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

Partners in Internal Medicine

An independent, physician-owned internal medicine practice in Canton, Michigan, with 8 clinicians caring for a Medicare panel of about 4,250 across western Wayne and Washtenaw counties

Remote Care Service Line Optimization Report

2026 Strategy Report

A scalable, profitable remote care service line for Partners in Internal Medicine: remote monitoring and chronic care management for PIIM's Medicare patients, built into eClinicalWorks, billed under PIIM's own NPIs at the Detroit locality's CY2026 Medicare rates, and run by CoachCare's care team under PIIM's physicians

Purpose of this document

Prepared by CoachCare, November 2026, as a discussion document for the physicians and leadership of Partners in Internal Medicine. It is the companion to PIIM's remote care strategy page and makes the same case at report length: why Medicare now pays a former Primary Care First practice for the months between visits, what PIIM's own Medicare claims show, how the program runs inside eClinicalWorks, and what the service line returns over 24 months at the Detroit locality's rates.

PIIM already does the preventive work well. This report is about the monthly work between visits, which Medicare would not pay a Primary Care First practice to bill separately, and which a care team PIIM does not have to hire can now run under PIIM's own NPIs.

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Executive Summary

Partners in Internal Medicine (PIIM) is an independent, physician-owned internal medicine practice in Canton that has cared for adults in western Wayne and Washtenaw counties for decades. Its 8 clinicians are seven physicians (six internists, two with geriatrics training, and a family physician) and an adult nurse practitioner, and they practice from one Canton office on one eClinicalWorks chart. Most of the physicians also teach residents at the region's academic hospitals.[1]

Their traditional-Medicare patients averaged 75 years old in CY2024, with a weighted risk score of 0.94 against a national 1.00. About seven in ten have hypertension, nearly one in four diabetes and one in five chronic kidney disease. That year PIIM's clinicians billed annual wellness visits for about 1,160 patients, advance care planning for about 910 and an in-office A1c for about 440. They billed **no remote monitoring, chronic care management or transitional care management at a volume CMS publishes**.[2]

Primary Care First explains the gap, and Primary Care First is over. PIIM took part in the CMS Primary Care First model, which paid a monthly population-based amount and, in return, denied chronic care management claims for a participating practice's attributed patients. The model's final performance period ended December 31, 2025. In 2026 the monthly between-visit work pays code by code under the fee schedule, at PIIM's own Medicare rates and under its own NPIs.[3]

Medicare Advantage is the majority payer in this market. About 62% of Medicare beneficiaries in Wayne and Washtenaw counties are in a Medicare Advantage plan. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The forecast prices every patient at the Medicare amount, so how each plan PIIM contracts with covers these codes is the second thing to confirm, after the chart count.[4]

The observation this report is built on

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

PIIM has the patients, the conditions, a wellness-visit and advance-care-planning habit across half its traditional Medicare panel, a two-sided Medicare Shared Savings Program arrangement that rewards controlled chronic disease, and an eClinicalWorks chart already in daily use. What it has not had is a way to bill the monthly work between visits. Staffed by CoachCare, governed by PIIM's physicians and billed under PIIM's NPIs, the service line returns the figures below without adding PIIM headcount.

What the Value Analysis returns

Full service line, CoachCare-staffed	Year 1	Year 2	24 months
Unique patients, end of period	468	706	706
Contribution margin	**$145,719**	**$547,267**	**$692,986**

[1] piim.org, retrieved November 4, 2026: home, physician and practice pages, the practice's insurance and referral pages, and the patient portal and bill-pay links, which run on eClinicalWorks.

[2] CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024, queried November 4, 2026 for every NPI reassigned to the practice; six have a CY2024 claims profile. Average age 75.1; HCC risk 0.94; hypertension 69.0%; diabetes 23.4%; CKD 19.9%. Annual wellness visits 1,161 beneficiaries; advance care planning (99497) 906; A1c (83036) 442. CMS suppresses lines under 11 beneficiaries.

[3] CMS Change Request 11419 (Transmittal 10141), Appendix B: chronic care management codes 99487, 99489, 99490 and 99491 denied for beneficiaries attributed to a Primary Care First practice. CMS Innovation Center Primary Care First model page, retrieved November 4, 2026, and the Innovation Center model participants file.

[4] CMS Medicare Advantage State/County Penetration, October 2026: Wayne County 64.93%, Washtenaw County 59.37%; modeled at their simple mean, 62.15%. Cross-checked against CMS Medicare Monthly Enrollment, July 2026 (64.35% and 59.85%).

CoachCare Value Analysis: Medicare panel of 4,250, 3,400 in scope, remote monitoring and chronic care management, 8 referring clinicians, one CoachCare-funded on-site enrollment specialist, CY2026 Detroit locality amounts. Contribution margin is what PIIM keeps from the service line. No shared-savings dollars are included.

1. **Enrollment pace sets year one; the panel sets year two.** New patients join at up to about 74 a month, and 468 unique patients are enrolled by month 12. Remote monitoring reaches its eligible ceiling in month 16 and chronic care management in month 17, after which about 706 unique patients stay enrolled. Year two returns 3.8 times year one for that reason.
2. **The enrollment specialist is CoachCare's cost and PIIM's biggest lever.** Without an on-site enrollment specialist neither program reaches its ceiling inside two years and the forecast falls by $476,345. A second specialist cannot raise the ceiling, but reaches it sooner, by month 12, and adds $129,994.
3. **The chart count is the first number to confirm.** On the narrowest reading of the claims the forecast is $527,580; at Wayne County's Medicare Advantage share it is $723,562.
4. **Positive from month 2, and $47,831 a month from month 18.** Contribution margin runs slightly negative in month 1 while the program ramps; every month after is positive.
5. **The program lives in eClinicalWorks, PIIM's chart today.** CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically (Section 4).
6. **It supports the accountable care work.** Controlled blood pressure, A1c on schedule and fewer avoidable admissions are what the quality measures and total-cost results of PIIM's Shared Savings Program arrangement turn on (Section 7).
7. **Transitional care at every discharge; APCM and behavioral health integration named at zero dollars.** Each runs on the same care team and the same chart once the program is running.
8. **The CY2027 proposed rule takes $90,361 off the 24-month contribution margin.** A 20.5% cut to device supply leaves $602,625 over 24 months instead of $692,986, with enrollment held constant (Section 8).

The ask is a working session to confirm PIIM's Medicare chart count by payer, check how each Medicare Advantage contract covers the care-management codes, agree how the program fits PIIM's accountable care work, and scope the eClinicalWorks integration, before the first patient enrolls.

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

Medicare is changing what it pays primary care for, and four shifts are under way at once. Each lands in the same place: the weeks between a patient's visits. For a practice whose Medicare patients carry hypertension, diabetes and kidney disease together, those weeks decide how the year goes.

The shift	What it means for PIIM
1. The panel is the unit of care, not the appointment	A PIIM patient on a chronic medication sees an internist a few times a year. Blood pressure drifts in the months between, glucose climbs in them, and the admission that follows starts in them. Population health means knowing which of roughly 4,250 Medicare patients in PIIM's panel are trending the wrong way before they reach an emergency department. That takes data from home and a team assigned to act on it every month.
2. Primary Care First has ended	Primary Care First paid participating practices a monthly population-based amount, and in return CMS denied chronic care management claims for their attributed patients. That is why PIIM's CY2024 claims show none, next to annual wellness visits for about 1,160 patients and advance care planning for about 910. The model's final performance period ended December 31, 2025, so 2026 is the first year PIIM can bill this work code by code.
3. Accountable care and Medicare Advantage, at 62%	CMS wants every Traditional Medicare beneficiary in an accountable care relationship by 2030, and PIIM is already in a two-sided Medicare Shared Savings Program arrangement, where quality scores and total cost of care decide shared savings. In Wayne and Washtenaw counties about 62% of Medicare beneficiaries are in Medicare Advantage. 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 shift	What it means for PIIM
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 Medicare payments.[5] Chronic care management pays for care-team time with any patient who has two or more chronic conditions. At the Detroit locality's CY2026 rates one hypertensive patient on remote monitoring and chronic care management (99454, 99457 and 99490) is worth **$168.83 a month** in Medicare allowed charges.

Each shift pays for, or measures, what happens between visits. PIIM's revenue cycle already picks up new codes: its clinicians billed the visit-complexity add-on, G2211, 1,097 times for 862 patients in CY2024, the code's first year.

2. PIIM Today: Internists, a Geriatric Panel and a Preventive Record

Partners in Internal Medicine is an independent, physician-owned internal medicine practice in Canton that has cared for adults in western Wayne and Washtenaw counties for decades. Its traditional-Medicare patients average 75 years old, and about seven in ten have hypertension. PIIM already does the preventive work well: in CY2024 its clinicians billed annual wellness visits for about 1,160 traditional-Medicare patients and advance care planning for about 910. Monthly care between visits is the piece Medicare would not pay a Primary Care First practice for, and 2026 is the first year that rule is gone.

2.1 Eight clinicians, one office, one chart

Who	How many	What they bring to a remote care program
Internists	6	Adult primary care for an older panel; two carry geriatrics training
Family physician	1	Joined in November 2025
Adult nurse practitioner	1	Chronic-care and follow-up visits alongside the physicians
Managed care staff	At the office	Already run referrals and authorizations for HMO and POS patients, plan by plan
Billing team	In house	Reconciles and files claims under PIIM's billing entity and NPIs

piim.org physician and practice pages, November 2026; CMS PECOS reassignment, September 2026.

All 8 clinicians practice from the Canton office, on one eClinicalWorks chart, so a program built into that chart reaches every clinician's patients at once. The practice has carried a Patient-Centered Medical Home designation for chronic disease management, care coordination and preventive screening reminders, and its managed care staff already work plan by plan, which is the skill a Medicare Advantage coverage check needs.[6]

2.2 What the CY2024 claims say

The CY2024 Medicare by-provider and by-provider-and-service files were queried for every clinician reassigned to PIIM. The profile below is the traditional-Medicare panel of the 6 clinicians with a CY2024 claims record.

Panel	CY2024	Condition	Share
Beneficiary-clinician relationships	2,395	**Hypertension**	**69%, a floor**

[5] CoachCare Value Analysis for Partners in Internal Medicine, 2026: 99445 and 99470 together, 16.9% of 24-month remote-monitoring Medicare payments.

[6] CMS Doctors and Clinicians (July 2026), PECOS reassignment (September 2026) and Quality Payment Program eligibility (2025 and 2026) files for the practice's billing organization: 9 reassigned NPIs, 6 with a CY2024 claims profile. Three of today's clinicians, the family physician who joined in 2025, a returning internist and the nurse practitioner, have no CY2024 profile of their own.

Panel	CY2024	Condition	Share
Established-visit relationships	2,298	High cholesterol	70%, a floor
Medicare allowed	$536,495	Arthritis	40%
Average age	**75.1**	**Diabetes**	**23%**
Weighted HCC risk score	**0.94**	Ischemic heart disease	22%
Dual-eligible	5%	**Chronic kidney disease**	**20%**
Annual wellness visits	**About 1,160**	Atrial fibrillation	15%
Advance care planning	**About 910**	Depression	11%
In-office A1c	About 440	**Heart failure**	**11%**
Visit-complexity add-on, G2211	About 860	**COPD**	**10%**
Remote monitoring, chronic or principal care management, transitional care, APCM, behavioral health integration	No program at meaningful scale	Asthma	11%

CMS Medicare Physician & Other Practitioners, CY2024, the 6 clinicians with a claims record. Program rows are beneficiaries; relationships count a patient once per clinician seen. CMS caps published prevalence at 75% per clinician, so the two most common conditions are floors, and suppresses lines under 11 beneficiaries.

This is the panel remote care is built for: hypertension in about seven of ten patients, diabetes in nearly one in four, kidney disease in one in five, ischemic heart disease in about one in five, and an average age of 75. 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 preventive record is strong: a wellness visit for about half the traditional-Medicare panel, and advance care planning for more than a third. **The monthly work is what the claims do not show**. Chronic care management is the code family Primary Care First restricted; transitional care was not on that list and is simply absent at the volumes CMS publishes.[7]

2.3 How the practice got here

Stage	What happened
Internists	A physician-owned internal medicine group, built around adult and geriatric primary care, whose physicians teach residents at the region's academic hospitals.
Medical home	Designated a Patient-Centered Medical Home for chronic disease management, care coordination and preventive screening reminders.
Primary Care First	Joined the CMS Primary Care First model in the Michigan region. The model paid a monthly population-based amount in place of chronic care management billing.
Prevention at scale	By CY2024, annual wellness visits for about 1,160 traditional-Medicare patients and advance care planning for about 910.
Accountable care	Entered a two-sided Medicare Shared Savings Program arrangement, where quality and total cost of care decide shared savings.
One office	A family physician joined in November 2025, an internist returned, and all eight clinicians now practice together from Canton.
Next: between visits	**Daily readings and monthly care management behind every eligible Medicare patient, inside eClinicalWorks and billed under PIIM's NPIs.**

[7] CMS by Provider and Service, CY2024, searched code by code for the remote monitoring, remote therapeutic monitoring, chronic care management, principal care management, APCM, transitional care and behavioral health integration codes for every PIIM clinician with a claims profile: no code in these families at 11 or more beneficiaries. CY2025 claims are not yet published.

2.4 The market, and the rate basis

Wayne County held 353,813 Medicare beneficiaries in July 2026 and Washtenaw County 68,887. About 62% of them were in a Medicare Advantage plan on CMS's October 2026 penetration file, 64.93% in Wayne, where Canton sits, and 59.37% in Washtenaw. 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. With nearly two in three local beneficiaries on Medicare Advantage, PIIM's own payer mix, and each plan's coverage of remote monitoring and chronic care management, decide how much of this forecast bills as modeled. PIIM's share may sit below the county figure, depending on which plans it contracts with. At about 1.0% of the two counties' Medicare beneficiaries, the modeled panel is a credible share for a practice of eight clinicians.[8]

PIIM's Canton office sits in the Detroit payment locality (carrier 08202, locality 01), and every dollar in this report is priced at that locality's CY2026 amounts.[9]

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 PIIM's own billing through eClinicalWorks. The forecast carries the two monthly programs; transitional care stays on the stack and carries no dollars.

Program	What it does clinically	Who it fits on this panel
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
Remote physiologic monitoring (RPM)	Cellular cuffs, glucometers, scales and pulse oximeters send readings between visits against thresholds PIIM's physicians set; 99453, 99454 or 99445, 99457, 99458, 99470	Hypertension and diabetes first, then heart failure, kidney disease, COPD and atrial fibrillation
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; not in the forecast

Codes	What they pay for	CY2026 Detroit
99490 · 99439	Chronic care management, first 20 minutes · each additional 20	$66.67 · $50.69
99453	Remote monitoring setup and education, once	$21.43
99454 · 99445	**Device supply, 16+ days · 2 to 15 days in 30 (99445 new in CY2026)**	**$50.52 · $50.52**
99457 · 99458	Treatment management, first 20 minutes · each additional 20	$51.64 · $41.64
99470	**Treatment management, 10 to 19 minutes (new in CY2026)**	**$25.98**
99495 · 99496	Transitional care, visit within 14 days · within 7 days	$220.23 · $298.36
G0556 · G0557 · G0558	Advanced primary care management, levels 1 to 3	$16.57 · $54.00 · $117.98
99484	Behavioral health integration, 20 minutes a month	$57.97

[8] CMS Medicare Monthly Enrollment, July 2026, and CMS Medicare Advantage State/County Penetration, October 2026. PIIM's patients straddle the Wayne and Washtenaw county line, so the forecast uses the simple mean of the two counties, 62.15%; each county's share is run as a sensitivity in Section 6.4.

[9] CY2026 Physician Fee Schedule, carrier 08202, locality 01 (Detroit): geographic indices work 1.000, practice expense 0.965, malpractice 1.686; conversion factor $33.4009. ZIP 48187 maps to this locality, as do the ZIP codes of PIIM's Washtenaw County patients.

How the rates apply

CY2026 non-facility amounts, Detroit locality (carrier 08202, locality 01), ZIP 48187. One device code, one first-tier management code and one care-management program (chronic care management or advanced primary care management) bill for a patient in a given month; transitional care bills once per discharge alongside either.

About 62% of Wayne and Washtenaw county Medicare beneficiaries are in Medicare Advantage. 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 Transitional care at every discharge

PIIM's CY2024 claims show no transitional care management at a volume CMS publishes. The code pays $220.23 for the 14-day level and $298.36 for the 7-day level, and its hardest requirement is the first one: an interactive contact within two business days of discharge. A care team that makes that call and the medication reconciliation after every discharge PIIM learns of means more discharges qualify, and PIIM furnishes the visit and bills the code. Remote monitoring and chronic care management then carry the patient past day 30, when most readmissions happen, and under a Shared Savings Program arrangement every avoided readmission also counts toward total cost of care. The forecast carries no transitional care dollars.

3.3 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. Former Primary Care First practices know the model well, and it fits best where a practice is already accountable for the total cost of its patients' care, as PIIM is through its Shared Savings Program arrangement.[10] It appears here at zero dollars, as a named option. Moving patients from chronic care management to APCM is a program decision to make together once PIIM's accountable care contracts and payer mix are mapped; remote monitoring bills alongside either, and the same staff and workflow carry over.

Behavioral health integration is the adjacency. Depression appears on 11% of the panel's claims, about one in nine, and it drives poor adherence in chronic disease. Behavioral health integration (99484, $57.97 a month) can run on the same care-manager calls once the program is running. It carries no dollars here.

4. eClinicalWorks: The Program Lives in PIIM's Chart

PIIM already runs on eClinicalWorks: the chart, the worklists, the patient portal and the billing queue. CoachCare works inside eClinicalWorks' own workflows, so PIIM's physicians and staff never open a second system. Evidence of care, vitals and care plans are attached to each chart every month, enrollment status is visible in the chart, and a flagged patient reaches the first day of service in under five days.[11] 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 PIIM's physicians approve, at a chronic-care visit, an annual wellness visit or on an outreach list
Enrollment by services and devices	The clinician orders by service and by device (cuff, glucometer, scale, pulse oximeter), the way a lab is ordered
Exchange of health history	Diagnoses, medications, vitals and lab results pass to the care team at intake; the care plan comes back

[10] 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. CMS Shared Savings Program participant file, performance year 2026, and Quality Payment Program eligibility, 2026.

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

Integration pillar	What happens in eClinicalWorks
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; PIIM's billing team reconciles and files them

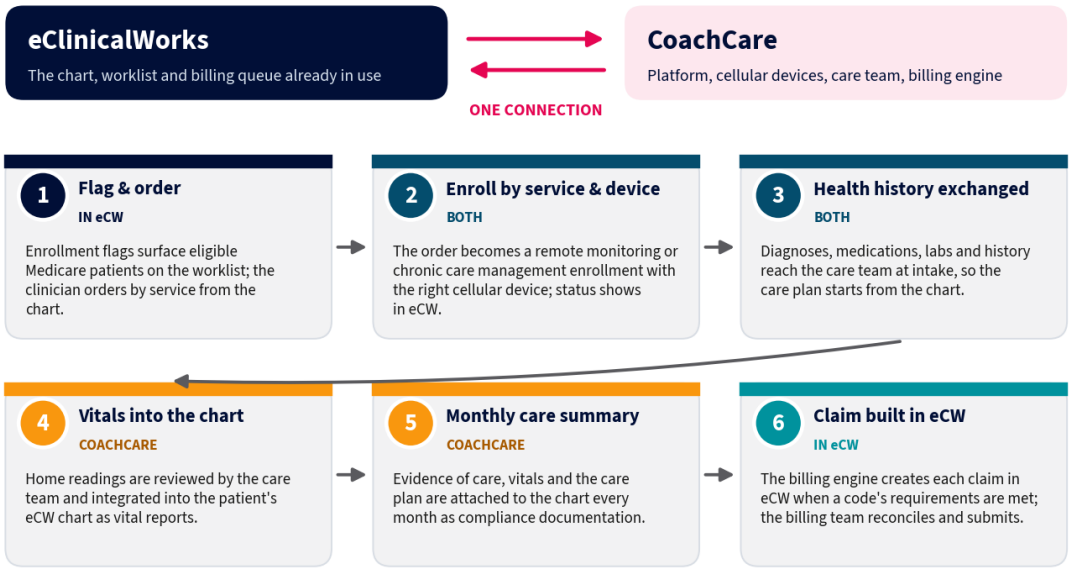


Figure 1. From a flag in the chart to a claim: the six steps CoachCare and eClinicalWorks run every month for every enrolled patient. CoachCare eClinicalWorks integration overview.

The annual wellness visit and the advance care planning conversation are natural enrollment points: the goals a patient sets there become the monthly care plan, and the care team checks them every month instead of every year.

5. Clinical Governance & Escalation

Every reading routes through one escalation engine with defined thresholds, trend rules, routing and documentation, so the practice never carries surveillance liability it did not agree to. Thresholds and routing are set with PIIM's physicians before the first patient enrolls.[12]

5.1 One shared escalation engine

Branch	The rule	Why
Critical value	**Escalate to the practice, regardless of symptoms**	No practice preference can suppress it. A critical reading on its own goes to the clinic, not to 911
Out of range, not critical	Retake, then a structured symptom check	Most out-of-range readings resolve here, which keeps inboxes usable

[12] 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
Trend	**Three consecutive readings an hour or more apart for blood pressure, glucose or oxygen saturation; 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 PIIM 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. PIIM shapes routing for everything else.

5.3 Routing, the post-discharge cadence and an older panel

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 physician or nurse PIIM 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**

Care managers work readings and escalations on business hours, Monday to Friday, 8 a.m. to 5 p.m. local patient time, which matches the hours PIIM's office keeps, so every escalation lands while a physician 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.

Any emergency visit or hospitalization in the previous 60 days triggers a three-touch cadence: stabilize on days 1 to 2 (what led to the visit, discharge medications reconciled, a follow-up visit confirmed within 7 to 14 days), detect on days 5 to 8 (adherence, triggers, appointments and labs), and secure on days 12 to 14 (medication and risk review, then a handoff into monthly monitoring). After a hospital or observation stay it is also the transitional care episode described in Section 3.2.

PIIM's traditional-Medicare patients average 75 years old, two of its internists carry geriatrics training, and the program is set up for that panel. 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. 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 PIIM's physicians.

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 4,250, 3,400 in scope, at the CY2026 Detroit locality amounts, with 8 referring clinicians and one CoachCare-funded on-site enrollment specialist. No transitional care, APCM, behavioral health integration or shared-savings payment is in these numbers.[13]

Full service line	Year 1	Year 2	24 months
Unique patients, end of period	468	706	706
Contribution margin	**$145,719**	**$547,267**	**$692,986**

Year two returns 3.8 times year one because year one is spent building the census: the program enters year two with 468 unique patients and fills to its ceilings by month 17. Year two returns **$547,267 of the $692,986 contribution margin**, and from month 18 the line runs at $47,831 a month to PIIM, about $573,969 a year if the census holds.

6.2 Two deployments, side by side

PIIM can start with remote monitoring alone, with chronic care management staying with PIIM's own team, or run both programs through CoachCare. Both deployments run on the same enrollment plan, so remote monitoring reaches the same 553 patients in both, by month 16. The full line adds chronic care management for 510 patients and $355,564 more contribution margin over 24 months.

24 months	Remote monitoring on its own	Full service line, RPM + CCM
Contribution margin	**$337,422**	**$692,986**
Unique patients at month 24	553	706
Active program enrollments at month 24	553	1,063
Hospitalizations avoided	About 54	About 54

The 1,063 active program enrollments at month 24 belong to 706 unique patients, because most care-management patients are also monitored. Hospitalizations avoided are the same in both columns because the forecast credits them to remote monitoring.

6.3 The ramp, month by month

Contribution margin runs −$6,096 in month 1 while the program ramps, on 12 enrollments. It is positive from month 2, with $1,203 on 30 enrollments, and cumulative contribution margin is above zero by the end of month 4. Referrals and the on-site enrollment specialist build to full speed over twelve months, when new patients join at about 74 a month; remote monitoring reaches its ceiling in month 16 and chronic care management in month 17, after which new enrollments replace attrition and the monthly contribution margin holds at $47,831. Cumulative contribution margin passes $17,262 at month 6, $145,719 at month 12 and $692,986 at month 24.

Month	Active enrollments	Monthly contribution margin	Cumulative contribution margin
M1	12	**−$6,096**	−$6,096
M2	30	$1,203	−$4,893

[13] CoachCare Value Analysis for Partners in Internal Medicine, 2026, the source of all Section 6 figures; sensitivity runs change one input at a time on the same workbook.

Month	Active enrollments	Monthly contribution margin	Cumulative contribution margin
M3	58	$2,485	−$2,408
M6	203	$9,020	$17,262
M9	430	$19,237	$63,974
M12	699	$31,378	$145,719
M15	960	$43,148	$263,633
M18	1,063	$47,831	$406,002
M24	1,063	**$47,831**	**$692,986**

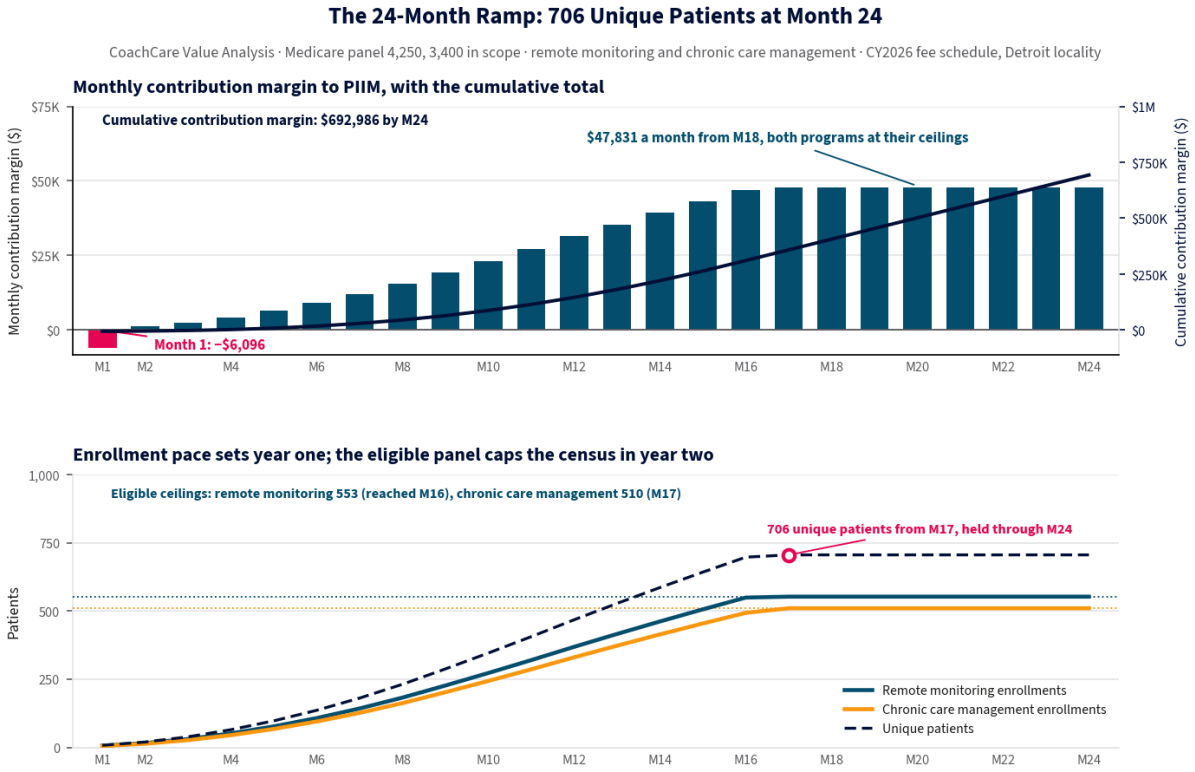


Figure 2. Monthly contribution margin, with cumulative contribution margin, and the enrollment census by program against the two eligible ceilings. CoachCare Value Analysis, full service line.

6.4 Pace sets year one, the panel sets year two

Program	Eligible share of the 3,400 in scope	Acceptance	Ceiling	Reached
Remote physiologic monitoring	65%, 2,210 patients	25%	**553**	**Month 16**
Chronic care management	75%, 2,550 patients	20%	**510**	**Month 17**

Say the constraint out loud

Two limits set this forecast, one after the other. In year one the limit is enrollment pace: referrals from 8 clinicians and one on-site enrollment specialist build to about 74 new patients a month, and 468 unique patients are enrolled by month 12. In year two the limit is the eligible panel: both programs reach their ceilings by month 17 and about 706 unique patients stay enrolled. The forecast holds new enrollment under 1,500 patients a year, the most one care team onboards well, and at this pace that cap never binds.

Read it as two questions: how fast, and how many. A second on-site enrollment specialist cannot raise the ceiling, but reaches it sooner, by month 12, and adds $129,994 of contribution margin from the extra patient-months. PIIM's own Medicare chart count, by payer, sets how many. 4 CoachCare care managers, at 165 patients each, cover the census by month 24.

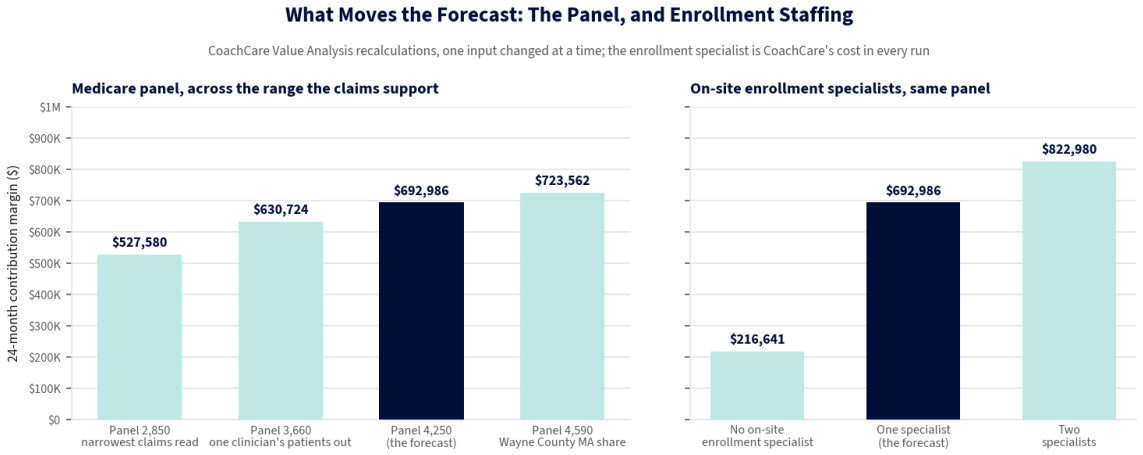


Figure 3. 24-month contribution margin across the panel sizes the claims support, and with none, one or two on-site enrollment specialists on the same panel. CoachCare Value Analysis recalculations.

Scenario	24-month contribution margin	Unique at M24	Ceilings reached (RPM / CCM)
Base: panel 4,250, 3,400 in scope, 8 clinicians, one enrollment specialist	**$692,986**	**706**	**M16 / M17**
Panel 2,850: the narrowest reading of the CY2024 claims	$527,580	473	M13 / M13
Panel 3,660: one CY2024 clinician's patients left out	$630,724	608	M15 / M15
Panel 3,960: Washtenaw County's Medicare Advantage share	$663,759	657	M16 / M16
Panel 4,590: Wayne County's Medicare Advantage share	$723,562	762	M17 / M18
Panel 4,250 with 60% in scope	$573,254	529	M13 / M14
Panel 4,250 with all of it in scope	$775,357	882	M20 / M20
Six referring clinicians instead of eight	$673,040	706	M17 / M18
No on-site enrollment specialist	$216,641	324	not by M24 / not by M24
A second on-site enrollment specialist	$822,980	706	M12 / M12

CoachCare Value Analysis recalculations, one input changed at a time; panel runs keep 80% in scope.

Enrollment capacity moves this forecast most. Without the on-site specialist, contribution margin falls by $476,345, because neither program reaches its ceiling inside two years. A second specialist adds $129,994, more than counting the whole panel in scope ($82,371), because in a pace-limited first year capacity is the scarcer input. The panel matters too: on the narrowest reading of the claims the forecast is $165,406 lower, at $527,580, and at Wayne County's Medicare Advantage share it rises to $723,562.[14]

6.5 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	**85,667**	Blood pressure, glucose, weight and oxygen saturation values arriving between visits
Claims and billable units	**30,666**	Created in eClinicalWorks for PIIM's billing team
Care-management tasks	61,332	Outreach, care-plan updates and medication reviews
Patient conversations	9,200	Live contacts across 511 hours of call time
Care-team hours	**13,515**	**About 6.5 full-time-equivalent years of work PIIM does not employ**
Hospitalizations avoided	**About 54**	Admissions, emergency visits and the follow-up they bring that never happen

Annual admission rate among enrolled patients	20% (the workbook's baseline)	30%	40%	50%
Hospitalizations avoided over 24 months	54	82	**109**	136

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 109.

6.6 Published results from CoachCare programs

- **Blood pressure.** Cardiac Solutions, a physician-owned cardiology practice with three West Phoenix offices, put 2,738 patients on CoachCare remote monitoring. Stage 2 hypertension patients saw a 29.1 mmHg average systolic drop, and 94.8% improved. Patients who took readings consistently dropped 8.53 mmHg against 3.54 mmHg for those who did not.[15]
- **Readmissions, at the same practice.** Across 26,689 patients, the 30-day readmission rate was 7% for CoachCare patients against 15% for the rest.[16]
- **Heart failure.** Iowa Heart enrolled 450 advanced heart-failure patients and recorded zero readmissions over six months.[17]

[14] Panel method: 2,298 established-visit relationships in CY2024 (each clinician's 99212 to 99215 patients, capped at that clinician's total) × 0.70 for patients seen by more than one clinician ÷ (1 − 62.15% Medicare Advantage) = 4,250, modeled as 4,250. The six clinicians in the CY2024 claims include one no longer on PIIM's roster; the forecast assumes those patients stayed with the practice. The range 2,850–4,590 brackets these assumptions.

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

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

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

7. Quality and Accountable Care: The Measures PIIM Is Scored On

PIIM is scored on a fixed set of quality measures through the Shared Savings Program measure set, and in a two-sided arrangement shared savings depend on them as well as on total cost of care. Most of those measures turn on work this program does every month.[18]

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 and medication changes on schedule; home glucose shows slippage early
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 physician
Q484 Admissions, multiple chronic conditions	Unplanned admissions among patients with several chronic conditions, calculated by CMS from claims	Daily readings, outreach on a confirmed trend and the post-discharge cadence
Q479 Hospital-wide 30-day readmission	Unplanned readmissions within 30 days of discharge, calculated by CMS from claims	The two-business-day call, devices home before the follow-up visit, readings from day two

With hypertension in about seven of ten of PIIM's traditional-Medicare patients, Q236 covers most of the panel, and a month of home readings is a better basis for it than one office reading. PIIM already runs in-office A1c testing for about 440 patients a year; home glucose and blood pressure fill the months between draws. The two claims-based measures improve the same way total cost of care does: an admission that does not happen does not count. None of this appears as a shared-savings dollar in the forecast.

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 the Detroit locality on the forecast's own billing mix, with enrollment held constant.[19]

[18] CMS Quality Payment Program and Medicare Shared Savings Program measure specifications, 2026: Q236 Controlling High Blood Pressure; Q001 Diabetes: Hemoglobin A1c Poor Control (> 9%); Q134 Screening for Depression and Follow-Up Plan; Q484 Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions; Q479 Hospital-Wide, 30-Day, All-Cause Unplanned Readmission Rate.

[19] CMS-1848-P, published July 2026. CoachCare repricing at carrier 08202, locality 01, conversion factor $32.8409 against $33.4009: device supply 31.5% of the remote-monitoring basket; remote monitoring 48.9% of the line.

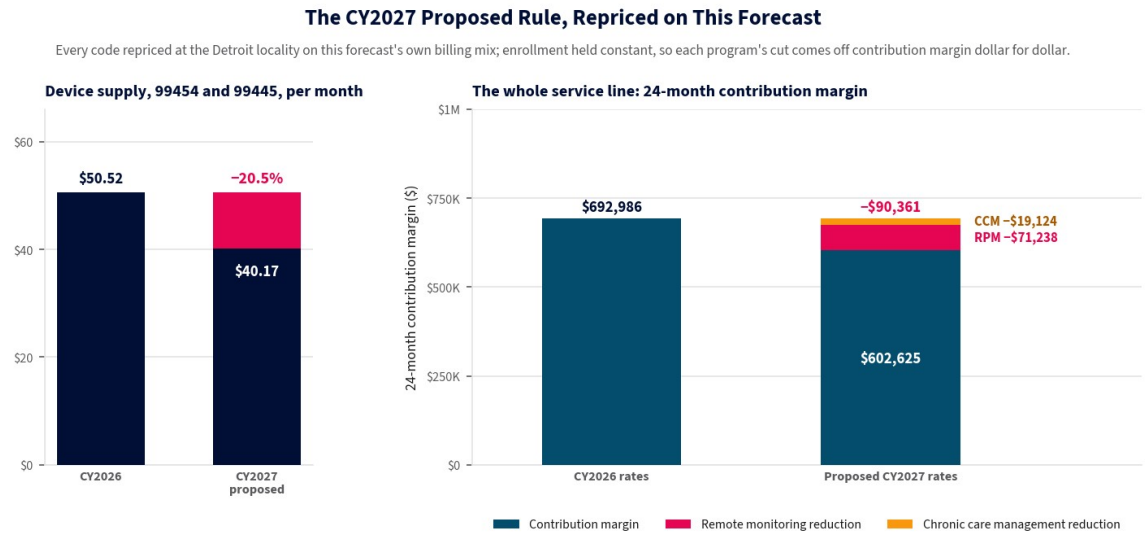


Figure 4. The CY2027 cascade on this forecast: the one code CMS proposes to cut, then the 24-month contribution margin of the whole service line at CY2026 and proposed CY2027 rates, with the reduction from each program shown. Enrollment held constant.

Level	Proposed change	Over 24 months	What changes
Device supply, 99454 and 99445	**−20.5% a month, from $50.52 to $40.17**		The code CMS proposes to cut
Remote monitoring	−9.0%	**−$71,238**	Device supply is 31.5% of the remote monitoring basket
Chronic care management	−2.3%	−$19,124	Routine rate changes only; not targeted
Whole service line	**−5.6%**	**−$90,361**	Contribution margin $692,986 at CY2026 rates, $602,625 at proposed CY2027 rates

The cascade reads as three numbers, each smaller only because its base is larger: −20.5% on device supply, −9.0% on the remote monitoring program, −5.6% on the whole line. With enrollment held constant, every dollar of repricing comes off contribution margin: $71,238 from remote monitoring and $19,124 from chronic care management, which leaves $602,625 over 24 months. CoachCare will rerun the forecast at the final rates.

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 Detroit locality 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	PIIM
Identification and enrollment	Registry query in eClinicalWorks starting with the hypertension, diabetes, heart-failure and kidney patients; an on-site enrollment specialist; telephonic outreach; devices shipped, cellular-paired and replaced	Approves the criteria and target list; physicians order at the chronic-care or wellness visit
Medicare Advantage coverage	A worklist that shows which plan each candidate holds and which codes that plan covers	Managed care staff confirm each contract's terms once, centrally
Transitional care	Two-business-day contact and medication reconciliation after each discharge PIIM learns of; visit booked inside the 7- or 14-day window	Furnishes the visit and bills 99495 or 99496
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; receives escalations**
Documentation, billing, reporting	Monthly care documents in eClinicalWorks, claims created automatically, operational and clinical outcomes reports by 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	**4,250 patients, 3,400 in scope; traditional Medicare and Medicare Advantage**
Medicare Advantage	About 62% in Wayne and Washtenaw counties (62.15% modeled); every patient priced at the Medicare amount. 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.
Referring clinicians	8: seven physicians (six internists, two with geriatrics training, and a family physician) and an adult 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, 25% accept; chronic care management 75%, 20%; 70% of care-management patients also monitored; 3% monthly attrition
Enrollment plan	5 referrals per clinician a month, 70% accepted; one CoachCare-funded on-site enrollment specialist plus telephonic outreach, building to full pace over twelve months; ceilings reached in months 16 and 17
Staffing	CoachCare care managers at 165 patients each; no PIIM headcount added
EMR	eClinicalWorks, integrated as described in Section 4
Rates	CY2026 fee schedule, non-facility, Detroit locality, ZIP 48187

9.3 The first 90 days, and after

Window	What happens	Result
Weeks 0–6 Integrate and charter	eClinicalWorks workshop with PIIM's billing and practice leads; chart counts and payer mix, plan by plan; how the program fits PIIM's accountable care work; thresholds and routing agreed; the transitional care workflow mapped	Integration live, protocol signed
Weeks 6–12 Launch	Enrollment from the first week at chronic-care and annual wellness visits; remote monitoring for hypertension and diabetes, care management for two-plus conditions; the post-discharge cadence live	12 enrollments in month 1, 30 by month 2, 58 by month 3

Window	What happens	Result
Months 3–12 **Build to full pace**	Heart failure, kidney disease and atrial fibrillation cohorts added; advance care planning goals carried into monthly care plans	468 unique patients by month 12
Months 13–17 **Fill the panel**	Enrollment continues at full pace until both programs reach their ceilings; the APCM decision made once accountable care contracts and payer mix are mapped	Both programs at their ceilings by month 17, 706 unique patients
Months 18–24 **At the ceilings**	Census held; behavioral health integration scoped; the panel re-counted as clinicians join	Year 2: $547,267 of contribution margin

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

9.4 What we would confirm together

1. **The Medicare chart count, by payer.** Traditional Medicare against each Medicare Advantage plan, and how many patients carry hypertension, diabetes or two or more conditions. The panel sets the ceiling, so this is the first number to confirm.
2. **The Medicare Advantage contracts.** 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 PIIM's patients hold, and whether each pays chronic care management and remote monitoring, is confirmed plan by plan.
3. **How the program fits PIIM's accountable care work.** What care management the Shared Savings Program arrangement already supplies, so the program adds to it rather than duplicating it, and how results are reported for the quality measures.
4. **Who ran care coordination under Primary Care First.** Whether that work and the people who did it are still in place, and how they fit alongside CoachCare's care team.
5. **APCM or chronic care management.** Which patients, if any, move to advanced primary care management once the contracts and payer mix are mapped.
6. **Which clinicians are in scope.** The eight modeled, how the panels of the clinicians who joined or returned in 2025 are growing, and any clinicians joining.
7. **Coinsurance at consent.** How the monthly Part B coinsurance is explained at enrollment, and who answers billing questions afterwards.

10. Recommendations

1. **Start billing the monthly work Primary Care First did not pay for separately.** Staffed by CoachCare, the service line returns $692,986 of contribution margin over 24 months ($145,719 in year one, $547,267 in year two), positive from month 2, with nobody hired.
2. **Build it into eClinicalWorks from the first patient.** Flags, orders, readings and claims in the chart PIIM already uses.
3. **Pull the Medicare chart count by payer in week one.** The panel in scope sets the ceiling the program reaches in year two.
4. **Confirm Medicare Advantage coverage plan by plan before launch.** With nearly two in three local beneficiaries on Medicare Advantage, each contract's terms for the care-management codes decide how much of the forecast bills as modeled.
5. **Enroll at the wellness visit and the chronic-care visit.** Hypertension and diabetes first: care management for the plan, a cellular cuff or glucometer for the readings, the visit as the enrollment conversation.
6. **Keep the enrollment specialist at full pace through year one.** Pace sets year one; a second specialist is worth weighing once the chart count is known.

7. **Take the call after every discharge.** Transitional care for the discharges PIIM learns of, and every avoided readmission counted toward total cost of care.
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.

PIIM's physicians already know their panel: who has had the wellness visit, who has set goals for their care, whose A1c is drifting. The Medicare panel PIIM already manages supports a service line that returns $692,986 of contribution margin over 24 months on CoachCare's staffing, and 2026 is the first year PIIM can bill the monthly work between visits under its own NPIs. It also gives an independent practice a recurring line of its own, funded from its own panel.

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 PIIM already does.** Annual wellness visits, advance care planning, in-office A1c testing and a medical home's care coordination are already part of the week. CoachCare adds the monthly contact; it does not replace the people who do the rest.
- **It runs inside the chart PIIM already uses.** Readings, documentation and claims live in eClinicalWorks, so physicians never open a second system.
- **A care team PIIM does not have to hire.** Care managers at 165 patients each, with enrollment, devices, business-hours alert triage and billing preparation on CoachCare's payroll.
- **Clinicians stay in charge.** PIIM's physicians and nurse practitioner 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 PIIM's Medicare chart count by payer, check how each Medicare Advantage contract covers the care-management codes, agree how the program fits PIIM's accountable care work, and scope the eClinicalWorks integration, before the first patient enrolls.

Contact

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References & Data Sources

- **Partners in Internal Medicine:** piim.org, retrieved November 4, 2026, for the practice, physician, insurance, referral and billing pages.
- **CMS provider, eligibility and value-based care files:** Doctors and Clinicians, July 2026; PECOS reassignment, September 2026; Quality Payment Program eligibility, 2025 and 2026; Medicare Shared Savings Program participants, performance year 2026; Innovation Center model participants; Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024.
- **Primary Care First:** CMS Change Request 11419 (Transmittal 10141), Appendix B; the CMS Innovation Center Primary Care First model page.
- **Medicare payment rules:** the CY2026 Physician Fee Schedule final rule, Addendum B, RVU file and Detroit locality geographic indices; CMS-1848-P, the CY2027 proposed rule.
- **Market:** CMS Medicare Advantage State/County Penetration, October 2026; CMS Medicare Monthly Enrollment, July 2026, by county.
- **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 Partners in Internal 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 1,063 active program enrollments belonging to 706 unique patients, because a patient may hold both enrollments. The 4,250-patient panel covers traditional Medicare and Medicare Advantage; the 2,395 beneficiary-clinician relationships in the CY2024 claims are traditional Medicare only.