ALABAMA MEDICAL GROUP, P.C.

Mobile & Saraland, Alabama · Independent and physician-owned since 1946

Remote Care Service Line Optimization

2026 Strategy Report

A practice-owned Remote Care Service Line (RPM + CCM + PCM) as the operating spine of chronic-panel economics — and of shared-savings performance under two-sided risk

Purpose of this report

Prepared for the leadership of Alabama Medical Group, P.C. as a strategy discussion document. It combines the practice's own public footprint, verified CMS program data, and a CoachCare Value Analysis forecast built at Alabama Medicare locality rates. All modeled figures are illustrative, modeled — verify against practice data. Sources and data vintages are listed in the References section.

Prepared with CoachCare · July 2026

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Executive Summary

Alabama Medical Group, P.C. (“AMG”) was founded in 1946 and marks 80 years of continuous, physician-owned operation in 2026. It describes itself as the largest independently owned multi-specialty medical clinic in Mobile, Alabama, operating from a main campus on Memorial Hospital Drive in Mobile and two clinics in Saraland, with a public roster of 23 physicians and 15 advanced-practice providers across internal medicine, family medicine, infectious disease, neurology, rheumatology, radiology, and a walk-in clinic. Behind that roster sits an unusually complete in-house diagnostic and treatment engine for an independent group: a clinical laboratory; accredited imaging spanning ultrasound, vascular ultrasound, mammography, echocardiography, CT, and MRI; in-house cardiac diagnostics (echocardiography, stress echo, routine stress testing); an infusion services center; and physical therapy. (Practice website and CMS NPPES registry, retrieved July 2026.)

Two facts define AMG's 2026 starting position. **First, Alabama Medical Group PC is a verified PY2026 participant in the Medicare Shared Savings Program (MSSP)**, through ACO A4894 — an ENHANCED-track ACO carrying two-sided risk, in an agreement period that began January 2022 (CMS ACO Participants dataset, PY2026 vintage, published January 2026). Under two-sided risk, avoidable utilization in the attributed panel cuts both ways: savings are shared, and losses are owed. **Second, on public evidence the practice operates no remote-care infrastructure**: no remote patient monitoring (RPM), chronic care management (CCM), principal care management (PCM), or advanced primary care management (APCM) program appears anywhere on its website (reviewed July 2026; absence inferred from public materials — confirm in discovery). The group is carrying two-sided, total-cost-of-care accountability without the between-visit monitoring layer that most directly influences that cost.

> **The central argument**
>
> **Turn the panel you already manage into a profit-generating service line.** A practice-owned Remote Care Service Line — RPM + CCM + PCM, delivered on CoachCare's platform and CoachCare-funded enrollment staffing but billed under AMG's own provider numbers — is modeled to produce **$2,999,184 in net reimbursement and $891,459 in practice profit over 24 months at a 42.29% margin**, while generating exactly the daily-touch chronic care that shared-savings economics reward. The same build defends the ACO quality reporting that sets AMG's shared-savings rate, adds a longitudinal monitoring layer on top of the practice's in-house diagnostic engine, and diversifies revenue in the way that keeps an 80-year-old independent group independent. All figures are illustrative, modeled — verify against practice data.

The forecast is deliberately conservative in structure. It is priced at a 2% discount from CoachCare list at Alabama Medicare locality rates (MAC carrier 10112, locality 00), and it models RPM, CCM, and PCM only: **APCM — for which AMG's verified MSSP participation establishes eligibility — is intentionally not modeled**, and is held as incremental upside pending a CCM/APCM program-mix decision (APCM and CCM cannot both be billed for the same patient in the same month). The model is also **ceiling-limited, not pace-limited**: enrollment saturates the modeled eligibility ceilings early — PCM by month 5, RPM by month 10, CCM by month 14 — and total active census plateaus at roughly 1,721 program enrollments from month 14 onward. The constraint is the eligibility definition, not outreach capacity. That is why validating the 8,500-patient traditional-Medicare panel

estimate (range 7,000–9,900) against actual chart counts is the single most consequential next step: the panel estimate drives the 24-month number directly. Month one is modestly negative (−$3,303, reflecting one-time implementation and EMR setup); the program is margin-positive from month two, and cumulative profit turns positive in month two.

2026–2027 priority recommendations

1. **Validate the panel first.** Confirm the traditional-Medicare panel against chart counts in discovery. Every program ceiling — and therefore the entire 24-month forecast — scales linearly with this one number.
2. **Stand up the Remote Care Service Line as a practice-owned asset.** Launch RPM + CCM + PCM on CoachCare's platform with a CoachCare-funded on-site enrollment specialist; billing runs under AMG provider numbers. Modeled at margin-positive from month two.
3. **Make the CCM/APCM program-mix decision at proposal stage.** MSSP participation makes APCM verified-eligible today; because APCM and CCM are mutually exclusive for the same patient in the same month, the mix is a design decision — model both configurations against the validated panel.
4. **Wire the programs into the ACO scorecard.** Track avoided admissions, blood-pressure and glycemic control, and care-management touch rates against the ACO's quality and cost measures, so the service line's contribution to shared savings is visible at reconciliation.
5. **Confirm the Veradigm configuration in contracting.** The Veradigm EMR family is confirmed from public evidence; the exact product (Professional vs. TouchWorks) is confirmed during contracting, and integration proceeds on CoachCare's established Veradigm pathway.
6. **Plan the post-saturation levers now.** From month 14 the census plateaus by design. The growth levers are the eligibility definition itself: panel validation upside, the unused APCM eligibility slice, transitional care management (TCM) at discharge, and extension of the same infrastructure to Medicare Advantage populations (~63% of Alabama Medicare beneficiaries, mid-2024).

1. Practice Profile & Operating Position

1.1 Footprint and clinical roster

AMG operates three sites, all in Mobile County: the main campus at 101 Memorial Hospital Drive in Mobile and two clinics on Industrial Parkway in Saraland. The practice's homepage cites 33 providers and 200+ employees; its About Us page cites more than 250 staff; and the public provider roster lists 38 clinicians (23 physicians, 15 advanced-practice providers) — the roster is the basis used in the Value Analysis, and the discrepancy is a discovery item, not a material risk. The organization NPI is 1841712684 (taxonomy: internal medicine). (Practice website and NPPES, retrieved July 2026.)

Specialty	Physicians	Advanced-practice providers
Internal medicine	11	4
Family medicine	4	3
Infectious disease	4	5
Neurology	2	—
Rheumatology	1	1
Radiology	1	—
Walk-in clinic	—	2
Total	**23**	**15**

Public provider roster, retrieved July 2026. The practice also lists a physical therapist and an esthetician; the Value Analysis models 38 referring clinicians.

Fifteen of the 23 physicians — and 22 of the 38 clinicians — practice adult primary care (internal medicine and family medicine). That is the panel that matters for this report: a large, multi-chronic adult population with hypertension, type 2 diabetes, heart failure, CKD, and COPD concentrated in a single practice, managed longitudinally by the group that also owns the diagnostics.

1.2 The in-house chronic-disease diagnostic engine

For an independent group, AMG's ancillary depth is striking: a clinical laboratory; imaging accredited across general and vascular ultrasound, mammography, echocardiography, CT, and MRI (accreditations announced March 2026), with designation as a Lung Cancer Screening Center; in-house cardiac diagnostics — echocardiography, stress echocardiography, and routine stress testing — performed without staff cardiologists; an infusion services center supporting its infectious disease, rheumatology, and neurology practices; and physical therapy. (Practice website, retrieved July 2026.)

The strategic reading: AMG is **diagnosis-rich and monitoring-light**. The practice can characterize a chronic disease as well as any group in its market — echo and stress testing for cardiac status, vascular ultrasound, advanced imaging, and infusion-based treatment — but on public evidence nothing follows the patient home between visits. A remote-care layer converts each diagnostic

finding into a longitudinal management pathway the practice owns and bills: the hypertensive with an abnormal echo gets a connected blood-pressure cuff and titration follow-up; the diabetic gets glucometry with monthly care management; the heart-failure patient gets weight and symptom monitoring under PCM. The diagnostic engine generates the clinical justification; the service line captures the recurring value.

1.3 Starting position: what is present, and what is absent

- **Present:** verified MSSP participation through ACO A4894 (ENHANCED track, two-sided risk, agreement period beginning January 2022; PY2026 CMS participant list) — meaning shared-savings economics already attach to every avoidable admission in the attributed panel.
- **Present:** a FollowMyHealth patient portal (a Veradigm product) and InstaMed billing — evidence of a Veradigm-family EMR and of a patient base already accustomed to digital touchpoints.
- **Absent (on public evidence):** any RPM, CCM, PCM, or APCM program; any telehealth-forward chronic-care offering; any care-coordination service line marketed to patients. Website reviewed July 2026 — absence is inferred from public materials, and the practice's ACO relationship may already supply some care-management tooling; both are first-call discovery items.
- **Market context:** roughly 63% of Alabama Medicare beneficiaries were enrolled in Medicare Advantage as of mid-2024 — among the highest penetration rates in the country. The traditional-Medicare panel is therefore a finite, definable asset (consistent with the ceiling analysis in Section 3.3), and the same remote-care infrastructure extends to MA members under plan-specific terms.

2. The Remote Care Service Line — The Spine

2.1 What it is

The Remote Care Service Line is a managed clinical operation, not a software purchase: enrollment, connected devices, 24/7 alert-and-triage monitoring, nurse care management, documentation, and billing capture, run as one program across the practice's chronic panel. For an adult internal-medicine group, the workhorse stack is RPM plus CCM, with PCM covering the single-condition high-risk subset and TCM available at every discharge:

Program	Who it serves	What it looks like monthly
RPM — remote physiologic monitoring	Hypertension, T2D, HF cohorts with connected BP cuffs, glucometers, scales	16+ days of device readings; 20+ min of monitoring and interactive review
CCM — chronic care management	Patients with 2+ chronic conditions expected to last 12+ months — the core of an adult IM panel	20+ min of documented non-face-to-face care management against a shared care plan
PCM — principal care management	A single high-risk condition (e.g., heart failure) managed intensively for 3+ months	30+ min of condition-specific management
TCM — transitional care management	Every hospital discharge back to the practice	Contact within 2 business days; visit within 7–14 days (per-discharge, not modeled in Section 3)
APCM — advanced primary care management	A bundled monthly alternative to CCM for the primary-care panel; requires value-model participation — AMG qualifies via MSSP	13 service elements, no minute tracking; three complexity tiers (verified-eligible; not modeled in Section 3)

> **One coordination rule shapes the program mix**
>
> APCM is a bundled payment: it **cannot be billed alongside CCM, PCM, or TCM for the same patient in the same month** — while APCM + RPM is allowed. The forecast in Section 3 therefore models the CCM configuration; converting part or all of the panel to APCM is a design decision to make at proposal stage against validated panel data, not a foreclosed option. Whichever mix is chosen, the operating rules are the same: one shared care plan in the EMR, a defined attribution policy for patients touched by multiple programs, and no double-billing across program boundaries.

Design principles carried through every section of this report: **longitudinal by default** (every chronic patient has a between-visit touchpoint), **one front door** (a single enrollment and consent workflow across programs), **digital as care, not as an app** (device readings trigger human clinical response), and **practice-owned billing** (every claim runs under AMG provider numbers; the asset and the revenue belong to the practice).

2.2 Standalone value: four layers and the 2026 billing stack

1. **Per-panel recurring revenue without added headcount.** Enrollment staffing is CoachCare-funded (one on-site enrollment specialist is included in the model as CoachCare's expense — embedded value, not a practice cost), and monitoring and care-management labor is delivered by CoachCare's clinical team under practice supervision. The practice adds a subscription-like professional-fee line without hiring.
2. **Quality-score defense.** MSSP quality reporting gates the shared-savings rate an ACO keeps. Structured monthly touches generate exactly the documented evidence — blood-pressure control, glycemic follow-up, medication reconciliation, care-plan currency — that quality measures score.
3. **Shared-savings contribution.** Verified for AMG (Section 4): under an ENHANCED-track, two-sided arrangement, the ~97.5 hospitalizations the model projects avoiding over 24 months land directly on the ACO benchmark math — value the forecast in Section 3 deliberately does not count.
4. **Independence preservation.** A recurring, practice-owned revenue line — modeled at roughly $49,200 of monthly profit at steady state — is revenue diversification of precisely the kind that lets an independent group stay independent rather than sell to a hospital system or private-equity buyer.

The CY2026 billing stack

Service / code family	Payment type	~CY2026 magnitude	Notes
TCM 99495 / 99496	Per discharge	~$200 / ~$280	Contact in 2 business days; visit in 14 / 7 days. Not modeled in Section 3 — additive.
RPM 99453	One-time setup	~$20	Device setup and patient education
RPM 99454 / 99445	Monthly	~$52	99454 = 16–30 days of readings; 99445 (new for 2026) = 2–15 days — short windows now billable
RPM 99457 / 99470 / 99458	Monthly	~$52 / ~$26 / ~$41	First 20 min / new first-10-min code (2026) / each additional 20 min
PCM 99424–99427	Monthly	~$60 + ~$50 addl.	Single high-risk condition, physician and clinical-staff codes
CCM 99490/99439; 99491/99437; 99487/99489	Monthly	~$60 + ~$47 addl.	2+ chronic conditions; staff, physician, and complex variants
APCM G0556 / G0557 / G0558	Monthly bundle	~$15 / ~$49 / ~$107	By complexity tier; G0558 = QMB/dual-eligible. Verified-eligible via MSSP; not modeled in Section 3.

Illustrative national non-facility magnitudes for CY2026; actual payment is locality-adjusted by the Medicare Administrative Contractor. The Section 3 forecast is computed at AMG's own locality (MAC carrier 10112, locality 00, Alabama) — these are reference points, not quotes. Verify against the current-year physician fee schedule.

Recurring-revenue mechanics

Each enrolled patient generates a predictable monthly claim set — RPM device-supply and management codes, or CCM/PCM care-management codes, or both where concurrency rules allow (RPM stacks with CCM and with PCM; discrete time and documentation are maintained per program). The result behaves like subscription revenue on a panel the practice already manages: modeled steady state for AMG is ~$162,740 of net reimbursement and ~$49,200 of practice profit per month from month 15 onward.

2.3 Connective tissue: one infrastructure, every value lever

The same build — enrollment, devices, monitoring, navigation, documentation, billing — serves every value lever AMG cares about at once. Build once, reuse everywhere:

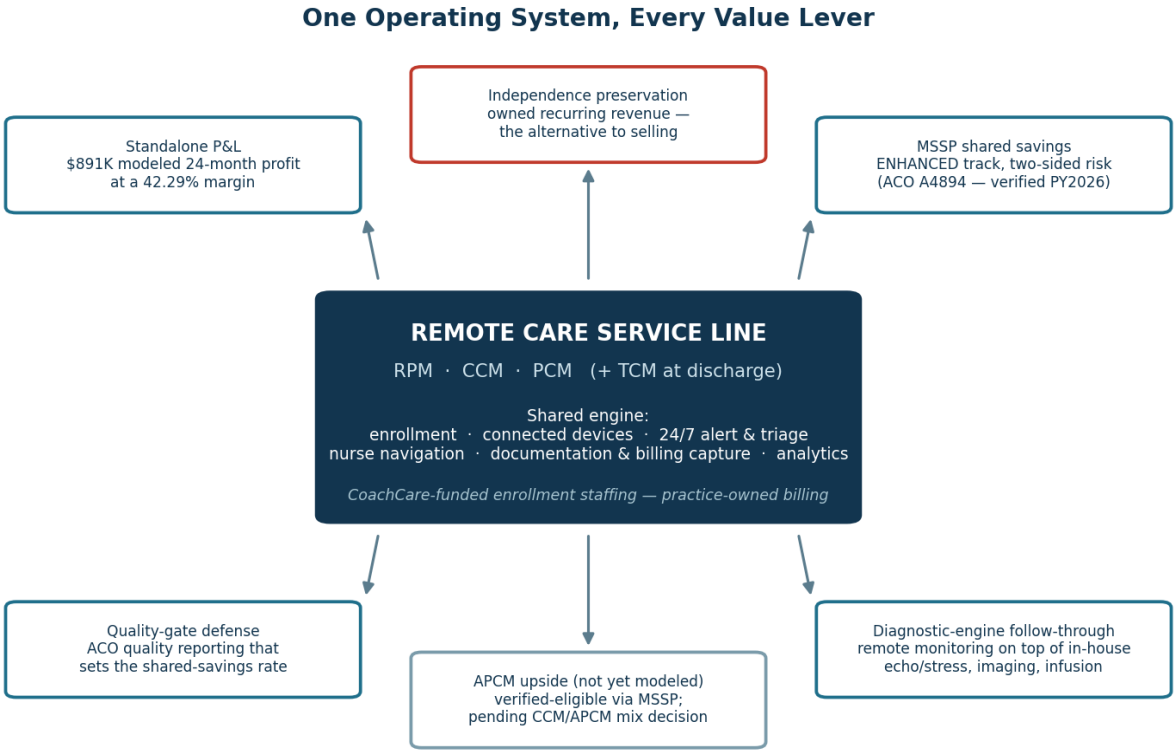

Figure 1. One shared remote-care infrastructure powers the standalone P&L, the MSSP shared-savings position, quality reporting, the diagnostic-engine follow-through, and the independence strategy. APCM is verified-eligible but intentionally unmodeled.

Value lever	What the shared infrastructure supplies	Status in this report
Standalone program P&L	Billable RPM/CCM/PCM services at top-of-license staffing	**Modeled** — $891,459 profit / 24 mo (Section 3)
MSSP shared savings (ACO A4894, ENHANCED)	Avoided admissions, chronic-condition control, documented longitudinal touch on the attributed panel	**Participation verified**; savings contribution not modeled — upside (Section 4)
ACO quality reporting	Structured monthly documentation of control	Qualitative — defends the

Value lever	What the shared infrastructure supplies	Status in this report
	measures and care-plan currency	shared-savings rate
Diagnostic-engine follow-through	Monitoring pathways attached to in-house echo/stress, imaging, and infusion findings	Qualitative — deepens existing service lines
APCM program mix	The same panel, enrolled under a bundled monthly payment where the mix decision favors it	**Verified-eligible**; intentionally not modeled — pending program-mix decision (Section 4.2)
Independence preservation	Owned recurring revenue and a differentiated chronic-care offering	Strategic (Section 5)

3. Value Analysis — The 24-Month Modeled Forecast

The forecast below comes from the CoachCare Value Analysis workbook built for AMG in July 2026 (*Alabama_Medical_Group_CoachCare_Value_Analysis_2026.xlsx*), computed at Alabama Medicare locality rates (MAC carrier 10112, locality 00). All figures are illustrative, modeled — verify against practice data.

3.1 Model inputs and the panel estimate

Input	Value used
Practice / locality	Alabama Medical Group, Mobile, AL 36608 — MAC 10112-00 (Alabama) rates
Specialty basis	Primary care / internal medicine eligibility profile
Traditional-Medicare panel	**8,500 — estimate; range 7,000–9,900** (see callout below); full panel in scope in year 1
Referring clinicians	38 (23 physicians + 15 APPs, public roster)
Programs modeled	RPM + CCM + PCM. **APCM off by design** — verified-eligible, held as upside (Section 4.2)
Eligibility × conversion	RPM 30% × 30% · CCM 40% × 25% · PCM 5% × 25%
Enrollment staffing	1 on-site enrollment specialist at 80 enrollments/month — CoachCare-funded (CoachCare's expense; not netted from practice margin)
EMR	Veradigm (confirmed family; product confirmed in contracting) — integration fees included in the modeled fee schedule
Pricing	2% discount from CoachCare list (see Section 3.2)

The panel estimate — and why it is the number to validate

The 8,500 traditional-Medicare panel is an estimate, triangulated two ways: (a) roughly 22 adult primary-care clinicians at a typical ~450 traditional-Medicare patients each puts the upper bound near 9,900; (b) against a Mobile County traditional-Medicare market on the order of 80–90,000 beneficiaries, 8,500 implies roughly a 10% share — credible for the market's largest independent

multi-specialty group. The working range is 7,000–9,900. **Every program ceiling in Section 3.3 — and therefore the entire 24-month forecast — scales linearly with this number. Chart-count validation in discovery is the key next step.**

3.2 Headline economics

	Year 1	Year 2	24-month total
Net reimbursement to practice	$1,046,599	$1,952,585	**$2,999,184**
CoachCare fees (incl. ancillary)	$744,756	$1,362,969	$2,107,725
Practice profit	$301,843	$589,616	**$891,459**
Margin (profit ÷ fees)			**42.29%**

Program (24-month)	Net reimbursement	Practice profit	Margin
RPM (ceiling 765 patients)	$1,288,842	$344,578	36.49%
CCM (ceiling 850 patients)	$1,516,347	$542,662	55.73%
PCM (ceiling 106 patients)	$193,996	$64,073	49.32%

Pricing note: at CoachCare list, the modeled 24-month margin is 39.53%; a 2% contract discount — the smallest that clears the ~42% margin target — lands it at 42.29%. Alabama had no prior locality precedent; this is a near-list market.

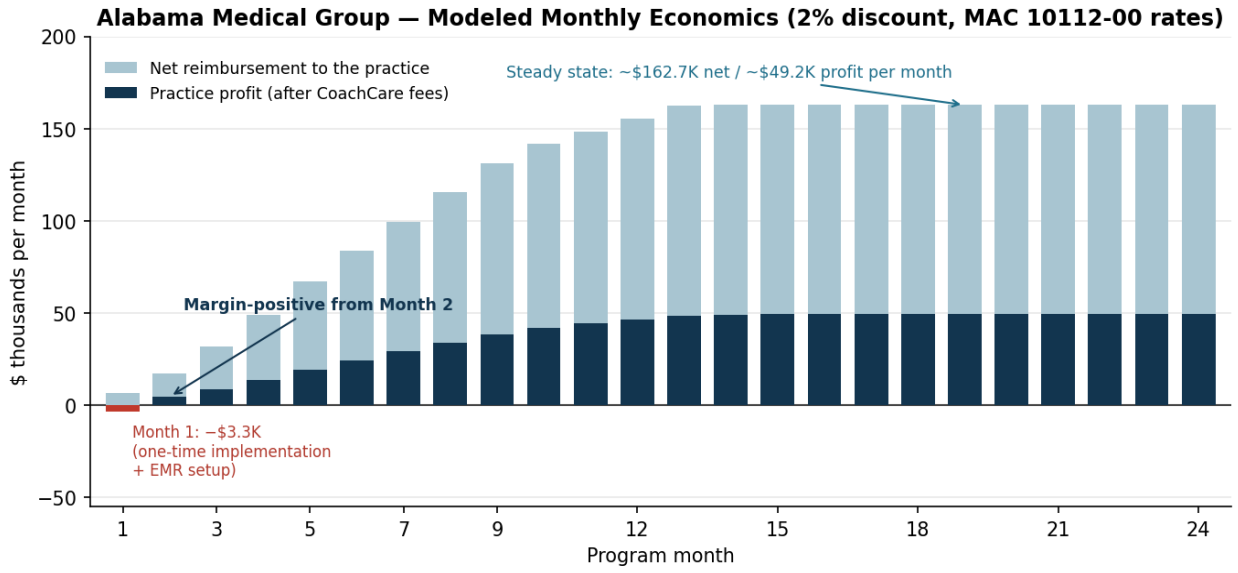

Figure 2. Modeled monthly net reimbursement and practice profit. Month 1 absorbs one-time implementation and EMR-setup fees; steady state is reached as the last program ceiling saturates.

Month-one economics — stated plainly

Month 1 is modeled at **−$3,303** (one-time implementation plus EMR setup landing in a single month). Monthly profit is positive from month 2 (+$4,583), and cumulative profit turns positive in month 2. The

honest claim is “margin-positive from month two” — not sooner.

3.3 The ceiling story: saturation by design

This account's forecast is **ceiling-limited, not pace-limited** — an unusual and important property. Each program's enrollment ceiling is the arithmetic product of the panel, an eligibility share, and a conservative conversion rate:

Program	Ceiling	Arithmetic	Saturation month
PCM	106 patients	8,500 × 5% eligible × 25% conversion	**Month 5**
RPM	765 patients	8,500 × 30% eligible × 30% conversion	**Month 10**
CCM	850 patients	8,500 × 40% eligible × 25% conversion	**Month 14**

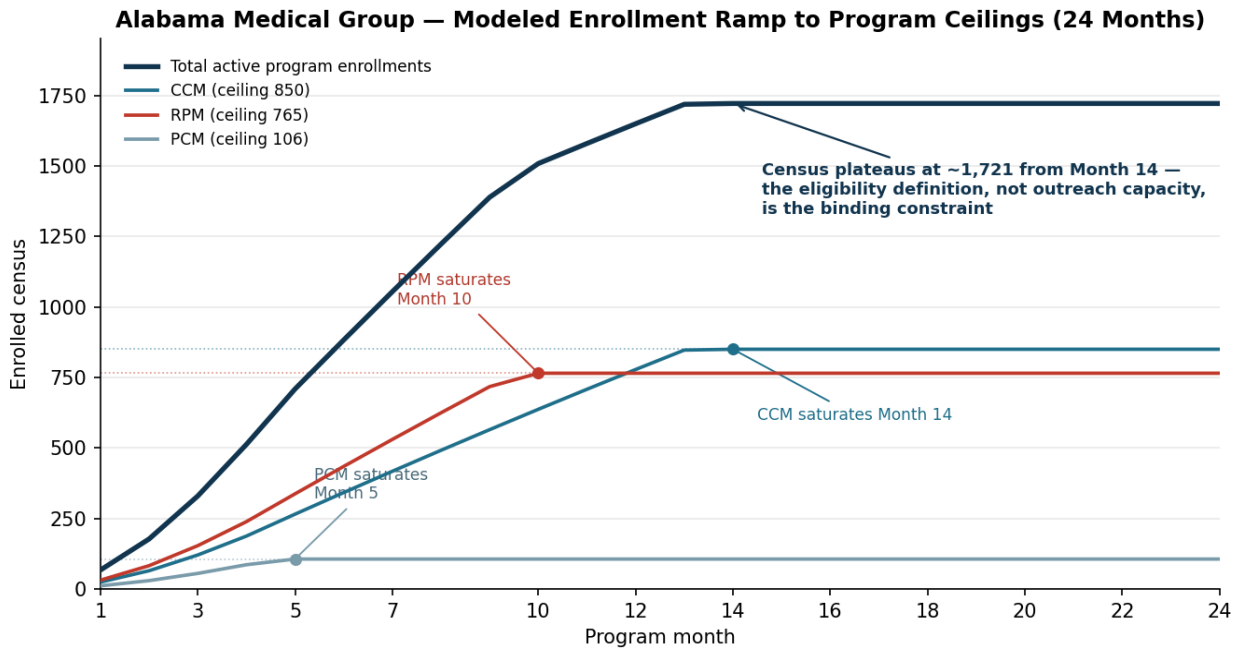

Figure 3. Modeled enrollment ramp. Every program hits its eligibility ceiling within 14 months; total active census plateaus at ~1,721 program enrollments (sum of program enrollments, not unique patients — unique patients ≈ RPM census + 0.3 × (CCM + PCM census) under the model's 70% dual-enrollment assumption).

Say the plateau out loud

With 38 referring clinicians, a CoachCare-funded enrollment specialist at 80 enrollments per month, and telephonic outreach behind them, enrollment capacity outruns the eligible pool in every program. The census plateaus at ~1,721 from month 14 **because the model runs out of eligible patients, not because outreach slows down. The constraint is the eligibility definition, not outreach capacity.** The growth levers are therefore definitional: validate the panel (a panel at the 9,900 upper bound raises every ceiling ~16%), activate the unused APCM eligibility slice, add TCM at discharge, and extend to Medicare Advantage populations.

3.4 Clinical and operational value

Measure (modeled)	Year 1	Year 2	24-month total
Physiologic readings captured	57,190	96,390	153,580
Claims / billable units produced	21,681	39,599	61,280
Hospitalizations avoided	36.3	61.2	**~97.5**
Care-team hours absorbed by CoachCare	9,741	18,459	28,200 (~13.6 FTE-years)

Two readings of this table matter. Clinically, ~97.5 avoided hospitalizations over 24 months is the mechanism by which the service line touches ACO economics (Section 4). Operationally, the ~28,200 care-team hours are absorbed by CoachCare's monitoring and care-management staff — the equivalent of roughly 13.6 FTE-years the practice does not hire, train, or manage. That staffing is CoachCare's expense inside its fees; it is embedded value, and it is never subtracted from the practice margin shown above.

4. Powering the ACO Position: Shared Savings Under Two-Sided Risk

4.1 Why chronic-care programs drop straight into shared-savings economics

Alabama Medical Group PC appears on the CMS PY2026 MSSP participant list under ACO A4894 — an ENHANCED-track ACO, the program's highest two-sided risk arrangement, with an agreement period running since January 2022. ENHANCED-track ACOs keep the largest share of savings generated against their benchmark and owe losses when spending exceeds it. For a practice inside such an ACO, the economics of chronic-care management change qualitatively: every avoided admission is paid for twice — once as the fee-for-service program revenue that funded the monitoring, and again as benchmark savings at annual reconciliation.

The Section 3 forecast projects ~97.5 avoided hospitalizations over 24 months from daily physiologic surveillance of hypertension, diabetes, and heart-failure cohorts, early exacerbation detection, and monthly medication-adherence and care-plan touches. **None of that shared-savings value is counted in the $891,459 modeled profit** — the forecast is fee-for-service only. The ACO contribution rides on top, and under two-sided risk it also works defensively: the same avoided utilization that generates savings protects against owed losses. The practical step is instrumentation, not persuasion — wire the service line's avoided-admission and control-rate metrics into the measures the ACO already reports, so the contribution is visible at reconciliation.

4.2 APCM: a verified-eligible lever, held as upside

> **Why APCM is not in the forecast — deliberately**
>
> APCM (G0556/G0557/G0558, ~$15/~$49/~$107 monthly by complexity tier) requires participation in an advanced value model; **AMG's MSSP participation satisfies that requirement today — APCM is verified-eligible.** It is nonetheless intentionally absent from the Section 3 model, because APCM

> and CCM cannot both be billed for the same patient in the same month: enabling APCM is not additive on top of CCM, it is a program-mix decision — which patients are better served (and better reimbursed) under a bundled monthly payment with 13 service elements and no minute tracking, versus minute-based CCM. The model's 20% APCM eligibility slice sits entirely unused. Treat APCM as incremental upside to be modeled at proposal stage against the validated panel — including the dual-eligible share, which drives the high-value G0558 tier. APCM + RPM remains billable together in either configuration.

4.3 Complementary by design

As an MSSP participant, AMG may already receive population-health analytics, attribution reporting, or care-coordination support through its ACO relationship. A practice-owned remote-care service line does not compete with that layer — it operationalizes it. ACO-level tooling identifies which patients drive risk; it does not put a blood-pressure cuff in the home, staff 24/7 alert triage, document care-management minutes, or produce compliant claims. CoachCare supplies exactly that operational layer — device logistics, monitoring labor, documentation, and billing capture — under AMG's own provider numbers, so the revenue and the asset belong to the practice rather than to any intermediary. A first-call discovery item: inventory what care-management tooling exists today through the ACO relationship, so the programs are wired together rather than duplicated.

5. Independence, Quality, and the Mobile Market

AMG's market position is defined by a fact it advertises on its own homepage: 80 years independent, the largest independently owned multi-specialty clinic in its market. That independence exists inside a consolidating environment — area hospital systems and an expanding academic health presence continue to acquire practices and employ physicians across the region — and independence is defended with economics, not sentiment. Three properties of the Remote Care Service Line bear directly on it:

- **Owned recurring revenue.** A modeled ~$49,200 of monthly steady-state profit (~$590,000 in year 2) is a durable, practice-owned income line uncorrelated with visit volume — the kind of diversification that reduces the financial pressure to sell, and that accrues to the physician-owners rather than to an acquirer.
- **A differentiated patient offering.** Connected-device chronic care with 24/7 monitoring is a service patients can see and feel. It gives an independent group a concrete answer to the scale story of employed networks — and it compounds AMG's existing consumer-facing strengths (walk-in access, in-house imaging and lab, the FollowMyHealth portal).
- **Quality-measure defense.** The ACO quality gate (Section 4) is the near-term scoreboard, and the structured documentation the service line produces — controlled blood pressure, glycemic follow-up, reconciled medications, current care plans — is the raw material of quality reporting. The same documentation positions the practice for Medicare Advantage plan quality programs as the mix decision extends the infrastructure to MA members.

On Medicare Advantage: with roughly 63% of Alabama Medicare beneficiaries in MA plans (mid-2024; county-level figures not published), the traditional-Medicare panel modeled in Section 3 is the minority of AMG's senior population. That cuts two ways — it is why the forecast's ceilings are finite, and it is why the post-saturation extension to MA populations (plan terms permitting) is the largest unmodeled expansion path this report identifies.

6. EMR Integration: Veradigm

AMG's EMR is confirmed as a Veradigm (Allscripts) system: the vendor family is crawl-verified, and the practice's FollowMyHealth patient portal — a Veradigm product — corroborates it. The exact product configuration (Veradigm Professional vs. TouchWorks) is confirmed during contracting; CoachCare maintains established integration pathways across the Veradigm ambulatory family, so the configuration determines the connector, not the feasibility.

- **Enrollment and demographics:** eligible-patient identification and demographic sync from the Veradigm system, so outreach lists are generated from the practice's own panel data.
- **Documentation flow:** care-management notes, device-reading summaries, and alert dispositions delivered into the patient chart, keeping the EMR the single source of truth and the shared care plan current (the coordination rule of Section 2.1).
- **Billing handoff:** month-end claim-ready files (codes, minutes, dates of service, supervising provider) delivered to the practice's existing revenue cycle, with billing under AMG provider numbers.
- **Patient experience continuity:** FollowMyHealth remains the practice's portal; CoachCare's patient app and connected devices add the monitoring layer without disturbing the existing digital front door.

EMR integration setup and per-patient integration fees are already included in the modeled fee schedule in Section 3 — the one-time setup is part of the month-1 economics stated there.

7. Implementation Playbook

7.1 Scope, target populations, and staffing

Launch scope is the adult primary-care panel across all three sites, with cohorts prioritized in this order: hypertension and type 2 diabetes (RPM + CCM — the volume engine), heart failure and other single-condition high-risk patients (PCM, with weight and symptom monitoring), then multimorbid CCM-only patients without device indications. The infectious disease, rheumatology, and neurology practices contribute referrals where chronic-condition criteria are met.

Role	Supplied by	Notes
On-site enrollment specialist (80 enrollments/mo)	**CoachCare — CoachCare's expense**	Embedded value; never netted from practice margin
Monitoring nurses, 24/7 alert & triage, care managers	CoachCare	Delivers the ~28,200 modeled care-team hours (~13.6 FTE-years)
Billing capture & claim-file production	CoachCare	Claims run under AMG provider numbers
Physician champion & escalation pathway	AMG	One IM/FM physician lead; defined escalation criteria per cohort
Consent & ordering workflow	AMG (CoachCare-supported)	Folded into existing visit flow; portal-assisted where possible

7.2 Clinical workflow and billing architecture

The operating loop: eligible patients are identified from the Veradigm panel and consented (in-visit or telephonic); devices ship and are activated with the patient; readings stream to CoachCare's monitoring team, which manages thresholds, triages alerts 24/7, and escalates per the practice's criteria; care managers deliver the monthly CCM/PCM touches against the shared care plan; every minute and reading is documented; and month-end claim files land in AMG's revenue cycle. The practice sees a dashboard, an escalation channel, and a monthly reconciliation — not a new department to run.

7.3 KPI dashboard

Domain	KPI	Modeled reference point
Enrollment	Active census vs. ceiling, by program	765 RPM / 850 CCM / 106 PCM; plateau ~1,721 by month 14
Enrollment	Time-to-first-billable-enrollment	Within month 1
Engagement	16-day device-transmission adherence (RPM)	Program integrity gate for 99454
Capture	Billable-minute capture rate (CCM/PCM)	Documented minutes ÷ enrolled census
Financial	Net revenue per enrolled patient per month; margin	Steady state ~$162,740/mo net; 42.29% 24-mo margin
Clinical / ACO	Avoided admissions; BP & glycemic control	~97.5 avoided hospitalizations / 24 mo;

Domain	KPI	Modeled reference point
	rates	feeds ACO quality reporting

7.4 Twelve-month roadmap

When	Milestone
Month 0–1	Contracting; Veradigm product confirmation and integration; chart-count validation of the 8,500-panel estimate; physician-champion designation; first cohort consented
Month 1	Launch — first billable enrollments; one-time implementation and EMR setup absorbed (the modeled −$3,303 month)
Month 2	Margin-positive run rate; cumulative profit positive
Month 5	PCM reaches its 106-patient ceiling — first saturation checkpoint
Month 6	Program-mix review: CCM vs. APCM configuration decision against validated panel data, ahead of CCM saturation
Month 10	RPM reaches its 765-patient ceiling
Month 12	Year-1 review: revenue vs. model, ACO measure contribution, panel re-validation; TCM-at-discharge activation decision
Month 14+	CCM ceiling (850); census plateaus ~1,721 — eligibility-definition review: panel upside, APCM slice, Medicare Advantage extension

Expected steady state from month 15: ~$162,740 in monthly net reimbursement and ~$49,200 in monthly practice profit at the modeled census — with the shared-savings contribution, APCM mix, TCM, and MA extension all sitting above those figures as unmodeled upside.

References & Data Sources

1. Alabama Medical Group website — homepage, About Us, Services, Providers roster, Contact, FollowMyHealth portal page, and News pages (imaging accreditations and 80-year anniversary items dated March 2026). Retrieved July 2026. alabamamedicalgroup.com
2. CMS National Plan & Provider Enumeration System (NPPES) — Alabama Medical Group, P.C., organization NPI 1841712684. Retrieved July 2026.
3. CMS Medicare Shared Savings Program, Accountable Care Organization Participants dataset (PY2026 vintage, published January 2026) — “ALABAMA MEDICAL GROUP PC” listed as a participant of ACO A4894 (ENHANCED track; agreement period start January 2022). data.cms.gov. Retrieved July 2026.
4. CMS ACO REACH participant materials (PY2025 list, January 2025; PY2023 provider-level dataset) — no record found for Alabama Medical Group; REACH participation not confirmed. Retrieved July 2026.
5. Medicare Advantage penetration: healthinsurance.org Alabama Medicare overview (~63% of Alabama Medicare beneficiaries in MA, mid-2024; ~1.13M total Alabama Medicare enrollees, September 2025); KFF, Medicare Advantage in 2026 (55% national MA share). Retrieved July 2026.
6. CY2026 Medicare Physician Fee Schedule — RPM (99453/99454/99457/99458 and new 99445/99470), CCM, PCM, TCM, and APCM (G0556–G0558) code values; illustrative national non-facility magnitudes, locality-adjusted in the model at MAC 10112-00 (Alabama).
7. CoachCare Value Analysis workbook: Alabama_Medical_Group_CoachCare_Value_Analysis_2026.xlsx (built July 2026) — all modeled census, reimbursement, fee, profit, ceiling, and clinical-value figures in Section 3.

Global caveat

This report is a strategy discussion document. Modeled figures are illustrative, modeled — verify against practice data; reimbursement values are locality-adjusted estimates, not quotes, and should be re-verified against the current-year physician fee schedule and the practice's Medicare Administrative Contractor. Public facts carry the retrieval dates noted above; items flagged as estimates or as inferred from public materials (panel size, EMR product configuration, absence of existing programs, provider counts) are discovery-validation items, not settled facts. CMS program participation should be re-confirmed against current CMS participant lists at contracting.