



SERVICE LINE STRATEGY • Connected Care, by CoachCare.

Family HealthCare Network

A federally qualified health center in California's southern San Joaquin Valley, fifty years old in 2026: 40 health center sites and two mobile units across Tulare, Kings, Fresno and Kern counties, 19,942 Medicare patients, and eClinicalWorks at every site

Remote Care Service Line Optimization Report

2026 Strategy Report

A scalable, profitable remote care service line for Family HealthCare Network: remote monitoring, chronic care management and advanced primary care management for the Medicare patients the health center already serves, billed under FHCN's own NPIs on top of the PPS encounter and run by a CoachCare care team inside eClinicalWorks

Purpose of this document

Prepared by CoachCare, October 2026, as a discussion document for the leadership of Family HealthCare Network. It is the companion to FHCN's remote care strategy page and makes the same argument at report length: why Medicare's payment rules make this the year, where FHCN stands today, how the service line runs inside eClinicalWorks, what it returns over 24 months at the national Medicare rates health centers bill, and why CoachCare is the partner to run it.

The argument is short. More than half of FHCN's Medicare patients also qualify for Medi-Cal, which makes advanced primary care management worth more here than at almost any other health center. FHCN already coordinates care month to month for its highest-need Medi-Cal patients and has raised blood-pressure control every year since 2021. What it does not yet have is daily readings and a monthly Medicare care team for every eligible Medicare patient at all 40 sites. This report shows what that program returns, who does the work, and how it starts without capital or a hire.

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Table of Contents

Executive Summary.....	3
1. Why Now: Medicare Pays Health Centers for the Month Between Visits.....	4
2. FHCN Today: Fifty Years, Four Counties.....	5
2.1 Forty sites from the foothills to Bakersfield.....	5
2.2 The patients FHCN serves.....	6
2.3 How FHCN scores where remote care helps.....	6
2.4 Fifty years of growth.....	7
2.5 What FHCN already runs, and the gap.....	7
2.6 The market, and the rate basis.....	7
3. The Service Line: RPM, CCM and APCM.....	8
3.1 G0511 is gone: each code now pays on its own.....	8
3.2 The clinical and billing stack.....	8
3.3 Advanced primary care management and the dual-eligible panel.....	9
3.4 The care team, and the hours it keeps.....	9
3.5 Transitional care, behavioral health and community health.....	9
3.6 Two deployments, and what FHCN keeps.....	9
3.7 What the codes pay.....	10
4. eClinicalWorks: The Program Lives in the Chart.....	11
5. Clinical Governance & Escalation.....	11
5.1 One shared escalation engine.....	11
5.2 The emergent pathway.....	12
5.3 Three-way routing, on business hours.....	12
5.4 The post-discharge cadence.....	12
5.5 Language access, designed in.....	13
5.6 Continuity and discharge governance.....	13
6. Value Analysis: The 24-Month Forecast.....	13
6.1 The headline economics.....	13
6.2 Two deployments, side by side.....	13
6.3 Full Service or Self Service.....	14
6.4 Where the revenue comes from.....	15
6.5 The ramp, month by month.....	16
6.6 Onboarding pace, ceilings, and what moves them.....	17
6.7 What the program produces clinically and operationally.....	17
6.8 Published results from CoachCare programs.....	18
7. Quality: The UDS Measures and the ACO.....	18
8. Equity and Access: Farmworker Families, Language and Distance.....	19
9. Policy Watch: The CY2027 Proposed Rule, Repriced on This Forecast.....	20
10. Implementation Roadmap.....	21
10.1 Who runs what.....	21
10.2 The model inputs.....	22
10.3 The first 90 days, and the two years after.....	22
10.4 What we would confirm together.....	23
11. Recommendations.....	23
About CoachCare.....	24
References & Data Sources.....	24

Executive Summary

Family HealthCare Network opened in 1976 in a renovated gas station in Porterville to care for farmworker families. Fifty years on it is a federally qualified health center headquartered in Visalia, with 40 health center sites and two mobile units across Tulare, Kings, Fresno and Kern counties, nearly 2,000 employees and eClinicalWorks at every site.¹

FHCN reported **255,355 patients to HRSA for 2025, 19,942 of them on Medicare**, up 32% since 2021. Of those Medicare patients, 11,485 (58%) also qualify for Medi-Cal; across all ages, 40,477 patients carry hypertension and 26,595 diabetes. Blood-pressure control has risen from 63.6% to 70.3% since 2021, poor diabetes control has fallen nine points, and HRSA names FHCN a National Quality Leader in diabetes health. FHCN's clinicians bill inside a Medicare Shared Savings Program ACO since 2021, now on the Enhanced track, the two-sided one.²

The observation this report is built on

FHCN's dual-eligible mix makes advanced primary care management worth more here than almost anywhere, and the enrollment and engagement work is CoachCare's.

FHCN has the panel, the conditions, the record system and a care-coordination habit it already runs for its highest-need Medi-Cal patients. What it does not yet have is daily readings and a monthly Medicare care team for every eligible Medicare patient at all 40 sites. This service line fills that gap: staffed by CoachCare, governed by FHCN's clinicians, billed under FHCN's NPIs from inside eClinicalWorks.

What the Value Analysis returns

Full service line	Year 1	Year 2	24 months
Net reimbursement	\$2,213,797	\$8,432,923	\$10,646,720
CoachCare cost (program and integration fees)	\$1,304,641	\$4,818,384	\$6,123,024
Net to FHCN	\$909,156	\$3,614,539	\$4,523,696
Margin to FHCN	41.1%	42.9%	42.5%

CoachCare Value Analysis: 19,942 Medicare patients, all in scope; remote monitoring, chronic care management and advanced primary care management; 171 referring clinicians; one CoachCare-funded on-site enrollment specialist; CY2026 national non-facility amounts. Margin is net to FHCN divided by net reimbursement.

FHCN can take this two ways, and both are net-positive. CoachCare can run remote monitoring first while Medicare care management stays with FHCN's own team or comes later: **\$4,505,965 of net reimbursement and \$1,901,775 to FHCN over 24 months**, for 4,537 patients. Or CoachCare can run all three programs across the Medicare panel, the forecast of record above, for 5,883 unique patients. Section 6.3 sets that Full Service model beside Self Service, in which FHCN's own staff run the same devices and software.

- 1. Positive from month 2, with nobody hired.** Implementation and the eClinicalWorks setup post in month 1; every month after is positive, and by month 24 the program nets \$362,624 a month. CoachCare delivers 66,181 care-team hours over 24 months, about 31.8 full-time-equivalent years, with 18 care managers at month 12 and 36 by month 24, at 165 patients each.

¹ fhcn.org, October 2026: history (founded 1976 in Porterville), locations and the October 2026 workplace-awards release (nearly 2,000 employees); HRSA Health Center Service Delivery Sites file, October 26, 2026: 40 service delivery sites and two mobile units in Tulare, Kings, Fresno and Kern counties; grant H80CS00786.

² HRSA UDS 2025, FHCN (H80CS00786): 255,355 patients, 19,942 Medicare, 11,485 dual-eligible, 40,477 hypertension, 26,595 diabetes; Medicare patients 2021 to 2025: 15,073, 15,547, 15,554, 19,596, 19,942. CMS Shared Savings Program ACO Participants, 2021 to 2026.

2. **Enrollment pace sets the first year; the Medicare panel sets the ceiling.** Year 1 onboards about 268 new patients a month to 2,997 unique patients at month 12. Then each program reaches its eligible share of the panel: advanced primary care management in month 13, chronic care management in month 17 and remote monitoring in month 23, for 9,024 active program enrollments across 5,883 unique patients. The Medicare chart count by payer is discovery item number one.
3. **The dual-eligible share is the APCM lever.** Level 3 advanced primary care management (G0558, \$117.24 a month) is reserved for Qualified Medicare Beneficiaries, a group within the 58% of FHCN's Medicare patients who are dual-eligible. It pays more than twice level 2 (G0557, \$53.78).
4. **The program lives in eClinicalWorks.** A flagged patient reaches the first day of service in under five days, enrollment status shows in the chart at every site, and claims are created in eClinicalWorks every month (Section 4).
5. **It works the measures HRSA and the ACO both count.** Blood pressure, diabetes control, depression remission, colorectal screening and admissions for patients with several chronic conditions all move with monthly work between visits (Section 7).
6. **It is built for the patients FHCN serves.** Cellular devices that need no home internet, a language plan settled before launch, and a care team that reaches farm towns and foothill sites as easily as Visalia (Section 8).
7. **The CY2027 proposed rule takes 4.9% off this line.** A 20.6% cut to device supply is 9.5% on the remote-monitoring arm and \$520,384 over 24 months on the whole line. Section 9 draws the cascade.

The ask is a working session with FHCN's leadership to confirm the Medicare chart count by payer (traditional Medicare, Medicare Advantage and dual-eligible) and ACO assignment, walk through how care coordination and the Navigation Center run today, review what the ACO partner already provides for care management, and scope the eClinicalWorks workflow and the first sites.

1. Why Now: Medicare Pays Health Centers for the Month Between Visits

Medicare is changing what it pays health centers for. Four shifts are under way at once, and each lands in the same place: the weeks between a patient's visits. For a health center whose Medicare patients carry hypertension, diabetes and depression together, those weeks decide how the year goes.

The shift	What it means for FHCN
1. From visits to panels	Four visits a year leave 361 days without a reading. Population health at FHCN's scale means knowing which of its 19,942 Medicare patients, across 40 sites in four counties, are trending the wrong way before they reach an emergency department. That takes data from home and a team assigned to act on it every month.
2. Accountability for total cost	FHCN's clinicians have billed inside a Medicare Shared Savings Program ACO since 2021, and the ACO now sits on the Enhanced track, the two-sided one. Medicare patients are assigned by where they get their primary care, and every admission among them counts against the ACO's spending benchmark. The ACO is scored each year on blood pressure, diabetes control, depression screening and admissions for patients with several chronic conditions. ³
3. Paid for the month	Since January 1, 2026 health centers bill remote monitoring, chronic care management and advanced primary care management as individual Medicare codes, each paid on top of the PPS encounter. Advanced primary care management pays a monthly amount per patient for running the whole panel, and its top tier is reserved for Qualified Medicare Beneficiaries. 58% of FHCN's Medicare patients also qualify for Medi-Cal. About 37.1% of Medicare beneficiaries in Tulare County, where most FHCN sites are, are in Medicare Advantage, and 48.9% in Fresno County. 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. ⁴

³ CMS Shared Savings Program ACO Participants, 2021 to 2026: FHCN listed each year since 2021; 2026 file: Enhanced track, retrospective assignment.

⁴ CY2026 Physician Fee Schedule final rule: health centers report the individual care-management and remote-monitoring codes, paid in addition to the PPS rate. CMS Medicare Advantage State/County Penetration, October 2026.

The shift	What it means for FHCN
4. Codes for the work between visits	Remote monitoring pays when a patient takes readings on 16 or more days in a month, and two codes new in 2026, 99445 and 99470, pay for shorter months; in this forecast they carry 17% of remote-monitoring reimbursement. ⁵ At the CY2026 national rates health centers bill, one hypertensive patient on remote monitoring and chronic care management (99454, 99457 and 99490) is worth \$170.01 a month in Medicare allowed charges, on top of the PPS visit.

Each shift pays for, or measures, what happens between visits. A remote care service line is how FHCN covers that time for every eligible Medicare patient. FHCN already works this way for its highest-need Medi-Cal patients through Enhanced Care Management. Medicare now pays for the same monthly work for its Medicare patients.

2. FHCN Today: Fifty Years, Four Counties

FHCN started as one clinic in Porterville serving farmworker families. Today it runs a health center in nearly every Tulare County town, two in Kings County, ten in Fresno County and two in Kern. Most sites bring family medicine, internal medicine, pediatrics, women's health and behavioral health under one roof, and many add dental, optometry and an in-house pharmacy.

2.1 Forty sites from the foothills to Bakersfield

Where	Sites	What it means for this program
Tulare County 26 sites and two mobile units	Visalia (Bridge, Oak, School Avenue, Mooney, Court Street), Porterville (the 1976 health center, Downtown and a dental center), Tulare (four sites), Goshen, Cutler-Orosi, Woodlake, Exeter, Farmersville, Strathmore, Terra Bella, Three Rivers, Pixley, Ivanhoe, Traver, Dinuba and Springville	The core of the panel and the largest medical schedules; the program starts here. Foothill and farm-town sites get readings every day whether or not the site is open
Kings County 2 sites	Hanford 5th Street and Hanford 12th Avenue	Hanford 5th Street is one of FHCN's largest sites, with an in-house pharmacy
Fresno County 10 sites	Six Fresno sites, two in Reedley, Selma and Squaw Valley	Fresno First carries the second-largest clinician roster in the network
Kern County 2 sites	Delano (2024) and Bakersfield (June 2026)	The newest sites join on the same eClinicalWorks workflow as the rest

HRSA Health Center Service Delivery Sites file and fhcn.org location pages, October 2026. Of the 40 sites, one is dental-only, one is a women's health center and one is a pediatrics practice; the rest see adult primary-care patients.

FHCN's provider directory lists 351 clinicians. The forecast counts 171 of them as referring clinicians, the adult-medicine prescribers: 31 physicians, 91 physician assistants and 49 nurse practitioners, located 114 in Tulare County, 32 in Fresno, 16 in Kings and 9 in Kern. Advanced practice clinicians outnumber primary-care physicians about five to one in adult medicine, so they will order most of this program. Thirteen FHCN hospitalists care for FHCN patients in the hospital.⁶

⁵ CoachCare Value Analysis for Family HealthCare Network, 2026: 99445 and 99470 carry 17.2% of 24-month remote-monitoring gross reimbursement.

⁶ fhcn.org provider directory, captured October 26, 2026: 351 clinicians; adult-medicine prescribers are family-medicine and internal-medicine physicians, physician assistants and nurse practitioners; 13 hospitalists listed separately.

2.2 The patients FHCN serves

HRSA UDS 2025	Count	What it means for the service line
Patients served	255,355	All ages and payers; the panel the care team already knows
Medicare patients	19,942	Traditional Medicare and Medicare Advantage together, up 32% since 2021; the forecast's panel, with no gross-up
Dual-eligible	11,485 (58%)	Drives the advanced primary care management tier mix
Patients aged 65 and over	23,087	Includes patients who are not yet in FHCN's Medicare count
Hypertension, all ages	40,477	The largest group whose home readings would change treatment
Diabetes, all ages	26,595	Home glucose and the monthly call between lab draws

This is the panel remote care is built for. Hypertension and diabetes are the norm, more than half of Medicare patients also qualify for Medi-Cal, and the Medicare count grew from 15,073 in 2021 to 19,942 in 2025. 76.1% of FHCN's patients are Hispanic or Latino, 31.8% have limited English proficiency, and 77% live at or below the federal poverty line, so language and access are part of the program design (Sections 5.5 and 8).⁷

2.3 How FHCN scores where remote care helps

FHCN's 2025 HRSA Uniform Data System report card places it against every health center in the country. Quartile 1 is the best-performing quarter on HRSA's adjusted ranking.⁸

Clinical quality measure, UDS 2025	Population	FHCN	HRSA quartile
Controlling high blood pressure	Hypertensive patients under 140/90 · higher is better · 63.6% in 2021	70.34%	Quartile 2
Diabetes: HbA1c poor control (> 9%)	Patients with diabetes · lower is better · 38.6% in 2021	29.80%	Quartile 3
Statin therapy for cardiovascular disease	Patients at high cardiovascular risk · higher is better	64.22%	Quartile 4
Depression screening and follow-up	Patients 12 and older · higher is better	87.18%	Quartile 1
Colorectal cancer screening	Adults 45–75 · higher is better	35.83%	Quartile 3
Depression remission at twelve months	Patients with major depression · higher is better	6.16%	Quartile 4

HRSA UDS 2025, FHCN's own filing. Current HRSA badges: National Quality Leader, Diabetes Health; Advancing Health Information Technology for Quality; Preventive Health.

The visit already works at FHCN, and it keeps getting better. Blood-pressure control rose from 63.6% to 70.34% between 2021 and 2025, with 28,471 hypertensive patients under 140/90 last year; poor diabetes control fell from 38.6% to 29.80%. The next points come from home readings and medication changes between visits, across 40,477 hypertensive patients and the 7,924 patients with diabetes still above 9% or untested. Depression screening sits in the top quartile; remission at twelve months, at 6.16%, is the measure that lags, and it depends most on follow-up between visits.

⁷ HRSA UDS 2025, FHCN: Hispanic or Latino 76.1%; limited English proficiency 31.8%; at or below 100% of the federal poverty guideline 77.2%.

⁸ HRSA UDS 2025 clinical quality measures and adjusted quartiles, FHCN (H80CS00786), with the 2021 values for blood-pressure and A1c control; HRSA Community Health Quality Recognition badges.

2.4 Fifty years of growth

Year	What happened
1976	FHCN opens in a renovated gas station in Porterville to care for farmworker families. The Porterville Health Center on West Poplar Avenue still anchors the network
1989–2002	Ivanhoe, Visalia Bridge, Cutler-Orosi, Three Rivers and Visalia Oak carry the model across Tulare County and into the Sierra foothills
2012–2018	Woodlake, Farmersville, Terra Bella, Goshen, Tulare, Pixley, Traver, Strathmore, Dinuba and two more Visalia sites; Hanford takes FHCN into Kings County in 2017
2019–2022	Reedley, Selma, Squaw Valley and Exeter in 2019, then four Fresno sites by 2022. From 2021 FHCN's clinicians bill inside a Medicare Shared Savings Program ACO
2024–2025	Delano, the first Kern County site; FHCN PACE in Visalia; new hospitalists; Springville, a second Reedley center, a Fresno women's health center and two practices joined in Tulare and Visalia
2026	The 50th anniversary; Bakersfield opens in June; 255,355 patients in 2025 and a Medicare panel of 19,942
Next	Daily readings and monthly care management for every eligible Medicare patient at all 40 sites, run by a CoachCare care team inside eClinicalWorks and billed under FHCN's NPIs

2.5 What FHCN already runs, and the gap

What exists	Status	What it means for this program
eClinicalWorks, with healow	Live at every site	The program's host: flags, orders, readings, care documents and claims (Section 4). Patients already book through healow and use the eClinicalWorks portal
Health Home and Enhanced Care Management	Care coordinators and LVNs for Medi-Cal	Credited and kept. The coordinators build health action plans, follow up after admissions and help with housing for the highest-need Medi-Cal patients; they keep that work
Navigation Center	Central calls, portal and text messages, nurse triage, extended hours	CoachCare handles device questions and missed-reading outreach and sends the Navigation Center and the sites only what needs a clinician
Hospitalist team	13 FHCN hospitalists	A clean hand-off for the post-discharge call and transitional care
In-house pharmacies	Eight health centers	Home trends reach the prescriber before a titration; missed refills surface as a flag
Integrated behavioral health	20 clinicians alongside primary care	Positive screens on the monthly call route straight to them
FHCN PACE	Visalia, capitated	Its participants stay outside these programs
Medicare remote monitoring and care management	No published program	The gap this service line fills

The gap is specific. FHCN coordinates care month to month for its highest-need Medi-Cal patients, answers the phones centrally and follows its patients into the hospital. None of its published services or open positions describes a Medicare remote monitoring or care-management program. Home readings and a monthly Medicare care team do not yet reach every eligible Medicare patient at all 40 sites, with the claims built in eClinicalWorks automatically.⁹

2.6 The market, and the rate basis

Across the four site counties about 40% of Medicare beneficiaries were in a Medicare Advantage plan in October 2026: 37.1% in Tulare, 37.8% in Kings, 47.5% in Kern and 48.9% in Fresno. The 19,942 Medicare patients in the

⁹ fhcn.org services, location and resource pages and FHCN's open positions, October 2026: Health Home and Enhanced Care Management care coordination, Navigation Center, hospitalists, pharmacy, behavioral health and PACE.

UDS count already include FHCN's Medicare Advantage and dual-eligible patients, so the forecast needs no gross-up; the payer split is the first thing to confirm.¹⁰

Health centers bill these codes at the national non-facility amount at every site, in addition to the PPS encounter, so every dollar in this report is priced at the CY2026 national amounts, and every patient is priced at the Medicare amount.¹¹

3. The Service Line: RPM, CCM and APCM

3.1 G0511 is gone: each code now pays on its own

Health centers are paid a prospective payment per qualifying visit. For years, the between-visit work for chronic patients was billed under one flat monthly code, G0511, whatever the services, minutes or programs behind it. **Since January 1, 2026 health centers bill remote monitoring, chronic care management and advanced primary care management as individual codes, each paid in addition to the PPS encounter.** Each code carries its own eligibility test, consent, time capture and documentation standard. That is more work for a billing office and more revenue for a health center that does the work; the claims in this forecast are built in eClinicalWorks, not by hand.¹²

The forecast counts Medicare only, including the Medicare-primary claims of dual-eligible patients, because Medi-Cal pays health centers per visit at the PPS rate and the DHCS provider manual says remote patient monitoring is not a reimbursable telehealth service for health centers.¹³

3.2 The clinical and billing stack

Three monthly programs on one infrastructure. Remote monitoring supplies the daily signal; chronic care management or advanced primary care management supplies the monthly care plan around it. Enrollment, devices, monitoring, escalation, documentation and claims run on the same CoachCare workflow for all three.

Program	What it does clinically	Who it fits on this panel	Net reimbursement per patient-month
Remote physiologic monitoring (RPM)	Cellular cuffs, glucometers and scales send readings between visits against thresholds FHCN's clinicians set; 99453, 99454 or 99445, 99457, 99458, 99470	Hypertension and diabetes first, then kidney disease and heart failure; 12,962 eligible	\$98.39
Chronic care management (CCM)	A documented care plan and at least 20 minutes of clinical staff time a month for patients with two or more chronic conditions; 99490, 99439	The multi-chronic core: hypertension with diabetes, kidney disease, heart disease or depression; 7,977 eligible	\$110.75
Advanced primary care management (APCM)	A monthly amount for running the patient's primary care, with no minute count, tiered by complexity; G0556, G0557, G0558	Patients with an ongoing primary-care relationship; level 3 for Qualified Medicare Beneficiaries; 6,980 eligible	\$69.86

¹⁰ CMS Medicare Advantage State/County Penetration, October 2026: Tulare 37.1%, Kings 37.8%, Kern 47.5%, Fresno 48.9%; four-county figure weighted by FHCN site count.

¹¹ CY2026 Physician Fee Schedule final rule, Addendum B national non-facility amounts, conversion factor \$33.4009; health centers bill the individual care-management and remote-monitoring codes at these amounts.

¹² CY2026 Physician Fee Schedule final rule, RHC and FQHC care management: G0511 retired; individual codes billed and paid at the national non-facility amount in addition to the PPS encounter.

¹³ DHCS Medi-Cal Provider Manual, Part 2, Rural Health Clinics and FQHCs, updated July and October 2026: "An e-consult, e-visit, or remote patient monitoring is not a reimbursable telehealth service for RHCs or FQHCs"; a visit is paid at the PPS rate.

One coordination rule, set at enrollment

Chronic care management and advanced primary care management never bill for the same patient in the same month: each patient carries one care-management program, chosen at enrollment. Remote monitoring bills alongside either. The eligible pools overlap; the billing does not.

3.3 Advanced primary care management and the dual-eligible panel

Advanced primary care management pays a monthly amount per patient for the work of running a primary-care panel: access, care planning, coordination and population management, without a minute count. Level 1 (G0556) covers patients with one chronic condition or none, level 2 (G0557) two or more, and level 3 (G0558) Qualified Medicare Beneficiaries with two or more.¹⁴

That last tier is why FHCN's panel matters. 58% of FHCN's Medicare patients are dual-eligible, and Qualified Medicare Beneficiaries are a group within them. The forecast sets the tier mix at 10% level 1, 50% level 2 and 40% level 3, anchored to the dual-eligible share and held below it, because not every dual-eligible patient is a Qualified Medicare Beneficiary. At \$117.24 a month, a level 3 patient-month pays more than twice a level 2 patient-month at \$53.78. Advanced primary care management is the first program to fill, reaching its ceiling of 2,094 in month 13. Which patients carry it rather than chronic care management is a program decision to make together.

3.4 The care team, and the hours it keeps

CoachCare hires, trains and manages the care managers, at 165 patients each: 18 care managers at month 12, for 2,997 unique patients, and 36 by month 24. An on-site enrollment specialist on CoachCare's payroll works beside FHCN's medical assistants and enrolls patients during the visit, and telephonic outreach reaches the rest. Devices are cellular, with no Wi-Fi, smartphone or pairing needed, which matters as much in Three Rivers and Squaw Valley as in Visalia and Fresno. Monitoring runs on business hours: devices transmit daily, and care managers review readings, run outreach and send escalations Monday to Friday, 8 a.m. to 5 p.m. Pacific. Patients are told at consent to call 911 for an emergency and FHCN for anything urgent.

3.5 Transitional care, behavioral health and community health

Transitional care management (99495 at \$220.11, 99496 at \$298.60) pays for the month after a hospital or observation stay: contact within two business days, medication reconciliation and an FHCN visit within 14 days, or 7 for high-complexity patients. FHCN's own hospitalists care for its patients in the hospital, which makes the hand-off unusually clean: the clinician who discharges the patient works for the same health center that books the follow-up. CoachCare makes the first call and books the visit; FHCN furnishes the visit and bills the code. The forecast carries no dollars for it. Whether a discharge notice reaches FHCN from the hospitals where FHCN's patients are admitted is discovery item number five.

Behavioral health integration (99484, \$57.45 a month) fits the same care-manager calls and the same chart, and remission at twelve months is the measure it is built for. **Community health integration** (G0019, \$86.17) pays for time spent on the social needs that get in the way of treatment, the work FHCN's care coordinators already do for Medi-Cal patients. Both run on the same care team and carry no dollars in this forecast.

3.6 Two deployments, and what FHCN keeps

FHCN has already built part of the answer to build-versus-partner. Its care coordinators run Health Home and Enhanced Care Management for Medi-Cal patients, its Navigation Center runs nurse triage, and its hospitalists follow patients into the hospital. None of that is a Medicare program, so the forecast counts chronic care

¹⁴ CY2025 and CY2026 Physician Fee Schedule final rules: APCM (G0556 to G0558) effective January 1, 2025; G0558 for Qualified Medicare Beneficiaries with two or more chronic conditions; billed in place of chronic care management for the same patient and month.

management and advanced primary care management from zero. CoachCare can take on as much or as little of the Medicare care management as FHCN wants.

Deployment	What CoachCare runs	What FHCN keeps
Remote monitoring first	Remote monitoring for the hypertension, diabetes and heart-failure patients, at the same onboarding pace	Medicare care management stays with FHCN's own team or comes later; coordinators keep their Medi-Cal work
The full service line, RPM + CCM + APCM (the forecast of record)	All three programs, enrolling every eligible patient into a care-management program as well as monitoring	Its coordinators' Medi-Cal work, and any patients it chooses to manage itself

- **FHCN keeps clinical governance, the patients and the revenue.** Its clinicians set thresholds, routing and discharge criteria and sign the care plans; claims go out under FHCN's NPIs, and in the full service line FHCN keeps 42.5% of net reimbursement after CoachCare's fees.
- **CoachCare supplies the program.** Devices, an on-site enrollment specialist, care managers, business-hours alert triage, monthly documentation and automated claims, priced per active patient per month. None of it is FHCN's headcount, inventory or capital.
- **Nobody is called twice.** The overlap between the Medicare panel and the patients FHCN's coordinators already carry under Enhanced Care Management is discovery item number three.

3.7 What the codes pay

Codes	What they pay for	CY2026 national
99453	Remote monitoring setup and education, once	\$21.71
99454 · 99445	Device supply, 16+ days · 2 to 15 days in 30 (99445 new in CY2026)	\$52.11 · \$52.11
99457 · 99458	Treatment management, first 20 minutes · each additional 20	\$51.77 · \$41.42
99470	Treatment management, 10 to 19 minutes (new in CY2026)	\$26.05
99490 · 99439	Chronic care management, first 20 minutes · each additional 20	\$66.13 · \$50.44
G0556 · G0557 · G0558	Advanced primary care management, levels 1 to 3	\$16.37 · \$53.78 · \$117.24
99495 · 99496	Transitional care, visit within 14 days · within 7 days (not in the forecast)	\$220.11 · \$298.60
99484 · G0019	Behavioral health integration · community health integration (not in the forecast)	\$57.45 · \$86.17

How the rates apply

CY2026 Medicare Physician Fee Schedule, national non-facility amounts: the rate a federally qualified health center bills for these codes at every site, in addition to the PPS encounter.

One device code (99454 or 99445), one first-tier management code (99457 or 99470) and one care-management program (chronic care management or advanced primary care management) bill per patient per month. One hypertensive patient on remote monitoring and advanced primary care management level 2 (99454, 99457 and G0557) is worth \$157.66 a month.

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. The forecast prices every patient at the Medicare amount.

4. eClinicalWorks: The Program Lives in the Chart

CoachCare's integration uses the workflows already built into eClinicalWorks, so FHCN's clinicians and staff enroll and monitor patients without learning a new system. Care teams enroll qualified Medicare patients for the health center, prompted by enrollment flags that trigger ordering by service. Enrollment status shows in the existing clinical workflow in real time, and patients begin receiving care management and remote monitoring in under five days.¹⁵

Integration area	What happens in eClinicalWorks
Integrated enrollment	Flags in the chart prompt the order for patients who meet criteria FHCN's clinicians approve; the clinician orders at a visit, an annual wellness visit or from an outreach list, and status flows back to the chart
Enrollment by services and devices	The order becomes a remote monitoring, chronic care management or advanced primary care management enrollment with the right cellular device
Exchange of health history	Diagnoses, medications, vitals and labs pass to the care team at intake; the care plan comes back
Integrated vital reports	Home readings land in the chart, so the clinician sees home averages at the next visit
Compliance documentation and integrated care summary	Evidence of care, vitals and the care plan attached to the chart every month for every enrolled patient
Automated claim generation	CoachCare's billing engine creates each claim in eClinicalWorks once a code's requirements are met (16 reading days, 20 minutes, two conditions), which removes the manual claim step for each patient, every month. FHCN's billing team reconciles the batch in its own work queue

Enrollment does not wait for a visit. Telephonic enrollment reaches eligible patients from the outreach list, and cellular devices ship ready to use, with no home internet and nothing to pair. FHCN's patients already book through healow and use the eClinicalWorks portal; the program asks nothing new of them beyond taking a reading. FHCN runs one eClinicalWorks system across all 40 sites, so Bakersfield and Delano enter the program on the same workflow as Porterville and Visalia. The eClinicalWorks integration carries a \$4,000 setup fee, \$150 a month and \$1.50 per enrolled patient a month, with terms confirmed in contracting; implementation, the integration and telephonic outreach are inside the \$6,123,024 of CoachCare cost over 24 months.

5. Clinical Governance & Escalation

Every reading routes through one escalation engine with defined thresholds, trend rules, routing and documentation, so FHCN never carries surveillance liability it did not agree to. Thresholds and routing are set with FHCN's clinicians, site by site, before the first patient enrolls.¹⁶

5.1 One shared escalation engine

Branch	The rule	Why
Critical value	Escalate to the site, regardless of symptoms	No client preference can suppress it. A critical reading on its own goes to the site, not to 911
Out of range, not critical	Retake, then a structured symptom check	Most out-of-range readings resolve here, which keeps clinician inboxes usable
Trend	Three consecutive readings an hour or more apart for blood pressure or glucose; three within seven days for heart rate; weight gain past the agreed threshold	A confirmed trend escalates like a single threshold breach

¹⁵ CoachCare eClinicalWorks integration overview: integrated enrollment, enrollment by services and devices, exchange of health history, integrated vital reports, compliance documentation and integrated care summary, automated claim generation; patients begin services in less than five days.

¹⁶ CoachCare Care Management Programs standard operating procedures, March 2026: escalation logic, trend definitions, emergent protocol, care-management hours (Monday to Friday, 8:00 a.m. to 5:00 p.m. local patient time), post-discharge sequence and discharge governance.

Branch	The rule	Why
Patient unreachable	Document, leave a callback message, and escalate anyway if the reading was critical or a confirmed trend	Silence never downgrades a clinical finding
Documentation	Six fields: vital • findings • method • contact • outcome • follow-up	Any episode can be reconstructed end to end

5.2 The emergent pathway

Non-negotiable, and stated as such

Triggers. Chest pain • new shortness of breath • signs of stroke • syncope • worst-ever headache • sudden swelling, reported by the patient on a call.

Action. The care team calls 911 with the patient on the line, then notifies the FHCN site the same day. A critical reading alone, without those symptoms, goes to the site instead.

If the patient refuses. The site is called with the patient still on the line and directs care; if the site cannot be reached, CoachCare activates emergency services.

The floor. CoachCare's emergent policy supersedes any client escalation preference. FHCN shapes routing for everything else.

5.3 Three-way routing, on business hours

Route	What goes there	Who sees it
Emergency	Active emergent symptoms reported on a call	911 with the patient on the line; the site notified
Needs the health center	A critical reading, or an out-of-range reading or trend confirmed after a retake	The clinician or nurse each site designates, in eClinicalWorks, with readings and a recommended next step
Stable or resolved	Worked, retaken and resolved	Documented as an FYI in the chart, without paging anyone

The matrix is agreed per site. Care managers work readings and escalations Monday to Friday, 8 a.m. to 5 p.m. local patient time; a reading that arrives on a weekend or overnight is worked the next business day. The patient's standing instruction for anything urgent is FHCN's own line, where the Navigation Center's nurse triage and extended hours already answer, or 911. Sites open fewer days a week, and the two mobile units, route their escalations to a designated clinician at another FHCN site.

5.4 The post-discharge cadence

Any emergency visit or hospitalization in the previous 60 days triggers the cadence. After a hospital or observation stay it is also the transitional care episode, and inside the ACO each admission it prevents is spending that never posts against the benchmark.

Touch	Window	What happens
1 • Stabilize	Day 1–2	What led to the visit; discharge medications reconciled against what is in the house; an FHCN follow-up visit confirmed within 7 to 14 days, with the hospitalist's discharge plan in the chart
2 • Detect	Day 5–8	Adherence verified, triggers re-checked, appointment and ordered labs confirmed; the in-house pharmacy looped in on new prescriptions
3 • Secure	Day 12–14	Medication and risk review, visit outcome, and a handoff into monthly monitoring and care management

5.5 Language access, designed in

In 2025, 76.1% of FHCN's patients were Hispanic or Latino and 31.8% had limited English proficiency.¹⁷ A patient who cannot follow a welcome call cannot take a reading that counts, so language is a design requirement, settled before launch. Enrollment scripts, consent language, device instructions and outreach are scoped with FHCN for Spanish-preferring patients, including who carries their calls and how preferred language is flagged in the chart. FHCN's own staff and interpreter practice are part of that design. It is discovery item number six.

5.6 Continuity and discharge governance

1. **Unreachable patients escalate on a fixed clock.** A monitoring patient unreachable 45 days from enrollment goes to the site; non-compliance at 90 days triggers a second escalation; care management's first escalation comes at six months.
2. **There is a hard backstop.** Without an instruction from the site, discharge from monitoring proceeds at 180 days, with the site notified.
3. **FHCN always decides.** Discharge criteria, thresholds and routing belong to FHCN's clinicians, with the single exception of the emergent floor in Section 5.2.

6. Value Analysis: The 24-Month Forecast

6.1 The headline economics

The forecast covers all three programs across FHCN's 19,942 Medicare patients, all in scope, at CY2026 national amounts, with 171 referring clinicians, one CoachCare-funded on-site enrollment specialist at 80 enrollments a month and telephonic outreach. It counts fee-for-service reimbursement only: no transitional care, behavioral or community health integration, Medi-Cal, shared savings or grant dollars.¹⁸

Full service line	Year 1	Year 2	24 months
Remote physiologic monitoring	\$719,058	\$3,786,907	\$4,505,965
Chronic care management	\$690,853	\$2,890,560	\$3,581,413
Advanced primary care management	\$803,886	\$1,755,456	\$2,559,342
Net reimbursement	\$2,213,797	\$8,432,923	\$10,646,720
CoachCare cost: program fees, eClinicalWorks integration, implementation and telephonic enrollment	\$1,304,641	\$4,818,384	\$6,123,024
Net to FHCN	\$909,156	\$3,614,539	\$4,523,696
Margin to FHCN	41.1%	42.9%	42.5%

The margin rises from 41.1% in year one to 42.9% in year two as the one-time setup falls away and the census fills. Year two carries most of the value: **\$8,432,923 of net reimbursement, \$3,614,539 of it kept by FHCN.**

6.2 Two deployments, side by side

Each deployment is priced on its own, at the same onboarding pace, and the full service line is the forecast of record. The avoided admissions are the same in both because they come from the monitoring. The full line adds a care-management program, reaches 1,346 more patients than monitoring alone, and returns \$2,621,921 more to FHCN over 24 months.

¹⁷ HRSA UDS 2025, FHCN: Hispanic or Latino 76.1% of patients; limited English proficiency 31.8%.

¹⁸ CoachCare Value Analysis for Family HealthCare Network, 2026, the source of all Section 6 figures; sensitivity runs change one input at a time on the same workbook.

24 months	Remote monitoring first	Full service line, RPM + CCM + APCM
Net reimbursement	\$4,505,965	\$10,646,720
Net to FHCN after fees	\$1,901,775	\$4,523,696
Unique patients at month 24	4,537	5,883
Hospitalizations avoided	About 305	About 305

CoachCare Value Analysis, each deployment priced on its own. The remote-monitoring deployment runs at a 42.2% margin and nets -\$4,691 in its first month.

6.3 Full Service or Self Service

Two ways to run the same program, on the same Medicare panel, the same national rates and the same 24 months. **Full Service** is the forecast of record: devices, software and the CoachCare care team, which staffs enrollment, monitoring, care management and claims preparation inside eClinicalWorks and carries the payroll. **Self Service** gives FHCN the same devices and software inside eClinicalWorks and leaves the care team, enrollment and the monthly minutes to FHCN's own staff, the way its care coordinators run Enhanced Care Management today.

Self Service runs the same enrollment engine with two things an in-house team carries: enrollment at three-quarters of the pace, because nobody's whole job is enrolling, and a quarter fewer billable remote-monitoring and chronic-care minutes, because time-based codes pay only when the minutes are logged every month. Software and device fees are at list price, and FHCN employs the clinical minutes.

24 months	Full Service	Self Service
Net reimbursement	\$10,646,720	\$7,206,923
CoachCare fees	\$6,123,024	\$1,228,586
FHCN staffing (care team, program lead, enrollment role)	\$0	\$3,038,626
Net to FHCN	\$4,523,696	\$2,939,711
Margin to FHCN	42.5%	40.8%
Program enrollments by month 6	1,855	1,391
Net to FHCN, Year 1 • Year 2	\$909,156 • \$3,614,539	\$492,419 • \$2,447,291
First net-positive month	Month 2	Month 3
FHCN hires	None	12.50 clinical FTEs by month 12 (33.00 at the peak), plus a program lead and an enrollment role
CoachCare care managers by month 24	36	None

Full Service or Self Service: Monthly Net to FHCN, Both Models

After every CoachCare fee and, in Self Service, FHCN's own care-team payroll - same panel, same national rates, same 24 months

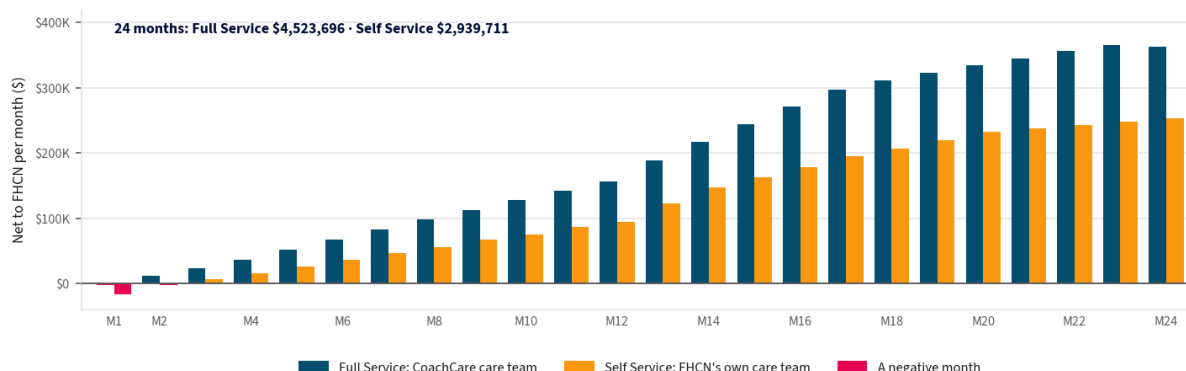


Figure 1. Monthly net to FHCN in both models, after every CoachCare fee and, in Self Service, FHCN's own care-team payroll. CoachCare Value Analysis and the Self Service comparison built on the same census.

Where Self Service wins, and where it loses

Self Service keeps the care team on FHCN's payroll and under its own supervision, and it gives FHCN's staff the work. As run in-house it loses on execution: \$1,583,985 less to FHCN over 24 months, hiring ahead of the census while every Valley health center competes for the same nurses, enrollment nobody owns, and minutes nobody logs.

At equal execution, Self Service comes out ahead. If an in-house team matched CoachCare's enrollment pace and logged every minute, Self Service would net FHCN \$4,597,815 over 24 months, \$74,119 more than Full Service, and it would mean recruiting and keeping 46 clinical FTEs at the peak. That is the real trade: a small margin difference against a hiring plan the size of a new department.

6.4 Where the revenue comes from

24 months	Net reimbursement	CoachCare fees	Net to FHCN
Remote physiologic monitoring	\$4,505,965	\$2,564,345	\$1,941,620
Chronic care management	\$3,581,413	\$1,825,141	\$1,756,272
Advanced primary care management	\$2,559,342	\$1,479,138	\$1,080,203
Implementation, eClinicalWorks integration, telephonic enrollment		\$254,399	-\$254,399
Total	\$10,646,720	\$6,123,024	\$4,523,696

Remote monitoring is the largest line, \$4,505,965 on 4,537 enrollments at month 24, and it produces the readings, the alerts and the avoided admissions. Chronic care management carries \$3,581,413 on 2,393 enrollments and the highest yield per patient-month, \$110.75, because the 99439 add-on is earned in most months. Advanced primary care management carries \$2,559,342 on 2,094 enrollments with no minute count behind it, and it is the program that fills first. The **9,024 active program enrollments at month 24 belong to 5,883 unique patients**, because most monitored patients also hold a care-management enrollment. The two codes new in 2026 carry 17% of remote-monitoring gross reimbursement on this mix, \$835,245 over 24 months.¹⁹

¹⁹ CoachCare Value Analysis: 99445 \$715,944 and 99470 \$119,301 of \$4,864,739 remote-monitoring gross reimbursement over 24 months.

6.5 The ramp, month by month

Month 1 nets -\$2,184, because the one-time implementation fee and the eClinicalWorks setup post against 134 enrollments. The program is positive from month 2, with \$12,180 on 353 enrollments, and 656 by month 3. Onboarding adds about 268 new patients a month in the first year, and by month 24 the program nets \$362,624 a month. Cumulative net to FHCN passes \$189,398 at month 6, \$909,156 at month 12 and \$4,523,696 at month 24.

Month	Active enrollments	Net reimbursement	CoachCare fees	Net to FHCN
M1	134	\$12,527	\$14,711	-\$2,184
M2	353	\$32,258	\$20,078	\$12,180
M3	656	\$59,277	\$36,107	\$23,170
M6	1,855	\$165,141	\$97,510	\$67,631
M9	3,062	\$270,962	\$158,031	\$112,930
M12	4,215	\$372,092	\$215,870	\$156,222
M15	6,162	\$571,728	\$327,304	\$244,424
M18	7,610	\$718,522	\$407,684	\$310,837
M21	8,500	\$804,046	\$458,837	\$345,209
M24	9,024	\$848,789	\$486,165	\$362,624

The 24-Month Ramp: 9,024 Program Enrollments Across 5,883 Unique Patients

CoachCare Value Analysis - 19,942 Medicare patients across 40 sites, all in scope - CY2026 national non-facility amounts

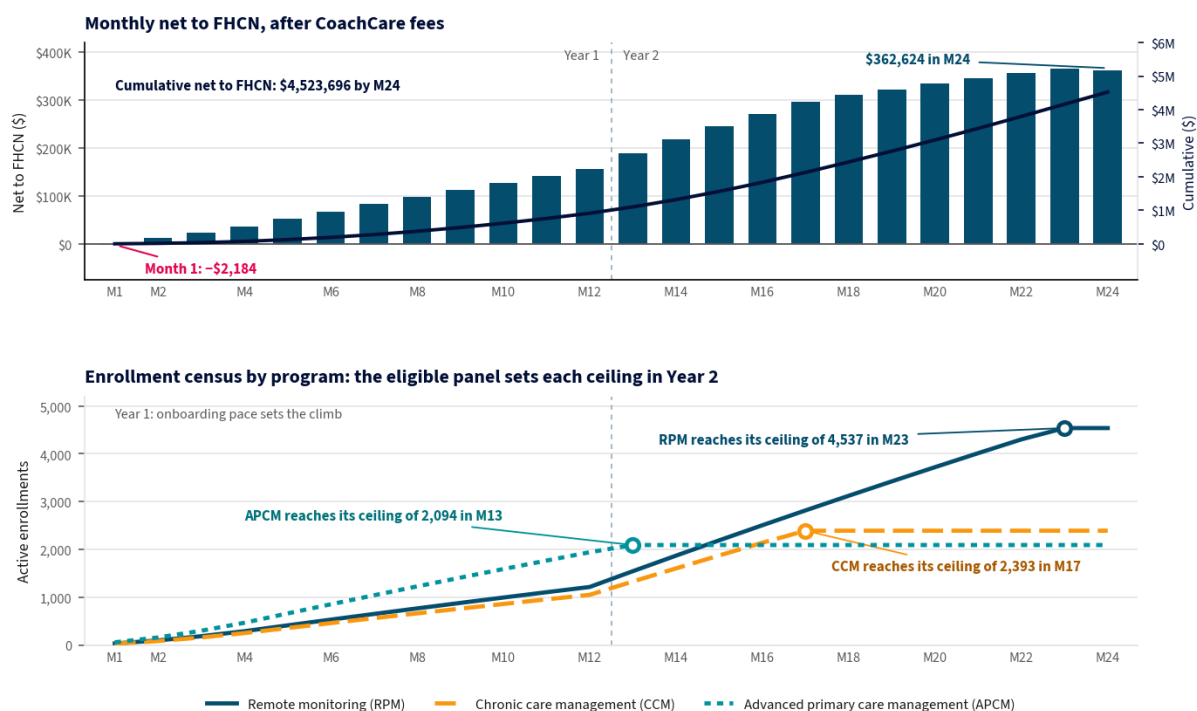


Figure 2. Monthly net to FHCN after CoachCare fees, with cumulative net, and the enrollment census by program with the three ceiling months marked. CoachCare Value Analysis, full service line.

6.6 Onboarding pace, ceilings, and what moves them

Two things set this forecast, one after the other. **In the first year, onboarding pace sets it.** No new program can absorb thousands of patients in its first months, so enrollment is planned at about 268 new patients a month on average, never more than about 310, to 2,997 unique patients at month 12. That is a staffing plan: 18 CoachCare care managers at month 12 and 36 at month 24, hired as the census grows. **In the second year, the Medicare panel sets it.** Each program reaches its eligible share of the panel: advanced primary care management in month 13, chronic care management in month 17 and remote monitoring in month 23.

Program	Eligible share of the 19,942 in scope	Acceptance	Ceiling	Reached
Advanced primary care management	35%, 6,980 patients	30%	2,094	M13
Chronic care management	40%, 7,977 patients	30%	2,393	M17
Remote physiologic monitoring	65%, 12,962 patients	35%	4,537	M23

Say the constraint out loud

Enrollment pace sets the first year; the size of FHCN's Medicare panel sets the ceiling by the end of the second. A second on-site enrollment specialist cannot raise the ceiling, but reaches it sooner: remote monitoring in month 22 instead of 23 and advanced primary care management in month 11 instead of 13, adding \$741,469 of net reimbursement and \$316,672 to FHCN over 24 months. With no on-site specialist, remote monitoring does not reach its ceiling inside 24 months and net reimbursement falls to \$9,800,895.

The chart count is discovery item number one. The 19,942 is FHCN's own UDS Medicare count for 2025. A chart pull by payer and site replaces it, and every ceiling moves with it.

Scenario, one input changed at a time	24-month net reimbursement	Net to FHCN
Forecast of record: panel 19,942, 171 referring clinicians, one on-site enrollment specialist	\$10,646,720	\$4,523,696
No on-site enrollment specialist	\$9,800,895	\$4,162,300
A second on-site enrollment specialist	\$11,388,189	\$4,840,368
Panel 19,596, FHCN's 2024 UDS Medicare count	\$10,559,703	\$4,486,296
Panel 23,087, FHCN's UDS 2025 patients aged 65 and over	\$11,278,356	\$4,794,516
137 referring clinicians, the Medicare reassignment count	\$10,160,911	\$4,320,713
91 referring clinicians, the CMS Doctors and Clinicians count	\$9,287,423	\$3,948,873

CoachCare Value Analysis sensitivity runs, one input changed at a time, every panel fully in scope.

Margin holds near 42.5% in every run. Fewer referring clinicians, or no on-site specialist, slows the climb, and remote monitoring is still filling at month 24. A panel of 23,087 raises every ceiling, but remote monitoring is still climbing at month 24, so most of the extra value arrives after the forecast window; at 23,087, 24-month net to FHCN is \$4,794,516. Onboarding staffing and the chart count are the two levers to settle first.

6.7 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	480,868	Blood pressure, glucose and weight values arriving between visits
Claims and billable units	153,546	Created in eClinicalWorks for FHCN's billing team

Output over 24 months	Volume	What it represents
Care-management tasks	307,092	Outreach, care-plan updates and medication reviews
Chart updates	76,773	Care documents and readings filed to the eClinicalWorks chart
Patient conversations	46,064	Live contacts across 2,559 hours of call time
Care-team hours	66,181	About 31.8 full-time-equivalent years of work FHCN does not employ
Hospitalizations avoided	About 305	About \$4.58 million at \$15,000 per admission

CoachCare Value Analysis, 24-month totals, full service line. The avoided-admission count uses the workbook's baseline admission rate; at a 40% annual admission baseline, realistic for a multi-chronic Medicare panel, it is about 610.

Two ledgers, kept separate

Fee margin funds the program. \$4,523,696 to FHCN over 24 months, on fee-for-service reimbursement in addition to the PPS encounter.

Avoided admissions and quality speak to the ACO. About 305 admissions avoided, about \$4.58 million at \$15,000 each, plus monthly work on the measures in Section 7. Under two-sided risk the new Part B care-management spend also sits on the ACO's ledger, which is why avoided admissions and quality carry the argument there, more than the fee revenue does.²⁰

6.8 Published results from CoachCare programs

- **Blood pressure.** Cardiac Solutions, a physician-owned practice with three offices, put 2,738 patients on CoachCare remote monitoring with home blood-pressure monitoring. Stage 2 hypertension patients saw a 29.1 mmHg average systolic drop, and 94.8% improved. Patients who took readings consistently dropped 8.53 mmHg against 3.54 mmHg for those who did not.²¹
- **Readmissions, at the same practice.** Across 26,689 patients, the 30-day readmission rate was 7% for CoachCare patients against 15% for the rest.²²
- **Heart failure.** Iowa Heart enrolled 450 advanced heart-failure patients and recorded zero readmissions over six months.²³

The result followed the patients who kept taking readings, so the care team's monthly work is outreach and engagement, and clinician time goes to the escalations that need it.

7. Quality: The UDS Measures and the ACO

FHCN reports clinical quality to HRSA every year, and its clinicians have taken part since 2021 in a Medicare Shared Savings Program ACO, now on the Enhanced track, that is scored on an overlapping set. Most of these measures depend on work this program does every month.²⁴

Measure	Reported in	FHCN 2025	What the program does each month
CMS165 Controlling high blood pressure	HRSA UDS · Shared Savings Program	70.34%, quartile 2 63.6% in 2021	Home averages give an accurate reading of control and a monthly chance to act; the documented status reflects home data, not one rushed office reading

²⁰ CoachCare Value Analysis: 305.3 hospitalizations avoided over 24 months at the workbook's baseline admission rate, \$15,000 each.

²¹ Cardiac Solutions case study, April 2026: 2,738 remote-monitoring patients enrolled 12 months or more.

²² Cardiac Solutions readmissions case study: 7% against 15% across 26,689 patients.

²³ Iowa Heart case study, 2026: 450 NYHA class III to IV patients over six months.

²⁴ HRSA UDS 2025 clinical quality measures (CMS165, CMS122, CMS159, CMS130); Shared Savings Program quality reporting through the APM Performance Pathway, with measure 484 calculated by CMS from claims.

Measure	Reported in	FHCN 2025	What the program does each month
CMS122 Diabetes: A1c poor control (> 9%)	HRSA UDS · Shared Savings Program	29.80%, quartile 3 38.6% in 2021	Care management keeps A1c testing and medication changes on schedule; home glucose shows slippage before the next lab
CMS159 Depression remission at twelve months	HRSA UDS	6.16%, quartile 4	A PHQ-9 on the monthly call for every enrolled patient with depression, routed to FHCN behavioral health when the score does not fall
CMS130 Colorectal cancer screening	HRSA UDS · Shared Savings Program	35.83%, quartile 3	An overdue screening is flagged on the call, the FIT kit or referral drafted for the clinician to sign, and completion documented in eClinicalWorks
Q484 Admissions, multiple chronic conditions	Shared Savings Program, from claims	Calculated by CMS	Daily readings, outreach on a confirmed trend, a fixed cadence after any emergency visit or admission

FHCN has improved blood-pressure control and diabetes control since 2021. The program's job is to keep that going across 40,477 hypertensive and 26,595 diabetic patients at 40 sites, with home data behind every documented result. Depression remission and colorectal screening, both below the national middle, are where a scheduled monthly call has the most room to move a score.

How these programs sit inside the ACO

FHCN bills these codes claim by claim for every Medicare patient, whether or not the patient is assigned to the ACO, and the same monthly work counts toward the ACO's quality score and its spending benchmark.²⁵

The assigned share of FHCN's Medicare patients, and what your ACO partner already provides for care management (analytics, coordinators, any remote monitoring or care-management offering), are discovery item number two. Either way the monthly work is the same, and it is the work the ACO's quality score and spending benchmark respond to.

8. Equity and Access: Farmworker Families, Language and Distance

FHCN was founded for farmworker families, and in 2025 **more than a third of its patients, 95,619 people, were agricultural workers or their families.** Of all its patients, 76.1% are Hispanic or Latino, 31.8% have limited English proficiency and 77% live at or below the federal poverty line. A monthly program only works for these patients if it is built around how they live and work.²⁶

What gets in the way	How the service line is built around it
Work hours in the fields and packing houses	Readings are taken at home, morning or evening, on the patient's schedule; the monthly call is booked around the work day, and a missed reading prompts a friendly call
Language	Scripts, consent, device instructions and outreach scoped with FHCN for Spanish-preferring patients before the first enrollment (Section 5.5)
Distance	Sites run from Three Rivers and Springville in the foothills to Pixley, Terra Bella and Squaw Valley, plus two mobile units. Readings arrive every day whether or not the site is open
No home internet	Cellular cuffs, glucometers and scales that ship ready to use, with no Wi-Fi, smartphone or pairing

²⁵ CMS Shared Savings Program ACO Participants, 2026: FHCN's ACO is not in the prospective primary-care payment option, so health-center claims for assigned patients are paid normally.

²⁶ HRSA UDS 2025, FHCN: 95,619 agricultural workers or dependents among 255,355 patients; Hispanic or Latino 76.1%; limited English proficiency 31.8%; at or below 100% of the federal poverty guideline 77.2%.

What gets in the way	How the service line is built around it
Cost at the kitchen table	Coinsurance is explained plainly at consent, and Qualified Medicare Beneficiaries cannot be billed Medicare cost-sharing

FHCN already works this way for its highest-need Medi-Cal patients: a care coordinator, a health action plan and follow-up after admissions. The service line brings the same monthly touch to the Medicare panel and documents it, which gives FHCN a longitudinal record of contact with patients who are hardest to reach between visits.

Eight in-house pharmacies and 340B

Eight FHCN health centers dispense on site, and FHCN participates in the federal 340B drug pricing program. The service line feeds that work: home blood-pressure and glucose trends reach the prescriber before a titration, the monthly call confirms the patient is taking what was dispensed, and a missed refill shows up as a flag instead of a high reading at the next visit. The forecast puts no dollar figure on it.²⁷

9. Policy Watch: The CY2027 Proposed Rule, Repriced on This Forecast

CMS published its proposed CY2027 physician fee schedule in July 2026. The comment period closed September 14, 2026, the final rule is expected in early November 2026, and the changes take effect January 1, 2027. The proposal cuts the remote-monitoring device-supply codes. Every code in this forecast was repriced at the proposed CY2027 national amounts on FHCN's own billing mix and tier weights, with enrollment held constant.²⁸

The CY2027 Proposed Rule, Repriced on This Forecast: Three Numbers, One Scale

Every code repriced at the proposed national amounts on FHCN's own billing mix; enrollment held constant. Device supply is 32% of the remote-monitoring basket; remote monitoring is 42% of the line.

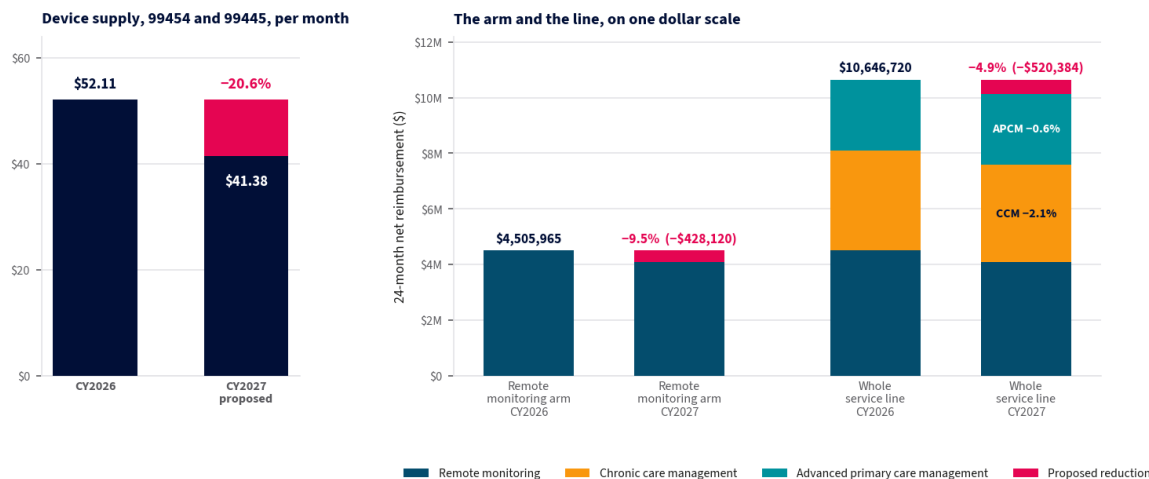


Figure 3. The CY2027 cascade on this forecast: the one code CMS proposes to cut, then the remote-monitoring arm and the whole service line on one dollar scale, with the proposed reduction in coral. CoachCare repricing at the proposed CY2027 amounts.

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
Device supply, 99454 and 99445	\$52.11 a month	\$41.38 a month, -20.6%	The code CMS proposes to cut

²⁷ fhcn.org pharmacy page: on-site pharmacies at eight health centers; HRSA 340B Office of Pharmacy Affairs covered-entity listing.

²⁸ CMS-1848-P, published July 2026. CoachCare repricing at the proposed CY2027 national amounts, conversion factor \$32.8409 against \$33.4009: device supply 32.0% of the remote monitoring basket; remote monitoring 42.3% of the line.

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
The remote monitoring arm	\$4,505,965 over 24 months	-9.5%, -\$428,120	Device supply is 32% of the remote monitoring basket
Chronic care management	\$3,581,413 over 24 months	-2.1%, -\$76,994	Routine rate changes only; not targeted
Advanced primary care management	\$2,559,342 over 24 months	-0.6%, -\$15,270	Routine rate changes only; not targeted
The whole service line	\$10,646,720 over 24 months	-4.9%, -\$520,384, to \$10,126,336	Remote monitoring is 42% of the line

Each number is smaller than the last only because its base is larger: more than half of this line rests on the two care-management programs, which the proposal does not target. CoachCare will rerun the forecast at the final rates. The Self Service model in Section 6.3 already prices the unbundled alternative: software and devices on their own, with FHCN running the care team.

Code	What it pays for	CY2026 national	Proposed CY2027 national	Change
99453	Remote monitoring setup	\$21.71	\$20.03	-7.7%
99454 / 99445	Device supply, 16+ days / 2-15 days	\$52.11	\$41.38	-20.6%
99457	Treatment management, first 20 minutes	\$51.77	\$49.59	-4.2%
99458	Each additional 20 minutes	\$41.42	\$40.39	-2.5%
99470	Treatment management, 10-19 minutes	\$26.05	\$20.69	-20.6%
99490	Chronic care management, first 20 minutes	\$66.13	\$64.04	-3.2%
99439	Each additional 20 minutes	\$50.44	\$49.92	-1.0%
G0557	Advanced primary care management, level 2	\$53.78	\$53.20	-1.1%
G0558	Advanced primary care management, level 3	\$117.24	\$116.91	-0.3%

CY2026 Addendum B and CMS-1848-P proposed CY2027 Addendum B, national non-facility amounts, the basis of the repricing above. Section 1848(c)(7) of the Act limits how far a code's relative value can fall in one year.

10. Implementation Roadmap

10.1 Who runs what

Function	CoachCare	FHCN
Identification and enrollment	Registry query in eClinicalWorks starting with the hypertension, diabetes, kidney and heart-failure patients; an on-site enrollment specialist at 80 enrollments a month; telephonic enrollment; devices shipped, cellular-paired and replaced	Approves the criteria and target list by site; clinicians order at the visit or the annual wellness visit
Language	Scripts, consent, device instructions and outreach scoped for Spanish-preferring patients before launch	Sets the language plan; flags preferred language in the chart
Transitional care	Two-business-day contact and medication reconciliation; visit booked inside the 7- or 14-day window	Hospitalists hand off the discharge; FHCN furnishes the visit and bills 99495 or 99496
Monitoring and escalation	Reading review, monthly outreach, business-hours alert triage and the post-discharge cadence, at 165 patients per care manager	Sets thresholds and routing per site; receives escalations in eClinicalWorks
Documentation, billing, reporting	Monthly care documents in eClinicalWorks, claims created automatically, operational and clinical outcomes reports aligned with the UDS measures	Reconciles and files under its own NPIs; keeps the revenue; names a program lead

Function	CoachCare	FHCN
Care coordination	Medicare remote monitoring and care management	Health Home and Enhanced Care Management for Medi-Cal patients, as today

10.2 The model inputs

Input	Value in this forecast
Medicare panel	19,942 patients (HRSA UDS 2025), all in scope, including Medicare Advantage and dual-eligible patients
Referring clinicians	171 adult-medicine prescribers in FHCN's provider directory: 31 physicians, 91 physician assistants and 49 nurse practitioners
Programs	Remote monitoring, chronic care management and advanced primary care management; transitional care, behavioral health integration and community health integration at zero dollars
Eligibility and acceptance	Remote monitoring 65% eligible, 35% accept; chronic care management 40%, 30%; advanced primary care management 35%, 30%; 8 referrals per clinician a month at 80% acceptance; 70% of monitored patients also in a care-management program; 1.5% monthly attrition
APCM tier mix	10% level 1, 50% level 2, 40% level 3
Enrollment staffing	One CoachCare-funded on-site enrollment specialist at 80 a month, plus telephonic enrollment; onboarding planned to about 2,997 unique patients at month 12
EMR	eClinicalWorks: \$4,000 setup, \$150 a month, \$1.50 per enrolled patient a month, confirmed in contracting
Rates	CY2026 fee schedule, national non-facility amounts, the rate health centers bill; every patient priced at the Medicare amount, Medicare Advantage included

10.3 The first 90 days, and the two years after

Window	What happens	Result
Weeks 0–6 Integrate and charter	eClinicalWorks workshop with FHCN's clinical, billing and IT leads; chart counts by payer, site and ACO assignment; today's Enhanced Care Management patients mapped so nobody is called twice; thresholds, routing and the language plan agreed	Integration live, protocol and language plan signed
Weeks 6–12 The largest Tulare County sites	The enrollment specialist working the largest medical schedules first: Visalia Oak, Visalia School Avenue, Visalia Bridge and Porterville Downtown; remote monitoring for hypertension and diabetes, a care-management program for two-plus conditions; the post-discharge cadence live with the hospitalists	134 enrollments in month 1, 353 by month 2, 656 by month 3
Months 3–6 Kings, then Fresno and Kern	Hanford next, then Fresno First and the other Fresno sites, Reedley and Selma, then Delano and Bakersfield, with the remaining Tulare County towns on the same protocols	1,855 enrollments by month 6
Months 7–12 Every medical site, at the planned pace	Onboarding at about 268 new patients a month; 18 care managers in place by month 12	2,997 unique patients and 4,215 enrollments at month 12
Months 13–24 Fill the ceilings	Advanced primary care management reaches 2,094 in month 13, chronic care management 2,393 in month 17 and remote monitoring 4,537 in month 23; eligibility re-checked against chart data; behavioral health integration scoped	9,024 enrollments, 5,883 unique patients; year 2: \$3,614,539 to FHCN at 42.9%

These programs carry Part B coinsurance, so the consent conversation explains the monthly cost plainly; Qualified Medicare Beneficiaries cannot be billed for Medicare cost-sharing, and 58% of FHCN's Medicare patients are dual-eligible. FHCN PACE participants, more than 100 of them, are capitated and stay outside these programs.

10.4 What we would confirm together

1. **The Medicare chart count by payer.** Traditional Medicare, Medicare Advantage, dual-eligible and Qualified Medicare Beneficiary patients, by site, and how many carry hypertension, diabetes or two or more conditions. Every ceiling in Section 6 moves with it.
2. **ACO assignment, and what your ACO partner already provides.** The number of Medicare patients assigned to the ACO, and any analytics, coordinators or remote monitoring and care-management offering the ACO partner supplies today.
3. **Overlap with today's care coordination.** Which Medicare patients the Health Home and Enhanced Care Management coordinators already carry, any chronic care management FHCN's own staff already provide, and how the programs sit side by side without anyone being called twice.
4. **Medicare Advantage terms.** 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. About 40% of Medicare beneficiaries across the four counties are in a plan.
5. **The hospital feed for transitional care.** Whether a discharge notice reaches FHCN from the hospitals where FHCN's patients are admitted, and how the hospitalists hand off to the post-discharge call.
6. **The language plan.** The share of Medicare patients who prefer Spanish, by site, and who carries their calls.
7. **Coinsurance at consent.** How the monthly coinsurance is explained, and how the Medi-Cal crossover is handled for dual-eligible patients.
8. **The PACE carve-out.** The current PACE census, so its participants are excluded from enrollment lists.

11. Recommendations

1. **Launch the full service line at the largest Tulare County sites, then Kings, Fresno and Kern.** \$4,523,696 to FHCN over 24 months at a 42.5% margin, positive from month 2, with nobody hired.
2. **Pull the Medicare chart count by payer and ACO assignment in week one.** Onboarding pace sets the first year; the chart count sets every ceiling after it.
3. **Start with the hypertension and diabetes patients.** A care-management program for the plan, a cellular cuff and glucometer for the readings, the annual wellness visit as the enrollment conversation.
4. **Put the dual-eligible patients on advanced primary care management.** Qualified Medicare Beneficiaries carry level 3 at \$117.24 a month; the tier is set at enrollment.
5. **Launch Full Service, and revisit staffing once the census is running.** CoachCare carries the care team while the program fills, which nets \$1,583,985 more than Self Service as an in-house team would run it; at equal execution Self Service comes out \$74,119 ahead but needs 46 clinical FTEs at the peak. FHCN's coordinators keep their Medi-Cal work, and both deployments are net-positive.
6. **Use FHCN's hospitalists for transitional care at every discharge.** CoachCare makes the call; FHCN bills 99495 or 99496.
7. **Set the language plan before the first patient enrolls.** Scripts, consent, device instructions and outreach for Spanish-preferring patients, flagged in the chart.
8. **Aim the monthly work at the UDS and ACO measures, and keep clinical governance where it is.** Keep blood-pressure and diabetes control climbing across 40 sites, move depression remission, and avoid about 305 admissions over 24 months. FHCN's clinicians decide; CoachCare does the work and documents it.

The Medicare panel FHCN already serves supports a \$10,646,720 service line at a 42.5% margin over 24 months, on staff FHCN does not hire and devices it does not buy. What remains is to build it once, inside eClinicalWorks, and run it as FHCN's own at all 40 sites.

About CoachCare

The experience to get it right

CoachCare manages more than 500,000 patients across over 400 conditions, with more than 10,000 clinicians running remote care programs on its platform day to day. Its teams have stood up more than 1,000 programs, built the care-plan coding and billing behind more than 5 million claims, and recorded over 100 million vitals.

- **It builds on what FHCN already does.** FHCN already coordinates care month to month for its highest-need Medi-Cal patients and runs a Navigation Center with nurse triage. This program brings the same discipline to the Medicare panel, adds daily readings, and Medicare pays for it.
- **It runs inside the eClinicalWorks chart FHCN already uses.** Readings, documentation and claims live in the chart at all 40 sites, and enrollment status is visible at every site.
- **Fully staffed, no hiring.** Care managers at 165 patients each, enrollment, devices, business-hours alert triage and billing preparation on CoachCare's payroll, with fees per active patient per month.
- **Clinicians stay in charge.** FHCN's physicians and advanced practice clinicians set the protocols, sign the care plans and make every clinical decision.
- **Designed for FHCN's patients.** Cellular devices with nothing to pair, for Three Rivers, Pixley and Squaw Valley as much as for Visalia and Fresno, and a language plan scoped with FHCN before the first enrollment.
- **Published results.** A 29.1 mmHg drop in Stage 2 hypertension at Cardiac Solutions, half the 30-day readmission rate at the same practice, and zero readmissions among 450 advanced heart-failure patients at Iowa Heart.

The ask is a working session with FHCN's leadership to confirm the Medicare chart count by payer (traditional Medicare, Medicare Advantage and dual-eligible) and ACO assignment, walk through how care coordination and the Navigation Center run today, review what the ACO partner already provides for care management, and scope the eClinicalWorks workflow and the first sites.

Contact

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