



Monsey Health Center

Community Medical and Dental Care, Inc.

COACHCARE | SERVICE LINE STRATEGY

A HRSA Health Center Program look-alike in Monsey, New York, serving Rockland County in Yiddish, Hebrew, Spanish and Creole from a main campus, a behavioral-health division, a fertility center and a mobile medical unit

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line for the health center's 766 Medicare patients, half of them dually eligible: remote physiologic monitoring, chronic care management and advanced primary care management, billed under the rules that have paid a health center for those codes individually, on top of the PPS encounter, since October 2025, and staffed by CoachCare

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of Monsey Health Center. It brings together the health center's own HRSA record, the Medicare structure of Rockland County, 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 Veradigm integration it lives in, the New York Medicaid rail beside it, and the cultural design a Monsey program has to get right.

The argument is short. Half of this health center's Medicare patients are dually eligible. Since last October, Medicare pays a health center for the month of care between visits as its own codes, at national amounts, on top of every visit, and the dual mix makes the monthly code worth more here than almost anywhere. The panel is small and it fills in seven months. The people to run it are ours.

Prepared by CoachCare for discussion with Monsey Health Center. © 2026 CoachCare.

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Executive Summary

Monsey Health Center is a HRSA Health Center Program look-alike in Monsey, New York, in the Town of Ramapo, Rockland County. It has served the county for over thirty years and grew into behavioral health, fertility care and a mobile medical unit while keeping one main campus on Robert Pitt Drive.¹ Its 2025 Uniform Data System report counts 18,211 patients: 2,103 aged 65 or older, 766 with Medicare as primary payer, 381 of those dually eligible, 12,768 on Medicaid or CHIP, 1,706 with hypertension and 1,172 with diabetes.² It serves patients in Yiddish, Hebrew, Spanish and Creole, and over five reporting years it cut diabetes poor control from 37.88% to 23.46% and lifted depression screening from 19.74% to 62.73%.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 careers page lists internal medicine, nurse practitioner and physician assistant openings and no care-manager or remote-monitoring role. The 1,706 patients with hypertension and 1,172 with diabetes are seen a few times a year; blood-pressure control sits at 64.01%.

Rockland County's Medicare population is 32.68% Medicare Advantage (September 2026), so two-thirds of Medicare here is still Original Medicare, and 21.6% of the county's beneficiaries are dual-eligible.⁵ Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.

The observation this report is built on

Half of this health center's Medicare patients are dually eligible. Since last October, Medicare pays a health center for the month of care between visits as its own codes, at national amounts, on top of every visit, and the dual mix makes the monthly code worth more here than almost anywhere. The panel is small and it fills in seven 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 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 New York Medicaid, which covers 70% of this health center's patients, has paid for remote physiologic monitoring since January 2025.⁷

¹ HRSA Health Center Program: look-alike LALCS00146 (Health Center Program look-alike, designated August 1, 2013). The health center's own site: opened 1993; adult medicine, pediatrics, endocrinology, obstetrics and gynecology, behavioral health, dental, vision and other specialties; a behavioral-health division at a second Monsey address; a fertility center in Suffern; a mobile medical unit.

² HRSA Uniform Data System, look-alike LALCS00146, reporting year 2025: total patients 18,211; aged 65 and over 2,103 (11.55%); Medicare 766 (4.21%); dually eligible 381; Medicaid/CHIP 12,768 (70.11%); hypertension 1,706 (19.83% of medical patients); diabetes 1,172 (14.28%); medical patients 11,052; dental 7,978; mental health 954.

³ HRSA UDS 2021 and 2025 clinical quality measures: diabetes A1c above 9% or untested 37.88% (2021) to 23.46% (2025); depression screening and follow-up 19.74% to 62.73%; statin therapy 25.99% to 74.21%; controlling high blood pressure 59.01% to 64.01%. Languages as advertised on the health center's site: English, Spanish, Yiddish, Hebrew, French Creole.

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 lines under the health center. FQHC visits and care management billed on the FQHC claim do not appear in this professional-claims file.

⁵ CMS Medicare Advantage State/County Penetration, September 2026: Rockland County, 60,807 eligibles, 19,873 enrolled in Medicare Advantage (32.68%). CMS Medicare Monthly Enrollment, CY2024: 58,705 beneficiaries, 40,159 in Original Medicare, 12,693 dual-eligible (21.6%).

⁶ CY2025 Physician Fee Schedule Final Rule (CMS-1807-F, 89 FR 97710): rural health clinics and Federally Qualified Health Centers report the individual CPT and HCPCS codes for care management in place of G0511, paid at national non-facility Physician Fee Schedule amounts in addition to the PPS encounter; G0511 retired September 30, 2025 after a transition period; advanced primary care management adopted on the same basis. CY2026 Final Rule (CMS-1832-F) for 2026 dates of service.

⁷ New York State Medicaid Update, October 2024 (Vol. 40, No. 11): CPT 99457 covered from January 1, 2025, with Medicaid managed-care plans required to comply from March 1, 2025. HRSA UDS 2025: Medicaid/CHIP 12,768 of 18,211 patients (70.11%).

What the Value Analysis returns

The forecast prices a service line for the health center's own Medicare panel, 766 patients as reported to HRSA for 2025, Original Medicare and Medicare Advantage together, referred by the eight internists, physician assistants and nurse practitioners in adult medicine, 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	\$302,940	\$386,574	\$689,514
CoachCare fees	\$176,911	\$217,611	\$394,522
Net to the health center	\$126,029	\$168,963	\$294,992
Margin to the health center	41.60%	43.71%	42.78%

CoachCare Value Analysis. CY2026 national non-facility Physician Fee Schedule amounts, the rail a health center bills care-management codes on. 766 Medicare patients in scope; RPM + CCM + APCM. Margin is net to the health center divided by net reimbursement.

- 1. This is a \$295,000 two-year net line on a 766-patient panel, and it fills in seven months.** It is not a seven-figure program, and the report does not dress it as one. Every program reaches its ceiling inside the first year: APCM in M3, CCM in M5, RPM in M7. At M24 the program holds 347 active program enrollments across 226 unique patients, the same census it holds at M12. The binding constraint is the size of the Medicare panel, not enrollment capacity or clinician count.
- 2. The program funds itself from the second month.** Month 1 nets -\$3,736 to the health center, because implementation lands before enrollment revenue does. The first positive month is M2, at \$3,511. From M8 the service line runs at \$32,214 in monthly net reimbursement and \$14,080 net to the health center.
- 3. The dual mix is the wedge.** 381 of the 766 Medicare patients are dually eligible. Advanced primary care management pays its highest tier, G0558 at \$117.24 a month, for Qualified Medicare Beneficiaries, which puts the APCM blend here at \$70.37 per patient-month and makes G0558 the best-paying monthly code on the page.
- 4. Nobody is hired.** CoachCare delivers 4,622 hours of care-team work over 24 months, about 2.2 full-time-equivalent years, including an on-site enrollment specialist carried at CoachCare's expense, for a health center currently recruiting an internist, a nurse practitioner and a physician assistant. No capital outlay and no new requisition.
- 5. The growth is in the panel, and the report says where.** The health center reports 2,103 patients aged 65 and over against 766 with Medicare as primary payer; reconciling those two numbers by payer is discovery item one, and it is the input that moves every ceiling. The second rail is New York Medicaid remote monitoring, sized separately from the health center's own hypertension and diabetes registries, where most of its chronic-disease volume sits.
- 6. The clinical return is concrete.** The forecast projects 23.9 avoided hospitalizations over 24 months, roughly \$358,000 at \$15,000 per admission, from 37,570 device readings worked through one escalation protocol, with the discharge from either Rockland County hospital as one trigger.

⁸ CoachCare Value Analysis for Monsey Health Center, 2026. Basis: CY2026 national non-facility Physician Fee Schedule amounts; 766 Medicare patients in scope; 8 referring clinicians; RPM, CCM and APCM.

1. The Health Center Today

1.1 Thirty years in Rockland County, in four languages

Monsey Health Center, the legal entity Community Medical and Dental Care, Inc., opened in 1993 and has held HRSA Health Center Program look-alike status since August 2013. It is enrolled with Medicare as a Federally Qualified Health Center and carries a facility shortage-area designation with a score of 12.⁹ HRSA lists three active sites: the main campus on Robert Pitt Drive, a mobile medical unit added in 2022, and a fertility center in Suffern added to scope in 2025; the health center's own site adds a behavioral-health division at a second Monsey address.¹⁰ The patient base is young, Medicaid-dominant and multilingual: 70% of patients are on Medicaid or CHIP, 42% have limited English proficiency, and the health center advertises care in English, Spanish, Yiddish, Hebrew and French Creole.

UDS 2025	Count	What it means for the service line
Total patients	18,211	Medical 11,052 · dental 7,978 · mental health 954
Medicare patients	766 (4.21%)	The panel this forecast runs on; Medicare Advantage and the 381 duals are inside it
Aged 65 and over	2,103 (11.55%)	Nearly three times the Medicare-primary count; the payer reconciliation is discovery item one
Dually eligible	381	Half the Medicare panel; the APCM level-3 tier
Medicaid and CHIP	12,768 (70.11%)	Outside the Medicare forecast; New York Medicaid pays for remote monitoring (Section 5)
Hypertension	1,706 (19.83% of medical patients)	The RPM cohort; blood-pressure control 64.01%
Diabetes	1,172 (14.28%)	Glucose monitoring; A1c poorly controlled in 23.46%
Patient support services	2,212, up from 471 in 2024	The enabling-services layer a monthly documented touch builds on

HRSA Uniform Data System, look-alike LALCS00146, reporting years 2021–2025 (2025 is the latest).

1.2 Quality the record can verify

The five-year quality trend is the earned compliment. Between the 2021 and 2025 reports the share of diabetic patients with poorly controlled or untested A1c fell from 37.88% to 23.46%, a 14-point improvement that puts the health center in HRSA's second quartile among look-alikes. Depression screening and follow-up rose from 19.74% to 62.73%. Statin therapy for cardiovascular prevention went from 25.99% to 74.21%. Blood-pressure control reached 64.01%, up from 59.01%, and it is the measure a monitoring program moves most directly.¹¹ A health center that has already moved its diabetes measure 14 points has shown it can change a number; the between-visit gap is what remains.

Clinical quality measure, UDS	2021	2025	HRSA quartile 2025
Controlling high blood pressure	59.01%	64.01%	3
Diabetes: A1c above 9% or untested (lower is better)	37.88%	23.46%	2

⁹ CMS Federally Qualified Health Center Enrollments, July 17, 2026 vintage: CCN 331887, one PECOS associate identifier, corporation incorporated September 19, 1996 in New York. HRSA primary-care HPSA file: FQHC look-alike facility designation, score 12, designated August 1, 2013, updated March 30, 2026.

¹⁰ HRSA Health Center Service Delivery and Look-Alike Sites file, pulled September 22, 2026: three active records (the main campus, a mobile van added May 2022, and the Suffern clinic added June 2025). The behavioral-health division appears on the health center's site footer and as an organization record in NPPES (September 2024).

¹¹ HRSA UDS clinical quality measures, reporting years 2021–2025, with HRSA's adjusted quartile ranking among look-alikes for 2025: controlling high blood pressure 64.01% (quartile 3); diabetes A1c above 9% or untested 23.46% (quartile 2); statin therapy 74.21% (quartile 4); aspirin or antiplatelet therapy 72.83% (quartile 3); depression screening 62.73% (quartile 4); adult BMI screening 68.28% (quartile 3); early entry into prenatal care 86.81% (quartile 1).

Clinical quality measure, UDS	2021	2025	HRSA quartile 2025
Statin therapy for cardiovascular prevention	25.99%	74.21%	4
Aspirin or antiplatelet therapy for vascular disease	54.97%	72.83%	3
Depression screening and follow-up	19.74%	62.73%	4
Adult BMI screening and follow-up	18.59%	68.28%	3
Early entry into prenatal care	89.01%	86.81%	1

HRSA Uniform Data System clinical quality measures, 2021 and 2025, with HRSA's adjusted quartile ranking among look-alikes (1 is best).

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.¹² CMS suppresses any provider-and-code line under 11 beneficiaries, and care management billed on the health center's own claim does not appear in that professional-claims file at all, so the precise finding is that there is **no remote-care or care-management program at meaningful scale in CY2024 claims**.

The rest of the record points the same way, and it is a structural observation rather than a criticism. The careers page in September 2026 advertised for an internal medicine physician, an adult nurse practitioner, an adult physician assistant, a dermatologist, midwives, therapists and receptionists, and no care manager, care coordinator or remote-monitoring role.¹³ What the record does show is a health center building the layer beneath a program: patient support services rose from 471 to 2,212 patients between the 2024 and 2025 reports. A monthly documented touch in Yiddish, Spanish or Creole reaches patients an office schedule does not, and that is the layer this service line builds on.

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

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

Federally Qualified Health Centers are paid a prospective payment per qualifying encounter. For years, everything a health center did for chronic patients between those encounters was compressed into one bundled monthly code, G0511, one flat payment regardless of how many services, minutes or programs a patient carried. That code was retired on September 30, 2025. From October 1, 2025 a health center reports the individual CPT and HCPCS codes, the CCM, RPM and APCM families among them, and Medicare pays each at the **national non-facility Physician Fee Schedule amount, in addition to the PPS encounter**.¹⁴

CY2026 also added two codes that matter for a health center whose patients are discharged from either of the two acute-care hospitals in Rockland County: 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 \$65,253 of gross

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

¹³ The health center's careers page and job board, retrieved September 22, 2026: postings for an internal medicine physician, an adult family nurse practitioner, an adult physician assistant, a dermatologist, a midwife, an obstetrician-gynecologist, occupational and speech therapists, a quality improvement director, and reception roles. HRSA UDS: patient support services 471 (2024) and 2,212 (2025).

¹⁴ CMS-1807-F (see note 6): G0511 retired with a transition period through September 30, 2025; from October 1, 2025 the individual codes are the standing requirement. CMS-1832-F added the APCM behavioral-health add-on codes for health centers effective January 1, 2026.

reimbursement over 24 months, about 9.5% of net reimbursement, revenue that did not exist a year ago.¹⁵

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

2.2 What the codes pay a health center

The Value Analysis is priced at the national amounts a health center is paid for these codes: the CY2026 non-facility Physician Fee Schedule at the national conversion factor with no geographic adjustment. That is the rail a health center bills care-management codes on, and it is the only basis on any page of this report.¹⁶

Code	What it pays for	Cadence	CY2026 national amount
99453	RPM setup and patient education	One-time	\$21.71
99454	Device supply, 16–30 days of readings	Monthly	\$52.11
99445	Device supply, 2–15 days of readings (new 2026)	Monthly	\$52.11
99457	RPM management, first 20 minutes	Monthly	\$51.77
99470	RPM management, first 10 minutes (new 2026)	Monthly	\$26.05
99458	RPM management, each additional 20 minutes	Monthly	\$41.42
99490	CCM, first 20 minutes of clinical staff time	Monthly	\$66.13
99439	CCM, each additional 20 minutes	Monthly	\$50.44
G0556	APCM, level 1: one chronic condition	Monthly	\$16.37
G0557	APCM, level 2: two or more chronic conditions	Monthly	\$53.78
G0558	APCM, level 3: Qualified Medicare Beneficiary	Monthly	\$117.24
99495	Transitional care management, moderate complexity	Per discharge	\$220.11 (named, not in the forecast)
99496	Transitional care management, high complexity	Per discharge	\$298.60 (named, not in the forecast)
99484	Behavioral health integration, first 20 minutes	Monthly	\$57.45 (named, not in the forecast)

CY2026 national non-facility Physician Fee Schedule amounts, the Value Analysis basis. The APCM tier blend in the forecast (15% level 1, 50% level 2, 35% level 3) yields \$70.37 per patient-month, with the level-3 weight set to the Qualified Medicare Beneficiary share implied by 381 duals in a panel of 766.

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 two-thirds of the county's Medicare still in Original Medicare, that contract check is a discovery item, not a load-bearing assumption.

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 10,721 claims

¹⁵ CoachCare Value Analysis, Financial Value detail: 99445 and 99470 together carry \$65,253 of gross reimbursement over 24 months against \$689,514 of net reimbursement (9.5%), on this forecast's code frequencies. CMS Hospital General Information, September 2026: two CMS-certified acute-care hospitals in Rockland County.

¹⁶ CY2026 Physician Fee Schedule national non-facility amounts (CMS RVU26A, January 2026 release): total non-facility relative value units times the \$33.4009 conversion factor, with every geographic practice cost index at 1.000. Health centers bill the care-management codes at the national amount regardless of the locality their ZIP code falls in.

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 Veradigm. The health center's own billing team files the FQHC 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. New York Medicaid pays for remote physiologic monitoring and does not pay CCM, APCM, TCM or BHI.¹⁷ Medicaid and CHIP cover 70% 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 5 sets out the Medicaid remote-monitoring rail as its own line, scoped separately.

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

3.1 The clinical and billing stack

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

Program	Who qualifies	What it is	Billing
RPM	498 of the 766 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	306 (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	268 (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 Rockland County 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.

3.2 Half the 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, \$16.37) covers one chronic condition; level 2 (G0557, \$53.78)

¹⁷ eMedNY physician fee schedule, Physician Medicine tab, effective July 1, 2026: 99457, 99470, 99091, 99453 and 99454 listed; 99490, 99439, 99491, G0556–G0558, 99495, 99496 and 99484 absent. HRSA UDS 2025: Medicaid/CHIP 12,768 patients (70.11%).

covers two or more; level 3 (G0558, \$117.24) applies to a Qualified Medicare Beneficiary with two or more. In most panels the level-3 tier is a small minority. Here, 381 of 766 Medicare patients, 49.7%, are dually eligible, and roughly two-thirds of Rockland County's duals hold Qualified Medicare Beneficiary status.¹⁸ The forecast weights the tiers 15% level 1, 50% level 2 and 35% level 3, which blends to \$70.37 per patient-month. That makes G0558 the single best-paying monthly code on the page and the reason APCM earns its place beside CCM on a panel this size: 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 UDS measures the health center will defend next year, blood-pressure control at 64.01% and diabetes poor control at 23.46%, 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 23.9 avoided hospitalizations come from.

3.3 The Medicare panel it runs on

The forecast is built on **766 Medicare patients**, the health center's own count as reported to HRSA for 2025, Original Medicare and Medicare Advantage together; Medicare Advantage and the 381 duals are already inside it, with no gross-up. From that panel the eligibility model carves the program pools: 498 patients RPM-eligible (65%), 306 CCM-eligible (40%), 268 APCM-eligible (35%). The pools overlap; the coordination rule keeps the billing disjoint.¹⁹

The same report counts 2,103 patients aged 65 and over, nearly three times the Medicare-primary figure. UDS assigns each patient one primary payer, so the gap is made of patients whose Medicare sits behind another primary coverage in the health center's records, or of patients the Medicare line does not capture. Which it is, and how many of the 2,103 carry Medicare at all, is the first question of the working session in Section 13, because it is the input that moves every ceiling in Section 4.

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

Each discharge home from either of the two acute-care hospitals in Rockland County 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).²⁰ TCM is on the recommended stack for that reason, and it 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 7.5 runs on the same contact the TCM code requires. It is the discharge-to-monitoring loop, never the revenue base.

3.5 Behavioral health integration: the next arm, named

A health center with an in-house behavioral-health division, 954 mental-health patients in its 2025 report, and a depression-screening rate that tripled in five years 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.²¹ It is the same infrastructure, the same monthly cadence and the same billing engine, applied to a population the health center already treats. This

¹⁸ HRSA UDS 2025: 381 dually eligible of 766 Medicare patients (49.7%). CMS Medicare Monthly Enrollment, CY2024, Rockland County: 12,693 dual-eligible beneficiaries, of whom 8,302 are Qualified Medicare Beneficiaries with full Medicaid and 738 Qualified Medicare Beneficiaries only (about two-thirds). Value Analysis APCM tier weights 15% / 50% / 35%, blending to \$70.37 per patient-month at the national amounts.

¹⁹ HRSA UDS 2025 (see note 2). CoachCare Value Analysis eligibility model: RPM 65%, CCM 40%, APCM 35% of the in-scope panel.

²⁰ 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 Rockland County. TCM is carried at zero dollars in every figure in this report.

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: an eight-clinician bench

The health center's adult-medicine page lists eight clinicians: five internists, two physician assistants and one nurse practitioner, with two endocrinologists alongside as chronic-disease feeders.²² Those eight are the referring bench in the forecast; pediatrics, obstetrics, behavioral, dental and vision clinicians are excluded, and the two endocrinologists are not counted as referrers. Three of the eight are physician assistants or 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 4,622 hours of care-team work across the 24 months, about **2.2 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 with an internist, a nurse practitioner and a physician assistant requisition open at once, the service line adds the working capacity of two hires and zero requisitions, and it adds them 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.

4. Value Analysis: The 24-Month Forecast

4.1 Headline economics

Over 24 months the service line produces **\$689,514 in net reimbursement** to Monsey Health Center. CoachCare's fees total \$394,522, including \$22,049 of ancillary items: implementation, the Veradigm integration and telephonic outreach. Net to the health center is **\$294,992, a 42.78% margin** on the program, 41.60% in Year 1 and 43.71% in Year 2.²³

²¹ HRSA UDS 2025: mental-health patients 954; depression screening and follow-up 62.73% (19.74% in 2021). CPT 99484, CY2026 national non-facility amount \$57.45. BHI is carried at zero dollars in every figure in this report.

²² The health center's adult-medicine page, retrieved September 2026: five internal medicine physicians, two physician assistants and one family nurse practitioner; the endocrinology page: two endocrinologists. Each name resolved against NPPES; clinicians enumerated at the campus address but absent from the current page are not counted.

²³ CoachCare Value Analysis, 24-month forecast: monthly net reimbursement, fees and net-to-health-center series; Year 1 margin 41.60%, Year 2 margin 43.71%, 24-month margin 42.78%, each defined as net to the health center divided by net reimbursement. Ancillary fees of \$22,049 over 24 months: implementation \$2,500; Veradigm integration \$2,400 setup, \$150 a month and \$1.50 per patient-month; telephonic outreach.

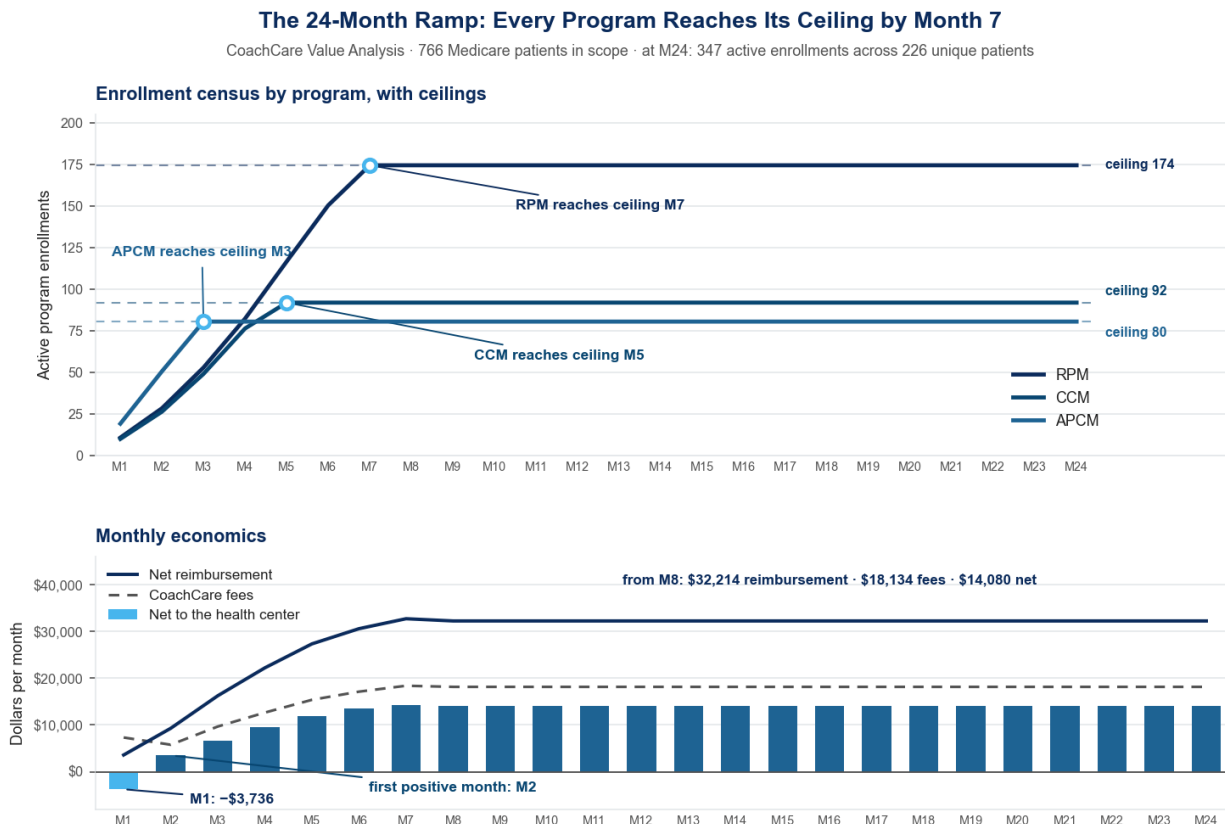


Figure 1. The 24-month ramp: enrollment census by program with ceilings (above) and monthly net reimbursement, CoachCare fees and net to the health center (below). Month 1 nets -\$3,736; the first positive month is M2; from M8 the line holds at \$14,080 net per month.

The shape of the curve is worth reading precisely. Month 1 is negative, -\$3,736, because implementation and enrollment effort land before the first full billing months do. Month 2 turns positive at \$3,511, month 3 nets \$6,576, and the line climbs as the three programs fill: M7, the month RPM reaches its ceiling, is the peak at \$32,691 of net reimbursement and \$14,320 net; from M8 the line settles at \$32,214 of net reimbursement, \$18,134 of fees and \$14,080 net a month once setup codes fall away and the census holds at ceiling. 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	\$146,783	\$201,682	\$348,465	\$195,634	\$152,831
CCM	\$99,212	\$122,001	\$221,213	\$110,083	\$111,131
APCM	\$56,945	\$62,891	\$119,836	\$66,756	\$53,079
Ancillary (implementation, integration, outreach)	—	—	—	\$22,049	-\$22,049
All programs	\$302,940	\$386,574	\$689,514	\$394,522	\$294,992

CoachCare Value Analysis, per-program economics by contract year. Ancillary items: implementation \$2,500; Veradigm integration \$2,400 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	\$81,274	\$65,510	\$114,361	\$87,321
CCM	\$49,371	\$49,841	\$60,711	\$61,290
APCM	\$31,722	\$25,223	\$35,034	\$27,857

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

RPM is the volume engine at 3,578 patient-months and \$348,465 of net reimbursement. CCM is the yield engine at \$110.75 of net reimbursement per patient-month across 1,997 patient-months, against \$97.39 for RPM and \$65.19 for APCM over its 1,838. APCM earns its place a different way, as Section 3.2 sets out: no minute-tracking, a bundled monthly payment, and the level-3 tier on a panel where half the Medicare patients are dually eligible. Year 2 outruns Year 1 by \$83,634 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 \$348,465 · CCM \$221,213 · APCM \$119,836

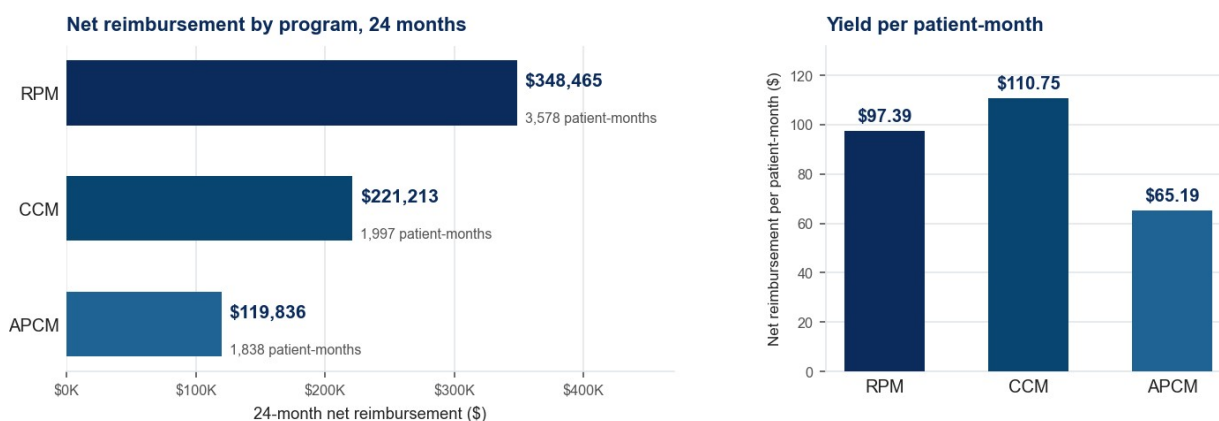


Figure 2. Service-line composition: per-program 24-month net reimbursement and net reimbursement per patient-month.

4.3 The ramp: every ceiling reached by month 7

This account is ceiling-limited in all three programs inside the first year. APCM reaches its ceiling of 80 enrollments in month 3, CCM its 92 in month 5, and RPM its 174 in month 7. From M8 the forecast is flat because there is no one left to add.²⁴ The first 90 days move fast: 40 new enrollments across the three programs in month 1, 66 in month 2, 79 in month 3.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
RPM	498	174	Month 7	174
CCM	306	92	Month 5	92
APCM	268	80	Month 3	80
All programs		347		347 enrollments · 226 unique patients

Enrollment counts are program enrollments, not unique patients; the 347 enrollments at M24 belong to 226 unique patients (226 at M12), because a patient may carry a monitoring enrollment and a care-management enrollment at the same time.

²⁴ CoachCare Value Analysis enrollment model: program ceilings 174 (RPM), 92 (CCM), 80 (APCM); ceilings reached in months 7, 5 and 3; 347 active enrollments across 226 unique patients at month 24 and at month 12. Dedup: the care-management enrollments plus the RPM enrollments not already carrying a wrapper.

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 under \$300,000, 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 Medicare payer reconciliation of the 2,103 patients aged 65 and over against the 766 Medicare-primary count, the New York Medicaid remote-monitoring rail in Section 5, and the behavioral-health arm in Section 3.5 once the first three programs are full. The on-site enrollment specialist cannot raise a ceiling, but it reaches every ceiling months sooner, and Section 12 prices what that is worth.

4.4 What the program produces

24-month output	Volume
Claims generated, billing-ready	10,721
Device readings monitored	37,570
Care-management tasks completed	21,442
Chart updates written to Veradigm	5,361
Patient conversations held	3,216 (179 hours of call time)
Care-team hours delivered	4,622 (≈ 2.2 FTE-years)
Hospitalizations avoided	23.9 · ≈ \$358,000 at \$15,000 per admission

CoachCare Value Analysis operational and clinical outputs, 24 months.

The avoided-admission line deserves its own sentence. 23.9 avoided hospitalizations over 24 months is roughly \$358,000 of cost that never lands on anyone: not on Medicare, not on the plans that cover a third of the county, and not on a bed in either Rockland County hospital.²⁵ It is also the entry requirement for every accountable-care arrangement: a consented, documented, monthly-managed panel with continuous readings, which this service line builds under fee-for-service first.

5. The Second Rail: New York Medicaid Pays for Remote Monitoring

Seventy percent of the health center's patients are on Medicaid, and most of its 1,706 hypertensive and 1,172 diabetic patients are among them. New York Medicaid pays for remote physiologic monitoring on its physician fee schedule: 99457 at \$41.80, covered since January 1, 2025, with managed-care plans required to comply from March 1, 2025; 99470 at \$22.42, covered since January 1, 2026; 99091 at \$48.84; 99454 at \$49.40; and 99453 at \$16.98, on the fee schedule effective July 1, 2026.²⁶ A health center on the state's Ambulatory Patient Group methodology can bill them, and this health center has been on the state's APG opt-in list since 2014.²⁷ New York Medicaid does not pay CCM, APCM, TCM or BHI.

²⁵ CoachCare Value Analysis clinical-outcomes module: 23.9 avoided hospitalizations over 24 months, valued at \$15,000 per avoided admission (≈\$358,000).

²⁶ New York State Medicaid Update, October 2024 (Vol. 40, No. 11); Medicaid Update special edition, January 2023 (99091); NYS Medicaid Telehealth Policy Manual, July 2026 (99470 from January 1, 2026); eMedNY physician fee schedule effective July 1, 2026: 99457 \$41.80, 99470 \$22.42, 99091 \$48.84, 99454 \$49.40, 99453 \$16.98.

²⁷ New York State Department of Health, FQHC Ambulatory Patient Group opt-in list: the health center (operating certificate 4353204) opted in for every period from January 1, 2014 through 'January 1, 2024 and forward'. Medicaid Update, January 2023: health centers that have opted out of APGs cannot bill remote physiologic monitoring; those on APGs bill through the APG fee schedule.

How the Medicaid rail is handled in this report

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

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

The point for the executive team is the order of operations. The Medicare service line is built first because its rail is explicit and it is ready to bill. The Medicaid rail is where the health center's chronic-disease volume sits, and the same devices, the same escalation engine and the same Veradigm workflow serve it once the registries have been counted by payer.

6. Veradigm Integration: The Program Lives in the Record

The health center runs on Veradigm, and the forecast prices CoachCare's Veradigm integration at the catalog tier: \$2,400 setup, \$150 a month and \$1.50 per patient-month.²⁸ The program operates inside the record rather than beside it. CoachCare's integration uses the workflows already in Veradigm, 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 Veradigm 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 Veradigm Practice Management.** The CoachCare billing engine creates the monthly claim lines automatically in Veradigm Practice Management, the step that makes individual-code billing workable at 10,721 claims over 24 months. The health center's own billing team files the FQHC claims with the care-management codes.
- **The discharge feed.** Hospital discharges reach the program from the record, which arms the post-discharge cadence in Section 7.5 without anyone relaying a message; the interface from each Rockland County hospital is an integration-scope item.

7. Clinical Governance and Escalation

7.1 A monitoring program is a clinical operation first

A monitoring program is a clinical operation before it is a revenue line. This section sets out the machinery the health center inherits on the first day of the program: CoachCare's Care Management Programs standard operating procedures, March 2026 edition, rendered as seven process maps covering qualification, monitoring, escalation and discharge.²⁹ The purpose is keeping a patient with heart failure or uncontrolled diabetes at home in Monsey, managed in the language the family speaks, rather than in a hospital bed.

²⁸ EHR as stated by the health center (Veradigm), September 2026; the patient-portal link on every page of the health center's site resolves to Veradigm's portal. CoachCare integration pricing for Veradigm as carried in the Value Analysis: \$2,400 setup, \$150 a month, \$1.50 per patient-month.

²⁹ CoachCare Care Management Programs standard operating procedures, March 2026 edition, and the seven derived process maps: qualification and device assignment; the RPM patient lifecycle; the care-management lifecycle; alert-and-escalation decision logic; the emergent/urgent communication protocol; the post-discharge follow-up sequence; and the discharge decision flow.

7.2 One shared escalation engine

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

7.3 The emergent pathway

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

7.4 Qualification, device assignment and routing

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

7.5 The post-discharge cadence

A hospitalization within the last 60 days fires a fixed three-touch follow-up sequence: a first contact on day 1 or 2, a second on days 5 to 8, and a third on days 12 to 14. Each touch is documented, and any clinical alert surfaced during a touch escalates under the same shared logic; the post-discharge window gets more contact, not a different rulebook. For a discharge from either Rockland County 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 23.9 avoided hospitalizations in Section 4.4 are won.

7.6 Discharge governance and continuity

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

8. Built for Monsey: Cultural and Operational Design

Monsey is unlike any other place CoachCare runs a program, and the program has to be built for it rather than adapted to it afterward. The community's median age is 16.1; 81% of residents speak a language other than English at home, 78% of them a Yiddish-family language; the health center keeps the Sabbath and opens on Sundays.³⁰ Six design decisions follow.

³⁰ U.S. Census Bureau ACS 2024 five-year estimates, Monsey census-designated place: population 28,160; median age 16.1; 81.2% speaking a language other than English at home; 78.0% other Indo-European languages (the Yiddish family); 41.4% speaking English less than very well. The health center's published hours: Monday to Thursday 8 a.m. to 9 p.m., Friday to mid-afternoon, no Saturday hours, Sunday 9 a.m. to 5 p.m.

- **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. In a community where many households do not carry a smartphone, that is the difference between a reading and a device in a drawer.
- **Device instructions and call scripts in Yiddish, Hebrew, Spanish and Creole.** Patient-facing materials, enrollment scripts and outreach calls are prepared in the four languages the health center already advertises, matched to the patient's language of record in Veradigm.
- **Sabbath and holiday quiet windows, with the escalation pathway running regardless.** No outbound calls and no non-urgent alert follow-up from Friday afternoon through Saturday night or on Jewish holidays, on a calendar set with the health center. The emergent pathway in Section 7.3 runs every hour of every day; a critical reading on a Saturday is escalated the same way as on a Tuesday. Only the routine contact waits.
- **Sunday hours used for enrollment.** The health center's Sunday clinic day is an enrollment day: the on-site enrollment specialist works the Sunday schedule, when families bring older relatives to the clinic.
- **Enrollment lists pulled by condition, not by age.** In a panel whose median age is 16, an age-based pull finds almost nobody. 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.
- **Referrals from the whole adult-medicine floor.** Eight internists, physician assistants and nurse practitioners flag patients in the chart; the two endocrinologists see the diabetes cohort and feed the same list. The flag is the whole clinician workflow.

9. Market Context: Rockland County Medicare

Rockland County had 58,705 Medicare beneficiaries in CY2024, 40,159 of them in Original Medicare and 12,693 (21.6%) dually eligible, a high dual share for a county with a \$109,959 median household income, driven by the low-income clusters in Monsey, New Square and Spring Valley.³¹ In September 2026 the county's Medicare population was 32.68% Medicare Advantage, which leaves two-thirds of Medicare here in Original Medicare. Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.

Rockland County and Monsey	Value
County population (ACS 2024 five-year)	341,883
County residents aged 65 and over	53,669 (15.7%)
County median household income	\$109,959
Medicare beneficiaries, CY2024	58,705 (Original Medicare 40,159)
Dual-eligible share of beneficiaries, CY2024	21.6% (12,693)
Medicare Advantage penetration, September 2026	32.68%
Monsey population / median age	28,160 / 16.1
Monsey residents speaking a language other than English at home	81.2%
Monsey residents speaking a Yiddish-family language at home	78.0%
Monsey residents speaking English less than very well	41.4%

³¹ CMS Medicare Monthly Enrollment, CY2024, Rockland County: 58,705 beneficiaries; Original Medicare 40,159 (68.4%); dual-eligible 12,693 (21.6%), 11,393 full duals. U.S. Census Bureau ACS 2024 five-year: median household income \$109,959. CMS Medicare Advantage State/County Penetration, September 2026 (see note 5).

U.S. Census Bureau ACS 2024 five-year estimates, Rockland County and the Monsey census-designated place; CMS Medicare Advantage State/County Penetration, September 2026; CMS Medicare Monthly Enrollment, CY2024.

The market fact that shapes the program is the language profile, not the payer mix. A county where 44% of residents speak another language at home, and a village where 81% do, is where a monthly documented touch in the patient's own language does the work an office schedule cannot.³²

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.³³

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: \$348,465 over 24 months, -9.5%, -\$33,172. Device supply is 32% of the remote monitoring basket; management time moves little.

Chronic care management: \$221,213, -2.1%, -\$4,756. Advanced primary care management: \$119,836, -0.6%, -\$762. Conversion-factor and relative-value movement only; the proposal does not target these codes. The care-management movement is \$5,518 of the total.

The whole service line: \$689,514 over 24 months, -5.6%, -\$38,690, to \$650,824. Remote monitoring is 51% 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 -5.6%, -\$38,690 of \$689,514

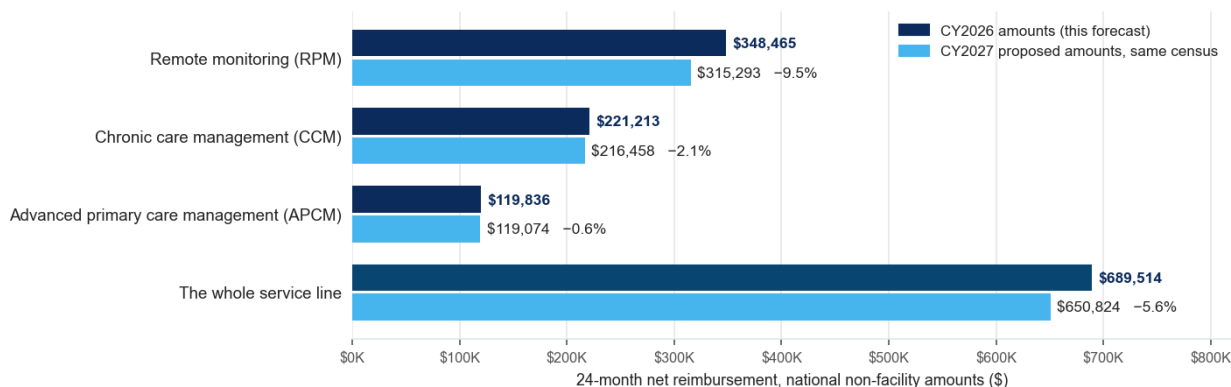


Figure 3. The CY2027 proposed rule on this forecast, at the national amounts on both sides: each arm and the whole line, CY2026 against the CY2027 proposed amounts, same census.

³² U.S. Census Bureau ACS 2024 five-year, Rockland County: 44.2% of residents aged 5 and over speak a language other than English at home; 20.7% speak English less than very well; table C16001: 47,003 speak German or other West Germanic languages including Yiddish, 47,365 Spanish, 12,029 French, Haitian or Cajun.

³³ 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% (-\$33,172); CCM -2.1% (-\$4,756); APCM -0.6% (-\$762); service line -5.6% (-\$38,690, from \$689,514 to \$650,824). Enrollment held constant.

11. Implementation and the First 90 Days

11.1 Who runs what

CoachCare delivers	Monsey Health Center keeps
Telephonic and on-site enrollment in four languages; the enrollment specialist is CoachCare's expense	Referral flags in Veradigm; clinical oversight under general supervision
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans, escalation preferences and the Sabbath and holiday calendar
Monitoring, documentation and the escalation protocol of Section 7	Responses to clinic-routed escalations; the discharge feed from each hospital
Automated claim creation into Veradigm Practice Management	Filing the FQHC claims with the care-management codes; billing review; the revenue
Monthly operating reports against the dashboard in 11.3	Program governance; the patient-support-services relationship

11.2 Model inputs

Input	Value
Medicare panel in scope	766 patients, the health center's UDS 2025 Medicare count; reconciled against the 2,103 patients aged 65 and over by payer in the first 30 days
Referring clinicians	8 in adult medicine (5 internists + 2 physician assistants + 1 nurse practitioner); the two endocrinologists feed the diabetes list and are not counted
Programs	RPM + CCM + APCM; TCM and BHI named, not in the forecast; PCM off
Program-eligible pools	RPM 498 · CCM 306 · APCM 268
Enrollment ceilings	RPM 174 (M7) · CCM 92 (M5) · APCM 80 (M3)
Acceptance	RPM 35% · CCM and APCM 30% of the eligible pool
Enrollment engine	8 referrals per clinician per month at 80% acceptance; one CoachCare-funded on-site enrollment specialist at 80 enrollments a month; telephonic outreach on; 1.5% monthly attrition
Rate basis	CY2026 national non-facility Physician Fee Schedule amounts, the rail a health center bills care-management codes on
APCM tier blend	15% level 1 · 50% level 2 · 35% level 3 = \$70.37 per patient-month
Medicare Advantage	32.68% of Rockland County's Medicare (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	Veradigm, priced at the catalog integration tier (\$2,400 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 Veradigm integration workplan. The Medicare payer reconciliation, 766 against 2,103, and the hypertension and diabetes registries by payer, the two inputs that move the model most. ICD-10 screening of the Medicare panel per the qualification map, device logistics staged, escalation routing set, the Sabbath and holiday calendar agreed, materials and scripts finalized in Yiddish, Hebrew, Spanish and Creole, and clinician orientation to the general-supervision workflow.

Days 31–60: enrollment live. Telephonic, in-clinic and Sunday enrollment running; first devices in homes; first billable service months. Month 1 nets –\$3,736 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. 79 new enrollments in month 3, APCM at its ceiling, CCM two months from its own. First monthly operating report against the dashboard. Second working session on the Medicaid remote-monitoring rail, with the registries counted by payer.

The operating dashboard from month one:

- Enrollment census by program against ceiling (174 / 92 / 80)
- Time from referral flag to first billable enrollment (target: under five days from flag to first service)
- Discharges captured: hospital discharges that entered the three-touch cadence
- Device-reading days per patient-month against the 16-day 99454 threshold, with 99445 capturing 2- to 15-day months
- Escalations by pathway: emergent, clinic-routed, documented, with the quiet-window log
- Claims generated against expected claims, and claims filed on the FQHC claim
- Blood-pressure control and A1c control among enrolled patients, against the UDS 2025 baseline of 64.01% and 23.46%
- Net to the health center per month against the \$14,080 steady-state line

12. Recommendations

1. **Stand up the Medicare service line now, sized honestly.** The individual-code rail has been live since October 2025. This is a \$294,992 two-year net line that fills in seven months; each month of delay pushes it one month further out, and nothing about it waits on a hire.
2. **Reconcile the Medicare panel by payer in the first 30 days.** The 766-patient figure is the health center's own UDS count and drives every ceiling in the forecast. The 2,103 patients aged 65 and over are the upper bound; where the true Medicare count lands between them is the single largest lever in this report, and the table below prices each step.
3. **Lead with APCM on the dual-eligible half of the panel.** Half the Medicare patients are dually eligible, and G0558 at \$117.24 a month is the best-paying monthly code on the page. Set the wrapper rule at enrollment so the dual-eligible patients with two or more conditions land on APCM level 3.
4. **Size the New York Medicaid remote-monitoring rail as its own line.** Seventy percent of the health center's patients are on Medicaid, and New York Medicaid pays 99457, 99470, 99091 and 99454. 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 Monsey from the first day.** Cellular devices, materials in four languages, the Sabbath and holiday calendar with the emergent pathway running through it, Sunday enrollment, condition-based lists. None of these is a retrofit.
6. **Keep the CoachCare-funded enrollment specialist in the plan.** The specialist cannot raise the ceilings, but reaches them months sooner, and is worth \$91,597 of 24-month net reimbursement against the no-specialist case in the table below; without it, remote monitoring does not fill until month 14.
7. **Make the hospital discharge the front door.** Wire the discharge feed from both Rockland County 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: 766 panel, 8 clinicians, 1 enrollment specialist	\$689,514	\$294,992	42.78%	M7 / M5 / M3
No on-site enrollment specialist	\$597,917	\$254,887	42.63%	M14 / M10 / M6
Second on-site enrollment specialist	\$717,005	\$307,032	42.82%	M5 / M4 / M2
6 referring clinicians	\$681,755	\$291,624	42.78%	M8 / M5 / M3
10 referring clinicians (open requisitions filled)	\$696,248	\$297,934	42.79%	M7 / M5 / M3
Panel 1,013 (the health center's UDS 2024 Medicare count)	\$883,090	\$380,322	43.07%	M9 / M6 / M4
Panel 1,248 (the health center's UDS 2023 Medicare count)	\$1,055,302	\$456,298	43.24%	M10 / M7 / M4
Panel 2,103 (every patient aged 65 and over; upper bound pending the payer reconciliation)	\$1,577,215	\$687,249	43.57%	M17 / M10 / M6

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.³⁴

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.** 766 patients with Medicare as primary payer against 2,103 patients aged 65 and over: how many of the 2,103 carry Medicare at all, and under what primary coverage the rest sit in the health center's records. This one number sets every ceiling.
2. **The hypertension and diabetes registries by payer.** 1,706 and 1,172 patients respectively; the Medicare slice sizes the RPM cohort in this forecast, and the Medicaid slice sizes the second rail.
3. **The current care-team roster.** Who on the current staff carries patient-support, nursing and care-coordination work, and which of the three open adult-medicine requisitions are expected to fill.
4. **The Veradigm product line and interfaces.** Which Veradigm products the health center runs and which interfaces are available, so the integration workplan can be written.

³⁴ CoachCare Value Analysis recalculations at the same pricing: no on-site enrollment specialist \$597,917 / \$254,887 / 42.63%; second specialist \$717,005 / \$307,032 / 42.82%; 6 clinicians \$681,755 / \$291,624 / 42.78%; 10 clinicians \$696,248 / \$297,934 / 42.79%; panel 1,013 \$883,090 / \$380,322 / 43.07%; panel 1,248 \$1,055,302 / \$456,298 / 43.24%; panel 2,103 \$1,577,215 / \$687,249 / 43.57%. The specialist is worth \$91,597 of 24-month net reimbursement against the no-specialist case.

Everything else in this report, the Medicare Advantage contract terms, the discharge feed from each Rockland County hospital, the Sabbath and holiday calendar, and the non-maternity status of the Medicaid device codes, is a workplan item that follows the session rather than a condition of it.

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.³⁵

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 look-alike page for LALCS00146 (reporting years 2021–2025, retrieved September 2026), the Health Center Service Delivery and Look-Alike Sites file (three active records), and the primary-care Health Professional Shortage Area file (facility designation, score 12, designated August 2013).
- **CMS Federally Qualified Health Center Enrollments (July 17, 2026 vintage):** one certification number, 331887, under one PECOS associate identifier; corporation incorporated in New York in 1996.
- **The health center's website,** retrieved September 2026: the adult-medicine, specialty, locations, hours and careers pages and the site's brand assets; the EHR (Veradigm) as stated by the health center, with the patient-portal link on every page as corroboration.
- **CMS National Plan and Provider Enumeration System,** queried September 2026 for every clinician named on the health center's adult-medicine page and every individual enumerated at the main campus address; four organization records under the health center.
- **CMS Quality Payment Program eligibility records, 2025 and 2026,** for every clinician on the adult-medicine roster: no Alternative Payment Model participation under the health center's billing organization.
- **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 (CMS-1807-F) and CY2026 Final Rule (CMS-1832-F):** retirement of G0511 on September 30, 2025; individual-code reporting for health-center care management from October 1, 2025; payment at national non-facility amounts in addition to the PPS encounter; APCM adopted for health-center payment; the CY2026 additions 99445 and 99470.

³⁵ 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):** national non-facility amounts for the eleven forecast codes, the two transitional care codes and the behavioral health integration code, at the \$33.4009 conversion factor with no geographic adjustment.
- **CMS-1848-P, the proposed CY2027 Physician Fee Schedule (July 2026):** the proposed national non-facility amounts used in the Section 10 repricing; comment period closed September 14, 2026.
- **New York State Medicaid:** the Medicaid Update of October 2024 (remote physiologic monitoring 99457 from January 1, 2025; managed-care compliance from March 1, 2025); the Medicaid Update special edition of January 2023 (99091; the Ambulatory Patient Group rule for health centers); the Telehealth Policy Manual (July 2026); the eMedNY physician fee schedule effective July 1, 2026; and the Department of Health's FQHC APG opt-in list, on which the health center appears continuously from January 1, 2014.
- **CMS Medicare Advantage State/County Penetration, September 2026, and CMS Medicare Monthly Enrollment, CY2024:** Rockland County's 60,807 eligibles and 32.68% MA penetration; 58,705 beneficiaries with 40,159 in Original Medicare and 12,693 (21.6%) dual-eligible, 8,302 of them Qualified Medicare Beneficiaries with full Medicaid.
- **U.S. Census Bureau American Community Survey 2024 five-year estimates** (profiles DP02, DP03 and DP05 and table C16001), Rockland County and the Monsey census-designated place: population, age, income, language and English proficiency.
- **CMS Hospital General Information and Care Compare, September 2026:** the two CMS-certified acute-care hospitals in Rockland County, referenced by county only.
- **CoachCare Care Management Programs standard operating procedures, March 2026,** and the seven process maps derived from them: the shared alert-and-escalation decision logic, trend definitions, the emergent communication protocol, three-way routing, the post-discharge three-touch sequence and the discharge decision flow reproduced in Section 7.
- **CoachCare Veradigm 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 Veradigm Practice Management through the CoachCare billing engine.
- **CoachCare Value Analysis for Monsey 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 766 Medicare patients in scope, 8 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 347 active program enrollments belonging to 226 unique patients, because a patient may carry a monitoring enrollment and a care-management enrollment at the same time. Wherever this report gives a patient count it says patients; wherever it gives an enrollment count it says enrollments.

The panel figure is the health center's own. Health-center visits bill on the FQHC claim rather than under individual clinicians, so clinician-level Medicare claims files structurally undercount a health-center panel. The 766-patient figure is the Medicare count the health center reported to HRSA for 2025, and the first implementation step reconciles it against the 2,103 patients aged 65 and over by payer.

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