



Neighborhood Medical Center

Neighborhood Medical Center, Inc.

COACHCARE | SERVICE LINE STRATEGY

A HRSA-funded community health center serving Tallahassee and the Big Bend of Florida from the historic Frenchtown neighborhood beside Florida A&M University, with five clinical sites in Leon and Gadsden counties, an in-house pharmacy and a Ryan White HIV program

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line for the health center's 940 Medicare patients, nearly all of them dually eligible: remote physiologic monitoring, chronic care management and advanced primary care management, billed as individual codes on top of the PPS encounter since October 2025, and built for a health center that is already in a Medicare accountable care organization, staffed by CoachCare

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of Neighborhood Medical Center. It brings together the health center's own HRSA record, the Medicare structure of Leon and Gadsden counties, the Medicare accountable care organization the health center already belongs to, 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 athenaOne integration it lives in, the Florida Medicaid rail beside it, and the community design a Big Bend program has to get right.

The argument is short. Nearly every one of this health center's Medicare patients is dually eligible, and most of them are Qualified Medicare Beneficiaries, which makes the monthly advanced-primary-care code worth more here than almost anywhere. The health center is already in a Medicare accountable care organization whose shared savings turn on the exact two measures this program moves: blood-pressure and diabetes control, the two measures the health center ranks worst on today. The panel is small and it fills in eight months. The people to run it are ours.

Prepared by CoachCare for discussion with Neighborhood Medical Center. © 2026 CoachCare.

Table of Contents

Executive Summary.....	X
1. The Health Center Today.....	X
1.1 Fifty years in the Big Bend.....	X
1.2 Quality the record can verify.....	X
1.3 The gap: the month between visits.....	X
2. The Medicare ACO: Why This Is the Moment.....	X
2.1 Already in a shared-savings ACO, built for this exact work.....	X
2.2 The two measures the ACO scores are the two this program moves.....	X
2.3 Three payment rails, and which one this forecast uses.....	X
3. What Changed: A Health Center Now Bills the Month Between Visits.....	X
3.1 G0511 is gone; the individual codes pay on top of the PPS encounter.....	X
3.2 What the codes pay a health center.....	X
3.3 The work the change creates, and who carries it.....	X
4. The Service Line: RPM, CCM and APCM on the Medicare Panel.....	X
4.1 The clinical and billing stack.....	X
4.2 Nearly the whole panel is dually eligible: why APCM pays more here.....	X
4.3 The Medicare panel it runs on.....	X
4.4 Transitional care at the hospital discharge, named and not in the forecast.....	X
4.5 Behavioral health integration: the next arm, named.....	X
4.6 Built the way the codes work: an eight-clinician bench.....	X
4.7 Staffing: nobody is hired.....	X
5. Value Analysis: The 24-Month Forecast.....	X
5.1 Headline economics.....	X
5.2 Program economics by year.....	X
5.3 The ramp: every ceiling reached by month 8.....	X
5.4 What the program produces.....	X
6. The Second Rail: Florida Medicaid Pays for Remote Monitoring.....	X
7. athenaOne Integration: The Program Lives in the Record.....	X
8. Clinical Governance and Escalation.....	X
8.1 A monitoring program is a clinical operation first.....	X
8.2 One shared escalation engine.....	X
8.3 The emergent pathway.....	X
8.4 Qualification, device assignment and routing.....	X
8.5 The post-discharge cadence.....	X
8.6 Discharge governance and continuity.....	X
9. Built for the Big Bend: Community and Operational Design.....	X
10. Market Context: Leon and Gadsden County Medicare.....	X
11. The CY2027 Proposed Rule, Repriced on This Forecast.....	X
12. Implementation and the First 90 Days.....	X
12.1 Who runs what.....	X
12.2 Model inputs.....	X
12.3 The 90-day plan and the operating dashboard.....	X

13. Recommendations.....X

14. The Ask: A Working Session.....X

About CoachCare.....X

References and Data Sources.....X

Executive Summary

Neighborhood Medical Center is a HRSA-funded community health center in Tallahassee, Florida, rooted in the historic Frenchtown neighborhood beside Florida A&M University and serving Leon and Gadsden counties, the Big Bend safety net. It has cared for the community since 1974 and grew from a single clinic into five sites, an in-house pharmacy and a Ryan White HIV program.¹ Its 2025 Uniform Data System report counts 9,585 patients: 940 with Medicare as primary payer, 878 of them dually eligible, 3,830 on Medicaid or CHIP, 1,452 with hypertension and 726 with diabetes; 67% of patients are Black and a third are uninsured.² On the one quality measure where a protocol is already in place, statin therapy for cardiovascular prevention, the health center sits in HRSA's best quartile at 85.29%.³

What the record does not yet show is a Medicare revenue line for the month between visits. Across every clinician on the health center's adult-medicine roster, CY2024 Medicare fee-for-service claims show **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 that file either, so that is the precise claim.⁴ The 1,452 patients with hypertension and 726 with diabetes are seen a few times a year. Blood-pressure control sits at 51.86% and diabetes poor control at 31.68%, the two measures a documented monthly touch and continuous readings move most directly, and the two the health center ranks worst on.

The health center is already in a Medicare accountable care organization. Since January 1, 2025 it has been a participant in **VitaSavings Florida**, a Medicare Shared Savings Program ACO for Florida community health centers, on the one-sided, upside-only track, and one that draws up-front infrastructure funding meant to build care capacity in underserved areas.⁵ That arrangement turns on the same two measures a remote care service line moves. The care-management revenue is additive to the ACO, and the quality lift feeds it.

Medicare Advantage covers most of the county's Medicare, 60.3% in Leon and 71.4% in Gadsden (September 2026), so most of the 940-patient panel is in a Medicare Advantage plan.⁶ Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.

¹ The health center's own site and HRSA Health Center Program records: a community health center serving Tallahassee since 1974, a Federally Qualified Health Center since 2014, with primary care, dental, behavioral health, women's care, a Ryan White HIV program and an in-house pharmacy across five active sites in Leon and Gadsden counties.

² HRSA Uniform Data System, the health center's awardee reporting, reporting year 2025: total patients 9,585; Medicare 940 (9.81%); dually eligible 878; Medicaid/CHIP 3,830 (39.96%); uninsured 3,293 (34.36%); hypertension 1,452; diabetes 726; Black or African American 67%; patients experiencing homelessness 15%.

³ HRSA UDS clinical quality measures, 2021 and 2025: statin therapy for cardiovascular prevention 76.25% (2021) to 85.29% (2025), HRSA adjusted quartile 1 among health centers.

⁴ CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024 (released May 2026), queried per National Provider Identifier for every clinician on the adult-medicine roster for codes 99453, 99454, 99457, 99458, 99445, 99470, 99091, 99490, 99439, 99491, 99487, 99489, 99424, 99426, G0556–G0558, G0511, 99495, 99496 and 99484. No care-management or remote-monitoring lines under the health center. Health-center visits and care management billed on the institutional claim do not appear in this professional-claims file.

⁵ CMS Medicare Shared Savings Program PY2026 participant file: the health center is a participant in the accountable care organization VitaSavings Florida, BASIC track, one-sided (upside-only), lower-revenue, with advance investment payments, initial start date January 1, 2025, prospective assignment.

⁶ CMS Medicare Advantage State/County Penetration, September 2026: Leon County 60.3%, Gadsden County 71.4%.

The observation this report is built on

Nearly every one of this health center's Medicare patients is dually eligible, and most of them are Qualified Medicare Beneficiaries, which makes the monthly advanced-primary-care code worth more here than almost anywhere. The health center is already in a Medicare accountable care organization whose shared savings turn on the exact two measures this program moves: blood-pressure and diabetes control. The panel is small and it fills in eight months. The people to run it are ours.

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 the Physician Fee Schedule amounts, in addition to the PPS encounter.⁷ The short-window RPM codes new for 2026 (99445, 99470) fit post-discharge monitoring exactly. And Florida Medicaid, which covers 40% of this health center's patients, has paid for remote physiologic monitoring since 2025.⁸

What the Value Analysis returns

The forecast prices a service line for the health center's own Medicare panel, 940 patients as reported to HRSA for 2025, Original Medicare and Medicare Advantage together, referred by the eight clinicians in adult medicine, and delivered by CoachCare under the health center's clinical direction, priced at the CY2026 MAC-locality amounts a health center's ZIP codes fall in.⁹

	Year 1	Year 2	24 months
Net reimbursement	\$366,624	\$488,112	\$854,737
CoachCare fees	\$214,150	\$278,270	\$492,420
Net to the health center	\$152,474	\$209,843	\$362,317
Margin to the health center	41.59%	42.99%	42.39%

CoachCare Value Analysis. CY2026 non-facility Physician Fee Schedule amounts at Florida locality 99, the amounts the health center's ZIP codes resolve to. 940 Medicare patients in scope; RPM + CCM + APCM. Margin is net to the health center divided by net reimbursement.

- This is a \$362,000 two-year net line on a 940-patient panel, and it fills in eight 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 M4, CCM in M6, RPM in M8. At M24 the program holds 425 active program enrollments across 277 unique patients, the same census it holds at M12. The binding constraint is the size of the Medicare panel, not enrollment capacity or clinician count.
- The program funds itself from the second month.** Month 1 nets -\$2,244 to the health center, because implementation lands before enrollment revenue does. The first positive month is M2, at \$3,761. From M9 the service line runs at \$40,676 in monthly net reimbursement and \$17,487 net to the health center.
- The dual mix is the wedge.** 878 of the 940 Medicare patients are dually eligible, and roughly two in three of the county's dual-eligible beneficiaries are Qualified Medicare Beneficiaries. Advanced primary care management pays its highest tier, G0558 at \$116.73 a month, for that group, which

⁷ CY2025 Physician Fee Schedule Final Rule: rural health clinics and Federally Qualified Health Centers report the individual CPT and HCPCS codes for care management in place of G0511, paid at 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.

⁸ Florida Medicaid Practitioner Fee Schedule, effective October 1, 2025 (Rule 59G-4.002): remote physiologic monitoring codes priced. HRSA UDS 2025: Medicaid/CHIP 3,830 of 9,585 patients (39.96%).

⁹ CoachCare Value Analysis for Neighborhood Medical Center, 2026. Basis: CY2026 non-facility Physician Fee Schedule amounts at Florida locality 99; 940 Medicare patients in scope; 8 referring clinicians; RPM, CCM and APCM.

puts the APCM blend here at \$87.71 per patient-month and makes G0558 the best-paying monthly code on the page.

4. **The quality lift feeds the ACO.** Remote monitoring and chronic care management move blood-pressure control and diabetes control, the two measures the health center ranks worst on and two of the measures its shared-savings arrangement is scored on. The care-management revenue is additive to that arrangement, and no shared-savings dollars are forecast in these pages.
5. **Nobody is hired.** CoachCare delivers 5,539 hours of care-team work over 24 months, about 2.66 full-time-equivalent years, including an on-site enrollment specialist carried at CoachCare's expense. No capital outlay and no new requisition.
6. **The clinical return is concrete, and the growth is in the panel.** The forecast projects 28.4 avoided hospitalizations over 24 months, roughly \$426,000 at \$15,000 per admission, from 44,734 device readings worked through one escalation protocol. The growth beyond the base is the Medicare panel, which the health center's own UDS counts place between 856 and 1,278 across recent years, and the Florida Medicaid remote-monitoring rail on its hypertension and diabetes registries.

1. The Health Center Today

1.1 Fifty years in the Big Bend

Neighborhood Medical Center, the legal entity Neighborhood Medical Center, Inc., has served Tallahassee since 1974 and became a Federally Qualified Health Center in 2014. It is a HRSA-funded community health center, enrolled with Medicare under six health-center certification numbers held by one organization, and it carries federal malpractice coverage and 340B pharmacy eligibility that come with that status.¹⁰ HRSA records five active clinical sites across Leon and Gadsden counties, from the main campus on West Brevard Street in Frenchtown to school-based clinics and a site in Havana, with an in-house pharmacy and a Ryan White HIV program alongside primary care, dental, behavioral health and women's care.¹¹ The patient base is largely low-income, Medicaid- and uninsured-heavy, and predominantly Black, with a growing Hispanic share the health center serves in Spanish as well as English.

UDS 2025	Count	What it means for the service line
Total patients	9,585	Medical 4,904 · dental 4,728 · mental health 342
Medicare patients	940 (9.81%)	The panel this forecast runs on; Medicare Advantage and the 878 duals are inside it
Dually eligible	878	93% of the Medicare panel; the APCM level-3 tier and the low cost-share that eases enrollment
Medicaid and CHIP	3,830 (39.96%)	Outside the Medicare forecast; Florida Medicaid pays for remote monitoring (Section 6)
Uninsured	3,293 (34.36%)	A third of the panel; the sliding-fee population the enabling-services layer reaches
Hypertension	1,452 (40.96% of patients with conditions)	The RPM cohort; blood-pressure control 51.86%
Diabetes	726 (21.10%)	Glucose monitoring; A1c poorly controlled in 31.68%

¹⁰ CMS Federally Qualified Health Center Enrollments: six health-center certification numbers under one PECOS associate identifier; corporation incorporated in Florida in 1974; FQHC enrollments dating to 2014. HRSA Health Center Program status: a funded community health center, with federal malpractice coverage and 340B pharmacy eligibility.

¹¹ HRSA Health Center Service Delivery Sites file, retrieved September 2026: five active sites across Leon and Gadsden counties, including the main campus in Frenchtown, school-based clinics and a site in Havana; an in-house pharmacy; a Ryan White HIV program.

UDS 2025	Count	What it means for the service line
Black / African American	67%	A Frenchtown-and-rural-Gadsden panel; materials and outreach built for it, not adapted

HRSA Uniform Data System, the health center's awardee reporting for 2025, the latest reporting year.

1.2 Quality the record can verify

The earned compliment is specific: on the one cardiovascular measure that runs on a fixed protocol, statin therapy for patients with vascular disease, the health center is in HRSA's best quartile at 85.29%, up from 76.25% in 2021.¹² A team that hits the top quartile once a protocol is written is a team that executes; the between-visit gap is the missing protocol. It shows up on exactly the two measures a monitoring program moves. Blood-pressure control sits at 51.86%, HRSA's bottom quartile, and diabetes poor control at 31.68%, the third quartile. Those are the two measures continuous readings and a monthly documented touch move, and they are also two of the measures the health center's accountable care arrangement is scored on.

Clinical quality measure, UDS 2025	Value	HRSA quartile
Statin therapy for cardiovascular prevention	85.29%	1 (best)
Aspirin or antiplatelet therapy for vascular disease	83.19%	2
Controlling high blood pressure (below 140/90)	51.86%	4 (worst)
Diabetes: A1c above 9% or untested (lower is better)	31.68%	3
Depression screening and follow-up	69.18%	3
Breast cancer screening	51.39%	2
Adult BMI screening and follow-up	87.64%	1

HRSA Uniform Data System clinical quality measures, 2025, with HRSA's adjusted quartile ranking among health centers (1 is best). The two measures a remote care program moves most, blood-pressure and diabetes control, are the two ranked lowest.

1.3 The gap: the month between visits

Between-visit chronic care has no Medicare revenue line here yet. A sweep of CY2024 Medicare fee-for-service claims across every clinician on the adult-medicine roster returns no lines on any remote-monitoring code, any chronic-care-management code, any advanced-primary-care code, any transitional-care code or any behavioral-health-integration code under the health center.¹³ CMS suppresses any provider-and-code line under 11 beneficiaries, and care management billed on the health center's own institutional 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 CY2024 claims**.

This is a structural observation, not a criticism. What the record does show is a health center with the pieces of a program already in place: an in-house pharmacist who is also a certified diabetes educator, a chronic-disease clinic, and enabling-services staff who reach patients an office schedule does not. A documented monthly touch in the patient's own language, on continuous readings, is the layer this service line adds on top of work the health center already does, and it is reportable improvement on the quality measures the health center already files.

¹² HRSA UDS clinical quality measures, 2025, with HRSA's adjusted quartile ranking among health centers: statin therapy 85.29% (quartile 1); aspirin or antiplatelet therapy 83.19% (quartile 2); controlling high blood pressure 51.86% (quartile 4); diabetes A1c above 9% or untested 31.68% (quartile 3); depression screening and follow-up 69.18% (quartile 3); breast cancer screening 51.39% (quartile 2); adult BMI screening 87.64% (quartile 1).

¹³ CY2024 Medicare Physician & Other Practitioners sweep (see note 4).

2. The Medicare ACO: Why This Is the Moment

2.1 Already in a shared-savings ACO, built for this exact work

The reason to build this now is that the health center has already made the harder decision. Since January 1, 2025 it has been a participant in **VitaSavings Florida**, a Medicare Shared Savings Program accountable care organization for Florida community health centers. The arrangement is on the one-sided, upside-only track reserved for lower-revenue organizations, and it draws up-front infrastructure funding that Medicare advances to this kind of ACO to build care capacity in underserved areas ahead of any shared savings.¹⁴

That funding is meant to buy exactly one thing: the care infrastructure that improves quality and holds patients out of the hospital. A remote care service line is that infrastructure. It is the enrollment, the connected devices, the monitoring, the monthly documented touch and the escalation loop, delivered by CoachCare and running on the health center's own panel. The service line is additive to the accountable care arrangement, not in competition with it, and it is ready to bill under fee-for-service on the day it starts.

2.2 The two measures the ACO scores are the two this program moves

The link is direct. A shared-savings ACO earns when its patients score well on quality and stay out of avoidable hospital care. The two quality measures this health center ranks worst on, blood-pressure control at 51.86% and diabetes poor control at 31.68%, are exactly the two that continuous readings and a monthly care-management touch move, and they are among the measures the ACO is scored on. The same program that bills RPM and CCM as new fee-for-service revenue is the program that lifts those two numbers and reduces the admissions behind them. One build does both.

2.3 Three payment rails, and which one this forecast uses

Three rails, one of them modeled

Per-code fee-for-service. The basis of this forecast. Every figure in Sections 3 through 5 is per-claim fee-for-service at the Physician Fee Schedule amounts. The health center's ACO is on the Shared Savings Program's standard track, not its prospective primary-care payment option, so the primary-care codes are paid per claim for the whole panel; nothing zeroes them for assigned patients.¹⁵

The shared-savings overlay. Through the ACO, on top of the fee-for-service revenue and upside-only. The quality and avoided-utilization lift this program produces feeds it. This report forecasts no shared-savings dollars; it makes the fee-for-service case and names the overlay as the second reason to build.

Medicare Advantage. Most of the 940 panel is in a Medicare Advantage plan. Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.

The order of operations follows from the rails. The fee-for-service service line is built first because its rail is explicit and ready to bill, and because it is what improves the quality numbers the ACO reports. The shared-savings return is the second layer, and the Medicare Advantage contract terms are a working-session item, not a load-bearing assumption in the forecast.

¹⁴ CMS Medicare Shared Savings Program PY2026 participant file (see note 5). Advance investment payments are up-front infrastructure funding Medicare advances to lower-revenue accountable care organizations serving underserved areas, recovered from later shared savings.

¹⁵ The health center's accountable care organization is a Shared Savings Program participant on the standard track, not the program's prospective primary-care payment option (ACO PC Flex), confirmed absent from the CY2026 PC Flex participant list. Under the standard track the primary-care service codes, including CCM, APCM and TCM, are paid per claim as fee-for-service for the whole panel.

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

3.1 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 **Physician Fee Schedule amount, in addition to the PPS encounter**.¹⁶

CY2026 also added two codes that matter for a health center whose patients are discharged from either of the two acute-care hospitals in Tallahassee: 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 \$74,867 of gross reimbursement over 24 months, about 8.8% of net reimbursement, revenue that did not exist a year ago.¹⁷

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.

3.2 What the codes pay a health center

The Value Analysis is priced at the CY2026 MAC-locality amounts, Florida locality 99, the amounts the health center's ZIP codes resolve to. That is the conservative basis. A health center actually bills these codes at the national non-facility amounts, which run slightly above the locality amounts used here; billed at the national rail, the same forecast returns about \$10,090 more over 24 months, all of it to the health center.¹⁸

Code	What it pays for	Cadence	CY2026 amount
99453	RPM setup and patient education	One-time	\$21.12
99454	Device supply, 16–30 days of readings	Monthly	\$50.00
99445	Device supply, 2–15 days of readings (new 2026)	Monthly	\$50.00
99457	RPM management, first 20 minutes	Monthly	\$51.12
99470	RPM management, first 10 minutes (new 2026)	Monthly	\$25.73
99458	RPM management, each additional 20 minutes	Monthly	\$41.22
99490	CCM, first 20 minutes of clinical staff time	Monthly	\$65.97
99439	CCM, each additional 20 minutes	Monthly	\$50.16
G0556	APCM, level 1: one chronic condition	Monthly	\$16.38

¹⁶ CY2025 Physician Fee Schedule Final Rule (see note 7): G0511 retired with a transition period through September 30, 2025; from October 1, 2025 the individual codes are the standing requirement.

¹⁷ CoachCare Value Analysis, Financial Value detail: 99445 and 99470 together carry \$74,867 of gross reimbursement over 24 months against \$854,737 of net reimbursement (about 8.8%), on this forecast's code frequencies. CMS Hospital General Information, September 2026: two CMS-certified acute-care hospitals in Tallahassee.

¹⁸ CY2026 Physician Fee Schedule non-facility amounts (CMS RVU26A, January 2026 release) at Florida locality 99 (carrier 09102), the locality the health center's ZIP codes resolve to; and the national non-facility amounts a health center bills these codes at regardless of locality, which run about 0.6% above the locality amounts on median across this basket (up to about 4% on the device codes). CoachCare Value Analysis, national-amounts recalculation: net reimbursement \$864,827 against \$854,737, a difference of \$10,090, all of which falls to the health center because the fees are per-patient-month amounts that do not change.

Code	What it pays for	Cadence	CY2026 amount
G0557	APCM, level 2: two or more chronic conditions	Monthly	\$53.45
G0558	APCM, level 3: Qualified Medicare Beneficiary	Monthly	\$116.73
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)

The forecast codes (RPM, CCM, APCM) at the CY2026 MAC-locality amounts, Florida locality 99, the Value Analysis basis. TCM and BHI are shown at the national amounts and carry no dollars in the forecast. The APCM tier blend in the forecast (10% level 1, 30% level 2, 60% level 3) yields \$87.71 per patient-month, with the level-3 weight set to the Qualified Medicare Beneficiary share of the panel.

These are Original Medicare amounts. Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families. With most of the county's Medicare in Medicare Advantage, that contract check is a discovery item, taken up in the working session in Section 14.

3.3 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 12,844 claims over 24 months. In the operating model of Section 12, CoachCare carries the load: enrollment, device logistics, monitoring documentation and billing-ready claim generation inside athenaOne. The health 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 chronic care management; it does not pay advanced primary care management or transitional care management.¹⁹ Medicaid and CHIP cover 40% of the health center's patients, and none of that population is in this forecast. The Medicare forecast on these pages does not include a Medicaid dollar. Section 6 sets out the Florida Medicaid remote-monitoring rail as its own line, scoped separately.

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

4.1 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: an adult-medicine panel bills CCM or APCM, not the single-condition specialist code.

¹⁹ Florida Medicaid Practitioner Fee Schedule, effective October 1, 2025: 99453, 99454, 99457, 99458, 99091, 99490, 99439 and 99484 priced; the advanced-primary-care codes G0556–G0558 and the transitional-care codes 99495 and 99496 absent. HRSA UDS 2025: Medicaid/CHIP 3,830 patients (39.96%).

Program	Who qualifies	What it is	Billing
RPM	611 of the 940 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	376 (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	329 (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 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.

4.2 Nearly the whole panel is dually eligible: why APCM pays more here

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, \$16.38) covers one chronic condition; level 2 (G0557, \$53.45) covers two or more; level 3 (G0558, \$116.73) applies to a Qualified Medicare Beneficiary with two or more. In most panels the level-3 tier is a small minority. Here, 878 of 940 Medicare patients, 93%, are dually eligible, and roughly two in three of the county's dual-eligible beneficiaries hold Qualified Medicare Beneficiary status, so most of the panel maps to the top tier.²⁰ The forecast weights the tiers 10% level 1, 30% level 2 and 60% level 3, which blends to \$87.71 per patient-month. That makes G0558 the single 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 exactly this patient mix.

The service line pays the health center three ways. First, additive revenue: every care-management dollar lands on top of the PPS encounter, not inside it. Second, the quality measures the health center reports and its ACO is scored on, blood-pressure control at 51.86% and diabetes poor control at 31.68%, move on continuous readings and a monthly documented touch. Third, avoided admissions: a patient whose fluid weight climbs for four days is treated by phone and in clinic, not admitted three weeks later. That is where the forecast's 28.4 avoided hospitalizations come from.

²⁰ HRSA UDS 2025: 878 dually eligible of 940 Medicare patients (93%). CMS Medicare Monthly Enrollment, CY2024: in Leon and Gadsden counties, Qualified Medicare Beneficiaries are about 68% of dual-eligible beneficiaries. Value Analysis APCM tier weights 10% / 30% / 60%, blending to \$87.71 per patient-month at the locality amounts; the realized net reimbursement per patient-month across the ramp is \$81.24.

4.3 The Medicare panel it runs on

The forecast is built on **940 Medicare patients**, the health center's own count as reported to HRSA for 2025, Original Medicare and Medicare Advantage together; Medicare Advantage and the 878 duals are already inside it, with no gross-up. From that panel the eligibility model carves the program pools: 611 patients RPM-eligible (65%), 376 CCM-eligible (40%), 329 APCM-eligible (35%). The pools overlap; the coordination rule keeps the billing disjoint.²¹

Per-clinician Medicare density is low, so enrollment runs off condition registries, not an age list: the hypertension, diabetes and HIV registries are the enrollment lists. The health center's own UDS Medicare count has ranged from 856 to 1,278 across recent reporting years, and where it settles is the input that moves every ceiling in Section 5. The Florida Medicaid rail in Section 6 is the second place the program grows, on the far larger Medicaid and uninsured chronic-disease population.

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

Each discharge home from either of the two acute-care hospitals in Tallahassee 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) or 7 days (99496, \$298.60).²² TCM is on the recommended stack and carries no dollars anywhere in this forecast: the health center's discharge volume, the share of discharges that come home to a health-center patient, and visit-scheduling capacity are all discovery items. What TCM does in the forecast is clinical. A discharge is the highest-yield moment to enroll a patient in monitoring, and the three-touch post-discharge cadence in Section 8.5 runs on the same contact the TCM code requires. It is the discharge-to-monitoring loop, never the revenue base.

4.5 Behavioral health integration: the next arm, named

A health center with an in-house behavioral-health division 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.²³ Florida Medicaid covers it too. 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.

4.6 Built the way the codes work: an eight-clinician bench

The health center's adult-medicine bench is **eight clinicians, two physicians and six nurse practitioners and physician assistants**.²⁴ Those eight are the referring bench in the forecast; pediatrics, obstetrics, behavioral, dental and the health center's pharmacist are not counted as referrers. Six of the eight being nurse practitioners or physician assistants is the right shape for this service line, not a constraint. CCM, APCM and RPM are general-supervision code families: qualified clinical staff deliver the monthly work under a billing clinician's overall direction, without that clinician in the room, and the health center's in-house pharmacist, who is also a certified diabetes educator, is a ready billing-supervisor for the diabetes cohort. 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 13 shows the clinician count barely moves the result.

²¹ HRSA UDS 2025 (see note 2). CoachCare Value Analysis eligibility model: RPM 65%, CCM 40%, APCM 35% of the in-scope panel.

²² 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. CMS Hospital General Information, September 2026: two CMS-certified acute-care hospitals in Tallahassee. TCM is carried at zero dollars in every figure in this report.

²³ CPT 99484, CY2026 national non-facility amount \$57.45; covered by Florida Medicaid at \$27.71. BHI is carried at zero dollars in every figure in this report.

²⁴ The health center's provider pages, retrieved September 2026, resolved against NPPES and CMS Quality Payment Program eligibility records: eight adult-medicine clinicians, two physicians and six nurse practitioners and physician assistants, resolving to the health center's billing organization. Pediatrics, obstetrics, behavioral, dental clinicians and the in-house pharmacist are not counted as referrers.

4.7 Staffing: nobody is hired

CoachCare delivers 5,539 hours of care-team work across the 24 months, about **2.66 full-time-equivalent years**, without the health center hiring anyone. The on-site enrollment specialist is CoachCare's expense, not a program cost. For a health center managing a lean footprint, the service line adds working capacity and zero requisitions, and it adds it in the languages 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.

5. Value Analysis: The 24-Month Forecast

5.1 Headline economics

Over 24 months the service line produces **\$854,737 in net reimbursement** to Neighborhood Medical Center. CoachCare's fees total \$492,420, including \$23,458 of ancillary items: implementation, the athenaOne integration and telephonic outreach. Net to the health center is **\$362,317, a 42.39% margin** on the program, 41.59% in Year 1 and 42.99% in Year 2.²⁵

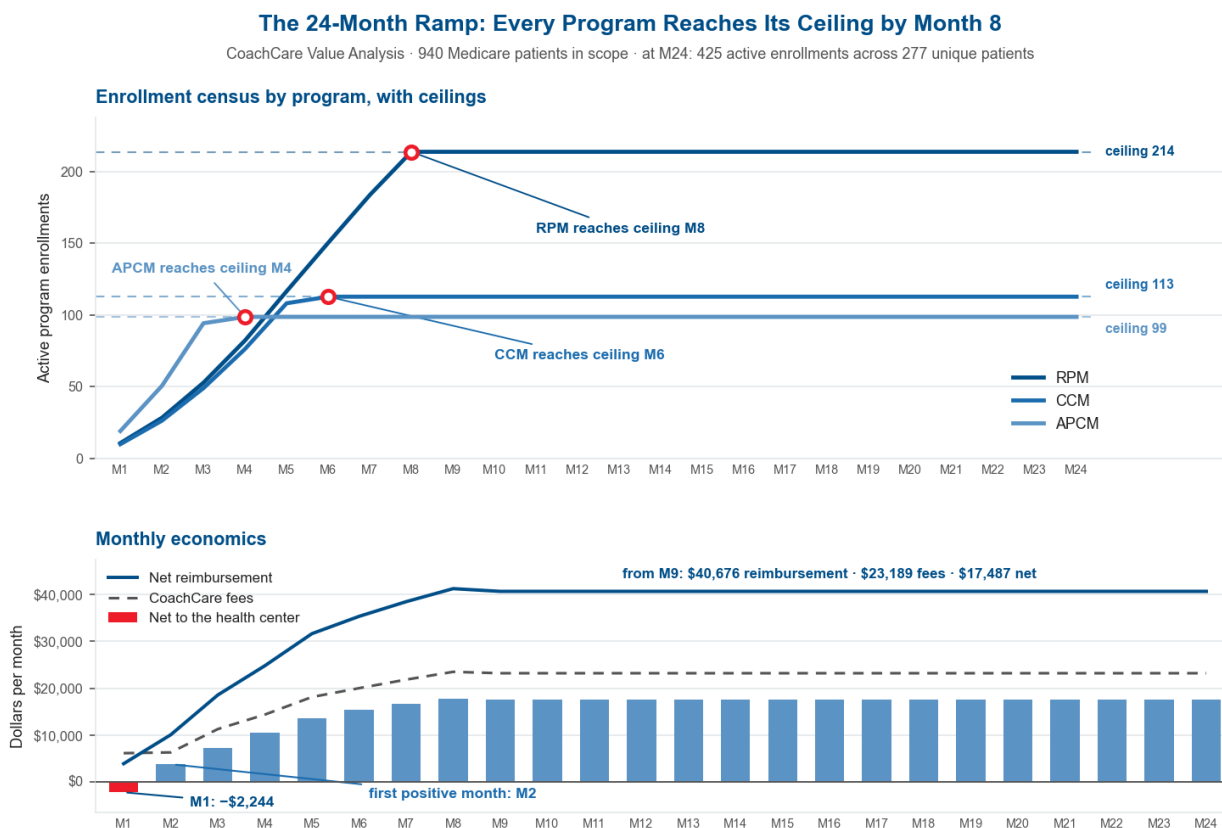


Figure 1. The 24-month ramp: enrollment census by program with ceilings (above) and monthly net reimbursement, CoachCare fees and net to the health center (below). Month 1 nets -\$2,244; the first positive month is M2; from M9 the line holds at \$17,487 net per month.

The shape of the curve is worth reading precisely. Month 1 is negative, -\$2,244, because implementation and enrollment effort land before the first full billing months do. Month 2 turns positive at \$3,761, month 3 nets \$7,284, and the line climbs as the three programs fill: M8, the month RPM reaches its ceiling, is the

²⁵ CoachCare Value Analysis, 24-month forecast: monthly net reimbursement, fees and net-to-health-center series; Year 1 margin 41.59%, Year 2 margin 42.99%, 24-month margin 42.39%, each defined as net to the health center divided by net reimbursement. Ancillary fees of \$23,458 over 24 months: implementation \$2,500; athenaOne integration \$1,000 setup, \$150 a month and \$1.50 per patient-month; telephonic outreach.

peak at \$41,257 of net reimbursement and \$17,771 net; from M9 the line settles at \$40,676 of net reimbursement, \$23,189 of fees and \$17,487 net a month once setup codes fall away and the census holds at ceiling. Month 12 and month 24 are the same month.

5.2 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	\$164,255	\$242,563	\$406,817	\$232,939	\$173,878
CCM	\$116,880	\$149,326	\$266,206	\$132,990	\$133,216
APCM	\$85,490	\$96,223	\$181,713	\$103,033	\$78,680
Ancillary (implementation, integration, outreach)	—	—	—	\$23,458	-\$23,458
All programs	\$366,624	\$488,112	\$854,737	\$492,420	\$362,317

CoachCare Value Analysis, per-program economics by contract year. Ancillary items: implementation \$2,500; athenaOne 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	\$92,629	\$71,625	\$140,310	\$102,253
CCM	\$58,390	\$58,490	\$74,600	\$74,727
APCM	\$48,473	\$37,016	\$54,559	\$41,664

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

RPM is the volume engine at 4,260 patient-months and \$406,817 of net reimbursement. CCM is the yield engine at \$110.32 of net reimbursement per patient-month across 2,413 patient-months, against \$95.49 for RPM and \$81.24 for APCM over its 2,237. APCM earns its place a different way, as Section 4.2 sets out: no minute-tracking, a bundled monthly payment, and the level-3 tier on a panel where nearly every Medicare patient is dually eligible. Year 2 outruns Year 1 by \$121,488 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 \$406,817 · CCM \$266,206 · APCM \$181,713

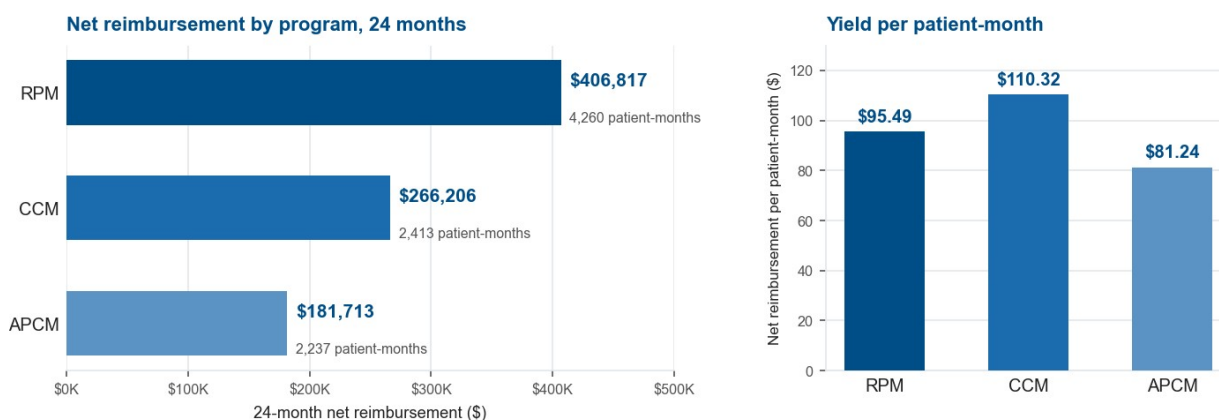


Figure 2. Service-line composition: per-program 24-month net reimbursement and net reimbursement per patient-month.

5.3 The ramp: every ceiling reached by month 8

This account is ceiling-limited in all three programs inside the first year. APCM reaches its ceiling of 99 enrollments in month 4, CCM its 113 in month 6, and RPM its 214 in month 8. From M9 the forecast is flat because there is no one left to add.²⁶ The first 90 days move fast: 40 new enrollments across the three programs in month 1, 66 in month 2, 92 in month 3.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
RPM	611	214	Month 8	214
CCM	376	113	Month 6	113
APCM	329	99	Month 4	99
All programs		425		425 enrollments · 277 unique patients

Enrollment counts are program enrollments, not unique patients; the 425 enrollments at M24 belong to 277 unique patients (277 at M12), because a patient may carry a monitoring enrollment and a care-management enrollment at the same time.

Say the constraint out loud: what binds this program is the size of the Medicare panel, not enrollment capacity, and not clinician count. That cuts two ways. It caps the forecast at a two-year net line around \$362,000, 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: the size of the Medicare panel, which the health center's own UDS counts place between 856 and 1,278 across recent years; the Florida Medicaid remote-monitoring rail in Section 6; and the behavioral-health arm in Section 4.5 once the first three programs are full. The on-site enrollment specialist cannot raise a ceiling, but it reaches every ceiling months sooner, and Section 13 prices what that is worth.

5.4 What the program produces

24-month output	Volume
Claims generated, billing-ready	12,844
Device readings monitored	44,734
Care-management tasks completed	25,688
Chart updates written to athenaOne	6,422
Patient conversations held	3,853 (214 hours of call time)
Care-team hours delivered	5,539 (≈ 2.66 FTE-years)
Hospitalizations avoided	28.4 · ≈ \$426,000 at \$15,000 per admission

CoachCare Value Analysis operational and clinical outputs, 24 months.

The avoided-admission line deserves its own sentence. 28.4 avoided hospitalizations over 24 months is roughly \$426,000 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 hospital.²⁷ It is also what a shared-savings arrangement rewards: a consented, documented, monthly-managed panel with continuous readings, which this service line builds under fee-for-service first.

²⁶ CoachCare Value Analysis enrollment model: program ceilings 214 (RPM), 113 (CCM), 99 (APCM); ceilings reached in months 8, 6 and 4; 425 active enrollments across 277 unique patients at month 24 and at month 12. Dedup: the care-management enrollments plus the RPM enrollments not already carrying a wrapper.

²⁷ CoachCare Value Analysis clinical-outcomes module: 28.4 avoided hospitalizations over 24 months, valued at \$15,000 per avoided admission (about \$426,000).

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

Forty percent of the health center's patients are on Medicaid, and most of its 1,452 hypertensive and 726 diabetic patients are among them. Florida Medicaid pays for remote physiologic monitoring and chronic care management on its practitioner fee schedule, effective October 1, 2025: RPM at 99453 \$14.25, 99454 \$33.96, 99457 \$37.79, 99458 \$30.38 and 99091 \$40.85; CCM at 99490 \$38.09 and 99439 \$34.97; and behavioral health integration at 99484 \$27.71.²⁸ Florida Medicaid does not pay advanced primary care management or transitional care management; those are Medicare-only rails for this account.

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.

One item to confirm with the state sizes the rail: how a health center bills these codes relative to its Medicaid encounter payment. It is the first question of the Medicaid working session, and it decides how much of the far larger Medicaid chronic-disease population the second rail reaches.

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 the bulk of the health center's chronic-disease volume sits, and the same devices, the same escalation engine and the same athenaOne workflow serve it once the registries have been counted by payer.

7. athenaOne Integration: The Program Lives in the Record

The health center runs on athenaOne, and the forecast prices CoachCare's athenaOne integration at the catalog tier: \$1,000 setup, \$150 a month and \$1.50 per patient-month.²⁹ The program operates inside the record rather than beside it. CoachCare's integration uses the workflows already in athenaOne, 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 athenaOne 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. Patients begin receiving services in under five days from the flag.
- **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 athenaOne billing.** The CoachCare billing engine creates the monthly claim lines automatically in athenaOne, the step that makes individual-code billing workable at 12,844 claims over 24 months. The health center's own billing team files the claims with the care-management codes.

²⁸ Florida Medicaid Practitioner Fee Schedule, effective October 1, 2025 (Rule 59G-4.002): 99453 \$14.25, 99454 \$33.96, 99457 \$37.79, 99458 \$30.38, 99091 \$40.85; 99490 \$38.09, 99439 \$34.97; 99484 \$27.71. Transitional care management and advanced primary care management are not on the schedule.

²⁹ EHR as indicated by the patient-portal link on every page of the health center's site (athenahealth / athenaOne), September 2026. CoachCare integration pricing for athenaOne as carried in the Value Analysis: \$1,000 setup, \$150 a month, \$1.50 per patient-month.

- **The discharge feed.** Hospital discharges reach the program from the record, which arms the post-discharge cadence in Section 8.5 without anyone relaying a message; the interface from each Tallahassee hospital is an integration-scope item.

8. Clinical Governance and Escalation

8.1 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, March 2026 edition, rendered as seven process maps covering qualification, monitoring, escalation and discharge.³⁰ The purpose is keeping a patient with heart failure or uncontrolled diabetes at home in the Big Bend, managed in the language the family speaks, rather than in a hospital bed.

8.2 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.

8.3 The emergent pathway

An active emergent symptom reported during any outreach contact triggers the 911 pathway. That policy supersedes any site-specific escalation preference and any quiet window in Section 9: whichever clinic the patient belongs to, whichever day of the week it is, the emergent floor does not move.

8.4 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.

8.5 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 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 28.4 avoided hospitalizations in Section 5.4 are won.

³⁰ CoachCare Care Management Programs standard operating procedures, March 2026 edition, and the seven derived process maps: qualification and device assignment; the RPM patient lifecycle; the care-management lifecycle; alert-and-escalation decision logic; the emergent/urgent communication protocol; the post-discharge follow-up sequence; and the discharge decision flow.

8.6 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.

9. Built for the Big Bend: Community and Operational Design

This program has to be built for the population it serves rather than adapted to it afterward. Two-thirds of the health center's patients are Black, a third are uninsured, and one in seven is homeless; the panel sits in Frenchtown, in rural Gadsden County, and along the corridors between them, with a growing Hispanic share.³¹ 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 password, no home broadband. For a low-income, partly rural panel, that is the difference between a reading and a device in a drawer.
- **Materials and call scripts in English and Spanish.** Patient-facing materials, enrollment scripts and outreach calls are prepared in English and Spanish for the growing Hispanic share, matched to the patient's language of record in athenaOne.
- **Enrollment lists pulled by condition, not by age.** Per-clinician Medicare density is low, so an age-based pull is inefficient. Enrollment lists come from the hypertension, diabetes, heart-failure and HIV 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.
- **Dignity-first, in the health center's own voice.** The outreach voice matches the one the health center already uses with its patients: warm, neighborly, plain. A monthly call that treats a patient as a neighbor is the one that gets answered next month.
- **Enrollment where the patients already are.** The on-site enrollment specialist works the clinic schedule across the health center's sites, enrolling patients at the visit, when a family member is often in the room to help set up the first device.
- **Referrals from the whole adult-medicine floor.** Eight clinicians flag patients in the chart; the in-house pharmacist and diabetes educator feeds the diabetes cohort onto the same list. The flag is the whole clinician workflow.

10. Market Context: Leon and Gadsden County Medicare

The health center's two core counties hold about 63,000 Medicare beneficiaries. Leon County had 51,969 in CY2024 and Gadsden 11,094, and the dual-eligible share is high for the region: 13.9% in Leon and 24.8% in Gadsden, driven by the low-income communities the health center serves.³² In September 2026 Medicare Advantage covered 60.3% of Leon County's Medicare and 71.4% of Gadsden's. Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.

³¹ HRSA UDS 2025: 67% of patients Black or African American, 34.36% uninsured, 15% experiencing homelessness, with a growing Hispanic share served in Spanish. U.S. Census Bureau ACS 2024 five-year: Gadsden County 52.2% Black, 27.9% poverty, 15.7% uninsured.

³² CMS Medicare Monthly Enrollment, CY2024: Leon County 51,969 beneficiaries (Original Medicare 20,882, 40.2%; dual-eligible 13.9%); Gadsden County 11,094 (Original Medicare 3,267, 29.5%; dual-eligible 24.8%). CMS Medicare Advantage State/County Penetration, September 2026 (see note 6).

Leon and Gadsden counties	Value
Medicare beneficiaries, CY2024	Leon 51,969 · Gadsden 11,094
Original Medicare (fee-for-service)	Leon 20,882 (40.2%) · Gadsden 3,267 (29.5%)
Medicare Advantage penetration, September 2026	Leon 60.3% · Gadsden 71.4%
Dual-eligible share of beneficiaries, CY2024	Leon 13.9% · Gadsden 24.8%
Qualified Medicare Beneficiary share of duals	about two in three (68%)
Gadsden County poverty / uninsured (ACS 2024 five-year)	27.9% / 15.7%
Gadsden County, share of residents who are Black	52.2%

CMS Medicare Advantage State/County Penetration, September 2026; CMS Medicare Monthly Enrollment, CY2024; U.S. Census Bureau American Community Survey 2024 five-year estimates, Leon and Gadsden counties.

The market fact that shapes the economics is the dual mix, not the headcount. A panel where nearly every Medicare patient is dually eligible, in a market where two in three duals are Qualified Medicare Beneficiaries, is a panel where the monthly advanced-primary-care code pays its top tier for most of the population, and where the patient owes no cost-share that would slow enrollment.³³

11. 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 same MAC-locality amounts on this account's own billing mix, with enrollment held constant.³⁴

The cascade: one code, one arm, one line

Device supply, 99454 and 99445: \$50.00 → \$39.74 a month, -20.5%. The code CMS proposes to cut.

The remote monitoring arm: \$406,817 over 24 months, -9.1%, -\$36,923. Device supply is 32% of the remote monitoring basket; management time moves little.

Chronic care management: \$266,206, -2.3%, -\$6,068. Advanced primary care management: \$181,713, -0.5%, -\$903. Conversion-factor and relative-value movement only; the proposal does not target these codes. The care-management movement is \$6,971 of the total.

The whole service line: \$854,737 over 24 months, -5.1%, -\$43,894, to \$810,843. Remote monitoring is 48% of the line, and two of the three programs are not the one being repriced.

³³ CMS Medicare Monthly Enrollment, CY2024, Leon and Gadsden counties: Qualified Medicare Beneficiaries are about 68% of dual-eligible beneficiaries. Qualified Medicare Beneficiaries owe no Medicare cost-sharing.

³⁴ CMS-1848-P, proposed CY2027 Physician Fee Schedule (July 2026); comment period closed September 14, 2026. CoachCare repricing at the CY2026 Florida locality 99 amounts on this forecast's code frequencies and APCM tier weights: device supply 99454 and 99445 from \$50.00 to \$39.74 (-20.5%); RPM arm -9.1% (-\$36,923); CCM -2.3% (-\$6,068); APCM -0.5% (-\$903); service line -5.1% (-\$43,894, from \$854,737 to \$810,843). Enrollment held constant. A statutory phase-in caps single-year reductions.

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

Device supply 99454 and 99445: \$50.00 → \$39.74 a month (−20.5%) · the RPM arm −9.1% · the line −5.1%, −\$43,894 of \$854,737

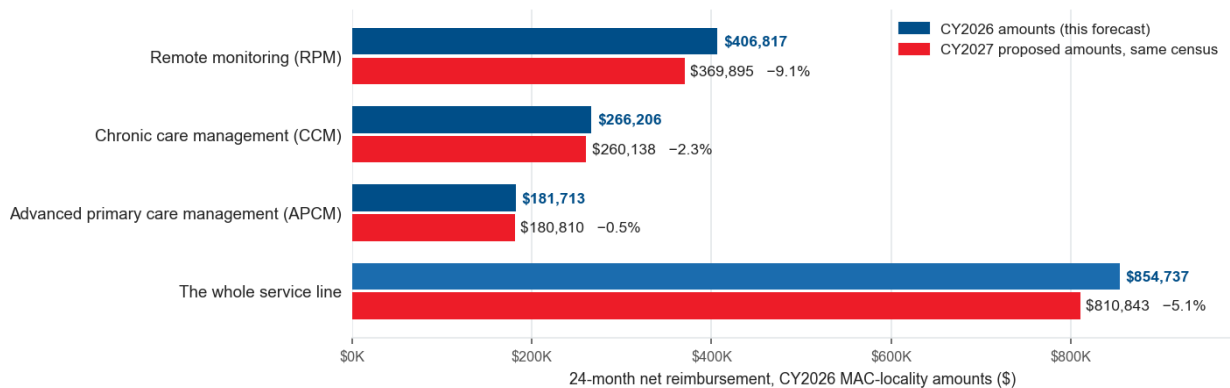


Figure 3. The CY2027 proposed rule on this forecast, at the CY2026 MAC-locality amounts against the CY2027 proposed amounts: each arm and the whole line, same census.

The side-by-side code table below reads the proposed change at the national Addendum B amounts, the figures CMS publishes for comment; the cascade above is priced at the MAC-locality amounts this forecast uses. The two bases do not reconcile to the dollar, by design, because they answer two different questions: what the proposal does to this forecast, and what the proposal does to each published code.³⁵

Code	What it pays for	CY2026 national	CY2027 proposed	Change
99454 / 99445	RPM device supply	\$52.11	\$41.38	−20.6%
99457	RPM management, first 20 min	\$51.77	\$49.59	−4.2%
99470	RPM management, first 10 min	\$26.05	\$20.69	−20.6%
99458	RPM management, additional 20 min	\$41.42	\$40.39	−2.5%
99490	CCM, first 20 min	\$66.13	\$64.04	−3.2%
99439	CCM, additional 20 min	\$50.44	\$49.92	−1.0%
G0557	APCM, level 2	\$53.78	\$53.20	−1.1%
G0558	APCM, level 3 (QMB)	\$117.24	\$116.91	−0.3%

Proposed CY2027 national non-facility amounts (CMS-1848-P, Addendum B) against CY2026, for the codes in this forecast. The device-supply reduction is the one that moves the service line; the care-management codes move a point or two through conversion-factor and relative-value changes the proposal does not target.

12. Implementation and the First 90 Days

12.1 Who runs what

CoachCare delivers	Neighborhood Medical Center keeps
Telephonic and on-site enrollment in English and Spanish; the enrollment specialist is CoachCare's expense	Referral flags in athenaOne; clinical oversight under general supervision
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans and escalation preferences

³⁵ The cascade is priced at the CY2026 Florida locality 99 amounts, the Value Analysis basis; the side-by-side code table reads the proposed change at the national Addendum B amounts CMS publishes for comment. The two bases do not reconcile to the dollar, by design.

CoachCare delivers	Neighborhood Medical Center keeps
Monitoring, documentation and the escalation protocol of Section 8	Responses to clinic-routed escalations; the discharge feed from each hospital
Automated claim creation into athenaOne	Filing the claims with the care-management codes; billing review; the revenue
Monthly operating reports against the dashboard in 12.3	Program governance; the relationship with the ACO

12.2 Model inputs

Input	Value
Medicare panel in scope	940 patients, the health center's UDS 2025 Medicare count; Medicare Advantage and the 878 duals are inside it, with no gross-up
Referring clinicians	8 in adult medicine (2 physicians + 6 nurse practitioners and physician assistants); the in-house pharmacist and diabetes educator feeds the diabetes list and is not counted as a referrer
Programs	RPM + CCM + APCM; TCM and BHI named, not in the forecast; PCM off
Program-eligible pools	RPM 611 · CCM 376 · APCM 329
Enrollment ceilings	RPM 214 (M8) · CCM 113 (M6) · APCM 99 (M4)
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 non-facility Physician Fee Schedule amounts at Florida locality 99; the national amounts a health center bills run slightly above and are carried as a disclosed upside
APCM tier blend	10% level 1 · 30% level 2 · 60% level 3 = \$87.71 per patient-month
Medicare Advantage	60.3% of Leon County's Medicare and 71.4% of Gadsden's (September 2026). Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.
EMR	athenaOne, priced at the catalog integration tier (\$1,000 setup, \$150 a month, \$1.50 per patient-month)

12.3 The 90-day plan and the operating dashboard

Days 0–30: foundation. Program agreement and the athenaOne integration workplan. ICD-10 screening of the Medicare panel per the qualification map, with the hypertension, diabetes and HIV registries by payer, the two inputs that size each rail. Device logistics staged, 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 and in-clinic enrollment running; first devices in homes; first billable service months. Month 1 nets –\$2,244 as implementation lands; month 2 turns positive. The forecast carries 40 new enrollments in month 1 and 66 in month 2.

Days 61–90: scale and file. 92 new enrollments in month 3, APCM at its ceiling, CCM one month 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.

The operating dashboard from month one:

- Enrollment census by program against ceiling (214 / 113 / 99)

- 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 2025 baseline of 51.86% and 31.68%
- Net to the health center per month against the \$17,487 steady-state line

13. Recommendations

1. **Stand up the Medicare service line now, sized honestly.** The individual-code rail has been live since October 2025. This is a \$362,317 two-year net line that fills in eight months; each month of delay pushes it one month further out, and nothing about it waits on a hire.
2. **Build it as the ACO's care infrastructure.** The health center is already in a shared-savings ACO, and this program lifts the two quality measures that arrangement is scored on while it bills as new fee-for-service revenue. Treat the service line as the infrastructure the ACO's up-front funding is meant to buy, and report its quality lift into the ACO.
3. **Lead with APCM on the dual-eligible panel.** Nearly every Medicare patient is dually eligible, and G0558 at \$116.73 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.** Forty percent of the health center's patients are on Medicaid, and Florida Medicaid pays RPM and CCM. 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 the community from the first day.** Cellular devices, materials in English and Spanish, condition-based enrollment lists, and enrollment at the visit across the health center's sites. None of these is a retrofit.
6. **Keep the CoachCare-funded enrollment specialist in the plan.** The specialist cannot raise the ceilings, but reaches them months sooner, and is worth \$138,495 of 24-month net reimbursement against the no-specialist case in the table below; without it, remote monitoring does not fill until month 17.
7. **Make the hospital discharge the front door.** Wire the discharge feed from both Tallahassee 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.
8. **Set the attribution rule at enrollment.** Each patient carries one care-management wrapper, CCM or APCM, never both in a month, plus RPM where indicated and a transitional care episode after a discharge. One rule, set once in the enrollment workflow, prevents every double-billing collision the code families allow.

What moves the number

Scenario	24-month net reimbursement	Net to the health center	Margin	Ceiling reached RPM / CCM / APCM
Base: 940 panel, 8 clinicians, 1 enrollment specialist	\$854,737	\$362,317	42.39%	M8 / M6 / M4
No on-site enrollment specialist	\$716,242	\$302,901	42.29%	M17 / M11 / M6

Scenario	24-month net reimbursement	Net to the health center	Margin	Ceiling reached RPM / CCM / APCM
Second on-site enrollment specialist	\$893,156	\$378,804	42.41%	M6 / M4 / M3
6 referring clinicians	\$842,314	\$357,025	42.39%	M9 / M6 / M4
10 referring clinicians	\$864,213	\$366,357	42.39%	M8 / M5 / M3
Panel 856 (the health center's UDS 2024 Medicare count)	\$786,192	\$332,642	42.31%	M8 / M5 / M3
Panel 1,278 (the health center's UDS 2023 Medicare count)	\$1,112,188	\$473,838	42.60%	M11 / M7 / M4
Billed at the FQHC national amounts (a health center's own rail)	\$864,827	\$372,407	43.06%	M8 / M6 / M4

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

Read the table from the bottom up. The clinician-count rows barely move the result, because every program fills inside the first year on eight referrers. The specialist rows move the timing, not the ceilings. The panel rows are the only rows that move the ceilings, and the panel is the health center's own number to confirm. The national-amounts row is the rail a health center is actually paid on, and it runs slightly above the conservative locality basis this report ships.³⁶

14. 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 5; the session is about the four inputs that would move it, in the order they matter.

- 1. The Medicare panel and its payer mix.** The 940-patient count is the health center's own UDS figure; which plans cover the Medicare Advantage majority, and on what terms they pay the care-management code families, sizes the certain fee-for-service slice against the contract-dependent one.
- 2. The hypertension and diabetes registries by payer.** 1,452 and 726 patients respectively; the Medicare slice sizes the RPM cohort in this forecast, and the Medicaid slice sizes the second rail, along with how a health center bills these codes under Florida Medicaid.
- 3. The care-team roster and the diabetes protocol.** Who on the current staff carries enabling-services, nursing and care-coordination work, and how the in-house pharmacist and diabetes educator would supervise the diabetes cohort.
- 4. The athenaOne product line and interfaces.** Which athenaOne modules the health center runs and which interfaces are available, so the integration workplan and the hospital discharge feeds can be written.

Everything else in this report, the Medicare Advantage contract terms, the discharge feed from each Tallahassee hospital, and how the service line reports its quality lift into the ACO, is a workplan item that follows the session rather than a condition of it.

³⁶ CoachCare Value Analysis recalculations at the same pricing: no on-site enrollment specialist \$716,242 / \$302,901 / 42.29%; second specialist \$893,156 / \$378,804 / 42.41%; 6 clinicians \$842,314 / \$357,025 / 42.39%; 10 clinicians \$864,213 / \$366,357 / 42.39%; panel 856 \$786,192 / \$332,642 / 42.31%; panel 1,278 \$1,112,188 / \$473,838 / 42.60%; billed at the national amounts \$864,827 / \$372,407 / 43.06%. The specialist is worth \$138,495 of 24-month net reimbursement 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.³⁷

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 awardee reporting for 2021–2025 (2025 is the latest, retrieved September 2026), the Health Center Service Delivery Sites file (the active sites across Leon and Gadsden counties), and the health center's Section 330 award and Ryan White Part C grant.
- **CMS Federally Qualified Health Center Enrollments:** six health-center certification numbers under one PECOS associate identifier; corporation incorporated in Florida in 1974; FQHC enrollments dating to 2014.
- **The health center's website,** retrieved September 2026: the adult-medicine, services, locations, hours and careers pages and the site's brand assets; the EHR (athenahealth / athenaOne) as indicated by the patient-portal link on every page.
- **CMS National Plan and Provider Enumeration System,** queried September 2026 for the organization's records and for every clinician named on the health center's provider pages.
- **CMS Quality Payment Program eligibility records, 2025 and 2026,** for every clinician on the adult-medicine roster: the clinicians resolve to the health center's billing organization, each carrying the health center's Medicare Shared Savings Program participation.
- **CMS Medicare Shared Savings Program PY2026 participant file:** the health center is a participant in VitaSavings Florida, an accountable care organization for Florida community health centers, on the one-sided BASIC track, lower-revenue, with advance investment payments, with an initial start date of January 1, 2025.
- **CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024** (released May 2026): the sweep of every remote-monitoring, care-management, advanced-primary-care, transitional-care and behavioral-health-integration code across every clinician on 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 Physician Fee Schedule amounts in addition to the PPS encounter; advanced primary care management adopted for health-center payment; the CY2026 additions 99445 and 99470.

³⁷ CoachCare company statistics, 2026: patients served, managed conditions, providers on the platform, implementations completed, claims generated and vitals recorded.

- **CY2026 Physician Fee Schedule rate files (CMS RVU26A, January 2026 release):** non-facility amounts for the forecast codes at Florida locality 99, and the national non-facility amounts a health center bills, at the \$33.4009 conversion factor.
- **CMS-1848-P, the proposed CY2027 Physician Fee Schedule (July 2026):** the proposed national non-facility amounts used in the Section 11 repricing; comment period closed September 14, 2026.
- **Florida Medicaid:** the Practitioner Fee Schedule effective October 1, 2025 (remote physiologic monitoring, chronic care management and behavioral health integration priced; transitional care management and advanced primary care management absent), and the telehealth coverage rule.
- **CMS Medicare Advantage State/County Penetration, September 2026, and CMS Medicare Monthly Enrollment, CY2024:** Leon and Gadsden county Medicare beneficiaries, Original Medicare and Medicare Advantage shares, dual-eligible counts and the Qualified Medicare Beneficiary share of duals.
- **U.S. Census Bureau American Community Survey 2024 five-year estimates** (profiles DP02, DP03 and DP05), Leon and Gadsden counties and the city of Tallahassee: population, age, income, language and insurance coverage.
- **CMS Hospital General Information and Care Compare, September 2026:** the two CMS-certified acute-care hospitals in Tallahassee, referenced by city only.
- **CoachCare Care Management Programs standard operating procedures, March 2026,** and the seven process maps derived from them: the shared alert-and-escalation decision logic, trend definitions, the emergent communication protocol, three-way routing, the post-discharge three-touch sequence and the discharge decision flow reproduced in Section 8.
- **CoachCare athenaOne 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 athenaOne through the CoachCare billing engine.
- **CoachCare Value Analysis for Neighborhood Medical Center, 2026, and the CY2027 repricing of the same forecast:** every financial, enrollment, clinical-output and operational figure in Sections 3, 5, 11, 12 and 13, built on 940 Medicare patients in scope, 8 referring clinicians, one on-site enrollment specialist, and CY2026 Florida locality 99 non-facility amounts for RPM, CCM and APCM.

How this report counts

Patients and program enrollments are different numbers. At M24 the program holds 425 active program enrollments belonging to 277 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 institutional claim rather than under individual clinicians, so clinician-level Medicare claims files structurally undercount a health-center panel. The 940-patient figure is the Medicare count the health center reported to HRSA for 2025.

No individual is named anywhere in this report. Governance, leadership, clinician composition and the accountable care organization's officers are described by count, role and organization only.