PREPARED FOR THE EXECUTIVE LEADERSHIP OF

State of Franklin Healthcare Associates, PLLC

Remote Care
Service Line Optimization

2026 Strategy Report

A heart failure value analysis for a group carrying full risk — avoided admissions first, fee revenue second

PURPOSE OF THIS REPORT

This is a discovery-stage business case, not a proposal and not a quotation. Following the 29 April 2026 discovery call it is scoped to the population SOFHA asked us to model: a cohort of 5,000 heart failure patients, run as remote patient monitoring plus chronic care management, with a remote-monitoring-only comparison alongside it.

SOFHA participates in ACO REACH on its traditional Medicare population and holds risk contracts on its Medicare Advantage book, which it describes as full-risk capitated Medicare contracts. This report is written for a group that carries full risk. The primary value line is therefore avoided admissions and total cost of care; fee-schedule reimbursement is the second layer, and it is presented with the loss-ratio question addressed rather than ignored.

Every financial figure in this report is illustrative and modeled. The Medicare population and the cohort size are discovery-stage estimates, not chart counts. **The Value Analysis is a fee-for-service model and does not model capitated or shared-risk economics.** All of it must be validated against SOFHA's own registry, chart counts and risk contracts before any commitment is made on either side.

21 clinic sites · 5 towns · 200+ providers
Johnson City · Kingsport · Bristol · Elizabethton, TN · Gate City, VA

Prepared by CoachCare
July 2026

Contents

Executive Summary

State of Franklin Healthcare Associates is an independent, physician-led, 100% employee-owned multi-specialty group anchored in adult primary care. It operates 21 clinic sites across five towns — Johnson City, Kingsport, Bristol and Elizabethton in Tennessee, and Gate City in Virginia — with more than 200 providers and over 1,000 employees. SOFHA's own provider directory returned 205 provider records on 23 July 2026, of which 49 are tagged family medicine and 24 internal medicine, alongside 68 hospital-based providers, 21 OB/GYN and 19 pediatric clinicians, plus clinical pharmacists, physical therapy, palliative care, sleep medicine, wound care and nutrition. CMS's Doctors and Clinicians file independently shows 247 distinct NPIs billing under SOFHA's Medicare group (PAC ID 2466346291, 272 group members), of which roughly 83 are adult primary care physicians — about 36 internal medicine and 47 family practice. Adult primary care is, unambiguously, the dominant service line.

SOFHA carries risk, and that determines how this report is written. SOFHA participates in ACO REACH for its traditional Medicare population and holds risk contracts on its Medicare Advantage book, which it describes as full-risk capitated Medicare contracts. A group in that position does not read a remote care business case the way a pure fee-for-service group does. Fee-schedule billing of RPM and chronic care management is, on capitated lives, partly a cost line against the medical loss ratio rather than a clean revenue win. SOFHA said so directly on the 29 April call: the concern is adding charges that run against loss ratios under full-risk contracts. The stated goals are admissions per 1,000, hospitalizations, medication adherence and overall cost of care — with outcomes improving, not merely holding.

This report therefore leads with avoided cost and treats fee revenue as the second layer. The starting position is unusually strong for that argument. SOFHA already employs the hardest and most expensive part of a remote care program: the certified nurses and care managers. Its chronic care management program is run by five nurses handling roughly 330 patients per month, centralized across all clinics and administered by a physician board member. Alongside it sit a case management and care coordination department running textbook transitional care — three-to-five-day post-discharge appointments, medication education, home-safety assessment, coordination with hospitalists and primary care physicians — an Elevated Blood Pressure Program, a Diabetic Monitoring Program, a home-visit arm, and an Acute Care Clinic that has been treating exacerbations of chronic disease as an alternative to hospitalization since 2015. There is no remote patient monitoring program today, and no Advanced Primary Care Management billing today.

THE CENTRAL ARGUMENT

Hypertension and diabetes alone do not generate savings in excess of what gets billed. Heart failure, CKD stage 2–3 and COPD do, because that is where the $15,000–$20,000 admissions are. A monitoring program pointed at a general chronic-disease panel bills against the loss ratio without moving admissions far enough to pay for itself. Pointed at heart failure, the arithmetic inverts.

On the recommended configuration — RPM plus CCM across a cohort of 5,000 heart failure patients — the modeled avoided admission cost over 24 months is approximately $3,148,557, and it is larger than the **$2,425,867 of net fee margin**. For a group carrying full risk, the avoided-cost line is the one that matters, and here it is the bigger of the two. Together they are roughly $5.5M of 24-month value, and the fee side is retained at a 44.5% practice margin on net reimbursement.

The avoided-admission figure is also the bridge between the two economies. The Value Analysis is a fee-for-service model. It does not model capitated or shared-risk economics, and on capitated lives the fee revenue behaves differently. The admissions line translates; the actual risk-side impact has to be modeled against SOFHA's own contracts.

The recommended configuration is remote patient monitoring plus chronic care management, and it is the build the workbook on file computes. A remote-monitoring-only comparison is carried alongside it in Section 6.4, derived from the same per-patient-month economics with CCM switched off. Principal care management and Advanced Primary Care Management are switched off in both — heart failure is the dominant condition in this cohort and CCM carries it.

The market context still matters, and it reinforces the same conclusion. Medicare Advantage penetration across the six counties SOFHA touches runs from 61.1% in Washington County to 71.1% in Scott County, Virginia — against 53.7% for Tennessee as a whole (CMS Medicare Monthly Enrollment, April 2026). Only about 44,100 Original Medicare lives exist across the entire six-county area, and SOFHA's Medicare Advantage book carries risk. So the majority of the lives in question sit where total cost of care, not the fee schedule, sets the return. SOFHA already holds Humana's Best in Region award for the highest STAR score in the Tri-Cities and Southwest Virginia, and BlueCross BlueShield's Medicare Advantage Consistent High Performer recognition. Those are assets to defend, and continuous physiologic data is the most direct way to defend them. Commercial payers are out of scope: deductible plans put patient responsibility where it becomes a non-starter.

2026–2027 Priority Recommendations

1. Point the first cohort at heart failure. Five thousand heart failure patients, identified by ICD from SOFHA's own registry. Weight plus blood pressure is the canonical heart failure protocol, the admissions it prevents are the expensive ones, and the cohort is condition-defined rather than panel-defined — which is what keeps the billing from outrunning the savings.

2. Run it as RPM plus CCM. Monitoring produces the signal; care management produces the medication adherence and the between-visit contact that converts the signal into a prevented admission. The comparison in Section 6.4 shows monitoring alone delivers the same avoided admissions on a smaller fee base — the case for adding CCM is adherence, outcomes and a materially better margin rate.

3. Gate enrollment, and put the gate in SOFHA's hands. Enrollment is restricted to the agreed cohort. SOFHA's care team screens and approves the candidate list, and a referral flag on a patient outside the cohort does not auto-enroll. No provider can add volume against the loss ratio unilaterally.

4. Keep the clinical protocols and the scripting under SOFHA's control. Standard operating procedures, alert thresholds and health-coach scripting are reviewed and customized with SOFHA's physician leadership at implementation, and tuned thereafter. What a health coach says must not contradict what the provider says.

5. Chain the discharge. SOFHA employs both the hospital-based providers who discharge its patients and the primary care physicians who receive them back. Bill transitional care management at discharge, instrument days 1–14 under the new 99445, and convert the patient to ongoing RPM plus CCM from day 15. Send deteriorating readings to the Acute Care Clinic, not the emergency department. Heart failure readmission is the single highest-yield target in this account.

6. Add no capital and no headcount. The enrollment specialist sits on site but is funded by CoachCare, devices are supplied rather than purchased, and SOFHA's own nurses stay at top of license. Reaching 1,275 CCM enrollments is roughly four times the volume the current five-nurse team carries, and in-house programs typically wall out around 200–300 patients — this is a question of cost and ceiling, never of quality.

7. Use the native Veradigm integration from day one. SOFHA's ambulatory electronic health record is Veradigm, and CoachCare integrates with it natively: ordering and enrollment inside the existing clinical

workflow, enrollment status visible in real time, patients receiving CCM and RPM services in under five days, vital reports landing in the chart as data rather than as PDFs, and supporting documentation attached to the chart every month. CoachCare is the only care management application integrated with Veradigm Practice Management that creates claims automatically, which removes the manual per-patient, per-month claim step entirely.

8. **Model the risk side against SOFHA's own contracts before scaling.** The forecast in Section 6 is fee-for-service. The avoided-admission figure is the piece that carries across to ACO REACH and to the Medicare Advantage risk contracts, and it should be re-run against those contracts rather than assumed. That is a joint exercise, and it is the first thing to do after the cohort is confirmed.

1. Footprint and Operating Model

1.1 What SOFHA already operates

The published footprint as of 23 July 2026 is 21 clinic sites across five towns and four counties: 14 in Johnson City, three in Kingsport, one in Bristol, two in Elizabethton, and one in Gate City, Virginia. The clinical estate is primary-care-anchored with modest specialty arms, and it carries an ancillary depth that is unusual for an independent group of this size.

Asset already in place	What it is	Why it matters to a remote care service line
Case management and care coordination	A case-management department of RNs board-certified in case management (CCM®), LPNs and lay coordinators. 3–5 day post-discharge appointments, medication education, home-safety assessment, face-to-face hospital and office visits, coordination with hospitalists and PCPs.	The clinical labor a remote care program normally has to hire is already employed and already doing transitional care.
Chronic care management program 5 nurses · ~330 patients/month	A centralized CCM program run by five nurses across all clinics, carrying roughly 330 patients per month and administered by a physician board member. Scheduled telephone contact on the care plan, disease and medication education, red-flag coaching. Provider-initiated enrollment at an office visit. Confirmed directly by SOFHA, April 2026.	An enrolled CCM cohort, a referral habit and physician governance already exist. The modeled cohort requires roughly four times the current monthly volume — a question of cost and ceiling, not of quality.
No remote patient monitoring today	Confirmed directly by SOFHA: no RPM program is running, and Advanced Primary Care Management is not being billed.	The device layer, the transmitted reading and the alert queue are the additions. Everything clinical around them already exists.
Elevated Blood Pressure Program	For patients reading above 140/90 in office: a trained nurse rechecks in a calm setting and coaches home measurement technique — cuff validation, placement, five-minute rest.	Hypertension RPM without the device layer. No connected device, no transmission, no dashboard and therefore no 99453/99454/99457 claim.
Diabetic Monitoring Program and Diabetes Clinic	An ADA-recognized Diabetes Self-Management Education program run with ETSU Bill Gatton College of Pharmacy, plus professional CGM — 3-day, retrospective, receiver-based, referral-only.	Episodic diagnostic CGM, not continuous monitoring. The education infrastructure that makes RPM adherence work is already built.
Home visits	Nurse practitioners, a physician assistant and social workers visiting homebound and recently discharged patients, with prescribing and lab ordering in the home.	The escalation tier for a patient whose readings deteriorate but who cannot travel.

Asset already in place	What it is	Why it matters to a remote care service line
Acute Care Clinic (since 2015)	Treats mild-to-moderate exacerbations of chronic conditions as an alternative to hospitalization.	A destination that is not an emergency department when an alert fires. Most groups running RPM do not have one.
Own hospitalist group	SOFHA employs its own hospitalists (68 hospital-based providers in the directory).	Both ends of the discharge handoff sit inside one organization. See Section 4.
Ancillary depth	Own CLIA clinical laboratory, Imaging Center, cardiovascular imaging, Comprehensive Breast Center, AASM-accredited sleep testing, four clinical pharmacists, physical therapy, nutrition/RDN, palliative care, shared medical appointments.	Pharmacist-led titration, lab confirmation and sleep testing are all in-house, which shortens every loop a monitoring program opens.

A NOTE ON HOW THIS SECTION IS WRITTEN

The footprint and program descriptions are drawn from SOFHA's own published pages, retrieved July 2026. The chronic care management staffing and volume, the absence of RPM and APCM today, and the risk-contract position were confirmed directly by SOFHA on 29 April 2026 and are marked as such. Anything not confirmed is treated as a discovery question and listed in Section 9 — not as an assertion, and certainly not as a criticism.

The build-versus-partner comparison in this document is about the cost of scaling and the ceiling a nurse-staffed program reaches, never about the quality of what exists.

1.2 Quality and recognition position

SOFHA's published recognitions are the starting-position diagnosis for this report: this is a high performer with quality assets to defend, not an organization that needs to be persuaded that chronic disease management matters.

Recognition	Issuer	What it signals
Best in Region — highest STAR score, Tri-Cities and Southwest Virginia	Humana	Top Medicare Advantage quality performance in the region. Directly defensible with continuous physiologic data.
Medicare Advantage Consistent High Performer	BlueCross BlueShield of Tennessee	Sustained MA quality performance across periods, not a one-year result.
Best in Class — Quality Care Partnership Initiative	BlueCross BlueShield of Tennessee	Participation and performance in the payer's provider quality program.
5-Star Best in Class — Preventive Screenings	BlueCross BlueShield of Tennessee	Screening-gate closure capability, which is the same operational muscle CCM outreach uses.
Achieving Quality Outcomes for Patients	BlueCare	Quality performance recognized on the Medicaid line as well as Medicare.
Best Performer — multiple practices	MGMA	Operational performance recognized at practice level.
Distinction in Behavioral Health Integration (announced Nov 2019)	NCQA	Only available to NCQA-Recognized Patient-Centered Medical Homes — which corroborates PCMH recognition as of that date.

TWO CAVEATS ON THIS TABLE

SOFHA's awards page does not date-stamp its recognitions, so the vintage of each is unconfirmed. Confirm which are current before any of them is used externally.

NCQA Patient-Centered Medical Home recognition is claimed by SOFHA, but the recognition year and current scope are unverified. The November 2019 Behavioral Health Integration Distinction corroborates recognition as of that date and no later.

1.3 Operating design principles

Six principles shape everything that follows. They are how a remote care service line is designed for a group that carries risk, so that it strengthens the practice rather than adding another program to run — and another set of charges to carry.

Principle	What it means in practice
Avoided cost before billed revenue	On a risk-bearing book the first question is what the program prevents, not what it charges. Every design decision here is tested against admissions per 1,000 first and against the fee schedule second.
Condition-defined, not panel-defined	Enrollment follows an agreed diagnosis cohort selected by ICD, approved by SOFHA's own care team. Volume is a consequence of the cohort definition, never of referral enthusiasm.
One shared engine, many levers	Enrollment, devices, alert triage, nurse navigation, documentation and claim capture are built once and reused across RPM, CCM and TCM. Nothing is stood up per program.
Top of license, no new headcount	SOFHA's RNs and CCM® -certified care managers do clinical work. Enrollment, device logistics, first-line triage and billing mechanics are absorbed by the partner.
Margin before mission-creep	The fee-side layer must still stand on its own — cash-flow positive in year one out of professional-fee revenue, before any quality bonus, savings distribution or contract change is counted. Avoided cost is the reason to do it; self-funding is what makes it safe to do.
Documented or it did not happen	Every reading, every minute and every care-plan touch lands in the chart in a form that supports the claim, the audit and the quality measure simultaneously.

2. The Remote Care Service Line — The Spine

2.1 What it is

A Remote Care Service Line is a set of billable services running on one operating engine. For the heart failure cohort modeled in this report the pair that does the work is remote patient monitoring and chronic care management, with transitional care management captured at every discharge. They share one enrollment process, one device fleet, one alert queue, one documentation trail and one claim engine.

Service	Clinical anchor	Who delivers it	Cadence
RPM / Remote patient monitoring	Heart failure first — daily weight plus blood pressure is the canonical protocol. CKD stage 2–3 and COPD are the natural extensions.	Patient transmits from a connected device. Partner-supplied team triages alerts 24/7 against SOFHA-approved thresholds; SOFHA's nurses and physicians act on the clinical exceptions.	Continuous transmission; monthly device and treatment-management billing.

Service	Clinical anchor	Who delivers it	Cadence
CCM / Chronic care management	Two or more chronic conditions expected to last at least 12 months. Medicare heart failure beneficiaries carry several chronic conditions on average, so nearly all of the cohort qualifies.	SOFHA's RNs and LPNs, supported by partner-supplied care-management time and documentation.	Comprehensive care plan plus at least 20 minutes of clinical staff time per calendar month.
TCM / Transitional care management	Every discharge back to a SOFHA primary care physician — the point of highest readmission risk, and in heart failure the most expensive one.	SOFHA's care managers, who already run 3–5 day post-discharge appointments.	Contact within two business days; face-to-face visit within 7 or 14 days depending on complexity.

WHAT IS SWITCHED OFF, AND WHY

Principal care management is off. PCM exists for the single-high-risk-condition patient who does not meet CCM criteria. In a cohort defined by heart failure, that patient is rare — heart failure is the dominant condition and CCM carries it. Turning PCM on would add codes without adding clinical work, and PCM and CCM cannot both bill for one patient in one month.

Advanced Primary Care Management is off. APCM (G0556, G0557, G0558) is a fee-schedule primary care management service billable in Original Medicare. It is excluded from every modeled figure in this report and is mentioned only as a fee-schedule service. SOFHA is not billing it today.

One coordination rule still needs settling before the first enrollment. RPM stacks: it may be billed alongside CCM in the same month provided the time and documentation are discrete and separately recorded. Default attribution — primary care owns the longitudinal wrapper, the discharge event owns TCM, RPM attaches to the clinician managing the monitored condition. One shared care plan in the chart, one owner per patient per month.

2.2 Where the value comes from

For a group carrying full risk the value layers do not sit in the usual order. Avoided cost comes first, because that is the line that moves the contracts SOFHA is actually paid under. Fee revenue comes second — it matters, and it is what makes the program self-funding, but it is not the argument.

LAYER 1 — AVOIDED ADMISSIONS AND TOTAL COST OF CARE

A heart failure admission costs roughly $15,000 to $20,000. Daily weight and blood pressure, read against a threshold and acted on within hours, is the intervention with the best-established relationship to that admission — fluid accumulation is visible on a scale days before it is visible in an emergency department. The modeled forecast puts approximately 210 avoided hospitalizations over 24 months, worth about $3,148,557 at roughly $15,000 per admission. On a full-risk book that figure is not upside sitting on top of the model — it is the primary return, and it is larger than the fee margin beneath it. Illustrative, modeled — verify against practice data.

LAYER 2 — RECURRING FEE REVENUE THAT MAKES THE PROGRAM SELF-FUNDING

Every enrolled patient generates a documented, billable event every month for as long as they remain clinically appropriate. That is what allows the program to pay for itself rather than requiring a capital request against an expected savings distribution. The staffing model is what makes it margin-positive rather than margin-neutral: enrollment labor, device logistics, first-line alert triage and claim generation are absorbed by

the partner, so the practice's own nurses spend their time on clinical exceptions rather than on program administration. Over 24 months the modeled net to the practice is $2,425,867 on $5,453,555 of net reimbursement — a 44.5% practice margin after every fee. The loss-ratio caveat is real and is addressed directly in Section 3.2 — the answer is cohort discipline, not volume.

LAYER 3 — QUALITY-SCORE DEFENSE

Continuous physiologic data and a documented monthly touch are the raw material for the measures SOFHA is already being judged on — MIPS quality and improvement-activity performance on the fee-for-service side, and Medicare Advantage STAR and HEDIS performance on the much larger MA side. Medication adherence, one of SOFHA's four stated goals, is measured directly. Section 3 maps the specific measures. The relevant point here is that the same infrastructure produces the avoided admission, the revenue and the evidence.

THE CY2026 BILLING STACK

Code	Service	Type	CY2026 rate	Notes
99453	RPM — device setup and patient education	One-time	$19.49	Requires at least 2 days of transmitted data.
99454	RPM — device supply, 16–30 days of readings	Monthly	$47.24	The long-standing device code.
99445 NEW	RPM — device supply, 2–15 days of readings	Monthly	$47.24	New for CY2026. Makes short windows — post-discharge, post-titration — billable for the first time.
99457	RPM — treatment management, first 20 minutes	Monthly	$48.42	Interactive communication required.
99470 NEW	RPM — treatment management, 10–19 minutes	Monthly	$24.38	New for CY2026. Captures the months that fall short of the 20-minute floor.
99458	RPM — treatment management, each additional 20 minutes	Monthly	$39.01	
99490	CCM — first 20 minutes of clinical staff time	Monthly	$62.29	2+ chronic conditions expected to last 12 months or until death.
99439	CCM — each additional 20 minutes	Monthly	$47.35	
99495 / 99496	TCM — moderate / high complexity	Per discharge	~$200 / ~$280	National illustrative magnitude; locality rate to be confirmed. Excluded from the model.
99426 / 99427	PCM — principal care management	Monthly	off	Switched off in both configurations. Heart failure is the dominant condition and CCM carries it.
G0556 / G0557 / G0558	APCM — by complexity level	Monthly bundle	off	A fee-schedule primary care management service billable in Original Medicare. Switched off; excluded from every modeled figure.

HOW THE FEE LAYER ACTUALLY BEHAVES — AND WHERE IT MEETS THE LOSS RATIO

Rates shown are CY2026 non-facility amounts for the Tennessee locality served by Palmetto GBA (carrier 10312, locality 35), except where marked as national illustrative magnitudes. Tennessee is a comparatively low-reimbursement locality; these are not the national averages quoted in most vendor material.

A single RPM patient billed at 99454 plus 99457 in a month, with a one-time 99453 at setup, produces a predictable per-patient-per-month amount. Blended net reimbursement per active patient-month, after denials and coinsurance bad debt, is modeled at approximately $90.32 for RPM and $104.15 for CCM. Multiply by an enrolled census that grows and then holds and the result is a revenue line that behaves like a subscription rather than like visit volume.

On capitated lives that same predictability cuts both ways. A charge raised against a patient inside a full-risk contract is partly a cost against the medical loss ratio. That is precisely why the cohort is defined by diagnosis and gated by SOFHA's own care team rather than opened to every provider and every patient — the savings have to exceed what gets billed, and in heart failure they do.

Illustrative, modeled — verify against practice data. Rates are locality-adjusted and set by the regional MAC; confirm current CY2026 amounts and Medicare Advantage plan-level coverage before relying on any figure here.

2.3 Connective tissue

The reason to build this as a service line rather than as three separate programs is that the expensive parts are shared. Enrollment, connected devices, 24/7 alert triage, nurse navigation, documentation and automated claim capture are built once. Every lever below draws on the same engine.

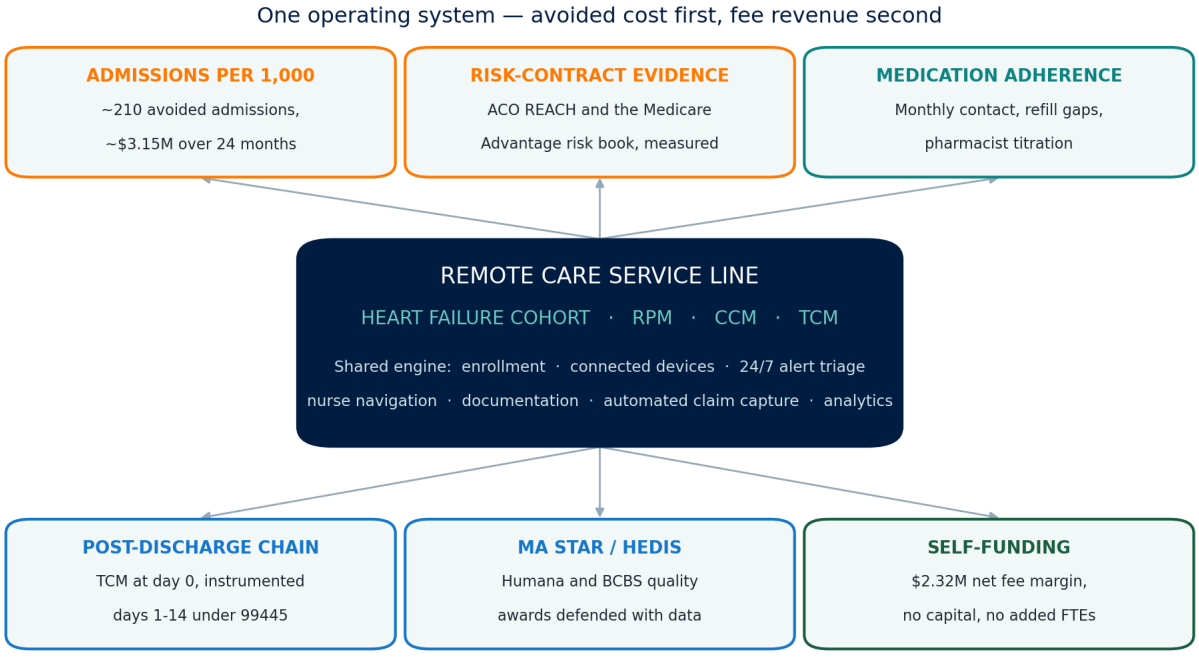

Figure 1 — One operating system, every value lever. The shared engine is built once; each lever draws on the same enrollment, device, triage, documentation and billing infrastructure.

Lever	What the shared engine supplies	What it produces for SOFHA
Admissions per 1,000	Daily weight and blood pressure on a heart failure cohort, thresholds set with SOFHA's physicians, alerts triaged within hours, escalation to the Acute Care Clinic or a home visit.	The stated goal, measured directly. Approximately 210 avoided admissions over 24 months in the modeled forecast — the primary return on a risk-bearing book.
Risk-contract performance	The same readings, contacts and escalations, attributable to the ACO REACH population and to the Medicare Advantage risk book.	The evidence base for total-cost-of-care performance. The fee model in Section 6 does not quantify this; it has to be run against SOFHA's own contracts.
Medication adherence	The monthly CCM contact, with refill checks, titration follow-up and pharmacist escalation built into the script.	A stated SOFHA goal and a directly measured Medicare Advantage star measure — improved on the same touch that produces the claim.
Post-discharge chain	TCM workflow at day 0, instrumented days 1–14 under 99445, conversion to ongoing RPM plus CCM at day 15.	A closed loop between SOFHA's own hospitalists and its own primary care physicians, with the Acute Care Clinic as the escalation destination.
Medicare Advantage STAR and HEDIS	Continuous readings, documented monthly clinical contact, medication-adherence touchpoints, post-discharge follow-up evidence.	Defense of the Humana Best in Region and BlueCross Consistent High Performer positions with measured data rather than chart abstraction.
Self-funding, without capital	Partner-supplied devices, partner-funded on-site enrollment specialist, partner-run billing engine.	A service line that is cash-flow positive in-year with no capital outlay and no additional full-time employees — $2,425,867 of net fee margin at a 44.5% practice margin, so the avoided-cost case does not have to be pre-funded.

3. Risk-Bearing Economics and the Medicare Book

3.1 The market SOFHA actually serves

Any remote care business case that leads with fee-for-service billing will mis-frame this account twice over — once on the payer mix, and once on the contracts. SOFHA's counties are among the most Medicare-Advantage-saturated in the country: total Medicare in a market is the sum of traditional fee-for-service and the local Medicare Advantage population, and here the second is roughly twice the first. On top of that, SOFHA participates in ACO REACH for its traditional Medicare population and carries risk on the Medicare Advantage side.

County	Total Medicare	Original Medicare (FFS)	Medicare Advantage	MA penetration
Washington Co., TN (Johnson City)	34,583	13,454	21,129	61.1%
Sullivan Co., TN (Kingsport / Bristol)	45,193	14,148	31,045	68.7%
Carter Co., TN (Elizabethton)	14,952	4,812	10,140	67.8%
Greene Co., TN	20,853	7,998	12,855	61.6%
Unicoi Co., TN	5,498	1,806	3,692	67.2%
Scott Co., VA (Gate City)	6,650	1,920	4,730	71.1%
Six-county total	127,729	44,138	83,591	65.4%
Tennessee statewide, for reference	1,523,210	705,908	817,302	53.7%

Source: CMS Medicare Monthly Enrollment, April 2026. Three consequences follow. First, only about 44,100 Original Medicare lives exist across the entire six-county area. Second, the majority of the lives in question sit on the Medicare Advantage side, where SOFHA's contracts carry risk. Third — and this is the framing decision for the whole report — for lives inside a capitated or shared-risk arrangement, the return on this service line is set by total cost of care, not by the fee schedule.

Commercial payers are out of scope. Deductible plans place the patient responsibility for a monthly monitoring and care-management service at a level that makes enrollment a non-starter. The scope of this report is Medicare, Medicare Advantage and the qualified Medicare beneficiary and dual-eligible population.

3.2 What full risk changes about the business case

SOFHA described the concern precisely on the 29 April call: adding a large volume of charges that run against loss ratios under full-risk contracts. That objection is correct, and it is the reason this report is scoped the way it is. It deserves a direct answer rather than a reframing.

The concern	The answer built into this scope
Fee-for-service billing on capitated lives is partly a cost line, not a clean revenue win.	Agreed, and stated plainly. That is why the report leads with avoided admissions and treats fee revenue as the second layer. On the recommended configuration the modeled avoided admission cost ($3,148,557) exceeds the net fee margin ($2,425,867) over 24 months.
Hypertension and diabetes monitoring bills more than it saves.	Also agreed. Those conditions do not generate savings in excess of what gets billed. The cohort is therefore heart failure — where the $15,000–$20,000 admissions are — with CKD stage 2–3 and COPD as the natural extensions. This is the same logic SOFHA articulated.
Every provider enrolling every patient would add charges without adding value.	Enrollment is gated. It is restricted to the agreed cohort, SOFHA's care team screens and approves the candidate list, and a referral flag on a patient outside the cohort does not auto-enroll. The mechanism is set out in Section 8.1.
A vendor's model will not reflect our contracts.	It does not, and the report says so. The Value Analysis is a fee-for-service model. The avoided-admission figure is the bridge to the risk side; the risk-side impact itself has to be modeled against SOFHA's ACO REACH and Medicare Advantage contracts jointly.

WHY THE FEE ECONOMICS STILL TRAVEL ACROSS BOTH BOOKS

Medicare Advantage plans are required to pay non-contracted providers no less than Original Medicare would have paid for a covered service, and contracted rates for these management codes are commonly benchmarked to the physician fee schedule. In practice that means the modeled RPM and CCM economics are broadly comparable across the fee-for-service and Medicare Advantage books — for lives that are not capitated.

For capitated lives the fee revenue behaves differently, and this model does not attempt to represent that. Confirm code-level coverage, prior-authorization posture, contracted rates and the capitated treatment of these codes plan by plan before relying on any of it. It is a discovery item, not an assumption.

3.3 Quality performance, dual eligibles and patient responsibility

SOFHA already holds Humana's Best in Region award for the highest STAR score in the Tri-Cities and Southwest Virginia, and BlueCross BlueShield's Medicare Advantage Consistent High Performer recognition.

Those positions are earned annually and defended annually, and on risk contracts they carry economic weight of their own. Remote care is the most direct operational way to defend them, because it produces measured evidence continuously rather than retrospectively.

Measure domain	How the remote care service line contributes
Medication adherence	The monthly CCM touch is the natural place to detect and resolve non-adherence, measured across diabetes agents, antihypertensives and statins. This is one of the four goals SOFHA stated directly, and it is measured directly.
Transitions of care and readmissions	TCM at every discharge plus instrumented days 1–14 under 99445, with the Acute Care Clinic as an alternative to an emergency-department return. Heart failure is the highest-yield diagnosis for this measure.
Blood pressure control	Transmitted home readings with an alert queue and a titration loop, instead of readings captured only at visits. Blood pressure is already half the heart failure monitoring protocol, so the measure is closed as a by-product.
Care for older adults and screening gates	The same outreach engine that enrolls patients closes screening and assessment gaps, which is where SOFHA's existing preventive-screening recognition came from.
Diabetes care	Connected data feeding the existing ADA-recognized self-management education program and the clinical pharmacists, with monthly documented contact for gap closure — relevant to the large share of the heart failure cohort that also carries type 2 diabetes.

Measure specifications, weights and cut points change year to year and vary by plan. Treat this table as the mapping of clinical activity to measure domains, and confirm the current measure set with each plan before setting targets.

DUAL ELIGIBLES AND PATIENT RESPONSIBILITY

Approximately 16.4% of Medicare beneficiaries across SOFHA's six-county service area are dual-eligible — 20,890 of 127,729 — which is high, and consistent with the regional income profile. That has a practical consequence for enrollment that is often missed: qualified Medicare beneficiaries cannot be balance-billed, so the coinsurance objection that slows CCM enrollment simply does not apply to a large slice of the population. For the remainder, patient responsibility on Medicare for RPM plus CCM runs roughly $20 to $40 per month. Below about $40 it is a scripted part of the enrollment conversation; above it, friction rises sharply. That threshold is the reason commercial deductible plans are out of scope, and it is also a reason to hold the configuration at RPM plus CCM rather than stacking further services onto the same patient. The modeled forecast in Section 6 already nets out an allowance for coinsurance that does not collect.

3.4 The value-model decision in front of SOFHA

This is not a future-state musing. SOFHA is inside a live model-selection decision, and the operating-capability question is the same whichever way it goes. SOFHA participates in ACO REACH for its traditional Medicare population today. ACO REACH sunsets on 31 December 2026, and SOFHA is actively modeling its successor — the LEAD Model — against a return to the Medicare Shared Savings Program, in which it has participated previously and in which it does not appear for PY2026. No shared-savings or capitation contribution appears in any modeled figure in this report.

What is changing	Detail, as published at July 2026
ACO REACH ends	The ACO Realizing Equity, Access, and Community Health model — the model SOFHA participates in for its traditional Medicare population — sunsets on 31 December 2026.

What is changing	Detail, as published at July 2026
LEAD begins	CMS's successor is the LEAD Model — Long-term Enhanced ACO Design — beginning 1 January 2027, with a ten-year performance period running through 2036. It is the longest accountable-care test CMS has run.
Two risk options	Professional Risk, at up to 50% shared savings and losses; Global Risk, at up to 100%.
Designed around practices of this profile	LEAD was designed with enhanced support for small, independent and rural practices delivering primary care, and an enhanced focus on rural, high-needs and dual-eligible beneficiaries. That description fits SOFHA closely — independent, physician-led, rural Appalachian, with 16.4% dual-eligible across its counties.
The first-year door has closed	CMS released the Request for Applications on 31 March 2026, and applications for the first performance year closed on 17 May 2026. Whether CMS opens later LEAD cohorts has not been published.

The doors that remain open are the Medicare Shared Savings Program's annual application cycle and a later LEAD cohort if CMS opens one. Which door SOFHA walks through matters less, for the purposes of this report, than what standing in front of it requires — because the requirement is identical either way, and identical again to what the Medicare Advantage risk contracts already ask for.

> **THE POINT, AND THE ONLY POINT**
>
> ACO REACH, LEAD, MSSP and a full-risk Medicare Advantage contract all ask for the same four operating capabilities: a consented longitudinal cohort, documented monthly care management, continuous physiologic data, and a readmission-prevention loop that actually closes.
>
> Those four are exactly what the Remote Care Service Line stands up. It stands them up under fee-for-service, paying for itself out of professional-fee revenue rather than out of a savings distribution that may or may not arrive — which is what makes it safe to build during a model transition rather than after one.
>
> The heart failure cohort is the right first population for that reason as well as the clinical one. Admissions per 1,000 is the metric ACO REACH, LEAD and every risk contract are scored on, and heart failure is where the avoidable admissions concentrate. The capability transfers whichever model SOFHA lands on.

4. The Discharge-to-Home Chain

4.1 Both ends of the handoff, under one roof

SOFHA employs both the hospital-based providers who discharge its patients and the primary care physicians who receive them back. Almost no independent group controls both ends of that handoff. It is a structural advantage, and it makes transitional care management unusually clean to capture — the discharge summary, the two-business-day contact, the medication reconciliation and the follow-up visit all sit inside one organization, on one care team, with one care-management department already booking three-to-five-day post-discharge appointments as standard practice.

For a heart failure cohort on a risk-bearing book this is the highest-value chain in the account. The thirty days after a heart failure discharge are when the readmission happens, the readmission is the $15,000–$20,000 event, and the signal that precedes it — two to three pounds of weight gain over forty-eight hours — is exactly what a connected scale reports. Every avoided readmission in this window lands against admissions per 1,000 and against the loss ratio simultaneously.

The CY2026 fee schedule added the code that completes the chain. 99445 pays for device supply across a 2–15 day window, where 99454 has always required at least 16 days of readings in a 30-day period. The first two weeks after a discharge are exactly the window that requirement used to exclude — and exactly the window in which deterioration is most likely and most preventable.

4.2 Chaining the codes across the first 30 days

Window	What happens clinically	What is billable	Who owns it
Day 0 — discharge	SOFHA hospitalist discharges; care manager is notified inside the same organization; contact made within two business days; medication reconciliation.	TCM 99495 or 99496, depending on complexity; face-to-face within 14 or 7 days.	Care management department, with the receiving PCP.
Days 1–14 — the instrumented window	Connected scale and cuff in the home; daily weight and blood pressure; three-touch post-discharge cadence; readings reviewed daily; thresholds set tighter than for a stable patient.	RPM 99453 at setup; 99445 for the 2–15 day device window; 99470 or 99457 for treatment management depending on time.	Partner-supplied triage against SOFHA-approved thresholds; SOFHA nurses on clinical exceptions.
Day 15 onward — conversion	Patient converts from a post-discharge episode to ongoing management of heart failure. Care plan updated; enrollment continues without a second onboarding.	RPM 99454 plus 99457/99458 monthly, alongside CCM 99490/99439.	Primary care physician as longitudinal owner.
Any point — deterioration	An out-of-range reading or a symptom flag triggers escalation. SOFHA has somewhere to send the patient that is not an emergency department.	Acute Care Clinic visit; home visit where the patient cannot travel.	Acute Care Clinic; home-visit arm.

THIS IS UPSIDE, NOT BASE CASE

Transitional care management (99495 / 99496) is excluded from every figure in the Value Analysis in Section 6, as is Advanced Primary Care Management. Neither appears in the modeled forecast. Both are real and both are billable today.

The reason for excluding TCM is discipline, not doubt: discharge volume attributable to SOFHA's heart failure cohort is not publicly documented, and this report does not estimate numbers it cannot source. Quantifying it is a first-call discovery item.

The same discipline applies to the avoided-admission figure. The modeled ~210 avoided admissions are derived from RPM patient-months on the cohort, not from SOFHA's own discharge data. Replacing that with SOFHA's actual heart failure admission and readmission rates is the single change that would most improve the forecast.

5. The Heart Failure Cohort

5.1 Why heart failure, and not hypertension and diabetes alone

The logic here is SOFHA's own, and this report adopts it rather than arguing with it. Hypertension and diabetes do not, on their own, generate savings in excess of what a monitoring program bills. The events they avoid are real but they are not expensive enough, often enough, to clear the cost of the codes raised to avoid

them. On a fee-for-service book that still leaves a margin. On a full-risk book it leaves a charge against the loss ratio and very little to show for it.

Heart failure, chronic kidney disease stage 2–3 and COPD are different, because that is where the $15,000 to $20,000 admissions are. The economics of a monitoring program are set by the cost of the event it prevents, not by the number of readings it collects. Heart failure is the strongest of the three as a starting cohort for four reasons.

1. **The admission is expensive and it is frequent.** Heart failure is among the highest-volume causes of admission and readmission in the Medicare population, and the readmission window is short and well characterized.

2. **The signal is early, cheap and unambiguous.** Fluid accumulation shows on a scale days before it shows in an emergency department. Daily weight plus blood pressure is the canonical protocol, and it needs two inexpensive devices, not a diagnostic workup.

3. **There is somewhere to send the patient.** A diuretic adjustment, a same-day Acute Care Clinic visit or a home visit absorbs a deterioration that would otherwise become an admission. SOFHA already operates all three. A monitoring program without an escalation destination generates alerts, not savings.

4. **The cohort is definable by ICD.** Heart failure can be selected from the registry precisely, which is what makes enrollment gateable and what keeps the billing from outrunning the savings. A cohort defined by diagnosis behaves; a cohort defined by referral enthusiasm does not.

> **CKD STAGE 2–3 AND COPD ARE THE NEXT TWO COHORTS, NOT THIS ONE**
>
> Both carry the same profile — expensive admissions, an early physiologic signal, an escalation path SOFHA already owns. Neither is modeled here. Phase one is heart failure alone, at 5,000 patients, because a single condition-defined cohort is the cleanest way to prove the admissions effect before widening anything.
>
> Widening the cohort is the growth lever discussed in Section 6.5. It is a clinical and registry decision made with SOFHA's physician leadership, not an outreach decision.

5.2 Regional chronic-disease burden

The conditions that drive heart failure, and the conditions that travel with it, are markedly more prevalent in SOFHA's counties than nationally. This is the clinical case for the cohort, independent of the financial one.

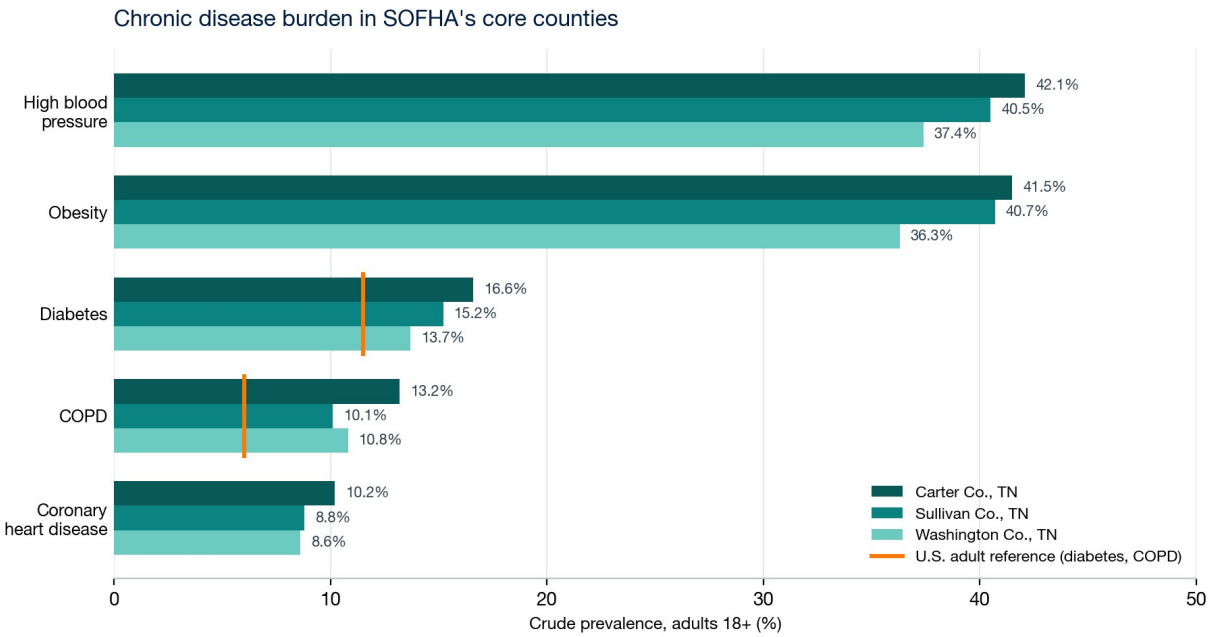

Figure 2 — Chronic disease burden, CDC PLACES 2024 release, model-based small-area estimates, crude prevalence among adults 18+. U.S. adult reference shown where a published comparison is available.

Measure (crude prevalence, adults 18+)	Washington Co.	Sullivan Co.	Carter Co.	U.S. adult reference
Diabetes	13.7%	15.2%	16.6%	~11–12%
COPD	10.8%	10.1%	13.2%	~6%
Coronary heart disease	8.6%	8.8%	10.2%	not shown
High blood pressure	37.4%	40.5%	42.1%	not shown
Obesity	36.3%	40.7%	41.5%	not shown

Carter County runs roughly 1.4 to 2.2 times the national rate on diabetes and COPD. Coronary heart disease — the dominant antecedent of heart failure — runs between 8.6% and 10.2% across the three core counties. Hypertension, obesity, diabetes and coronary disease are the four inputs to heart failure, and all four are elevated here and co-occur in the same patients. A regional heart failure burden above the national rate is the reasonable inference; SOFHA's registry is what will confirm it.

5.3 Sizing the cohort — and the caveats that go with it

The modeled scenario in Section 6 is built on a cohort of 5,000 heart failure patients in year one, drawn from an estimated Medicare population of approximately 32,000. Both numbers are discovery-stage estimates, not chart counts. They are the softest inputs in the entire model, and they are stated as estimates every time they appear.

Input	Value used	Status
Estimated total Medicare population	~32,000	Discovery-stage estimate, for context only. Total Medicare equals traditional fee-for-service plus the local Medicare Advantage population. Validate against SOFHA's chart counts.
Heart failure cohort in scope, year one	5,000	The scope agreed on the 29 April call. Condition-defined and selected by ICD from SOFHA's own registry — not a share of the panel. Validate the count, and agree the ICD definition, before anything is built.

Input	Value used	Status
Eligibility within the cohort	RPM 90% · CCM 85%	A deliberate condition-defined override of the panel-wide defaults, and near-full because the cohort is selected by diagnosis. Weight plus blood pressure is the canonical heart failure protocol, so nearly all of the cohort is RPM-appropriate; Medicare heart failure beneficiaries carry several chronic conditions on average, so nearly all qualify for CCM.
Enrollment acceptance	RPM 35% · CCM 30%	Standing acceptance baseline for a condition-defined cohort with physician endorsement and an on-site specialist.
Resulting active-enrollment ceilings	RPM 1,575 · CCM 1,275	The binding constraint on the entire forecast, and the number that should be checked first against SOFHA's own view of how many of these patients will consent.
Referring adult primary care providers	73	49 family medicine plus 24 internal medicine from SOFHA's published provider directory, 23 July 2026. Excludes hospital-based, OB/GYN, pediatric and ancillary clinicians. Confirm which sites are in phase one.
Fee schedule basis	CY2026, Palmetto GBA carrier 10312, locality 35	Tennessee locality rates, non-facility. Re-verify at contracting.

READ THE COHORT NUMBER FOR WHAT IT IS

Five thousand is the scope agreed for the value analysis, not a count of SOFHA's heart failure patients. The ~32,000 Medicare population behind it is a discovery-stage estimate and not a claim about attributed lives. Both are used to produce an order-of-magnitude forecast.

If the true cohort is smaller, every figure in Section 6 scales down close to proportionally; if it is larger, they scale up. The first substantive thing to do together is replace both estimates with SOFHA's own counts against an agreed ICD definition.

6. The Value Analysis — 24-Month Modeled Forecast

6.1 Modeling basis, and what this model does not do

The Value Analysis models the heart failure cohort end to end: enrollment pathways, eligibility, acceptance, attrition, code-level reimbursement at Tennessee locality rates, denials, coinsurance that does not collect, and all fees. RPM plus CCM is the recommended configuration and the build the workbook on file computes; a remote-monitoring-only comparison is carried alongside it. Every figure is illustrative and modeled and must be verified against practice data.

WHAT THIS MODEL IS, AND WHAT IT IS NOT

The Value Analysis is a fee-for-service model. It does not model capitated or shared-risk economics. On capitated lives the fee revenue behaves differently from the way it is represented here, and no attempt is made to net the billed amounts against a medical loss ratio.

The avoided-admission figure is the bridge between the two economies. Admissions prevented are worth the same on either side of the line, which is why this section leads with them. The actual risk-side impact — against ACO REACH and against the Medicare Advantage risk contracts — has to be modeled against SOFHA's own contracts, jointly, and is not attempted here.

No shared-savings distribution, capitation adjustment or quality bonus appears in any figure in this section.

Assumption	Value	Basis
Cohort in scope, year one	5,000 heart failure patients	The scope agreed on the 29 April call. Condition-defined, selected by ICD.
Estimated Medicare population	~32,000	Discovery-stage estimate, context only.
Referring adult primary care providers	73	SOFHA published directory, July 2026.
Programs modeled	RPM + CCM (recommended) · RPM only (comparison)	PCM and APCM are both switched off. Heart failure is the dominant condition and CCM carries it.
Eligibility within the cohort	RPM 90% · CCM 85%	A deliberate condition-defined override, near-full because the cohort is selected by diagnosis. Weight plus blood pressure is the canonical heart failure protocol; Medicare heart failure beneficiaries carry several chronic conditions on average, so nearly all qualify for CCM.
Enrollment acceptance	RPM 35% · CCM 30%	Standing acceptance baseline.
Resulting active-enrollment ceilings	RPM 1,575 · CCM 1,275	The binding constraint on the entire forecast.
Enrollment pathways	Physician referral into a gated cohort, on-site enrollment specialist, telephonic enrollment	Eight referrals per provider per month across 73 providers at an 80% patient accept rate, restricted to the approved cohort list; one on-site specialist at ~80 enrollments a month; telephonic enrollment as the third pathway.
On-site enrollment specialist	1 FTE, funded by CoachCare	Staffed at CoachCare's expense. Embedded value — never subtracted from the practice's margin.
Attrition	~1.5% per month	Applied to the active census every month.
Program start	Enrollment begins in month 1	No onboarding delay is modeled.
EMR integration	Included — implementation, integration and outreach at no cost	Native Veradigm integration including automated claims creation into practice management (Section 7). The implementation fee, the Veradigm setup, monthly and per-patient integration charges, and telephonic outreach are included at no cost for SOFHA, so ancillary cost across the 24 months is $0.
Revenue mechanics	Net, not gross	Stated after denials and after 20% coinsurance with a bad-debt haircut on that coinsurance, and at realistic code-completion rates rather than assuming every eligible code is billed every month.
Payer scope	Medicare, Medicare Advantage, QMB / dual-eligible	Commercial payers are out of scope — deductible plans put patient responsibility beyond the point where enrollment works.
Fee schedule basis	CY2026, Palmetto GBA carrier 10312, locality 35	Tennessee locality rates, non-facility.

6.2 Avoided admissions and total cost of care

This is the line that matters most, so it comes first. Across 24 months the recommended configuration models approximately 210 avoided hospitalizations, worth about $3,148,557 at roughly $15,000 per admission. At the upper end of the heart failure admission range the same 210 events are worth closer to $4.2M. The figure is derived from RPM patient-months on the cohort — it is a modeled effect, not a measurement of

SOFHA's own admission history, and replacing it with SOFHA's actual heart failure admission and readmission rates is the highest-value thing discovery can do to this forecast.

24-month modeled value	Amount	Where it lands
Avoided admission cost	$3,148,557	Total cost of care. Lands on the risk side — ACO REACH, the Medicare Advantage risk contracts, and admissions per 1,000.
Net fee margin to the practice	$2,425,867	Professional-fee revenue after every CoachCare fee — a 44.5% practice margin on net reimbursement. Lands on the fee-for-service side; behaves differently on capitated lives.
Combined modeled value	~$5.47M	The two lines are not additive across a single capitated life without contract-level modeling. Read them as two distinct returns, not as one total.

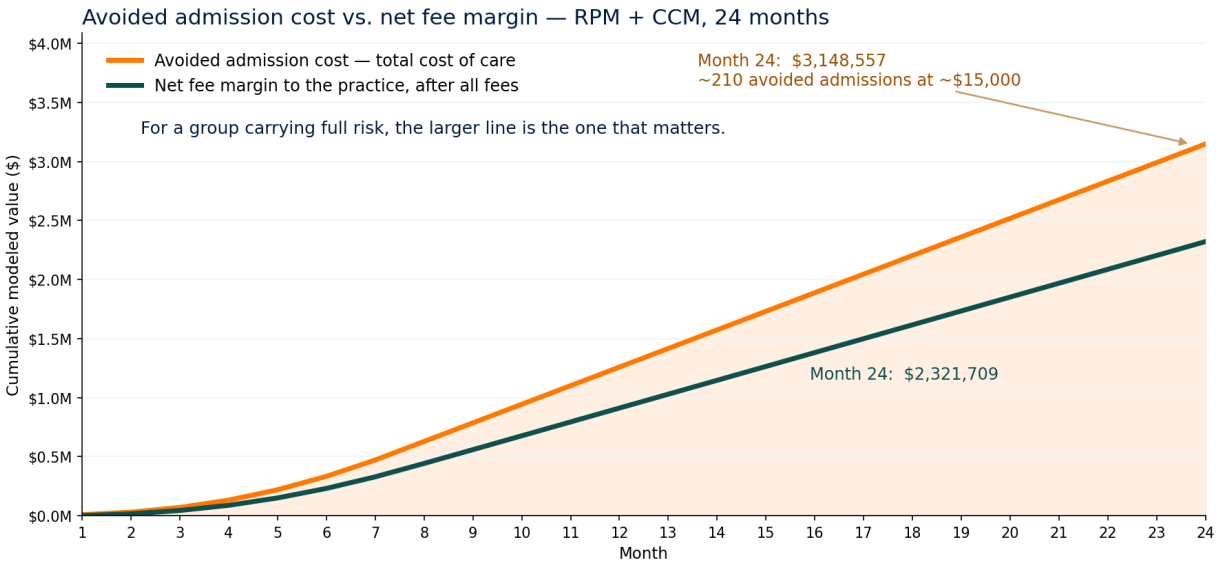

Figure 3 — The two value lines over 24 months, recommended configuration. Avoided admission cost exceeds net fee margin. Illustrative, modeled — verify against practice data.

THE HEADLINE FINDING

Avoided admission cost ($3,148,557) exceeds net fee margin ($2,425,867). For a group carrying full risk, the line that matters is the larger of the two. That is the argument this report is built around, and it is the reverse of the way a remote care business case is normally written.

It holds because of the cohort, not because of the volume. A monitoring program pointed at hypertension and diabetes bills against the loss ratio without moving admissions far enough to clear it. Pointed at heart failure — where the $15,000 to $20,000 admissions are — the arithmetic inverts.

Illustrative, modeled — verify against practice data. The avoided-admission figure is a modeled effect at roughly $15,000 per admission, not a measured result.

6.3 Recommended configuration — RPM + CCM

Monitoring produces the signal; care management produces the medication adherence and the between-visit contact that converts a signal into a prevented admission. This is the configuration the rest of the report assumes, and it is the one the workbook on file computes.

Program	Net reimbursement	Total fees	Net to practice
RPM — devices, weights & management	$2,843,849	$1,680,031	$1,163,818
CCM — chronic care management	$2,609,706	$1,347,657	$1,262,049
Implementation, Veradigm integration & telephonic outreach — included at no cost	—	$0	$0
24-month total	$5,453,555	$3,027,687	$2,425,867

By year	Net reimbursement	Total fees	Net to practice	Practice margin
Year 1	$2,169,757	$1,196,312	$973,446	44.9%
Year 2	$3,283,797	$1,831,376	$1,452,422	44.2%
24-month	$5,453,555	$3,027,687	$2,425,867	44.5%

Net reimbursement is stated after denials and after the share of patient coinsurance that does not collect. Net to the practice is stated after every CoachCare fee. The implementation fee, the Veradigm integration and telephonic outreach are included at no cost for SOFHA, so the only fee is the per-enrolled-patient program fee. Blended net reimbursement per active patient-month, on the same net basis, is approximately $90.32 for RPM and $104.15 for CCM. Because the cohort fills inside year one, Year 2 is a full year at steady state rather than a growth year. Illustrative, modeled — verify against practice data.

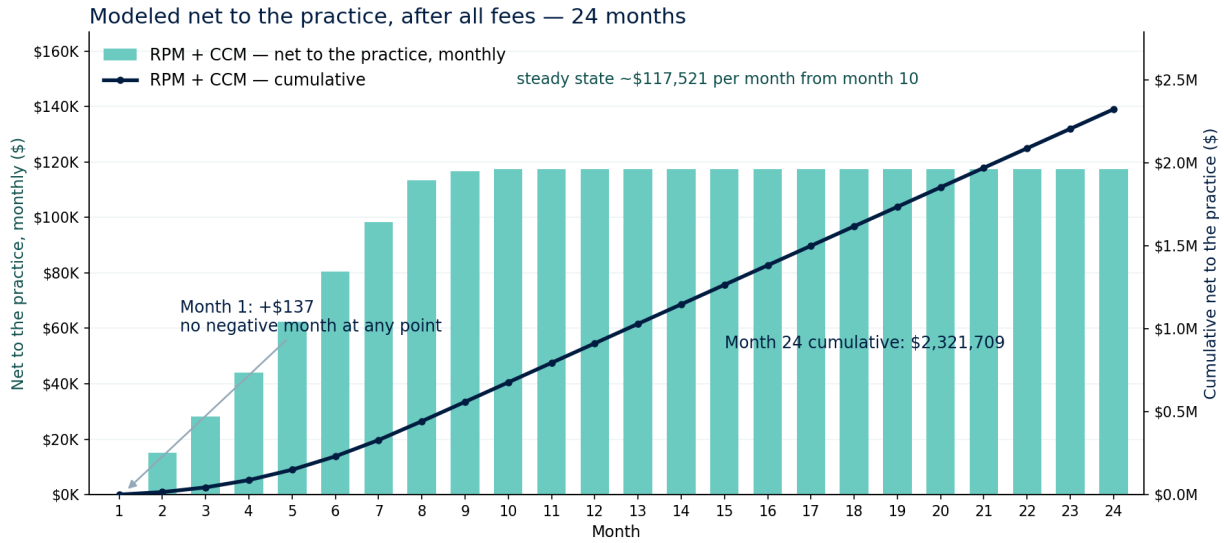

Figure 4 — Modeled net to the practice, after all fees, RPM + CCM. Monthly bars against the left axis, cumulative line against the right. Illustrative, modeled — verify against practice data.

MARGIN-POSITIVE FROM MONTH ONE — IN BOTH CONFIGURATIONS

Net to the practice is positive in month 1 (+$7,335) and in every month thereafter, reaching $32,390 by month 3 and roughly $121,035 per month at steady state from month 9. There is no negative month at any point, no J-curve to fund, no capital outlay, and no additional full-time employee to hire. The month-one figure is small because the enrolled census is small; the point is the sign, not the size.

With implementation, integration and outreach included at no cost, this holds for monitoring alone as well: the RPM-only comparison is +$4,350 in month one. Section 6.4 shows both.

The on-site enrollment specialist is staffed at CoachCare's expense. It is embedded value and is never subtracted from the practice's margin — it does not appear as a cost to SOFHA anywhere in this model, and it does not consume a SOFHA headcount slot.

6.4 Comparison configuration — RPM only

SOFHA asked to see monitoring on its own as well, so it is carried here. Switching CCM off removes roughly half the fee base and rather more than half the clinical contact — but, importantly, it does not change the avoided-admission line at all. The RPM-only column is derived from the same per-patient-month economics with CCM switched off, so read it as a directional comparison rather than a second workbook run.

Metric, 24 months	RPM + CCM (recommended)	RPM only (comparison)
Net reimbursement	$5,453,555	$2,843,849
Total fees (no one-time charges)	$3,027,687	$1,680,031
Net to the practice, after all fees	$2,425,867	$1,163,818
Practice margin, 24 months	44.5%	40.9%
Practice margin, year one	44.9%	not separately modeled
Active program enrollments at month 24	2,850	1,575
Unique patients at month 24	1,958	1,575
Hospitalizations avoided	~210	~210
Avoided admission cost	$3,148,557	$3,148,557
Net to the practice, month 1	+$7,335	+$4,350

THE MOST USEFUL FINDING IN THE COMPARISON

The avoided-admission figure is identical in both configurations — ~210 admissions, $3,148,557. Avoided admissions in this model are driven by RPM patient-months, and the RPM census is the same in both. Adding CCM does not change the modeled admissions effect; it changes the fee base, the medication-adherence contact, and the volume of care-team work absorbed.

So the case for adding CCM is not the avoided admissions. It is medication adherence — one of SOFHA's four stated goals, and a directly measured star measure — plus the documented monthly contact on 1,275 patients that supports the risk-side evidence base, plus $1,262,049 of additional retained margin and a better margin rate (44.5% against 40.9%) on the same cohort.

What it costs is a second set of billable charges on the same patients. Under full risk that is a judgement call about the loss ratio, and it is worth making deliberately rather than by default. With implementation, integration and outreach included at no cost, both configurations are margin-positive from month one: +$7,335 for RPM plus CCM and +$4,350 for RPM only.

6.5 Enrollment, saturation, and the honest ceiling

Program	Active enrollments at month 24	Ceiling reached
RPM	1,575	Month 8
CCM	1,275	Month 9
Total active program enrollments (services)	2,850	—
Unique patients at month 24, deduped	1,958	~70% cross-program dual enrollment

The two figures in that table measure different things and must not be conflated. 2,850 is the count of active program enrollments — services, not people. Because roughly 70% of enrolled patients carry both programs, the number of unique patients under management at month 24 is 1,958. Only the deduplicated figure may be described as patients.

The census reaches its ceiling well inside year one. RPM runs 81 active in month 1, 398 by month 3, 1,134 by month 6 and 1,575 — the ceiling — by month 8. CCM runs 59, 292, 832 and reaches its 1,275 ceiling in month 9. Month 12 and month 24 are the same number.

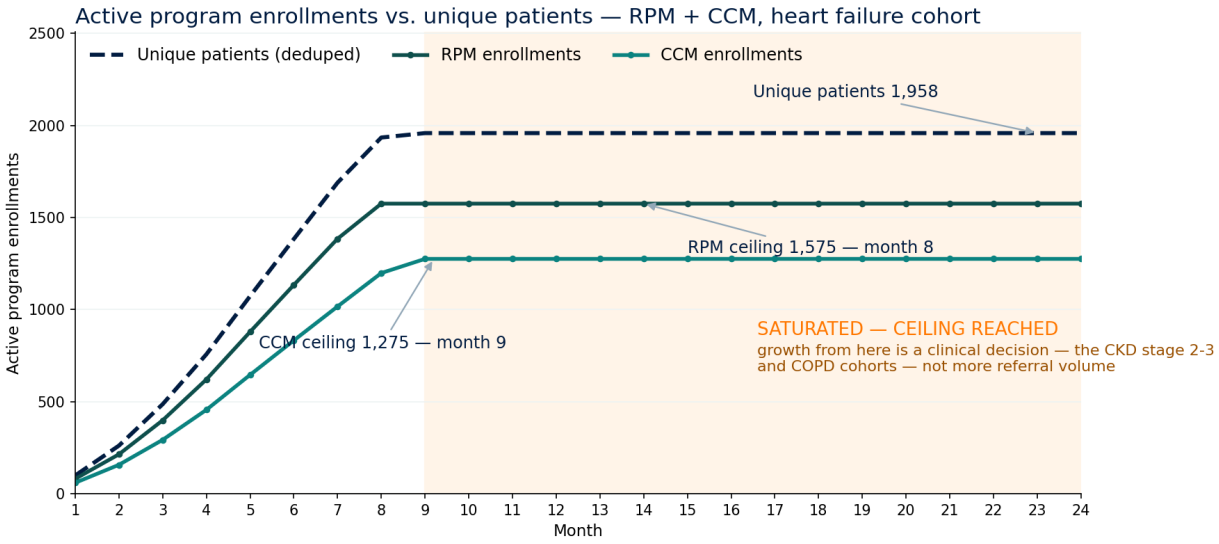

Figure 5 — Active program enrollments by program against unique patients, deduplicated for cross-program dual enrollment. The shaded region marks the saturation plateau.

AN HONEST FINDING: THIS COHORT SATURATES INSIDE YEAR ONE

Both programs reach their ceilings in the first year, and from that point the forecast is flat. This is not a modeling artifact and it is not hidden in the appendix — it is the most important structural fact about the scenario, and it is a direct consequence of defining the cohort tightly rather than opening it up.

The binding constraint is the cohort definition, not outreach capacity. The 73-provider referral engine, the on-site enrollment specialist and telephonic enrollment together generate more enrollment demand than 5,000 heart failure patients can absorb. Adding referral volume, adding providers or adding a second enrollment specialist would move the forecast very little — which is exactly the behavior a risk-bearing group should want from an enrollment engine.

The growth lever from there is a clinical decision, not a sales one: extending to the CKD stage 2–3 and COPD cohorts, both of which carry the same expensive-admission profile, once the admissions effect has been demonstrated on heart failure. That is a conversation with SOFHA's physician leadership and SOFHA's registry.

6.6 Operational value

Metric, 24 months	RPM + CCM	What it represents
Billed claims and units	109,903	Documented, billable events generated across RPM and CCM.
Physiologic readings captured	330,599	Transmitted weights and blood pressures that do not exist today — the data layer behind both the admissions effect and the risk-side evidence base.
Care-team hours absorbed	48,430 (~23.3 FTE)	Work absorbed by the partner rather than hired.

The care-team hours figure is the one to read carefully in this account. It is not a claim that SOFHA would shed 23.3 positions. It is the volume of enrollment, device logistics, triage, documentation and billing work that the service line generates and that the partner absorbs — work that would otherwise have to be hired for if the same census were built in-house. Set against a chronic care management program currently staffed by five nurses carrying roughly 330 patients a month, reaching 1,275 CCM enrollments is roughly four times

the current volume, and in-house programs of this kind typically wall out somewhere around 200 to 300 patients. That is a statement about cost and ceiling, not about quality.

EVERY FIGURE IN THIS SECTION

Illustrative, modeled — verify against practice data. The forecast rests on a discovery-stage cohort estimate, standing acceptance and attrition baselines, and CY2026 Tennessee locality rates. The Value Analysis is a fee-for-service model and does not represent capitated or shared-risk economics. Transitional care management, principal care management and Advanced Primary Care Management are excluded throughout.

7. Technology and Integration

7.1 The ambulatory EHR

SOFHA's ambulatory electronic health record is Veradigm, confirmed by SOFHA. Veradigm FollowMyHealth® is the patient-facing layer on top of it, hosted at sofha.followmyhealth.com. CoachCare integrates with Veradigm natively, and the integration reaches the practice management system as well as the chart — which is what makes the difference between an automated program and a manually administered one.

WHAT THIS SETTLES

The depth of automation available on day one is known, not contingent. Ordering and enrollment, documentation and claim creation are automated inside the workflow SOFHA's physicians already use. Nothing in the implementation plan depends on an integration that still has to be scoped.

The remaining technology question is a narrow one, settled at contracting: the exact Veradigm product and version, and the practice-management configuration the claims engine writes into.

7.2 What the native Veradigm integration delivers

This is what the integration delivers today, on SOFHA's own platform.

Capability	What it means operationally
Integrated ordering and enrollment	Enrollment flags and trigger ordering by service, with enrollment status visible in real time inside the existing clinical workflow — so a physician refers without leaving the chart.
Time to first service	Patients begin receiving CCM and RPM services in under five days from the order.
Health history exchange at intake	Problem list, medications and relevant history flow into the monitoring platform at intake rather than being re-keyed.
Vitals written into the chart	Integrated vital reports land in the chart as structured data rather than as PDF attachments — which is what makes the readings usable for quality measurement, not just for billing. Remote vitals file beneath the office-based vitals rather than mixing with them, so thousands of home readings do not dilute the office data used to finalize controlled-blood-pressure quality reporting.
Monthly supporting documentation	Evidence of Care, vitals and care plans attached to the chart monthly, in the form an audit expects.
Automated claims creation	Claims generated automatically into Veradigm Practice Management by the CoachCare billing engine, eliminating the manual per-patient, per-month claim step that makes in-house programs labor-intensive to scale.

ON AUTOMATED CLAIM GENERATION

CoachCare is the only care management application integrated with Veradigm Practice Management that provides automated claims creation.

This matters more than it sounds. In a manually billed program, every enrolled patient requires a person to confirm the criteria were met and to raise a claim, every month. At the modeled census of 2,850 active program enrollments that step alone is a full-time function — and it is the step that most commonly caps how large a nurse-staffed program can grow, well before the clinical capacity runs out.

Cost to stand up: nothing. The implementation fee, the Veradigm integration (setup, monthly and per-patient) and telephonic outreach are included at no cost for SOFHA. There are no one-time charges and no integration pass-through, every figure in Section 6 is stated on that basis, and there is no capital outlay.

8. Implementation Playbook

8.1 Cohort definition, enrollment gating and staffing

The goal of phase one is a service line that is live, billing and margin-positive inside the first month, on a cohort SOFHA has defined and approved, with no capital outlay and no additional full-time employees. Everything else is sequencing.

ENROLLMENT IS GATED, AND SOFHA HOLDS THE GATE

SOFHA was explicit on the 29 April call: it does not want every provider enrolling every patient against the loss ratio, and it wants its own care team screening candidates. That is the correct instinct on a risk-bearing book, and it is built into the operating model rather than promised around. Four mechanisms enforce it.

1. **The cohort is defined by ICD, jointly.** SOFHA's physician leadership and CoachCare agree the heart failure diagnosis definition before anything is built. The registry query is run against SOFHA's data, and the output is a list — not a rule that fires forever.

2. **SOFHA's care team screens and approves the candidate list.** Clinical suitability, likely adherence, device capability and patient responsibility are assessed before an enrollment conversation happens. Approval is SOFHA's, not the partner's.

3. **A referral flag outside the cohort does not auto-enroll.** If a provider flags a patient who is not on the approved list, the referral is held for review rather than actioned. There is no path by which enrollment volume grows without SOFHA deciding it should.

4. **Cohort expansion is a governed decision.** Adding the CKD stage 2–3 or COPD cohorts, or widening the heart failure definition, requires the same joint sign-off as the original list. Growth is a clinical decision reviewed quarterly, not an outreach target.

PHASE-ONE POPULATIONS

Target population	Program	Why first
Heart failure cohort — 5,000 patients, selected by ICD	RPM + CCM	The agreed scope. Daily weight plus blood pressure is the canonical protocol, the admissions it prevents are the expensive ones, and the cohort is definable and therefore gateable. Start with the sickest, not the largest: the launch list is the heart failure patients with a hospitalization or ER visit in the last 12 months.
Heart failure patients discharged from SOFHA's own hospitalist service	TCM → RPM → CCM	Both ends of the handoff are internal, and the thirty days after a heart failure discharge are the highest-yield window in the account. Excluded from the forecast as upside.
Heart failure patients already enrolled in the chronic care management program	CCM + RPM	Consent, care plan and a physician-governed program already exist. The addition is the device layer and the capacity to carry the census.
CKD stage 2–3 cohort	phase two	Same expensive-admission profile. Not modeled here; a governed expansion decision once the admissions effect is demonstrated.
COPD cohort	phase two	Same expensive-admission profile. Not modeled here.

STAFFING MODEL

- **SOFHA's RNs and CCM® -certified care managers stay clinical.** They review exceptions, adjust care plans, and make the calls that require a license. They do not chase enrollment, manage device logistics or assemble claims. The five-nurse chronic care management team keeps its physician-board governance and gains capacity rather than responsibility.
- **One on-site enrollment specialist, funded by CoachCare.** Physically present in SOFHA clinics, working the approved candidate list and consenting patients — and staffed at CoachCare's expense. This is embedded value; it is never subtracted from the practice's margin and it does not occupy a SOFHA headcount slot.
- **24/7 alert triage supplied by the partner, against SOFHA's thresholds.** Out-of-range readings are triaged before they reach SOFHA's team, so the clinical staff see exceptions rather than raw data. Under 10% escalation is the operating target. The thresholds are SOFHA's; see Section 8.2.
- **Telephonic enrollment as the third pathway,** running alongside physician referral and the on-site specialist rather than replacing either — and restricted to the same approved list.
- **Clinical pharmacists as the titration tier.** Four PharmDs already sit inside SOFHA. Pharmacist-led diuretic and guideline-directed medical therapy titration on transmitted weights is the highest-yield use of that capability, and it is where the medication-adherence goal is actually met.

8.2 Protocol governance and scripting control

SOFHA asked for control of the clinical protocols and of what is said to its patients. That is a reasonable requirement and a standard part of implementation, not a concession. A health coach must never contradict the provider — the program is only useful if the patient hears one voice.

What SOFHA controls	How it works	When it is set
Clinical standard operating procedures	CoachCare's standard SOPs for heart failure monitoring are reviewed line by line with SOFHA's physician leadership and customized before go-live. They are SOFHA's protocols running on CoachCare's engine, not the other way round.	Implementation, before the first enrollment.

What SOFHA controls	How it works	When it is set
Alert thresholds	Weight-change, blood-pressure and symptom thresholds are tunable per condition and per patient, and are adjusted as the program learns which alerts are producing action and which are noise.	Implementation, then continuously.
Escalation pathways	What happens on an alert, in what order, and who is called. SOFHA's Acute Care Clinic, home-visit arm and on-call structure define the destinations; the partner routes into them.	Implementation, reviewed quarterly.
Health-coach scripting	The scripts used on monthly care-management calls — including how medication adherence, symptom checks and escalation are worded — are reviewed and approved by SOFHA. Anything clinical that is not in an approved script routes to a SOFHA clinician rather than being improvised.	Implementation, reviewed quarterly.
Patient-facing language on cost	How patient responsibility is explained at consent, including the QMB and dual-eligible case where no balance billing applies.	Implementation.
Documentation standards	What lands in the chart, in what form, and against which care-plan elements — so that the documentation satisfies SOFHA's own audit expectations, not merely the claim.	Implementation.

ONE VOICE TO THE PATIENT

The governance rule is simple: no clinical statement reaches a SOFHA patient that SOFHA's physicians have not approved. Scripts, thresholds and escalation paths are SOFHA's. The partner supplies the labor, the devices, the triage capacity and the documentation engine — and operates inside SOFHA's clinical envelope.

Where a patient question falls outside the approved script, it routes to a SOFHA clinician. That is a defined workflow step, not an exception. Two rules are not negotiable: a critical value escalates regardless of symptoms, and an active emergent symptom reported during outreach moves straight to the emergency pathway with the patient still on the line.

STATED PLAINLY

Overnight coverage exists, but this is not true telemetry monitoring — nobody is watching a live feed at 3am and calling the minute a reading lands. Out-of-hours escalation routes into whatever after-hours coverage SOFHA already operates, and that pipe is configured during implementation.

8.3 Clinical workflow and architecture

1. Identify. Run SOFHA's registry against the agreed heart failure ICD definition and rank by admission risk, recent discharge and open quality gaps.

2. Screen and approve. SOFHA's care team reviews the candidate list for clinical suitability, likely adherence and device capability. The approved list is the enrollment universe; nothing outside it is worked.

3. Refer. Physician orders the service inside the chart at an office visit; enrollment status is visible in the workflow rather than in a separate system. A flag on a patient outside the approved list is held for review.

4. Enroll and consent. On-site specialist completes consent using SOFHA-approved language, explains patient responsibility where it applies, and schedules device delivery. Enrollment begins in month one; there is no onboarding delay modeled.

5. Instrument. Connected scale and blood-pressure cuff shipped and activated; two days of readings establish 99453; thresholds set per SOFHA's protocol and tightened for recently discharged patients.

6. Monitor and triage. Readings transmit daily; partner-supplied team triages 24/7 against SOFHA's thresholds; only exceptions route to SOFHA's nurses.

7. Act. Nurse or pharmacist titrates against SOFHA's protocol; physician is engaged on clinical exceptions; the Acute Care Clinic or a home visit absorbs deterioration that would otherwise become an admission. This step is where the avoided admission is actually produced.

8. Document and bill. Time, readings and care-plan touches are captured as a by-product of the work; the claim is generated automatically each month.

9. Measure. Admissions per 1,000 in the enrolled cohort, enrolled census, capture rate, adherence and net per patient per month reviewed monthly against the scorecard below.

8.4 Scorecard and 12-month roadmap

Domain	Metric	Why it is on the scorecard
Cost of care	Admissions per 1,000 in the enrolled cohort, against a matched unenrolled comparison; 30-day readmission	The first metric on the board, because it is the one the risk contracts are scored on. Everything else supports it.
Adherence	Proportion of enrolled patients adherent to guideline-directed therapy; refill gaps closed per month	A stated SOFHA goal, a directly measured star measure, and the mechanism through which the monthly CCM contact earns its place.
Clinical	Alerts producing a documented action; time from alert to action; readings per enrolled patient per month	Distinguishes a monitoring program that generates data from one that prevents admissions.
Transitions	TCM capture rate on SOFHA-attributed heart failure discharges; conversion to ongoing RPM at day 15	The lever unique to this account, because both ends of the handoff are internal.
Growth	Active program enrollments by program; unique patients under management	Two separate numbers, never conflated. Services drive revenue; patients drive clinical load.
Gating	Referrals held for review as a share of referrals received; cohort additions approved	Evidence that the gate is working. A rising hold rate is a sign the gate is doing its job, not a sign of friction.
Capture	Billable months captured as a share of eligible months	The gap between what was clinically delivered and what was billed is where nurse-staffed programs lose money.
Financial	Net reimbursement per active patient-month; net to the practice per month	Confirms the modeled per-patient-month economics against reality, early.

Phase	Months	What happens
Confirm and design	Pre-launch	Agree the heart failure ICD definition and replace the 5,000 estimate with a registry count; confirm the Veradigm product, version and practice-management configuration; review and customize the clinical SOPs, thresholds and coach scripting with physician leadership; set the enrollment gate and the approval workflow; confirm plan-level coverage and the capitated treatment of these codes with each Medicare Advantage payer; set the attribution policy.
Launch the cohort	Months 1–3	Instrument the approved heart failure list, starting with patients who have a hospitalization or ER visit in the last 12 months. On-site enrollment specialist in clinic. First claims out in month one. Weekly capture review and weekly alert-to-action review. Roughly 690 active enrollments by day 90.

Phase	Months	What happens
Chain the discharge	Months 4–8	Turn on the post-discharge chain with the hospitalist service. Pharmacist-led titration protocols live. RPM census reaches its ceiling around month 8.
Scale to ceiling	Months 6–12	CCM census reaches its ceiling around month 9, and both censuses are fully built inside the first year. Scorecard shifts from growth to capture, adherence and admissions.
Measure and decide	Months 12–24	Read admissions per 1,000 against the comparison group; re-run the risk-side economics against SOFHA's ACO REACH and Medicare Advantage contracts with real data; quantify the TCM contribution; take the documented outcomes into the LEAD-versus-MSSP decision; decide on the CKD stage 2–3 and COPD cohorts.

9. Discovery Agenda — What We Validate First

This report is deliberately explicit about what it does not know. The items below are ordered by how much they move the answer. Each is a question for SOFHA, not an assumption made on SOFHA's behalf.

1. The heart failure cohort count, against an agreed ICD definition. The 5,000 figure is the agreed modeling scope, not a chart count, and the ~32,000 Medicare population behind it is a discovery-stage estimate. Replace both with SOFHA's own counts and every figure in Section 6 rescales accordingly. This is the softest input in the model.

2. SOFHA's own heart failure admission and readmission rates. The ~210 avoided admissions are a modeled effect derived from RPM patient-months, valued at roughly $15,000 each. With SOFHA's actual rates and its actual per-admission cost, the single most important number in this report stops being an estimate.

3. The risk contracts themselves. The ACO REACH arrangement and the Medicare Advantage risk contracts — what share of the heart failure cohort sits inside each, how these codes are treated under capitation, and what an avoided admission is actually worth under each. This is what converts the avoided-cost line from a bridge into a modeled return.

4. Where SOFHA lands on LEAD versus a return to MSSP. The operating capability is the same either way, but the timing of the decision affects sequencing and the evidence base the program should be producing by which date.

5. Medicare Advantage plan-level coverage and contracted rates. For each Medicare Advantage payer: code-level coverage for RPM and CCM, prior-authorization posture, how these services interact with each plan's quality program, and how they are treated inside a capitated arrangement.

6. The enrollment gate, in operational detail. Who on SOFHA's care team approves the candidate list, on what cadence, against what criteria, and what happens to a held referral. The principle is settled; the workflow is not.

7. Which sites and which providers are in phase one. The 73-provider figure is drawn from SOFHA's published directory. Phase-one scope should be set by site readiness, not by the full count.

8. Discharge volume attributable to SOFHA's heart failure cohort. Transitional care management is excluded from the forecast because this number is not publicly documented. With it, the TCM contribution can be quantified rather than described.

9. **How the current chronic care management program is billed today.** SOFHA confirmed the staffing and the monthly volume. What technology sits behind it, and how it is billed, was not established and is not assumed anywhere in this report.

10. **The exact Veradigm product and version, and the practice-management configuration.** A contracting-stage confirmation rather than an open question — the integration itself is native and the automation is known. This simply pins the build to the right instance.

11. **Current NCQA Patient-Centered Medical Home recognition status.** Recognition is claimed by SOFHA and corroborated indirectly by the November 2019 Behavioral Health Integration Distinction, which requires it. The current year and scope are unverified.

> **THE FIRST THREE ARE THE ONES THAT MOVE THE ANSWER**
>
> The cohort count, SOFHA's own heart failure admission rates, and the treatment of these codes inside the risk contracts. Everything else in this list refines the forecast; those three determine whether it is the right forecast.
>
> Advanced Primary Care Management is presented throughout this report only as a fee-schedule primary care management service billable in Original Medicare. It is switched off in every modeled figure and SOFHA is not billing it today.

References and Data Sources

SOFHA PUBLISHED SOURCES, RETRIEVED JULY 2026

- State of Franklin Healthcare Associates — About Us, Our Story, Executive Leadership, Physician Leadership, Awards and Achievements
- Clinic Locations (21 sites across Johnson City, Kingsport, Bristol and Elizabethton, TN, and Gate City, VA)
- Chronic Care Management / Senior Services program page and its six component pages
- Case Management and Care Coordination (CCM® -certified RNs, LPNs and lay coordinators; 3–5 day post-discharge appointments)
- Medicare Chronic Care Management Program page
- Elevated Blood Pressure Program page
- Diabetes Clinic (ADA-recognized DSME with ETSU Bill Gatton College of Pharmacy; professional CGM)
- Home Visits for SOFHA Patients; Palliative Care; Pharmacy Services; Laboratory; Imaging Center; Cardiovascular Imaging; Sleep Services; Hospitalists; Physical Therapy; Acute Care Clinic (launched 2015)
- Patient Portal page (Veradigm FollowMyHealth®); ambulatory EHR confirmed as Veradigm directly by SOFHA, July 2026
- NCQA Distinction in Behavioral Health Integration announcement, November 2019
- Provider directory, WordPress REST API, retrieved 23 July 2026 — 205 provider records

GOVERNMENT AND PUBLIC DATA

- CMS Doctors and Clinicians National Downloadable File — State of Franklin Healthcare Associates, PLLC, group PAC ID 2466346291; 247 distinct NPIs, 272 group members
- CMS Medicare Monthly Enrollment, April 2026 — county-level total Medicare, Original Medicare, Medicare Advantage and dual-eligible counts for Washington, Sullivan, Carter, Greene, Unicoi (TN) and Scott (VA)

- CMS Medicare Physician Fee Schedule, CY2026 — non-facility rates, Palmetto GBA carrier 10312, locality 35 (Tennessee); CY2026 addition of HCPCS 99445 and 99470
- CMS Medicare Shared Savings Program, PY2026 Accountable Care Organization Participants file — SOFHA does not appear for PY2026; SOFHA has participated previously and is weighing a return
- CDC PLACES: County Data (GIS Friendly Format), 2024 release — model-based small-area estimates, crude prevalence, adults 18+
- CMS Innovation Center — ACO REACH model, ending 31 December 2026; LEAD Model (Long-term Enhanced ACO Design), Request for Applications released 31 March 2026, first-performance-year applications closed 17 May 2026, performance period 1 January 2027 through 2036

CONFIRMED DIRECTLY BY SOFHA, DISCOVERY CALL OF 29 APRIL 2026

- ACO REACH participation for the traditional Medicare population; risk contracts on the Medicare Advantage book, described as full-risk capitated Medicare contracts; active modeling of the LEAD Model against a return to the Medicare Shared Savings Program
- Chronic care management program staffed by 5 nurses carrying roughly 330 patients per month, centralized across all clinics and administered by a physician board member
- No remote patient monitoring program today; Advanced Primary Care Management not billed today
- Ambulatory EHR confirmed as Veradigm; Veradigm integration, implementation and telephonic outreach included at no cost
- Agreed value-analysis scope: 5,000 heart failure patients
- Stated goals: reduce admissions per 1,000, reduce hospitalizations, improve medication adherence, reduce overall cost, while improving outcomes
- Scope limited to Medicare, Medicare Advantage and the QMB / dual-eligible population; commercial payers out of scope on patient-responsibility grounds

COACHCARE

- CoachCare Value Analysis, Tennessee locality build, heart failure cohort, RPM + CCM, July 2026 — the modeled forecast in Section 6
- CoachCare Veradigm integration overview — integrated ordering and enrollment, health history exchange, integrated vital reports, monthly supporting documentation, automated claims creation
- CoachCare Care Management Programs — standard operating procedures. The escalation logic, trend definitions, emergent pathway and post-discharge cadence referenced in Sections 4 and 8 are recreated from those procedures

GLOBAL CAVEAT

Every financial figure in this report is illustrative and modeled and must be verified against practice data. The heart failure cohort size and the Medicare population behind it are discovery-stage estimates, not chart counts. Fee schedule amounts are locality-adjusted, set by the regional Medicare Administrative Contractor, and change annually — confirm current CY2026 amounts before relying on any of them.

The Value Analysis is a fee-for-service model. It does not model capitated or shared-risk economics, and on capitated lives the fee revenue behaves differently. The avoided-admission figure is the bridge between the two, and the actual risk-side impact has to be modeled against SOFHA's own contracts. No shared-savings distribution, capitation adjustment or quality bonus appears in any modeled figure.

Transitional Care Management, principal care management and Advanced Primary Care Management are excluded from every modeled figure. Advanced Primary Care Management is referred to only as a fee-schedule service billable in Original Medicare. The on-site enrollment specialist is staffed at CoachCare's expense and is never subtracted from the practice's margin.

Connor Knapp · CoachCare · connor.knapp@coachcare.com

Discovery-stage business case · July 2026