COACHCARE | SERVICE LINE STRATEGY

Valley Clinics

An independent, privately owned adult primary care and internal medicine practice in Oregon's Willamette Valley: three offices in Corvallis, Albany and Salem, nine adult-medicine clinicians, a certified Patient-Centered Primary Care Home, and a Medicare panel inside a full-risk accountable-care arrangement

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line for the Medicare panel across three offices: remote physiologic monitoring, chronic care management and transitional care at every discharge, billed under the CY2026 rules at Oregon locality 99 amounts, run inside Practice Fusion, staffed by CoachCare and owned by the practice

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the owners and leadership of Valley Clinics. It brings together the shape of the practice's Medicare panel as the CY2024 claims files show it, the accountable-care position the practice holds in 2026, the three counties its patients live in, the record system the program would live in, and a 24-month financial forecast priced at the practice's own Medicare locality.

The argument is short. The practice already manages a multi-chronic Medicare panel in thirty-minute visits, already integrates behavioral health, and already sits inside an arrangement that pays for keeping those patients out of the hospital. What the claims do not show is a monthly, staffed program between the visits. This report shows what that program returns on this panel, who does the work, and how it starts without capital or a hire.

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Executive Summary

Valley Clinics is a privately owned adult primary care and internal medicine practice with three offices in Oregon's Willamette Valley: Corvallis, Albany and Salem. It describes itself as veteran owned and operated, holds Patient-Centered Primary Care Home certification from the Oregon Health Authority, schedules thirty-minute visits by design, offers same-day appointments and integrates behavioral health with primary care. The public roster is three physicians, five physician assistants and one family nurse practitioner in adult medicine, with a licensed professional counselor alongside them. The practice runs Practice Fusion.[1]

The panel that matters here is the Medicare panel across the three offices. The CY2024 Medicare fee-for-service claims for the clinicians billing at the practice describe it: an average age of 71 to 75, a weighted risk score of 1.17, and **hypertension in 71% of beneficiaries, hyperlipidemia in 72%, diabetes in 30%, chronic kidney disease in 28%, depression in 28%, COPD in 18% and heart failure in 13%**. Fifteen distinct services were billed, annual wellness visits and advance care planning among them, and no chronic care management, remote monitoring, transitional care, principal care, advanced primary care management or behavioral health integration code appears on any clinician in CY2023 or CY2024. The forecast in Section 6 covers a Medicare panel of 1,800 across the three offices, 1,440 of them in scope.[2]

Two facts set this account apart from the usual independent-practice workup. The practice's clinicians are participant providers in **an ACO REACH entity on the Global option**, the full-risk track, verified in CMS's own eligibility records for 2026, and the practice has run voluntary Medicare alignment from its website since 2020. ACO REACH ends December 31, 2026, and the practice's 2027 arrangement is not confirmed. Whatever follows will want the same thing the current arrangement rewards: a consented, documented, monthly relationship with the panel. That is what this service line builds, under fee-for-service, on the practice's own billing.[3]

The observation this report is built on

The panel is here. The conditions are here. The between-visit billing is not.

Valley Clinics already does the hard part: it holds a multi-chronic Medicare panel, sees it in thirty-minute visits, runs a certified primary care home and sits inside a full-risk arrangement. What the CY2024 claims show is that none of the between-visit work is billed as a program at meaningful scale under any practice clinician. The service line in this report is that program, supplied and staffed by a partner, governed by the practice's clinicians, billed under Valley Clinics, and built to outlast the 2027 model change.

What the Value Analysis returns

	Year 1	Year 2	24 months
Net reimbursement	**$582,623**	**$801,022**	**$1,383,644**
CoachCare fees	$341,496	$455,352	$796,848

[1] valleyclinics.com home, location, services and mental-health pages, retrieved September 22, 2026: three offices (Corvallis, Albany, Salem); "veteran owned & operated" on each location page; Patient-Centered Primary Care Home certification by the Oregon Health Authority stated on the site; thirty-minute visits; same-day appointments; integrated mental health for established patients. Roster: 2 DO, 1 MD, 5 PA-C, 1 FNP, 1 LPC. Patient Portal link resolves to the Practice Fusion patient portal.

[2] CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024, the eight roster clinicians with rows: 706 beneficiary-clinician pairs; $285,918 allowed; 71 dual-eligible; weighted HCC risk 1.17; average age 71 to 75; beneficiary-weighted prevalence hypertension 71%, hyperlipidemia 72%, diabetes 30%, chronic kidney disease 28%, depression 28%, COPD 18%, heart failure 13%; 145 G0439 beneficiaries; 15 distinct HCPCS codes; no 99490, 99439, 99491, 99487, 99453, 99454, 99457, 99458, 99091, 99445, 99470, 99495, 99496, 99424 to 99427, G0556 to G0558 or 99484 on any roster clinician in CY2023 or CY2024.

[3] CMS Quality Payment Program eligibility API, performance years 2025 and 2026: apmName "ACO REACH MODEL", subdivision "ACO REACH - GLOBAL", providerRelationshipCode P, advancedApmFlag true, for seven of the nine adult-medicine clinicians under the practice's billing entity in 2026. CMS ACO REACH Providers file, PY2024: the practice's legal business name as a participant provider. valleyclinics.com/medicare-alignment, first captured by the Internet Archive September 27, 2020. ACO REACH model end date December 31, 2026, per CMS.

	Year 1	Year 2	24 months
Net to the practice	**$241,126**	**$345,670**	**$586,796**
Practice margin	41.4%	43.2%	**42.4%**

CoachCare Value Analysis: 1,800 Medicare patients across three offices, 1,440 in scope, RPM + CCM, 9 referring clinicians, one CoachCare-funded on-site enrollment specialist at 80 enrollments a month, CY2026 fee schedule at the Oregon locality 99 amounts. Margin is net to the practice divided by net reimbursement. Transitional care management is recommended and is not in the forecast.

One market fact sits under every number above. Medicare Advantage covers 49% of Benton County's Medicare beneficiaries, 61% of Linn County's and 65% of Marion County's, about 57% across the three offices weighted by clinician count. 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 is priced at the Medicare fee schedule for the whole panel.

1. **The service line is positive from month 2.** Month 1 nets −$4,783 on 42 enrollments, because the one-time implementation and Practice Fusion integration setup post ahead of the ramp. Month 2 nets $4,764, month 3 $8,983, and the program holds $28,806 a month from month 8 once both programs are full.
2. **Nobody at the practice is hired.** CoachCare delivers 11,739 care-team hours over 24 months, about 5.6 full-time-equivalent years of care-management labor. The on-site enrollment specialist, the care managers and the device logistics are CoachCare's payroll, embedded in the fee, never deducted from practice margin. The nine clinicians refer and supervise; the practice's own billing department files the claims.
3. **The margin holds at about 42% whatever the panel turns out to be.** At a 1,400-patient panel the program returns $467,580 to the practice over 24 months; at 2,400 it returns $751,681; at 3,000, $900,326. The fee scales with the census, so the margin stays between 41.9% and 42.6% in every run. Section 6.4 is the table.
4. **The binding constraint is the eligible Medicare panel, not outreach.** Remote monitoring reaches its ceiling of 328 active enrollments in month 7 and chronic care management reaches its ceiling of 324 in the same month. From then on the program holds 652 active program enrollments across 425 unique patients, which is every patient the two programs can take on a 1,440-patient in-scope panel. The chart count by office is discovery item number one.
5. **Transitional care management belongs on the stack, and is not in the forecast.** The practice's patients are admitted at the two regional health systems and come back to their own primary care home afterwards. The two-business-day contact and the 7- or 14-day visit that 99495 and 99496 pay for are the cadence the program already runs; CoachCare makes the first call and the practice bills the episode.
6. **The program lives in Practice Fusion.** A certified cloud record with a FHIR patient-data API and a patient portal the practice's patients already use. CoachCare integrates over FHIR for reads and document exchange for documentation; the integration is priced as a custom integration in the forecast, with scope confirmed in contracting. Section 4 is the path.
7. **Advanced primary care management is the named next lever, at zero dollars.** The practice's verified value-model participation clears the eligibility gate for the APCM codes. The choice between chronic care management and APCM depends on real enrollment data and on the arrangement that follows ACO REACH in 2027, so this forecast carries the codes at zero. Section 3.2 frames it.
8. **The CY2027 proposed rule takes 5.7% off this line and leaves the case intact.** A 20.6% cut to device supply is a 9.7% change to the remote-monitoring arm and 5.7% to the whole service line, $78,795 over 24 months. Section 7 draws the cascade.

1. The Practice, and the Panel It Already Manages

1.1 Three offices in the Willamette Valley

Valley Clinics is an independent adult primary care and internal medicine practice with three offices along the Interstate 5 corridor between Corvallis and Salem. Each office lists its own clinicians and its own hours; all three share one record system, one billing department and one certification as a Patient-Centered Primary Care Home. The practice schedules thirty-minute visits, offers same-day appointments, takes walk-ins for acute migraine, runs telehealth, and integrates a licensed professional counselor with primary care for established patients.[4]

Office	County	Adult-medicine clinicians	What it means for this program
Corvallis **981 NW Spruce Ave**	Benton	**Four**	The largest office and the launch site. Benton County is 49% Medicare Advantage, the lowest of the three, so the fee-for-service share of the panel is highest here
Albany **3388 Pacific Blvd SW**	Linn	**Two**	Switched on in the second wave on the same protocols and the same integration; Linn County is 61% Medicare Advantage
Salem **350 Miller St SE**	Marion	**Three**	The newest office, open since 2022, in the largest Medicare county of the three; Marion is 65% Medicare Advantage

valleyclinics.com location pages, retrieved September 22, 2026. Clinician counts are the practice's own listings by office; the licensed professional counselor works across Albany and Salem and is not counted as a referring clinician.

Two other pieces of the practice matter to enrollment. The thirty-minute visit is the enrollment conversation: there is time in it to explain a cuff, sign a consent and place a referral order without moving the schedule. And the patient portal is already in use, so device instructions, the monthly check-in and the care plan have a channel the patient recognizes. A practice that recruits on the promise of chronic and complex disease management, and targets thirteen to sixteen visits a day per clinician, has no spare hours for a monitoring program of its own. That is the gap the partner model fills.

1.2 What the CY2024 claims say

The CY2024 Medicare by-provider and by-provider-and-service files were queried for every clinician on the practice's public roster. Eight of the nine adult-medicine clinicians carry a CY2024 row; two physicians do not, because their Medicare volume sat under the eleven-beneficiary suppression floor or they joined after CY2024. The profile below is the fee-for-service population the clinicians billing at the practice already see.[5]

CY2024 Medicare fee-for-service, clinicians billing at the practice	Value
Beneficiary-clinician pairs	**706**
Medicare allowed amount	$285,918
Dual-eligible beneficiaries	71
Annual wellness visits, G0439 (beneficiaries)	145
Distinct services billed	15

[4] valleyclinics.com/corvallis, /albany, /salem, retrieved September 22, 2026: addresses, hours (Corvallis Monday to Friday; Albany Monday to Thursday; Salem Tuesday to Friday) and clinician listings by office. Salem page first captured by the Internet Archive May 24, 2022. valleyclinics.com/careers: open positions for a mental health therapist (Corvallis) and an internal medicine physician assistant or nurse practitioner (Salem) with a target of 13 to 16 visits a day.

[5] CMS Medicare Physician & Other Practitioners by Provider (dataset 8889d81e-2ee7-448f-8713-f071038289b5) and by Provider and Service (dataset 92396110-2aed-4d63-a6a2-5d6207d46a29), CY2024 vintage, and the CY2023 equivalents, retrieved September 22, 2026, queried by rendering NPI for each roster clinician. The organization NPI returns no rows because the file is rendering-NPI only. Two physicians (the MD and one DO) have no CY2024 row.

CY2024 Medicare fee-for-service, clinicians billing at the practice	Value
Chronic care management, remote monitoring, transitional care, advanced primary care management, behavioral health integration	none on any practice clinician
Average beneficiary age	**71 to 75**
Weighted HCC risk score	**1.17**
Hypertension	**71%**
Hyperlipidemia	72%
Diabetes	30%
Chronic kidney disease	28%
Depression	28%
COPD	18%
Heart failure	13%

CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024, the eight roster clinicians with rows. CMS suppresses counts under 11. Pairs count a patient once per clinician seen; prevalence is weighted by beneficiaries.

Read the two halves of that table together. The lower half is the profile remote care is built for: an older panel where seven in ten beneficiaries carry hypertension, three in ten are diabetic, nearly three in ten have chronic kidney disease and nearly three in ten carry a depression diagnosis. The chronic care management codes require two or more chronic conditions expected to last a year, which on this panel is most patients. The remote monitoring codes want a condition whose readings change treatment between visits, and hypertension with diabetes is the largest such cohort here.

The upper half is the shape of the billing around that panel. Annual wellness visits, advance care planning and the longitudinal-care add-on G2211 are all billed, which means the practice already documents a continuing relationship with these patients. What the claims do not show is a monthly, staffed program between the visits: **no remote-care or care-management program at meaningful scale is visible in the CY2023 or CY2024 claims under any practice clinician**. Section 3.4 bounds that claim.[6]

1.3 The accountable-care position

CMS's Quality Payment Program eligibility records for 2025 and 2026 place seven of the nine adult-medicine clinicians, under the practice's own billing entity, inside **an ACO REACH entity on the Global option**, as participant providers. The CMS ACO REACH provider file for 2024 lists the practice's legal business name as a participant provider in the same model. The practice is not a Medicare Shared Savings Program participant in 2026. Its website has carried a voluntary Medicare alignment page since 2020, asking patients to name a primary clinician in their Medicare account, which is the mechanism the model uses to attribute beneficiaries.[7]

Three consequences follow. First, the Global option is full risk: the ACO is paid on the total cost of care of its aligned beneficiaries, and fewer emergency visits and admissions among a hypertensive, multi-chronic panel are exactly what remote monitoring and chronic care management produce. The practice's fee-for-service care-management revenue therefore also serves a full-risk ledger. Second, the practice's verified participation clears the value-model gate for the advanced primary care management codes, which

[6] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2023 and CY2024, every clinician-and-code row for the roster searched for 99453, 99454, 99457, 99458, 99445, 99470, 99490, 99491, 99439, 99487, 99489, 99424 to 99427, 99484, 99091, G0556 to G0558, 99495 and 99496: none. Present on most clinicians: 99213 to 99215, G0439, 99497, G2211, G0008, G0009, 36415, 93000, 96372. CMS suppresses clinician-and-code lines under 11 beneficiaries.

[7] CMS Quality Payment Program eligibility API, performance years 2025 and 2026 (note 3). CMS ACO REACH Providers file, PY2024, provider class PART. CMS Medicare Shared Savings Program participant file, 2026-01-01: no Valley Clinics entity. ACO REACH and the Shared Savings Program are mutually exclusive for the same billing entity.

Section 3.2 takes up. Third, ACO REACH ends December 31, 2026, and the practice's 2027 arrangement is not confirmed. The Value Analysis in Section 6 is fee-for-service and does not model any distribution from the ACO; any care-management resources the ACO supplies to its practices are a co-existing layer, and whether the practice uses them is a discovery item. Because the clinicians are Advanced Alternative Payment Model participants in 2026, the same monthly documentation also stands behind whatever quality reporting the practice carries.

1.4 The three counties, and the rate basis

Office	County	Medicare beneficiaries, CY2025	Medicare Advantage share, September 2026	Dual-eligible share
Corvallis	Benton	19,539	**49.3%**	12%
Albany	Linn	32,740	61.1%	19%
Salem	Marion	71,448	64.8%	20%

CMS Medicare Monthly Enrollment, county level, CY2025; CMS Medicare Advantage State/County Penetration, September 2026. About 46,700 beneficiaries across the three counties remain in Original Medicare.

About half of Benton County's Medicare beneficiaries and roughly two thirds of Linn and Marion counties' are in a Medicare Advantage plan; weighted by the clinicians at each office, the practice's markets are about 57% 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 in Section 6 is priced at the Medicare fee schedule for the whole panel; which plans hold the practice's members, and their terms for these code families, is the second thing to confirm after the chart count.[8]

The rate basis follows the geography. All three offices fall in Oregon locality 99, "Rest of Oregon", under the Noridian JF contractor. It is a mid-table locality, ranked 37th to 42nd of the 109 localities on the care-management codes and 2 to 3% under the national median: 99490 pays $65.32, 99454 pays $51.80 and 99457 pays $51.25 at the CY2026 non-facility amounts. Every dollar in this report is priced at the locality 99 amounts.[9]

2. Why This Year

Three things line up for an independent Willamette Valley primary care practice in 2026, and one of them has a date attached.

What changed	Why it matters to Valley Clinics
CY2026 opened the short-window remote monitoring codes	99445 pays for device supply when a patient transmits on 2 to 15 days of a 30-day period, at the same $51.80 as the 16-day code, and 99470 pays $25.79 for 10 to 19 minutes of treatment management. Before 2026 a patient who transmitted on twelve days earned nothing for the month. On a panel that averages 71 to 75 years, partial-month adherence is the normal case. On this forecast the two new codes carry about 17% of remote-monitoring reimbursement[10]

[8] CMS Medicare Advantage State/County Penetration, September 2026: Benton 49.30%, Linn 61.11%, Marion 64.78%. CMS Medicare Monthly Enrollment, county level, CY2025: Benton 19,539 beneficiaries (dual 12.0%), Linn 32,740 (18.8%), Marion 71,448 (19.8%); about 46,700 Original Medicare beneficiaries across the three counties. Office weighting by adult-medicine clinicians: Corvallis 4, Albany 2, Salem 3, giving 57.1%.

[9] CY2026 Medicare Physician Fee Schedule, non-facility amounts, Noridian JF carrier 02302, Oregon locality 99 "Rest of Oregon" (Benton, Linn and Marion counties); geographic indices work 1.000, practice expense 0.996, malpractice 0.703; conversion factor $33.4009: 99490 $65.32; 99439 $49.84; 99453 $21.43; 99454 and 99445 $51.80; 99457 $51.25; 99458 $40.94; 99470 $25.79; G0556 $16.14; G0557 $53.17; G0558 $115.82. National non-facility: 99490 $66.13; 99454 $52.11; 99457 $51.77. Locality 99 ranks 37th to 42nd of 109 localities on these codes.

[10] CoachCare Value Analysis for Valley Clinics, 2026: blended net reimbursement per enrolled patient-month, chronic care management $109.41 and remote physiologic monitoring $96.49, on the code frequencies in the forecast at the Oregon locality 99 amounts. Transitional care management is not in the forecast.

What changed	Why it matters to Valley Clinics
The accountable-care model turns over on December 31, 2026	ACO REACH ends, and the practice's 2027 arrangement is not confirmed. Every successor arrangement CMS has described asks for the same evidence: a consented longitudinal panel, documented monthly care management, continuous physiologic data and a working readmission-prevention loop. This service line builds all four under fee-for-service, on the practice's own billing, before any deadline exists, and it survives whichever arrangement follows
No capital and no headcount are required	Under the partner model the on-site enrollment specialist, the care managers, the cellular devices, the 24/7 alert triage and the claim construction are CoachCare's payroll and CoachCare's inventory, priced per active patient per month. The practice adds a referral order in Practice Fusion and a supervising clinician per office. For a practice with a visit target of thirteen to sixteen a day per clinician and open positions already posted, the program starts without a build cost and without a hiring plan

Share of remote-monitoring gross reimbursement carried by 99445 and 99470 on this forecast's billing mix: CoachCare Value Analysis, 24 months.

3. The Service Line: RPM, CCM and TCM on the Medicare Panel

3.1 The clinical and billing stack

Two monthly programs and one episode code for the Medicare panel. One enrollment conversation, one care team, one billing pipeline into the practice's own billing department through Practice Fusion. Each answers a different clinical question and each is separately payable under the CY2026 fee schedule. The forecast in Section 6 carries the two monthly programs; transitional care management is recommended and not in the forecast.[11]

Program	What it does clinically	Who it fits on this panel	Net reimbursement per enrolled patient-month
Chronic care management (CCM)	A documented care plan for patients with two or more chronic conditions, with at least 20 minutes of clinical staff time each month; 99490 and 99439	The multi-chronic core of the panel: hypertension with hyperlipidemia, diabetes, kidney disease, depression or COPD in one patient. The longitudinal wrapper, and the program that carries the larger share of the forecast	**$109.41**
Remote physiologic monitoring (RPM)	A cellular blood pressure cuff and scale transmit readings between visits, reviewed against thresholds the practice's clinicians set; 99453 setup, 99454 or 99445 device supply, 99457, 99458 and 99470 treatment management	The hypertension, diabetes and heart-failure cohorts: 71% of the panel carries hypertension, and the readings that change a dose are the readings a cuff sends	**$96.49**
Transitional care management (TCM)	Contact within two business days of discharge, medication reconciliation, and a face-to-face visit within 14 days (99495, moderate complexity) or 7 days (99496, high complexity); one payment per discharge	Every panel patient discharged from a hospital or observation stay at either of the two regional health systems and returning to the practice afterwards	**Per discharge; not in the forecast**

[11] CY2026 Medicare Physician Fee Schedule, Oregon locality 99 amounts for G0556, G0557 and G0558. CMS advanced primary care management requirements include participation in a qualifying value-based arrangement; the practice's ACO REACH participation (note 3) satisfies the gate in 2026. Advanced primary care management and chronic care management may not be billed for the same patient in the same month; remote physiologic monitoring may be billed alongside either.

Blended net reimbursement per enrolled patient-month for the two monthly programs, CoachCare Value Analysis, CY2026 Oregon locality 99 amounts. Transitional care management carries no dollars in the forecast.

Code	What it pays for	CY2026 Oregon locality 99 amount
99490	Chronic care management, first 20 minutes of clinical staff time	$65.32
99439	Each additional 20 minutes	$49.84
99453	Remote monitoring setup and patient education, once	$21.43
99454	Device supply with daily recording or alerts, 16 or more days in 30	$51.80
99445	**Device supply, 2 to 15 days in 30 (new in CY2026)**	**$51.80**
99457	Treatment management, first 20 minutes, with interactive communication	$51.25
99458	Each additional 20 minutes	$40.94
99470	**Treatment management, 10 to 19 minutes (new in CY2026)**	**$25.79**
99495	Transitional care management, moderate complexity, visit within 14 days of discharge	Per discharge
99496	Transitional care management, high complexity, visit within 7 days of discharge	Per discharge
G0556	Advanced primary care management, level 1, per month	$16.14
G0557	Advanced primary care management, level 2, two or more chronic conditions	$53.17
G0558	Advanced primary care management, level 3, qualified Medicare beneficiary	$115.82

CY2026 Medicare Physician Fee Schedule, non-facility amounts, Oregon locality 99 (Noridian JF, carrier 02302), ZIP 97330; the same locality covers Albany and Salem. 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.

A patient can hold a care-management enrollment and a monitoring enrollment in the same month, and on this panel most monitored patients qualify for both. Transitional care management is billed once per discharge and sits alongside either. Advanced primary care management is a pathway decision, taken up next; it carries no dollars here.

3.2 Advanced primary care management: the next lever

Advanced primary care management (G0556, G0557 and G0558) pays a monthly per-patient amount for continuous primary-care management with no minute threshold, tiered by complexity. CMS ties the codes to participation in a value-based arrangement, and the practice's verified participation in an ACO REACH entity clears that gate in 2026. Few independent practices of this size can say the same.[12]

It appears at zero dollars. Advanced primary care management and chronic care management cannot both be billed for the same patient in the same month, so moving the multi-chronic panel from one to the other is a pathway decision: which patients, at which tier, with what documentation, and inside which arrangement. The arrangement that follows ACO REACH in 2027 is not confirmed, and the APCM gate travels with it. Those are the practice's decisions and this forecast does not pre-empt them. Remote monitoring bills alongside either, so the monitoring arm is unchanged whichever way the decision goes. The decision belongs in months 7 to 24 of the roadmap, once the chronic care management census, the documentation workflow and the 2027 arrangement are real.

[12] valleyclinics.com, retrieved September 22, 2026, and CMS by Provider and Service, CY2023 and CY2024 (note 6). Voluntary alignment page first captured September 27, 2020. No care-manager, nurse or care-coordinator position is posted on the practice's careers page.

3.3 Behavioral health: the adjacency

The practice already integrates counseling with primary care, and depression appears in 28% of the Medicare panel's CY2024 claims. The monthly chronic care management touch is where a PHQ-9 gets repeated, a medication question gets asked and a warm handoff to the counselor gets made. Behavioral health integration billing (99484) is an adjacency to scope once the program is running and the counseling workflow and the care-management workflow have met in the chart. It carries no dollars in this report.

3.4 What exists today, stated plainly

This is the build-versus-partner section, and it starts with what the practice has already built: a certified primary care home, thirty-minute visits, integrated behavioral health, a patient portal in use, annual wellness visits and advance care planning on the claims, and a voluntary alignment page that has run since 2020. That is more longitudinal infrastructure than most three-office practices carry.[13]

Asset	Status in 2026	What it means for this program
Practice Fusion	**Live; certified cloud record with a FHIR API**	The program's host. FHIR reads, document exchange for documentation. Section 4
Patient portal	**Live**	The channel for device instructions, the monthly check-in and the care plan
Thirty-minute visits and same-day access	**Live**	The enrollment conversation has time in it; the referral order is placed in the visit
Integrated behavioral health	**Live; one licensed professional counselor**	The depression cohort, 28% of the panel, gets a warm handoff from the monthly touch; behavioral health integration billing is the adjacency
Chronic care management billing	None on any practice clinician in CY2023 or CY2024	Supplied by CoachCare's care team, documented in Practice Fusion, billed by the practice
Remote monitoring	None on any practice clinician in CY2023 or CY2024	Devices, the monitoring workflow, alert triage and the care team are supplied by CoachCare
Transitional care billing	None on any practice clinician in CY2023 or CY2024	CoachCare's post-discharge cadence makes the first call; the practice bills the episode

valleyclinics.com, retrieved September 22, 2026; CMS Medicare Physician & Other Practitioners by Provider and Service, CY2023 and CY2024.

- **What exists now is the panel, the record and the relationship.** The CY2024 claims show no remote-monitoring, care-management or transitional-care code under any practice clinician. CMS suppresses any clinician-and-code line under 11 beneficiaries, so the supportable statement is the one this report makes, no program at meaningful scale in CY2023 or CY2024, rather than a claim that no patient was ever billed.
- **What the ACO may already supply is a co-existing layer.** The ACO makes care-management resources available to its practices. Whether Valley Clinics uses them, who makes the post-discharge call today and whether any device is in a patient's home are the first discovery questions. Nothing in the practice's own claims shows a program, and the service line in this report is the practice's own: governed by its clinicians, billed under its name, and still standing when the ACO arrangement changes on January 1, 2027.
- **What the partner model supplies is the program.** Devices sourced, shipped and replaced; an on-site enrollment specialist; care managers at about 160 patients each; 24/7 alert triage under a

[13] Practice Fusion is an ONC-certified cloud electronic health record with a standards-based FHIR patient-data API, a patient portal and electronic prescribing. Identification: the practice's Patient Portal link resolves to the Practice Fusion patient portal, and a Practice Fusion-generated public scheduling profile exists for the practice. The certified API covers reads; write-back is scoped in the integration workshop. Custom integration in the forecast: $4,000 setup, $150 a month, $1.50 per enrolled patient-month.

written escalation protocol; monthly documentation into Practice Fusion; claims constructed and landed billing-ready for the practice's billing department. None of it is the practice's headcount, inventory or software to maintain, and all of it is priced per active patient per month.

- **What the practice keeps is clinical governance, the patients and the revenue.** The clinicians set the thresholds, the routing and the discharge criteria, supervise the program, file the claims under Valley Clinics and keep 42.4% of net reimbursement after CoachCare's fee. Nothing about the arrangement changes who practices medicine, and nothing about it changes who owns the practice.

4. Practice Fusion: The Program Lives in the Chart

Practice Fusion is a certified cloud electronic health record with a FHIR patient-data API, a patient portal and electronic prescribing. The vendor was identified from the practice's own patient-portal link; confirming the vendor and version is a first-call item. CoachCare integrates over FHIR for reads of the patient, condition, encounter and observation resources, and over document exchange for the monthly documentation. Write-back of care plans and charge capture into the chart is scoped in the integration workshop with the practice's administrator and billing lead, and the integration is priced as a custom integration in the forecast, with scope confirmed in contracting.[14]

Step	What happens in Practice Fusion	Who does it
Eligibility	Patients meeting the agreed criteria are identified from the condition and encounter feeds and flagged; the flag is the enrollment prompt at the point of care	CoachCare configures the criteria the practice's clinicians approve
Referral	The clinician places a referral order the way they would order a lab. The order is the enrollment	Any of the nine clinicians, in the visit
Device	A cellular blood pressure cuff and scale ship to the patient, pre-paired; no smartphone, WiFi or app required, though the portal carries the instructions for patients who use it	CoachCare sources, ships, replaces
Outreach	The patient is reached, educated and consented; readings, alert dispositions, enrollment status and monthly care documents return to the chart through the documented exchange path	CoachCare's on-site enrollment specialist and care team
Claims	Each month's codes are constructed from logged time and transmission days and land billing-ready in the workflow the practice's billing department already runs	CoachCare generates; the practice files and keeps the revenue

The custom integration carried in this forecast is $4,000 for setup, $150 a month and $1.50 per enrolled patient-month. Together with implementation and telephonic outreach, those ancillary items total $31,755 over 24 months, and they are inside the $796,848 of CoachCare fees, not on top of it. A certified FHIR record typically integrates in four to six weeks, run in parallel with onboarding, training and care-team assignment, so the interface does not hold up the first enrollments.

5. Clinical Governance & Escalation

Section 6 shows the service line pays. This section shows it is safe. Every reading a patient takes routes through one shared escalation engine with defined thresholds, a defined trend rule, defined routing and a defined documentation standard, so the practice never carries surveillance liability it did not agree to. Thresholds and routing are set with the practice's clinicians, office by office, not by default, and signed off before the first patient enrolls.[15]

[14] CoachCare Care Management Programs standard operating procedures, March 2026: alert and escalation decision logic, trend definitions, emergent and urgent communication protocol, escalation routing, post-discharge cadence and discharge governance, as reproduced in this section.

[15] CoachCare Value Analysis for Valley Clinics, 2026. All Section 6 figures. Inputs: 1,800 Medicare patients, 1,440 in scope; 9 referring clinicians; one on-site enrollment specialist at 80 enrollments a month; remote monitoring 65% eligible and 35% acceptance; chronic care management 75% eligible and 30% acceptance; 8 referrals per clinician per month at 80% acceptance; telephonic outreach on; 70% dual

5.1 One shared escalation engine

Branch	The rule	Why it is written this way
Critical value	**Escalate immediately, regardless of symptoms**	A reading at a critical threshold escalates whether or not the patient reports symptoms. There is no wait-and-see branch on a critical value, and no client preference can suppress it
Out of range, not critical	Retake, then a structured symptom check	A non-critical out-of-range reading is worked rather than forwarded: confirm technique, request a repeat, run the symptom check. Most out-of-range readings resolve here, which is why the clinicians' inboxes stay usable
Trend	**Three consecutive readings at least one hour apart for blood pressure or glucose; three readings within seven days for heart rate; a weight gain over the agreed threshold in the agreed window**	A trend is a definition rather than a judgment call. A confirmed trend escalates on the same footing as a single threshold breach
Patient unreachable	Document the attempt, leave a voicemail with the callback line and advice to seek care if symptoms worsen, and escalate anyway if the reading was critical or a confirmed trend	Silence never downgrades a clinical finding. This is the branch that separates a monitoring program from a data-collection exercise
Documentation	**Six fields on every escalation: vital · findings · method · contact · outcome · follow-up**	The same six fields every time, so any episode can be reconstructed end to end. Parameter changes are documented in the same record

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. Any of these reported during an outreach call activates the emergent protocol immediately.

Action. 911 is called with the patient still on the line. The call is not ended and handed off. The escalation record follows the patient, and the office that manages them is notified the same day.

If the patient refuses. The office's care team is called with the patient still on the line and directs care. If the care team cannot be reached, CoachCare activates emergency services regardless. Either way the office is notified and the chart records the symptoms, the 911 status, the contact made and the instructions given.

The floor. CoachCare's urgent and emergent policy supersedes any client-specific escalation preference. The practice shapes routing for everything else. It cannot lower the floor on an emergency, and neither can we.

Recent or changing symptoms that are not actively emergent, inside a 72-hour window, route as an escalation under the office's stated preference and are documented the same way. A patient told to seek same-day care is directed to their own office, which offers same-day appointments, so the visit, the record and the follow-up stay inside the practice.

5.3 Three-way routing

The failure mode of a monitoring program inside a busy primary care office is not a missed alert. It is an inbox nobody reads, because everything arrives as an alert. Escalations route three ways, and the split is agreed before the first patient enrolls.

Route	What goes there	Who sees it
Emergency	Emergent symptoms, or a critical value with clinical instability	911 activated, with the office's care team notified

enrollment; 1.5% monthly attrition; CY2026 fee schedule at Oregon locality 99 amounts; custom integration $4,000 setup, $150 a month, $1.50 per enrolled patient-month. Sensitivity runs on the same workbook with one input changed at a time.

Route	What goes there	Who sees it
Non-critical	A confirmed out-of-range reading or trend without emergent features	The clinician or medical assistant each office designates in its escalation matrix, within the agreed window
Stable or resolved	**Worked, retaken, resolved, patient asymptomatic**	**Documented in the record as a note rather than pushed as an alert. This is the branch that keeps the program sustainable for clinicians carrying thirteen to sixteen visits a day**

The matrix is agreed per office, because the covering clinician in Corvallis is not the covering clinician in Salem, and the offices keep different days: Albany is closed on Fridays and Salem on Mondays. The after-hours branch is defined alongside the practice's existing telehealth and on-call arrangements, so evening and weekend readings have a route that does not depend on anyone's memory. Each office switched on adds a row, not a redesign.

5.4 The post-discharge cadence, and the TCM episode

Triggered by any emergency visit or hospitalization in the previous 60 days. For Valley Clinics the trigger usually fires from the discharge summary that arrives from one of the two regional health systems, from the patient's own call, or from a reading that changes after an admission. When the event was a hospital or observation admission the cadence is also the transitional care episode: the first touch is the two-business-day contact 99495 and 99496 require, and the confirmed follow-up is the 7- or 14-day visit with the practice. This cadence is the mechanism behind the avoided admissions in Section 6.5, and under a full-risk arrangement each one is total-cost-of-care arithmetic as well as a patient kept home.

Touch	Window	What happens
1 · Stabilize	**Day 1–2**	Identify what precipitated the visit; reconcile discharge medications against what is in the house; confirm a follow-up appointment exists within 7 to 14 days; symptom assessment, documented and escalated per the engine above
2 · Detect	**Day 5–8**	The window in which post-discharge decompensation usually declares itself. Verify medication adherence; re-evaluate the original triggers; confirm the appointment was attended; verify ordered labs were completed
3 · Secure	**Day 12–14**	Medication and risk review; review the outcome of the completed visit; final symptom assessment; hand the patient into the longitudinal monitoring panel so the window closes with continuity rather than a cliff

5.5 Continuity and discharge governance

1. **An unreachable patient escalates on a fixed cadence.** A monitoring patient unreachable 45 days from enrollment is escalated to the care team; non-compliance at 90 days triggers a second escalation plus 90 more days of monitoring. Care management runs a longer clock, with the first escalation at six months.
2. **There is a hard backstop.** If no instruction comes back from the care team, discharge proceeds at 180 days for monitoring. The office is notified in every case and discharges process in the first week of the following month, so a patient who stops transmitting is worked before a billing month is lost.
3. **The practice always decides.** Clinical discharge criteria, escalation thresholds and routing belong to the practice's clinicians. CoachCare executes them consistently and documents the execution. It does not overrule clinical judgment, with the single exception of the emergent floor in Section 5.2.
4. **Auditable by design.** Because every escalation carries the same six documented fields, any episode can be reconstructed end to end, which is what the per-code documentation rules require in any case and what an accountable-care quality review asks for.

6. Value Analysis: The 24-Month Forecast

6.1 The headline economics

The forecast covers chronic care management and remote physiologic monitoring across a Medicare panel of 1,800 at the three offices, with 1,440 in scope, priced at the CY2026 Oregon locality 99 amounts, with 9 referring clinicians and one CoachCare-funded on-site enrollment specialist at 80 enrollments a month. Transitional care management is recommended in Section 3 and carries no dollars here; no distribution from the accountable-care arrangement is in these numbers.[16]

	Year 1	Year 2	24 months
Net reimbursement	**$582,623**	**$801,022**	**$1,383,644**
CoachCare fees, including the Practice Fusion integration and implementation	$341,496	$455,352	$796,848
Net to the practice	**$241,126**	**$345,670**	**$586,796**
Practice margin	41.4%	43.2%	**42.4%**

The margin moves from 41.4% in year one to 43.2% in year two because the one-time implementation and integration setup fall out and the census is full from the first month of the year. Year two is the steady state: **$801,022 of net reimbursement, $345,670 of it kept, at 43.2%**.

6.2 Where the revenue comes from

Program	Year 1	Year 2	24 months	Per enrolled patient-month
Chronic care management	$299,800	$425,395	**$725,196**	$109.41
Remote physiologic monitoring	$282,822	$375,626	**$658,449**	$96.49
Total	**$582,623**	**$801,022**	**$1,383,644**	

Net reimbursement by program and year, CoachCare Value Analysis. Year columns sum to within a dollar of the totals after rounding.

24 months	Net reimbursement	CoachCare fees	Net to the practice
Chronic care management	$725,196	$378,491	**$346,705**
Remote physiologic monitoring	$658,449	$386,603	**$271,846**
Implementation, Practice Fusion integration setup and monthly, per-patient EMR, telephonic outreach		$31,755	−$31,755
Total	**$1,383,644**	**$796,848**	**$586,796**

Fees and net to the practice by program, 24 months, CoachCare Value Analysis.

Chronic care management is the larger line, $725,196 on 324 active enrollments at month 24, because the multi-chronic core of this panel is large and the 99439 add-on is earned in most months. That is what

[16] CMS-1848-P, CY2027 Medicare Physician Fee Schedule proposed rule, published July 2026; comment period ended September 14, 2026. CoachCare repricing of this forecast at the proposed CY2027 amounts, Oregon locality 99 (conversion factor $32.8409 versus $33.4009): 99454 and 99445 $51.80 to $41.12 (−20.6%); remote monitoring arm −9.7% (−$63,725) with device supply 32.4% of that basket; chronic care management −2.1% (−$15,070); service line −5.7% (−$78,795), $1,383,644 to $1,304,849, with remote monitoring 47.6% of the line. Enrollment held constant.

a multi-chronic primary care panel should produce. Remote monitoring carries $658,449 on 328 enrollments and is the program that produces the readings, the alerts and the avoided admissions. The **652 active program enrollments at month 24 belong to 425 unique patients**, because most monitored patients also hold a care-management enrollment.

6.3 The ramp, month by month

Month 1 is negative, because the one-time implementation fee and the Practice Fusion setup post in that month against 42 enrollments. Month 2 nets $4,764 on 111 enrollments and month 3 nets $8,983 on 206. Both programs fill in month 7, and the program holds $28,806 a month from month 8.

Month	Net reimbursement	CoachCare fees	Net to the practice
M1	$4,708	$9,491	**−$4,783**
M2	$12,025	$7,261	$4,764
M3	$22,056	$13,073	$8,983
M4	$33,986	$19,937	$14,049
M5	$47,840	$27,895	$19,945
M6	$61,269	$35,530	$25,739
M7	$66,979	$38,579	$28,400
M8 onward	**$66,752**	$37,946	**$28,806**

The commercially important number in that table is not the 24-month total. It is that the program pays its own way from its second month and every month after, with no devices purchased, no software licensed and no headcount added by the practice. Cumulative net to the practice passes $68,697 at month 6, $241,126 at month 12 and $586,796 at month 24. A service line that funds itself inside two months competes with nothing else on the practice's plans.

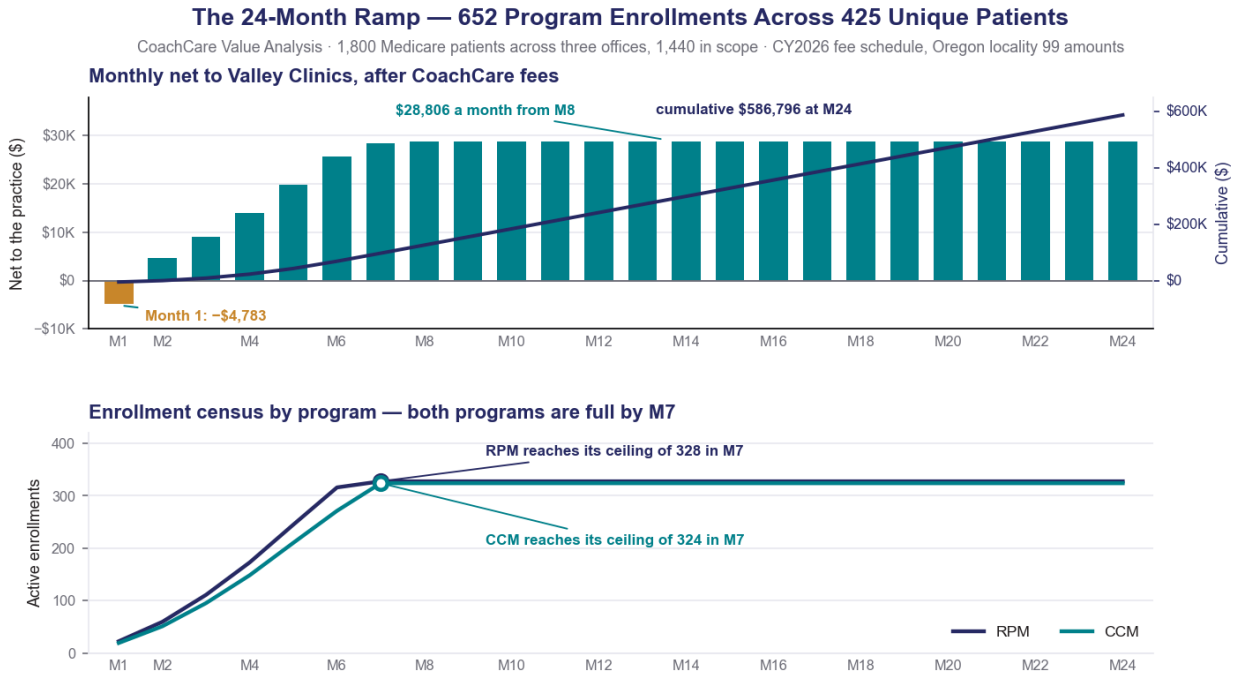

Figure 1 — monthly net to the practice after CoachCare fees, with cumulative net overlaid, and the enrollment census by program with the two ceiling months marked. CoachCare Value Analysis.

6.4 Ceilings, and what moves them

Program	Eligible share of the 1,440 in scope	Acceptance	Ceiling	Reached
Remote physiologic monitoring	65% — 936 patients	35%	**328**	**M7**
Chronic care management	75% — 1,080 patients	30%	**324**	**M7**

Say the constraint out loud

The binding constraint on this program is the size of the eligible Medicare panel and the eligibility definition, not outreach capacity. By month 7 every patient the two programs can take is enrolled, and the enrollment specialist has nowhere further to go on this year's panel. That is why the sensitivity table below reads the way it does: a second on-site enrollment specialist cannot raise the ceiling but reaches it sooner, in month 5, and adds $67,284 of net reimbursement over 24 months; no specialist at all costs $255,000 and pushes the care-management ceiling out to month 17. The panel and the eligibility definition raise the ceiling, and nothing else does.

The chart count is discovery item number one. The 1,800 is the forecast's basis across the three offices and all payers, sized from the practice's own claims and the Medicare Advantage share of its three counties. A chart pull by office in week one replaces it, and every ceiling in this report moves with it.

Scenario	24-month net reimbursement	Net to the practice	Margin	Unique patients at M24	Ceilings reached
Base: panel 1,800, 1,440 in scope, 9 clinicians, one enrollment specialist	**$1,383,644**	**$586,796**	**42.4%**	**425**	M7 / M7
Panel 1,000, 800 in scope	$814,293	$341,376	41.9%	236	M5 / M5
Panel 1,400, 1,120 in scope	$1,106,976	$467,580	42.2%	330	M6 / M6
Panel 2,400, 1,920 in scope	$1,766,809	$751,681	42.5%	566	M8 / M9
Panel 3,000, 2,400 in scope	$2,112,835	$900,326	42.6%	708	M10 / M11
Panel 1,800 with 60% in scope (1,080)	$1,071,534	$452,284	42.2%	319	M5 / M6
Panel 1,800 with 100% in scope	$1,674,434	$711,959	42.5%	531	M8 / M9
No on-site enrollment specialist	$1,128,644	$473,581	42.0%	425	M12 / M17
A second on-site enrollment specialist	$1,450,928	$616,302	42.5%	425	M5 / M5
10 referring clinicians	$1,391,267	$590,063	42.4%	425	M6 / M7
The three physicians and one advanced practice clinician referring	$1,331,636	$564,370	42.4%	425	M8 / M9

CoachCare Value Analysis sensitivity runs, one input changed at a time. Ceilings reached: remote monitoring / chronic care management.

Read across the rows. Moving the panel from 1,000 to 3,000 moves 24-month net to the practice from $341,376 to $900,326 at the same margin; revenue is close to linear in the panel because both programs are ceiling-limited. The in-scope share does the same work: at 100% of the panel the program reaches 531 unique patients and $711,959. Clinician count and enrollment staffing change timing only. A tenth referring clinician is worth about $3,000 over 24 months; four referrers instead of nine cost about $22,000, and the ceilings arrive a month or two later either way. The panel is the lever; everything else is timing.

6.5 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	**71,653**	Blood pressure and weight values arriving between visits from a panel where seven in ten beneficiaries carry hypertension
Claims and billable units generated	**26,291**	Constructed, coded and landed billing-ready for the practice's billing department through the Practice Fusion integration
Care-management tasks completed	52,582	Outreach attempts, care-plan updates, medication reviews and follow-up actions
Patient conversations	7,887	Live contacts across 438 hours of call time
Chart updates	13,146	Documentation returned to Practice Fusion for the clinicians to act on
Care-team hours delivered by CoachCare	**11,739**	**About 5.6 full-time-equivalent years of care-management labor the practice does not employ**
Hospitalizations avoided	**About 45**	About $682,000 at $15,000 per admission, cost that never lands on a payer, a patient or the ACO's total-cost-of-care ledger

CoachCare Value Analysis, 24-month totals. The avoided-admission figure is computed on a conservative baseline admission rate for the enrolled cohort; at a 40% annual admission baseline, which is realistic for a multi-chronic Medicare panel of this risk, the count is about 91.

The two layers, kept separate

Fee margin funds the program. $586,796 to the practice over 24 months, positive from month 2, paid claim by claim by Medicare and by Medicare Advantage plans at their contracted terms.

Avoided admissions speak to the accountable-care ledger. About 45 over 24 months on this census, about $682,000 at $15,000 each, plus the documented monthly relationship with 425 patients that holds their alignment to the practice. Under the Global option those are the ACO's total-cost-of-care arithmetic; under whatever arrangement follows in 2027, they are the evidence every CMS primary care model asks for. The practice's aligned-beneficiary count is the number to bring to the first working session; the ACO holds it.[17]

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

CMS published its proposed CY2027 physician fee schedule in July 2026. The comment period ended September 14, 2026; the final rule arrives in early November; the changes take effect January 1, 2027. The proposal that matters here is a reduction to the remote monitoring device-supply codes. Every code in this forecast was repriced at Oregon locality 99 on this account's own billing mix, with enrollment held constant.[18]

[17] CoachCare Value Analysis for Valley Clinics, 2026: 99445 and 99470 together carry 17.4% of 24-month remote-monitoring gross reimbursement on this forecast's code frequencies.

[18] CoachCare Value Analysis for Valley Clinics, 2026: 45.5 hospitalizations avoided over 24 months on the enrolled census at the workbook's baseline admission rate, valued at $15,000 per admission; about 91 at a 40% annual admission baseline.

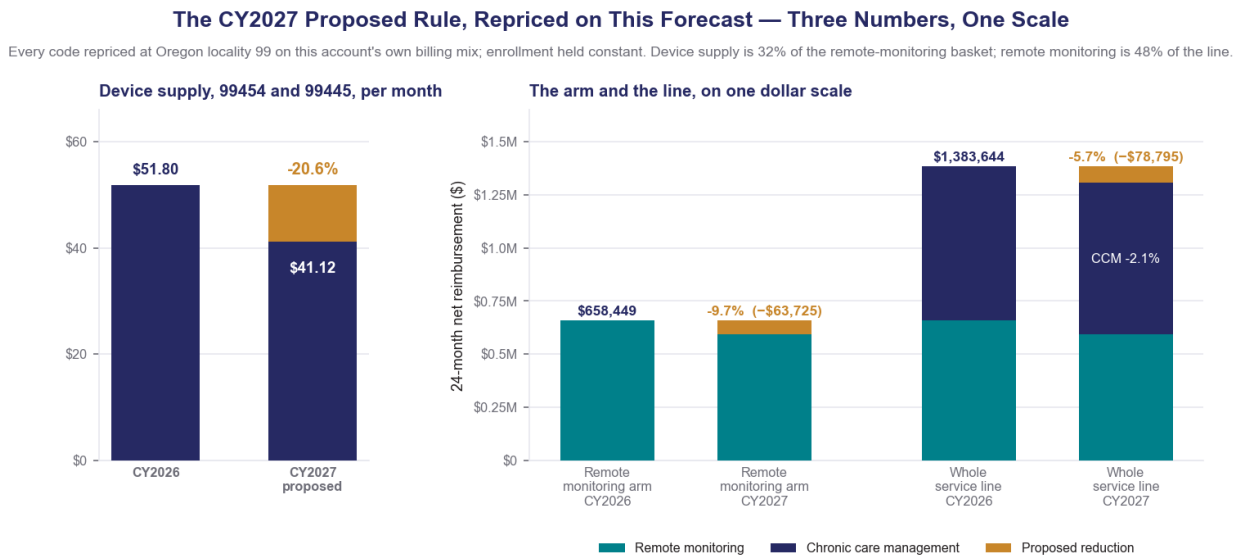

Figure 2 — the CY2027 cascade on this forecast. Left: the one code CMS proposes to cut, per month at Oregon locality 99. Right: the remote-monitoring arm and the whole service line on one dollar scale, with the proposed reduction in one colour and absolute dollars beside each percentage. CoachCare repricing of the Value Analysis at the proposed CY2027 amounts.

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
Device supply, 99454 and 99445	$51.80 a month	**$41.12 a month, −20.6%**	The code CMS proposes to cut
The remote monitoring arm	$658,449 over 24 months	**−9.7%, −$63,725**	Device supply is 32% of the remote monitoring basket; treatment management moves little
Chronic care management	$725,196 over 24 months	−2.1%, −$15,070	Conversion-factor and relative-value churn only; the proposal does not target these codes
The whole service line	$1,383,644 over 24 months	**−5.7%, −$78,795, to $1,304,849**	Remote monitoring is 48% of the line; the rest moves two points

CoachCare repricing of this forecast at the CY2027 proposed amounts, Oregon locality 99, on the code frequencies in this Value Analysis.

Three numbers, each smaller than the last only because its base is larger. A 20.6% cut to one code is a 5.7% change to the service line, because this line is built on two programs of similar size and only the smaller one holds the code being repriced. CoachCare filed comments on the remote-monitoring provisions and will rerun this forecast against the final rates the week they publish. Two contingencies are already in build: an unbundled arrangement, with the software platform, device logistics and program enablement priced separately, and an arrangement in which CoachCare manages the staffing while the practice owns the clinical program and the billing. Whichever way the final rule lands, the program does not have to be rebuilt.

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%

Code	What it pays for	CY2026 national	Proposed CY2027 national	Change
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%
G0556	Advanced primary care management, level 1	$16.37	$16.09	−1.7%
G0557	Advanced primary care management, level 2	$53.78	$53.20	−1.1%
G0558	Advanced primary care management, level 3	$117.24	$116.91	−0.3%

CY2026 Addendum B and CMS-1848-P proposed CY2027 Addendum B, national non-facility amounts. The repricing above uses Oregon locality 99 amounts and this table uses national amounts; the two bases do not reconcile to the dollar, by design. The device-supply and short-treatment codes are held to a one-year maximum reduction by section 1848(c)(7) of the Act, so CY2027 is the capped year.

8. Implementation Roadmap

8.1 Who runs what

Function	CoachCare	Valley Clinics
Patient identification	Registry query in Practice Fusion against the agreed inclusion criteria, starting from the hypertension, diabetes, kidney-disease and heart-failure cohorts on the Medicare panel	Approves the criteria and the target list, by office
Enrollment	**One on-site enrollment specialist at 80 enrollments a month, on CoachCare's payroll; the eligibility flag and referral order in Practice Fusion**	Clinician referral at the point of care, in the thirty-minute visit; nine clinicians across three offices
Transitional care	Discharge captured from the discharge summary or the patient's call; two-business-day contact and medication reconciliation completed and documented; visit scheduled inside the 7- or 14-day window	Furnishes the face-to-face visit and bills 99495 or 99496
Devices	Sourced, configured, cellular-paired, shipped, replaced	Nothing purchased, nothing stocked
Monitoring and escalation	Reading review, monthly outreach, alert triage, post-discharge cadence, protocol execution and documentation, at about 160 patients per care manager	**Sets thresholds, routing and after-hours cover per office; receives escalations**
Documentation and billing	Time logs, monthly care documents to Practice Fusion, claims constructed and landed billing-ready	**Files under its own identifiers through its own billing department; keeps the revenue**
Reporting	Monthly enrollment, engagement, escalation and revenue reporting per office, in a form the accountable-care arrangement can count	Standing monthly operating call with the owners; a named program lead

8.2 The model inputs

Input	Value in this forecast
Medicare panel	**1,800 patients across the three offices, 1,440 in scope**; all payers
Referring clinicians	9: three physicians, five physician assistants and one family nurse practitioner

Input	Value in this forecast
Eligibility and acceptance	Remote monitoring 65% eligible, 35% accept; chronic care management 75% eligible, 30% accept; 8 referrals per clinician per month at 80% acceptance; 70% of monitored patients also in care management; 1.5% monthly attrition
Enrollment staffing	One CoachCare-funded on-site enrollment specialist at 80 enrollments a month, plus clinician referral and telephonic outreach; the specialist, care managers and device logistics are CoachCare's payroll, embedded in the fee
EMR	Practice Fusion; custom integration per Section 4 at $4,000 setup, $150 a month and $1.50 per enrolled patient-month, scope confirmed in contracting
Rates	CY2026 physician fee schedule, non-facility, Oregon locality 99 (Noridian JF), ZIP 97330; the same locality covers Albany and Salem. 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.
Programs	RPM + CCM in the forecast; transitional care management recommended at every hospital or observation discharge, not in the forecast; advanced primary care management named as the next lever at zero dollars; behavioral health integration an adjacency to scope later

8.3 The first 90 days, and after

Window	What happens	Result at the end of it
Weeks 0–6 Integrate and charter	Integration workshop with the practice's administrator and billing lead: FHIR read scope, the documentation path, write-back and charge capture; the EHR vendor and version confirmed. Chart counts and the Medicare Advantage plan mix pulled by office. Escalation thresholds, per-office routing and after-hours cover agreed with the clinicians. Billing configuration with the billing department. Protocol sign-off for the hypertension, diabetes and kidney pathways. The ACO's care-management reporting aligned so the same touch counts on both ledgers. A named program lead	Scope signed, cohorts defined, integration live, protocol signed
Weeks 6–12 Launch the Corvallis cohorts	The on-site enrollment specialist working the Corvallis schedule alongside the medical assistants. Chronic care management wave across the two-plus-condition panel; remote monitoring for the hypertension and diabetes cohorts. Cellular cuffs and scales shipped and paired. Transitional care and the post-discharge cadence live from the first week	42 enrollments by month 1, 111 by month 2, 206 by month 3; positive from month 2
Months 3–7 Add Albany and Salem, reach the ceilings	The Albany and Salem offices switched on with the same protocols and their own routing rows. Both programs climb to ceiling: remote monitoring 328 and chronic care management 324, both in month 7. Monthly scorecard to the owners	652 active enrollments across 425 unique patients; $28,806 a month from month 8
Months 7–24 Widen the definition	Re-validate eligibility against chart data; decide the chronic care management versus advanced primary care management mix once the 2027 arrangement is known; scope behavioral health integration billing; align the program's documentation with whatever quality and cost measures that arrangement carries	Year 2 at $801,022 net reimbursement, $345,670 to the practice, 43.2%

8.4 What we would confirm together

These are the discovery items, and every one lives in Practice Fusion or one call away. None of them holds up the start; the first window of the roadmap collects them.

1. **The chart count and the payer split behind the 1,800.** A registry pull in week one, by office: active patients 65 and older, traditional Medicare versus Medicare Advantage plan by plan, and how many carry hypertension, diabetes or two or more chronic conditions. This is discovery item number one, and every ceiling in Section 6 moves with it.

2. **The Medicare Advantage plan mix.** Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The plan-by-plan read sets each program's target list and is the second thing to confirm after the chart count.
3. **The EHR vendor and version.** Practice Fusion was identified from the practice's own patient-portal link. The integration workshop confirms the vendor, the version, the FHIR endpoint and whether care-plan notes, time logs and charge capture can be written into the chart directly or travel by document exchange. That settles the final integration scope.
4. **The 2027 accountable-care arrangement.** ACO REACH ends December 31, 2026. Which arrangement carries the practice's aligned patients from January 2027, and on what terms, decides whether the care-management revenue sits inside a total-cost-of-care reconciliation and when the advanced primary care management decision can be made.
5. **The ACO's care-management resources.** Whether the ACO places a care manager with the practice today, who makes the post-discharge call, whether any device is in a patient's home, and whether the ACO restricts or claims any care-management billing for its participants. The program in this report co-exists with any such layer; the working session draws the line.
6. **The aligned-beneficiary count.** The number of Medicare beneficiaries aligned to the practice under the current arrangement, which the ACO holds, bounds the panel from the accountable-care side the way the chart count bounds it from the practice side.
7. **Hospital and observation admissions on the panel.** The count of panel patients admitted at either regional health system in the last twelve months sizes the transitional care episodes this forecast carries at zero.
8. **The behavioral health workflow.** How the counselor's schedule, notes and referrals sit in the chart today, so the monthly care-management touch and the warm handoff meet in one record and behavioral health integration billing can be scoped later.

9. Recommendations

1. **Launch the partner-run service line at the Corvallis office.** $586,796 to the practice over 24 months at a 42.4% margin on the full panel, positive from month 2, with nobody hired and nothing bought. Corvallis has four clinicians and the lowest Medicare Advantage share of the three counties; Albany and Salem follow on the same integration inside the first seven months.
2. **Build the integration in the workshop, on the certified API.** FHIR reads of patient, condition, encounter and observation; document exchange for the monthly documentation; write-back scoped with the administrator and billing lead. Confirm the vendor and version in the same session.
3. **Point the first enrollment wave at the multi-chronic hypertensive core.** Seven in ten beneficiaries carry hypertension, three in ten are diabetic, nearly three in ten have kidney disease. Chronic care management for the care plan, a connected cuff and scale for the readings, and the thirty-minute visit as the enrollment conversation.
4. **Bill transitional care management at every hospital or observation discharge the offices learn of.** The two-business-day contact and the 7- or 14-day visit are the cadence the program already runs; CoachCare makes the first call and the practice bills 99495 or 99496. Not in the forecast; sized by the panel's own admission count.
5. **Pull the chart count in week one.** The binding constraint is the eligible Medicare panel. Between 1,000 and 3,000 patients, 24-month net to the practice runs from $341,376 to $900,326 at the same margin; the registry, not the estimate, sets the number.
6. **Run the program as the practice's own, beside whatever the ACO supplies.** The service line is governed by the practice's clinicians, billed under Valley Clinics and documented in its own chart. It co-exists with any ACO care-management layer today and is still standing on January 1, 2027,

whichever arrangement follows. The avoided admissions, about 45 over 24 months on this census, are the layer a full-risk arrangement rewards.

7. **Hold advanced primary care management as the named next lever, and decide it once the 2027 arrangement is known.** The gate is cleared in 2026. The pathway choice between chronic care management and APCM is the practice's, made on real enrollment data, in months 7 to 24.
8. **Read the Medicare Advantage contracts early.** About 57% of the Medicare beneficiaries in the practice's markets are in a 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 plan-by-plan read decides how far past traditional Medicare the program reaches.
9. **Scope behavioral health integration once the program is running.** Depression appears in 28% of the panel's claims and the practice already integrates counseling. The monthly touch is the referral path; 99484 is the adjacency.
10. **Keep clinical governance where it is.** The clinicians set thresholds and routing, sign the care plans and make every clinical decision; the claims go out under Valley Clinics; the revenue stays with the owners. CoachCare executes and documents. That division is the arrangement an independent practice needs, and it is the reason the model preserves the practice's control without a capital line.

The Medicare panel Valley Clinics already manages supports a $1,383,644 service line at a 42.4% practice margin inside 24 months, positive from its second month, on staff the practice does not have to hire and devices it does not have to buy. The panel is older and multi-chronic, the visits are long enough to enroll in, the record is certified and connected, and the practice sits inside an arrangement that pays for the same outcomes. What remains is to build the service line once, with a partner, and own it through the 2027 model change and beyond.

About CoachCare

> **About CoachCare**
>
> CoachCare operates remote care and care-management programs for more than 500,000 patients, with over 10,000 clinicians on the platform. Its teams have completed more than 1,000 implementations, generated over 5 million claims through care-plan coding and billing, and recorded more than 100 million patient vitals.

Six reasons this partnership fits Valley Clinics specifically, not remote care in general.

- **The record you already run, integrated once.** CoachCare integrates with a certified FHIR endpoint for the reads the program needs and with document exchange for the documentation it returns. Eligibility flags and referral orders stay in Practice Fusion; vitals, monthly care documents and billing-ready claims come back to it. There is no second system for the clinicians and no re-keying for the billing department.
- **Full service, priced per patient.** The on-site enrollment specialist, care managers at about 160 patients each, device logistics, 24/7 alert triage and claim construction are CoachCare's payroll. A practice already recruiting for a therapist and a Salem clinician does not add a care-management hiring cycle; the program arrives staffed, at a 42.4% margin. Fees are per active patient per month; if the census does not build, CoachCare is not paid, with implementation and integration fees the exceptions.
- **The work your accountable-care arrangement already rewards.** Fewer emergency visits and admissions among aligned patients are what a Global-option arrangement is paid on. The monthly touches that generate care-management revenue are the same touches that produce them, and

the documented care plan is what holds alignment. One program, both ledgers, with the fee-for-service margin funding it.

- **Revenue that belongs to the practice.** A recurring service line with its own margin is the alternative to selling the practice to fund the next hire. The revenue in this report is billed under Valley Clinics, governed by its clinicians and owned by its owners. CoachCare supplies staff, devices, platform and billing preparation under that governance.
- **Your clinicians stay in charge.** The clinicians set the protocols, sign the care plans and make every clinical decision; critical readings escalate through one engine whose urgent policy supersedes any preference; and every discharge the offices learn of becomes a transitional care episode with the first call already made.
- **No lock-in, no capital, paid as you enroll.** There is no capital outlay and no payroll ramp. The forecast, the workbook and the companion documents are the practice's to keep either way, and the plan is measured twice, against the chart count and the plan mix, before it goes to paper.

The ask is a working session with the owners and the practice administrator: validate the Medicare panel against a chart count by office, hold the integration workshop with the billing lead, confirm the ACO's care-management reporting, and set go-live for the Corvallis cohorts.

Contact

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References & Data Sources

- **Valley Clinics' own published materials** (retrieved September 22, 2026): valleyclinics.com, for the three location pages, hours and clinician listings by office, the services offered, the Patient-Centered Primary Care Home statement, the patient-portal links, the Medicare alignment page and the careers page with its visit-volume target; the Internet Archive for the first-capture dates of the Salem and Medicare alignment pages.
- **CMS Quality Payment Program eligibility records** (qpp.cms.gov API, performance years 2025 and 2026, retrieved September 22, 2026), for each roster clinician's alternative payment model participation under the practice's billing entity: ACO REACH Model, Global option, participant provider, Advanced APM flag set, for seven of the nine adult-medicine clinicians in 2026.
- **CMS ACO REACH files** (data.cms.gov, retrieved September 2026): the ACO REACH Providers file for performance year 2024, listing the practice's legal business name as a participant provider; the ACO REACH ACOs file for performance year 2026, for the entity's risk option and service area. Model end date December 31, 2026, per CMS.
- **Medicare Shared Savings Program participant file, 2026** (data.cms.gov, retrieved September 2026): no Valley Clinics entity.
- **CMS provider and claims files** (data.cms.gov, retrieved September 2026): NPPES records for the practice's organization and each roster clinician; the Medicare Physician & Other Practitioners by Provider file, CY2023 and CY2024, for beneficiary counts, allowed amounts, age, dual-eligible counts, chronic-condition prevalence and risk scores; and the by Provider and Service file, CY2023 and CY2024, queried for every roster clinician across the evaluation-and-management, annual wellness, advance care planning, remote monitoring, chronic care management, principal care, transitional care, advanced primary care management and behavioral health integration code families. CMS suppresses lines under 11 beneficiaries.
- **Medicare payment rules:** the CY2026 Medicare Physician Fee Schedule final rule and Addendum B, for the remote monitoring family including the new 99445 and 99470, the chronic care management family, the transitional care codes and the G0556 to G0558 advanced primary care management tiers; CMS-1848-P, the CY2027 proposed rule published July 2026, for the proposed

device-supply repricing and the comment deadline; and the CY2026 RVU file and Addendum E geographic indices for Oregon locality 99 under the Noridian JF contractor, used for every dollar in this report.

- **Market sources:** CMS Medicare Advantage State/County Penetration, September 2026, for the Benton, Linn and Marion county shares; CMS Medicare Monthly Enrollment, county level, CY2025, for beneficiary counts and dual-eligible shares.
- **CoachCare Care Management Programs standard operating procedures, March 2026:** the shared clinical alert and escalation decision logic, the trend definitions, the emergent and urgent communication protocol, the three-way escalation routing, the post-discharge three-touch sequence and the discharge decision flow reproduced in Section 5.
- **CoachCare Value Analysis for Valley Clinics, 2026:** every financial, enrollment, clinical-output and operational figure in Sections 6, 7, 8 and 9, including the sensitivity runs, built on 1,800 Medicare patients with 1,440 in scope, 9 referring clinicians, one on-site enrollment specialist at 80 enrollments a month, and the CY2026 fee schedule at the Oregon locality 99 amounts for chronic care management and remote physiologic monitoring.

A note on how this report handles counts and names

Unique patients and program enrollments are different numbers. At month 24 the program holds 652 active program enrollments belonging to 425 unique patients, because a patient may hold a care-management enrollment and a monitoring enrollment at the same time. Wherever this report gives a patient count it says patients; wherever it gives an enrollment count it says enrollments.

The panel figure is the forecast's basis; the claims describe its shape. The 1,800 covers all three offices and all payers. The 706 beneficiary-clinician pairs in the CY2024 claims file are fee-for-service only, count a patient once per clinician seen, and omit any clinician-and-code line under 11 beneficiaries, so the two numbers describe different things and are not in conflict.

No individual at the practice or its partners is named in this report. Clinicians, owners, administrators and accountable-care personnel are described by count and role only, and the practice's ACO by its model and risk option rather than by name.