STALLANT HEALTH & WELLNESS

COACHCARE | SERVICE LINE STRATEGY

A Medicare-certified rural health clinic in Crescent City and Highland, California, delivering primary care, dental, mental health, chiropractic, nutrition and physical therapy under extended hours, on a lifestyle-medicine brand

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line for the practice's 650 Medicare patients: remote physiologic monitoring, chronic care management and advanced primary care management, billed under the rules that have paid a rural health clinic for those codes individually, on top of the per-visit rate, since October 2025, and staffed by CoachCare

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of Stallant Health. It brings together the practice's Medicare enrollment record, the Medicare structure of Del Norte and San Bernardino counties, the billing rules a rural health clinic works under since October 2025, a 24-month Value Analysis for a remote care service line on the Medicare panel, the clinical governance that would run it, the athenahealth integration it lives in, the Medi-Cal rail beside it, and the rural design a two-site clinic 80 miles from the nearest metropolitan hospital has to get right.

The argument is short. In Del Norte County 96 of every 100 Medicare patients are in Original Medicare. Since last October, Medicare pays a rural health clinic for the month of care between visits as its own codes, at national amounts, on top of every visit. The practice already runs extended hours and lifestyle medicine; what it does not have is a revenue line for the days between visits. The panel is small and it fills in seven months. The people to run it are ours.

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Executive Summary

Stallant Health is a Medicare-certified rural health clinic with two sites in California: Crescent City, in Del Norte County on the state's far northwest coast, open since 2020, and Highland, in San Bernardino County, open since early 2025.[1] The practice runs extended hours — the Crescent City clinic sees patients Sunday through Thursday until 8 p.m. — and delivers primary care, dental, mental health, chiropractic, nutrition and physical therapy under one roof, on a lifestyle-medicine brand and a 4.7-star patient rating across 134 reviews.[2] The care team on the primary-care roster is one physician and five nurse practitioners and physician assistants.[3]

What the practice does not have is a Medicare revenue line for the month between visits. There is **no evidence of a remote-care or care-management program**: none on the practice's site or careers page, and none in the CY2024 Medicare claims — where a rural health clinic's care-management billing would not appear in any case, because those visits bill on institutional claims under the clinic's certification number rather than under the individual clinicians.[4] The clinic sits in a county where one in five residents is 65 or older and one in five reports a disability, and where chronic disease is managed a few visits a year across long rural distances.

Del Norte County's Medicare population is 4.26% Medicare Advantage (CMS, July 2026), so effectively 96 of every 100 Medicare patients at the Crescent City site are in Original Medicare, and 29.9% of the county's beneficiaries are dually eligible.[5] Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.

The observation this report is built on

In this county 96 of every 100 Medicare patients are Original Medicare. Since last October, Medicare pays a rural health clinic for the month of care between visits as its own codes, at national amounts, on top of every visit. The practice already runs extended hours and lifestyle medicine; what it does not have is a revenue line for the days between visits. The panel is small and it fills in seven months. The people to run it are ours.

G0511, the bundled code rural health clinics used for care management, was retired on September 30, 2025. From October 1, 2025 a rural health clinic bills chronic care management, remote physiologic monitoring and advanced primary care management as individual codes at national non-facility Physician Fee Schedule amounts, in addition to the per-visit rate.[6] The short-window RPM codes new for 2026 (99445, 99470) fit post-discharge monitoring exactly, for a clinic three blocks from a community hospital.

[1] CMS Rural Health Clinic Enrollments, July 2026 vintage: two Part A rural health clinic enrollments under one PECOS associate identifier — Crescent City, Del Norte County (enrolled 2020) and Highland, San Bernardino County (enrolled 2025); the corporation incorporated 2019. The practice is absent from the CMS health-center enrollment file.

[2] Stallant Health website, retrieved September 2026: two sites; primary care, dental, mental health, chiropractic, nutrition and physical therapy; Crescent City hours Sunday to Thursday 8 a.m. to 8 p.m. and Friday mornings; a lifestyle-medicine brand; a 4.7-star patient rating across 134 public reviews.

[3] Stallant Health care-team pages and CMS NPPES, retrieved September 2026: one physician and five nurse practitioners and physician assistants on the primary-care roster; a sixth advanced-practice provider enumerated at the Crescent City address in early 2026.

[4] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024, queried per National Provider Identifier for the practice's clinicians for codes 99453, 99454, 99457, 99458, 99445, 99470, 99091, 99490, 99439, 99491, 99487, 99489, 99424, 99426, G0556–G0558, G0511, 99495, 99496 and 99484. No lines under the practice. Rural health clinic encounters and care management billed on the institutional claim do not appear in this professional-claims file.

[5] CMS Medicare Advantage State/County Penetration, July 2026: Del Norte County 4.26%. CMS Medicare Monthly Enrollment, 2025: Del Norte County 6,727 beneficiaries, 6,338 in Original Medicare, 2,011 dual-eligible (29.9%).

[6] CY2025 Physician Fee Schedule Final Rule: rural health clinics report the individual CPT and HCPCS codes for care management in place of G0511, paid at national non-facility Physician Fee Schedule amounts in addition to the per-visit rate; G0511 retired September 30, 2025 after a transition period; advanced primary care management adopted on the same basis. CY2026 Final Rule for 2026 dates of service.

What the Value Analysis returns

The forecast prices a service line for a Medicare panel of 650 patients, referred by the one physician and five nurse practitioners and physician assistants in primary care and delivered by CoachCare under the practice's clinical direction, priced at the national amounts a rural health clinic is paid for these codes.[7]

	Year 1	Year 2	24 months
Net reimbursement	**$256,903**	**$324,639**	**$581,542**
CoachCare fees	$149,271	$182,621	$331,892
Net to the practice	**$107,632**	**$142,018**	**$249,650**
Margin to the practice	41.90%	43.75%	**42.93%**

CoachCare Value Analysis. CY2026 national non-facility Physician Fee Schedule amounts, the rail a rural health clinic bills care-management codes on. 650 Medicare patients in scope; RPM + CCM + APCM. Margin is net to the practice divided by net reimbursement.

1. **This is a $249,650 two-year net line on a 650-patient panel, and it fills in seven months.** It is not a seven-figure program, and the report does not dress it as one. Every program reaches its ceiling inside the first year: APCM in M3, CCM in M5, RPM in M7. At M24 the program holds 294 active program enrollments across 192 unique patients, the same census it holds at M12. The binding constraint is the size of the Medicare panel, not enrollment capacity or clinician count.
2. **The program funds itself from the second month.** Month 1 nets −$2,495 to the practice, because implementation lands before enrollment revenue does. The first positive month is M2, at $3,073. From M8 the service line runs at $27,053 in monthly net reimbursement and $11,835 net to the practice.
3. **The dual-eligible tier lifts APCM.** About 30% of the county's Medicare beneficiaries are dually eligible. Advanced primary care management pays its highest tier, G0558 at $117.24 a month, for Qualified Medicare Beneficiaries, and weighting that tier to the county's dual share puts the APCM blend at $65.33 per patient-month.
4. **Nobody is hired.** CoachCare delivers 3,948 hours of care-team work over 24 months, about 1.9 full-time-equivalent years, including an on-site enrollment specialist carried at CoachCare's expense, for a practice recruiting a Highland medical director and medical assistants. No capital outlay and no new requisition.
5. **The growth is in the panel, and the report says where.** The 650-patient figure is the modeled midpoint the forecast runs on; the practice's own Medicare chart count across both sites is the single largest lever, and it is discovery item one. Highland's Medicare panel grows from here, and the practice's Medi-Cal managed-care book is a second rail sized separately.
6. **The clinical return is concrete.** The forecast projects 20.4 avoided hospitalizations over 24 months, roughly $306,000 at $15,000 per admission, from 32,105 device readings worked through one escalation protocol, with the discharge from the community hospital three blocks away as one trigger.

1. The Practice Today

1.1 A rural clinic that kept adding front doors

Stallant Health is a rural health clinic, incorporated in 2019, that opened its Crescent City site in Del Norte County in 2020 and added a second site in Highland, San Bernardino County, in early 2025, both certified

[7] CoachCare Value Analysis for Stallant Health, 2026. Basis: CY2026 national non-facility Physician Fee Schedule amounts; 650 Medicare patients in scope; six referring clinicians; RPM, CCM and APCM.

with Medicare as rural health clinics under one corporate entity.[8] The Crescent City clinic runs Sunday through Thursday from 8 a.m. to 8 p.m. and Friday mornings, with primary care, dental, mental health, chiropractic, on-site X-ray and lab. Over five years it grew the model: primary care first, then dental, behavioral health, chiropractic, nutrition and physical therapy, then a second site, with a lifestyle-medicine brand running through all of it.[9] The payer posture is Medi-Cal first, which is the starting point for the second rail in Section 5.

The practice today	Detail	What it means for the service line
Sites	**Two**: Crescent City (2020) and Highland (2025)	One Medicare panel across both; Highland's Medicare book grows from a small base
Care team	**6**: one physician and five NPs/PAs	The referring bench; five of six clinicians are advanced-practice providers
Service lines	Primary care, dental, mental health, chiropractic, nutrition, physical therapy	In-house behavioral health is the natural home for the BHI arm in Section 3.5
Hours	Crescent City Sunday–Thursday to 8 p.m.; extended and weekend access	The Sunday and evening clinics are enrollment windows (Section 8)
Patient rating	**4.7 stars** across 134 reviews	An access-and-experience record a monthly documented touch builds on
EHR	**athenahealth**	The program runs inside the record the clinicians already use (Section 6)

Stallant Health website and CMS rural health clinic enrollment records, retrieved September 2026.

1.2 What the record can verify

The earned compliment is the operating model. A clinic that opened in 2020, put primary care, dental, behavioral health, chiropractic, nutrition and physical therapy under one roof, kept Sunday and evening hours, opened a second site in 2025, and holds a 4.7-star patient rating across 134 reviews has already done the hard part: it is the place a rural county's patients come to.[10] The lifestyle-medicine brand is the clinical bridge for this service line. Blood-pressure, weight and glucose readings are exactly the signals a lifestyle-medicine plan is written around, and a monthly documented touch is how that plan reaches a patient between visits.

What the record does not show is a program for the days in between. A rural health clinic already sees its Medicare patients a few times a year; the service line in this report adds the month of care around those visits, on the panel the practice already holds, in a county where the drive to specialty care is measured in hours.

1.3 The gap: the month between visits

Between-visit chronic care has no Medicare revenue line here yet, and it is a structural observation rather than a criticism. A sweep of CY2024 Medicare fee-for-service claims across the practice's clinicians returns no lines on any remote-monitoring code, any chronic-care-management code, any advanced-primary-care code, any transitional-care code or any behavioral-health-integration code.[11] A rural health clinic's encounters bill on institutional claims under its certification number, so its care management would not appear in that professional-claims file even if it existed; combined with a site and careers page that

[8] CMS Rural Health Clinic Enrollments, July 2026 vintage (see note 1): the corporation incorporated in 2019, holding both site enrollments under one associate identifier.

[9] Stallant Health website, retrieved September 2026: services, hours and site pages; the Crescent City site added dental, mental health, chiropractic, on-site X-ray and laboratory alongside primary care; the Highland site added nutrition and physical therapy.

[10] Stallant Health website and public review profile, retrieved September 2026: the service lines, extended hours, second-site expansion and 4.7-star rating across 134 reviews; the lifestyle-medicine positioning on the practice's blog and service pages.

[11] CY2024 Medicare Physician & Other Practitioners sweep (see note 4); Stallant Health website and careers page, retrieved September 2026, which name no monitoring or care-coordination program.

name no monitoring or care-coordination program, the finding is that there is **no evidence of a remote-care or care-management program** and a clean field to build one on.

The careers page in September 2026 advertised for a Highland medical director, medical assistants and an X-ray technician, and no care manager, care coordinator or remote-monitoring role.[12] The practice is building capacity the ordinary way, by hiring clinical and support staff. The service line offers the same capacity for the between-visit work without a requisition, in the languages the panel speaks, which is the subject of Section 8.

2. What Changed: A Rural Health Clinic Now Bills the Month Between Visits

2.1 G0511 is gone; the individual codes pay on top of the per-visit rate

Rural health clinics are paid an all-inclusive rate per qualifying visit. For years, everything a clinic did for chronic patients between those visits was compressed into one bundled monthly code, G0511, a single flat payment regardless of how many services, minutes or programs a patient carried. That code was retired on September 30, 2025. From October 1, 2025 a rural health clinic reports the individual CPT and HCPCS codes, the CCM, RPM and APCM families among them, and Medicare pays each at the **national non-facility Physician Fee Schedule amount, in addition to the per-visit rate**.[13]

CY2026 also added two codes that matter for a clinic three blocks from a community hospital: 99445 pays the device-supply month when a patient transmits 2 to 15 days of readings rather than 16 or more, and 99470 pays the first 10 minutes of monthly management time where 20 minutes is not reached. A patient discharged on the 20th of the month used to produce an unbillable partial month; now it bills. In this forecast the two codes carry $53,761 of gross reimbursement over 24 months, about 9.2% of net reimbursement, revenue that did not exist a year ago.[14]

The structural consequence is the point. Between-visit care stops being a flat bundled payment and becomes a per-service revenue line that scales with enrollment and delivered work, on a panel the practice already sees.

2.2 What the codes pay a rural health clinic

The Value Analysis is priced at the national amounts a rural health clinic is paid for these codes: the CY2026 non-facility Physician Fee Schedule at the national conversion factor with no geographic adjustment. That is the rail a rural health clinic bills care-management codes on, and it is the only basis on any page of this report.[15]

Code	What it pays for	Cadence	CY2026 national amount
99453	RPM setup and patient education	One-time	$21.71
99454	Device supply, 16–30 days of readings	Monthly	$52.11
99445	Device supply, 2–15 days of readings (new 2026)	Monthly	$52.11
99457	RPM management, first 20 minutes	Monthly	$51.77
99470	RPM management, first 10 minutes (new 2026)	Monthly	$26.05

[12] Stallant Health careers page and public job listings, retrieved September 2026: postings for a Highland medical director, medical assistants and an X-ray technician; no care-manager, care-coordinator or remote-monitoring role.

[13] CY2025 Physician Fee Schedule Final Rule (see note 6): G0511 retired with a transition period through September 30, 2025; from October 1, 2025 the individual codes are the standing requirement for rural health clinics; care-management codes are paid at national non-facility amounts in addition to the per-visit rate.

[14] CoachCare Value Analysis, Financial Value detail: 99445 and 99470 together carry $53,761 of gross reimbursement over 24 months against $581,542 of net reimbursement (about 9.2%), on this forecast's code frequencies.

[15] CY2026 Physician Fee Schedule national non-facility amounts (CMS RVU26A, January 2026 release): total non-facility relative value units times the $33.4009 conversion factor, with every geographic practice cost index at 1.000. A rural health clinic bills the care-management codes at the national amount regardless of the locality its ZIP code falls in.

Code	What it pays for	Cadence	CY2026 national amount
99458	RPM management, each additional 20 minutes	Monthly	$41.42
99490	CCM, first 20 minutes of clinical staff time	Monthly	$66.13
99439	CCM, each additional 20 minutes	Monthly	$50.44
G0556	APCM, level 1: one chronic condition	Monthly	$16.37
G0557	APCM, level 2: two or more chronic conditions	Monthly	$53.78
G0558	APCM, level 3: Qualified Medicare Beneficiary	Monthly	$117.24
99495	Transitional care management, moderate complexity	Per discharge	$220.11 (named, not in the forecast)
99496	Transitional care management, high complexity	Per discharge	$298.60 (named, not in the forecast)
99484	Behavioral health integration, first 20 minutes	Monthly	$57.45 (named, not in the forecast)

CY2026 national non-facility Physician Fee Schedule amounts, the Value Analysis basis. The APCM tier blend in the forecast (20% level 1, 50% level 2, 30% level 3) yields $65.33 per patient-month, with the level-3 weight set to the roughly 30% dual share of the county's Medicare beneficiaries.

These are Original Medicare amounts. Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families. With Medicare Advantage at 4.26% in Del Norte, effectively every Medicare patient at the Crescent City site is in Original Medicare, so that contract check is a discovery item, not a load-bearing assumption; the Highland site sits in a county where most Medicare is Medicare Advantage, one sentence in Section 9.

2.3 The work the change creates, and who carries it

Individual-code billing pays more and asks more. Each code carries its own eligibility test, consent, time capture and documentation standard, and the claim volume is real: this forecast generates 9,158 claims over 24 months. In the operating model of Section 11, CoachCare carries the load: enrollment, device logistics, monitoring documentation and billing-ready claim generation inside athenahealth. The practice's own billing team files the claims, and the clinicians keep the clinical decisions.

One structural note on Medi-Cal, because the deal design has to respect it. Medi-Cal pays physicians and qualified health professionals for remote physiologic monitoring under fee-for-service, but a rural health clinic is paid the per-visit rate, and the Medi-Cal rural-health-clinic manual excludes remote patient monitoring from the services a clinic may bill that way.[16] Medi-Cal covers most of the practice's patients, and none of that population is in this forecast. The Medicare forecast on these pages does not include a Medi-Cal dollar. Section 5 sets out the Medi-Cal rail as its own line, scoped separately.

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

3.1 The clinical and billing stack

Three programs, one infrastructure. Remote physiologic monitoring supplies the daily signal; chronic care management and advanced primary care management supply the monthly coordination wrapper. Enrollment, devices, monitoring, escalation, documentation and claims run on the same CoachCare engine for all three. Principal care management is off: a primary-care panel bills CCM or APCM, not the single-condition specialist code.

[16] California Medi-Cal provider manual: the Evaluation and Management chapter lists remote physiologic monitoring and chronic care management for physicians and qualified health professionals; the rural-health-clinic chapter (July 2026) excludes remote patient monitoring from the services a clinic may bill at the per-visit rate.

Program	Who qualifies	What it is	Billing
RPM	422 of the 650 Medicare patients (65%): hypertension, diabetes, heart failure, COPD	Cellular-connected devices (blood-pressure cuff, glucose meter, scale, pulse oximeter); readings monitored against clinical thresholds; monthly management time	99453 setup; 99454/99445 supply; 99457/99470/99458 management
CCM	260 (40%): two or more chronic conditions expected to last twelve months or more	Monthly non-face-to-face coordination: comprehensive care plan, medication reconciliation, referrals, outreach	99490 + 99439
APCM	227 (35%): ongoing primary-care relationship; level set by condition count and Qualified Medicare Beneficiary status	Monthly bundle of thirteen practice-capability elements; no minute tracking	G0556 / G0557 / G0558
TCM	Any inpatient discharge home from the community hospital three blocks away, or from the systems the Highland site refers into	Contact within two business days, medication reconciliation, a face-to-face visit within 7 or 14 days	99495 / 99496, named and not in the forecast

Eligible-pool counts from the Value Analysis eligibility model; pools overlap, billing does not (see the coordination rule below).

One coordination rule, set at enrollment

APCM and CCM never bill for the same patient in the same month; a patient carries one care-management wrapper, not two. RPM stacks with either. A transitional care episode runs for 30 days after a discharge and does not overlap APCM for that patient in that month. The enrollment workflow assigns each patient a wrapper (CCM or APCM) plus RPM where clinically indicated, so the code families never collide on a claim.

3.2 The dual-eligible tier and why APCM earns its place

Advanced primary care management is a monthly bundle with three tiers, and the tier is set by the patient, not the minutes. Level 1 (G0556, $16.37) covers one chronic condition; level 2 (G0557, $53.78) covers two or more; level 3 (G0558, $117.24) applies to a Qualified Medicare Beneficiary with two or more. About 30% of Del Norte's Medicare beneficiaries are dually eligible, a high dual share for a rural county, and the forecast weights the level-3 tier to that share.[17] The tiers blend to $65.33 per patient-month at 20% level 1, 50% level 2 and 30% level 3. That is why APCM earns its place beside CCM on a panel this size: no minute-tracking, a bundled monthly payment, and a top tier written for exactly the dual-eligible patients a rural clinic sees most.

The service line pays the practice three ways. First, additive revenue: every care-management dollar lands on top of the per-visit rate, not inside it. Second, control of the chronic-disease measures a lifestyle-medicine clinic already cares about — blood pressure, weight and glucose move on continuous readings and a monthly documented touch. Third, avoided admissions: a patient whose fluid weight climbs for four days is treated by phone and in clinic, not admitted three weeks later. That is where the forecast's 20.4 avoided hospitalizations come from.

3.3 The Medicare panel it runs on

The forecast is built on **650 Medicare patients**, the modeled midpoint for the two sites together; Medicare Advantage and the dual-eligible patients are already inside it, with no gross-up. From that panel the

[17] CMS Medicare Monthly Enrollment, 2025: Del Norte County 2,011 dual-eligible beneficiaries of 6,727 (29.9%); San Bernardino County dual share 28.6%. CoachCare Value Analysis APCM tier weights 20% / 50% / 30%, blending to $65.33 per patient-month at the national amounts, with the level-3 weight set to the county dual share.

eligibility model carves the program pools: 422 patients RPM-eligible (65%), 260 CCM-eligible (40%), 227 APCM-eligible (35%). The pools overlap; the coordination rule keeps the billing disjoint.[18]

A rural health clinic's Medicare panel does not appear in the physician claims files, because its visits bill on institutional claims under the clinic's certification number. The 650-patient figure is therefore the practice's own number to confirm, and the count of active Medicare charts across the two sites is the first question of the working session in Section 13, because it is the input that moves every ceiling in Section 4. Section 12 prices the panel both below and above the midpoint.

3.4 Transitional care at the hospital discharge, named and not in the forecast

Each discharge home from the community hospital three blocks away, or from the four acute-care systems the Highland site refers into, opens a transitional care management episode: an interactive contact within two business days, medication reconciliation, and a face-to-face visit within 14 days (99495, $220.11 at the national amount) or 7 days (99496, $298.60).[19] TCM is on the recommended stack for that reason, and it carries no dollars anywhere in this forecast: the practice's discharge volume, the share of discharges that come home to a Stallant patient, and visit-scheduling capacity are all discovery items. What TCM does in the forecast is clinical. A discharge is the highest-yield moment to enroll a patient in monitoring, and the three-touch post-discharge cadence in Section 7.5 runs on the same contact the TCM code requires. It is the discharge-to-monitoring loop, never the revenue base.

3.5 Behavioral health integration: the next arm, named

A practice with in-house mental health on the roster has an obvious fourth program waiting: behavioral health integration, 99484, $57.45 a month at the national amount for the first 20 minutes of care-manager time under a treating clinician's plan.[20] It is the same infrastructure, the same monthly cadence and the same billing engine, applied to a population the practice already treats. This forecast carries it at zero dollars and names it once, here, as the natural next arm once the three Medicare programs are at ceiling.

3.6 An APP-led bench the codes are written for

The primary-care roster is one physician and five nurse practitioners and physician assistants, with a sixth advanced-practice provider enumerated in early 2026 as upside.[21] Those six are the referring bench in the forecast. Five of the six are nurse practitioners or physician assistants, and for this service line that is the right shape. CCM, APCM and RPM are general-supervision code families: qualified clinical staff deliver the monthly work under a billing clinician's overall direction, without that clinician in the room, and a rural health clinic bills the care-management codes without a separate physician visit. The referral motion is one step — a clinician flags a qualifying patient in the chart, and the program runs from there. At eight referrals per clinician per month, the bench fills every program inside the first year; Section 12 shows the clinician count barely moves the result.

3.7 Staffing: nobody is hired

CoachCare delivers 3,948 hours of care-team work across the 24 months, about **1.9 full-time-equivalent years**, without the practice hiring anyone. The on-site enrollment specialist is CoachCare's expense, not a program cost. For a practice recruiting a Highland medical director and medical assistants, the service line adds the working capacity of nearly two hires and zero requisitions, and it adds them in the

[18] CoachCare Value Analysis eligibility model: RPM 65%, CCM 40%, APCM 35% of the in-scope panel of 650; eligible pools 422, 260 and 227 respectively.

[19] CPT 99495 and 99496 requirements (interactive contact within two business days of discharge; face-to-face visit within 14 or 7 days; moderate or high medical decision-making); CY2026 national non-facility amounts $220.11 and $298.60. The community hospital three blocks from the Crescent City site is a CMS-certified acute-care hospital. TCM is carried at zero dollars in every figure in this report.

[20] CPT 99484, CY2026 national non-facility amount $57.45 for the first 20 minutes of behavioral-health care-manager time under a treating clinician's plan. The practice carries mental health on its care-team roster. BHI is carried at zero dollars in every figure in this report.

[21] Stallant Health care-team pages and CMS NPPES, retrieved September 2026: one physician and five nurse practitioners and physician assistants on the primary-care roster; a sixth advanced-practice provider enumerated at the Crescent City address in early 2026 is treated as upside and not counted in the base forecast.

languages the panel speaks. The practice's clinicians contribute the two things only they can: the referral flag that starts each enrollment and clinical judgment at the escalation points.

4. Value Analysis: The 24-Month Forecast

4.1 Headline economics

Over 24 months the service line produces **$581,542 in net reimbursement** to Stallant Health. CoachCare's fees total $331,892, including $18,657 of ancillary items: implementation, the athenahealth integration and telephonic outreach. Net to the practice is **$249,650, a 42.93% margin** on the program, 41.90% in Year 1 and 43.75% in Year 2.[22]

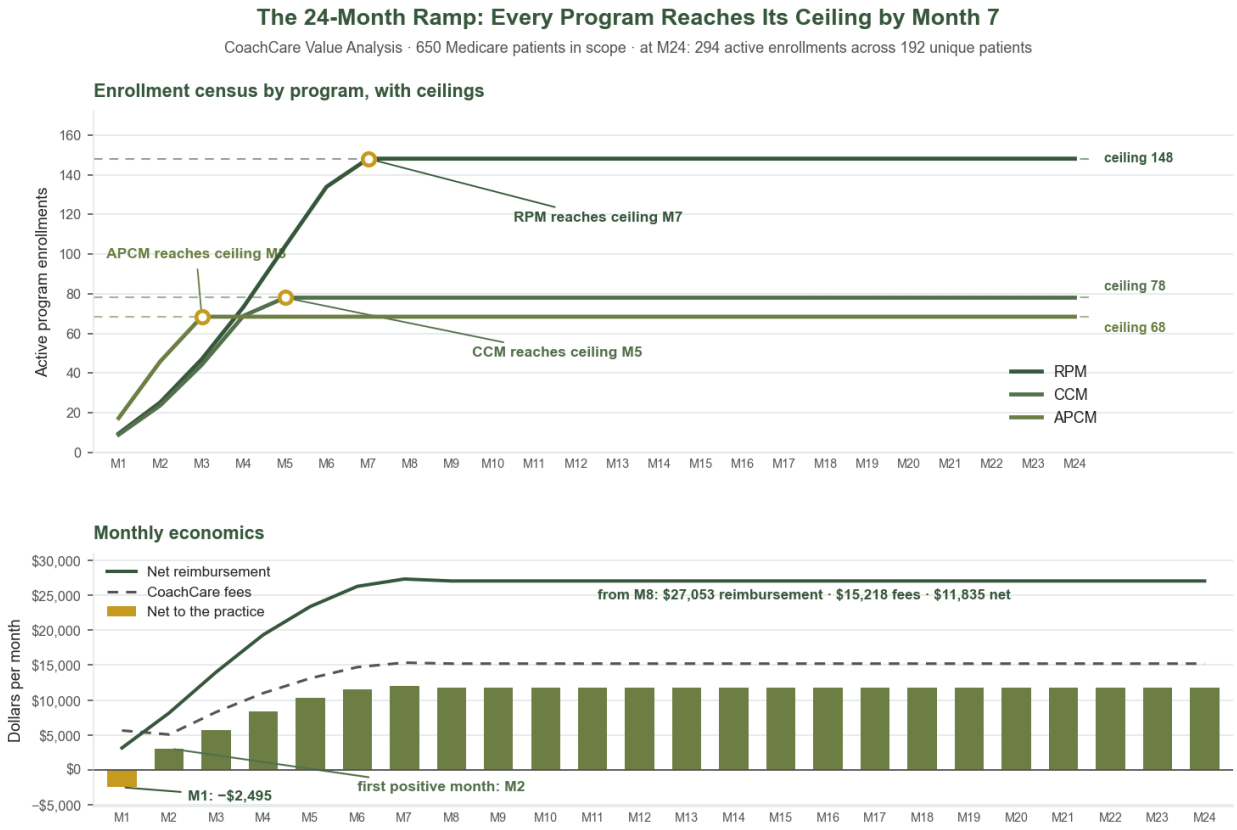

Figure 1. The 24-month ramp: enrollment census by program with ceilings (above) and monthly net reimbursement, CoachCare fees and net to the practice (below). Month 1 nets −$2,495; the first positive month is M2; from M8 the line holds at $11,835 net per month.

The shape of the curve is worth reading precisely. Month 1 is negative, −$2,495, because implementation and enrollment effort land before the first full billing months do. Month 2 turns positive at $3,073, month 3 nets $5,716, and the line climbs as the three programs fill: M7, the month RPM reaches its ceiling, is the peak at $27,334 of net reimbursement and $11,976 net; from M8 the line settles at $27,053 of net reimbursement, $15,218 of fees and $11,835 net a month once setup codes fall away and the census holds at ceiling. Month 12 and month 24 are the same month.

[22] CoachCare Value Analysis, 24-month forecast: monthly net reimbursement, fees and net-to-practice series; Year 1 margin 41.90%, Year 2 margin 43.75%, 24-month margin 42.93%, each defined as net to the practice divided by net reimbursement. Ancillary fees of $18,657 over 24 months: implementation $2,500; athenahealth integration $1,000 setup, $150 a month and $1.50 per patient-month; telephonic outreach.

4.2 Program economics by year

Program	Year 1 net reimbursement	Year 2 net reimbursement	24-month net reimbursement	24-month CoachCare fees	24-month net to the practice
RPM	$126,452	$171,308	$297,760	$167,178	$130,583
CCM	$85,235	$103,661	$188,896	$94,001	$94,896
APCM	$45,215	$49,670	$94,885	$52,057	$42,828
Ancillary (implementation, integration, outreach)	—	—	—	$18,657	−$18,657
All programs	**$256,903**	**$324,639**	**$581,542**	**$331,892**	**$249,650**

CoachCare Value Analysis, per-program economics by contract year. Ancillary items: implementation $2,500; athenahealth integration $1,000 setup plus $150 a month and $1.50 per patient-month; telephonic outreach.

Program	Year 1 fees	Year 1 net	Year 2 fees	Year 2 net
RPM	$70,040	$56,412	$97,138	$74,170
CCM	$42,416	$42,820	$51,585	$52,076
APCM	$24,807	$20,409	$27,251	$22,419

Per-program fees and net to the practice by contract year, before ancillary items.

RPM is the volume engine at 3,058 patient-months and $297,760 of net reimbursement. CCM is the yield engine at $110.75 of net reimbursement per patient-month across 1,706 patient-months, against $97.38 for RPM and $60.51 for APCM over its 1,568. APCM earns its place a different way, as Section 3.2 sets out: no minute-tracking, a bundled monthly payment, and the level-3 tier on the county's dual-eligible patients. Year 2 outruns Year 1 by $67,736 of net reimbursement because Year 1 carries the ramp and Year 2 runs all three programs at ceiling from its first month.

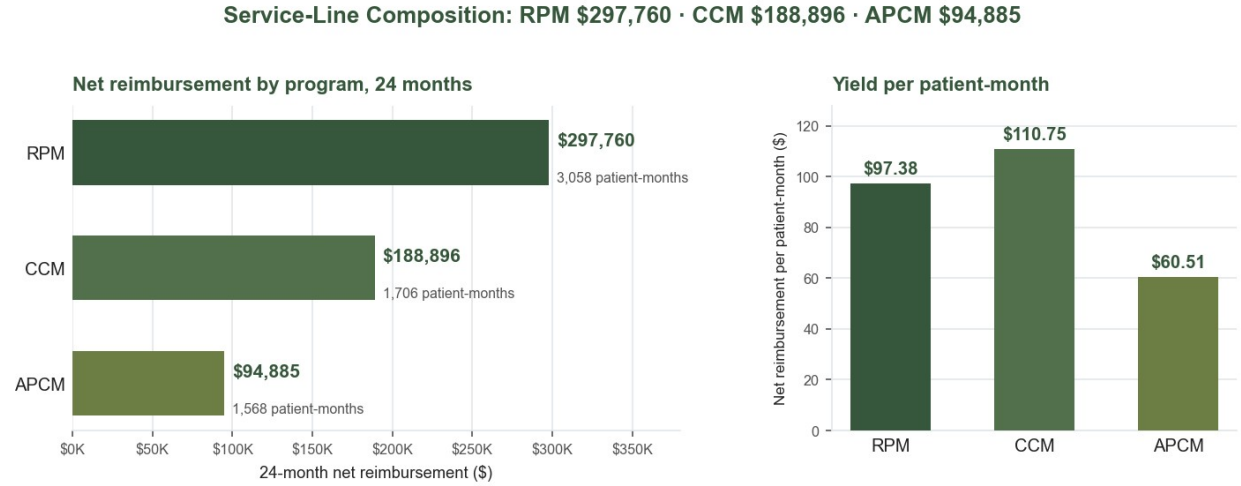

Figure 2. Service-line composition: per-program 24-month net reimbursement and net reimbursement per patient-month.

4.3 The ramp: every ceiling reached by month 7

This account is ceiling-limited in all three programs inside the first year. APCM reaches its ceiling of 68 enrollments in month 3, CCM its 78 in month 5, and RPM its 148 in month 7. From M8 the forecast is flat

because there is no one left to add.[23] The first 90 days move fast: 36 new enrollments across the three programs in month 1, 60 in month 2, 66 in month 3.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
RPM	422	148	Month 7	148
CCM	260	78	Month 5	78
APCM	227	68	Month 3	68
All programs		**294**		**294 enrollments · 192 unique patients**

Enrollment counts are program enrollments, not unique patients; the 294 enrollments at M24 belong to 192 unique patients (192 at M12), because a patient may carry a monitoring enrollment and a care-management enrollment at the same time.

Say the constraint out loud: what binds this program is the size of the Medicare panel, not enrollment capacity, and not clinician count. That cuts two ways. It caps the forecast at a two-year net line around a quarter of a million dollars, and it de-risks it, because the model asks the clinicians for no heroic enrollment performance, only a panel that exists. Three things move the ceiling upward: the practice's own Medicare chart count across the two sites, Highland's growing Medicare panel, and the behavioral-health arm in Section 3.5 once the first three programs are full. The on-site enrollment specialist cannot raise a ceiling, but it reaches every ceiling months sooner, and Section 12 prices what that is worth.

4.4 What the program produces

24-month output	Volume
Claims generated, billing-ready	9,158
Device readings monitored	32,105
Care-management tasks completed	18,316
Chart updates written to athenahealth	4,579
Patient conversations held	2,747 (153 hours of call time)
Care-team hours delivered	3,948 (≈ 1.9 FTE-years)
Hospitalizations avoided	**20.4 · ≈ $306,000 at $15,000 per admission**

CoachCare Value Analysis operational and clinical outputs, 24 months.

The avoided-admission line deserves its own sentence. 20.4 avoided hospitalizations over 24 months is roughly $306,000 of cost that never lands on anyone: not on Medicare, and not on a bed in the community hospital three blocks away.[24] It is also the entry requirement for every accountable-care arrangement: a consented, documented, monthly-managed panel with continuous readings, which this service line builds under fee-for-service first.

[23] CoachCare Value Analysis enrollment model: program ceilings 148 (RPM), 78 (CCM), 68 (APCM); ceilings reached in months 7, 5 and 3; 294 active enrollments across 192 unique patients at month 24 and at month 12. Dedup: the care-management enrollments plus the RPM enrollments not already carrying a wrapper.

[24] CoachCare Value Analysis clinical-outcomes module: 20.4 avoided hospitalizations over 24 months, valued at $15,000 per avoided admission (about $306,000).

5. The Second Rail: Medi-Cal and the Rural Health Clinic Per-Visit Rate

Most of the practice's patients are on Medi-Cal, and most of its chronic-disease volume sits there. Medi-Cal does pay for remote physiologic monitoring and for chronic care management under fee-for-service, but for physicians and qualified health professionals billing the professional fee schedule, not for a rural health clinic billing the per-visit rate.[25] The Medi-Cal manual for rural health clinics states that remote patient monitoring is not a reimbursable service for a clinic paid the per-visit rate, and care-management codes are not qualifying visits. For Stallant as a rural health clinic, then, Medi-Cal care-management revenue is not a fee-for-service line; it would have to come from a managed-care plan contract that pays outside the per-visit rate.

How the Medi-Cal rail is handled in this report

The Medicare forecast on these pages does not include a Medi-Cal dollar. Whether the practice's Medi-Cal managed-care plans will pay for remote monitoring or care management outside the per-visit rate is a contract question, sized in a second working session from the practice's own hypertension and diabetes registries by payer, as its own line beside the Medicare forecast, never folded into it.

Two design facts carry over. The same devices, the same escalation engine and the same athenahealth workflow serve both rails. Billing is done by the practice as the enrolled provider; CoachCare manages the devices and the month.

The point for the leadership team is the order of operations. The Medicare service line is built first because its rail is explicit and it is ready to bill. The Medi-Cal question is where the practice's chronic-disease volume sits, and it is a plan-contract conversation that follows once the Medicare line is running and the registries have been counted by payer.

6. athenahealth Integration: The Program Lives in the Record

The practice runs on athenahealth, and the forecast prices CoachCare's athenahealth integration at the catalog tier: $1,000 setup, $150 a month and $1.50 per patient-month.[26] The program operates inside the record rather than beside it. CoachCare's integration uses the workflows already in athenahealth, so the practice's clinicians and billing staff learn no new system.

- **Out of the chart: enrollment flags and orders.** Qualifying patients are flagged and orders triggered by service inside the athenahealth workflow; CoachCare enrolls flagged Medicare patients on the practice's behalf, and clinicians see enrollment status in real time in the chart they already use.
- **Back into the chart: vitals, documentation and status.** Device readings land as integrated vital reports; Evidence of Care, care plans and the care summary attach to the chart monthly; enrollment status and time capture write back to the record.
- **Automated claims into athenaCollector.** The CoachCare billing engine creates the monthly claim lines automatically in athenaCollector, the step that makes individual-code billing workable at 9,158 claims over 24 months. The practice's own billing team files the claims.

[25] California Medi-Cal provider manual, Evaluation and Management chapter (remote physiologic monitoring and chronic care management payable to physicians and qualified health professionals under fee-for-service) and rural-health-clinic chapter, July 2026 (remote patient monitoring not reimbursable at the per-visit rate).

[26] EHR as evidenced by the athenahealth patient-portal domains on every page of the practice's site, September 2026. CoachCare integration pricing for athenahealth as carried in the Value Analysis: $1,000 setup, $150 a month, $1.50 per patient-month.

- **The discharge feed.** Hospital discharges reach the program from the record, which arms the post-discharge cadence in Section 7.5 without anyone relaying a message; the interface from the community hospital three blocks away is an integration-scope item.

7. Clinical Governance and Escalation

7.1 A monitoring program is a clinical operation first

A monitoring program is a clinical operation before it is a revenue line. This section sets out the machinery the practice inherits on the first day of the program: CoachCare's Care Management Programs standard operating procedures, March 2026 edition, rendered as seven process maps covering qualification, monitoring, escalation and discharge.[27] The purpose is keeping a patient with heart failure or uncontrolled diabetes at home in a rural county, an hour or more from specialty care, rather than in a hospital bed.

7.2 One shared escalation engine

Every program, RPM and the care-management wrappers alike, routes through one alert-and-escalation decision logic. A critical value escalates immediately, regardless of symptoms. An out-of-range reading that is not critical gets worked before it escalates: the patient retakes the reading and answers a symptom check, so the clinic hears clinical signal rather than cuff artifacts. Trend rules are explicit. Three consecutive out-of-range blood-pressure or glucose readings at least an hour apart, or three abnormal heart-rate readings inside seven days, count as a trend and draw clinical review even when no single reading is critical.

7.3 The emergent pathway

An active emergent symptom reported during any outreach contact triggers the 911 pathway. That policy supersedes any site-specific escalation preference and any quiet window in Section 8: whichever site the patient belongs to, whichever day of the week it is, the emergent floor does not move.

7.4 Qualification, device assignment and routing

Enrollment starts with the panel, not the device inventory. The population is screened by ICD-10 code and routed to the right program and device, and device assignment follows a fixed, ordered hierarchy in which the highest-priority qualifying diagnosis wins: a patient with heart failure and diabetes gets the device that the higher-acuity condition needs. Once monitoring runs, escalations route three ways: emergencies to the emergent pathway, non-critical clinical items to the clinic for direction, and informational items documented to the chart.

7.5 The post-discharge cadence

A hospitalization within the last 60 days fires a fixed three-touch follow-up sequence: a first contact on day 1 or 2, a second on days 5 to 8, and a third on days 12 to 14. Each touch is documented, and any clinical alert surfaced during a touch escalates under the same shared logic; the post-discharge window gets more contact, not a different rulebook. For a discharge home to a Stallant patient the first touch is also the interactive contact a transitional care episode requires, and the day-12-to-14 touch lands inside the 14-day visit window. One workflow serves both, and it is where most of the 20.4 avoided hospitalizations in Section 4.4 are won.

[27] CoachCare Care Management Programs standard operating procedures, March 2026 edition, and the seven derived process maps: qualification and device assignment; the RPM patient lifecycle; the care-management lifecycle; alert-and-escalation decision logic; the emergent/urgent communication protocol; the post-discharge follow-up sequence; and the discharge decision flow.

7.6 Discharge governance and continuity

Discharge from the program is governed, not ad hoc. Discharge criteria and unreachable-patient timelines are defined per program, and the clinic is notified in every case. For monitoring patients the sequence is explicit: a recommended discharge first escalates to the clinic for instructions, re-escalates every 30 days, and if the clinic has given no instruction by 180 days the discharge proceeds. Processed discharges post in the first week of the following month. Nobody quietly falls out of the program, and nobody quietly stays in it either.

8. Built for a Rural Panel: Distance, Language and Access

Del Norte County is California's far northwest corner, roughly 80 miles from the nearest metropolitan hospital, a super-rural stretch where the drive to specialty care is measured in hours. A monitoring program in this county is built for that geography rather than adapted to it afterward, and it is where the service line does the work an office schedule cannot.[28] Six design decisions follow.

- **Cellular devices, not app- or broadband-dependent.** A cellular cuff or glucose meter transmits the moment it is used: nothing to pair, no smartphone, no app, no home broadband. In a rural county where connectivity is uneven, that is the difference between a reading and a device in a drawer.
- **Monitoring replaces the drive.** Remote care is the answer to distance: readings travel instead of patients. A daily blood-pressure or weight signal reaches the clinic without an 80-mile round trip, and the patient is managed at home until a visit is actually needed.
- **Spanish-language materials and call scripts for the Highland panel.** Patient-facing materials, enrollment scripts and outreach calls are prepared in Spanish as well as English for the Highland site, where a majority of residents are Hispanic and roughly one in seven speaks English less than very well, matched to the patient's language of record in athenahealth.
- **Sunday and evening hours used for enrollment.** The Crescent City clinic's Sunday and evening schedule is an enrollment window: the on-site enrollment specialist works those hours, when families bring older relatives to the clinic.
- **Enrollment lists pulled by condition, with the payer attached.** Enrollment lists come from the hypertension, diabetes, heart-failure and COPD registries, screened by ICD-10 code per the qualification map, with payer attached so the Medicare and Medi-Cal rails stay distinct from the first list.
- **Referrals from the whole care team.** The physician and the five nurse practitioners and physician assistants flag patients in the chart; the flag is the whole clinician workflow, and the general-supervision codes let the advanced-practice team carry it.

9. Market Context: Del Norte and San Bernardino Medicare

Del Norte County had 6,727 Medicare beneficiaries in 2025, 6,338 of them in Original Medicare and 2,011 (29.9%) dually eligible, one of the lowest Medicare Advantage counties in California.[29] In July 2026 the county's Medicare population was 4.26% Medicare Advantage, which leaves effectively every Crescent City Medicare patient in Original Medicare and makes the individual-code rail immediately billable on the panel. Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.

[28] U.S. Census Bureau ACS 2024 five-year estimates, Del Norte County: population 27,107; 20.5% aged 65 and over; 21.1% reporting a disability; median household income $67,058. The Crescent City site is a super-rural pricing locality roughly 80 miles from the nearest metropolitan hospital.

[29] CMS Medicare Monthly Enrollment, 2025, Del Norte County: 6,727 beneficiaries, 6,338 in Original Medicare, 2,011 dual-eligible (29.9%). CMS Medicare Advantage State/County Penetration, July 2026: Del Norte County 4.26%.

Del Norte County and the Crescent City site	Value
County population (ACS 2024 five-year)	27,107
County residents aged 65 and over	20.5%
County residents reporting a disability	21.1%
County median household income	$67,058
Medicare beneficiaries, 2025	6,727 (Original Medicare 6,338)
Dual-eligible share of beneficiaries, 2025	**29.9%** (2,011)
Medicare Advantage penetration, July 2026	**4.26%**

U.S. Census Bureau ACS 2024 five-year estimates, Del Norte County; CMS Medicare Advantage State/County Penetration, July 2026; CMS Medicare Monthly Enrollment, 2025.

The Highland site tells a different market story in one sentence. San Bernardino County is about two-thirds Medicare Advantage (67.24%, July 2026), a majority-Hispanic county where one in seven residents speaks English less than very well; the Medicare panel there grows from a small base as the site matures, and the Medicare Advantage floor above applies to it.[30] California's rural health transformation funding names remote monitoring among its priorities, which is worth noting as context for a rural clinic building this capability, though nothing in this forecast depends on it.

The market fact that shapes the program is distance, not payer mix. A county 80 miles from the nearest metropolitan hospital, where one in five residents is 65 or older and one in five reports a disability, is where a monthly documented touch and a daily reading do the work a few office visits a year cannot.[31]

10. The CY2027 Proposed Rule, Repriced on This Forecast

CMS published its proposed CY2027 physician fee schedule in July 2026. Comments on CMS-1848-P closed September 14, 2026; the final rule arrives in early November; the changes take effect January 1, 2027, and a statutory phase-in caps how far any code's payment can fall in a single year. The proposal that matters here is a reduction to the remote monitoring device-supply codes. Every code in this forecast was repriced at the national amounts on this account's own billing mix, with enrollment held constant; the forecast's basis and the repricing table use the same national amounts on both sides.[32]

The cascade: one code, one arm, one line

Device supply, 99454 and 99445: $52.11 → $41.38 a month, −20.6%. The code CMS proposes to cut.

The remote monitoring arm: $297,760 over 24 months, −9.5%, −$28,346. Device supply is 32% of the remote monitoring basket; management time moves little.

Chronic care management: $188,896, −2.1%, −$4,061. Advanced primary care management: $94,885, −0.7%, −$646. Conversion-factor and relative-value movement only; the proposal does not target these codes. The care-management movement is $4,707 of the total.

The whole service line: $581,542 over 24 months, −5.7%, −$33,053, to $548,489. Remote monitoring is 51% of the line, and two of the three programs are not the one being repriced.

[30] CMS Medicare Advantage State/County Penetration, July 2026: San Bernardino County 67.24%. U.S. Census Bureau ACS 2024 five-year estimates, San Bernardino County: 55.2% Hispanic or Latino; 15.3% speaking English less than very well. California Rural Health Transformation Program materials name telehealth and remote monitoring among stakeholder priorities.

[31] U.S. Census Bureau ACS 2024 five-year estimates, Del Norte County: 20.5% aged 65 and over; 21.1% reporting a disability. The nearest metropolitan hospitals are roughly 80 miles from Crescent City.

[32] CMS-1848-P, proposed CY2027 Physician Fee Schedule (July 2026); comment period closed September 14, 2026. CoachCare repricing at the national non-facility amounts on this forecast's code frequencies and APCM tier weights: 99454 and 99445 from $52.11 to $41.38 (−20.6%); RPM arm −9.5% (−$28,346); CCM −2.1% (−$4,061); APCM −0.7% (−$646); service line −5.7% (−$33,053, from $581,542 to $548,489). Enrollment held constant.

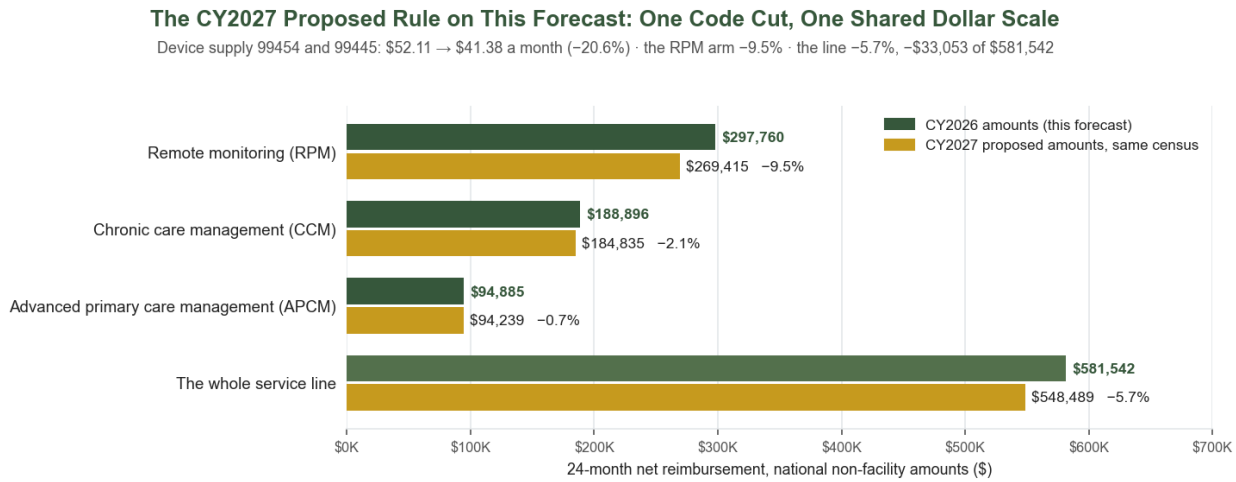

Figure 3. The CY2027 proposed rule on this forecast, at the national amounts on both sides: each arm and the whole line, CY2026 against the CY2027 proposed amounts, same census.

11. Implementation and the First 90 Days

11.1 Who runs what

CoachCare delivers	Stallant Health keeps
Telephonic and on-site enrollment in English and Spanish; the enrollment specialist is CoachCare's expense	Referral flags in athenahealth; clinical oversight under general supervision
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans, escalation preferences and the site quiet-window calendar
Monitoring, documentation and the escalation protocol of Section 7	Responses to clinic-routed escalations; the discharge feed from the community hospital
Automated claim creation into athenaCollector	Filing the care-management claims; billing review; the revenue
Monthly operating reports against the dashboard in 11.3	Program governance; the patient relationship

11.2 Model inputs

Input	Value
Medicare panel in scope	650 patients, the modeled midpoint across both sites; reconciled against the practice's own Medicare chart count in the first 30 days
Referring clinicians	6 (one physician and five nurse practitioners and physician assistants); a sixth advanced-practice provider enumerated in early 2026 is upside
Programs	RPM + CCM + APCM; TCM and BHI named, not in the forecast; PCM off
Program-eligible pools	RPM 422 · CCM 260 · APCM 227
Enrollment ceilings	RPM 148 (M7) · CCM 78 (M5) · APCM 68 (M3)
Acceptance	RPM 35% · CCM and APCM 30% of the eligible pool
Enrollment engine	8 referrals per clinician per month at 80% acceptance; one CoachCare-funded on-site enrollment specialist at 80 enrollments a month; telephonic outreach on; 1.5% monthly attrition

Input	Value
Rate basis	CY2026 national non-facility Physician Fee Schedule amounts, the rail a rural health clinic bills care-management codes on
APCM tier blend	20% level 1 · 50% level 2 · 30% level 3 = $65.33 per patient-month
Medicare Advantage	Del Norte 4.26%; San Bernardino 67.24% (July 2026). Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.
EHR	athenahealth, priced at the catalog integration tier ($1,000 setup, $150 a month, $1.50 per patient-month)

11.3 The 90-day plan and the operating dashboard

Days 0–30: foundation. Program agreement and the athenahealth integration workplan. The practice's own Medicare chart count across both sites, and the hypertension and diabetes registries by payer, the two inputs that move the model most. ICD-10 screening of the Medicare panel per the qualification map, device logistics staged, escalation routing set, the site quiet-window calendar agreed, materials and scripts finalized in English and Spanish, and clinician orientation to the general-supervision workflow.

Days 31–60: enrollment live. Telephonic, in-clinic and weekend enrollment running; first devices in homes; first billable service months. Month 1 nets −$2,495 as implementation lands; month 2 turns positive. The forecast carries 36 new enrollments in month 1 and 60 in month 2.

Days 61–90: scale and file. 66 new enrollments in month 3, APCM at its ceiling, CCM two months from its own. First monthly operating report against the dashboard. Second working session on the Medi-Cal plan-contract question, with the registries counted by payer.

The operating dashboard from month one:

- Enrollment census by program against ceiling (148 / 78 / 68)
- Time from referral flag to first billable enrollment (target: under five days from flag to first service)
- Discharges captured: hospital discharges that entered the three-touch cadence
- Device-reading days per patient-month against the 16-day 99454 threshold, with 99445 capturing 2- to 15-day months
- Escalations by pathway: emergent, clinic-routed, documented, with the quiet-window log
- Claims generated against expected claims, and claims filed
- Blood-pressure and glucose control among enrolled patients, against the practice's own baseline
- Net to the practice per month against the $11,835 steady-state line

12. Recommendations

1. **Stand up the Medicare service line now, sized honestly.** The individual-code rail has been live since October 2025. This is a $249,650 two-year net line that fills in seven months; each month of delay pushes it one month further out, and nothing about it waits on a hire.
2. **Confirm the Medicare panel across both sites in the first 30 days.** The 650-patient figure is the modeled midpoint and drives every ceiling in the forecast. The practice's own count of active Medicare charts across Crescent City and Highland is the single largest lever in this report, and the table below prices the range around it.
3. **Lead with APCM on the dual-eligible tier.** About 30% of the county's Medicare beneficiaries are dually eligible, and G0558 at $117.24 a month is the best-paying monthly code on the page. Set the wrapper rule at enrollment so the dual-eligible patients with two or more conditions land on APCM level 3.

4. **Take the Medi-Cal question to the plans, as its own line.** Most of the practice's patients are on Medi-Cal, and the per-visit rate excludes remote monitoring for a rural health clinic. Count the hypertension and diabetes registries by payer and take the plan-contract question to the practice's Medi-Cal managed-care plans in a second session, beside the Medicare forecast, never inside it.
5. **Build the program for the geography from the first day.** Cellular devices, materials in English and Spanish, the site quiet-window calendar with the emergent pathway running through it, Sunday and evening enrollment, condition-based lists. None of these is a retrofit.
6. **Keep the CoachCare-funded enrollment specialist in the plan.** The specialist cannot raise the ceilings, but reaches them months sooner, and is worth $97,963 of 24-month net reimbursement against the no-specialist case in the table below; without it, remote monitoring does not fill until month 16.
7. **Make the hospital discharge the front door.** Wire the discharge feed from the community hospital three blocks away, enroll at the first post-discharge contact, and bill transitional care on every discharge home to a Stallant patient. TCM is in the forecast at zero dollars; every episode billed is upside, and every episode enrolled is a monitoring patient from the day they most need it.
8. **Set the attribution rule at enrollment.** Each patient carries one care-management wrapper, CCM or APCM, never both in a month, plus RPM where indicated and a transitional care episode after a discharge. One rule, set once in the enrollment workflow, prevents every double-billing collision the code families allow.

What moves the number

Scenario	24-month net reimbursement	Net to the practice	Margin	Ceiling reached RPM / CCM / APCM
Base: 650 panel, 6 clinicians, 1 enrollment specialist	**$581,542**	**$249,650**	42.93%	M7 / M5 / M3
No on-site enrollment specialist	$483,579	$206,712	42.75%	M16 / M11 / M6
Second on-site enrollment specialist	$605,426	$260,146	42.97%	M5 / M4 / M2
5 referring clinicians	$578,190	$248,184	42.92%	M7 / M5 / M3
7 referring clinicians (new provider counted)	$584,894	$251,116	42.93%	M7 / M5 / M3
Panel 400 (low end of the range)	$371,834	$157,031	42.23%	M5 / M4 / M2
Panel 900 (high end of the range)	$775,648	$335,497	43.25%	M9 / M6 / M4
Panel 1,300 (both sites at maturity, upper bound)	$1,055,946	$459,687	43.53%	M12 / M8 / M5

CoachCare Value Analysis recalculations at the same pricing. The binding constraint is the size of the Medicare panel, not enrollment capacity or clinician count; the enrollment specialist changes when each ceiling is reached, not where it sits.

Read the table from the bottom up. The clinician-count rows barely move the result, because every program fills inside the first year on six referrers. The specialist rows move the timing, not the ceilings. The panel rows are the only rows that move the ceilings, and the panel is the practice's own number to confirm.[33]

[33] CoachCare Value Analysis recalculations at the same pricing: no on-site enrollment specialist $483,579 / $206,712 / 42.75%; second specialist $605,426 / $260,146 / 42.97%; 5 clinicians $578,190 / $248,184 / 42.92%; 7 clinicians $584,894 / $251,116 / 42.93%; panel 400 $371,834 / $157,031 / 42.23%; panel 900 $775,648 / $335,497 / 43.25%; panel 1,300 $1,055,946 / $459,687 / 43.53%. The specialist is worth $97,963 of 24-month net reimbursement against the no-specialist case.

13. The Ask: A Working Session

CoachCare asks for one working session with the practice's leadership, clinical lead and billing lead. The forecast stands on the figures in Section 4; the session is about the four inputs that would move it, in the order they matter.

1. **The Medicare panel across both sites.** The count of active Medicare charts at Crescent City and Highland, Original Medicare and Medicare Advantage together. This one number sets every ceiling, and it is the reason the report prices the panel both below and above the 650 midpoint.
2. **The hypertension and diabetes registries by payer.** The Medicare slice sizes the RPM cohort in this forecast; the Medi-Cal slice sizes the second rail and the plan-contract question.
3. **Highland staffing and the care-team roster.** Who sees patients at Highland today, the status of the medical-director hire, and who on the current staff carries care-coordination work.
4. **The athenahealth configuration and interfaces.** Which athenahealth products the practice runs and which interfaces are available, so the integration workplan can be written, and whether the community hospital's discharge feed can reach the record.

Everything else in this report, the Medicare Advantage contract terms at Highland, the discharge feed, the site quiet-window calendar, and the Medi-Cal plan-contract question, is a workplan item that follows the session rather than a condition of it.

About CoachCare

CoachCare runs remote care programs for rural health clinics, specialty practices and health systems: the enrollment, the devices, the clinical monitoring, the documentation and the claims, inside the EHR the organization already uses.[34]

Measure	CoachCare, 2026
Patients managed	over 400 managed conditions for 500,000+ patients
Clinicians on the platform	10,000+ providers running remote care programs day to day
Implementations	1,000+ programs stood up and running in market
Claims generated	care-plan coding and billing behind more than 5 million claims
Vitals recorded	over 100 million vitals recorded; 4 million+ care actions enabled

References and Data Sources

- **CMS Rural Health Clinic Enrollments (July 2026 vintage):** two certification numbers under one PECOS associate identifier, both Part A rural health clinic enrollments; the corporation incorporated in 2019; the Crescent City site enrolled 2020 and the Highland site 2025. Absent from the CMS health-center enrollment file.
- **The practice's website,** retrieved September 2026: the site, care-team, services, hours and careers pages and the brand assets; the EHR (athenahealth) as evidenced by the patient-portal domains on every page.
- **CMS National Plan and Provider Enumeration System,** queried September 2026 for every clinician named on the practice's care-team pages and every individual enumerated at the clinic addresses; two organization records under the practice.

[34] CoachCare company statistics, 2026: patients served, managed conditions, providers on the platform, implementations completed, claims generated and vitals recorded.

- **CMS Quality Payment Program eligibility records, 2025 and 2026,** for the practice's clinicians: no Alternative Payment Model participation under the practice's own billing organization.
- **CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024:** the sweep of every remote-monitoring, care-management, advanced-primary-care, transitional-care and behavioral-health-integration code across the practice's clinicians. A rural health clinic's care management billed on the institutional claim does not appear in this professional-claims file.
- **The CY2025 Physician Fee Schedule Final Rule and CY2026 Final Rule:** retirement of G0511 on September 30, 2025; individual-code reporting for rural-health-clinic care management from October 1, 2025; payment at national non-facility amounts in addition to the per-visit rate; APCM adopted for rural-health-clinic payment; the CY2026 additions 99445 and 99470.
- **CY2026 Physician Fee Schedule rate files (CMS RVU26A, January 2026 release):** national non-facility amounts for the eleven forecast codes, the two transitional care codes and the behavioral health integration code, at the $33.4009 conversion factor with no geographic adjustment.
- **CMS-1848-P, the proposed CY2027 Physician Fee Schedule (July 2026):** the proposed national non-facility amounts used in the Section 10 repricing; comment period closed September 14, 2026.
- **The California Medi-Cal provider manual:** the Evaluation and Management chapter (remote physiologic monitoring and chronic care management for physicians and qualified health professionals, updated 2026) and the rural-health-clinic chapter (July 2026), which excludes remote patient monitoring from the services a clinic may bill at the per-visit rate.
- **CMS Medicare Advantage State/County Penetration, July 2026, and CMS Medicare Monthly Enrollment, 2025:** Del Norte County 4.26% Medicare Advantage, 6,727 beneficiaries with 6,338 in Original Medicare and 2,011 (29.9%) dual-eligible; San Bernardino County 67.24% Medicare Advantage.
- **U.S. Census Bureau American Community Survey 2024 five-year estimates** for Del Norte and San Bernardino counties: population, age, income, disability, ethnicity, language and English proficiency.
- **CMS Hospital Enrollments,** September 2026: the community hospital in Crescent City and the acute-care systems the Highland site refers into, referenced by proximity only.
- **CoachCare Care Management Programs standard operating procedures, March 2026,** and the seven process maps derived from them: the shared alert-and-escalation decision logic, trend definitions, the emergent communication protocol, three-way routing, the post-discharge three-touch sequence and the discharge decision flow reproduced in Section 7.
- **CoachCare athenahealth integration overview:** integrated ordering and enrollment, enrollment status in the clinical workflow, integrated vital reports, monthly Evidence of Care, vitals and care-plan documents, and automated claims creation into athenaCollector through the CoachCare billing engine.
- **CoachCare Value Analysis for Stallant Health, 2026, and the CY2027 repricing of the same forecast:** every financial, enrollment, clinical-output and operational figure in Sections 2, 4, 10, 11 and 12, built on 650 Medicare patients in scope, six referring clinicians, one on-site enrollment specialist, and CY2026 national non-facility amounts for RPM, CCM and APCM.

How this report counts

Patients and program enrollments are different numbers. At M24 the program holds 294 active program enrollments belonging to 192 unique patients, because a patient may carry a monitoring enrollment and a care-management enrollment at the same time. Wherever this report gives a patient count it says patients; wherever it gives an enrollment count it says enrollments.

The panel figure is the practice's own to confirm. A rural health clinic's visits bill on institutional claims under its certification number rather than under individual clinicians, so clinician-level Medicare claims files structurally do not show its panel. The 650-patient figure is the modeled midpoint the forecast runs on, and the first implementation step is the practice's own count of active Medicare charts across both sites; Section 12 prices the panel both below and above it.

No individual is named anywhere in this report. Governance, leadership and clinician composition are described by count, role and organization only.