COACHCARE | SERVICE LINE STRATEGY

Jordan Health

A HRSA-funded Federally Qualified Health Center serving Rochester's northeast and west neighborhoods and Canandaigua from nine sites, with an urgent care, an in-house pharmacy and a New York Medicaid Health Home care-management agency

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line for the health center's 2,498 Medicare patients, two of every three of them dually eligible: remote physiologic monitoring, chronic care management and advanced primary care management, billed under the CY2026 rules that pay a health center for those codes individually, on top of the PPS encounter, and built on the between-visit work the health center already does for Medicaid through its Health Home program

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of Jordan Health. It brings together the health center's own HRSA record, the Medicare structure of Monroe County, the CY2026 billing rules for health centers, a 24-month Value Analysis for a remote care service line on the Medicare panel, the quality measures the program moves, the clinical governance that would run it, and the eClinicalWorks integration it lives in.

The argument is short. Two of every three Medicare patients at Jordan Health are dually eligible. That mix makes advanced primary care management worth more here than at almost any health center in the country. The health center already does the between-visit work for Medicaid through Health Home. Since January, Medicare pays for it too, as its own codes at national rates on top of every visit. This is the plan to put devices, documentation and a Medicare revenue line under work Jordan Health already knows how to do.

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Executive Summary

Jordan Health is a HRSA Section 330 Federally Qualified Health Center in Rochester, New York. Its services trace to 1904, and it runs nine HRSA-listed sites, eight in the city's northeast and west neighborhoods and one in Canandaigua: family medicine, internal medicine, pediatrics, adolescent health, OB/GYN, dental, behavioral health, clinical pharmacy, optometry, podiatry, WIC and HIV and hepatitis C care, with an urgent care, imaging and an in-house pharmacy at the main site on Holland Street.[1] Its 2025 Uniform Data System report counts 18,686 patients, of whom 2,498 are on Medicare; 1,713 of those, 68.6%, are dually eligible for Medicare and Medicaid; 2,418 patients are aged 65 or older; 4,909 carry a hypertension diagnosis, 43% of the panel, and 2,130 a diabetes diagnosis.[2] It holds HRSA's Patient Centered Medical Home badge and Joint Commission ambulatory accreditation, and it operates a New York Medicaid Health Home care-management agency with care managers, registered-nurse care managers and behavioral-health navigators on staff.[3]

That is a health center that already does between-visit work, for Medicaid, under a program built for it. What the record does not yet show is a Medicare revenue line for that month of work. Across every clinician billing under the health center, 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] Meanwhile 4,909 patients with hypertension and 2,130 with diabetes are seen in person a few times a year; blood pressure is controlled in 58.1% of the hypertensive panel and diabetes is poorly controlled in 35.5% of the diabetic panel, both in HRSA's fourth quartile for 2025. Those two measures are what daily readings and a monthly call are built to move.

Monroe County's Medicare population is **77.1% Medicare Advantage** (September 2026), among the highest shares of any urban county in the country, and 21.8% of the county's beneficiaries are dually eligible.[5] That mix shapes the revenue math in one specific way. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. Many dually eligible members are in dual special-needs plans, so the plans that cover the health center's Medicare panel are few, which makes the contract conversation short. This report prices everything at the fee schedule and makes the contract check a first-week discovery item.

[1] HRSA Health Center Program: awardee H80CS21582 (Section 330 grantee, not a look-alike; no program conditions). HRSA Health Center Service Delivery and Look-Alike Sites file, pulled September 22, 2026: nine active service sites (eight in Rochester, one in Canandaigua) and one administrative site. Service lines from the health center's website, retrieved the same day.

[2] HRSA Uniform Data System, awardee H80CS21582, reporting year 2025: total patients 18,686; Medicare 2,498 (13.37%); dually eligible 1,713; aged 65 and over 2,418 (12.94%); Medicaid/CHIP 13,410 (71.76%); hypertension 4,909 (43.02% of medical patients); diabetes 2,130 (19.55%); controlling high blood pressure 58.06%; diabetes A1c above 9% or untested 35.45%.

[3] HRSA UDS awardee page, Community Health Quality Recognition badges displayed: Patient Centered Medical Home; Advancing Health Information Technology for Quality. The health center's website: Joint Commission Gold Seal ambulatory accreditation; the Health Home and Care Coordination page describing care-manager-led coordination for Medicaid and dually eligible members; care-manager, registered-nurse care-manager and behavioral-health-navigator roles in the health center's postings and news items.

[4] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024 (released May 2026), queried per National Provider Identifier across every clinician resolving to the health center's billing organization for codes 99453, 99454, 99457, 99458, 99445, 99470, 99091, 99490, 99439, 99491, 99487, 99489, G0556–G0558, G0511, 99495, 99496, 99484 and G0323. No lines returned. 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: Monroe County, 176,295 eligibles, 135,892 enrolled in Medicare Advantage (77.08%). CMS Medicare Monthly Enrollment, CY2024: 170,578 beneficiaries, 37,249 dually eligible (21.8%; 31,188 full-benefit).

The observation this report is built on

Two of every three Medicare patients at Jordan Health are dually eligible. That mix makes advanced primary care management worth more here than at almost any health center in the country. The health center already does the between-visit work for Medicaid through Health Home. Since January, Medicare pays for it too, as its own codes at national rates on top of every visit.

G0511, the bundled code health centers used for care management, has been retired. For 2026 dates of service a Federally Qualified 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 new short-window RPM codes (99445, 99470) fit post-discharge monitoring exactly. And the top tier of advanced primary care management, G0558 at $113.17 a month at the New York amount, is written for Qualified Medicare Beneficiaries, which is the tier 1,713 of the health center's 2,498 Medicare patients sit in.

What the Value Analysis returns

The forecast prices a service line for the health center's own Medicare panel, 2,498 patients as reported to HRSA for 2025, traditional Medicare and Medicare Advantage together, referred by the nineteen physicians, nurse practitioners and physician assistants in adult medicine on the health center's provider roster, and delivered by CoachCare under the health center's clinical direction.[7]

	Year 1	Year 2	24 months
Net reimbursement	**$739,951**	**$1,228,131**	**$1,968,082**
CoachCare fees	$431,145	$699,025	$1,130,170
Net to the health center	**$308,806**	**$529,106**	**$837,913**
Margin to the health center	41.73%	43.08%	**42.58%**

CoachCare Value Analysis. CY2026 non-facility Physician Fee Schedule, New York locality 99 (Rest of New York), a deliberately conservative basis; health-center claims pay national amounts (Section 2.2). 2,498 Medicare patients in scope; RPM + CCM + APCM. Margin is 24-month net to the health center divided by net reimbursement.

1. **The program funds itself from the second month.** Month 1 nets −$4,692 to the health center, because implementation lands before enrollment revenue does. The first positive month is M2, at $5,319. From M14 the service line runs at $102,315 in monthly net reimbursement and $44,078 net to the health center.
2. **Nobody is hired.** CoachCare delivers 13,389 hours of care-team work over 24 months, about 6.4 full-time-equivalent years, including an on-site enrollment specialist carried at CoachCare's expense. No capital outlay, no requisitions, and a bilingual care team in English and Spanish, which for this panel is a design requirement rather than a courtesy.
3. **All three programs reach their ceilings inside the 24 months.** APCM reaches its ceiling in M5, CCM in M8, RPM in M13. At M24 the program holds 1,130 active program enrollments across 737 unique patients. The binding constraint is the size of the Medicare panel, not enrollment capacity. The top of the health center's own five-year Medicare range, the discharges from Rochester's hospitals, and the behavioral-health arm are the three ways the ceiling moves.

[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; advanced primary care management adopted on the same basis. CY2026 Final Rule (CMS-1832-F) for 2026 dates of service.

[7] CoachCare Value Analysis for Jordan Health, 2026. Basis: CY2026 non-facility Physician Fee Schedule at New York locality 99; 2,498 Medicare patients in scope; 19 referring clinicians; RPM, CCM and APCM.

4. **The dual-eligible mix is the wedge.** With 68.6% of the Medicare panel dually eligible, the forecast weights 40% of advanced primary care management enrollments to the top tier, $113.17 a month, for a blended $72.83 per patient-month. That is the strongest advanced primary care economics of any health center CoachCare has modelled.
5. **The rate basis is deliberately conservative.** The forecast prices at New York locality 99. Health-center claims pay national non-facility amounts, and locality 99 sits 3% to 6% below the national amount on every code in the basket. Repriced on the national rail, the same census adds $76,667 of 24-month net reimbursement, all of it net to the health center, and lifts the margin to 44.73%. None of that is in the headline.
6. **The clinical return is concrete.** The forecast projects 67.1 avoided hospitalizations over 24 months, roughly $1.01 million at $15,000 per admission, from 105,723 device readings worked through one escalation protocol, with hospital admission and discharge alerts from Rochester's hospitals as one trigger.
7. **The staffing shape already fits the codes.** Ten of the nineteen referring clinicians are nurse practitioners and physician assistants. CCM, APCM and RPM are general-supervision code families; a care team led by advanced-practice clinicians with a physician layer is the configuration they were written for.

1. The Health Center and Its Neighborhoods

1.1 Nine sites, a Health Home, and a century of service

Jordan Health, the Anthony L. Jordan Health Corporation, is a HRSA Health Center Program awardee (grant H80CS21582) with no program conditions, and a Medicare FQHC with eight certification numbers under one PECOS associate identifier; the main site has participated in Medicare since 1993.[8] The organization traces its services to 1904, took its present name in the early 1970s from the Rochester physician it honors, and absorbed two west-side health centers in 2011, a Canandaigua primary-care practice in 2013, and a school-based site and a neighborhood site in 2014.[9]

UDS 2025	Count	What it means for the service line
Total patients	18,686	Nine service sites in two counties
Medicare patients	**2,498** (13.37%)	The panel this forecast runs on; Medicare Advantage and the 1,713 duals are inside it
Dually eligible	**1,713**	68.6% of the Medicare panel; the advanced primary care management top tier
Aged 65 and over	2,418 (12.94%)	Held steady across five reporting years
Medicaid and CHIP	13,410 (71.76%)	Outside the forecast: New York's Medicaid care-management vehicle is the Health Home program the health center already runs (Section 2.3)
Hypertension	**4,909** (43.02% of medical patients)	The RPM cohort; blood-pressure control 58.06%
Diabetes	**2,130** (19.55%)	Glucose monitoring; A1c poorly controlled or untested in 35.45%
Limited English proficiency	3,897 (20.86%)	Bilingual care management is a design requirement

[8] HRSA UDS awardee page (grantee status, no conditions); CMS Federally Qualified Health Center Enrollments, July 2026 vintage, and CMS Provider of Services file, Q2 2026: eight active FQHC CCNs under PECOS associate identifier 8729079785, main site CCN 331838 at 82 Holland Street, participating since January 1, 1993.

[9] The health center's history page and the HRSA sites file: services trace to 1904; the Rochester Neighborhood Health Center of 1968 renamed for a Rochester physician in the early 1970s; IRS ruling date 1973; two west-side sites absorbed in 2011; the Canandaigua practice in 2013; the school-based and neighborhood sites in 2014.

UDS 2025	Count	What it means for the service line
Patients by service	Medical 15,837 · dental 4,527 · mental health 356 · vision 189 · school-based 285	Nine sites, one record, one board

HRSA Uniform Data System, awardee H80CS21582, reporting year 2025 (the latest of five on the awardee page).

The site list matters for the service line because every one of the nine is a referral source and a place a device can be handed over: the main center on Holland Street with its urgent care, imaging and in-house pharmacy; Jordan Health Link on Upper Falls Boulevard, where WIC and the Health Home program sit; Brown Square on Lake Avenue and Woodward on Genesee Street on the west side; Community Place on Parsells Avenue; the school-based site at the Franklin Educational Campus on Norton Street; a dental clinic on Lake Avenue; and the Canandaigua practice.[10] The Health Home program is the part of the list this report builds on. As a New York Medicaid Health Home care-management agency the health center already coordinates care for Medicaid and dually eligible members with two or more chronic conditions: transportation, housing, treatment adherence, medication management and benefits, run by a care manager. The human layer of between-visit care exists here. Medicare has no revenue line under it yet.[11]

1.2 Recognition the record can verify

HRSA's Community Health Quality Recognition badges for the health center include the Patient Centered Medical Home badge and the Advancing Health Information Technology for Quality badge. The health center reports NCQA recognition as a medical home, Joint Commission Gold Seal accreditation in ambulatory care, and a Target: BP recognition for its blood-pressure measurement program.[12] Those are the credentials of an organization that already runs structured chronic care: a certified medical-home workflow, an accredited quality program, an in-house pharmacy with a clinical-pharmacy service line, and a lifestyle-medicine program. A remote care service line does not ask the health center to become something else. It asks it to put a device, a documentation standard and a Medicare code under the work the badges already describe. Section 4 sets out the measures that work moves.

1.3 Rochester and Monroe County: younger, poorer, bilingual, and mostly Medicare Advantage

The health center's sites sit in the city of Rochester's northeast and west quadrants, so the city, not the county, is the better description of its panel. The city has 208,772 residents with a median age of 33.7; 27.8% live in poverty, and 21.2% of those aged 65 and over do; median household income is $47,213 against $76,382 for the county; 54.4% have public coverage; 19.1% speak a language other than English at home; 19.6% are Hispanic or Latino, 14.7% Puerto Rican; 36.2% are Black.[13] Inside the health center the concentration is stronger still: 33.8% of patients are Hispanic or Latino, 65% are Black, one patient in five has limited English proficiency, 89% of those with a known income live below 200% of the federal poverty guideline, and 40% are served at public-housing sites.[14]

[10] HRSA sites file (see note 1) and the health center's locations and services pages, retrieved September 2026: urgent care and imaging at 82 Holland Street; the in-house pharmacy at 82 Holland Street Unit 100, in HRSA scope since October 2024; WIC and Health Home at Jordan Health Link, 273 Upper Falls Boulevard.

[11] The health center's Health Home and Care Coordination page, retrieved September 2026: eligibility (Medicaid or Medicaid and Medicare; Monroe County resident; two chronic conditions, HIV or serious mental illness), services (transportation, food and clothing referrals, housing, treatment referrals, treatment-plan adherence, benefits, medication management), referral via the state, a community agency or a health center provider. New York State Department of Health, Medicaid Health Home program.

[12] HRSA UDS awardee page badges (see note 3). The health center's mission page: NCQA certification as a medical home; Joint Commission Gold Seal, Ambulatory Care; Target: BP recognition (American Heart Association and American Medical Association), year not stated. No outcome figure from that program is used in this report.

[13] U.S. Census Bureau American Community Survey 2024 five-year estimates, profiles DP02, DP03 and DP05: City of Rochester (population 208,772; median age 33.7; poverty 27.8%, 21.2% among those 65 and over; median household income $47,213; public coverage 54.4%; language other than English at home 19.1%; Hispanic or Latino 19.6%, Puerto Rican 14.7%; Black alone 36.2%) and Monroe County (median household income $76,382; poverty 13.6%).

Monroe County's 176,295 Medicare eligibles were **77.1% enrolled in Medicare Advantage** in September 2026, one of the highest shares of any urban county in the country; Original Medicare covers roughly 40,000 people county-wide. Of the county's 170,578 beneficiaries in CY2024, 37,249 (21.8%) were dually eligible and 12.6% qualified through disability rather than age.[15] Four acute-care hospitals serve the city, none of them owned by the health center; in CMS's fiscal-year 2026 readmission measures, the two nearest the health center's sites carry excess readmission ratios above 1.0 for heart failure, COPD and pneumonia.[16]

City of Rochester and Monroe County	Value
City population (ACS 2024 five-year) / median age	208,772 / 33.7
City poverty rate (all residents / aged 65 and over)	27.8% / 21.2%
City median household income (county)	$47,213 ($76,382)
City residents with public coverage	54.4%
City residents speaking a language other than English at home	19.1%
City Hispanic or Latino (Puerto Rican) / Black	19.6% (14.7%) / 36.2%
County Medicare eligibles (September 2026)	176,295
County Medicare Advantage penetration (September 2026)	**77.1%**
County dual-eligible share of beneficiaries (CY2024)	21.8% (37,249 of 170,578)
Health center's dual-eligible share of its Medicare panel (UDS 2025)	**68.6%** (1,713 of 2,498)

U.S. Census Bureau ACS 2024 five-year estimates; CMS Medicare Advantage State/County Penetration, September 2026; CMS Medicare Monthly Enrollment, CY2024; HRSA UDS 2025.

What 77.1% Medicare Advantage does to the revenue model

Medicare Advantage plans are required to cover Part B services and to pay at least the Medicare rate. That is the floor under more than three-quarters of Medicare in this county. What the floor does not settle is whether each plan pays the care-management code families on the same terms and cadence as traditional Medicare; individual contracts set their own terms for the care-management code families.

The forecast in Section 6 prices the whole panel at the fee schedule. The matching operational move is early: confirm RPM, CCM and APCM payment terms with the plans that cover the health center's Medicare patients during discovery, contract by contract (Recommendation 3). Because so many of those patients are dually eligible, many sit in dual special-needs plans, and the list of plans that matter is short.

The dual share works the other way. Advanced primary care management pays its highest tier, G0558 at $113.17 a month here, for Qualified Medicare Beneficiaries, and 1,713 of the health center's 2,498 Medicare patients, 68.6%, are dually eligible.

1.4 Two of every three Medicare patients are dually eligible

The number that sets this account apart is 68.6%. In every one of the five reporting years on the health center's UDS page, dually eligible patients have been between 64% and 69% of its Medicare count; in

[14] HRSA UDS 2025 patient characteristics: Hispanic or Latino 33.83%; Black or African American 65.13% of patients with known race; limited English proficiency 20.86% (3,897); at or below 200% of the federal poverty guideline 89.38% of patients with known income; public-housing site patients 39.78% (7,434).

[15] CMS Medicare Advantage State/County Penetration, September 2026 (see note 5). CMS Medicare Monthly Enrollment, CY2024, Monroe County: 40,252 in Original Medicare; 21,486 qualifying through disability (12.6%); May 2026: 175,609 beneficiaries, 40,717 in Original Medicare.

[16] CMS Provider of Services file, Q2 2026: four short-term acute-care hospitals with CITY_NAME Rochester, none a critical access hospital, none enrolled under the health center. CMS Hospital Readmissions Reduction Program, fiscal year 2026 (performance period July 2021 to June 2024): excess readmission ratios above 1.0 for heart failure, COPD and pneumonia at the two hospitals nearest the health center's sites. Hospitals are not named in this report.

2025 the figure is 1,713 of 2,498.[17] A dually eligible patient is, in almost every case, a Qualified Medicare Beneficiary, and the advanced primary care management family pays its top tier for exactly that status: G0558, $113.17 a month at the New York amount, against $51.96 for a patient with two or more chronic conditions and $15.80 for one. Nothing about the patient's clinical complexity changes the arithmetic; the tier follows the coverage. A health center whose Medicare panel is two-thirds dual therefore earns more per care-management month than a practice with the same conditions and a typical 20% dual share, and it earns it on the patients it already has. Section 3.3 sets out how the forecast weights the tiers.

1.5 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 billing under the health center 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.[18] 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**.

That is a structural observation, not a criticism, and the health center's own record explains it: New York pays for Medicaid care management through the Health Home program, and the health center built its care-management team for that program. Medicare had no code a health center could bill for the same work until this year. So 4,909 patients with hypertension and 2,130 with diabetes are seen in person a few times a year, in a city where 27.8% of residents live in poverty and one patient in five speaks limited English, and the month in between is where the readings go unread. The gap is buildable, and the people who would fill it are already on the payroll.

2. The CY2026 Billing Change for Health Centers

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 during 2025. For 2026 dates of service 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**.[19]

CY2026 also added two codes that matter for a health center whose patients are admitted to hospitals it does not own: 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 from a Rochester hospital on the 20th of the month used to produce an unbillable partial month; now it bills. In this forecast the two codes carry $174,554 of gross reimbursement over 24 months, about 8.9% of net reimbursement, revenue that did not exist two years ago.[20]

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, which is what makes

[17] HRSA UDS, awardee H80CS21582, Medicare patients and dually eligible patients by reporting year: 3,025 and 2,004 (2021); 2,806 and 1,944 (2022); 2,683 and 1,855 (2023); 2,855 and 1,903 (2024); 2,498 and 1,713 (2025). The dual share of the Medicare count is between 64% and 69% in every year.

[18] CY2024 Medicare Physician & Other Practitioners sweep (see note 4).

[19] CMS-1807-F (see note 6): G0511 retired with a transition period during 2025; for 2026 dates of service 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.

[20] CoachCare Value Analysis, Financial Value detail: 99445 and 99470 together carry $174,554 of gross reimbursement over 24 months ($149,281 and $25,273) against $1,968,082 of net reimbursement (8.9%), on this forecast's code frequencies.

a staffed, managed program worth running, and what lets a health center that already runs a Medicaid care-management team put a Medicare revenue line under the same people.

2.2 What the codes pay here

The Value Analysis prices every code at the CY2026 non-facility Physician Fee Schedule for New York locality 99, Rest of New York, the National Government Services jurisdiction that covers ZIP 14605 and every other Rochester and Canandaigua ZIP the health center serves.[21]

Code	What it pays for	Cadence	CY2026 rate, NY locality 99
99453	RPM setup and patient education	One-time	$20.46
99454	Device supply, 16–30 days of readings	Monthly	$49.42
99445	Device supply, 2–15 days of readings (new 2026)	Monthly	$49.42
99457	RPM management, first 20 minutes	Monthly	$49.87
99470	RPM management, first 10 minutes (new 2026)	Monthly	$25.10
99458	RPM management, each additional 20 minutes	Monthly	$40.03
99490	CCM, first 20 minutes of clinical staff time	Monthly	$63.92
99439	CCM, each additional 20 minutes	Monthly	$48.67
G0556	APCM, level 1: one chronic condition	Monthly	$15.80
G0557	APCM, level 2: two or more chronic conditions	Monthly	$51.96
G0558	APCM, level 3: Qualified Medicare Beneficiary	Monthly	$113.17
99495	Transitional care management, moderate complexity	Per discharge	$212.18 (named, not in the forecast)
99496	Transitional care management, high complexity	Per discharge	$288.02 (named, not in the forecast)
99484	Behavioral health integration, first 20 minutes	Monthly	$55.64 (named, not in the forecast)

CY2026 non-facility Physician Fee Schedule, New York locality 99 (Rest of New York), the Value Analysis basis. The APCM tier blend in the forecast (10% level 1, 50% level 2, 40% level 3) yields $72.83 per patient-month, with the level-3 weight set from the 68.6% of the Medicare panel that is dually eligible.

[21] CY2026 Physician Fee Schedule non-facility amounts, carrier 13282 locality 99 (Rest of New York), National Government Services Jurisdiction K; ZIP 14605 maps to this locality in the CMS ZIP-to-locality crosswalk (April 2026), as do ZIPs 14608, 14609, 14611, 14621 and 14424. Conversion factor $33.4009; GPCIs work 1.000, practice expense 0.950, malpractice 0.703. These are the rates priced into the Value Analysis.

The national rail runs in the health center's favor

The health center bills these codes at national non-facility amounts; the figures in this report use the New York locality amounts and are therefore conservative. Locality 99 prices below the national amount on every code in the basket, by 3% to 6%, most of all on the device-supply codes.[22]

Repriced at the national amounts, the same census adds $76,667 over 24 months, every dollar of it net to the health center: $1,968,082 of net reimbursement becomes $2,044,749, $837,913 net becomes $914,579, and the margin moves from 42.58% to 44.73%. The forecast keeps the locality basis; the national rail is quantified upside.

These are traditional-Medicare amounts. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. With 77.1% of the county's Medicare in Medicare Advantage, that contract check belongs in the first week of discovery rather than on a rate schedule.

2.3 The work the change creates, who carries it, and where Medicaid sits

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 31,014 claims over 24 months. A health-center reimbursement office absorbing that by hand would resent every one of them. In the operating model of Section 9, CoachCare carries the load: enrollment, device logistics, monitoring documentation and billing-ready claim generation inside eClinicalWorks. The health center's own reimbursement team files the FQHC claims with the care-management codes, and the clinicians keep the clinical decisions.

One structural note on Medicaid, because 72% of the health center's patients are covered by it and the deal design has to respect that. New York Medicaid does not cover chronic care management, transitional care management or advanced primary care management; a health center billing Medicaid under the prospective payment system cannot bill Medicaid remote monitoring; and the Health Home program, which the health center already runs, is where Medicaid care management already pays.[23] So the Medicare slice is the plan. The service line is built on the 2,498 Medicare patients, where the individual-code rail is explicit, and it carries no Medicaid dollars; the Health Home team keeps doing what it does for the Medicaid panel, and the dually eligible patients who sit in both are where the two programs meet.

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

3.1 The clinical and billing stack

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

[22] CY2026 national non-facility amounts (CMS RVU26A, GPCI 1.000) against New York locality 99: 99454 and 99445 $52.11 national versus $49.42 (−5.2%); 99453 $21.71 versus $20.46 (−5.8%); 99490 $66.13 versus $63.92 (−3.3%); G0558 $117.24 versus $113.17 (−3.5%). Locality 99 ranks between 23rd and 29th lowest of 109 localities on every code in the basket. Health centers bill the care-management codes at the national amount.

[23] New York State Medicaid Telehealth Policy Manual, updated July 2026: 'FQHCs that bill using PPS are unable to bill for RPM services at this time'; 99457 covered from January 1, 2025 and 99470 from January 1, 2026; device-supply codes payable for pregnant and postpartum members only. Medicaid Update, May 2025: FQHCs that have opted into ambulatory patient groups may bill 99457 from July 1, 2025. New York Medicaid Physician Medicine Services fee schedule effective July 1, 2026: no 99490/99491/99439, no 99495/99496, no G0556–G0558. New York State Department of Health, Medicaid Health Home program. HRSA UDS 2025: Medicaid/CHIP 13,410 patients (71.76%).

Program	Who qualifies	What it is	Billing
RPM	1,624 of the 2,498 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	999 (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	874 (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 a Rochester 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. Patients already carried by the Health Home team keep that Medicaid care manager; the Medicare wrapper is documented alongside, not instead.

The service line pays the health center four ways. First, additive revenue: every care-management dollar lands on top of the PPS encounter, not inside it. Second, it reaches patients where they are. A morning blood-pressure reading from a kitchen table on Parsells Avenue or in a public-housing tower reaches a nurse the same morning, in the patient's own language, without a bus ride to Holland Street. Third, avoided admissions: a patient whose fluid weight climbs for four days is treated by phone and in clinic, not admitted three weeks later, which is where the forecast's 67.1 avoided hospitalizations come from. Fourth, the staffing model does not depend on recruiting: CoachCare's clinical staff deliver the monitoring layer, so the program's growth does not wait on hiring nurses in Rochester.

3.2 The Medicare panel it runs on

The forecast is built on **2,498 Medicare patients**, the health center's own count as reported to HRSA for 2025, traditional Medicare and Medicare Advantage together; Medicare Advantage and the 1,713 duals are already inside it, with no gross-up. The first implementation step compares it with chart counts by payer.[24] From that panel, the eligibility model carves the program pools: 1,624 patients RPM-eligible (65%), 999 CCM-eligible (40%), 874 APCM-eligible (35%). The pools overlap; the coordination rule keeps the billing disjoint.

[24] HRSA UDS 2025 (see note 2). CoachCare Value Analysis eligibility model: RPM 65%, CCM 40%, APCM 35% of the in-scope panel; the 1,713 dually eligible patients are 68.6% of the 2,498.

3.3 The dual-eligible tier: why advanced primary care management is worth more here

Advanced primary care management is a monthly bundle with no minute tracking, paid at one of three levels. Level 1 covers a patient with one chronic condition; level 2, two or more; level 3, a Qualified Medicare Beneficiary, the status almost every dually eligible patient holds. At the New York amounts those levels pay $15.80, $51.96 and $113.17 a month. The forecast weights the health center's APCM enrollments 10% to level 1, 50% to level 2 and 40% to level 3, a level-3 weight set below the 68.6% dual share because not every dually eligible patient holds full Qualified Medicare Beneficiary status, and the blend comes to $72.83 per patient-month.[25]

That blend is the highest CoachCare has modelled for any health center. Two comparators make the point: health centers with dual shares in the low sixties price the same bundle a few dollars lower, and a typical primary-care practice with a 20% dual share prices it in the fifties. The difference is not clinical effort; the three tiers describe the same thirteen practice capabilities. It is the coverage of the panel, and the health center's panel is what it is because of the neighborhoods it serves. For once, the demographics of a safety-net panel work in the safety-net provider's favor on a Medicare fee schedule.

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

Each discharge home from one of Rochester's hospitals opens a transitional care management episode: an interactive contact within two business days, medication reconciliation, and a face-to-face visit within 14 days (99495, $212.18 at this locality) or 7 days (99496, $288.02). The health center owns no hospital, so the episode starts from a hospital admission and discharge alert rather than from a shared record; wiring that alert feed, through the regional health information exchange or the hospitals' own notification services, is a weeks-0-to-4 implementation item in Section 9.[26] TCM is on the recommended stack for that reason, and it carries no dollars anywhere in this forecast: the discharge count, the share that go 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 5.5 runs on the same contact the TCM code requires.

3.5 Behavioral health integration: the next arm, named

A health center with an integrated behavioral-health service line, behavioral-health navigators on its Health Home team, and a depression-screening measure in HRSA's fourth quartile at 48.3% has an obvious fourth program waiting: behavioral health integration, 99484, $55.64 a month at this locality for the first 20 minutes of care-manager time under a treating clinician's plan.[27] It is the same infrastructure, the same monthly cadence and the same billing engine, applied to a measure the health center already screens for and wants to move. 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.

[25] CoachCare Value Analysis, APCM tier weights 0.10 / 0.50 / 0.40 at the New York locality 99 amounts $15.80 / $51.96 / $113.17, blended $72.83 per patient-month. The level-3 weight is set below the 68.6% dual share because not every dually eligible patient holds full Qualified Medicare Beneficiary status. CY2026 Final Rule (CMS-1832-F): G0558 is the APCM level for Qualified Medicare Beneficiaries.

[26] 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 non-facility amounts at New York locality 99: $212.18 and $288.02. Four CMS-certified acute-care hospitals serve the city of Rochester; none is owned by the health center. TCM is carried at zero dollars in every figure in this report; the admission and discharge alert feed is an implementation item, not a description of a current data feed.

[27] CY2026 non-facility amount at New York locality 99 for CPT 99484: $55.64. HRSA UDS 2025: screening for depression and follow-up plan 48.27%, HRSA quartile 4; mental health patients 356. The health center's behavioral-health service line and behavioral-health-navigator roles from its website. BHI is carried at zero dollars.

3.6 Built the way the codes work: a care team led by nurse practitioners and physician assistants

Of the nineteen physicians, nurse practitioners and physician assistants in adult medicine on the health center's provider roster, nine are physicians in family and internal medicine and ten are nurse practitioners and physician assistants.[28] For this service line that is the right shape, not a gap to apologize for. 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. A care team led by advanced-practice clinicians with a physician layer is the configuration these codes were designed to pay. The referral motion is one step, a clinician flags a qualifying patient in the chart, and the program runs from there.

3.7 Staffing: nobody is hired, the Health Home team stays, and the care team is bilingual

CoachCare delivers 13,389 hours of care-team work across the 24 months, about **6.4 full-time-equivalent years**, without the health center hiring anyone. The on-site enrollment specialist is CoachCare's expense, not a program cost. The service line adds the working capacity of more than six hires and zero requisitions.

This is a build-on, not a replacement. The health center already runs a Medicaid Health Home care-management agency with care managers, registered-nurse care managers and behavioral-health navigators, a Director of Quality, a clinical-pharmacy service line and a lifestyle-medicine program.[29] That team was built for Medicaid because that is where New York pays for care management. This plan puts cellular devices, structured documentation and a Medicare revenue line under the same model. The Health Home care managers stay the relationship and trust layer for the patients they carry; CoachCare's staff carry the recurring work of monitoring review, outreach, documentation and escalation handling for the Medicare programs, and hand clinical items to the health center's clinicians. The in-house pharmacy is where the readings and the refills meet: a glucose trend that points to non-adherence is a clinical-pharmacy conversation, one floor away.

The care team is bilingual by design. One patient in five at the health center has limited English proficiency, a third are Hispanic or Latino, and 14.7% of the city is Puerto Rican. A monitoring program that calls a Spanish-speaking patient about a blood-pressure reading in English does not have that patient for long. CoachCare staffs Spanish-speaking care managers and enrollment staff for this panel, writes patient materials in English and Spanish, and treats a third language as a discovery item, not an afterthought.[30]

4. The Quality Case: What Daily Readings and a Monthly Call Move

The health center reports nineteen clinical quality measures to HRSA. On several it leads: aspirin or antiplatelet use in ischemic vascular disease is in the top quartile at 83.3%, as is weight assessment and counseling for children and adolescents at 89.3%; HIV screening is in the second quartile at 64.1%.[31]

[28] The health center's providers page, retrieved September 2026: nineteen adult-medicine prescribers (nine physicians in family and internal medicine; ten nurse practitioners and physician assistants). Pediatric, OB/GYN, infectious-disease, podiatry, dental, pharmacy and behavioral clinicians are excluded from the referral count. The recommendations table tests 8 and 15 referring clinicians.

[29] The health center's website: Health Home and Care Coordination, Clinical Pharmacy and Pharmacy pages; the leadership page's description of a Director of Quality reporting under the associate chief medical officer; postings for registered-nurse care-manager and Health Home care-manager roles; a lifestyle-medicine program referenced in August 2026 news coverage. No headcount is asserted.

[30] HRSA UDS 2025: limited English proficiency 20.86%; Hispanic or Latino 33.83%. ACS 2024 five-year, City of Rochester: Puerto Rican 14.7%; language other than English at home 19.1%. CoachCare staffing commitment for this account: Spanish-speaking care management and enrollment staff; patient materials in English and Spanish.

[31] HRSA Uniform Data System clinical quality measures, reporting year 2025, with HRSA's adjusted quartile: controlling high blood pressure 58.06% (4); diabetes A1c above 9% or untested 35.45% (4); depression screening and follow-up 48.27% (4); statin therapy 77.53% (3); ischemic vascular disease aspirin or antiplatelet 83.33% (1); HIV screening 64.06% (2); child and adolescent weight assessment 89.32% (1). Population arithmetic: 4,909 × (1 − 0.5806) ≈ 2,050; 2,130 × 0.3545 ≈ 755.

Three measures sit in the fourth quartile for 2025, and they are the three a remote care service line is built to move.

Clinical quality measure, UDS 2025	Health center	HRSA quartile
Controlling high blood pressure (below 140/90)	**58.06%**	4
Diabetes: A1c above 9% or untested (lower is better)	**35.45%**	4
Depression screening and follow-up plan	**48.27%**	4
Statin therapy for cardiovascular prevention	77.53%	3
Ischemic vascular disease: aspirin or antiplatelet use	83.33%	1
HIV screening, ages 15 to 65	64.06%	2
Child and adolescent weight assessment and counseling	89.32%	1

HRSA Uniform Data System clinical quality measures, 2025, with HRSA's adjusted quartile ranking (1 is best).

Read the two chronic-disease measures as populations rather than percentages. Blood pressure is controlled in 58.06% of the health center's hypertensive patients, which means roughly 2,050 of its 4,909 hypertensive patients are not at goal on the day they are measured. A1c is above 9% or untested in 35.45% of its diabetic patients, roughly 755 of 2,130. Those are the RPM and CCM cohorts. Nothing in a quarterly visit can see a blood pressure that runs at 160 for three weeks and settles the morning of the appointment; a cellular cuff in the kitchen sees it every day, and a care manager who calls the same week can adjust a refill, catch a missed dose or move the visit up. That is the mechanism by which the two measures move, and it is why the same infrastructure carries a quality argument and a revenue argument at once.

The framing matters. This is a health center with a certified medical home, an accredited quality program and a Target: BP recognition, whose panel is 43% hypertensive, 89% low-income and one-fifth limited-English. The measures describe the population, not the clinicians. What a remote care service line adds is the between-visit contact those patients do not get today, documented monthly under a Medicare code, and the operating dashboard in Section 9.4 tracks blood-pressure control and A1c control among enrolled patients against the 2025 baseline from month one.

> **One entry requirement, every door**
>
> Every value-based payment arrangement a health center might join has the same entry requirement: a consented longitudinal panel, documented monthly care management, and continuous physiologic data. The service line builds all three under fee-for-service, with the revenue in Section 6, before any application is written. No participation in any such arrangement is asserted in this report, and none is needed for the forecast.

5. The Discharge Loop: Clinical Governance and Escalation

5.1 A monitoring program is a clinical operation first

Most remote care programs are bolted onto a clinic and hope the hospital tells them about admissions. The health center owns no hospital, so it cannot learn about a discharge from a shared inpatient record; it learns from hospital admission and discharge alerts, and the program has to be built to act on them within a day. A monitoring program is a clinical operation before it is a revenue line. This section sets out the machinery the health center inherits on day one 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.[32] The argument here is not a penalty program. It is keeping a patient with heart failure or COPD at home on Parsells Avenue instead of in a bed across town.

5.2 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, in English or Spanish, 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.

5.3 The emergent pathway

An active emergent symptom reported during any outreach contact triggers the 911 pathway. That policy supersedes any site-specific escalation preference: whichever clinic the patient belongs to, whichever language the call is in, the emergent floor does not move.

5.4 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.

5.5 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. The sequence is triggered by the hospital admission and discharge alert, and for a discharge home the first touch is also the interactive contact a transitional care episode requires, while the day-12-to-14 touch lands inside the 14-day visit window. One workflow serves both, and it is where most of the 67.1 avoided hospitalizations in Section 6.4 are won.

5.6 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.

6. Value Analysis: The 24-Month Forecast

6.1 Headline economics

Over 24 months the service line produces **$1,968,082 in net reimbursement** to Jordan Health. CoachCare's fees total $1,130,170, including $50,869 of ancillary items: implementation, the

[32] 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.

eClinicalWorks integration and telephonic outreach. Net to the health center is **$837,913, a 42.58% margin** on the program, 41.73% in Year 1 and 43.08% in Year 2.[33]

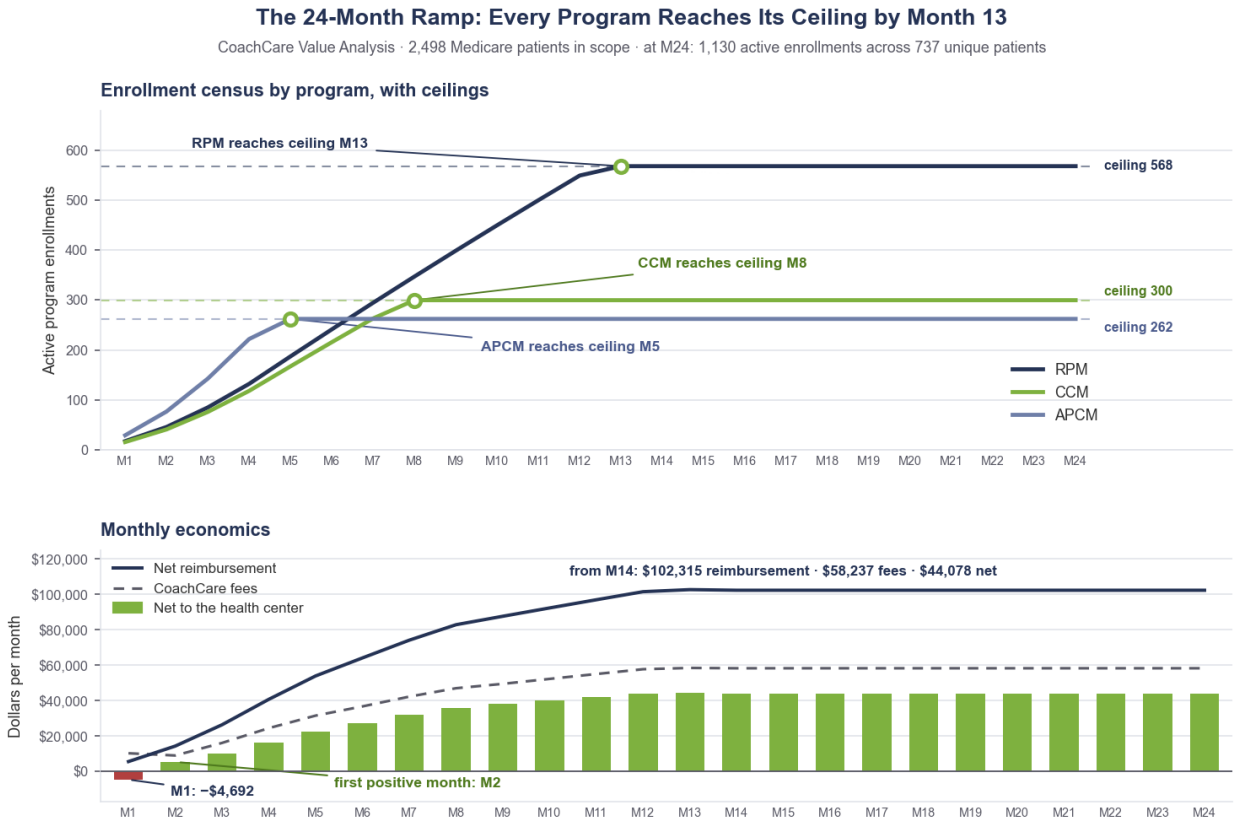

Figure 1. The 24-month ramp: enrollment census by program with ceilings (above) and monthly net reimbursement, CoachCare fees and net to the health center (below). Month 1 nets −$4,692; the first positive month is M2; from M14 the line holds at $44,078 net per month.

The shape of the curve is worth reading precisely. Month 1 is negative, −$4,692, because implementation and enrollment effort land before the first full billing months do. Month 2 turns positive at $5,319, month 3 nets $10,260, and the line compounds as the three programs fill: by M12 net reimbursement reaches $101,501 and net to the health center $43,810; M13, the month RPM reaches its ceiling, is the peak at $102,666 of net reimbursement and $44,244 net; from M14 the line settles at $102,315 of net reimbursement, $58,237 of fees and $44,078 net a month once setup codes fall away and the census holds at ceiling.

6.2 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	$310,675	$631,209	$941,884	$537,263	$404,622
CCM	$256,079	$384,675	$640,755	$322,195	$318,560
APCM	$173,197	$212,247	$385,444	$219,843	$165,600

[33] CoachCare Value Analysis, 24-month forecast: monthly net reimbursement, fees and net-to-health-center series; Year 1 margin 41.73%, Year 2 margin 43.08%, 24-month margin 42.58%, each defined as net to the health center divided by net reimbursement. Ancillary fees of $50,869 over 24 months: implementation $2,500; eClinicalWorks integration $4,000 setup, $150 a month and $1.50 per patient; telephonic outreach. Program net rows print the whole-dollar figure; the APCM row prints $165,600 so that the column sums to the 24-month total.

Program	Year 1 net reimbursement	Year 2 net reimbursement	24-month net reimbursement	24-month CoachCare fees	24-month net to the health center
Ancillary (implementation, integration, outreach)	—	—	—	$50,869	−$50,869
All programs	**$739,951**	**$1,228,131**	**$1,968,082**	**$1,130,170**	**$837,913**

CoachCare Value Analysis, per-program economics by contract year. Ancillary items: implementation $2,500; eClinicalWorks integration $4,000 setup plus $150 a month and $1.50 per patient; telephonic outreach.

RPM is the volume engine at 10,069 patient-months and $941,884 of net reimbursement. CCM is the yield engine at $106.96 of net reimbursement per patient-month across 5,991 patient-months, against $93.54 for RPM and $67.46 for APCM over its 5,714. APCM earns its place a different way: no minute-tracking, a bundled monthly payment, and the level-3 tier for Qualified Medicare Beneficiaries, $113.17 a month, on a panel where 68.6% of Medicare patients are dually eligible. Year 2 outruns Year 1 by $488,180 of net reimbursement because Year 1 carries the ramp and Year 2 runs all three programs at ceiling from its first month.

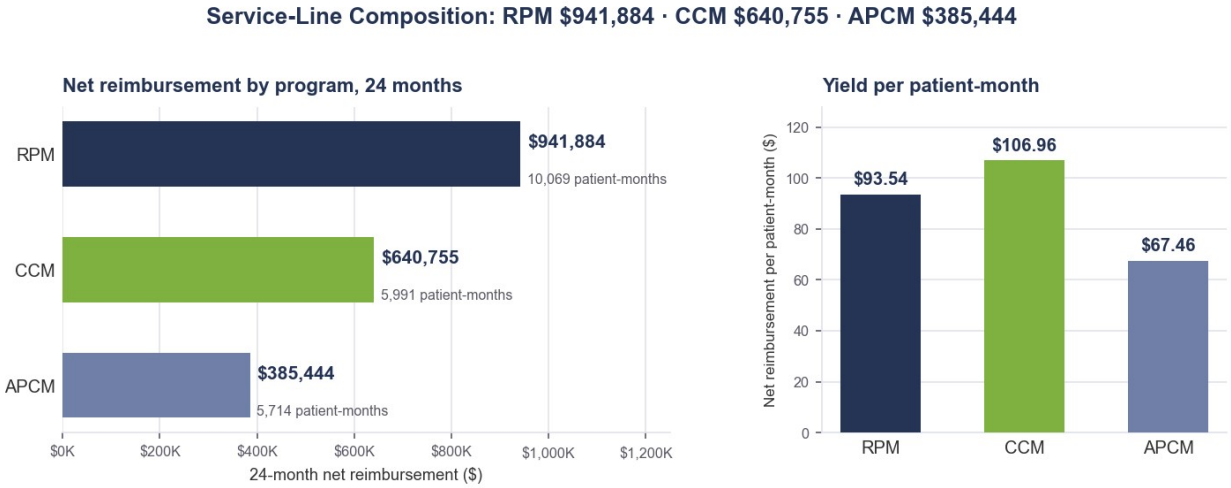

Figure 2. Service-line composition: per-program 24-month net reimbursement and net reimbursement per patient-month.

6.3 The ramp: every ceiling reached by month 13

This account is ceiling-limited in all three programs inside the 24 months. APCM reaches its ceiling of 262 enrollments in month 5, CCM its 300 in month 8, and RPM keeps climbing until month 13, when it reaches 568. From M14 the forecast is flat because there is no one left to add.[34] The first 90 days move fast: 61 enrollments across the three programs in month 1, 163 by month 2, 303 by month 3.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
RPM	1,624	568	Month 13	568
CCM	999	300	Month 8	300
APCM	874	262	Month 5	262
All programs		**1,130**		**1,130 enrollments · 737 unique patients**

[34] CoachCare Value Analysis enrollment model: program ceilings 568 (RPM), 300 (CCM), 262 (APCM); ceilings reached in months 13, 8 and 5; 1,130 active enrollments across 737 unique patients at month 24 (718 at month 12). Dedup: the care-management enrollments plus the RPM enrollments not already carrying a wrapper.

Enrollment counts are program enrollments, not unique patients; the 1,130 enrollments at M24 belong to 737 unique patients (718 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. That cuts two ways. It caps the forecast, and it de-risks it, because the model asks the clinicians to produce no heroic enrollment performance, only a panel that exists. Three things move the ceiling upward: the top of the health center's own five-year Medicare range rather than the 2025 count, the discharges from Rochester's hospitals feeding enrollment within a day of the alert, 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 10 prices what that is worth.

6.4 What the program produces

24-month output	Volume
Claims generated, billing-ready	31,014
Device readings monitored	105,723
Care-management tasks completed	62,027
Chart updates written to eClinicalWorks	15,507
Patient conversations held	9,304 (517 hours of call time)
Care-team hours delivered	13,389 (≈ 6.4 FTE-years)
Hospitalizations avoided	**67.1 · ≈ $1.01 million at $15,000 per admission**

CoachCare Value Analysis operational and clinical outputs, 24 months.

The avoided-admission line deserves its own sentence. 67.1 avoided hospitalizations over 24 months is roughly $1.01 million of cost that never lands on anyone: not on Medicare, not on the plans that cover 77.1% of the county, and not on a bed in one of the hospitals whose heart-failure and COPD readmission ratios already run above expected.[35]

7. eClinicalWorks Integration: The Program Lives in the Record

The health center's chart is eClinicalWorks, with the patient portal on healow, and the forecast prices CoachCare's eClinicalWorks integration ($4,000 setup, $150 a month and $1.50 per patient); the integration scope is confirmed in contracting.[36] The program operates inside the record rather than beside it.

- **Out of the chart: eligibility flags and referral orders.** Qualifying patients are flagged and orders triggered by service inside the eClinicalWorks workflow; CoachCare enrolls flagged Medicare patients on the health center's behalf, and clinicians see enrollment status in real time in the chart they already use. 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, not attached PDFs; evidence of care, care plans and the integrated care summary attach

[35] CoachCare Value Analysis clinical-outcomes module: 67.1 avoided hospitalizations over 24 months, valued at $15,000 per avoided admission (≈$1.01 million). CMS Hospital Readmissions Reduction Program, fiscal year 2026 (see note 16).

[36] Confirmed with the health center, April 2026, and corroborated by the patient-portal link on the health center's homepage, which resolves to an eClinicalWorks-hosted portal instance, and by the healow app references on the mission page. CoachCare integration pricing for eClinicalWorks as carried in the Value Analysis: $4,000 setup, $150 a month, $1.50 per patient.

to the chart monthly; enrollment status and time capture write back to the record, where the Health Home care manager can see them too.

- **Billing-ready claims.** The CoachCare billing engine assembles the monthly claim lines automatically, the step that makes individual-code billing workable at 31,014 claims over 24 months. The health center's own reimbursement team files the FQHC claims with the care-management codes.
- **The alert feed.** Hospital admission and discharge alerts from Rochester's hospitals reach the program through the regional health information exchange or the hospitals' own notification services and arm the post-discharge cadence in Section 5.5 without anyone relaying a message; wiring that feed is a weeks-0-to-4 item, and the interface is an integration-scope item.

CoachCare runs remote care programs for more than 500,000 patients across 400+ managed conditions, with 10,000+ providers on the platform, 1,000+ implementations completed, more than five million claims generated, and over 100 million vitals recorded.[37]

8. 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 New York locality on this account's own billing mix, with enrollment held constant.[38]

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
Device supply, 99454 and 99445	$49.42 a month	**$39.23 a month, −20.6%**	The code CMS proposes to cut
The remote monitoring arm	$941,884 over 24 months	**−9.5%, −$89,876**	Device supply is 32% of the remote monitoring basket; management time moves little
Chronic care management	$640,755 over 24 months	−2.1%, −$13,295	Conversion-factor and relative-value churn only; the proposal does not target these codes
Advanced primary care management	$385,444 over 24 months	−0.6%, −$2,318	The same conversion-factor movement; the bundle's relative values barely move
The whole service line	$1,968,082 over 24 months	**−5.4%, −$105,489, to $1,862,593**	Remote monitoring is 48% of the line; care management is $15,613 of the total

CoachCare repricing of this forecast at the CY2027 proposed amounts, New York locality 99, on the code frequencies and APCM tier weights in this Value Analysis.

Three numbers, each smaller than the last only because its base is larger. A 20.6% cut to one code is a 5.4% change to the service line, because the line is built on three programs and two of them are not the one being repriced. The dual-weighted advanced primary care bundle barely moves, which is one more reason it belongs in the stack. On the national rail a health center bills by rule, the same census carries more cushion than the locality basis shows.

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

[38] CMS-1848-P, proposed CY2027 Physician Fee Schedule (July 2026); comment period closed September 14, 2026. CoachCare repricing at New York locality 99 on this forecast's code frequencies and APCM tier weights: 99454 and 99445 from $49.42 to $39.23 (−20.6%); RPM arm −9.5% (−$89,876); CCM −2.1% (−$13,295); APCM −0.6% (−$2,318); service line −5.4% (−$105,489, from $1,968,082 to $1,862,593). Enrollment held constant.

9. Implementation and the First 90 Days

9.1 Who runs what

CoachCare delivers	Jordan Health keeps
Telephonic and on-site enrollment, in English and Spanish; the enrollment specialist is CoachCare's expense	Referral flags in eClinicalWorks; clinical oversight under general supervision
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans and escalation preferences per site
Monitoring, documentation and the escalation protocol of Section 5	Responses to clinic-routed escalations; the Health Home care-management relationship for the patients it carries
Billing-ready claim generation inside eClinicalWorks	Filing the FQHC claims with the care-management codes; reimbursement review; the revenue
Monthly operating reports against the dashboard in 9.4	Program governance; the Medicare Advantage plan conversations; the hospital alert-feed relationship

9.2 Devices and patient materials, in English and Spanish

Devices ship cellular-connected. A cellular cuff transmits the moment it is used: nothing to pair, no app, no password, no home broadband required, which matters in neighborhoods where 27.8% of residents live in poverty and 40% of the health center's patients are served at public-housing sites. Patient-facing materials are written at a low reading level in English and Spanish, and the enrollment conversation, the symptom check and the monthly care-management call happen in the patient's language. Enrollment happens by phone, in any of the nine sites, and within a day of a hospital discharge alert, not through a portal.

9.3 Model inputs

Input	Value
Medicare panel in scope	2,498 patients, the health center's UDS 2025 Medicare count; compared with chart counts by payer in the first 30 days
Referring clinicians	19 in adult medicine on the health center's provider roster (9 physicians in family and internal medicine + 10 nurse practitioners and physician assistants)
Programs	RPM + CCM + APCM; TCM and BHI named, not in the forecast; PCM off
Program-eligible pools	RPM 1,624 · CCM 999 · APCM 874
Enrollment ceilings	RPM 568 (M13) · CCM 300 (M8) · APCM 262 (M5)
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, New York locality 99 (Rest of New York), ZIP 14605; conservative, since health-center claims pay national amounts (+$76,667 over 24 months, Section 2.2)
APCM tier blend	10% level 1 · 50% level 2 · 40% level 3 = $72.83 per patient-month, the level-3 weight set from the 68.6% dual share
Medicare Advantage	77.1% of Monroe County's Medicare (September 2026). Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. Care-management payment terms are confirmed contract by contract in discovery.

Input	Value
EMR	eClinicalWorks, priced at the catalog integration; integration scope confirmed in contracting
Languages	English and Spanish care management and materials; a third language is a discovery item

9.4 The 90-day plan and the operating dashboard

Days 0–30: foundation. Program agreement and the eClinicalWorks integration workplan. Chart counts by payer against the 2,498 UDS count, and the current care-team roster, the two inputs that move the model most. ICD-10 screening of the Medicare panel per the qualification map, device logistics staged, escalation routing localized per site, the hospital admission and discharge alert feed wired, the Health Home coordination rule agreed, and clinician orientation to the general-supervision workflow. The Medicare Advantage contract check with the plans that cover the panel starts in week one.

Days 31–60: enrollment live. Telephonic, in-clinic and post-discharge enrollment running in English and Spanish; first devices in homes; first billable service months. Month 1 nets −$4,692 as implementation lands; month 2 turns positive. The forecast carries 61 enrollments in month 1 and 163 by month 2.

Days 61–90: scale and file. Enrollment at 303 by month 3 and APCM already near its ceiling, which it reaches in month 5. First monthly operating report against the dashboard. First transitional care episodes billed on discharges the alert feed caught.

The operating dashboard from month one:

- Enrollment census by program against ceiling (568 / 300 / 262)
- Time from referral flag to first billable enrollment (target: under five days from flag to first service)
- Discharges captured: hospital discharge alerts that entered the three-touch cadence, against alerts received
- 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 on the FQHC claim
- Level-3 share of APCM enrollments against the 40% modelled weight
- Blood-pressure control and A1c control among enrolled patients, against the UDS 2025 baseline of 58.06% and 35.45%
- Net to the health center per month against the $44,078 steady-state line

10. Recommendations

1. **Stand up the service line on the Medicare panel now.** The individual-code rail has been live since January. The ramp is the ramp wherever it starts; each month of delay pushes the full $837,913 of 24-month net one month further out. No capital and no headcount are required, so it is a decision the current team can make.
2. **Confirm the chart counts and the care-team roster in the first 30 days.** The 2,498-patient figure is the health center's own UDS count and drives every ceiling in the forecast. Chart counts by payer and the current Health Home and nursing roster are the two inputs that move the model most, and the roster decides how the build-on in Section 3.7 is staffed.
3. **Take the Medicare Advantage question to the plans early.** With 77.1% of the county's Medicare in Medicare Advantage, parity is the floor: plans owe at least the Medicare rate, and individual contracts set their own terms for the care-management code families. Because so much of the

panel is dually eligible, the plans that matter are few; confirm RPM, CCM and APCM terms with each in the first two weeks of discovery.

4. **Bill the health-center rail at national rates from the first claim.** The forecast prices at New York locality 99; health-center claims pay national non-facility amounts, worth $76,667 more over 24 months, all of it net to the health center. Configure claims on the FQHC rail and capture it.
5. **Lead with the dual-eligible tier.** Confirm Qualified Medicare Beneficiary status at enrollment for every dually eligible patient, so that the level-3 weight in the forecast, 40% of APCM enrollments, is documented rather than assumed. Every patient confirmed above that weight is upside.
6. **Make the hospital discharge alert the front door.** Wire the admission and discharge alert feed in the first four weeks, enroll within a day of a discharge, and bill transitional care on every discharge home to a health-center patient. TCM is in the forecast at zero dollars; every episode billed is upside, and every episode enrolled is a monitoring patient from the day they most need it.
7. **Keep the CoachCare-funded enrollment specialist in the plan.** The specialist cannot raise the ceilings, but reaches them months sooner, and is worth $250,623 of 24-month net reimbursement against the no-specialist case in the table below.
8. **Set the coordination rule at enrollment, including the Health Home rule.** Each patient carries one Medicare care-management wrapper, CCM or APCM, never both in a month, plus RPM where indicated and a transitional care episode after a discharge; a patient already carried by the Health Home team keeps that care manager. 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: 2,498 panel, 19 clinicians, 1 enrollment specialist	**$1,968,082**	**$837,913**	42.58%	M13 / M8 / M5
No on-site enrollment specialist	$1,717,459	$730,523	42.54%	M19 / M12 / M7
Second on-site enrollment specialist	$2,083,832	$887,442	42.59%	M10 / M6 / M4
8 referring clinicians	$1,720,810	$732,943	42.59%	M20 / M12 / M6
15 referring clinicians	$1,903,233	$810,332	42.58%	M15 / M9 / M5
Panel 2,855 (the health center's UDS 2024 Medicare count)	$2,180,659	$929,816	42.64%	M14 / M9 / M5
Panel 3,025 (the health center's five-year Medicare high)	$2,275,794	$971,006	42.67%	M15 / M10 / M5
National health-center rate rail, same census	$2,044,749	$914,579	44.73%	M13 / M8 / M5

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

11. What We Would Confirm Together

Every item below is a discovery question, not a condition. The forecast stands on the figures in Section 6; these are the inputs that would move it, in the order they matter.

1. **Chart counts by payer and the current care-team roster.** The Medicare chart count against the 2,498 UDS figure, and who on the current staff carries the Health Home, nursing and care-coordination roles the health center built.

2. **The traditional-Medicare, Medicare Advantage and dual special-needs-plan split of the panel.** The county runs 77.1% Medicare Advantage; the health center's own mix decides how much of the forecast rides on plan contracts, and which plans.
3. **Medicare Advantage plan terms for the care-management code families.** RPM, CCM and APCM payment terms with each plan that covers the panel, contract by contract.
4. **The Qualified Medicare Beneficiary share of the duals.** The 1,713 duals in the UDS report against the level-3 weight of 40% of APCM enrollments in the forecast.
5. **The Medicaid billing election.** Whether the health center bills Medicaid under the prospective payment system or ambulatory patient groups, which decides whether Medicaid remote monitoring is billable at all; the forecast assumes it is not.
6. **The integration scope.** The eClinicalWorks modules in use and the interfaces available, confirmed in contracting.
7. **The hospital alert feed.** How a hospital admission or discharge reaches the health center today, whether through the regional health information exchange or the hospitals' own notification services, and the volume of discharges home to health-center patients; this sizes the transitional care opportunity the report leaves at zero.
8. **Which clinicians bill on the FQHC claim, and in which languages.** The nineteen adult-medicine clinicians on the provider roster against the health center's own list, including any clinician who also bills under another organization, and the languages the care team and enrollment staff will need beyond English and Spanish.

References and Data Sources

- **HRSA Health Center Program records:** the Uniform Data System awardee page for H80CS21582 (reporting years 2021–2025, retrieved September 2026), the Health Center Service Delivery and Look-Alike Sites file (nine service sites and one administrative site), and the Community Health Quality Recognition badges displayed on the awardee page.
- **CMS Federally Qualified Health Center Enrollments (July 2026 vintage) and Provider of Services file (Q2 2026):** eight active FQHC certification numbers under one PECOS associate identifier, main site CCN 331838, participating since January 1993.
- **CMS Provider of Services file (Q2 2026), Care Compare Hospital General Information and the fiscal-year 2026 Hospital Readmissions Reduction Program file:** four acute-care hospitals in the city of Rochester, none owned by the health center; excess readmission ratios above 1.0 for heart failure, COPD and pneumonia at the two nearest the health center's sites. Cited by count, never by hospital name.
- **The health center's website,** retrieved September 2026: the services, locations, providers, mission and Health Home pages, the healow patient-portal link, and the site's brand assets.
- **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 billing under the health center. 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; individual-code reporting for health-center care management; payment at national non-facility amounts in addition to the PPS encounter; APCM adopted for health-center payment; the CY2026 additions 99445 and 99470.
- **CY2026 Physician Fee Schedule rate files (CMS RVU26A, January 2026 release) and the CMS ZIP-to-locality crosswalk (April 2026):** non-facility amounts for the eleven forecast codes, the two transitional care codes and the behavioral health integration code at New York locality 99

(Rest of New York; carrier 13282; work GPCI 1.000, practice-expense 0.950, malpractice 0.703), and the national-rate comparison producing the +$76,667 differential.

- **CMS Medicare Advantage State/County Penetration, September 2026, and CMS Medicare Monthly Enrollment, CY2024 and May 2026:** Monroe County's 176,295 eligibles and 77.1% MA penetration; 170,578 beneficiaries in CY2024 with 37,249 (21.8%) dually eligible.
- **U.S. Census Bureau American Community Survey 2024 five-year estimates** (profiles DP02, DP03 and DP05), City of Rochester and Monroe County, New York: population, age, poverty, income, language, race and ethnicity, and insurance coverage.
- **New York State Department of Health, Medicaid:** the Medicaid Telehealth Policy Manual (July 2026) and Medicaid Update transmittals of September 2022, October 2024 and May 2025 on remote patient monitoring; the Physician Medicine Services fee schedule effective July 1, 2026 (no chronic care management, transitional care management or advanced primary care management codes); and the Health Home program pages.
- **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 5.
- **CoachCare eClinicalWorks integration overview:** integrated ordering and enrollment, enrollment status in the clinical workflow, integrated vital reports, monthly evidence-of-care and care-plan documents, and automated claim generation through the CoachCare billing engine.
- **CoachCare Value Analysis for Jordan Health, 2026, and the CY2027 repricing of the same forecast:** every financial, enrollment, clinical-output and operational figure in Sections 2, 6, 8, 9 and 10, built on 2,498 Medicare patients in scope, 19 referring clinicians, one on-site enrollment specialist, and CY2026 non-facility fee schedule rates at New York locality 99 for RPM, CCM and APCM.

How this report counts

Patients and program enrollments are different numbers. At M24 the program holds 1,130 active program enrollments belonging to 737 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 2,498-patient figure is the Medicare count the health center reported to HRSA for 2025, and the first implementation step compares it with chart counts by payer.

No individual is named anywhere in this report. Governance, leadership, clinician composition, care-management staffing and hospital relationships are described by count, role and organization only. The corporation carries the name of the physician it was named for in the 1970s, and that name appears here only as the organization's.