



Bond Community Health Center

A Federally Qualified Health Center serving Tallahassee and the Big Bend

COACHCARE | SERVICE LINE STRATEGY

A Federally Qualified Health Center serving Tallahassee and eight Big Bend counties from a main campus, a specialty and community wellness center, a neighborhood clinic, a school-based dental program and a mobile medical unit

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line for the health center's Original-Medicare panel: 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 January 2025, and run for a health center that since the same month has carried accountable-care responsibility for the quality and total cost of care of that panel, staffed by CoachCare

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of Bond Community Health Center. It brings together the health center's own HRSA record, the Medicare structure of Leon County and the Big Bend, the billing rules a health center works under since January 2025, a 24-month Value Analysis for a remote care service line on the Original-Medicare panel, the accountable-care responsibility the health center already carries, the clinical governance that would run it, the athenahealth integration it lives in, the Florida Medicaid rail beside it, and the access design an eight-county rural footprint requires.

The argument is short. This health center is a national quality leader on heart health and already carries accountable-care risk, yet it has no between-visit care-management line to move the numbers that risk is graded on. Since last year Medicare pays a health center for the month of care between visits as its own codes, at national amounts, on top of every visit. The panel is small and it fills in five months. The people to run it are ours.

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Executive Summary

Bond Community Health Center is a Federally Qualified Health Center in Tallahassee that has served Leon County and the eight-county Big Bend for more than thirty years. It runs adult primary care, an HIV and Ryan White program, behavioral-health integration and a mobile medical unit across a main campus, a specialty and community wellness center, a neighborhood clinic and a school-based dental program.¹ Its 2024 Uniform Data System report counts 9,079 patients, of whom about 1,014 carry Medicare as their primary payer and about 1,034 are 65 or older; 30.4% are on Medicaid or CHIP and 35.3% are uninsured.² It is a national quality leader on heart health, with controlled blood pressure at 53.5% and a 2025 national Heart Health recognition.³

Two facts sit next to each other. Since January 2025 this health center has carried accountable-care responsibility for the quality and total cost of care of its Original-Medicare panel: it joined a Medicare Shared Savings Program ACO that month, on the upside-only BASIC track with an Advance Investment Payment.⁴ And it runs no remote physiologic monitoring, chronic care management or advanced primary care management program today, with no care-manager or remote-monitoring role on its careers page. The measure it is nationally recognized on, blood-pressure control, is the one continuous monitoring moves fastest. This is a structural observation, not a criticism.

Leon County's Medicare population is 60.6% Medicare Advantage (June 2026), so the clean Original-Medicare billing base and the ACO-attributed population are the same 39.4% of the county's beneficiaries.⁵ Medicare Advantage plans reimburse these code families at no less than the Medicare amount; that parity is a floor, and payment terms vary by contract.

The observation this report is built on

This health center already carries accountable-care risk, and it is a national quality leader on heart health. But it has no between-visit care-management line to move the blood-pressure and total-cost numbers that risk is graded on. Since last year Medicare pays a health center for that month of care as its own codes, at national amounts, on top of every visit. The panel is small and it fills in five months. The people to run it are ours.

G0511, the bundled code health centers used for care management, is retired on a 2025 transition. Since January 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 exactly. And Florida Medicaid has paid for remote physiologic monitoring since July 2022.⁷

¹ HRSA Uniform Data System, 2024 reporting year, and the health center's own site: a Federally Qualified Health Center serving Tallahassee and the Big Bend for more than thirty years; adult primary care, an HIV and Ryan White program, behavioral-health integration, dental and specialty services, across a main campus, a specialty and community wellness center, a neighborhood clinic, a school-based dental program and a mobile medical unit.

² HRSA Uniform Data System, 2024: total patients 9,079; adults 6,669; children 2,410; Medicare as primary payer about 1,014 (11.2%); aged 65 and over about 1,034 (11.4%); Medicaid and CHIP 2,756 (30.4%); uninsured 3,202 (35.3%); private 2,106 (23.2%).

³ HRSA National Quality Leader recognition for heart health, 2025; HRSA Uniform Data System 2024 clinical quality measures: controlled blood pressure 53.5%.

⁴ CMS Medicare Shared Savings Program participant records, performance year 2026: the health center is a named participant on the upside-only BASIC track with an Advance Investment Payment and prospective assignment, participant start January 1, 2025. No shared-savings or Advance-Investment dollar figure is asserted or modeled in this report.

⁵ CMS Medicare Monthly Enrollment, Leon County, June 2026: 53,686 beneficiaries; Medicare Advantage and other 32,509 (60.6%); Original Medicare 21,177 (39.4%).

⁶ CY2025 Physician Fee Schedule Final Rule and CY2026 Final Rule: Federally Qualified Health Centers report the individual CPT and HCPCS codes for care management, remote monitoring and advanced primary care management in place of G0511, paid at national non-facility Physician Fee Schedule amounts in addition to the PPS encounter, from January 1, 2025; G0511 retired on a 2025 transition.

⁷ Florida Medicaid remote physiologic monitoring coverage, effective for dates of service on or after July 21, 2022.

What the Value Analysis returns

The forecast prices a service line for the health center's Original-Medicare panel, 400 patients, the cleanly billable and ACO-attributed base carved from the 1,014 Medicare patients in the 2024 report, referred by the nine physicians and nurse practitioners in adult primary care 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	\$172,471	\$195,750	\$368,221
CoachCare fees	\$101,729	\$110,557	\$212,287
Net to the health center	\$70,741	\$85,193	\$155,934
Margin to the health center	41.02%	43.52%	42.35%

CoachCare Value Analysis. CY2026 national non-facility Physician Fee Schedule amounts, the rail a health center bills care-management codes on. 400 Original-Medicare patients in scope; RPM + CCM + APCM. Margin is net to the health center divided by net reimbursement.

- 1. This is a \$155,934 two-year net line on a 400-patient panel, and it fills in five months.** It is not a seven-figure program, and the report does not dress it as one. Every program reaches its ceiling inside the first year: APCM in M2, CCM in M3, RPM in M5. At M24 the program holds 181 active program enrollments across 118 unique patients, the same census it holds at M12. The binding constraint is the size of the Original-Medicare panel, not enrollment capacity or clinician count.
- 2. The program funds itself from the second month.** Month 1 nets -\$2,362 to the health center, because implementation lands before enrollment revenue does. The first positive month is M2, at \$3,311. From month 6 the service line runs at \$16,313 in monthly net reimbursement, \$9,213 in fees and \$7,099 net to the health center.
- 3. The accountable-care layer is why the same engine matters twice.** The Medicare Shared Savings Program ACO the health center joined in January 2025, on the upside-only BASIC track with an Advance Investment Payment, is accountable for quality and total cost of care on its Original-Medicare panel, yet it has no care-management engine to move those numbers. Remote physiologic monitoring, chronic care management and advanced primary care management are ordinary Original-Medicare fee-schedule services, margin-positive on their own before a single shared-savings dollar; they are also exactly the engine that moves blood pressure and avoids admissions.
- 4. Nobody is hired.** CoachCare delivers 2,562 hours of care-team work over 24 months, about 1.23 full-time-equivalent years, including an on-site enrollment specialist carried at CoachCare's expense, for a workforce-constrained safety-net health center. No capital outlay and no new requisition.
- 5. The growth is in the panel, and the report says where.** Leon County is 60.6% Medicare Advantage, so the base runs on the 39.4% Original-Medicare share. As Medicare Advantage plans contract at parity, the in-scope panel expands toward the full 1,014 Medicare patients: the sensitivity rows in Section 12 show \$578,400 of net reimbursement at 650 and \$861,003 at 1,014. The Florida Medicaid remote-monitoring rail and the total cost of care the ACO is graded on are the other two levers.
- 6. The clinical return is concrete.** The forecast projects 13.4 avoided hospitalizations over 24 months, roughly \$200,000 at \$15,000 per admission, from 21,030 device readings worked through one escalation protocol, with the discharge from either of the Tallahassee acute-care hospitals as one trigger.

⁸ CoachCare Value Analysis for Bond Community Health Center, 2026. Basis: CY2026 national non-facility Physician Fee Schedule amounts; 400 Original-Medicare patients in scope; 9 referring clinicians; RPM, CCM and APCM.

1. The Health Center Today

1.1 Thirty years in Tallahassee and the Big Bend

Bond Community Health Center is a Federally Qualified Health Center that has served Tallahassee and the Big Bend for more than thirty years. HRSA lists a main campus on South Gadsden Street, a specialty and community wellness center, a neighborhood clinic, a school-based dental program and a mobile medical unit, serving Leon and seven surrounding counties: Gadsden, Wakulla, Jefferson, Taylor, Franklin, Liberty and Madison.⁹ The patient base is safety-net and chronic-disease heavy: 30.4% of patients are on Medicaid or CHIP and 35.3% are uninsured, and the health center runs adult primary care, an HIV and Ryan White program and behavioral-health integration alongside dental and specialty services.

UDS 2024	Count	What it means for the service line
Total patients	9,079	Adults 6,669 · children 2,410
Medicare patients	1,014 (11.2%)	The full Medicare count; the forecast runs on the Original-Medicare share of it
Aged 65 and over	1,034 (11.4%)	Tracks the Medicare-primary count; the older core of the panel
Original-Medicare panel in scope	400	39.4% of the 1,014, the cleanly billable and ACO-attributed base
Medicaid and CHIP	2,756 (30.4%)	Outside the Medicare forecast; Florida Medicaid pays for remote monitoring (Section 5)
Uninsured	3,202 (35.3%)	The equity case for a documented monthly touch
Controlled blood pressure	53.5%	The measure the health center is nationally recognized on; the one monitoring moves fastest

HRSA Uniform Data System, 2024 reporting year, the latest per-center awardee file.

1.2 A national quality leader on heart health

The earned compliment is a measured one. The health center is a national quality leader on heart health, recognized in 2025 for hypertension control, and its Uniform Data System record carries the chronic-disease measures that recognition rests on: controlled blood pressure at 53.5%, statin therapy for cardiovascular prevention at 87.2%, aspirin or antiplatelet therapy for vascular disease at 82.8%, and depression screening and follow-up at 62.3%.¹⁰ A health center already recognized nationally for moving a hypertension measure has shown it can change a number; the between-visit gap is what remains.

Clinical quality measure, UDS 2024	Rate	Relevance to the service line
Controlling high blood pressure	53.5%	The RPM and CCM cohort; continuous readings and a monthly touch move it directly
Statin therapy for cardiovascular prevention	87.2%	A mature chronic-care program already operating at the top of its range
Aspirin or antiplatelet therapy for vascular disease	82.8%	The same cardiovascular cohort the service line manages between visits

⁹ HRSA Health Center service-site file and the health center's own site: a main campus on South Gadsden Street, Tallahassee, plus a specialty and community wellness center, a neighborhood clinic, a school-based dental program and a mobile medical unit; service area Leon, Gadsden, Wakulla, Jefferson, Taylor, Franklin, Liberty and Madison counties.

¹⁰ HRSA Uniform Data System 2024 clinical quality measures: controlling high blood pressure 53.5%; statin therapy for cardiovascular prevention 87.2%; aspirin or antiplatelet therapy for vascular disease 82.8%; depression screening and follow-up 62.3%; colorectal cancer screening 42.4%. HRSA National Quality Leader heart-health recognition, 2025.

Clinical quality measure, UDS 2024	Rate	Relevance to the service line
Depression screening and follow-up	62.3%	The behavioral-health population behind the named next arm (Section 3.5)
Colorectal cancer screening	42.4%	The coordination and outreach layer a care-management wrapper builds on

HRSA Uniform Data System clinical quality measures, 2024 reporting year.

1.3 The gap: accountable for the numbers, without the engine that moves them

Since January 2025 the health center has carried accountable-care responsibility for its Original-Medicare panel. It joined a Medicare Shared Savings Program ACO that month, on the upside-only BASIC track with an Advance Investment Payment, which makes it accountable for the quality and total cost of care of the patients Original Medicare assigns to it.¹¹ That is the structural fact this report is built around, and it is a first-agreement, early-glide-path arrangement: the health center took on the responsibility and the advance dollars before it built the machinery to act on them.

The machinery is the gap. The health center runs no remote physiologic monitoring, chronic care management or advanced primary care management program today, and its careers page carries no care-manager or remote-monitoring role. The chronic-disease patients the ACO is graded on are seen a few times a year; between those visits there is no documented monthly touch, no continuous reading and no billed care-management line. Blood-pressure control sits at 53.5%, and it is the measure a monitoring program moves most directly. The service line in this report is that missing engine, and it is margin-positive under fee-for-service before it moves a single accountable-care number.

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, one flat payment regardless of how many services, minutes or programs a patient carried. Since January 1, 2025 a health center reports the individual CPT and HCPCS codes instead, 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**; G0511 is retired on a 2025 transition.¹²

CY2026 also added two codes that matter for a health center whose patients are discharged from either of the Tallahassee acute-care hospitals: 99445 pays the device-supply month when a patient transmits 2 to 15 days of readings rather than 16 or more, and 99470 pays the first 10 minutes of monthly management time where 20 minutes is not reached. A patient discharged on the 20th of the month used to produce an unbillable partial month; now it bills. In this forecast the two codes carry close to \$37,000 of gross reimbursement over 24 months, roughly a tenth of net reimbursement, revenue that did not exist a year ago.¹³

¹¹ CMS Medicare Shared Savings Program participant records, performance year 2026 (see note 4): upside-only BASIC track, Advance Investment Payment, participant start January 1, 2025.

¹² CY2025 Physician Fee Schedule Final Rule (see note 6): individual-code reporting for health-center care management from January 1, 2025, paid at national non-facility amounts in addition to the PPS encounter; G0511 retired on a 2025 transition.

¹³ CoachCare Value Analysis, Financial Value detail: 99445 and 99470 together carry close to \$37,000 of gross reimbursement over 24 months against \$368,221 of net reimbursement (about a tenth), on this forecast's code frequencies.

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, and it accrues on top of every PPS encounter rather than inside it.

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.¹⁴

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. These are the national amounts a health center is paid for these codes, the rail it bills them on regardless of the locality its ZIP code falls in.

These are Original Medicare amounts. Medicare Advantage plans reimburse these code families at no less than the Medicare amount; that parity is a floor, and payment terms vary by contract. Because the base runs on the Original-Medicare share of the panel, that contract check is a growth lever rather than a load-bearing assumption in the forecast.

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 5,944 claims over 24 months. In the operating model of Section 11, CoachCare carries the load: enrollment, device logistics, monitoring documentation and billing-ready claim generation inside athenahealth. The health center's own billing team files the claims with the care-management codes, and the clinicians keep the clinical decisions.

¹⁴ 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.

One structural note on Medicaid, because the deal design has to respect it. Florida Medicaid pays for remote physiologic monitoring and does not pay CCM, APCM, TCM or BHI.¹⁵ Medicaid and CHIP cover about 30% of the health center's patients and the uninsured another 35%, 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 Medicaid remote-monitoring rail as its own line, scoped separately.

3. The Service Line: RPM, CCM and APCM on the Original-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	260 of the 400 Original-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	160 (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	140 (35%): ongoing primary-care relationship; level set by condition count and Qualified Medicare Beneficiary status	Monthly bundle of practice-capability elements; no minute tracking	G0556 / G0557 / G0558
TCM	Any inpatient discharge home from either Tallahassee acute-care hospital	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.

¹⁵ Florida Medicaid remote physiologic monitoring coverage (99091, 99453, 99454, 99457, 99458), effective July 21, 2022; CCM, APCM, TCM and behavioral health integration are not on the Florida Medicaid remote-care schedule. HRSA Uniform Data System 2024: Medicaid and CHIP 30.4%, uninsured 35.3%.

3.2 The accountable-care layer: why the same engine matters twice

The three programs are ordinary Original-Medicare fee-schedule services, and that is the base case in Section 4: a recurring, margin-positive revenue line billed on top of every PPS encounter. The reason they matter twice here is the accountable-care responsibility the health center already carries. The Medicare Shared Savings Program ACO it joined in January 2025, on the upside-only BASIC track with an Advance Investment Payment, is accountable for the quality and total cost of care of its Original-Medicare panel. The ACO does not pay for these codes; it is the strategic reason the engine that bills them is worth building now.¹⁶

The wedge is plain. A first-agreement ACO on the advance-investment glide path has taken on the responsibility and the advance dollars but has no between-visit care-management engine to move the numbers that responsibility is graded on. This service line is that engine, and it earns its place three ways at once, none of which asks the reader to believe a shared-savings projection.

- **A recurring, additive-to-PPS revenue line.** Every care-management dollar lands on top of the PPS encounter, not inside it: \$155,934 net to the health center over 24 months, margin-positive from the second month, before any accountable-care upside is counted.
- **The quality measure the health center is recognized on.** Controlled blood pressure at 53.5% is exactly the measure continuous readings and a monthly documented touch move fastest, and it is the measure the ACO is graded on. The national heart-health recognition and the accountable-care responsibility point at the same cohort.
- **Total cost of care, as avoided admissions.** The forecast projects 13.4 avoided hospitalizations over 24 months, roughly \$200,000 at \$15,000 per admission. A consented, documented, monthly-managed panel with continuous readings is both the mechanism that avoids those admissions and the substrate every accountable-care arrangement asks for, built here under fee-for-service first.

3.3 The Original-Medicare panel it runs on

The forecast is built on **400 Original-Medicare patients**, the 39.4% Original-Medicare share of the 1,014 Medicare patients in the health center's 2024 report. Two reasons set the base there rather than at the full 1,014. A health center bills the care-management codes cleanly at the national amounts for Original-Medicare patients, and Shared Savings Program assignment is Original Medicare, so the billing base and the accountable-care population are the same people.¹⁷ From that panel the eligibility model carves the program pools: 260 patients RPM-eligible (65%), 160 CCM-eligible (40%), 140 APCM-eligible (35%). The pools overlap; the coordination rule keeps the billing disjoint.

The other 60.6% of Leon County's Medicare is Medicare Advantage, and that is the lead growth lever rather than a gap in the forecast. Medicare Advantage plans reimburse these code families at no less than the Medicare amount; that parity is a floor, and payment terms vary by contract. As plans contract at parity, the in-scope panel expands toward the full 1,014 Medicare patients the health center reports: the recalculations in Section 12 show \$578,400 of net reimbursement at a 650-patient panel and \$861,003 at 1,014. The base case claims none of that; it prices the panel the health center can bill cleanly today.

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

Each discharge home from either of the Tallahassee acute-care hospitals 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).¹⁸ TCM is on the recommended stack and carries no dollars anywhere in this forecast: the health center's

¹⁶ CMS Medicare Shared Savings Program participant records, performance year 2026 (see note 4). Remote monitoring, chronic care management and advanced primary care management are Original-Medicare fee-schedule services billed in addition to the PPS encounter; the accountable-care arrangement does not pay for them.

¹⁷ HRSA Uniform Data System 2024: Medicare as primary payer about 1,014. CMS Medicare Monthly Enrollment, Leon County, June 2026: Original Medicare 39.4% of the county's Medicare. Base in scope 400 (39.4% of 1,014). CoachCare Value Analysis eligibility model: RPM 65%, CCM 40%, APCM 35% of the in-scope panel.

share of discharges and its visit-scheduling capacity are 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 that already integrates with a community behavioral-health provider and screens for depression at 62.3% has an obvious fourth program waiting: behavioral health integration, 99484, \$57.45 a month at the national amount for the first 20 minutes of care-manager time under a treating clinician's plan.¹⁹ 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 at ceiling.

3.6 Built the way the codes work: a nine-clinician bench

The forecast refers from the nine physicians and nurse practitioners in adult primary care: three physicians and roughly six adult nurse practitioners, with a conservative core of eight.²⁰ Most of the bench are nurse practitioners, and for this service line that is the right shape. CCM, APCM and RPM are general-supervision code families: qualified clinical staff deliver the monthly work under a billing clinician's overall direction, without that clinician in the room. The referral motion is one step, a clinician flags a qualifying patient in the chart, and the program runs from there. At eight referrals per clinician per month, the bench fills every program inside the first year; Section 12 shows the clinician count barely moves the result.

3.7 Staffing: nobody is hired

CoachCare delivers 2,562 hours of care-team work across the 24 months, about **1.23 full-time-equivalent years**, without the health center hiring anyone. The on-site enrollment specialist is CoachCare's expense, not a program cost, embedded value rather than a line the health center carries. For a workforce-constrained safety-net center, the service line adds working capacity and zero requisitions. 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 **\$368,221 in net reimbursement** to Bond Community Health Center. CoachCare's fees total \$212,287, including \$14,471 of ancillary items: implementation, the athenahealth integration and telephonic outreach. Net to the health center is **\$155,934, a 42.35% margin** on the program, 41.02% in Year 1 and 43.52% in Year 2.²¹

¹⁸ 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. Transitional care management is carried at zero dollars in every figure in this report.

¹⁹ HRSA Uniform Data System 2024: depression screening and follow-up 62.3%. CPT 99484, CY2026 national non-facility amount \$57.45. Behavioral health integration is carried at zero dollars in every figure in this report.

²⁰ The health center's adult-primary-care roster: three physicians and roughly six adult nurse practitioners (conservative core eight). CCM, APCM and RPM are general-supervision code families delivered by qualified clinical staff under a billing clinician's overall direction.

²¹ CoachCare Value Analysis, 24-month forecast: monthly net reimbursement, fees and net-to-health-center series; Year 1 margin 41.02%, Year 2 margin 43.52%, 24-month margin 42.35%, each defined as net to the health center divided by net reimbursement. Ancillary fees of \$14,471 over 24 months: implementation \$2,500; the athenahealth integration \$1,000 setup, \$150 a month and \$1.50 per patient-month; telephonic outreach.

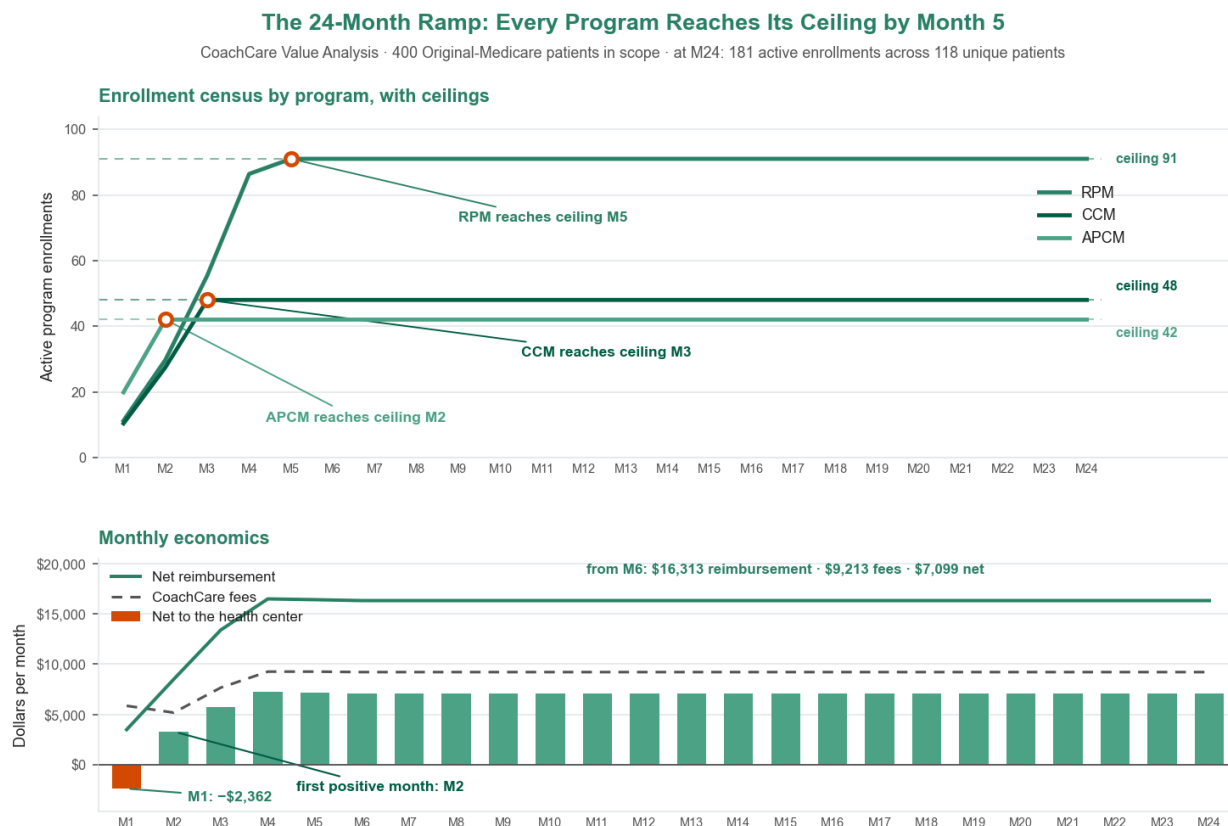


Figure 1. The 24-month ramp: enrollment census by program with ceilings (above) and monthly net reimbursement, CoachCare fees and net to the health center (below). Month 1 nets -\$2,362; the first positive month is M2; from month 6 the line holds at \$7,099 net per month.

The shape of the curve is worth reading precisely. Month 1 is negative, -\$2,362, because implementation and enrollment effort land before the first full billing months do. Month 2 turns positive at \$3,311, month 3 nets \$5,728, and month 4 is the high month at \$7,223 net on \$16,482 of net reimbursement, as the one-time setup codes bill. From month 6 the line settles at \$16,313 of net reimbursement, \$9,213 of fees and \$7,099 net a month once setup codes fall away and the census holds at its ceilings. Month 12 and month 24 are the same month.

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	\$89,631	\$105,296	\$194,927	\$109,508	\$85,418
CCM	\$57,348	\$63,791	\$121,139	\$60,283	\$60,857
APCM	\$25,492	\$26,663	\$52,155	\$28,025	\$24,130
Ancillary (implementation, integration, outreach)	—	—	—	\$14,471	-\$14,471
All programs	\$172,471	\$195,750	\$368,221	\$212,287	\$155,934

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

Program	Year 1 fees	Year 1 net	Year 2 fees	Year 2 net
RPM	\$49,802	\$39,829	\$59,706	\$45,589
CCM	\$28,538	\$28,810	\$31,745	\$32,047
APCM	\$13,698	\$11,794	\$14,327	\$12,336

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

RPM is the volume engine at 2,003 patient-months and \$194,927 of net reimbursement. CCM is the yield engine at \$110.75 of net reimbursement per patient-month across 1,094 patient-months, against \$97.32 for RPM over its 2,003 and \$52.90 for APCM over its 986. APCM is the smallest arm here and the report does not inflate it: Leon County's dual-eligible share is moderate, so the level-3 tier is weighted conservatively and the arm earns its place on the bundled monthly payment and the absence of minute-tracking rather than on a dual-heavy tier mix. Year 2 outruns Year 1 by \$23,279 of net reimbursement because Year 1 carries the ramp and Year 2 runs all three programs at ceiling from its first month.

Service-Line Composition: RPM \$194,927 · CCM \$121,139 · APCM \$52,155

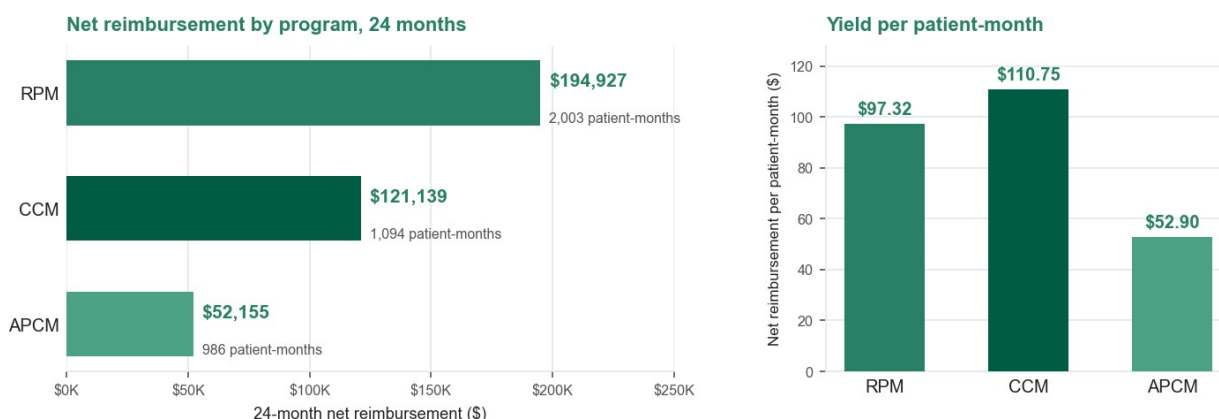


Figure 2. Service-line composition: per-program 24-month net reimbursement and net reimbursement per patient-month.

4.3 The ramp: every ceiling reached inside the first year

This account is ceiling-limited in all three programs inside the first year. APCM reaches its ceiling of 42 enrollments in month 2, CCM its 48 in month 3, and RPM its 91 in month 5. From month 6 the forecast is flat because there is no one left to add.²² The first 90 days move fast: 41 new enrollments across the three programs in month 1, 58 in month 2, 48 in month 3.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
RPM	260	91	Month 5	91
CCM	160	48	Month 3	48
APCM	140	42	Month 2	42
All programs		181		181 enrollments · 118 unique patients

²² CoachCare Value Analysis enrollment model: program ceilings 91 (RPM), 48 (CCM), 42 (APCM); ceilings reached in months 5, 3 and 2; 181 active enrollments across 118 unique patients at month 24 and at month 12. Dedup: the care-management enrollments plus the RPM enrollments not already carrying a wrapper.

Enrollment counts are program enrollments, not unique patients; the 181 enrollments at M24 belong to 118 unique patients (118 at M12), because a patient may carry a monitoring enrollment and a care-management enrollment at the same time.

Say the constraint out loud: what binds this program is the size of the Original-Medicare panel, not enrollment capacity, and not clinician count. That cuts two ways. It caps the forecast at a two-year net line near \$156,000, and it de-risks it, because the model asks the clinicians for no heroic enrollment performance, only a panel that exists. Three things move the ceiling upward: Medicare Advantage plans contracting at parity, which carries the in-scope panel toward the full 1,014; the Florida Medicaid remote-monitoring rail in Section 5; and the total cost of care the ACO is graded on. The on-site enrollment specialist cannot raise a ceiling, but it reaches every ceiling months sooner, and Section 12 prices what that is worth.

4.4 What the program produces

24-month output	Volume
Claims generated, billing-ready	5,944
Device readings monitored	21,030
Care-management tasks completed	11,889
Chart updates written to athenahealth	2,972
Patient conversations held	1,783 (99 hours of call time)
Care-team hours delivered	2,562 (≈ 1.23 FTE-years)
Hospitalizations avoided	13.4 · ≈ \$200,000 at \$15,000 per admission

CoachCare Value Analysis operational and clinical outputs, 24 months.

The avoided-admission line deserves its own sentence. 13.4 avoided hospitalizations over 24 months is roughly \$200,000 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 either Tallahassee acute-care hospital.²³ It is also the total-cost-of-care return the accountable-care responsibility in Section 3.2 is graded on, built here under fee-for-service first.

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

About 30% of the health center's patients are on Medicaid and another 35% are uninsured, and most of its hypertensive and diabetic patients are among them. Florida Medicaid has paid for remote physiologic monitoring since July 21, 2022: 99453 and 99454 for setup and device supply, 99457 and 99458 for management time, and 99091 for physician data review, with frequency limits (99453, 99454 and 99091 once per 30 days; 99457 and 99458 once per calendar month). 99457 requires real-time synchronous audio, at least 20 minutes a month, and a chronic-care treatment plan.²⁴ Florida Medicaid does not pay CCM, APCM, TCM or BHI.

²³ CoachCare Value Analysis clinical-outcomes module: 13.4 avoided hospitalizations over 24 months, valued at \$15,000 per avoided admission (about \$200,000).

²⁴ Florida Medicaid remote physiologic monitoring coverage: 99091, 99453, 99454, 99457 and 99458 covered for dates of service on or after July 21, 2022; frequency limits as stated; 99457 requiring real-time synchronous audio, at least 20 minutes a month and a chronic-care treatment plan.

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, as its own line beside the Medicare forecast, never folded into it.

One billing question is confirmed with the state before that line is sized: whether a Florida health center bills these codes separately from the PPS encounter, or bundled into the managed-care wrap. Billing is done by the health center as the Medicaid-enrolled provider; CoachCare manages the devices and the month.

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 Medicaid rail is where most of the health center's chronic-disease volume sits, and the same devices, the same escalation engine and the same athenahealth workflow serve it once the registries have been counted by payer and the state billing question is confirmed.

6. athenahealth Integration: The Program Lives in the Record

The health center runs on athenahealth, and the forecast prices CoachCare's athenahealth integration at the catalog tier: \$1,000 setup, \$150 a month and \$1.50 per patient-month.²⁵ The program operates inside the record rather than beside it. CoachCare is the only care-management partner with automated athenahealth claim creation, and patients begin chronic care management or remote monitoring in under five days, inside the existing athenahealth workflow, so the health center's clinicians and billing staff learn no new system.

- **Bidirectional enrollment by service.** Qualifying patients are flagged and enrolled by service inside the athenahealth workflow; CoachCare enrolls flagged Original-Medicare patients on the health center's behalf, and clinicians see enrollment status in the chart they already use.
- **Exchange of health history.** Problem lists, medications and relevant history move between athenahealth and the CoachCare program, so the monthly work is informed by the record rather than a separate intake.
- **Integrated discrete vitals.** Device readings land in the chart as integrated discrete vitals, not as scanned attachments, so a blood-pressure trend is usable clinical data inside athenahealth.
- **Escalation tasks.** An out-of-range reading or a clinical flag creates an escalation task routed to the clinic inside athenahealth, under the shared logic of Section 7, without a message relayed by hand.
- **Compliance documentation and the integrated care summary.** Evidence of care, care plans and the integrated care summary attach to the chart on the monthly cadence the codes require, so the documentation standard is met in the record.
- **Automated claim generation.** The CoachCare billing engine creates the monthly claim lines automatically, the step that makes individual-code billing workable at 5,944 claims over 24 months; the health center's own billing team files them with the care-management codes.

²⁵ The health center's EHR (athenahealth, athenaOne), confirmed from the patient-portal and referral workflow it publishes. CoachCare athenahealth integration pricing as carried in the Value Analysis: \$1,000 setup, \$150 a month, \$1.50 per patient-month.

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 process maps covering qualification, monitoring, escalation and discharge.²⁶ The purpose is keeping a patient with heart failure or uncontrolled diabetes at home in the Big Bend, managed between visits, rather than in a hospital bed.

7.2 One shared escalation engine

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

7.3 The emergent pathway

An active emergent symptom reported during any outreach contact triggers the 911 pathway. That policy supersedes any site-specific escalation preference and any quiet window: whichever clinic 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 either Tallahassee acute-care hospital 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 13.4 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

²⁶ CoachCare Care Management Programs standard operating procedures and the 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.

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: Community and Access Design

The service line has to be built for an eight-county rural footprint, not adapted to it afterward. The health center reaches Leon and seven surrounding Big Bend counties, where transportation is the adherence barrier a clinic schedule cannot solve, and the patient base is safety-net and uninsured-heavy.²⁷ Five 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. For a rural, uninsured-heavy panel, that is the difference between a reading and a device in a drawer.
- **The monthly documented touch as the equity mechanism.** A documented monthly contact reaches patients across an eight-county footprint that an office schedule and a long drive do not. Transportation is a barrier the health center already addresses with a transportation service and a mobile medical unit; the monthly touch works with them.
- **Enrollment lists pulled by condition, with payer attached.** Enrollment lists come from the hypertension, diabetes, heart-failure and COPD registries, screened by ICD-10 code per the qualification map, with payer attached so the Medicare and Medicaid rails stay distinct from the first list.
- **Advanced-practice delivery, fitted to the codes.** Most of the adult-primary-care bench are nurse practitioners, and CCM, APCM and RPM are general-supervision code families: the monthly work is delivered by qualified clinical staff under a billing clinician's direction, which fits the team the health center already has.
- **Referrals from the whole adult-primary-care floor.** Nine physicians and nurse practitioners flag patients in the chart; the flag is the whole clinician workflow, one step and back to the visit.

9. Market Context: Leon County Medicare

Leon County had 53,686 Medicare beneficiaries in June 2026, 21,177 of them in Original Medicare and 7,074 (13.2%) dually eligible, of whom 3,443 (6.4%) are full duals. Medicare Advantage covers 60.6% of the county's Medicare, the majority, and its share has risen each year: 59.8% in 2024, 60.3% in 2025, 60.6% in June 2026.²⁸ Medicare Advantage plans reimburse these code families at no less than the Medicare amount; that parity is a floor, and payment terms vary by contract.

Leon County Medicare, June 2026	Value
Total Medicare beneficiaries	53,686
Medicare Advantage and other	32,509 (60.6%)
Original fee-for-service Medicare	21,177 (39.4%)
Dual-eligible (Medicare and Medicaid)	7,074 (13.2%)
— Full dual	3,443 (6.4%)
— Partial dual	3,631 (6.8%)
Aged 65 and over	49,005 (91.3%)
Disabled, under 65	4,681 (8.7%)

²⁷ HRSA service-area records: Leon plus seven surrounding Big Bend counties (Gadsden, Wakulla, Jefferson, Taylor, Franklin, Liberty, Madison). HRSA Uniform Data System 2024: Medicaid and CHIP 30.4%, uninsured 35.3%. Transportation service and mobile medical unit per the health center's own service list.

²⁸ CMS Medicare Monthly Enrollment, Leon County: June 2026, 53,686 beneficiaries, Original Medicare 21,177 (39.4%), dual-eligible 7,074 (13.2%), full duals 3,443 (6.4%), aged 65 and over 49,005 (91.3%); Medicare Advantage penetration 59.8% (2024), 60.3% (2025), 60.6% (June 2026).

CMS Medicare Monthly Enrollment, Leon County, June 2026 (the latest month).

The market fact that shapes this forecast is the payer split. With 60.6% of the county's Medicare in Medicare Advantage, the base runs on the 39.4% Original-Medicare share, the panel a health center bills cleanly today and the population the accountable-care responsibility attaches to. That same split is the growth story: as plans contract the care-management codes at parity, the in-scope panel expands toward the full Medicare count, and Section 12 prices each step.²⁹

10. The CY2027 Proposed Rule, Repriced on This Forecast

CMS published its proposed CY2027 physician fee schedule in July 2026. Comments on CMS-1848-P closed September 14, 2026; the final rule arrives in early November; the changes take effect January 1, 2027, and a statutory phase-in caps how far any code's payment can fall in a single year. The proposal that matters here is a reduction to the remote monitoring device-supply codes. Every code in this forecast was repriced at the national amounts on this account's own billing mix, with enrollment held constant; the forecast's basis and the repricing table use the same national amounts on both sides.³⁰

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: \$194,927 over 24 months, –9.5%, –\$18,559. Device supply is 32% of the remote monitoring basket; management time moves little.

Chronic care management: \$121,139, –2.15%, –\$2,604. Advanced primary care management: \$52,155, –0.80%, –\$415. Conversion-factor and relative-value movement only; the proposal does not target these codes. The care-management movement is \$3,020 of the total.

The whole service line: \$368,221 over 24 months, –5.86%, –\$21,578, to \$346,643. Remote monitoring is 53% 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 –5.9%, –\$21,578 of \$368,221

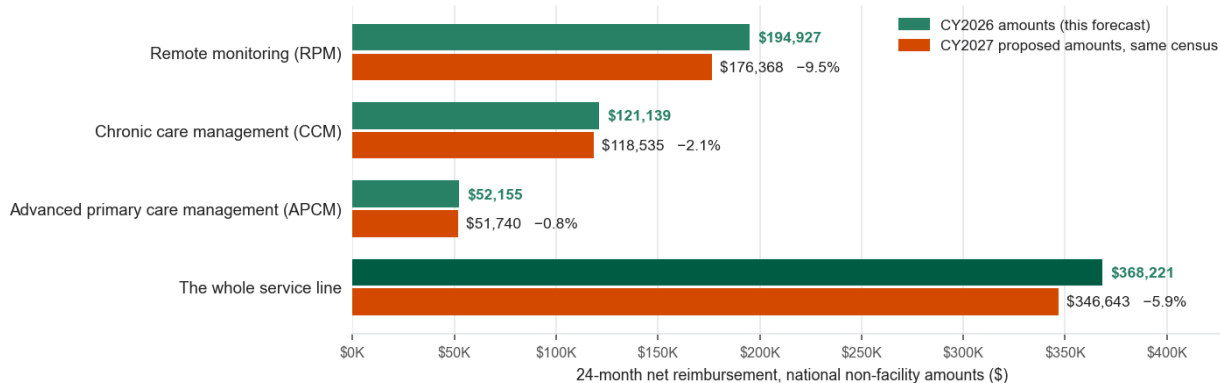


Figure 3. The CY2027 proposed rule on this forecast, at the national amounts on both sides: each arm and the whole line, CY2026 against the CY2027 proposed amounts, same census.

²⁹ CoachCare Value Analysis recalculations at the same pricing (see note 31).

³⁰ 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% (–\$18,559); CCM –2.15% (–\$2,604); APCM –0.80% (–\$415); service line –5.86% (–\$21,578, from \$368,221 to \$346,643). Enrollment held constant.

11. Implementation and the First 90 Days

11.1 Who runs what

CoachCare delivers	Bond Community Health Center keeps
Telephonic and on-site enrollment; the enrollment specialist is CoachCare's expense	Referral flags in athenahealth; clinical oversight under general supervision
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans 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 inside athenahealth	Filing the claims with the care-management codes; billing review; the revenue
Monthly operating reports against the dashboard in 11.3	Program governance; the accountable-care relationship the engine supports

11.2 Model inputs

Input	Value
Medicare panel in scope	400 Original-Medicare patients, the 39.4% Original-Medicare share of the 1,014 Medicare patients in the UDS 2024 report
Referring clinicians	9 in adult primary care (3 physicians and roughly 6 adult nurse practitioners); conservative core 8
Programs	RPM + CCM + APCM; TCM and BHI named, not in the forecast; PCM off
Program-eligible pools	RPM 260 · CCM 160 · APCM 140
Enrollment ceilings	RPM 91 (M5) · CCM 48 (M3) · APCM 42 (M2)
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
Medicare Advantage	60.6% of Leon County's Medicare (June 2026). Medicare Advantage plans reimburse these code families at no less than the Medicare amount; that parity is a floor, and payment terms vary by contract.
EMR	athenahealth (athenaOne), priced at the catalog integration tier (\$1,000 setup, \$150 a month, \$1.50 per patient-month)

11.3 The 90-day plan and the operating dashboard

Days 0–30: foundation. Program agreement and the athenahealth integration workplan. The Medicare payer reconciliation, how many of the 1,014 Medicare patients are Original Medicare against Medicare Advantage, and the hypertension and diabetes registries by payer, the two inputs that move the model most. ICD-10 screening of the Original-Medicare panel per the qualification map, device logistics staged, escalation routing set, and clinician orientation to the general-supervision workflow.

Days 31–60: enrollment live. Telephonic and in-clinic enrollment running; first devices in homes; first billable service months. Month 1 nets –\$2,362 as implementation lands; month 2 turns positive. The forecast carries 41 new enrollments in month 1 and 58 in month 2.

Days 61–90: scale and file. 48 new enrollments in month 3, APCM and CCM at their ceilings, RPM two months from its own. First monthly operating report against the dashboard. Second working session on the Florida Medicaid remote-monitoring rail, with the registries counted by payer and the state billing question confirmed.

The operating dashboard from month one:

- Enrollment census by program against ceiling (91 / 48 / 42)
- 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 among enrolled patients, against the UDS 2024 baseline of 53.5%
- Net to the health center per month against the \$7,099 steady-state line

12. Recommendations

1. **Stand up the Medicare service line now, sized honestly.** The individual-code rail has been live since January 2025. This is a \$155,934 two-year net line that fills in five months; each month of delay pushes it one month further out, and nothing about it waits on a hire.
2. **Run it as the accountable-care engine it already needs.** The health center carries accountable-care responsibility for its Original-Medicare panel and has no between-visit care-management engine to move the quality and total-cost numbers that responsibility is graded on. This service line is that engine, margin-positive under fee-for-service before a single shared-savings dollar.
3. **Lead with the heart-health measure the record already carries.** Blood-pressure control at 53.5% is the measure the health center is nationally recognized on and the one continuous readings and a monthly documented touch move fastest. Target the hypertension cohort first.
4. **Reconcile the Medicare panel by payer in the first 30 days.** The base runs on the 400-patient Original-Medicare share. How far Medicare Advantage plans contract the care-management codes at parity is the single largest lever in this report, and the table below prices each step up to the full 1,014-patient panel.
5. **Size the Florida Medicaid remote-monitoring rail as its own line.** Most of the health center's chronic-disease volume is on Medicaid or uninsured, and Florida Medicaid has paid remote monitoring since July 2022. Count the hypertension and diabetes registries by payer, confirm the PPS billing question with the state, and price that rail in a second session, beside the Medicare forecast, never inside it.
6. **Build the program for the Big Bend from the first day.** Cellular devices, condition-based enrollment lists with payer attached, and a monthly documented touch that works with the transportation service and the mobile unit. None of these is a retrofit.
7. **Keep the CoachCare-funded enrollment specialist in the plan.** The specialist cannot raise the ceilings, but reaches them months sooner, and is worth \$10,362 of 24-month net to the health center against the no-specialist case in the table below.
8. **Make the hospital discharge the front door.** Wire the discharge feed from both Tallahassee acute-care hospitals, 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.

What moves the number

Scenario	24-month net reimbursement	Net to the health center	Margin	Ceiling reached RPM / CCM / APCM
Base: 400-patient panel, 9 clinicians, 1 enrollment specialist	\$368,221	\$155,934	42.35%	M5 / M3 / M2
No on-site enrollment specialist	\$344,744	\$145,572	42.23%	M8 / M6 / M4
Second on-site enrollment specialist	\$376,699	\$159,667	42.39%	M4 / M3 / M2
6 referring clinicians	\$364,351	\$154,240	42.33%	M5 / M4 / M2
12 referring clinicians	\$370,816	\$157,063	42.36%	M4 / M3 / M2
Panel 650 (partial Medicare Advantage parity)	\$578,400	\$249,058	43.06%	M6 / M4 / M3
Panel 1,014 (full Medicare panel, Advantage at parity)	\$861,003	\$374,415	43.49%	M9 / M6 / M4

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

Read the table from the bottom up. The panel rows are the only rows that move the ceilings, and the panel is the health center's own number to grow through Medicare Advantage parity and the Medicaid rail. The clinician-count rows barely move the result, because every program fills inside the first year on the existing bench. The specialist rows move the timing, not the ceilings.³¹

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 four inputs that would move it, in the order they matter.

1. **The Medicare payer reconciliation.** How many of the 1,014 Medicare patients are Original Medicare against Medicare Advantage, and how far the plans contract the care-management codes at parity. This one split sets every ceiling and moves the forecast from \$368,221 toward \$861,003 of net reimbursement.
2. **The hypertension and diabetes registries by payer.** The Medicare slice sizes the RPM cohort in this forecast; the Medicaid slice sizes the second rail, once the state billing question is confirmed.
3. **The accountable-care quality and total-cost targets.** The measures and the total-cost-of-care the Original-Medicare panel is graded on, so the service line's clinical dashboard is set to the numbers that matter to the health center.
4. **The athenahealth product line and interfaces.** Which athenahealth products the health center runs and which interfaces are available, so the integration workplan and the discharge feed can be written.

Everything else in this report, the Medicare Advantage contract terms, the discharge feed from each Tallahassee acute-care hospital, and the Florida Medicaid billing question, is a workplan item that follows the session rather than a condition of it.

³¹ CoachCare Value Analysis recalculations at the same pricing: no on-site enrollment specialist \$344,744 / \$145,572 / 42.23%; second specialist \$376,699 / \$159,667 / 42.39%; 6 clinicians \$364,351 / \$154,240 / 42.33%; 12 clinicians \$370,816 / \$157,063 / 42.36%; panel 650 \$578,400 / \$249,058 / 43.06%; panel 1,014 \$861,003 / \$374,415 / 43.49%. The specialist is worth \$10,362 of 24-month net to the health center against the no-specialist case.

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.³²

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 per-center awardee file for the 2024 reporting year (the latest available), and the HRSA Health Center service-site file: a main campus, a specialty and community wellness center, a neighborhood clinic, a school-based dental program and a mobile medical unit across Leon and the surrounding Big Bend counties.
- **HRSA Uniform Data System, 2024:** 9,079 patients; adults 6,669 and children 2,410; Medicare as primary payer for about 1,014 patients and about 1,034 aged 65 and over; Medicaid and CHIP 30.4%; uninsured 35.3%; private 23.2%; controlled blood pressure 53.5%; statin therapy 87.2%; aspirin or antiplatelet therapy 82.8%; depression screening 62.3%; colorectal screening 42.4%.
- **HRSA National Quality Leader recognition, 2025:** the health center's national Heart Health recognition for hypertension control, consistent with the controlled-blood-pressure rate in the Uniform Data System record.
- **CMS Medicare Shared Savings Program participant records, performance year 2026:** the health center is a named participant, on the upside-only BASIC track with an Advance Investment Payment and prospective assignment, with a participant start date of January 1, 2025. No shared-savings, Advance-Investment or benchmark dollar figure is asserted or modeled anywhere in this report.
- **CMS Medicare Monthly Enrollment, Leon County, June 2026 (the latest month):** 53,686 beneficiaries; 21,177 in Original Medicare (39.4%) and 32,509 in Medicare Advantage and other (60.6%); 7,074 dually eligible (13.2%), of whom 3,443 are full duals (6.4%); 49,005 aged 65 and over.
- **The CY2025 Physician Fee Schedule Final Rule and the CY2026 Final Rule:** Federally Qualified Health Centers report the individual CPT and HCPCS codes for care management, remote monitoring and advanced primary care management in place of G0511, paid at national non-facility Physician Fee Schedule amounts in addition to the PPS encounter, from January 1, 2025, with G0511 retired on a 2025 transition; the CY2026 additions 99445 and 99470.
- **CY2026 Physician Fee Schedule rate files:** national non-facility amounts for the forecast codes, the two transitional care codes and the behavioral health integration code, at the national conversion factor with no geographic adjustment.
- **Florida Medicaid remote physiologic monitoring coverage:** 99091, 99453, 99454, 99457 and 99458 covered for dates of service on or after July 21, 2022, with the stated frequency limits;

³² CoachCare company statistics, 2026: patients served, managed conditions, providers on the platform, implementations completed, claims generated and vitals recorded.

99457 requiring real-time synchronous audio, at least 20 minutes a month and a chronic-care treatment plan; CCM, APCM, TCM and behavioral health integration not on the Florida Medicaid remote-care schedule.

- **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; statutory single-year phase-in.
- **The health center's athenahealth (athenaOne) deployment,** confirmed from the patient-portal and referral workflow the health center publishes; CoachCare integration pricing at the catalog tier: \$1,000 setup, \$150 a month and \$1.50 per patient-month.
- **CoachCare Care Management Programs standard operating procedures and the 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 athenahealth integration overview:** bidirectional enrollment by service, exchange of health history, integrated discrete vitals, escalation tasks, compliance documentation and the integrated care summary, and automated claim creation, with patients beginning services in under five days inside the athenahealth workflow.
- **CoachCare Value Analysis for Bond Community Health Center, 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 400 Original-Medicare patients in scope, 9 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 181 active program enrollments belonging to 118 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 and care management bill on the institutional claim rather than under individual clinicians, so clinician-level Medicare claims files do not show a health center's care-management billing at all. The 1,014-patient Medicare figure is the count the health center reported to HRSA for 2024, and the 400-patient base is its Original-Medicare share, the panel a health center can bill the care-management codes on cleanly and the population Shared Savings Program assignment attaches to.

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