



**NORTH FLORIDA
MEDICAL**

North Florida Medical Centers

A Federally Qualified Health Center · Tallahassee and the Florida Big Bend

COACHCARE | SERVICE LINE STRATEGY

A chronic-disease service line for the health center's 4,795 Medicare patients across ten counties: remote physiologic monitoring, chronic care management and advanced primary care management, billed under the rules that have paid a health center for those codes individually, on top of the PPS encounter, since October 2025, and staffed by CoachCare

Remote Care Service Line Performance & Optimization

2026 Strategy Report

Nearly 4,800 Medicare patients across ten counties, and no Medicare revenue line for the month of care between their visits. Since last October a health center bills that month as its own codes, at the national amounts, on top of every visit. The panel is deep enough that the only question is how fast it enrolls, and the enrolling is CoachCare's to do.

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of North Florida Medical Centers. It brings together the health center's own HRSA record, the Medicare structure of its ten-county footprint, the billing rules a health center 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 eClinicalWorks integration it lives in, the Florida Medicaid rail beside it, and the rural, dispersed design a Big Bend program has to get right.

The argument is short. This health center sees 4,795 Medicare patients across ten counties and bills nothing for the month of care between their visits. Since last October, Medicare pays a health center for that month as its own codes, at the national amounts, on top of every visit. The panel is deep enough that the binding constraint is how fast the program enrolls, not whether the patients exist, and the enrollment and the monthly work are CoachCare's to supply.

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Executive Summary

North Florida Medical Centers is a Federally Qualified Health Center serving the Florida Big Bend and eastern Panhandle. It has cared for the region for more than forty-five years and delivers primary, dental and behavioral health from ten medical sites, a mobile unit and three dental clinics across ten counties, and it is a recognized patient-centered medical home.¹ Its 2024 Uniform Data System report counts 22,997 patients: 4,431 aged 65 or older, 4,795 with Medicare as primary payer, 1,439 of those dually eligible, 4,306 on Medicaid, 8,270 uninsured, 5,953 with hypertension and 3,057 with diabetes.² Over five reporting years it lifted blood-pressure control from 51.32% to 56.35% and holds diabetes poor control at 23.0%.³

What the record does not yet show is a Medicare revenue line for the month between visits. Across the adult-medicine roster the health center runs **no remote monitoring, chronic care management or advanced primary care management program at meaningful scale**; CMS suppresses any provider-and-code line under 11 beneficiaries, and care management billed on a health-center claim is not visible in the Physician fee-for-service file either, so that is the precise claim.⁴ The 5,953 patients with hypertension and 3,057 with diabetes are seen a few times a year, with no care-manager or monitoring role posted to carry the month between.

Most of the health center's Medicare is in Medicare Advantage: 67.5% of Medicare eligibles in its main county, and from 34.6% to 76.4% across the ten-county footprint (March 2024).⁵ Medicare Advantage plans pay at least the Medicare amount, a floor, and individual plan contracts set their own terms for the care-management code families.

The observation this report is built on

North Florida Medical Centers sees nearly 4,800 Medicare patients across ten counties, and it has no Medicare revenue line for the month of care between their visits. Since last October a health center bills that month as its own codes, at the national amounts, on top of every visit. The panel is large enough that the only real question is how fast it enrolls, and the people who do the enrolling and the monthly work are CoachCare's.

G0511, the bundled code health centers used for care management, was retired on September 30, 2025. From October 1, 2025 a health center 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 PPS encounter.⁶ The short-window RPM codes new for 2026 (99445, 99470) fit post-discharge monitoring, and Florida Medicaid has paid for remote physiologic monitoring since 2023.⁷

¹ HRSA Health Center Program and Uniform Data System records for the health center, 2024 reporting year: a Federally Qualified Health Center serving ten counties in the Florida Big Bend and eastern Panhandle from ten medical sites, a mobile medical unit and three dental clinics; patient-centered medical home recognition recorded in the UDS file.

² HRSA Uniform Data System, 2024 reporting year: total patients 22,997; aged 65 and over 4,431; Medicare as primary payer 4,795; dually eligible 1,439 (30.0% of the Medicare panel); Medicaid 4,306; uninsured 8,270 (36%); hypertension 5,953; diabetes 3,057.

³ HRSA UDS clinical quality measures: controlling high blood pressure 51.32% (2019) to 56.35% (2024); diabetes A1c above 9% or untested 23.0%; statin therapy 78.07%; depression screening and follow-up 84.11%.

⁴ CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024, queried across the adult-medicine roster for the remote-monitoring, chronic-care-management, advanced-primary-care and transitional-care codes. CMS suppresses any provider-and-code line under 11 beneficiaries; care management billed on the FQHC claim does not appear in this professional-claims file.

⁵ Rural Policy Research Institute, share of Medicare eligibles enrolled in Medicare Advantage by county, March 2024: main county 67.5%; range across the ten-county footprint 34.6% to 76.4%.

⁶ CY2025 Physician Fee Schedule Final Rule: Federally Qualified Health Centers 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 PPS encounter; 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.

⁷ Florida Medicaid coverage policy for remote patient monitoring (covered since 2023); Florida Medicaid Practitioner Fee Schedule effective January 1, 2025.

What the Value Analysis returns

The forecast prices a service line for the health center's own Medicare panel, 4,795 patients as reported to HRSA for 2024, Original Medicare and Medicare Advantage together, referred by the eighteen physicians and nurse practitioners in adult medicine across the ten sites, and delivered by CoachCare under the health center's clinical direction, priced at the national amounts a health center is paid for these codes.⁸

	Year 1	Year 2	24 months
Net reimbursement	\$866,287	\$2,067,605	\$2,933,892
CoachCare fees	\$507,704	\$1,173,478	\$1,681,183
Net to the health center	\$358,583	\$894,126	\$1,252,709
Margin to the health center	41.39%	43.24%	42.70%

CoachCare Value Analysis. CY2026 national non-facility Physician Fee Schedule amounts, the rail a health center bills care-management codes on. 4,795 Medicare patients in scope; RPM + CCM + APCM. Margin is net to the health center divided by net reimbursement.

- This is a \$2.93 million two-year net-reimbursement line, and the panel is deep enough that it is paced by enrollment, not by the size of the panel.** Net to the health center is \$1,252,709 over 24 months, a 42.70% margin. Advanced primary care management reaches its ceiling in month 8 and chronic care management in month 15, but remote monitoring never reaches its ceiling in the two years: it climbs the whole way to 1,061 of 1,091 enrollments, 97% of the ceiling and still rising at month 24. At M24 the program holds 2,139 active program enrollments across 1,384 unique patients, more than the 1,519 enrollments it holds at M12. The binding constraint is enrollment throughput, not the size of the panel.
- The growth lever is enrollment capacity, and it is CoachCare's to supply.** Because remote monitoring is paced by enrollment, the CoachCare-funded on-site enrollment specialist raises what the program captures over the two years, on top of reaching each ceiling sooner. One specialist is worth \$818,781 of 24-month net reimbursement over the no-specialist case; a second adds \$475,105 and fills remote monitoring by month 18; a third fills it by month 14. Every specialist is on CoachCare's payroll, and none is a health-center cost.
- The program funds itself from the second month.** Month 1 nets -\$4,791 to the health center, because implementation lands before enrollment revenue does. The first positive month is M2, at \$5,025 net, and the line climbs the whole period, from \$134,255 of monthly net reimbursement at M12 to \$195,258 at M24, still rising.
- The dual-eligible share lifts the APCM tier.** 1,439 of the 4,795 Medicare patients, 30.0%, are dually eligible. Advanced primary care management pays its highest tier, G0558 at \$117.24 a month, for Qualified Medicare Beneficiaries, which puts the APCM blend here at \$61.01 per patient-month and makes G0558 the best-paying monthly code on the page.
- Nobody is hired.** CoachCare delivers 19,382 hours of care-team work over 24 months, about 9.3 full-time-equivalent years, including on-site enrollment specialists carried at CoachCare's expense, across a ten-county rural footprint where clinical staff are hard to recruit. No capital outlay and no new requisition.
- The clinical return is concrete.** The forecast projects 87.4 avoided hospitalizations over 24 months, roughly \$1.31 million at \$15,000 per admission, from 137,604 device readings worked through one escalation protocol, with the discharge from any acute-care hospital across the service area as one trigger.

⁸ CoachCare Value Analysis for North Florida Medical Centers, 2026. Basis: CY2026 national non-facility Physician Fee Schedule amounts; 4,795 Medicare patients in scope; 18 referring clinicians; RPM, CCM and APCM.

7. **A second rail sits beside the Medicare line.** Florida Medicaid pays for remote monitoring and basic chronic care management, and most of the health center's hypertension and diabetes volume is low-income. That rail is sized separately from the health center's own registries by payer, never folded into the Medicare forecast on these pages.

1. The Health Center Today

1.1 Forty-five years across ten counties

North Florida Medical Centers is a Federally Qualified Health Center that has served the Florida Big Bend and eastern Panhandle for more than forty-five years. It is enrolled with Medicare as a health center and is a recognized patient-centered medical home.⁹ It delivers care from ten medical sites, a mobile medical unit and three dental clinics spread across ten counties, from the Tallahassee area west toward the coast and the Panhandle and south into the rural Big Bend.¹⁰ Six of the ten counties it serves are non-metropolitan, which makes this a substantially rural health center, and chronic disease is managed inside primary care: there is no endocrinology, cardiology or nephrology service line.

UDS 2024	Count	What it means for the service line
Total patients	22,997	Primary care, dental and behavioral health across ten counties
Medicare patients	4,795 (as primary payer)	The panel this forecast runs on; Medicare Advantage and the 1,439 duals are inside it
Aged 65 and over	4,431	Close to the Medicare-primary count; the difference is under-65 patients on disability
Dually eligible	1,439 (30.0% of the Medicare panel)	The APCM level-3 tier (G0558)
Medicaid	4,306	Outside the Medicare forecast; Florida Medicaid pays for remote monitoring (Section 5)
Uninsured	8,270 (36%)	The low-income base a monthly documented touch is built to reach
Hypertension	5,953	The RPM cohort; blood-pressure control 56.35%
Diabetes	3,057	Glucose monitoring; A1c poorly controlled in 23.0%

HRSA Uniform Data System, 2024 reporting year (the latest).

1.2 Quality the record can verify

The quality trend is the earned compliment. Blood-pressure control rose from 51.32% in 2019 to 56.35% in 2024, the measure a monitoring program moves most directly. Diabetes poor control, the share of diabetic patients with A1c above 9% or untested, sits at 23.0%. Statin therapy for cardiovascular prevention is 78.07%, and depression screening and follow-up is 84.11%.¹¹ A health center that has already moved its blood-pressure number five points, across a ten-county rural panel, has shown it can change a measure; the between-visit gap is what remains.

Clinical quality measure, UDS 2024	Value	For the service line
Controlling high blood pressure	56.35% (51.32% in 2019)	Continuous readings and a monthly touch move this measure most directly
Diabetes: A1c above 9% or untested (lower is better)	23.0%	Glucose monitoring and coordination

⁹ The health center's Medicare enrollment as a Federally Qualified Health Center; HRSA UDS 2024 patient-centered medical home recognition.

¹⁰ HRSA Health Center Program service-area and site records for the health center: ten medical sites, a mobile medical unit and three dental clinics across ten counties in the Florida Big Bend and eastern Panhandle; six of the ten counties non-metropolitan.

¹¹ HRSA UDS clinical quality measures, 2024 reporting year, with the 2019 blood-pressure figure: controlling high blood pressure 56.35% (51.32% in 2019); diabetes A1c above 9% or untested 23.0%; statin therapy 78.07%; depression screening and follow-up 84.11%.

Clinical quality measure, UDS 2024	Value	For the service line
Statin therapy for cardiovascular prevention	78.07%	Medication adherence and review
Depression screening and follow-up	84.11%	The behavioral-health arm named in Section 3.5
Patients with hypertension	5,953	The largest single RPM cohort
Patients with diabetes	3,057	The second RPM cohort; glucose monitoring

HRSA Uniform Data System clinical measures, 2024 reporting year, with the 2019 blood-pressure figure for the five-year trend.

1.3 The gap: the month between visits

Between-visit chronic care has no Medicare revenue line here yet. A sweep of Medicare fee-for-service claims across the adult-medicine roster returns no program at meaningful scale on any remote-monitoring code, any chronic-care-management code, any advanced-primary-care code or any transitional-care code under the health center.¹² CMS suppresses any provider-and-code line under 11 beneficiaries, and care management billed on the health center's own claim does not appear in that professional-claims file at all, so the precise finding is that there is **no remote-care or care-management program at meaningful scale in the claims**.

It is a structural observation rather than a criticism. The 5,953 patients with hypertension and 3,057 with diabetes are seen a few times a year, and nobody is posted to carry the month between those visits. A monthly documented touch, in the patient's own language where that is Spanish, reaches patients across a ten-county rural footprint whom an office schedule does not, and that is the layer this service line builds on.

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

2.1 G0511 is gone; the individual codes pay on top of the PPS encounter

Federally Qualified Health Centers are paid a prospective payment per qualifying encounter. For years, everything a health center did for chronic patients between those encounters 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 health center 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 PPS encounter**.¹³

CY2026 also added two codes that matter for a health center whose patients are discharged from acute-care hospitals across a wide service area: 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 late in the month used to produce an unbillable partial month; now it bills, and neither code existed a year ago.¹⁴

¹² CY2024 Medicare Physician & Other Practitioners sweep (see note 4).

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.

¹⁴ CY2026 Physician Fee Schedule: 99445 (device supply for 2 to 15 days of readings) and 99470 (first 10 minutes of monthly management time) new for 2026 dates of service.

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 health center already sees.

2.2 What the codes pay a health center

The Value Analysis is priced at the national amounts a health center 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 health center 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
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 (18% level 1, 60% level 2, 22% level 3) yields \$61.01 per patient-month, with the level-3 weight set to the Qualified Medicare Beneficiary share implied by 1,439 duals in a panel of 4,795.

These are the national amounts a health center is paid. The health center's main site sits in a Florida locality that pays within about one percent of the national figures on these codes, so the basis choice is a wash; national is the rail a health center bills them on. These are also Original Medicare amounts. Medicare Advantage plans pay at least the Medicare amount, a floor, and individual plan contracts set their own terms for the care-management code families.

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 44,593 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 eClinicalWorks. The health

¹⁵ CY2026 Physician Fee Schedule national non-facility amounts: total non-facility relative value units times the national conversion factor, with every geographic practice cost index at 1.000. Health centers bill the care-management codes at the national amount regardless of the locality their ZIP code falls in; the health center's main-site locality pays within about one percent of the national amounts on these codes.

center's own billing team files the claims with the care-management codes, and the clinicians keep the clinical decisions.

One structural note on Medicaid, because the deal design has to respect it. Florida Medicaid pays for remote physiologic monitoring and basic chronic care management, and does not pay advanced primary care management, transitional care management, principal care management or complex chronic care management.¹⁶ More than a third of the health center's patients are uninsured and many more are on Medicaid, and none of that population is in this forecast. The Medicare forecast on these pages does not include a Medicaid dollar. Section 5 sets out the Florida Medicaid remote-monitoring 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.

Program	Who qualifies	What it is	Billing
RPM	3,117 of the 4,795 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	1,918 (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	1,678 (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 an acute-care hospital across the service area	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.

¹⁶ Florida Medicaid Practitioner Fee Schedule effective January 1, 2025: 99453, 99454, 99457, 99458, 99490 and 99439 listed; advanced primary care management (G0556–G0558), transitional care management (99495, 99496), principal care management and complex chronic care management absent.

3.2 The dual-eligible share and the APCM tier

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. Here, 1,439 of 4,795 Medicare patients, 30.0%, are dually eligible, and roughly two-thirds of a low-income dual population holds Qualified Medicare Beneficiary status.¹⁷ The forecast weights the tiers 18% level 1, 60% level 2 and 22% level 3, which blends to \$61.01 per patient-month. That makes G0558 the best-paying monthly code on the page and the reason APCM earns its place beside CCM: no minute-tracking, a bundled monthly payment, and a tier structure written for a low-income Medicare panel.

The service line pays the health center three ways. First, the revenue is additive: every care-management dollar lands on top of the PPS encounter, not inside it. Second, the UDS measures the health center reports and will defend, blood-pressure control at 56.35% and diabetes poor control at 23.0%, move on continuous readings and a monthly documented touch. Third, a patient whose fluid weight climbs for four days is treated by phone and in clinic, not admitted three weeks later, which is where the forecast's 87.4 avoided hospitalizations come from.

3.3 The Medicare panel it runs on

The forecast is built on **4,795 Medicare patients**, the health center's own count as reported to HRSA for 2024, Original Medicare and Medicare Advantage together; Medicare Advantage and the 1,439 duals are already inside it, with no gross-up. From that panel the eligibility model carves the program pools: 3,117 patients RPM-eligible (65%), 1,918 CCM-eligible (40%), 1,678 APCM-eligible (35%). The pools overlap; the coordination rule keeps the billing disjoint.¹⁸

This is the number that makes the account what it is. A panel of 4,795 Medicare patients is deep enough that the program does not run out of people to enroll inside two years. Advanced primary care management and chronic care management fill their pools, but remote monitoring does not, and the forecast is paced by how fast the program enrolls rather than by how many patients exist. Section 4.3 reads the ramp, and Section 12 prices what more enrollment capacity is worth.

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

Each discharge home from an acute-care hospital across the service area 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 discharge volume, the share of discharges that come home to a health-center patient, and visit-scheduling capacity across ten counties 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 health center with its own behavioral-health division and a depression-screening rate of 84.11% has an obvious fourth program waiting: behavioral health integration, 99484, \$57.45 a month at the national

¹⁷ HRSA UDS 2024: 1,439 dually eligible of 4,795 Medicare patients (30.0%). CoachCare Value Analysis APCM tier weights 18% / 60% / 22%, blending to \$61.01 per patient-month at the national amounts, with the level-3 weight set to the Qualified Medicare Beneficiary share implied by the dual count.

¹⁸ HRSA UDS 2024 (see note 2). CoachCare Value Analysis eligibility model: RPM 65%, CCM 40%, APCM 35% of the in-scope panel; eligible pools 3,117, 1,918 and 1,678.

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. TCM is carried at zero dollars in every figure in this report.

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 health center 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 running.

3.6 An eighteen-clinician bench, twelve of them nurse practitioners

The health center's adult-medicine bench is eighteen physicians and nurse practitioners across the ten sites, and twelve of them are nurse practitioners.²¹ Those eighteen are the referring bench in the forecast; pediatrics-only and behavioral-health-only clinicians and the dental staff are excluded. That the bench is nurse-practitioner-heavy is the right shape for this service line. 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. 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 feeds every program, and Section 12 shows the clinician count moves the result far less than enrollment capacity does.

3.7 Staffing: nobody is hired

CoachCare delivers 19,382 hours of care-team work across the 24 months, about **9.3 full-time-equivalent years**, without the health center hiring anyone. The on-site enrollment specialists are CoachCare's expense, not a program cost. For a rural, ten-county health center where clinical staff are hard to recruit, the service line adds working capacity and zero requisitions, and it adds it in the language the panel speaks. The health center'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 **\$2,933,892 in net reimbursement** to North Florida Medical Centers. CoachCare's fees total \$1,681,183, including \$75,457 of ancillary items: implementation, the eClinicalWorks integration and telephonic outreach. Net to the health center is **\$1,252,709, a 42.70% margin** on the program, 41.39% in Year 1 and 43.24% in Year 2.²²

²⁰ HRSA UDS 2024: depression screening and follow-up 84.11%. CPT 99484, CY2026 national non-facility amount \$57.45. Behavioral health integration is carried at zero dollars in every figure in this report.

²¹ The health center's staffing as published: eighteen adult-medicine physicians and nurse practitioners across the ten sites, twelve of them nurse practitioners, after excluding pediatrics-only and behavioral-health-only clinicians and the dental staff.

²² CoachCare Value Analysis, 24-month forecast: monthly net reimbursement, fees and net-to-health-center series; Year 1 margin 41.39%, Year 2 margin 43.24%, 24-month margin 42.70%, each defined as net to the health center divided by net reimbursement. Ancillary fees of \$75,457 over 24 months: implementation \$2,500; eClinicalWorks integration \$4,000 setup, \$150 a month and \$1.50 per patient-month; telephonic outreach.

The 24-Month Ramp: An Enrollment-Paced Program, RPM Still Climbing at Month 24

CoachCare Value Analysis · 4,795 Medicare patients in scope · at M24: 2,139 active enrollments across 1,384 unique patients

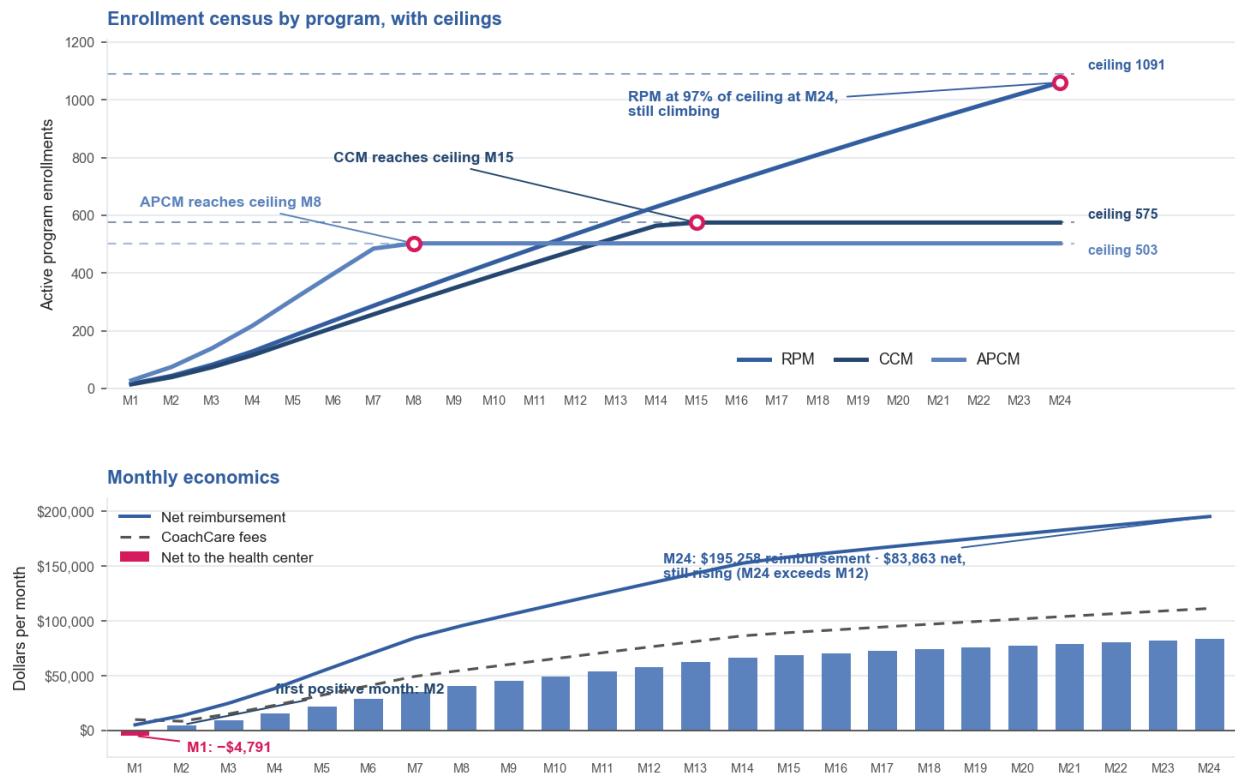


Figure 1. The 24-month ramp: enrollment census by program with ceilings (above) and monthly net reimbursement, CoachCare fees and net to the health center (below). Month 1 nets -\$4,791; the first positive month is M2; the line climbs the whole period, and month 24 exceeds month 12.

The shape of the curve is worth reading precisely. Month 1 is negative, -\$4,791, because implementation and enrollment effort land before the first full billing months do. Month 2 turns positive at \$5,025 net, and the line climbs as the three programs fill and remote monitoring keeps adding patients. Monthly net reimbursement is \$134,255 at month 12 and \$195,258 at month 24; net to the health center rises from \$58,047 at month 12 to \$83,863 at month 24, on \$111,395 of CoachCare fees that month. Month 24 is a larger month than month 12, because remote monitoring is still enrolling at the end of the two years.

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 health center
RPM	\$316,095	\$968,575	\$1,284,670	\$733,805	\$550,866
CCM	\$314,537	\$757,697	\$1,072,234	\$546,434	\$525,800
APCM	\$235,655	\$341,332	\$576,987	\$325,487	\$251,500
Ancillary (implementation, integration, outreach)	—	—	—	\$75,457	-\$75,457
All programs	\$866,287	\$2,067,605	\$2,933,892	\$1,681,183	\$1,252,709

CoachCare Value Analysis, per-program economics by contract year. Ancillary items: implementation \$2,500; eClinicalWorks integration \$4,000 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	\$177,393	\$138,702	\$556,412	\$412,164
CCM	\$160,295	\$154,242	\$386,139	\$371,558
APCM	\$132,937	\$102,719	\$192,550	\$148,781

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

RPM is the volume engine at 13,105 patient-months and \$1,284,670 of net reimbursement. CCM is the yield engine at \$110.75 of net reimbursement per patient-month across 9,682 patient-months, against \$98.03 for RPM and \$56.50 for APCM over its 10,211. 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 a low-income Medicare panel. Year 2 outruns Year 1 by \$1,201,318 of net reimbursement, because Year 1 carries the ramp and Year 2 runs two of the three programs at ceiling while remote monitoring keeps enrolling.

Service-Line Composition: RPM \$1,284,670 · CCM \$1,072,234 · APCM \$576,987

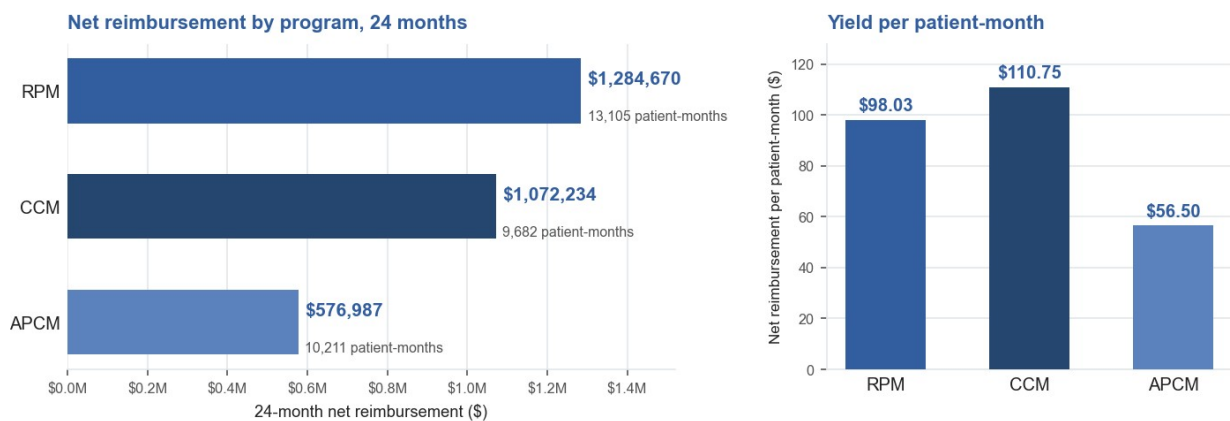


Figure 2. Service-line composition: per-program 24-month net reimbursement and net reimbursement per patient-month.

4.3 The ramp: a split regime, paced by enrollment

This account is paced by enrollment, and the three programs fill on different clocks. Advanced primary care management reaches its ceiling of 503 enrollments in month 8, and chronic care management its 575 in month 15. Remote monitoring never reaches its ceiling of 1,091 inside the two years: it climbs the whole way to 1,061 enrollments, 97% of the ceiling, and is still rising at month 24.²³ The first 90 days move fast: 60 new enrollments across the three programs in month 1, 100 in month 2, 140 in month 3.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
RPM	3,117	1,091	Not reached in 24 months	1,061 (97%, still climbing)
CCM	1,918	575	Month 15	575
APCM	1,678	503	Month 8	503
All programs				2,139 enrollments · 1,384 unique patients

²³ CoachCare Value Analysis enrollment model: program ceilings 1,091 (RPM), 575 (CCM), 503 (APCM); CCM reaches its ceiling in month 15 and APCM in month 8; RPM does not reach its ceiling in 24 months, climbing to 1,061 (97%) at month 24 and still rising; 2,139 active enrollments across 1,384 unique patients at month 24 (984 unique at month 12, 1,519 enrollments at month 12).

Enrollment counts are program enrollments, not unique patients; the 2,139 enrollments at M24 belong to 1,384 unique patients (984 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 paces this program is enrollment throughput, not the size of the Medicare panel and not clinician count. The panel is deep enough that remote monitoring is still adding patients at month 24, so the number that moves this forecast is how fast the program enrolls. Three things raise it: the CoachCare-funded on-site enrollment specialists, who on a panel this deep raise what the program captures over the two years and reach each ceiling sooner (Section 12 prices each one); the Florida Medicaid remote-monitoring rail in Section 5, where most of the chronic-disease volume sits; and the behavioral-health arm in Section 3.5 once the three Medicare programs are running.

4.4 What the program produces

24-month output	Volume
Claims generated, billing-ready	44,593
Device readings monitored	137,604
Care-management tasks completed	89,185
Chart updates written to eClinicalWorks	22,296
Patient conversations held	13,378 (743 hours of call time)
Care-team hours delivered	19,382 ($\approx$ 9.3 FTE-years)
Hospitalizations avoided	87.4 · $\approx$ \$1.31 million at \$15,000 per admission

CoachCare Value Analysis operational and clinical outputs, 24 months.

The avoided-admission line deserves its own sentence. 87.4 avoided hospitalizations over 24 months is roughly \$1.31 million of cost that never lands on anyone: not on Medicare, not on the plans that cover most of the county's Medicare, and not on a bed in any acute-care hospital across the service area.²⁴ It is also the entry requirement for any accountable-care arrangement: a consented, documented, monthly-managed panel with continuous readings, which this service line builds under fee-for-service first.

5. The Second Rail: Florida Medicaid Pays for Remote Monitoring

More than a third of the health center's patients are uninsured and thousands more are on Medicaid, and most of its 5,953 hypertensive and 3,057 diabetic patients are low-income. Florida Medicaid pays for remote physiologic monitoring and basic chronic care management on its practitioner fee schedule: 99453 at \$14.25, 99454 at \$33.96, 99457 at \$37.79, 99458 at \$30.38, and chronic care management 99490 at \$38.09 and 99439 at \$34.97 (effective January 1, 2025).²⁵ Florida Medicaid does not pay advanced primary care management, transitional care management, principal care management or complex chronic care management.

²⁴ CoachCare Value Analysis clinical-outcomes module: 87.4 avoided hospitalizations over 24 months, valued at \$15,000 per avoided admission ($\approx$ \$1.31 million).

²⁵ Florida Medicaid Practitioner Fee Schedule effective January 1, 2025, non-facility maximum fees: 99453 \$14.25, 99454 \$33.96, 99457 \$37.79, 99458 \$30.38, 99490 \$38.09, 99439 \$34.97. Advanced primary care management, transitional care management, principal care management and complex chronic care management are not on the schedule.

How the Medicaid rail is handled in this report

The Medicare forecast on these pages does not include a Medicaid dollar. A Medicaid remote-monitoring line is sized in a second working session from the health center's own hypertension and diabetes registries by payer, at the Medicaid amounts above, as its own line beside the Medicare forecast, never folded into it.

Two design facts carry over. Billing is done by the health center as the Medicaid-enrolled provider; CoachCare manages the devices and the month. The device is furnished by the health center's program, not by a pharmacy or a durable-medical-equipment supplier.

The point for the executive 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 Florida Medicaid rail is where the health center's chronic-disease volume sits, and the same devices, the same escalation engine and the same eClinicalWorks workflow serve it once the registries have been counted by payer.

6. eClinicalWorks Integration: The Program Lives in the Record

The health center runs on eClinicalWorks, and the forecast prices CoachCare's eClinicalWorks integration at the catalog tier: \$4,000 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 eClinicalWorks, so the health center'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 eClinicalWorks workflow; CoachCare enrolls flagged Medicare patients on the health center'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 integrated care summary attach to the chart monthly; enrollment status and time capture write back to the record.
- **Automated claims into eClinicalWorks.** The CoachCare billing engine creates the monthly claim lines automatically in eClinicalWorks billing, the step that makes individual-code billing workable at 44,593 claims over 24 months. The health center's own billing team files the claims with the care-management codes.
- **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 each hospital 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 health center inherits on the first day of the program: CoachCare's Care Management Programs standard operating procedures, 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, managed across a ten-county footprint, rather than in a hospital bed.

²⁶ EHR as evidenced by the health center's patient-portal domain (eClinicalWorks cloud). CoachCare integration pricing for eClinicalWorks as carried in the Value Analysis: \$4,000 setup, \$150 a month, \$1.50 per patient-month.

²⁷ CoachCare Care Management Programs standard operating procedures 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 and urgent communication protocol; the post-discharge follow-up sequence; and the discharge decision flow.

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: whichever of the ten sites the patient belongs to, and 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 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 from an acute-care hospital across the service area, 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 87.4 avoided hospitalizations in Section 4.4 are won.

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 the Big Bend: Rural and Operational Design

This health center is spread across ten counties and a mobile unit, most of them rural, and the program has to be built for that footprint rather than adapted to it afterward. Six design decisions follow.

- **Cellular devices, not app-dependent.** A cellular cuff or glucose meter transmits the moment it is used: nothing to pair, no smartphone, no app, no home broadband. Across the rural Big Bend, where broadband and cellular coverage are uneven, that is the difference between a reading and a device in a drawer.
- **Enrollment lists pulled by condition, not by age.** 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 Medicaid rails stay distinct from the first list.

- **Patient-facing materials in Spanish where the panel needs them.** Device instructions, enrollment scripts and outreach calls are prepared in Spanish for the patients whose language of record is Spanish, matched to the language field in eClinicalWorks.
- **An on-site enrollment specialist who travels the footprint.** The CoachCare-funded enrollment specialist works the ten sites and the mobile-unit schedule, enrolling patients where they already come for care rather than waiting for them to call in. On a panel this deep, adding specialists is the growth lever of Section 12.
- **Referrals from the whole adult-medicine floor.** Eighteen physicians and nurse practitioners across the ten sites flag patients in the chart. The flag is the whole clinician workflow, and the general-supervision code families fit a nurse-practitioner-heavy bench.
- **A monthly documented touch as the access layer.** Across a ten-county rural footprint, a documented monthly contact reaches patients an office schedule does not, which is the health-equity case for the program and the layer the UDS measures move on.

9. Market Context: A Ten-County Medicare Footprint

The health center's ten-county footprint runs from a metropolitan county in the east across the rural Big Bend and into the eastern Panhandle. Medicare Advantage penetration is high and uneven across it: 67.5% of Medicare eligibles in the main county, and from 34.6% to 76.4% county by county (March 2024).²⁸ Most of the health center's Medicare is therefore in Medicare Advantage. Medicare Advantage plans pay at least the Medicare amount, a floor, and individual plan contracts set their own terms for the care-management code families. The Value Analysis prices the whole panel at the national fee-schedule amounts, the floor a plan must meet, and the plan-by-plan terms are a discovery item rather than a load-bearing assumption.

County (with an NFMC site)	Medicare Advantage penetration, March 2024
Leon (main county)	67.5%
Gadsden	76.4% (highest in the footprint)
Wakulla	70.6%
Dixie	62.2%
Madison	56.3%
Taylor	54.4%
Franklin	53.6%
Lafayette	48.8%
Gulf	46.7%
Okaloosa	34.6% (lowest in the footprint)

Rural Policy Research Institute, share of Medicare eligibles enrolled in Medicare Advantage by county, March 2024.

The market fact that shapes the program is depth, not any single county. A Medicare panel of 4,795 spread across ten counties is large enough that the program is paced by enrollment for the whole of the forecast, and a documented monthly touch is how a dispersed rural panel gets between-visit care at all.

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,

²⁸ Rural Policy Research Institute, Medicare Advantage penetration by county, March 2024: main county 67.5%; Gadsden 76.4%; Wakulla 70.6%; Dixie 62.2%; Madison 56.3%; Taylor 54.4%; Franklin 53.6%; Lafayette 48.8%; Gulf 46.7%; Okaloosa 34.6%.

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.²⁹

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: \$1,284,670 over 24 months, -9.5%, to \$1,162,538. Device supply is 32% of the remote monitoring basket; management time moves little.

Chronic care management: \$1,072,234, -2.1%, to \$1,049,183. Advanced primary care management: \$576,987, -0.8%, to \$572,533. Conversion-factor and relative-value movement only; the proposal does not target these codes. The care-management movement is \$27,506 of the total.

The whole service line: \$2,933,892 over 24 months, -5.1%, -\$149,638, to \$2,784,254. Remote monitoring is 44% of the line, and two of the three programs are not the one being repriced.

The CY2027 Proposed Rule on This Forecast: One Code Cut, One Shared Dollar Scale

Device supply 99454 and 99445: \$52.11 → \$41.38 a month (-20.6%) · the RPM arm -9.5% · the line -5.1%, -\$149,638 of \$2,933,892

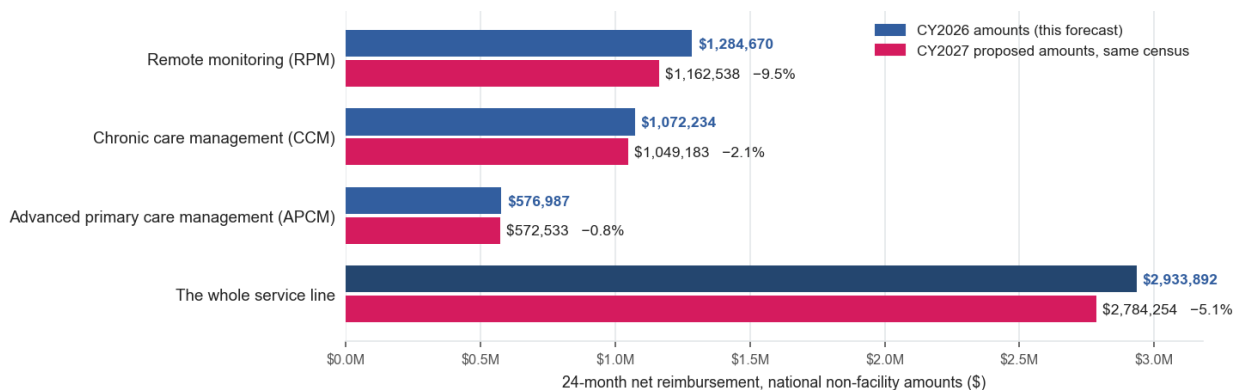


Figure 3. The CY2027 proposed rule on this forecast, at the national amounts on both sides: each arm and the whole line, CY2026 against the CY2027 proposed amounts, same census.

11. Implementation and the First 90 Days

11.1 Who runs what

CoachCare delivers	North Florida Medical Centers keeps
Telephonic and on-site enrollment across the ten sites and the mobile unit; the enrollment specialist is CoachCare's expense	Referral flags in eClinicalWorks; clinical oversight under general supervision
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans and escalation preferences
Monitoring, documentation and the escalation protocol of Section 7	Responses to clinic-routed escalations; the discharge feed from each hospital
Automated claim creation into eClinicalWorks billing	Filing the claims with the care-management codes; billing review; the revenue

²⁹ 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% (to \$1,162,538); CCM -2.1% (to \$1,049,183); APCM -0.8% (to \$572,533); service line -5.1% (-\$149,638, from \$2,933,892 to \$2,784,254). Enrollment held constant.

CoachCare delivers	North Florida Medical Centers keeps
Monthly operating reports against the dashboard in 11.3	Program governance; the enabling-services relationship

11.2 Model inputs

Input	Value
Medicare panel in scope	4,795 patients, the health center's UDS 2024 Medicare-as-primary-payer count; Medicare Advantage and the 1,439 duals are inside it, with no gross-up
Referring clinicians	18 in adult medicine (physicians and nurse practitioners across the ten sites), twelve of them nurse practitioners
Programs	RPM + CCM + APCM; TCM and BHI named, not in the forecast; PCM off
Program-eligible pools	RPM 3,117 (65%) · CCM 1,918 (40%) · APCM 1,678 (35%)
Enrollment regime	APCM ceiling 503 (reached M8) · CCM ceiling 575 (reached M15) · RPM ceiling 1,091, not reached in 24 months (1,061, 97%, still climbing)
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
Rate basis	CY2026 national non-facility Physician Fee Schedule amounts, the rail a health center bills care-management codes on
APCM tier blend	18% level 1 · 60% level 2 · 22% level 3 = \$61.01 per patient-month
Medicare Advantage	67.5% of the main county's Medicare, 34.6% to 76.4% across the footprint (March 2026 context; March 2024 penetration). Medicare Advantage plans pay at least the Medicare amount, a floor, and individual plan contracts set their own terms for the care-management code families.
EMR	eClinicalWorks, priced at the catalog integration tier (\$4,000 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 eClinicalWorks integration workplan. ICD-10 screening of the Medicare panel per the qualification map, with the hypertension and diabetes registries counted by payer, the input that sizes both the Medicare cohorts and the Florida Medicaid rail. Device logistics staged across the ten sites, escalation routing set, 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 mobile-unit enrollment running; first devices in homes; first billable service months. Month 1 nets –\$4,791 as implementation lands; month 2 turns positive. The forecast carries 60 new enrollments in month 1 and 100 in month 2.

Days 61–90: scale and file. 140 new enrollments in month 3, advanced primary care management approaching its ceiling, remote monitoring still climbing. First monthly operating report against the dashboard. Second working session on the Florida Medicaid remote-monitoring rail, with the registries counted by payer.

The operating dashboard from month one:

- Enrollment census by program against ceiling (1,091 / 575 / 503), with remote monitoring tracked against its ceiling because it is still climbing
- 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
- Claims generated against expected claims, and claims filed with the care-management codes
- Blood-pressure control and A1c control among enrolled patients, against the UDS 2024 baseline of 56.35% and 23.0%
- Net to the health center per month against the rising monthly line of Figure 1

12. Recommendations

1. **Stand up the Medicare service line now, at scale.** The individual-code rail has been live since October 2025. This is a \$2,933,892 two-year net-reimbursement line, \$1,252,709 net to the health center, on a panel deep enough to run the whole forecast; each month of delay pushes it one month further out, and nothing about it waits on a hire.
2. **Fund the enrollment capacity, because the panel is paced by it.** This is the growth lever. On a panel this deep, each CoachCare-funded on-site enrollment specialist raises what the program captures over the two years, on top of the speed at which it fills: the first is worth \$818,781 of 24-month net reimbursement over the no-specialist case; a second adds \$475,105 and fills remote monitoring by month 18; a third fills it by month 14. Every specialist is CoachCare's payroll.
3. **Lead APCM with the dual-eligible patients.** 30% of the Medicare panel is 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. **Size the Florida Medicaid remote-monitoring rail as its own line.** Most of the health center's chronic-disease volume is low-income, and Florida Medicaid pays 99453, 99454, 99457, 99458, 99490 and 99439. Count the hypertension and diabetes registries by payer and price that rail in a second session, beside the Medicare forecast, never inside it.
5. **Build the program for a ten-county rural footprint.** Cellular devices that need no home internet, condition-based enrollment lists, Spanish materials where the panel needs them, and an enrollment specialist who works the sites and the mobile unit. None of these is a retrofit.
6. **Make the hospital discharge a front door.** Wire the discharge feed from the hospitals across the service area, enroll at the first post-discharge contact, and bill transitional care on every discharge home to a health-center 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.
7. **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 health center	Margin	RPM at M24
Base: 4,795 panel, 18 clinicians, 1 enrollment specialist	\$2,933,892	\$1,252,709	42.70%	1,061 of 1,091 (97%, climbing)
No on-site enrollment specialist	\$2,115,111	\$898,123	42.46%	679 (RPM and CCM short of ceiling)
Second on-site enrollment specialist	\$3,408,997	\$1,453,749	42.64%	1,091 (RPM fills month 18)
Third on-site enrollment specialist	\$3,672,097	\$1,564,985	42.62%	1,091 (RPM fills month 14)

Scenario	24-month net reimbursement	Net to the health center	Margin	RPM at M24
14 referring clinicians	\$2,682,460	\$1,146,079	42.72%	914
24 referring clinicians	\$3,232,214	\$1,378,401	42.65%	1,091 (RPM fills month 20)
Panel 4,431 (only the patients aged 65 and over)	\$2,834,402	\$1,208,858	42.65%	1,008
Panel 3,835 (a fifth smaller, conservative)	\$2,624,499	\$1,117,199	42.57%	873

CoachCare Value Analysis recalculations at the same pricing. On a panel this deep the enrollment specialists raise what the program captures, because remote monitoring is paced by enrollment and has room to climb; the clinician-count and panel rows move the result less than the enrollment engine does.

Read the table from the enrollment engine down. The specialist rows are the ones that move the result most, because remote monitoring is paced by enrollment and has room to climb on a panel this deep: the first specialist is worth \$818,781 of 24-month net reimbursement, and a second is worth \$475,105 more. The clinician-count rows move the result less, and the panel rows barely move the margin, which confirms the panel itself is not the constraint. The enrollment engine is.³⁰

13. The Ask: A Working Session

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

1. **The enrollment plan.** The program is paced by enrollment, so the first decision is how many on-site enrollment specialists to run and where they travel across the ten sites and the mobile unit. Every specialist is CoachCare's payroll, and the table in Section 12 prices each one.
2. **The hypertension and diabetes registries by payer.** 5,953 and 3,057 patients respectively; the Medicare slice sizes the RPM cohort in this forecast, and the Medicaid slice sizes the second rail.
3. **The current care-team roster.** Who on the current staff carries enabling-services, nursing and care-coordination work, so the general-supervision workflow is set against real roles.
4. **The eClinicalWorks product line and interfaces.** Which eClinicalWorks products the health center runs and which interfaces are available, so the integration workplan can be written, including the discharge feed from each hospital.

Everything else in this report, the Medicare Advantage contract terms, the discharge feed from each hospital across the service area, and the Florida Medicaid billing mechanics for a health center, is a workplan item that follows the session rather than a condition of it.

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About CoachCare

CoachCare runs remote care programs for health centers, specialty practices and health systems: the enrollment, the devices, the clinical monitoring, the documentation and the claims, inside the EHR the organization already uses.³¹

³⁰ CoachCare Value Analysis recalculations at the same pricing: no on-site enrollment specialist \$2,115,111 / \$898,123 / 42.46%; second specialist \$3,408,997 / \$1,453,749 / 42.64%; third specialist \$3,672,097 / \$1,564,985 / 42.62%; 14 clinicians \$2,682,460 / \$1,146,079 / 42.72%; 24 clinicians \$3,232,214 / \$1,378,401 / 42.65%; panel 4,431 \$2,834,402 / \$1,208,858 / 42.65%; panel 3,835 \$2,624,499 / \$1,117,199 / 42.57%. The first specialist is worth \$818,781 of 24-month net reimbursement against the no-specialist case, and a second \$475,105 more.

³¹ CoachCare company statistics, 2026: patients served, managed conditions, providers on the platform, implementations completed, claims generated and vitals recorded.

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

- **HRSA Health Center Program records:** the Uniform Data System report for the health center, 2024 reporting year (retrieved September 2026): total patients, payer mix, the Medicare and dual-eligible counts, the hypertension and diabetes counts, and the clinical quality measures, including the patient-centered medical home recognition.
- **The health center's website and public materials,** retrieved September 2026: the locations, services and announcements pages, the site and service-area records for the ten counties, and the EHR (eClinicalWorks) as evidenced by the patient-portal domain.
- **CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024** (released 2026): the sweep of every remote-monitoring, care-management, advanced-primary-care and transitional-care code across the adult-medicine roster. CMS suppresses any provider-and-code line under 11 beneficiaries; care management billed on the health-center claim is not in this file.
- **The CY2025 Physician Fee Schedule Final Rule and CY2026 Final Rule:** retirement of G0511 on September 30, 2025; individual-code reporting for health-center care management from October 1, 2025; payment at national non-facility amounts in addition to the PPS encounter; APCM adopted for health-center payment; the CY2026 additions 99445 and 99470.
- **CY2026 Physician Fee Schedule rate files:** national non-facility amounts for the eleven forecast codes, the two transitional care codes and the behavioral health integration code, at the national 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.
- **Florida Medicaid:** the Florida Medicaid Practitioner Fee Schedule effective January 1, 2025, for the remote physiologic monitoring and chronic care management amounts in Section 5; the Florida Agency for Health Care Administration coverage policy for remote patient monitoring.
- **Rural Policy Research Institute,** Medicare Advantage penetration by county for the ten-county service area, March 2024, derived from CMS enrollment files.
- **CoachCare Care Management Programs standard operating procedures** and the seven derived process maps: 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 eClinicalWorks 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 eClinicalWorks billing through the CoachCare billing engine.
- **CoachCare Value Analysis for North Florida Medical Centers, 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 4,795 Medicare patients in scope, 18 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 2,139 active program enrollments belonging to 1,384 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 health center's own. Health-center visits bill on the FQHC claim rather than under individual clinicians, so clinician-level Medicare claims files structurally undercount a health-center panel. The 4,795-patient figure is the Medicare-as-primary-payer count the health center reported to HRSA for 2024.

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