PREPARED FOR THE MANAGING PARTNER AND PHYSICIAN LEADERSHIP OF

Annapolis Internal Medicine, LLC

Remote Care Service Line Optimization

2026 Strategy Report

A remote patient monitoring value analysis for a practice carrying two-sided risk — avoided admissions and total cost of care first, fee margin second.

PURPOSE OF THIS REPORT

This is a discovery-stage business case. It is not a proposal and it is not a quotation. It is written for a reader who manages total cost of care for a living, and it assumes no explanation of how attribution, benchmarks or shared savings work.

Annapolis Internal Medicine is a verified participant in the Maryland Primary Care Program under the AHEAD Model, listed with no Care Transformation Organization partner, and a participant TIN in an **Enhanced-track** Medicare Shared Savings Program ACO. Enhanced is two-sided risk. For a practice in that position gross fee revenue is the wrong headline, so this report leads with avoided admissions and total cost of care and treats fee margin as the second layer: what pays for the program while the risk-side benefit accrues.

The modeled program is remote patient monitoring. Chronic care management is not modeled, for a reason set out in Section 4.2 — and that constraint turns out to improve the case rather than weaken it.

Every financial figure here is illustrative and modeled. The Medicare panel and the cohort size are discovery-stage estimates, not chart counts. **The Value Analysis is a fee-for-service model and does not model shared-savings, capitated or care-management-fee economics.** Nothing in it should be read as a projection of ACO financial performance.

8 internal medicine physicians · 14 advanced practice providers · 23 clinicians from September 2026

Single campus, Suites 400 and 104 · 116 Defense Highway, Annapolis, MD 21401 · founded 1974 · group NPI 1477629681

MDPCP-AHEAD participant, no CTO partner · MSSP Enhanced, Aledade 204 Potomac (ACO A5527)

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Executive Summary

Annapolis Internal Medicine is an independent, physician-owned internal medicine practice founded in 1974, operating from a single campus at 116 Defense Highway — the main office in Suite 400 and a same-day acute care clinic in Suite 104, which keeps Saturday hours. Twenty-two clinicians practice there: eight internal medicine physicians and fourteen advanced practice providers, rising to twenty-three when Dr. Ena Tychus joins in September 2026, inside the window this report models. The physician bench runs from Stephen Hamilton (1991) through Titus Abraham (2008, Managing Partner since 2018), Katherine Anderson (2011), Jennifer Cuhran, Timothy Woods (2015), Patricia O'Neill (2016), Andre Colaco (2018) and Kirti Malhotra (2020). Four of them came to the practice from hospitalist careers at Anne Arundel Medical Center, now Luminis Health Anne Arundel Medical Center. The clinical interests published on the practice's own pages read like a monitoring cohort definition — hypertension, heart disease, chronic lung disease and diabetes for the Managing Partner; metabolic syndrome, diabetes and heart disease for Dr. Malhotra; cardiovascular health, hypertension, diabetes and healthy aging for Dr. Tychus — and the advanced-practice bench already carries gerontology clinical-nurse-specialist and certified diabetes educator capability.

Two verified facts set the frame, and both come from primary sources rather than inference. First, the Maryland Department of Health's 2026 MDPCP-AHEAD participating practice list — participation as of 1 January 2026 — carries Annapolis Internal Medicine at 116 Defense Highway Suite 400 with the entry “No CTO Partner.” Second, CMS's PY2026 Shared Savings Program participant file, queried live on 28 July 2026, returns ANNAPOLIS INTERNAL MEDICINE, LLC as a participant in ACO A5527, “Aledade 204 Potomac MSSP Enhanced” — Enhanced track, low-revenue physician-led ACO, retrospective assignment, agreement start 1 January 2025. The same CMS record names Titus Abraham as the ACO's Medical Director.

Enhanced is the highest-risk MSSP track: up to 75% of shared savings, and the matching share of losses. For an ACO-attributed beneficiary an incremental monitoring claim is a Part B expenditure — it raises measured total cost of care against the benchmark, and at the Enhanced sharing rate it erodes shared savings in proportion. A report that opened with a large gross-revenue figure would be describing something that partly cancels itself. So this one does not.

THE CENTRAL ARGUMENT

You already do the work. You are the only kind of practice in your county doing it without a CTO behind you — and the layer you are missing is the one that pays for itself.

A Care Transformation Organization, in Maryland's own words, “hires and manages an interdisciplinary care management team”; practices that partner with one “split their program payments” with it. Ten of the 36 MDPCP practices in Anne Arundel County operate without one. Every nearby Luminis, MedStar, Johns Hopkins and University of Maryland practice has institutional care-management infrastructure behind it. This practice kept the payments and carries the labor — a defensible choice, and the reason the missing layer is specifically infrastructure: connected devices, an alert queue that runs around the clock, enrollment labor, and monthly claim generation.

The recommendation is remote patient monitoring on a condition-defined high-risk cohort of roughly 2,500 patients — about half the estimated Medicare panel. Over 24 months that models **$1,646,725 of net reimbursement** — which is also $1,646,725 of Part B added against the ACO benchmark — and **$702,033 of margin to the practice** after every CoachCare fee — a 42.6% practice margin on net reimbursement. Against the claims added, the model's avoided-admission engine returns 106 avoided hospitalizations worth $1,595,585 at $15,000 each. Net total cost of care: + $51,140 over two years — essentially neutral. And that is on the model's generic 20% baseline admission rate, which is a whole-population figure. At a 40% baseline, realistic for a cohort defined by heart failure and advanced CKD, avoided cost is $3,191,170 and net total cost of care is −$1,544,445: genuinely favorable, with the fee margin retained on top.

Panel-wide is presented in Section 5.3 as the addressable ceiling and explicitly not as the plan: $1,906,292 of net reimbursement and $813,811 of margin over 24 months at a 42.7% practice margin — only 131 more patients than the cohort produces, because the cohort already contains most of the monitoring-appropriate population. Cohort selection, not panel size, is what makes the arithmetic work on a two-sided-risk book.

The most useful finding in this analysis is not the forecast, though. It is that a compliance constraint and the risk-side interest turn out to point the same way. Chronic care management cannot be billed to Medicare for beneficiaries attributed to an MDPCP practice — the program's own guidance says so, and Section 4.2 sets out the wording and its limits. Removing CCM from the model cut the claims added to the ACO benchmark substantially while increasing the avoided admissions, because with CCM switched off the enrollment pathways renormalize into monitoring and RPM patient-months rise. The rule that looks like a setback is the reason the program is now correctly scoped.

2026–2027 Priority Recommendations

1. Scope year one to a condition-defined cohort, not to the panel. Roughly 2,500 patients carrying heart failure, CKD stage 3b–4, COPD, or poorly controlled hypertension or type 2 diabetes — the conditions where admissions actually occur. Selected from athenaOne by diagnosis, screened and approved by the practice's own clinicians. Panel-wide sizing on a two-sided-risk book bills against the benchmark without a matching saving.

2. Read the answer as total cost of care first. Avoided admissions, then the sensitivity around the admission rate, then fee margin. The fee margin is what funds the program while the risk-side benefit accrues; it is not the case for doing it.

3. Build the program on remote patient monitoring. Device supply plus physiologic treatment management is a distinct service category, it is not named in the CCM restriction, and it is the lever with the direct line to an avoided admission. Everything modeled in Section 5 is RPM.

4. Treat chronic care management as an upside layer, not a line item. Three routes remain genuinely open — non-attributed Medicare fee-for-service patients, Medicare Advantage and commercial payers, and principal care management, which the restriction does not name. None of them is modeled and none of them carries a number in this report. Section 5.6 explains why that is the honest treatment.

5. Hold APCM out of the model and name it as the build-toward target. The participation gate passes on this account. Keeping it out of the forecast is deliberate, so that no part of this case depends on a code whose interaction with the care management fee is unresolved. Zero APCM dollars appear anywhere in this document.

6. Use the athenaOne integration from day one. Enrollment flags and trigger ordering by service inside the existing clinical workflow, real-time enrollment status, patients receiving services in under five days, and automated claim generation. The last of those matters most where no CTO supplies billing support.

7. Add no capital and no headcount. Devices are supplied rather than purchased. The on-site enrollment specialist is staffed at CoachCare's expense — embedded value, never subtracted from the practice's margin and never occupying a practice headcount slot. The practice's own clinicians stay on clinical exceptions.

8. Instrument the post-discharge window deliberately. A three-touch cadence on days 1–2, 5–8 and 12–14 after any hospitalization or emergency visit in the previous 60 days, with transitional care management captured at every discharge. TCM is not modeled in any figure here. This window is where the avoided readmission and the MSSP readmission measure meet.

9. Re-run the risk side against the ACO's own benchmark before scaling. The forecast in Section 5 is fee-for-service. The avoided-admission line is the bridge to the risk side; the interaction with a rebased, risk-adjusted Enhanced benchmark has to be modeled against the ACO's own data. That is a joint exercise and it is the first thing to do after the cohort is confirmed.

1. Practice Profile and Operating Position

1.1 What the practice operates today

The published footprint, retrieved from the practice's own pages in July 2026, is a single campus with two functions under one roof. Everything below is drawn from primary sources, and marked where it is an observation about published material rather than a statement about the practice's operations.

Asset in place	What it is	Why it matters to a remote care service line
22 practicing clinicians	Eight internal medicine physicians and fourteen advanced practice providers, rising to 23 when Dr. Ena Tychus joins in September 2026. Physician tenure runs from 1991 to 2026. Adult internal medicine only.	A 22-provider referral engine — substantial for a single-site practice, and the count used in the forecast. As Section 5.4 shows, the forecast is not constrained by referral capacity but by how the cohort is defined.
An advanced-practice-heavy bench	Fourteen advanced practice providers against eight physicians. The bench includes gerontology clinical-nurse-specialist credentialing and certified diabetes educator capability.	The clinical judgment a monitoring program escalates into already exists, and it is credentialed in exactly the two domains a Medicare chronic-disease cohort needs. What is missing is the device layer and the capacity to carry a census, not the clinical skill.
Suite 104 — same-day acute care clinic	A same-day, acute clinic on the same campus, staffed by certified nurse practitioners, open weekdays and Saturday mornings.	An escalation destination that is not an emergency department. Most practices running remote monitoring do not have one, and it is the single most important operational asset for converting an alert into an avoided admission.
Hospital-medicine background on the physician bench	Four physicians came to the practice from hospitalist careers at Anne Arundel Medical Center, now Luminis Health Anne Arundel Medical Center, per the practice's own physician biographies.	This group has managed avoidable admissions and readmissions from inside the hospital. The avoided-utilization argument does not need explaining here.
Chronic-disease clinical focus	Published interests across the roster include hypertension, heart disease, chronic lung disease, diabetes, metabolic syndrome, cardiovascular health and healthy aging.	The cohort in Section 5.2 is defined by the same conditions the physicians already name as their own interests. Nothing new has to be introduced clinically.
Care management, in house, with no CTO	The state's 2026 MDPCP-AHEAD list carries the practice with “No CTO Partner.” A CTO hires and manages an interdisciplinary care management team; practices that use one split their program payments with it.	The care-management function exists and is funded. What a CTO would otherwise supply — staffing depth, monitoring technology, billing infrastructure — is carried internally. That is the gap this report addresses, and it is structural, not a criticism.
athenaOne	The practice's electronic health record, confirmed on the call. CoachCare's athenahealth integration is native and bi-directional (Section 7).	The depth of automation available on day one is known rather than contingent — including automated claim generation, which matters most where no CTO supplies billing support.
Remote patient monitoring	No remote monitoring program is described anywhere on the practice's published pages. That is an observation about published material only; this report makes no assertion about whether such a program exists.	If none exists, the device layer, the transmitted reading and the alert queue are the additions. Confirmed or corrected on the first call.

A NOTE ON HOW THIS SECTION IS WRITTEN

The footprint and roster are drawn from the practice's own published pages, retrieved July 2026. The two program positions in Section 1.2 come from primary state and federal files with their vintages stated. The electronic health record was confirmed on the call and is treated as confirmed.

Nothing here asserts a quality rating, a panel size, a care-management staffing level, a financial position or an intention. Where a fact is not in evidence it is listed in Section 9 as a question rather than stated as a finding. The build-versus-partner comparison in this document is about the cost of scaling and the ceiling a self-staffed program reaches — never about the quality of what exists.

1.2 The two verified program positions

These are the two facts that separate this account from a fee-for-service internal medicine practice, and they are the reason the argument is ordered the way it is.

Position	Verified detail	Source and vintage
MDPCP-AHEAD participant, no CTO partner	Listed at 116 Defense Highway Suite 400, Annapolis 21401, Anne Arundel County, with the CTO partner field reading “No CTO Partner.” Only 10 of the 36 Anne Arundel practices on that list operate without a CTO.	Maryland Department of Health, 2026 MDPCP-AHEAD Participating Practice List; participation as of 1 January 2026.
MSSP Enhanced-track participant	ANNAPOLIS INTERNAL MEDICINE, LLC in ACO A5527, “Aledade 204 Potomac MSSP Enhanced.” Enhanced track, low-revenue (physician-led) ACO, retrospective beneficiary assignment, agreement start 1 January 2025.	CMS PY2026 Medicare Shared Savings Program participant file, queried live 28 July 2026.
ACO clinical leadership	The same CMS record names Titus Abraham, MD — the practice's Managing Partner since 2018 — as the ACO's Medical Director.	CMS PY2026 Shared Savings Program files. Public CMS data, cited as fact.
Enhanced track economics	Enhanced is the highest MSSP risk track: up to 75% of shared savings, with the matching downside exposure. Two-sided risk.	CMS Shared Savings Program track structure.
Identity	Independent physician-owned LLC, founded 1974. Group NPI 1477629681, primary taxonomy internal medicine, registered at 116 Defense Highway.	NPPES organizational record; practice website, retrieved July 2026.
What is deliberately not asserted	No Medicare Advantage or delegated-risk arrangement. No quality rating. No panel size. No care-management staffing level. No claim about the practice's finances or intentions.	Each is listed in Section 9 as a discovery item.

1.3 The structural point: no CTO

Maryland's Care Transformation Organization model exists because care management is labor, and labor has to be hired, trained, supervised and covered. The state's own description of a CTO is that it “hires and manages an interdisciplinary care management team”; the corresponding trade-off, also in the state's own material, is that practices partnering with a CTO “split their program payments” with it. Most practices in Anne Arundel County took that trade. Ten of 36 did not, and this practice is one of the ten.

That is the whole wedge, and it is worth being precise about what it does and does not mean. It does not mean anything is being done badly. It means the practice elected to keep 100% of its program payments and to carry the care-management labor itself — a rational choice, and one that leaves a specific and identifiable gap. A hospital-affiliated competitor across town receives connected devices, an around-the-clock alert queue, enrollment labor, documentation tooling and monthly claim generation from its system's care transformation

organization, and pays for them out of a share of its program payments. A practice with no CTO has to source that layer some other way, or not have it.

WHAT COACHCARE SUPPLIES, AND HOW IT IS PAID FOR

CoachCare supplies the infrastructure layer a CTO would supply — enrollment labor, connected devices, 24/7 alert triage, escalation, documentation and automated claim generation — and is not paid out of a share of MDPCP-AHEAD program payments. It is funded from the incremental fee-for-service revenue the service line itself generates, which is modeled in Section 5. The program payments stay where they are.

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

Aledade is the incumbent ACO enabler on this account, and this report is written around it rather than against it. An ACO enablement partner supplies attribution, benchmark analytics, gap reporting and quality submission. It does not supply device fleets, transmitted physiologic readings, 24/7 triage capacity, enrollment labor or automated monthly claim generation. Those are different functions and they coexist.

1.4 Operating design principles

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

Principle	What it means in practice
Avoided cost before billed revenue	On a two-sided-risk book the first question is what the program prevents, not what it charges. Every design decision here is tested against admissions and total cost of care first, and against the fee schedule second.
Condition-defined, not panel-defined	Enrollment follows an agreed diagnosis cohort, selected from athenaOne and approved by the practice's own clinicians. Volume is a consequence of the cohort definition, never of referral enthusiasm. This is the most consequential design decision on the account.
One shared engine, many levers	Enrollment, devices, alert triage, escalation, documentation and claim capture are built once and reused across every service the practice later chooses to add. Nothing is stood up per program.
Top of license, no new headcount	The practice's physicians and advanced practice providers do clinical work. Enrollment, device logistics, first-line triage and billing mechanics are absorbed by the partner. No hiring is required for the modeled census.
Self-funding before any risk-side upside	The fee layer must stand on its own — margin-positive from the first month out of professional-fee revenue, before any shared-savings distribution, quality bonus or program payment 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 athenaOne 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, and what is modeled

A Remote Care Service Line is a set of billable services running on one operating engine: one enrollment process, one device fleet, one alert queue, one documentation trail and one claim engine. On this account the service that does the work — and the only service modeled anywhere in this report — is remote patient monitoring. The others are named honestly for what they are: real, billable in defined circumstances, and excluded from every figure.

Service	Status here	Clinical anchor	How it runs
RPM / Remote patient monitoring	MODELED / the spine of the program	Blood pressure and weight first. The cohort is defined by heart failure, CKD stage 3b–4, COPD and poorly controlled hypertension or type 2 diabetes — the conditions where admissions actually occur.	Patient transmits from a cellular connected device. CoachCare triages alerts 24/7 against thresholds the practice approves; the practice's clinicians act on clinical exceptions. Monthly device-supply and treatment-management billing.
CCM / Chronic care management	NOT MODELED / restricted for attributed beneficiaries — §4.2	Two or more chronic conditions expected to last at least 12 months. Most of an adult internal medicine Medicare panel qualifies clinically.	MDPCP program guidance states that participating practices may not bill Medicare for CCM services furnished to attributed beneficiaries. Excluded from every figure. The routes that remain open are set out in Section 5.6 and carry no number.
PCM / Principal care management	NOT MODELED / unresolved	A single high-risk condition expected to last at least three months, for the patient who does not meet the CCM two-condition test.	PCM is not named in the CCM restriction, but it sits in the same care-management family. Treated as unresolved and excluded from every figure. Not banked.
TCM / Transitional care management	NOT MODELED / upside	Every discharge back to the practice — the point of highest readmission risk, and where the MSSP readmission measure is decided.	The practice's own care team, with the three-touch post-discharge sequence in Section 6.4 running alongside it. Contact within two business days; face-to-face within 7 or 14 days by complexity.
APCM / Advanced primary care management	OFF / build-toward target — §4.5	A monthly primary-care management bundle, by complexity tier.	The participation gate passes on this account and it is deliberately held out of the model. Zero APCM dollars appear anywhere in this report, and APCM is never presented as an ACO or shared-savings play.

THE COORDINATION RULES THAT STILL HAVE TO BE SETTLED

RPM stacks. Remote monitoring may be billed alongside a care-management service in the same month where the time and documentation are discrete and separately recorded. It is the layer that does not have to be traded against anything else.

Care-management services do not stack with each other. CCM and PCM cannot both be billed for the same patient in the same month. APCM, were it ever switched on, bundles and could not be billed with CCM, PCM or TCM for the same patient in the same month — though APCM plus RPM is permitted.

The attribution policy. One owner per patient per month and one shared care plan in athenaOne: the discharge event owns TCM, and RPM attaches to the clinician managing the monitored condition. Because only RPM is modeled here, the base case carries no cross-program double counting at all — active enrollments and unique patients are the same number (Section 5.4).

2.2 Where the value comes from

For a practice carrying two-sided risk the value layers do not sit in the usual order. Avoided cost comes first, because that is the line that moves the arrangement the practice is actually accountable under. Fee margin 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

This is the reader's profit and loss. A Medicare admission in the conditions that define the recommended cohort is a five-figure event; the model values an avoided admission at approximately $15,000, which is conservative

for heart failure and reasonable across a mixed high-risk cohort. Continuous physiologic data, read against a threshold and acted on within hours, is the intervention with the best-established relationship to that admission — weight gain shows on a scale days before it shows in an emergency department, and an uncontrolled blood pressure shows on a cuff months before it shows anywhere at all. On the recommended cohort the model returns approximately 106 avoided hospitalizations over 24 months at its generic 20% baseline admission rate, worth $1,595,585. Section 3.4 shows why that baseline understates a targeted cohort by roughly a factor of two. Illustrative, modeled — verify against practice data.

Layer 2 — recurring fee margin that funds the program

Every enrolled patient generates a documented, billable event every month for as long as they remain clinically appropriate. That is what allows the service line to pay for itself rather than requiring capital 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 CoachCare, so the practice's clinicians spend their time on clinical exceptions rather than on program administration. On the recommended cohort the modeled 24-month margin to the practice is $702,033 after every CoachCare fee — a 42.6% practice margin on net reimbursement — and it is positive in month one. The benchmark interaction that sits on top of that figure is dealt with directly in Section 3.3 rather than left out.

Layer 3 — quality and performance evidence

Continuous physiologic data and a documented monthly touch are the raw material for the measures this practice is already judged on: MSSP quality reporting and utilization performance, MDPCP-AHEAD's performance-based incentive payment, and MIPS-equivalent quality reporting. Blood-pressure control, diabetes control, adherence and transitions-of-care performance are measured off the same activity that produces the claim. Specifications and cut points change year to year — confirm the current measure set before setting targets.

Layer 4 — no-CTO infrastructure leverage

The fourth layer is the one specific to this practice. Care-management infrastructure in Maryland is normally acquired by giving a Care Transformation Organization a share of program payments. This practice does not do that. The consequence is that the infrastructure layer — devices, an around-the-clock alert queue, enrollment labor, documentation tooling, automated monthly claim generation — has to come from somewhere else or not exist at all. A remote care service line supplies exactly that layer, funded out of incremental fee-for-service revenue rather than out of a care management fee, and leaves the program payments intact. It is the only one of the four layers a hospital-affiliated competitor gets for free.

2.3 The CY2026 billing stack

Rates below are CY2026 non-facility amounts for the Maryland locality served by Novitas Solutions, Jurisdiction L — carrier 12302, locality 01, ZIP 21401. Maryland is a comparatively strong locality for these codes; these are not the national averages quoted in most vendor material.

Code	Service	Type	CY2026 rate	Notes
99453	RPM — device setup and patient education	One-time	$23.41	Requires at least 2 days of transmitted data.
99454	RPM — device supply, 16–30 days of readings	Monthly	$55.96	The long-standing device-supply code.
99445 new	RPM — device supply, 2–15 days of readings	Monthly	$55.96	New for CY2026, at the same value. Makes short windows — post-discharge, post-titration — billable for the first time.
99457	RPM — treatment management, first 20 minutes	Monthly	$54.61	Interactive communication required.

Code	Service	Type	CY2026 rate	Notes
99470 new	RPM — treatment management, 10–19 minutes	Monthly	$27.47	New for CY2026. Captures the months that fall short of the 20-minute floor.
99458	RPM — treatment management, each additional 20 minutes	Monthly	$43.50	
99490 / 99439	CCM — first 20 minutes / each additional 20 minutes	Monthly	$69.44 / $53.06 not modeled	Rates shown for completeness. Restricted for attributed beneficiaries and excluded from every modeled figure — Section 4.2.
99426 / 99427	PCM — first 30 minutes / each additional 30 minutes, staff	Monthly	$71.23 / $56.98 not modeled	Not named in the CCM restriction, but treated as unresolved and excluded.
99495 / 99496	TCM — moderate / high complexity	Per discharge	~$200 / ~$280 not modeled	National illustrative magnitude; locality rate to be confirmed. Real, billable at every discharge, and excluded from every figure.
G0556 / G0557 / G0558	APCM — by complexity level	Monthly bundle	off	Switched off. Zero dollars in this report. See Section 4.5.

HOW THE FEE LAYER BEHAVES — AND WHERE IT MEETS THE BENCHMARK

A single monitored patient billed at 99454 plus 99457 in a month, with a one-time 99453 at setup, produces a predictable per-patient-per-month amount. Multiply by an enrolled census that grows and then holds, subtract denials and the share of coinsurance that never collects, and the result behaves like a subscription rather than like visit volume. On the modeled cohort, net reimbursement per active patient-month runs approximately $103.21.

On an ACO-attributed beneficiary that same predictability cuts both ways. Every one of those claims is a Part B expenditure measured against the ACO's benchmark. That is precisely why the cohort is defined by diagnosis and gated by the practice's own clinicians rather than opened to the whole panel — the avoided cost has to exceed what gets billed, and only in a high-risk cohort does it.

The two codes new for CY2026 matter disproportionately here. 99445 pays for a 2–15 day device window and 99470 for 10–19 minutes of management, so the partial months that make up most of real-world monitoring now bill. Together those two codes carry $288,710 of the modeled net reimbursement — 17.5% of the total. Two years ago that revenue did not exist.

Illustrative, modeled — verify against practice data. Rates are locality-adjusted, set by the regional Medicare Administrative Contractor, and change annually. Confirm current CY2026 amounts against the Novitas JL fee schedule before relying on any figure here.

2.4 Connective tissue

The reason to build this as a service line rather than as a point solution is that the expensive parts are shared. Enrollment, connected devices, 24/7 alert triage, escalation, documentation and automated claim generation are built once. Every lever below draws on the same engine, including the ones this report does not model.

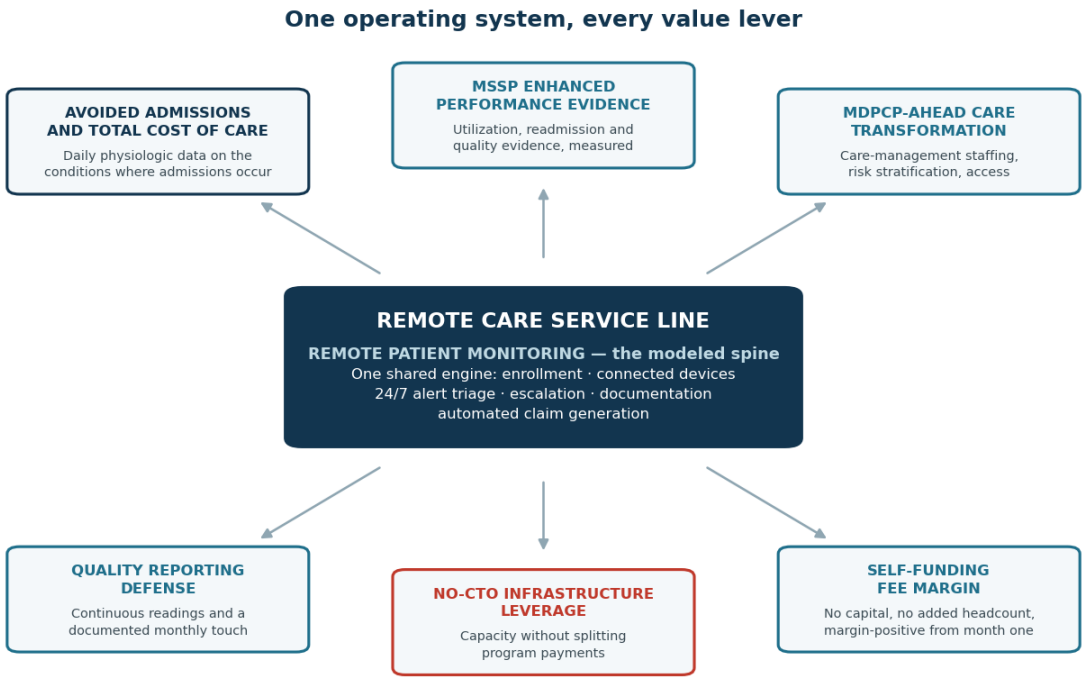

Figure 1 — One operating system, every value lever. The shared engine is built once; each lever draws on the same enrollment, device, triage, documentation and billing infrastructure.

Lever	What the shared engine supplies	What it produces for the practice
Avoided admissions and total cost of care	Daily physiologic data on a cohort defined by the conditions where admissions occur, thresholds set with the practice's physicians, alerts triaged within hours, escalation into the Suite 104 same-day clinic rather than an emergency department.	The line that moves the ACO's measured expenditure. Approximately 106 avoided admissions on the recommended cohort at the model's baseline rate, and roughly double that at a rate realistic for the cohort.
MSSP Enhanced performance evidence	The same readings, contacts and escalations, attributable to the ACO-assigned population and captured as structured data in athenaOne.	An evidence base for utilization and quality performance that exists continuously rather than retrospectively. The fee model in Section 5 does not quantify this; it has to be run against the ACO's own benchmark.
MDPCP-AHEAD care transformation	Care-management staffing depth, risk stratification against transmitted data, documented between-visit contact, and support for the program's extended-access and care-management requirements.	Capability against the program's stated care-transformation priorities, without hiring and without splitting program payments with a CTO.
Quality reporting defense	Continuous readings, a documented monthly clinical contact, medication-adherence touchpoints and post-discharge follow-up evidence.	Blood-pressure control, diabetes control, adherence and transitions-of-care performance improved on the same touch that produces the claim.
No-CTO infrastructure leverage	The device fleet, the 24/7 alert queue, enrollment labor, documentation tooling and automated claim generation — the layer a Care Transformation Organization would otherwise supply.	Equivalent operating capability to a system-backed competitor, funded from incremental fee-for-service revenue rather than from a share of MDPCP-AHEAD program payments.
Self-funding, without capital	Supplied devices, a CoachCare-funded on-site enrollment specialist, and a CoachCare-run billing engine.	A service line that is margin-positive from month one with no capital outlay and no additional headcount — so the avoided-cost case does not have to be pre-funded.

3. Two-Sided Risk — What It Changes About This Business Case

3.1 The Medicare market the practice actually serves

Two market facts matter here, and they pull in the same direction. Anne Arundel County is one of the least Medicare-Advantage-penetrated markets in the country — a structural consequence of Maryland's all-payer hospital rate environment — so the great majority of the practice's Medicare panel sits in Original Medicare, directly on the fee schedule these codes are paid from. That same population is the population an MSSP ACO attributes. Favorable fee economics and benchmark exposure are two descriptions of one group of patients.

Anne Arundel County, Maryland	Count	Share
Medicare eligibles	111,257	—
Enrolled in Medicare Advantage	22,074	19.84%
Remaining in Original Medicare	89,183	~80%

Source: CMS Medicare Advantage State/County Penetration file, July 2026. Roughly four in five of the county's Medicare beneficiaries are on the fee-for-service rails modeled in Section 5 — and on the rails an MSSP ACO attributes from. The direction of travel favours the program as well: Original Medicare enrolment in the county rose 3.1% year over year while Medicare Advantage fell 1.4% (CMS monthly enrolment, April 2025 to April 2026). The county's acute readmission rate is 19.9% and it records 483.5 emergency-department visits per 1,000 beneficiaries (CMS Geographic Variation, CY2024), so there is real utilization to move.

3.2 Why gross fee revenue is the wrong headline here

For a fee-for-service practice, a remote monitoring program is a revenue line and the analysis stops there. For a practice in an Enhanced-track ACO it does not, and the reason is mechanical rather than rhetorical. Shared savings are calculated against a benchmark built from expenditure. Every RPM claim raised on an attributed beneficiary is a Part B expenditure inside that calculation. At the Enhanced sharing rate, roughly three quarters of any net increase in measured total cost of care comes back out of the savings distribution.

So a program that bills a large amount against a stable population is not obviously worth running, while one that bills a smaller amount against a population where admissions actually happen is a different proposition, because the Part A side moves. The claim made below is narrow and checkable: on a correctly scoped cohort the Part A reduction plausibly exceeds the Part B addition, and the fee margin is retained either way. Whether that converts into a shared-savings distribution depends on a rebased, risk-adjusted benchmark this model does not have access to.

3.3 The benchmark arithmetic

The table below is the directional two-sided-risk interaction on the recommended base case over 24 months. It is arithmetic on modeled inputs, not an ACO financial projection, and every line can be checked.

24-month directional view — base case	At the model's 20% baseline	At a 40% baseline
Part B claims added against the ACO benchmark	+$1,646,725	+$1,646,725
Avoided hospitalizations	106	213
Part A avoided at $15,000 per admission	−$1,595,585	−$3,191,170
Net change in measured total cost of care	+$51,140 essentially neutral	−$1,544,445 genuinely favorable

24-month directional view — base case	At the model's 20% baseline	At a 40% baseline
Fee margin retained by the practice, after every CoachCare fee	+$702,033	+$702,033

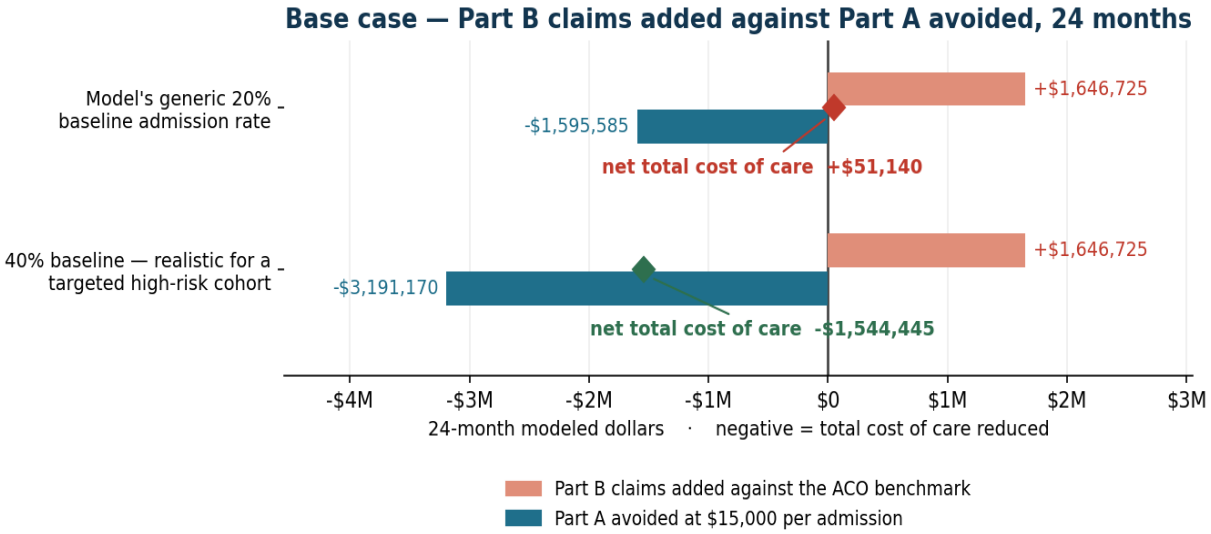

Figure 2 — Part B claims added against Part A avoided, base case, 24 months. Negative net means measured total cost of care falls. Illustrative, modeled — verify against practice data.

READ THE NEUTRAL CASE FIRST

At the model's own conservative baseline the program is approximately total-cost neutral: $1,646,725 of Part B added against $1,595,585 of Part A avoided, a net of $51,140 over two years. That is the floor of the argument, not the ceiling — and even at the floor, the practice retains $702,033 of fee margin for a program that does not move measured expenditure in either direction to any material degree.

The case improves from there rather than depending on optimism, because the 20% baseline is a whole-population admission rate applied to a cohort selected for the conditions that admit. Section 3.4 quantifies that.

3.4 The admission-rate sensitivity

The single most important assumption in the avoided-cost line is the baseline annual admission rate the model assumes for the enrolled population. It uses 20% — a reasonable figure for a general Medicare population, and the wrong figure for a cohort defined by heart failure, advanced chronic kidney disease and COPD. The table shows the whole range rather than the convenient point on it.

Baseline annual admission rate in the cohort	Avoided admissions over 24 months	Avoided cost at $15,000 each	Net change in total cost of care
20% — the model default, a whole-population rate	106	$1,595,585	+$51,140
30%	160	$2,393,378	−$746,653
40% — realistic for a targeted high-risk cohort	213	$3,191,170	−$1,544,445
50%	266	$3,988,963	−$2,342,238

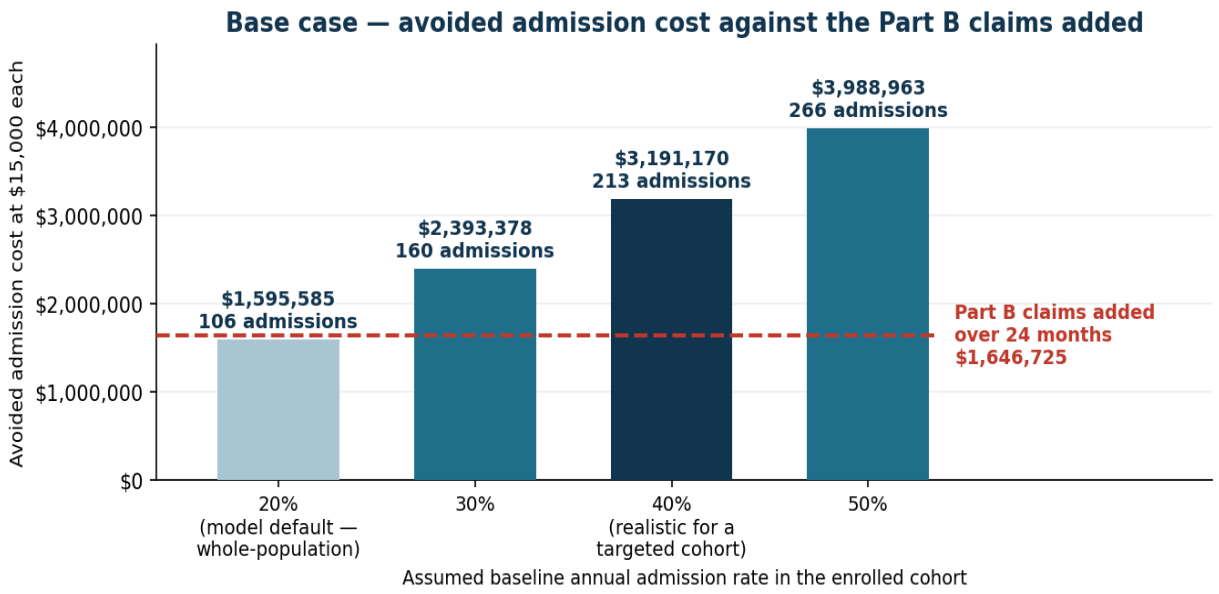

Figure 3 — Avoided admission cost across baseline admission rates, base case, against the $1,646,725 of Part B claims added over the same period. Illustrative, modeled — verify against practice data.

The crossover sits just above the model's default. Somewhere between a 20% and a 30% baseline the avoided cost passes the claims added, and every rate above that point reduces measured total cost of care. For a cohort chosen specifically because its members are admitted, that is not an aggressive assumption — it is the reason for choosing the cohort. The number to replace this table with is the practice's own admission rate in the selected cohort, which is the highest-value thing discovery can produce.

3.5 Why the compliance constraint and the risk-side interest agree

This is the finding worth carrying out of the document. Chronic care management is restricted for beneficiaries attributed to an MDPCP practice — Section 4.2 sets out the wording. Read as a commercial problem, that removes roughly half of a conventional care-management revenue stack. Read against an Enhanced-track benchmark, it does something more useful than that.

THE RULE THAT LOOKS LIKE A SETBACK IS THE REASON THE PROGRAM IS CORRECTLY SCOPED

Scoping chronic care management out cut the claims added to the ACO benchmark substantially — and raised the avoided admissions. With CCM switched off the enrollment pathways renormalize into monitoring, so RPM patient-months rise and the avoided-admission line rises with them. The enrollment effort concentrates on the device layer instead of splitting across two programs.

A configuration that adds a larger charge to a benchmark to buy fewer avoided admissions is a worse trade for a practice in an Enhanced-track ACO. The compliance constraint and the risk-side interest point the same way, which is an unusual and welcome thing. It also means the program does not need CCM to work, so none of the routes in Section 5.6 has to be resolved before anything is built.

3.6 What the Value Analysis does not model

HARD CAVEATS, CARRIED INTO EVERY FIGURE IN THIS REPORT

The Value Analysis is a fee-for-service model. It does not model shared-savings economics, capitated economics, or care-management-fee economics. No shared-savings distribution, capitation adjustment, quality bonus, care management fee, HEART payment or performance-based incentive payment appears in any modeled figure.

The benchmark interaction is directional, not a projection. MSSP benchmarks are risk-adjusted and rebased. The arithmetic in Sections 3.3 and 3.4 is a directional read on the mechanism, not an ACO financial projection, and it should be re-run against the ACO's own benchmark and attribution data.

Not every Medicare patient in this panel is attributed. Assignment is retrospective and plurality-based. Some of the practice's Medicare population sits outside the attributed group, where the benchmark interaction does not arise at all. The size of that group is unknown and is a discovery item.

The panel and cohort figures are estimates. The ~5,000 Medicare panel is a provider-based triangulation sanity-checked against the county's 111,257 Medicare eligibles, with a plausible range of roughly 4,000 to 6,300; no claims-based figure exists for this practice. The ~2,500 cohort is likewise an estimate, at roughly half of that panel, consistent with chronic-condition prevalence in an adult internal medicine Medicare population. Both must be replaced with athenaOne chart counts against an agreed diagnosis definition.

The avoided-admission figure is a modeled effect. It is derived from RPM patient-months at an assumed baseline admission rate and valued at approximately $15,000 per admission. It is not a measurement of this practice's admission history.

4. The MDPCP-AHEAD Layer

4.1 What MDPCP-AHEAD pays and requires in PY2026

The Maryland Primary Care Program was folded into the AHEAD Model and renamed MDPCP-AHEAD on 1 January 2026. The practice is a participant as of that date. The program's PY2026 shape matters commercially because it determines both what is already being paid for care management and what is available to spend.

PY2026 feature	Detail
Track structure	Only Track 2 is available for PY2026, so participation is Track 2 by program design.
Comprehensive Primary Care Payment split	65% / 35% for all participants — 65% of the Medicare primary-care payment arrives as prospective capitation, 35% as reduced fee-for-service.
Care Management Fee	$9–$100 per beneficiary per month, risk-tiered. Explicitly for care management — which is what makes the question in Section 4.2 unavoidable.
HEART payment	$110 per beneficiary per month for qualifying beneficiaries.
Optional benefit enhancements	Include telehealth visits and non-physician care management visits — an explicitly sanctioned mechanism for advanced-practice and nurse-delivered care management.
Program scale, January 2026	Approximately 460 practices and roughly 350,000 attributed Medicare fee-for-service beneficiaries statewide.

Source: Maryland Department of Health, Office of Advanced Primary Care all-call deck, 16 December 2025; 2026 MDPCP-AHEAD participating practice list, participation as of 1 January 2026.

4.2 Chronic care management and attributed beneficiaries

This is the finding that reshaped the model, and it deserves to be stated in the program's own words rather than paraphrased. The Maryland Primary Care Program's getting-started guidance addresses the overlap between the program's care management fee and Medicare's chronic care management codes directly:

MDPCP PROGRAM GUIDANCE, ON CCM

"Given the similarity between MDPCP and CCM services covered by Medicare FFS, MDPCP Practices in both Tracks may not bill Medicare for CCM services furnished to attributed Medicare beneficiaries."

Maryland Primary Care Program — Getting Started with the MDPCP Guide, page 28.

Three things follow, and the third is the one that matters most.

- **The restriction is real and it is scoped.** It applies to CCM services furnished to attributed Medicare beneficiaries. It does not, on its face, reach beneficiaries who are not attributed, and it does not reach non-Medicare payers. Section 5.6 sets out those routes without putting a number on any of them.
- **The wording names CCM specifically.** Principal care management is not named. That is not permission — PCM sits in the same care-management family and a reasonable reader would want it confirmed rather than inferred. It is treated as unresolved throughout this report and excluded from every figure.
- **Remote patient monitoring is a different service category.** Device supply and physiologic treatment management are not care coordination, they are not named in the restriction, and there is no evidence they sit inside the capitated primary-care payment. That is why the modeled program is built on RPM — and, as Section 3.5 shows, why the resulting scope is better for a two-sided-risk practice than the alternative.

TWO LIMITS ON THIS CITATION, STATED PLAINLY

The quoted wording is from the MDPCP getting-started guide, whose available edition dates to 2020. It predates both the AHEAD transition and the current 65/35 Comprehensive Primary Care Payment structure.

The document that would settle the current position — the MDPCP-AHEAD Payment Specifications — sits behind CMMI Connect authentication and could not be retrieved. So the restriction is treated here as the operative rule, because it is the clearest primary statement available, while remaining the first item to confirm with the Office of Advanced Primary Care. Nothing in the modeled forecast depends on the answer: CCM contributes zero dollars either way.

4.3 What is available, and deliberately not modeled

Several real revenue and funding mechanisms sit alongside the modeled program. None of them appears in any figure in this report. They are listed because a reader who manages this program will already know they exist, and leaving them out silently would look like an oversight rather than a discipline.

Mechanism	What it is	Why it is not modeled
HEART payment flexibility	$110 per beneficiary per month for qualifying beneficiaries. From 1 January 2026 practices may direct the HEART payment to beneficiary-level expenditures for any high-need beneficiaries the practice designates.	This is budget the practice already receives, and monitoring devices and services for high-need patients are a defensible use of it. That makes it a funding route rather than a revenue line — and it is the practice's decision, not a modeling assumption.
Non-physician care management visits	An optional benefit enhancement under MDPCP-AHEAD covering care management visits delivered by non-physician staff.	Directly aligned to an advanced-practice-delivered model, and relevant to how the program is staffed. Not a modeled revenue stream.
Transitional care management	99495 / 99496 at every discharge back to the practice.	Real and billable. Discharge volume attributable to the practice is not publicly documented and this report does not estimate numbers it cannot source. Quantifying it is a first-call item.

Mechanism	What it is	Why it is not modeled
Care Partner Arrangements under AHEAD	AHEAD provides a mechanism under which a hospital may fund care management delivered inside an independent practice. Under Maryland's fixed global budget an avoided admission improves hospital margin rather than reducing revenue, and the Readmissions Reduction Incentive Program adjusts hospital inpatient revenue by up to ±2% on readmission performance.	A strategic option, not a modeled figure. Worth noting that ZIP 21401 — this practice's own ZIP — is the largest single source of Medicare admissions to Luminis Health Anne Arundel Medical Center at 1,271 cases, and the hospital's published readmission position is short of its target. Confirm current-year standing before relying on it.

The Care Partner Arrangement point is made factually and is not a criticism of any organization. Under a global budget the hospital and an independent practice managing the same patients have genuinely aligned interests in avoided utilization — an alignment that does not exist in most of the country. Whether it is worth pursuing is a decision for the practice.

4.4 Program continuity and Maryland's reimbursement environment

Two timing facts are commonly got wrong, and getting them right matters for how durable the infrastructure investment looks.

- **MDPCP did not end.** It was renamed and folded into the AHEAD Model on 1 January 2026 as MDPCP-AHEAD. MDPCP-AHEAD continues through 2028, at which point CMS and the State decide whether to continue it; the AHEAD Model itself runs to 2035. The common assertion that MDPCP sunsets on 31 December 2026 is wrong.
- **Maryland telehealth reimbursement is durable.** The Maryland Preserve Telehealth Access Act of 2025 (HB 869, Chapter 482), approved 13 May 2025 and effective 1 June 2025, eliminated time restrictions on Medicaid and insurer telehealth reimbursement. That is a structural support for remote and between-visit care in this state rather than a temporary waiver.

> **WHY A BILLABLE FLOOR MATTERS UNDER A PROGRAM WITH A REVIEW DATE**
>
> CMS's own evaluation of MDPCP found the program cost in the region of $96 million a year without producing statistically significant savings, while improving post-exacerbation follow-up. That is not a criticism of the program or of the practices in it — the follow-up improvement is real and it is exactly the kind of capability MDPCP was built to create.
>
> The relevant point is narrower. A capability funded by a CMMI subsidy carries the subsidy's review date. A capability funded by billable, margin-positive fee-for-service revenue does not. Building the monitoring layer on the fee schedule puts a floor under infrastructure that would otherwise depend on a program decision in 2028 — and it does so without touching the care management fee.

4.5 APCM — gate passed, held off, named as the build-toward target

Advanced Primary Care Management requires value-model participation. On this account that gate passes on verified evidence: MDPCP-AHEAD participation as of 1 January 2026 and MSSP Enhanced participation in ACO A5527. This is the cleanest APCM qualification in the segment.

AND IT IS STILL SWITCHED OFF, DELIBERATELY

APCM contributes zero dollars to every figure in this report. It is named here as a build-toward target for a later phase, and nowhere as modeled revenue.

The reason is the same discipline that governs the rest of the document. APCM is a monthly primary-care management bundle, and its interaction with an MDPCP-AHEAD care management fee is exactly the question Section 4.2 leaves open for CCM. Modeling it would put the least certain element of the account into the headline. It is better revisited once the Office of Advanced Primary Care has answered the CCM question, because the same answer will largely settle APCM.

APCM is never presented in this report as an ACO or shared-savings play.

5. The Value Analysis — 24-Month Modeled Forecast

5.1 Modeling basis and assumptions

The Value Analysis models remote patient monitoring end to end: enrollment pathways, eligibility, consent conversion, attrition, code-level reimbursement at Maryland locality rates, denials, the share of patient coinsurance that does not collect, and all CoachCare fees. Two configurations are presented — the recommended base case on a condition-defined high-risk cohort, and the panel-wide ceiling, which is shown to bound the opportunity and is explicitly not the plan.

Assumption	Value	Basis
Programs modeled	RPM only	Chronic care management, principal care management, transitional care management and APCM are all excluded from every figure. Sections 4.2 and 5.6 explain why.
Cohort in scope, base case	~2,500 patients	Condition-defined: heart failure, CKD stage 3b–4, COPD, or poorly controlled hypertension or type 2 diabetes. About half of the estimated Medicare panel, consistent with chronic-condition prevalence in an adult internal medicine Medicare population. A discovery-stage estimate, not a chart count.
Medicare panel, ceiling case	~5,000 patients	Provider-based triangulation sanity-checked against 111,257 county Medicare eligibles (~4.5% of them), with a plausible range of roughly 4,000 to 6,300. No claims-based figure exists for this practice. Validate against athenaOne chart counts.
Referring providers	22	Eight internal medicine physicians and fourteen advanced practice providers. Rising to 23 in September 2026.
Eligibility within scope	85% base case / 50% ceiling case	A deliberate condition-defined override: the cohort is selected by diagnosis, so nearly all of it is monitoring-appropriate at 85%. The panel-wide case is derived bottom-up rather than taken from a default — the cohort's 2,125 device-appropriate patients plus roughly 15% of the 2,500 patients outside it gives about 2,500 across the whole panel, or 50%. The difference is deliberate, not an inconsistency.
Consent conversion	35%	Standing conversion baseline for a targeted cohort with physician endorsement and an on-site specialist, applied to both cases.
Enrollment pathways	Physician and advanced-practice referral into a gated cohort, on-site enrollment specialist, telephonic enrollment	Referral volume across 22 providers at eight referrals each per month and an 80% patient accept rate — roughly 141 referrals a month — restricted to the approved cohort list; one on-site specialist at 80 enrollments a month; telephonic enrollment as the third pathway. All three ramp over the first four months.
On-site enrollment specialist	1 FTE, funded by CoachCare	Staffed at CoachCare's expense. Embedded value — never subtracted from the practice's margin and never a practice headcount slot.

Assumption	Value	Basis
Attrition	~1.5% per month	Applied to the active census every month.
Revenue mechanics	Net, not gross	A 2.5% denial rate, 20% patient coinsurance with a 25% bad-debt assumption on that coinsurance, and realistic code-completion rates rather than assuming every eligible code is billed every month. Add-on codes are modeled at partial hit rates.
Program start	Enrollment begins in month 1	No onboarding delay is modeled.
athenaOne integration	$1,000 setup · $150 per month · per-patient integration fee	Catalog pricing, included in the modeled fees. Confirm in contracting.
Avoided admission valuation	~$15,000 per admission	Applied to modeled avoided hospitalizations. Conservative for heart failure.
Fee schedule basis	CY2026, Novitas JL carrier 12302, locality 01	Maryland non-facility rates, ZIP 21401. Re-verify at contracting.

5.2 The base case — RPM on the condition-defined cohort

This is the recommended Year-1 scope: approximately 2,500 patients carrying the conditions where admissions occur, selected from athenaOne by diagnosis and approved by the practice's own clinicians before any enrollment conversation happens.

Base case	Net reimbursement	CoachCare fees	Practice profit	Margin
Year 1	$734,505	$422,542	$311,963	42.47%
Year 2	$912,220	$522,150	$390,070	42.76%
24-month	$1,646,725	$944,692	$702,033	42.63%

Net reimbursement is stated after denials and after the share of patient coinsurance that does not collect. Practice profit is stated after every CoachCare fee, including $40,753 of ancillary fees across the 24 months — implementation, athenaOne integration setup, the monthly integration charge and per-patient integration fees. The monitoring program itself carries $1,646,725 of net reimbursement against $903,939 of program cost, for $742,786 of margin before those ancillary fees. Margin is practice profit divided by net reimbursement. Year totals are rounded to the dollar, so a column may sum $1 away from the 24-month figure. Illustrative, modeled — verify against practice data.

Base case — what it produces over 24 months	Value	Note
Avoided hospitalizations	106	At the model's generic 20% baseline admission rate — $1,595,585 at $15,000 each. 213 avoided admissions at a 40% baseline. See Section 3.4.
Active enrollments at month 24	744	The ceiling: 2,500 × 85% eligibility × 35% consent = 743.75. Reached in month 6.
Unique patients at month 24	744	Because only RPM is modeled, active enrollments and unique patients are the same number. There is no cross-program dual enrollment to deduplicate and none is described.
Patient-months of monitoring	15,956	Net reimbursement per active patient-month is approximately $103.21.
Billed claims and units	29,294	Documented, billable events generated.

Base case — what it produces over 24 months	Value	Note
Physiologic readings captured	167,536	Transmitted weights and blood pressures — the data layer behind both the admissions effect and the risk-side evidence base.
Care-team hours absorbed	11,369	Approximately 5.5 full-time-equivalent years of enrollment, device logistics, triage, documentation and billing work absorbed by the partner rather than hired.
Month-1 practice profit	+$76	Positive in month one and in every month thereafter. The figure is thin because the census is small; the point is the sign, not the size.

MARGIN-POSITIVE FROM MONTH ONE

Practice profit is positive in month 1 and in every month after it. There is no J-curve to fund, no capital outlay and no additional employee to hire. Because a monitoring-only build carries a lighter first-month fee load, the one-time implementation and integration fees are absorbed inside a positive first month.

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

5.3 The ceiling — RPM panel-wide

The panel-wide case is presented to bound the opportunity, not to propose it. It is what monitoring across the whole estimated Medicare panel would produce on the fee side — and, as Section 3 sets out, a larger claims addition against an Enhanced benchmark is not straightforwardly better. It is derived from the same per-patient-month economics as the base case with the panel-wide eligibility applied, so the two scenarios stay consistent.

Ceiling case — 24 months	Value	Note
Net reimbursement	$1,906,292	Panel-wide monitoring at the same locality rates.
CoachCare fees	$1,092,481	Net reimbursement less the practice margin below.
Practice margin	$813,811	A 42.7% margin on net reimbursement.
Active enrollments and unique patients at month 24	875	The ceiling: 5,000 × 50% eligibility × 35% consent = 875. Reached in month 6.
Avoided hospitalizations	~123	At the 20% baseline; approximately 246 at a 40% baseline.

WHY THE CEILING IS NOT THE RECOMMENDATION

Screening the other half of the panel adds only 131 more monitored patients — 875 against 744 — because the cohort already contains most of the monitoring-appropriate population. What it does add is $259,567 of additional Part B claims against the ACO benchmark, spread across patients selected by having a pulse rather than by having a diagnosis.

That is the whole argument for the cohort. Monitoring a stable, well-controlled hypertensive produces a monthly charge against the benchmark and very little avoided utilization; monitoring the patients where admissions actually happen produces most of the clinical benefit for a fraction of the claims exposure — and it keeps the alert queue clinically meaningful. Panel-wide is the ceiling. It is not the plan, and it should not be read as a growth target.

5.4 Enrollment, saturation and the honest ceiling

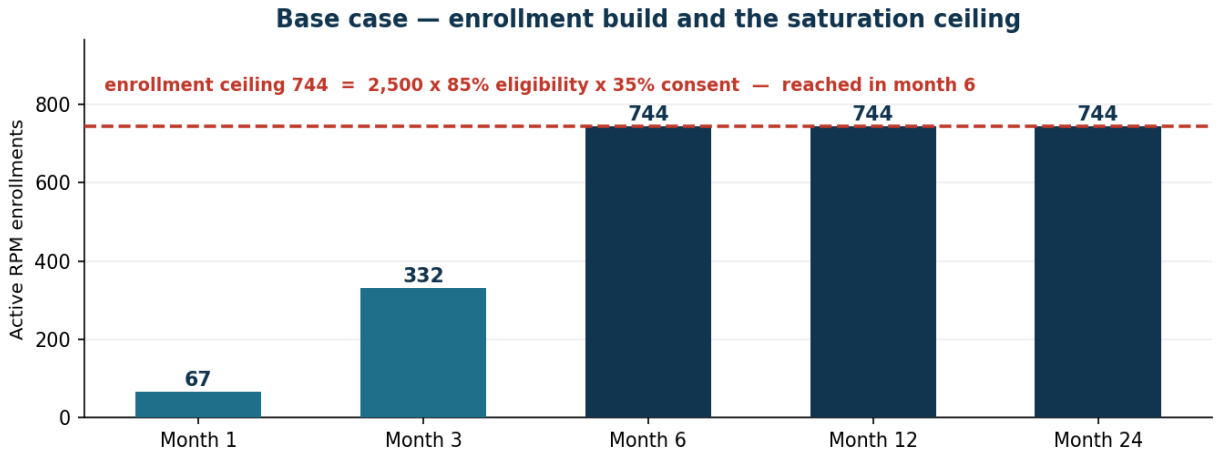

Figure 4 — Enrollment build against the saturation ceiling, base case. Active enrollments equal unique patients throughout, because only RPM is modeled.

THIS COHORT SATURATES IN MONTH 6

The census reaches its 744-patient ceiling in month 6 and the forecast is flat from there — the month-12 and month-24 counts are the same number. That is not a modeling artefact and it is not buried in an 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 and the consent rate, not outreach capacity. A 22-provider referral engine generates roughly 141 referrals a month before the on-site enrollment specialist adds anything, against a cohort ceiling of 744. Adding providers, adding referral volume or adding a second enrollment specialist would move the forecast very little — which is exactly the behavior a two-sided-risk practice should want from an enrollment engine.

The two levers that do move it are widening the cohort — a clinical decision, taken where the data earns it — and the consent rate. Widening is a conversation with the practice's physicians and with athenaOne, not an outreach target.

5.5 Base against ceiling

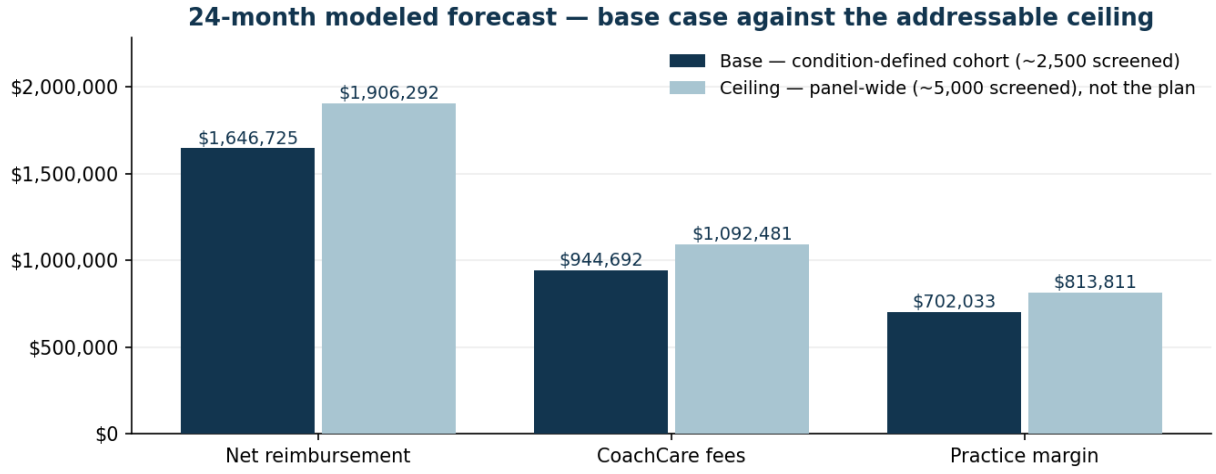

Figure 5 — The two modeled configurations over 24 months. Illustrative, modeled — verify against practice data.

Metric, 24 months	Base — cohort (~2,500)	Ceiling — panel-wide (~5,000)
Net reimbursement	$1,646,725	$1,906,292

Metric, 24 months	Base — cohort (~2,500)	Ceiling — panel-wide (~5,000)
Practice profit after every CoachCare fee	$702,033	$813,811
Margin on net reimbursement	42.63%	42.69%
Eligibility applied	85% (condition-defined)	50% (panel-wide)
Active enrollments and unique patients at month 24	744	875
Ceiling reached	Month 6	Month 6
Avoided hospitalizations at the 20% baseline	106	~123
Avoided hospitalizations at a 40% baseline	213	~246
Net change in total cost of care, 20% baseline	+$51,140	+$61,292
Month-1 practice profit	+$76	positive, as in the base case

Both configurations land at almost the same margin rate, which is the point: on the fee side, scale is close to neutral. What scale changes is the absolute charge landing against the benchmark and the number of stable patients carrying a device.

5.6 The CCM upside layer — real, unmodeled, unpriced

Chronic care management is excluded from every figure in this report. It is not, however, universally unavailable to this practice, and pretending otherwise would be as unhelpful as banking revenue that may not exist. Three routes remain genuinely open. None of them is modeled, and this report deliberately puts no number on any of them.

Route	Why it may be available	Why no number appears here
Non-attributed Medicare fee-for-service patients	The restriction is scoped to CCM services furnished to attributed beneficiaries. MSSP assignment is retrospective and based on a plurality of primary care, so a practice of this kind carries Medicare fee-for-service patients who are not attributed.	The size of the non-attributed group is unknown and cannot be estimated from public data. It is a discovery item. Sizing it would be a guess presented as a forecast.
Medicare Advantage and commercial payers	The restriction addresses billing Medicare. Roughly one in five Medicare beneficiaries in Anne Arundel County is in Medicare Advantage, and the practice accepts Aetna, CareFirst and CIGNA.	Code-level coverage, contracted rates and prior-authorization posture vary by plan and were not verified. Confirm plan by plan before any of it is counted.
Principal care management	PCM (99426 / 99427) is not named in the restriction, and it addresses the single-high-risk-condition patient rather than the multi-condition patient.	It sits in the same care-management family as CCM. Absence from the wording is not permission. Treated as unresolved and not banked.

WHY THIS IS THE RIGHT TREATMENT

The reader of this document manages an ACO's clinical strategy. A vendor that quietly modeled a restricted code, or that omitted the routes that remain open, would be caught either way. So the modeled forecast contains only monitoring, and every care-management route is listed with its own reason for being unpriced.

The practical consequence is that nothing in the recommended program depends on resolving any of this. The base case in Section 5.2 stands on RPM alone. Each of these routes, if it opens, is additive to a case that already works.

5.7 Operational value

The care-team hours figure is not a claim that the practice would shed positions. It is the volume of enrollment, device logistics, triage, documentation and billing work the service line generates and CoachCare absorbs — work that would otherwise have to be hired for if the same census were built in house. For a practice carrying its care management without a CTO, that is the whole proposition.

Metric, 24 months	Base case	What it represents
Billed claims and units	29,294	Documented, billable events generated across the monitoring program.
Physiologic readings captured	167,536	Transmitted weights and blood pressures that become the evidence base for both the admissions effect and ACO performance reporting.
Care-team hours absorbed	11,369	Approximately 5.5 full-time-equivalent years of work absorbed rather than hired. Set against a practice carrying care management with no CTO, this is the capacity line rather than a cost saving.
Additional practice headcount required	None	The enrollment specialist is CoachCare-funded and devices are supplied rather than purchased.

EVERY FIGURE IN THIS SECTION

Illustrative, modeled — verify against practice data. The forecast rests on discovery-stage panel and cohort estimates, standing conversion and attrition baselines, and CY2026 Maryland locality rates. The Value Analysis is a fee-for-service model and does not represent shared-savings, capitated or care-management-fee economics. Chronic care management, principal care management, transitional care management and APCM are excluded throughout.

6. Clinical Governance and Escalation

A monitoring program is only as good as what happens when a reading is out of range. This section sets out the governance that ships with the service line, because it is the part that determines whether transmitted data becomes an avoided admission or merely an alert. It is standard operating procedure, reviewed and customised with the practice's physicians before go-live rather than imposed.

6.1 One shared escalation engine

Every reading from every monitoring program routes through a single escalation engine — remote patient monitoring today, and chronic or principal care management if the practice later adds either. There is no separate escalation logic per program, which matters both clinically and for audit: one rule set, one documentation standard, one place to look when a case is reviewed.

Situation	What happens	Who decides
A critical value is transmitted	Escalation proceeds regardless of whether the patient reports symptoms. A critical reading is never worked down through a retake loop first.	Thresholds are set with the practice's physicians at implementation and tuned thereafter.
An out-of-range but non-critical value is transmitted	The patient is asked to retake the reading and is worked through a symptom check before anything escalates. Most out-of-range readings resolve here — which is what keeps the practice's clinicians seeing exceptions rather than raw data.	CoachCare, against the practice's protocol.

Situation	What happens	Who decides
An objective trend appears	A trend is defined rather than judged: three consecutive readings at least one hour apart for blood pressure or glucose, or three readings within seven days for heart rate. A confirmed trend escalates even where no single reading is critical.	Definition is fixed in protocol; the clinical response is the practice's.
The patient cannot be reached	A voicemail is left with a callback request. If the value is critical or a trend is confirmed, escalation proceeds anyway — an unreachable patient never stalls an escalation.	CoachCare escalates; the practice is notified.

6.2 Critical values, the retake loop and the trend definition

The retake-and-symptom-check step is what separates a program that generates signal from one that generates noise. A cuff placed wrong produces an alarming number; a patient who stood up too quickly produces another. Working those down before they reach a clinician is how a practice of this size carries a monitored census at all. The trend definition is deliberately objective for the same reason — three consecutive blood pressure or glucose readings at least an hour apart, or three heart-rate readings inside seven days, escalate on that basis alone. It removes the judgment call about whether a series of mildly abnormal readings matters, and it produces a documented, reviewable reason for every escalation.

6.3 Three-way routing and the emergent pathway

Once a reading has been confirmed as requiring action, it routes one of three ways. The routing is not discretionary.

Route	Trigger	What happens
Emergent — 911	Chest pain, new shortness of breath, signs of stroke, syncope, worst-ever headache, or sudden swelling reported during outreach.	911 is called with the patient still on the line. If the patient refuses, they are directed to the clinic and the practice is notified immediately. If the patient cannot or will not act, CoachCare activates 911.
Non-critical clinical escalation	A confirmed out-of-range value or trend that is not emergent.	Routed to a named member of the practice's care team, agreed at implementation, with the vital, the findings and the contact attempt documented.
Stable and resolved	An out-of-range reading that resolves on retake with no symptoms.	Documented in the record as an informational note. No escalation, but a permanent, reviewable trail.

ONE GOVERNANCE RULE THAT IS NOT NEGOTIABLE

CoachCare's urgent and emergent policy supersedes any client-specific escalation preference. Thresholds, routing destinations, named contacts and coach scripting are all the practice's to set — that is the subject of Section 8.3. The emergent pathway is not. If a patient reports an emergent symptom, 911 is activated whatever the local preference says.

This is stated plainly because it is the one place where the practice does not hold the pen, and a reader should know that before implementation rather than during an incident review.

Every escalation, whichever route it takes, documents the same six things: the vital or reading that triggered it, the clinical findings, the method of contact, who was contacted, the outcome, and the follow-up required. That record is what supports the claim, the audit and the quality measure simultaneously — and, on this account, what makes the activity visible as ACO performance evidence rather than only as a billed service.

6.4 The post-discharge sequence

Any hospitalization or emergency-department visit reported in the previous 60 days triggers a fixed three-touch cadence: days 1–2, days 5–8, and days 12–14. Each touch documents and escalates clinical alerts under the same protocol as any other reading. This is the highest-yield window in the entire program and it is worth being explicit about why on this account in particular.

Touch	Window	What it is for
First	Days 1–2	Medication reconciliation against what was actually dispensed at discharge, symptom check, confirmation that the follow-up appointment exists and that the patient can get to it. Device set up or resumed.
Second	Days 5–8	The window in which deterioration usually first becomes visible. Weight trend and blood pressure reviewed against the discharge baseline rather than against a general threshold.
Third	Days 12–14	Confirmation that the patient has been seen, that titration has happened where it was planned, and that the transition back to routine monitoring is safe.

WHY THIS WINDOW CARRIES THE AVOIDED-ADMISSION FIGURE AND THE ACO MEASURE AT ONCE

The 30 days after a discharge are when the readmission happens, the readmission is the expensive event, and the physiologic signal that precedes it — two or three pounds of weight gain across 48 hours, or a blood pressure trending the wrong way — is exactly what a connected scale and cuff report. The avoided-admission figures in Sections 3.3 and 3.4 are produced disproportionately in this window.

For an Enhanced-track ACO the same activity lands on readmission performance, which is measured and reported. And CY2026 added the code that makes the window billable: 99445 pays for device supply across a 2–15 day window, where the long-standing code has always required at least 16 days of readings. The first two weeks after a discharge are precisely the period that requirement used to exclude.

The Suite 104 same-day clinic is what closes the loop. A deteriorating reading in this window has somewhere to go that is not an emergency department — which is the difference between a program that detects deterioration and one that prevents an admission.

6.5 Unreachable patients, continuity and discharge governance

Programs fail quietly at the edges rather than loudly in the middle. Two governance rules cover the edges.

- **Unreachable patients re-escalate on a fixed cadence.** A patient who stops transmitting or cannot be contacted is escalated to the practice, and then re-escalated at fixed intervals rather than being quietly carried on the census. The practice decides whether to continue, intervene or discharge; if no instruction is received across the full escalation sequence, discharge proceeds.
- **The practice is notified at every decision point.** Enrollment, escalation, threshold change, unreachable status and discharge each generate a notification into the practice's workflow. There is no state a patient can be in that the practice cannot see, and no discharge that happens without the practice knowing.

7. Technology and Integration — athenaOne

7.1 The electronic health record is confirmed

The practice runs athenaOne, confirmed on the call. That settles a question that is usually left open at this stage, and it settles it favourably: CoachCare's athenahealth integration is native and bi-directional, so the depth of automation available on day one is known rather than contingent on a scoping exercise. Nothing in the implementation plan in Section 8 depends on an integration that still has to be built.

WHAT THAT SETTLES, AND THE ONE THING IT LEAVES

Ordering and enrollment, health-history exchange, discrete vitals, escalation tasks, compliance documentation and claim creation are all automated inside the workflow the practice's clinicians already use. The remaining technology question is narrow and is settled at contracting: the exact athenaOne configuration and the practice-management setup the claims engine writes into.

7.2 What the native athenahealth integration delivers

Capability	What it means operationally
Bidirectional enrollment by services	Enrollment flows both ways between athenaOne and the monitoring platform, per service, rather than being maintained twice.
Exchange of health history	Problem list, medications and relevant history flow into the monitoring platform at intake instead of being re-keyed by someone.
Integrated discrete vitals	Transmitted readings land in the chart as structured, discrete data rather than as PDF attachments — which is what makes them usable for quality measurement and ACO reporting, not only for billing.
Escalation tasks	An escalation becomes a task inside athenaOne, assigned to the named practice contact, rather than an email or a phone call that has to be transcribed into the record afterwards.
Compliance documentation and integrated care summary	Evidence of care, vitals and care summaries attached to the chart on a monthly cadence, in the form an audit expects.
Automated claim generation	Claims generated automatically by the CoachCare billing engine, eliminating the manual claim creation step for each patient, every month. See Section 7.3.
Enrollment flags and trigger ordering by service	Qualified patients surface as flags inside the existing clinical workflow, and the service is ordered from there — so a clinician refers without leaving the chart.
Real-time enrollment status	Enrollment status is visible in real time inside the clinical workflow rather than in a separate system anyone has to remember to check.
Time to first service	Patients begin receiving services in under five days from the order.

Source: CoachCare athenahealth integration overview. Integration setup and per-patient integration fees are included in the modeled fees in Section 5 at catalog rates — $1,000 setup, $150 per month. Confirm in contracting.

7.3 Automated claim generation, and why it matters most here

THE DIFFERENTIATOR, STATED PRECISELY

CoachCare is the only care management partner integrated with athenahealth providing automated claims creation via the CoachCare billing engine, eliminating the manual claim creation step for each patient, every month.

This matters more than it sounds, and on this account it matters more than usual. 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 744 monitored patients that step alone is a recurring administrative function — and it is the step that most commonly caps how large a self-staffed program can grow, well before clinical capacity runs out.

A practice operating with no CTO has no institutional billing organization absorbing that work. This is the specific place where the no-CTO position has an operational cost, and it is the specific place where the integration removes it.

“Key to achieving a program that is efficient, effective and sustainable is creating a seamless, intuitive user experience for the patient and provider, and that's what our integration with athenahealth accomplishes.”
— CoachCare

For context on scale behind that integration: CoachCare reports more than 500,000 patients across more than 400 managed conditions, more than 10,000 providers, more than 1,000 implementations, more than 5 million claims processed, more than 100 million vitals captured and more than 4 million care actions. Company-reported figures, 2026.

8. Implementation Playbook

8.1 Cohort definition and enrollment gating

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

> **ENROLLMENT IS GATED, AND THE PRACTICE HOLDS THE GATE**
>
> On a two-sided-risk book, uncontrolled enrollment is the failure mode: every additional stable patient is a monthly charge against the ACO benchmark with no matching saving. Four mechanisms prevent it, and they are built into the operating model rather than promised around.

1. **The cohort is defined by diagnosis, jointly.** The practice's physicians and CoachCare agree the diagnosis definition before anything is built — heart failure, CKD stage 3b–4, COPD, poorly controlled hypertension and type 2 diabetes is the starting proposal, not a fixed answer. The query runs against athenaOne and the output is a list, not a rule that fires forever.
2. **The practice's clinicians screen and approve the candidate list.** Clinical suitability, likely adherence, device capability and patient responsibility are assessed before an enrollment conversation happens. Approval is the practice'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 the practice deciding it should.
4. **Cohort expansion is a governed decision.** Widening the diagnosis definition or adding a second cohort requires the same joint sign-off as the original list. Growth is a clinical decision reviewed quarterly, not an outreach target.

Phase-one target population	Why first
The agreed high-risk cohort — approximately 2,500 patients, selected by diagnosis from athenaOne	The conditions where admissions actually occur. Condition-defined and therefore gateable, which is what keeps the billing from outrunning the avoided cost.
Patients within that cohort discharged from hospital in the previous 60 days	The highest-yield sub-population in the account. The three-touch post-discharge sequence and the 2–15 day device code make the window both clinically and commercially addressable. Transitional care management is excluded from the forecast as upside.
A second cohort, or a widened definition	Phase two. Not modeled here. A governed clinical decision once the admissions effect has been demonstrated on the first cohort.

8.2 Staffing model

- **The practice's clinicians stay clinical.** Physicians and advanced practice providers 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 gerontology clinical-nurse-specialist and diabetes-education capability already on the bench gains capacity rather than responsibility.

- **One on-site enrollment specialist, funded by CoachCare.** Physically present in the practice, 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 practice headcount slot.
- **24/7 alert triage supplied by CoachCare, against the practice's thresholds.** Out-of-range readings are worked through the retake and symptom-check loop before they reach the practice, so clinicians see exceptions rather than raw data.
- **Telephonic enrollment as the third pathway.** Running alongside provider referral and the on-site specialist rather than replacing either, and restricted to the same approved list.
- **Devices supplied, not purchased.** Cellular connected cuffs and scales are supplied as part of the service. There is no capital request and no device inventory for the practice to manage.

8.3 Protocol governance and scripting control

The practice controls the clinical content of the program. That is a standard part of implementation rather than a concession, and it matters for a simple reason: a health coach must never contradict the provider, because the program is only useful if the patient hears one voice.

What the practice controls	How it works	When it is set
Clinical standard operating procedures	CoachCare's standard monitoring procedures are reviewed with the practice's physicians and customised before go-live. They become the practice's protocols running on CoachCare's engine, not the other way round.	Implementation, before the first enrollment.
Alert thresholds	Blood-pressure, weight, glucose and symptom thresholds are tunable per condition and per patient, and are adjusted as the program learns which alerts produce action and which produce noise.	Implementation, then continuously.
Escalation destinations and named contacts	What happens on an alert, in what order, and who is called. The Suite 104 same-day clinic and the practice's on-call structure define the destinations; CoachCare routes into them.	Implementation, reviewed quarterly.
Health-coach scripting	The scripts used on monitoring calls — including how symptom checks, adherence and escalation are worded — are reviewed and approved by the practice. Anything clinical that is not in an approved script routes to a practice clinician rather than being improvised.	Implementation, reviewed quarterly.
Patient-facing language on cost	How patient responsibility is explained at consent, including the qualified Medicare beneficiary case where no balance billing applies.	Implementation.
Documentation standards	What lands in athenaOne, in what form, and against which care-plan elements — so the documentation satisfies the practice's own audit expectations, not merely the claim.	Implementation.

THE ONE EXCEPTION, RESTATED

Thresholds, scripts, destinations and documentation standards are the practice's. The urgent and emergent pathway in Section 6.3 is not — CoachCare's emergent policy supersedes any client-specific preference. Everything else is configurable.

8.4 Clinical workflow

1. Identify. Run athenaOne against the agreed diagnosis definition and rank by admission risk, recent discharge and open quality gaps.

2. Screen and approve. The practice's clinicians review 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. The provider orders the service inside athenaOne at a visit, prompted by an enrollment flag. 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. The on-site specialist completes consent using practice-approved language, explains patient responsibility where it applies, and schedules device delivery. Enrollment begins in month one; no onboarding delay is modeled.

5. Instrument. Connected cuff and scale shipped and activated; two days of readings establish the setup code; thresholds set per the practice's protocol and tightened for recently discharged patients.

6. Monitor and triage. Readings transmit daily. CoachCare triages 24/7 against the practice's thresholds, working out-of-range values through retake and symptom check; only exceptions and confirmed trends route to the practice.

7. Act. The practice titrates against its own protocol, engages a physician on clinical exceptions, and absorbs deterioration into the Suite 104 same-day clinic rather than an emergency department. 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, and the claim is generated automatically each month by the billing engine.

9. Measure. Admissions in the enrolled cohort against a matched unenrolled comparison, enrolled census, capture rate, alert-to-action time and net per patient per month, reviewed monthly against the scorecard below.

8.5 Scorecard and 12-month roadmap

Domain	Metric	Why it is on the scorecard
Total cost of care	Admissions in the enrolled cohort against a matched unenrolled comparison; 30-day readmission in the cohort	The first metric on the board, because it is the one the ACO is scored on. Everything else supports it — and it is the number that replaces the assumed baseline admission rate in Section 3.4 with a measured one.
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	Post-discharge three-touch completion rate; conversion from the post-discharge window to routine monitoring	The highest-yield window in the program, and where the ACO readmission measure is decided.
Growth	Active enrollments against the cohort ceiling; referrals held for review as a share of referrals received	A rising hold rate is evidence the gate is working, not evidence 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 self-staffed programs lose money.
Financial	Net reimbursement per active patient-month; practice profit per month	Confirms the modeled per-patient-month economics against reality, early.

Phase	Months	What happens
Confirm and design	Pre-launch	Put the CCM and PCM question to the Office of Advanced Primary Care and get a written position. Agree the diagnosis definition and replace the ~2,500 estimate with an athenaOne count. Confirm the athenaOne configuration and the practice-management setup the claims engine writes into. Review and customise protocols, thresholds and coach scripting with physician leadership. Set the enrollment gate and the approval workflow. Agree the attribution policy.
Launch the cohort	Months 1–3	Instrument the approved list. On-site enrollment specialist in the practice. First claims out in month one. Weekly capture review and weekly alert-to-action review.
Instrument the discharge window	Months 2–6	Turn on the three-touch post-discharge sequence for cohort patients with a hospitalization or emergency visit in the previous 60 days. Quantify discharge volume so transitional care management can be sized rather than described. The census reaches its ceiling in month 6.
Measure the admissions effect	Months 4–12	Read admissions in the enrolled cohort against a matched comparison. Replace the assumed baseline admission rate with the practice's own. Scorecard shifts from growth to capture and clinical effect.
Decide on scope and on the open questions	Months 9–18	Re-run the benchmark interaction against the ACO's own attribution and benchmark data with real admission numbers. Revisit APCM and any care-management route the Office of Advanced Primary Care has clarified. Decide on a second cohort or a widened definition.

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 the practice, not an assumption made on the practice's behalf.

1. The current MDPCP-AHEAD position on CCM and PCM, in writing. The restriction quoted in Section 4.2 comes from the getting-started guide, whose available edition dates to 2020 and predates the AHEAD transition and the 65/35 payment split. The current MDPCP-AHEAD Payment Specifications sit behind CMMI Connect and could not be retrieved. Three sub-questions: does the restriction still read this way; does it reach principal care management; and which codes sit inside the 65% Comprehensive Primary Care Payment bundle. Nothing in the modeled forecast depends on the answer, which is why it can be asked openly.

2. The cohort count, against an agreed diagnosis definition. The ~2,500 figure is an estimate at roughly half of an estimated ~5,000-patient Medicare panel, and the panel figure is itself a provider-based triangulation with a range of roughly 4,000 to 6,300. No claims-based figure exists for this practice. Replace both with athenaOne counts and every figure in Section 5 rescales close to proportionally. This is the softest input in the model.

3. The practice's own admission rate in the selected cohort. The avoided-admission line runs on an assumed baseline rate — 20% in the model, with 40% argued as realistic. The practice's own rate replaces the most consequential assumption in the document with a measurement. This is the single highest-value thing discovery can produce.

4. How much of the Medicare panel is ACO-attributed. Assignment is retrospective and plurality-based. The benchmark interaction in Section 3 applies only to attributed beneficiaries, and the non-attributed group is also the group for which the care-management routes in Section 5.6 may be open. One number answers two questions.

5. Whether a remote monitoring program exists today, and at what scale. No program is described on the practice's published pages, which is an observation about published material and not a finding about the practice. If one exists, the starting census and the incremental case both change.

6. Who carries care management today, and where the ceiling is. The state list establishes that there is no CTO. It does not establish who does the work, for how many patients, or how many high-acuity patients that capacity can carry. This report asserts none of those things.

7. Which providers and which suites are in phase one. The 22-provider figure covers both the main office and the Suite 104 clinic. Phase-one scope should be set by readiness rather than by the full count.

8. The athenaOne configuration, and the integration commercials. The integration is native and the automation is known; this pins the build to the right instance and confirms the practice-management setup the claims engine writes into. Integration pricing is quoted at catalog and is to be confirmed in contracting.

9. Payer-side coverage beyond Medicare fee-for-service. For each Medicare Advantage and commercial payer: code-level coverage for monitoring and for care management, prior-authorization posture, and contracted rates. Also worth establishing whether the practice participates in CareFirst's patient-centered medical home program, which carries care-planning fees that are a commercial analogue to Medicare care management. Not verified either way in public sources.

10. Whether HEART payment flexibility is already being used. From 1 January 2026 the payment may be directed to beneficiary-level expenditures for high-need beneficiaries the practice designates. If it is already committed, that changes the funding conversation; if it is not, it is the shortest path to a funded start. Either way it is the practice's decision and it is not modeled.

11. Discharge volume attributable to the practice. 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.

12. Appetite for a Care Partner Arrangement conversation. Whether a hospital-funded care-management arrangement under AHEAD is of interest at all, and confirmation of the hospital's current readmission-program standing before any of that is relied upon. A strategic option, raised because the mechanism exists and the incentives align under a global budget — not a recommendation.

13. When to revisit APCM. The participation gate passes today. The sensible trigger for revisiting it is the written position on care-management billing from item 1, because the same answer will largely settle APCM.

> **THE FIRST THREE ARE THE ONES THAT MOVE THE ANSWER**
>
> The cohort count, the practice's own admission rate in that cohort, and the current position on care-management billing. Everything else in this list refines the forecast; those three determine whether it is the right forecast.
>
> Two of the three are answerable from athenaOne in an afternoon. The third is a written question to the Office of Advanced Primary Care, and it is one this practice is better placed to ask than a vendor is.

References and Data Sources

Practice published sources, retrieved July 2026

- Annapolis Internal Medicine — practice website: physicians, clinicians, main-office and clinic advanced-practice pages, Medicare information, contact and locations
- Suite 400 main office and Suite 104 same-day acute care clinic, 116 Defense Highway, Annapolis, MD 21401; Saturday clinic hours
- Physician roster, join dates and stated clinical interests, including Dr. Ena Tychus joining September 2026
- Practice founded 1974; independent physician-owned LLC

Government and public data

- Maryland Department of Health — 2026 MDPCP-AHEAD Participating Practice List; participation as of 1 January 2026. Annapolis Internal Medicine, 116 Defense Highway Suite 400, Anne Arundel County, “No CTO Partner”

- Maryland Department of Health — Care Transformation Organization information: a CTO “hires and manages an interdisciplinary care management team”; participating practices “split their program payments”
- Maryland Department of Health, Office of Advanced Primary Care — AHEAD Primary Care Programs all-call deck, 16 December 2025: Track 2 only for PY2026; 65/35 Comprehensive Primary Care Payment split; Care Management Fee $9–$100 PBPM; HEART payment $110 PBPM and its 1 January 2026 flexibility; optional benefit enhancements including telehealth and non-physician care management visits; approximately 460 practices and 350,000 attributed Medicare fee-for-service beneficiaries
- Maryland Primary Care Program — Getting Started with the MDPCP Guide, page 28: MDPCP practices in both tracks may not bill Medicare for CCM services furnished to attributed Medicare beneficiaries. Available edition dates to 2020; current MDPCP-AHEAD Payment Specifications are behind CMMI Connect authentication and were not retrieved
- CMS — PY2026 Medicare Shared Savings Program participant file, queried live 28 July 2026: ANNAPOLIS INTERNAL MEDICINE, LLC; ACO A5527 “Aledade 204 Potomac MSSP Enhanced”; Enhanced track; low-revenue (physician-led) ACO; retrospective assignment; agreement start 1 January 2025; ACO Medical Director Titus Abraham
- CMS — Medicare Advantage State/County Penetration file, July 2026: Anne Arundel County, 111,257 Medicare eligibles, 22,074 in Medicare Advantage, 19.84% penetration; CMS monthly enrolment, April 2025 to April 2026: Original Medicare +3.1%, Medicare Advantage −1.4%
- CMS — Geographic Variation public use file, CY2024: Anne Arundel County Medicare acute readmission rate 19.9%; 483.5 emergency-department visits per 1,000 beneficiaries
- CMS — Medicare Physician Fee Schedule, CY2026 non-facility rates; Novitas Solutions Jurisdiction L, carrier 12302, locality 01, ZIP 21401; CY2026 addition of HCPCS 99445 and 99470
- CMS — Hospital Service Area file, 2025 data: ZIP 21401 as the largest single source of Medicare inpatient cases to Luminis Health Anne Arundel Medical Center, 1,271 cases
- Maryland Health Services Cost Review Commission — Readmissions Reduction Incentive Program; hospital inpatient revenue adjusted by up to ±2% on readmission performance. Confirm current-year hospital standing before relying on it
- CMS Innovation Center — AHEAD Model: MDPCP folded in and renamed MDPCP-AHEAD effective 1 January 2026; MDPCP-AHEAD continues through 2028 subject to a CMS and State decision; AHEAD runs to 2035. Care Partner Arrangements as a hospital funding mechanism
- CMS Innovation Center — MDPCP evaluation: program cost in the region of $96 million per year without statistically significant savings, alongside improved post-exacerbation follow-up
- Maryland Preserve Telehealth Access Act of 2025 (HB 869, Chapter 482), approved 13 May 2025, effective 1 June 2025 — time restrictions on Medicaid and insurer telehealth reimbursement eliminated
- NPPES — Annapolis Internal Medicine, LLC, organizational NPI 1477629681, primary taxonomy internal medicine

CoachCare

- CoachCare Value Analysis, Maryland locality build (Novitas JL 12302-01), July 2026 — the modeled forecast in Section 5, in both configurations
- CoachCare athenahealth integration overview — bidirectional enrollment by services, exchange of health history, integrated discrete vitals, escalation tasks, compliance documentation and integrated care summary, automated claim generation; enrollment flags and trigger ordering by service; real-time enrollment status; services beginning in under five days
- CoachCare Care Management Programs — standard operating procedures, March 2026. The escalation logic, trend definitions, three-way routing, emergent pathway and post-discharge cadence described in Section 6 are recreated from those procedures

- CoachCare scale, company-reported 2026 — 500,000+ patients, 400+ managed conditions, 10,000+ providers, 1,000+ implementations, 5M+ claims, 100M+ vitals, 4M+ care actions

Global caveat

> Every financial figure in this report is illustrative and modeled and must be verified against practice data. The Medicare panel and the cohort size 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 shared-savings, capitated or care-management-fee economics. No shared-savings distribution, capitation adjustment, quality bonus, care management fee, HEART payment or performance-based incentive payment appears in any modeled figure. MSSP benchmarks are risk-adjusted and rebased, so the benchmark arithmetic in Section 3 is directional and is not an ACO financial projection.
>
> Chronic care management, principal care management, transitional care management and Advanced Primary Care Management are excluded from every modeled figure. The avoided-admission figures are modeled effects derived from monitoring patient-months at an assumed baseline admission rate, not measurements of this practice's admission history. The on-site enrollment specialist is staffed at CoachCare's expense and is never subtracted from the practice's margin.

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