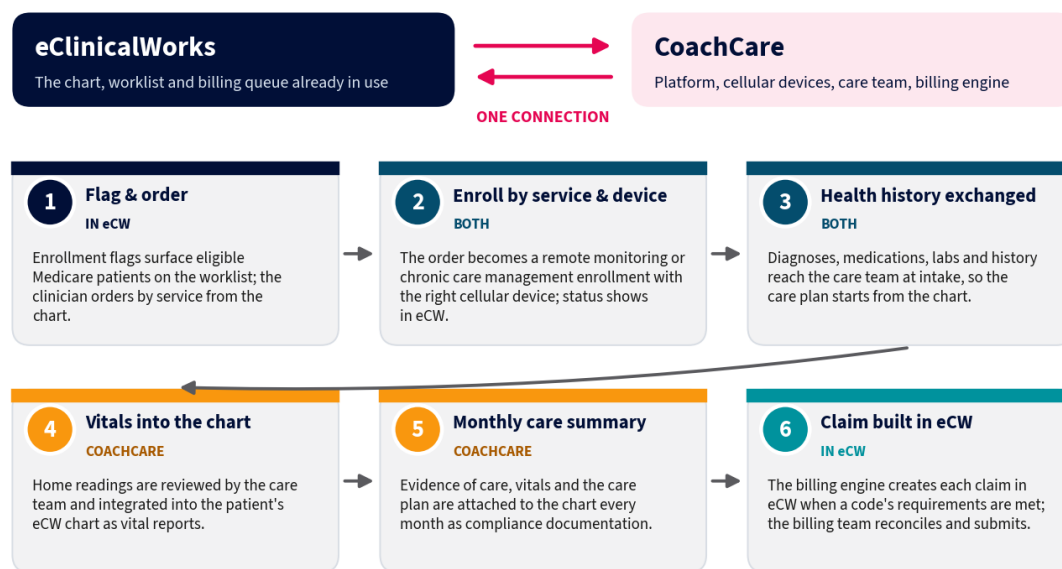
¹¹ CY2025 and CY2026 Physician Fee Schedule final rules: APCM (G0556 to G0558) effective January 1, 2025, billed in place of chronic care management for the same patient and month.

- **The existing support is a coexisting layer.** How the value-based programs function, the partners' nurses and a CoachCare chronic care management program divide the work is discovery item number three.
- **Independence is part of the return.** A recurring service line with its own margin funds the group's next decisions from its own panel.

4. eClinicalWorks: The Program Lives in the Chart

CoachCare works inside eClinicalWorks' own workflows, so the group's clinicians and staff do not learn a second system. Evidence of care, vitals and care plans are attached to each chart every month, enrollment status is visible at every office, and a flagged patient reaches the first day of service in under five days.¹² 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 the group's clinicians approve, at a chronic-care visit, 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 core-lab results pass to the care team at intake; the care plan comes back
Integrated vital reports	Home readings land in the chart, so the clinician sees home averages at the next visit
Compliance documentation and care summary	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; the group's billing team reconciles and files them



Repeats every month for every enrolled patient, at all ten offices, from the same chart. Source: CoachCare eClinicalWorks integration overview.

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.

¹² CoachCare eClinicalWorks integration overview, 2026: the six integration pillars; patients begin chronic care management and remote monitoring in less than five days.

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 \$245,906 over 24 months, inside the \$6,673,855 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 the group never carries surveillance liability it did not agree to. Thresholds and routing are set with the group's clinicians, for each office, before the first patient enrolls.¹³

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 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
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 patient's 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 practice escalation preference. This cannot be configured away. The group 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

¹³ 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.

The matrix is agreed for each of the ten offices. Care managers work readings and escalations Monday to Friday, 8 a.m. to 5 p.m. local patient time, which matches the hours the offices are open, so every escalation lands while a clinician is in the building. A reading that arrives on a weekend or overnight is worked the next business day, and the patient's standing instruction for anything urgent is the office's own line, 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 the group already bills, and inside the ACO each admission it prevents is spending that never posts against the benchmark.

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

5.5 Built for an older, phone-first panel

The group's traditional-Medicare patients average 74.5 years old, and two of its counties are more rural. 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 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 office; without an instruction from the office, discharge from monitoring follows at 180 days, and discharge criteria always belong to the group's clinicians.

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 32,000 at the ten offices, 25,600 in scope, at the CY2026 Virginia locality 00 amounts, with 79 referring clinicians and one CoachCare-funded on-site enrollment specialist. No transitional care, APCM, behavioral health integration or ACO payment is in these numbers.¹⁴

Full service line	Year 1	Year 2	24 months
Chronic care management	\$1,167,439	\$4,103,314	\$5,270,753
Remote physiologic monitoring	\$1,425,130	\$4,929,466	\$6,354,595
Net reimbursement	\$2,592,569	\$9,032,779	\$11,625,348
CoachCare fees, including eClinicalWorks integration and implementation	\$1,501,448	\$5,172,408	\$6,673,855
Net to Virginia Physicians	\$1,091,121	\$3,860,372	\$4,951,493
Practice margin	42.1%	42.7%	42.6%

Year two is about three and a half times year one because the census keeps climbing through all of it: the program enters year two with 3,000 unique patients and ends it with 6,998. The margin rises from 42.1% to

¹⁴ CoachCare Value Analysis for Virginia Physicians, 2026, the source of all Section 6 figures; sensitivity runs change one input at a time on the same workbook.

42.7% as the one-time setup falls away. Year two returns **\$9,032,779 of net reimbursement, \$3,860,372 of it kept by Virginia Physicians.**

6.2 Two deployments, side by side

Each deployment is priced on its own, and the full service line is the forecast of record. On its own, remote monitoring takes all of the onboarding capacity, so it reaches its ceiling of 5,824 patients in month 22 and avoids slightly more admissions. The full line spends the same capacity on two programs, adds chronic care management for 4,205 patients by month 24, and returns \$1,862,698 more to the group over 24 months.

24 months	Remote monitoring on its own	Full service line, RPM + CCM
Net reimbursement	\$7,256,287	\$11,625,348
Net to Virginia Physicians after fees	\$3,088,795	\$4,951,493
Unique patients at month 24	5,824	6,998
Hospitalizations avoided	About 503	About 440

6.3 Where the revenue comes from

24 months	Net reimbursement	CoachCare fees	Net to Virginia Physicians
Remote physiologic monitoring	\$6,354,595	\$3,691,868	\$2,662,728
Chronic care management	\$5,270,753	\$2,736,081	\$2,534,672
Implementation, eClinicalWorks integration, per-patient EMR fee, telephonic outreach		\$245,906	-\$245,906
Total	\$11,625,348	\$6,673,855	\$4,951,493

Remote monitoring is the larger program, \$6,354,595 on 5,737 enrollments at month 24, and it produces the readings, alerts and avoided admissions. Chronic care management carries \$5,270,753 on 4,205 enrollments, because the multi-chronic core of the panel is large and the 99439 add-on is earned in most months. The **9,942 active program enrollments at month 24 belong to 6,998 unique patients**, because most care-management patients are also monitored. The two codes new in 2026 carry 17.2% of remote-monitoring gross reimbursement on this mix.¹⁵

6.4 The ramp, month by month

Month 1 nets -\$568, because the one-time implementation fee and the eClinicalWorks setup post against 137 enrollments. The program is positive from month 2, with \$15,678 on 359 enrollments, and cumulative net to Virginia Physicians is above zero by the end of month 2. New patients join at about 310 a month through year one and about 410 a month through year two, so the monthly net climbs every month of the forecast, to \$430,350 in month 24. Cumulative net to the group passes \$234,533 at month 6, \$1,091,121 at month 12 and \$4,951,493 at month 24.

Month	Active enrollments	Net reimbursement	CoachCare fees	Net to Virginia Physicians
M1	137	\$15,264	\$15,832	-\$568
M2	359	\$38,648	\$22,970	\$15,678
M3	666	\$70,455	\$41,402	\$29,053
M6	1,880	\$193,914	\$112,188	\$81,726
M12	4,269	\$433,989	\$248,926	\$185,062

¹⁵ CoachCare Value Analysis: 99445 \$1,011,355 and 99470 \$168,790 of \$6,860,562 remote-monitoring gross reimbursement over 24 months (17.2%).

Month	Active enrollments	Net reimbursement	CoachCare fees	Net to Virginia Physicians
M18	7,234	\$733,352	\$419,990	\$313,362
M24	9,942	\$1,005,337	\$574,987	\$430,350

The 24-Month Ramp: 6,998 Unique Patients at Month 24

CoachCare Value Analysis · Medicare panel 32,000, 25,600 in scope · remote monitoring and chronic care management · CY2026 fee schedule, Virginia locality 00

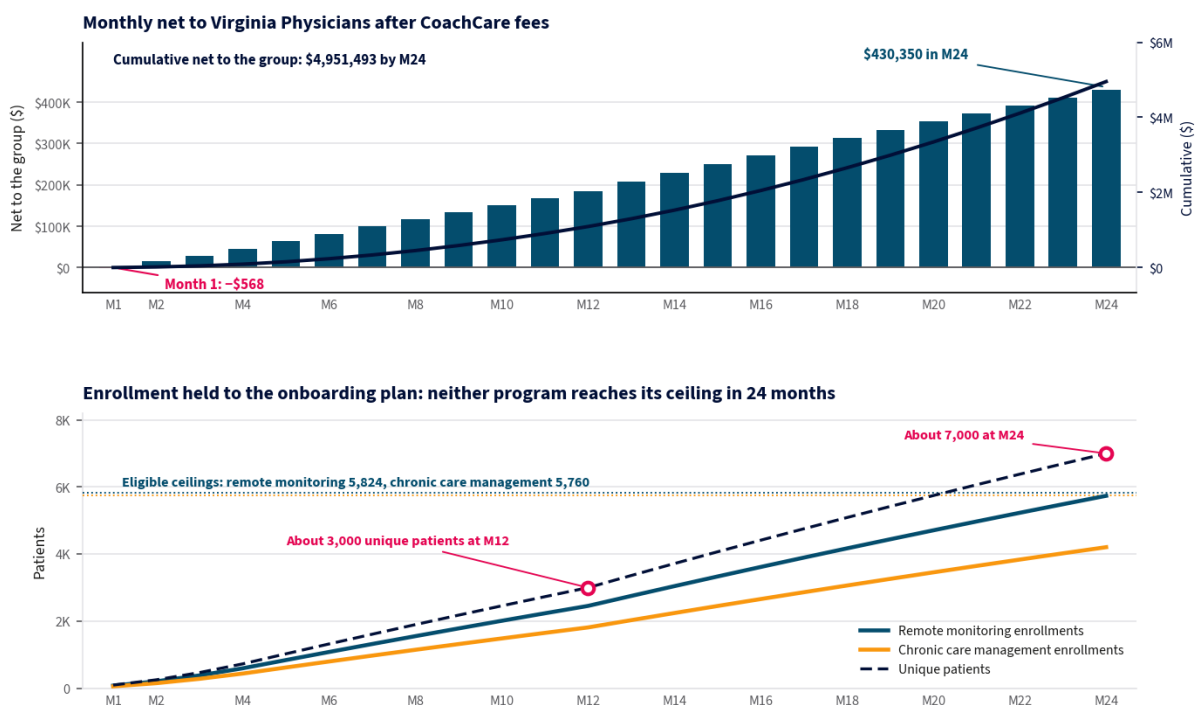


Figure 2. Monthly net to Virginia Physicians after CoachCare fees, with cumulative net, and the enrollment census by program against the two eligible ceilings, with unique patients at months 12 and 24. CoachCare Value Analysis, full service line.

6.5 Onboarding capacity sets the pace

Program	Eligible share of the 25,600 in scope	Acceptance	Ceiling	Month 24
Remote physiologic monitoring	65%, 16,640 patients	35%	5,824	5,737
Chronic care management	75%, 19,200 patients	30%	5,760	4,205

Say the constraint out loud

At Virginia Physicians the limit is onboarding capacity. The panel is large enough, and 79 clinicians referring at a normal pace would send more patients than any care team should absorb into a new program. The forecast therefore follows CoachCare's onboarding plan: no more than about 325 new patients a month in year one and 490 in year two, which lands at about 3,000 unique patients at month 12 and 7,000 at month 24. Neither program reaches its eligible ceiling inside two years.

Read it as a staffing plan. 18 CoachCare care managers at month 12 and 42 at month 24, at 165 patients each, hired and trained ahead of the census. Enrolling every referral as it arrived would add \$2,706,603 on paper (\$14,331,951 against \$11,625,348), and that is headroom for year three, not a forecast.

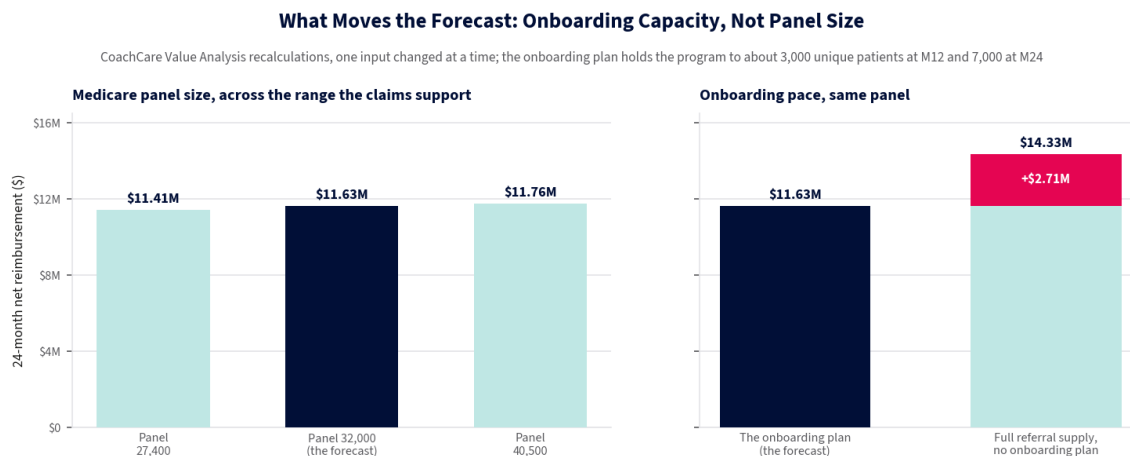


Figure 3. 24-month net reimbursement across the panel sizes the claims support, and the onboarding plan against the full referral supply on the same panel. CoachCare Value Analysis recalculations.

Scenario	24-month net reimbursement	Net to Virginia Physicians	Unique at M12	Unique at M24	Monitoring ceiling
Base: panel 32,000, 25,600 in scope, 79 clinicians, one enrollment specialist	\$11,625,348	\$4,951,493	3,000	6,998	Not by M24
Panel 27,400, 21,920 in scope	\$11,406,626	\$4,862,315	2,977	6,242	M21
Panel 40,500, 32,400 in scope	\$11,761,842	\$5,009,039	3,042	7,079	Not by M24
Panel 32,000 with 60% in scope (19,200)	\$11,091,717	\$4,736,314	2,960	5,619	M19
Panel 32,000 with all of it in scope	\$11,753,813	\$5,005,653	3,039	7,074	Not by M24
No on-site enrollment specialist	\$9,691,788	\$4,114,744	2,498	6,005	Not by M24
The 52 physicians referring alone	\$8,488,587	\$3,615,778	2,200	5,049	Not by M24
Full referral supply, no onboarding plan	\$14,331,951	\$6,112,443	4,128	7,289	M21

CoachCare Value Analysis recalculations, one input changed at a time; panel runs keep 80% in scope. Monitoring ceiling: the month remote monitoring reaches its eligible ceiling.

Panel size barely moves this forecast. From 27,400 to 40,500 patients, a panel 48% larger, 24-month net reimbursement rises 3.1%, because the onboarding plan, not the panel, sets how many patients join each month. The CoachCare-funded on-site enrollment specialist is worth \$1,933,560 of net reimbursement on its own, and the advanced practice clinicians' referrals matter: with the physicians referring alone the forecast is \$8,488,587. The margin barely moves in any run, because the fee scales with the census.¹⁶

6.6 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	692,302	Blood pressure, glucose and weight values arriving between visits
Claims and billable units	224,263	Created in eClinicalWorks for the group's billing team
Care-management tasks	448,526	Outreach, care-plan updates and medication reviews
Patient conversations	67,279	Live contacts across 3,738 hours of call time
Care-team hours	97,273	About 46.8 full-time-equivalent years of work the group does not employ

¹⁶ Panel sizes 27,400 to 40,500 bracket the group's CY2024 claims: the largest single visit code per clinician and the total relationship count, each grossed up for the Medicare Advantage share; 32,000 follows established-visit relationships $\times 0.70 \div (1 - 0.384) = 31,947$.

Output over 24 months	Volume	What it represents
Hospitalizations avoided	About 440	Admissions that never post against the ACO's spending benchmark

Annual admission rate among enrolled patients	20% (the workbook's baseline)	30%	40%	50%
Hospitalizations avoided over 24 months	440	659	879	1,099

CoachCare Value Analysis, full service line. The workbook prices avoided admissions at a 20% annual admission rate; the first patients enrolled, uncontrolled hypertension with diabetes, kidney disease or heart failure, run closer to 40%, which puts the figure near 879.

Two ledgers, kept separate

Fee margin funds the program. \$4,951,493 to Virginia Physicians over 24 months, paid claim by claim.

Avoided admissions and quality speak to the ACO. About 440 admissions avoided at the workbook's baseline, 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. The Value Analysis is fee-for-service and does not model shared savings.

6.7 Published results from CoachCare programs

- **Blood pressure.** Cardiac Solutions, a physician-owned cardiology practice with three West Phoenix offices, put 2,738 patients on CoachCare remote monitoring. Stage 2 hypertension patients saw a 29.1 mmHg average systolic drop, and 94.8% improved. 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. 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 Virginia Physicians' patients count in all five.²⁰

Measure	What it counts	What the program does each month
Q236 Controlling high blood pressure	Hypertensive patients whose latest blood pressure is under 140/90	Home averages give an accurate reading of control and a monthly chance to act
Q001 Diabetes: A1c poor control (> 9%)	Patients with diabetes whose latest A1c is above 9%; lower is better	Care management keeps A1c testing at the core lab 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

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 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
Q134 Depression screening and follow-up	Patients screened, with a follow-up plan when the screen is positive	PHQ-2 and PHQ-9 in monthly care management; positives routed to the group
Q479 Hospital-wide 30-day readmission	Unplanned readmissions within 30 days of discharge, from claims	A call within two business days, devices home before the follow-up visit

Two of the five come from claims, so an admission that does not happen does not count. With hypertension in seven of ten of the group's Medicare patients, Q236 covers most of the panel; the group already screens about 5,600 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 Virginia locality 00 on the forecast's own billing mix, with enrollment held constant.²¹

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

Every code repriced at Virginia locality 00 on this forecast's own billing mix; enrollment held constant. Remote monitoring is 54.7% of the line.

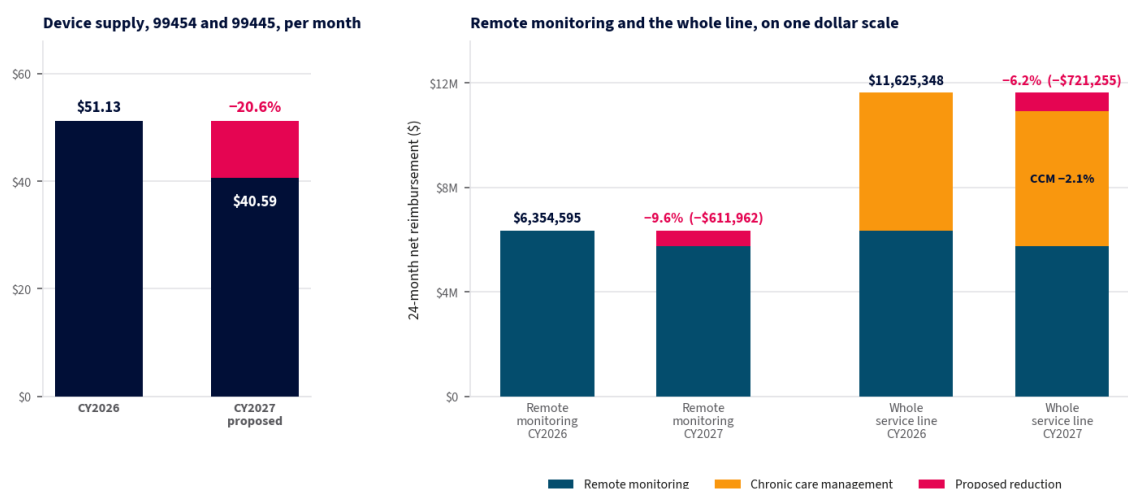


Figure 4. The CY2027 cascade on this forecast: the one code CMS proposes to cut, then the remote-monitoring arm and the whole service line on one dollar scale, with the proposed reduction in coral. CoachCare repricing at the proposed CY2027 amounts.

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
Device supply, 99454 and 99445	\$51.13 a month	\$40.59 a month, -20.6%	The code CMS proposes to cut
The remote monitoring arm	\$6,354,595 over 24 months	-9.6%, -\$611,962	Device supply is 32.0% of the remote monitoring basket
Chronic care management	\$5,270,753 over 24 months	-2.1%, -\$109,293	Routine rate changes only; not targeted

²¹ CMS-1848-P, published July 2026. CoachCare repricing at Virginia locality 00, conversion factor \$32.8409 against \$33.4009: device supply 32.0% of the remote-monitoring basket; remote monitoring 54.7% of the line.

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
The whole service line	\$11,625,348 over 24 months	-6.2%, -\$721,255, to \$10,904,094	Remote monitoring is 54.7% of the line

Each number is smaller than the last only because its base is larger: this line rests on two programs, 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 the group 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 Virginia 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	Virginia Physicians
Identification and enrollment	Registry query in eClinicalWorks starting with the hypertension, diabetes, kidney and heart-failure patients; 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 or wellness visit
Transitional care	Two-business-day contact and medication reconciliation after each discharge the group 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 existing support	Works beside the value-based programs function and the partners' nurses so that no patient is called twice	Decides how the work divides
Documentation, billing, reporting	Monthly care documents in eClinicalWorks, claims created automatically, operational and clinical outcomes reports by office and clinician	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	32,000 patients across the ten offices, 25,600 in scope; all payers
Referring clinicians	79: 52 physicians, 20 nurse practitioners, 7 physician assistants

Input	Value in this forecast
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%; 70% of care-management patients also monitored; 1.5% monthly attrition
Onboarding plan	About 3,000 unique patients by month 12 and 7,000 by month 24; one CoachCare-funded on-site enrollment specialist plus telephonic outreach
EMR	eClinicalWorks: \$4,000 setup, \$150 a month, \$1.50 per patient-month
Rates	CY2026 fee schedule, non-facility, Virginia locality 00, ZIP 23113; every patient priced at the Medicare amount

9.3 The staffing plan, and the order the offices go live

The onboarding plan is the staffing plan. CoachCare brings on care managers ahead of the census: 18 by month 12, when about 3,000 unique patients are enrolled, and 42 by month 24 at about 7,000. New patients arrive at about 310 a month in year one and 410 in year two, which is about 31 per office per month across the ten offices in year one. The on-site enrollment specialist and telephonic outreach cover the offices the schedule does not reach on a given day, and the clinicians' own orders at the visit do the rest.

The order the offices go live is a decision to make together. One sensible sequence starts in Chesterfield, where about half of the group's established Medicare patients are seen, adds the two Henrico offices next, and brings Hanover and Powhatan on by the end of the first quarter. Every office uses the same flags, devices and care team, so a later start changes only when its patients join, not how the program runs.

9.4 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; the value-based support and today's transitional care workflow mapped so nobody is called twice; thresholds, routing and the office go-live order agreed	Integration live, protocol signed, go-live order set
Weeks 6–12 Launch the first offices	Enrollment from the first week; remote monitoring for hypertension and diabetes, care management for two-plus conditions; the post-discharge cadence live	137 enrollments in month 1, 359 by month 2, 666 by month 3
Months 3–12 All ten offices	Same protocols at every office; heart failure, kidney disease and atrial fibrillation cohorts added; care managers added as the census grows	4,269 enrollments, 3,000 unique patients at month 12
Months 13–24 Scale to the plan	Year-two onboarding pace; the APCM mix decided together; behavioral health integration scoped	Year 2: \$3,860,372 to Virginia Physicians at 42.7%

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 confirms the two eligible ceilings and the headroom above the onboarding plan.
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 the group's patients hold, and whether those plans pay chronic care management and remote monitoring, is confirmed plan by plan.

3. **The value-based support and a chronic care management program.** Which patients the value-based programs function and the partners' nurses reach today, and how they and CoachCare's care team divide the work.
4. **Which clinicians and panels are in scope.** Whether any of the 79 clinicians' panels sit outside the program, and who refers from the start.
5. **Transitional care today.** Who runs the workflow at each of the nineteen clinicians' offices, where discharge notices come from, and how many discharges a year reach the group in time.
6. **The eClinicalWorks configuration.** 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.
8. **The office go-live order.** Which offices launch first, and where the on-site enrollment specialist works each day.

10. Recommendations

1. **Launch the full service line on the onboarding plan.** \$4,951,493 to Virginia Physicians over 24 months at a 42.6% margin (42.1% in year one, 42.7% in year two), positive from month 2, with nobody hired.
2. **Treat onboarding capacity as the plan, and staff to it.** 18 care managers by month 12 and 42 by month 24, on CoachCare's payroll; the referral supply is already there.
3. **Pull the Medicare chart count by payer in week one.** It confirms the ceilings the onboarding plan grows into.
4. **Start with the hypertension and diabetes patients at the chronic-care and wellness visits.** Care management for the plan, a cellular cuff and glucometer for the readings, the visit as the enrollment conversation.
5. **Extend the transitional care the group already bills.** CoachCare makes the two-business-day call after every discharge the group learns of; the group bills 99495 or 99496.
6. **Settle the division of work with the existing value-based support 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 440 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.** The group's clinicians decide; CoachCare does the work and documents it.

The Medicare panel Virginia Physicians already manages supports an \$11,625,348 service line at a 42.6% practice margin over 24 months, on staff the group does not hire and devices it does not buy. How fast it grows depends on onboarding capacity, which is CoachCare's to supply. What remains is to build it once, with a partner, and run it as the group'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 group already does.** Wellness visits, the core lab, dietitians, EKG and Holter monitoring, and transitional care after hospital stays are already part of the week across ten offices. Remote monitoring and chronic care management fill the months between them.
- **It runs inside the chart the group already uses.** Readings, documentation and claims live in eClinicalWorks, and enrollment status is visible at every office.
- **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.** The group'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 Virginia Physicians' Medicare chart count by payer, map how chronic care management sits beside the value-based support the group already has, scope the eClinicalWorks integration, and set the order the ten offices go live before the first patient enrolls.

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Prepared by CoachCare for discussion with Virginia Physicians. © 2026 CoachCare.

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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 Virginia Physicians, 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 9,942 active program enrollments belonging to 6,998 unique patients, because a patient may hold both enrollments. The 32,000-patient panel covers all payers; the 24,962 beneficiary-clinician relationships in the CY2024 claims are traditional Medicare only.