COACHCARE · REMOTE CARE SERVICE LINE

Heritage Health

Care Management Service Line — Performance & Optimization 2026 Strategy Report

A CoachCare Remote Care Service Line (**APCM · CCM · RPM**) as the operating spine — and the CY2026 reimbursement change that makes care management **billable now**, separately from the health center's PPS visit.

Dirne Health Center, Inc. DBA Heritage Health · Federally Qualified Health Center · Coeur d'Alene & Hayden, North Idaho

Purpose of this report

This report reads Heritage Health's starting position and makes a single, disciplined case: a managed care-management service line — APCM, CCM and RPM, staffed by CoachCare — is the highest-return operational move available to the health center in 2026. It is net-positive on its own economics from month two, it is additive to the PPS visit rather than carved out of it, and it is the operating layer underneath the quality and value-based commitments Heritage already carries.

Economics shown are illustrative and modeled from a CoachCare Value Analysis; every figure should be verified against the health center's own patient, payer and utilization data during discovery. Public organizational facts are sourced and date-stamped, and items that could not be verified are flagged as such.

Prepared for: Heritage Health leadership
Prepared by: CoachCare — Remote Patient Monitoring & Chronic Care Management
Date: July 2026 · Confidential — prepared for Heritage Health leadership

Table of Contents

Executive Summary

Heritage Health — legal entity Dirne Health Center, Inc. — is a 501(c)(3) federally qualified health center and HRSA Health Center Program (§330) grantee, grant **H80CS02331**, headquartered in Coeur d'Alene with administrative offices in Hayden. It is North Idaho's largest provider of integrated medical, dental and behavioral health care, built over forty years from a two-evening-a-week volunteer clinic into a roughly forty-site organization spanning primary care, pediatrics, urgent care, dental, an in-house 340B pharmacy, psychiatry, neurobehavioral services, substance-use recovery, Assertive Community Treatment and street medicine, plus an unusually large school-based health center network across Kootenai, Shoshone and Benewah counties. It has operated a Certified Community Behavioral Health Clinic platform since 2022. Its EHR is **athenahealth**. FY2024 total revenue was **$52.8M** against **$27.3M** of salaries and wages, and the center is expanding on two fronts at once: a $4M, 60,000-square-foot Phase II build that broke ground in February 2026 and an alliance with Coeur d'Alene Pediatrics announced the same month.

The starting position — and the CY2026 payment change. The single most consequential fact in Heritage's near-term environment is a change in how federally qualified health centers get paid for care management. CMS sunset the bundled **G0511** code on **October 1, 2025**. Since **January 1, 2026**, health centers bill the **individual** CCM, RPM and APCM codes at national non-facility Physician Fee Schedule rates — and each is **separately payable on top of the health center's PPS visit**, not carved out of it. For forty years the between-visit work of chasing blood pressures, closing HbA1c gaps and following up after a discharge was an unfunded cost absorbed into the encounter rate. As of this year it is a billable service line.

> **★ Time-sensitive — verify before contracting**
>
> The G0511 sunset and the January 2026 move to individual-code billing at national non-facility PFS rates are stated from public CY2026 final-rule summaries for health centers as of **July 2026**. From CY2027, new PFS care-management codes are set to auto-add for FQHCs and RHCs at national non-facility rates. Confirm the exact CY2026 rates, the current concurrency guidance, and any Idaho-specific billing instruction with Heritage's MAC (Noridian, Idaho locality) before any contract language.

APCM is the hook, and it is the largest line in the model. Advanced Primary Care Management (G0556 / G0557 / G0558) is the code family built for exactly the practice Heritage already runs. It is **not time-based** — no minute thresholds, no stopwatch discipline imposed on a workforce-constrained team — and it pays the most for the population a safety-net health center has in the greatest volume: **QMB dual-eligibles carrying two or more chronic conditions**, billed under G0558. At Heritage's Idaho locality the resolved CY2026 rates are $15.43, $50.78 and $110.53 per patient per month across the three levels. Across 24 months APCM produces **$1,158,436** of modeled net reimbursement — more than CCM ($1,044,483) and more than RPM ($846,747). At most accounts RPM is the headline program; at a health center with a dual-eligible book it is not.

The central argument

A managed care-management service line delivers value two ways at once, and both should be read together.

Standalone. Recurring, subscription-like professional-fee revenue — **$3,049,666** of modeled net reimbursement over 24 months and **$1,302,634** retained by the health center after all CoachCare fees — additive to the PPS structure rather than a reallocation of it, and net-positive from month two onward.

Connective tissue. One shared engine — enrollment, connected devices, monitoring and alert triage, documented escalation, billing capture and analytics — simultaneously produces UDS clinical-measure performance, Medicare shared-savings performance, Idaho Healthy Connections Value Care quality-pool performance, and the documented longitudinal touch that grant narratives are judged on. Build it once; every layer draws on it.

Accountability already exists — this de-risks it. Heritage is a confirmed participant in a **Medicare Shared Savings Program ACO** through the Community Health Center Network of Idaho, which has held Medicare contracts since 2018, and it participates in Idaho Medicaid's **Healthy Connections Value Care** model, which pays health centers per-member-per-month care-management fees on top of fee-for-service with downside limited to those fees. The measures both reward — blood-pressure control, HbA1c testing and control, readmissions, emergency-department use — are the measures a structured remote-care line moves fastest. The health center is not choosing whether to be accountable for quality; it already is, in three places at once, counting the annual UDS report.

The panel, stated honestly. Heritage served **21,042 unique patients** in CY2024 (HRSA Uniform Data System). This model does not run on that number. It runs on **roughly 5,000** — the estimated Medicare and dual-eligible slice of the panel, which is where RPM, CCM and APCM bill at Medicare PFS rates. **Medicaid-only and uninsured / sliding-fee patients are excluded from the modeled billable core**, because Idaho Medicaid's remote physiologic monitoring coverage is narrower than Medicare's and FQHC Medicaid services largely bundle into the PPS encounter rate. Idaho HCVC per-member-per-month care-management fees and Idaho's live-video parity are real but sit outside the model as upside. The exact CY2024 payer mix and QMB dual-eligible count is the single highest-value number still outstanding and is carried as discovery item #1.

Workforce relief is the delivery model, not a side benefit. Kootenai County is a federal primary-care, dental and mental-health shortage area; North Idaho is projected roughly 50 primary-care physicians short by 2030; and Heritage's own behavioral-health provider-to-population ratio sits materially below the Idaho average. Against $27.3M of annual salaries, a tool that requires the health center to hire care managers to operate it solves the wrong problem. **CoachCare supplies the enrollment and engagement labor — 17,008 staff-hours over 24 months, roughly an 8.2 FTE-equivalent of CoachCare-performed work — with no new health-center headcount.** Heritage's clinicians retain protocol governance and every clinical decision.

And the field is clear. Nothing on Heritage's published services, locations or patient-portal pages describes a remote patient monitoring, chronic care management or advanced primary care management program. The adjacent infrastructure that does exist — a 24/7 nurse advice line, Assertive Community Treatment and street medicine — is care-coordination muscle the center already funds without a billing rail underneath it. There is no incumbent vendor to displace. (Absence

of a program is an absence-based finding from public sources — **[UNVERIFIED]**; confirm no nascent effort exists inside the ACO or value-care workstream.)

The modeled economics (illustrative). A CoachCare Value Analysis built on Heritage's Idaho (Noridian) locality and a ~5,000-patient Medicare and dual-eligible in-scope population projects, over 24 months: **$3,049,666** of net professional-fee reimbursement (Year 1 $1,231,859; Year 2 $1,817,807), **$1,302,634** retained by the health center after all CoachCare fees, **37,860** reimbursable claims, **97,811** physiologic readings, and roughly **62 avoided hospitalizations** (≈$932K of avoided acute cost — a system-level benefit, not health-center revenue). Month 1 nets **−$591** because one-time implementation lands before the census ramps; the line turns positive in **month 2** and stays positive, reaching a steady state near $65,598 per month. No claim of day-one profitability is made. All figures are **illustrative, modeled — verify against practice data.**

2026–2027 Priority Recommendations

1. **Stand up the care-management service line now, APCM first.** The reimbursement change is already in effect; every month without a program is a month of care-management labor absorbed rather than billed. Charter it as a named service line with an owner, a P&L and a scorecard — not a pilot bolted onto one clinic.
2. **Lead with APCM on the dual-eligible cohort, then layer RPM and scale CCM.** APCM enrolls fastest because it is not time-based and requires no device, so it is the right first wave and the cleanest early proof of capture rate and revenue per patient-month. RPM follows into the hypertension and diabetes cohorts where devices change management; CCM carries the multi-chronic Medicare patients outside the APCM arm.
3. **Set the APCM-versus-CCM attribution policy before go-live.** APCM is not billed in the same month as CCM (or PCM or TCM) for the same patient; RPM may be billed alongside APCM. One written rule — dual-eligible and multi-chronic patients run APCM + RPM, the remaining multi-chronic Medicare patients run CCM + RPM — keeps the model reimbursement-accurate and audit-ready.
4. **Confirm the CY2024 payer mix and QMB dual-eligible count, then re-run the forecast.** All three programs reach their eligible-population ceilings by Month 24, so the forecast is bounded by the size of the confirmed Medicare and dual population rather than by enrollment pace. A larger confirmed population scales the whole forecast proportionally; this is the highest-leverage number in the entire analysis.
5. **Build it native to athenahealth from day one.** athenahealth is one of CoachCare's integrated EHRs, so enrollment flags and trigger ordering, exchange of patient health history, discrete vitals into the flowsheet, escalation tasks and automated claim generation all run inside the chart and billing workqueues Heritage's staff already use. Confirm the athenaOne versus athenaPractice deployment and the exact interface scope in contracting.
6. **Wire the output into UDS, shared savings and Idaho value care — deliberately.** The same enrolled patient produces a billable Medicare line, a UDS numerator, a shared-savings contribution and an Idaho value-care quality-pool data point. Assign that reporting linkage to a named owner in the first 180 days rather than discovering it at the next annual report.

1. Footprint & Operating Model

Heritage operates as North Idaho's safety-net anchor. Its flagship clinic sits at 1090 W. Park Place in Coeur d'Alene, with a behavioral-health, substance-use-recovery, psychiatry, neurobehavioral, ACT and workforce-training campus on Seltice Way, sites in Hayden, Rathdrum, Kellogg and St. Maries, and school-based health centers across the Lakeland, Coeur d'Alene, Post Falls, Kellogg, St. Maries and Timberlake districts. The organization began in 1985 as a volunteer-run free clinic, became an FQHC in 2003, and rebranded as Heritage Health in 2013. It is also a National Health Care for the Homeless grantee and a registered **340B covered entity**. Its §330 award has grown roughly fourfold since 2019, standing at approximately $9.2M across FY2025–FY2026.

Two expansions are underway simultaneously. The **Phase II Center for Healthy Living** — a $4M, 60,000-square-foot renovation on Seltice Way — broke ground on February 8, 2026 for completion in late 2026, adding primary care, pediatrics, pharmacy and dental alongside the behavioral-health services already on that campus. An alliance with **Coeur d'Alene Pediatrics**, announced February 22, 2026, brings an established local pediatric practice under Heritage. Neither is modeled as panel growth in this analysis; both mean the organization is actively absorbing capacity, which is exactly the condition under which a new service line either gets built properly or never gets built at all.

> **A note on entity, scale and data vintage**
>
> The legal entity is **Dirne Health Center, Inc.** (also styled Dirne Health Centers, Inc.), DBA Heritage Health. Patient counts in this report use the official **CY2024 HRSA UDS figure of 21,042 unique patients**. A separate figure of “approximately 30,000” appears in the center's own materials and in local press; it is best read as total individuals touched — including screenings and outreach contacts — rather than the countable UDS patient panel. Reconciling the two definitions is a discovery item.
>
> Workforce scale is cited publicly at roughly 100 providers and 300 employees as of **2019** — **[UNVERIFIED for 2026]** and materially stale, given revenue has risen from $39.0M (FY2022) to $52.8M (FY2024). Current provider and FTE counts by type, and current visit volume, are discovery items. The ~40 referring providers assumed in the financial model is a working estimate to be validated.

Remote-care posture: clean whitespace. No scalable RPM, CCM or APCM program was found on any public Heritage service, location or portal page as of July 2026. What does exist is adjacent and culturally aligned rather than competitive: a 24/7 nurse advice line staffed to meet the HRSA after-hours access requirement, 24/7 behavioral-health crisis coverage, an athenahealth patient portal used for messaging, results and refills, and Idaho Medicaid live-video visits reimbursed at parity. The health center already funds round-the-clock nursing labor; it simply has no billing rail underneath the between-visit chronic-care work. **PCMH recognition and Idaho Health Center Controlled Network participation are both plausible but [UNVERIFIED]** and are carried as discovery items.

Design principles for the service line

Principle	What it means for Heritage
Longitudinal by default	The Medicare and dual-eligible patient is managed between visits, every month — not re-encountered episodically when something breaks.

Principle	What it means for Heritage
Additive, never substitutive	Every care-management code is billed on top of the PPS visit. Nothing in this design reallocates encounter-rate revenue or changes how a visit is billed.
One service line, one scorecard	APCM, CCM and RPM run as a single named service line with one owner, one P&L and one scorecard — not three disconnected programs in three departments.
Staffed, not licensed	CoachCare supplies the enrollment and engagement labor. In a federal shortage area, a program that requires new hires to operate is a program that does not launch.
Clinical governance stays inside	Protocols, escalation preferences and every clinical decision remain Heritage's. CoachCare executes to documented standard operating procedures and documents every touch.
Built where the work already happens	Enrollment, vitals, escalation tasks and claims live inside athenahealth, so clinicians and billers do not learn a second system.

2. The Remote Care Service Line — The Spine

This is the centerpiece. The care-management service line is not a point solution bolted onto the health center; it is the operating spine that carries recurring PPS-additive revenue, UDS and value-based quality performance, and staffing leverage on one shared engine.

2.1 What It Is: The Care-Management Stack

Heritage owns a longitudinal primary-care panel, which is what makes the full stack billable here. Three programs run together, each with a distinct job.

Layer	Codes	Role in the health-center stack
APCM	G0556 / G0557 / G0558	Advanced Primary Care Management — non-time-based monthly management of the longitudinal panel. G0558 covers QMB dual-eligibles with two or more chronic conditions. The largest single line in the model.
CCM	99490 / 99439 (complex 99487 / 99489)	Chronic Care Management for Medicare patients with two or more chronic conditions who are not on the APCM arm — the longitudinal wrapper for hypertension, diabetes, asthma and depression in one panel.
RPM	99453 / 99454 / 99457 / 99458 (short-window 99445 / 99470)	Remote Physiologic Monitoring — blood pressure, weight and glucose. The continuous early-warning layer that makes chronic control measurable rather than episodic.

The one coordination rule

APCM bundles. It is not billed in the same month as CCM, PCM or TCM for the same patient — those services overlap with APCM by definition. **RPM may be billed alongside APCM.** So Heritage sets one written attribution policy and the model follows it: dual-eligible and multi-chronic patients run **APCM + RPM**; the remaining multi-chronic Medicare patients run **CCM + RPM**. Clean rules like this keep the model reimbursement-accurate and audit-ready. Confirm current concurrency guidance with the MAC before go-live.

2.2 Standalone Value: Five Value Layers

Before any shared-savings or value-care dollar, the service line pays for itself through five layers of value — the first of which is simply revenue that did not exist before January 2026.

1. **Care-management revenue additive to the PPS structure.** Recurring monthly APCM, CCM and RPM billing at national non-facility PFS rates, each separately payable on top of the encounter. A subscription-like revenue line the health center owns, on a population it already serves.
2. **UDS and HRSA quality performance.** Controlled blood pressure, HbA1c testing and control, and depression screening with follow-up are UDS clinical measures reported every year against the §330 grant — and they are precisely the measures structured monitoring and monthly contact move.
3. **Staffing leverage in a workforce-constrained setting.** 17,008 staff-hours of monitoring, outreach and documentation over 24 months — roughly an 8.2 FTE-equivalent of work — performed by CoachCare, not hired by Heritage and not added to existing staff.
4. **Grant-narrative and health-equity alignment.** A documented longitudinal touch, month after month, for patients whose barriers are transportation, housing and phone continuity. The §330, Health Care for the Homeless and behavioral-health expansion awards are all judged on exactly that evidence.
5. **340B pharmacy synergy.** Monthly care-management contact surfaces medication questions, adherence gaps and refill lapses and routes them to the prescriber, keeping more prescribing and refilling inside the health center's own pharmacy relationship. No 340B effect is included in any modeled figure — it is structural upside.

The CY2026 billing stack (illustrative Idaho-locality rates)

Service / code	Type	Rate	Notes
APCM G0556	Monthly bundle	$15.43	Level 1 — zero or one chronic condition
APCM G0557	Monthly bundle	$50.78	Level 2 — two or more chronic conditions
APCM G0558	Monthly bundle	$110.53	Level 3 — QMB dual-eligible with two or more chronic conditions
CCM 99490 / 99439	Monthly	$62.47 / $47.52	Two or more chronic conditions; complex CCM 99487 / 99489 where applicable

Service / code	Type	Rate	Notes
RPM 99453 setup	One-time	$19.68	Requires at least 2 days of transmitted data
RPM 99454 / 99445	Monthly	$47.79	99454 = 16–30 days; 99445 = new CY2026 2–15 day short window
RPM 99457 / 99470	Monthly	$48.66 / $24.50	First 20 minutes / new CY2026 first-10-minute code
RPM 99458	Monthly	$39.14	Each additional 20 minutes

Rates resolve to Heritage's Idaho locality (Noridian, 02202-00) from the CY2026 Physician Fee Schedule and are the magnitudes used in the Value Analysis model — **illustrative, not quotes**. Actual payment is locality-adjusted and set by the regional MAC; verify the current-year PFS before contracting. Every rate is user-editable in the model. The short-window RPM codes (99445 / 99470) are **not** included in the modeled figures — they are upside on top, and a natural fit for the 2–15 day window after an emergency-department visit or hospitalization.

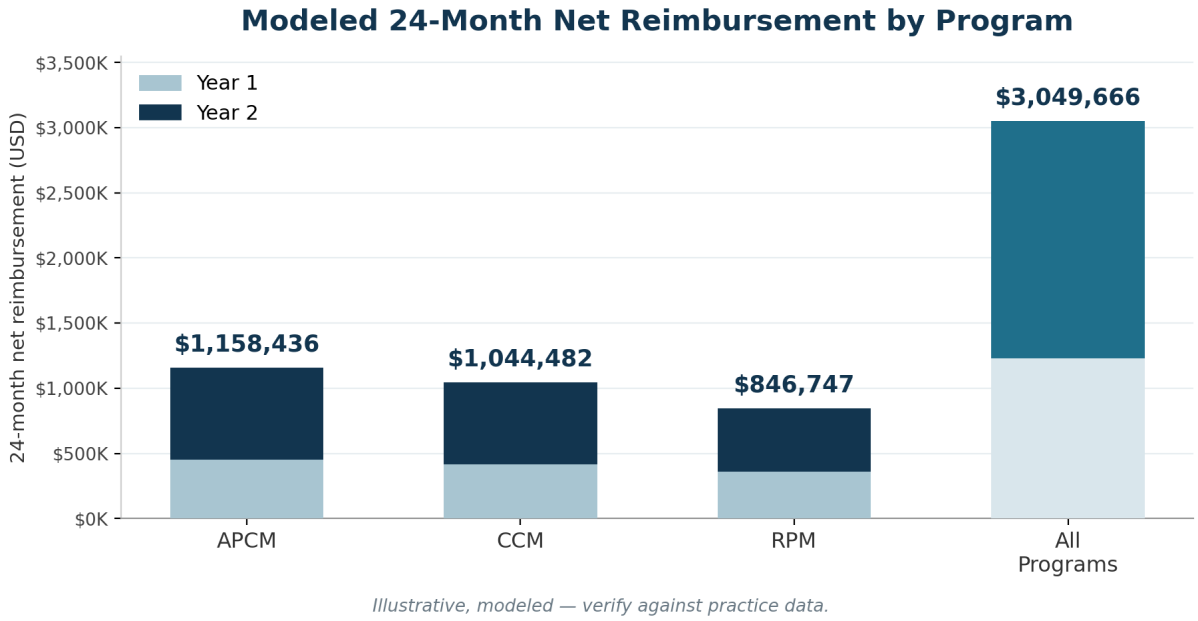


Figure 1. Modeled 24-month net professional-fee reimbursement by program, split Year 1 / Year 2. APCM is the largest single line — the pattern that distinguishes a health-center panel from every other setting. Illustrative, modeled from a CoachCare Value Analysis on a ~5,000-patient Medicare and dual-eligible in-scope population — verify against practice data.

How the recurring-revenue math works

Each enrolled patient generates a predictable monthly professional fee for as long as they remain clinically appropriate and engaged. Scale that across the in-scope population and the line compounds: the model reaches **1,000 APCM, 500 CCM and 450 RPM active program enrollments** by Month 24 — **1,950 enrolled services** in total, and **900 enrolled patients** once cross-program dual enrollment is de-duplicated. Blended net reimbursement per active patient-month, after denials and coinsurance bad debt, is modeled at approximately $58.73 for APCM, $104.49 for CCM and $90.90 for RPM.

Enrolled Patients versus Enrolled Services. A patient enrolled in APCM and RPM counts once as a patient and twice as a service. Program enrollments are never labeled “patients” anywhere in this report or in the companion workbook.

Modeling assumptions (read before quoting any number)

The forecast assumes a **~5,000-patient in-scope Medicare and dual-eligible population**, roughly 40 referring providers, one CoachCare-funded on-site enrollment specialist plus telephonic outreach, enrollment beginning in month 1, and approximately 1.5% monthly attrition. Program eligibility within the in-scope population is modeled at 30% for RPM, 40% for CCM and 80% for APCM, with enrollment conversion of 30% (RPM) and 25% (CCM and APCM) — producing active-enrollment ceilings of 450 RPM, 500 CCM and 1,000 APCM.

The APCM tier mix is a **modeled distribution**, not a count from Heritage's records: 15% Level 1, 55% Level 2, 30% Level 3, giving a blended $63.40 per patient-month before denials and coinsurance. The actual QMB dual-eligible count moves this more than any other assumption on the page.

Not included anywhere in the financial figures: Medicare shared-savings performance, Idaho HCVC per-member-per-month care-management fees, Idaho Medicaid live-video parity revenue, short-window RPM codes 99445 / 99470, transitional care management, any 340B pharmacy effect, and the ≈$932K of avoided acute cost. All are upside on top. **All financial figures are illustrative, modeled — verify against practice data.**

2.3 Connective Tissue: One Engine, Every Layer

The reason to build this as a service line rather than a series of disconnected point programs is that one shared engine carries every layer Heritage cares about. Enroll a patient once, ship one device, run one monitoring and escalation protocol, capture one billing workflow — and the same activity shows up in the professional-fee line, the UDS numerator, the shared-savings measure and the grant narrative.

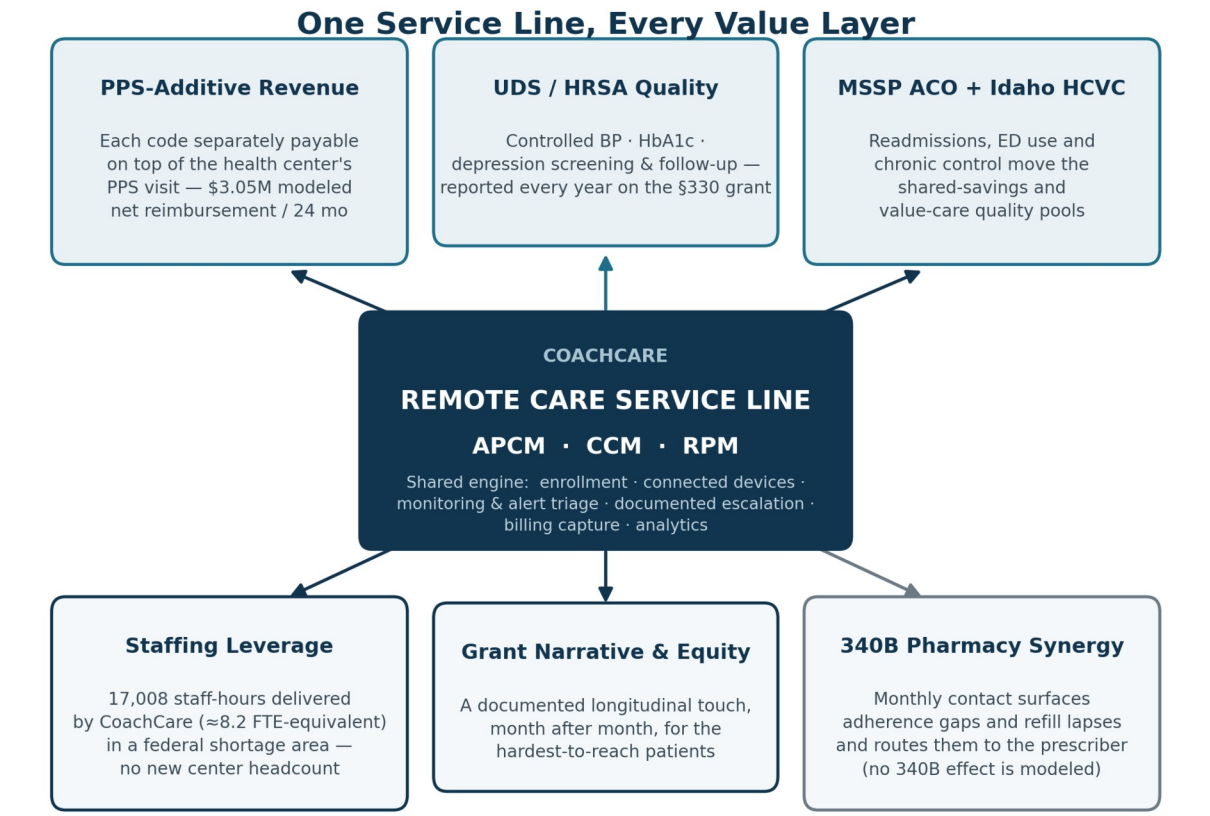


Figure 2. One service line, every value layer. Modeled figures are illustrative — verify against practice data. No 340B, shared-savings or Idaho value-care dollars are included in the modeled financials.

How the same infrastructure carries each layer

Value layer	What the shared engine contributes
PPS-additive revenue	Enrollment at scale, monthly documentation that satisfies the code requirements, and automated claim generation — the difference between a program and a result.
UDS / HRSA quality	Device-based home readings and monthly structured contact produce the numerators for controlled blood pressure, HbA1c testing and control, and depression screening with follow-up.
MSSP ACO performance	The post-discharge three-touch cadence and early decompensation detection move readmissions and emergency-department utilization — the measures shared savings is scored on.
Idaho Healthy Connections Value Care	The same readmission, ED, HbA1c-testing and screening data feeds Idaho's value-care quality set, where health centers enroll as accountable primary care organizations.
Staffing leverage	17,008 CoachCare-delivered staff-hours over 24 months absorb the enrollment, outreach, monitoring and documentation labor a shortage-area health center cannot recruit.

Value layer	What the shared engine contributes
Grant narrative & equity	A repeatable, documented outreach-and-escalation record for hard-to-reach patients — simultaneously the clinical goal, the quality numerator and the strongest grant language.
340B pharmacy	Monthly contact surfaces adherence gaps and refill lapses and routes them to the prescriber (structural upside; not modeled).

3. The CY2026 Payment Change — FQHC Care-Management Billing

This is the economic core of the report, and it is a policy fact rather than an opinion. For years, federally qualified health center care management was compressed into a single bundled code that paid roughly the same whether a center did a little or a lot. That structure is finished.

When	What changed	Why it matters at Heritage
October 1, 2025	The bundle sunset	**G0511** — the bundled FQHC/RHC general care-management code that aggregated roughly 22 distinct CCM, BHI and PCM services into one payment — was last billable 9/30/2025. Claims dated after that are denied.
January 1, 2026	Individual codes, national PFS rates	Health centers bill the individual codes as separate line items at national non-facility PFS rates: CCM (99490 / 99439, 99491 / 99437, complex 99487 / 99489), RPM (99453 / 99454 / 99457 / 99458), PCM, BHI and APCM (G0556 / G0557 / G0558). Related unbundlings include G0512 (psychiatric collaborative care) and G0071 (virtual communication).
Ongoing	Additive, not substitutive	These are not carve-outs of the encounter. RPM, CCM and APCM are separately payable Medicare lines that sit on top of the health center's PPS visit — turning between-visit care management from an unfunded cost center into a revenue line.
From CY2027	Auto-add of new codes	New PFS care-management codes are set to auto-add for FQHCs and RHCs at national non-facility rates, so the billable surface widens rather than narrows.

APCM: the code family built for a safety-net panel

Advanced Primary Care Management began January 1, 2025 under the CY2025 PFS final rule, and federally qualified health centers may furnish and bill it. Three properties make it the right first wave at Heritage. It is **not time-based** — there are no minute thresholds to track. It requires **no device**, so enrollment is not gated on logistics. And its top tier is aimed squarely at the population a health center has in the greatest volume.

Tier	Code	Who qualifies	Monthly rate	Modeled share
Level 1	G0556	Zero or one chronic condition	$15.43	15%
Level 2	G0557	Two or more chronic conditions	$50.78	55%
Level 3	G0558	QMB dual-eligible, two or more chronic conditions	$110.53	30%
Blended		*Across the modeled APCM cohort*	**$63.40**	**100%**

CY2026 Physician Fee Schedule rates resolved to Heritage's Idaho MAC locality. The tier mix is a **modeled distribution across the 1,000-patient APCM cohort, not a count from Heritage's records** — the actual QMB dual-eligible count is the single most important number still missing, and it moves this section more than any other assumption in the report. **Illustrative, modeled — verify against practice data.**

> **Idaho Medicaid — what is and is not in the model**
>
> Idaho Medicaid covers remote physiologic monitoring for established patients, does not reimburse store-and-forward, and reimburses live video at parity; health centers may bill virtual-care encounters. (Policy summary vintage: **July 2026**.) But the Idaho Medicaid RPM code set is narrower than Medicare's, and FQHC Medicaid services largely bundle into the PPS encounter rate — so the revenue thesis in this report is deliberately a **Medicare and dual-eligible story**.
>
> The exact Idaho Medicaid RPM and care-management codes, rates, and whether they are separately payable to health centers or bundled into the PPS rate, are **[UNVERIFIED]** and carried as a discovery item against the current state FQHC/RHC provider handbook. Idaho HCVC per-member-per-month care-management fees and live-video parity are treated as upside outside the model. One structural note that works in Heritage's favor: duals' Medicare coverage remains fee-for-service or Medicare Advantage, so Medicare stays the billing rail for the dual population regardless of Idaho's Medicaid managed-care sequencing.

4. Operating System for Service Line Performance

Running the service line well means managing it like a service line — with a balanced scorecard that puts clinical, operational, financial and quality measures on one page and in front of one owner.

Dimension	Representative measures
Clinical	Percentage of enrolled hypertensive patients at goal; HbA1c testing and poor-control rates in the enrolled cohort; depression screening with documented follow-up; readings-per-patient-per-month adherence.
Service line	Enrolled patients and enrolled services by program; time-to-first-billable-enrollment; monthly capture rate (billable months ÷ eligible enrolled months); net revenue per patient per month; attrition.

Dimension	Representative measures
Access & equity	Enrollment rate among housing-insecure, transportation-limited and rural-site patients; successful-contact rate; documented touches for patients with no completed visit in the prior six months.
Utilization	Emergency-department visits and admissions in the enrolled cohort; 30-day readmissions; completed post-discharge follow-up within 7–14 days.
Value-based	Shared-savings quality measure performance for the attributed Medicare panel; Idaho Healthy Connections Value Care quality-pool measures; annual UDS clinical-measure movement.
Governance	Escalations by category and time-to-resolution; protocol exceptions; documentation completeness; audit-readiness sampling.

Launch readiness checklist

- **In-scope population confirmed** — CY2024 payer mix and QMB dual-eligible count pulled from Heritage's own records, and the forecast re-run against them.
- **Attribution policy written** — APCM versus CCM assignment rules, and the standing rule that RPM stacks with either.
- **Protocols signed off** — hypertension, diabetes and the behavioral-health overlay, plus Heritage's stated escalation preferences for non-emergent findings.
- **athenahealth integration scoped** — deployment confirmed, interfaces defined, billing configuration tested end-to-end on a small cohort before scale.
- **Service-line governance named** — one owner, a monthly scorecard, and a standing slot in the existing quality or operations meeting rather than a new committee.
- **Reporting linkage assigned** — who carries service-line output into UDS reporting, shared-savings submissions and Idaho value-care quality reporting.

5. The Panel — Who Is Actually In Scope

Being precise about the denominator is the difference between a forecast a chief financial officer can defend and a number that falls apart in the first finance meeting. This section states the panel honestly, including what is excluded and why.

Heritage served **21,042 unique patients** in CY2024 under Health Center Program grant H80CS02331 (HRSA Uniform Data System, official). The model does not run on that number. It runs on roughly **5,000** — the estimated Medicare and dual-eligible slice of the panel, which is where RPM, CCM and APCM bill at Medicare Physician Fee Schedule rates. That estimate is a discovery-stage figure to be validated against Heritage's own chart and payer counts, not a count taken from them.

What is excluded, and why. Medicaid-only and uninsured / sliding-fee patients are excluded from the modeled billable core. Idaho Medicaid's remote physiologic monitoring coverage is thinner than Medicare's, and FQHC Medicaid services largely bundle into the PPS encounter rate — so including them would inflate the forecast with revenue that is not separately payable today. That exclusion is a

deliberate conservatism, not an oversight: it means the number in this report is a floor built on the clearest billing rail, with the Medicaid side treated as upside.

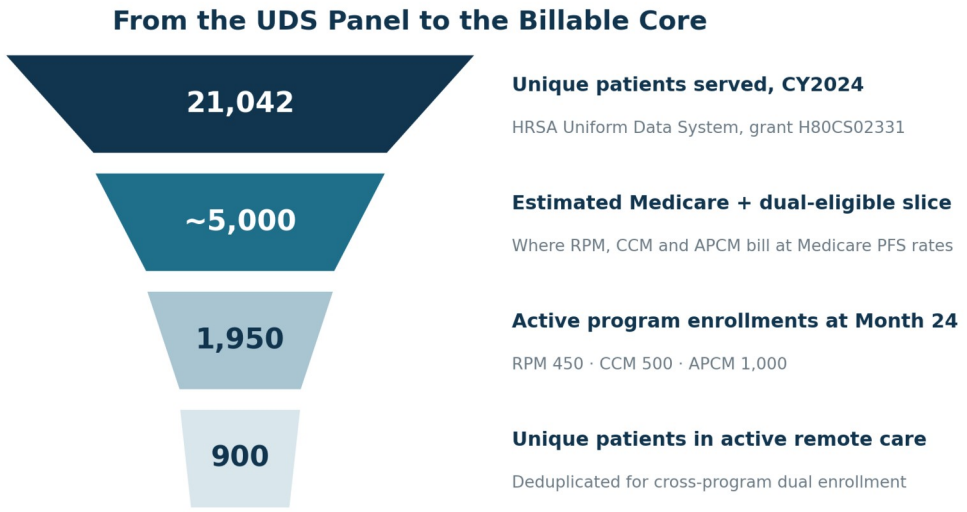


Figure 3. From the CY2024 UDS panel to the modeled billable core and the enrolled census at Month 24. The in-scope figure is a discovery-stage estimate, not a chart count. Illustrative, modeled — verify against practice data.

Upside deliberately left out of the model

- **Idaho HCVC care-management fees.** Idaho Medicaid's Healthy Connections Value Care model pays participating health centers per-member-per-month care-management fees on top of fee-for-service. Not in the forecast.
- **Medicaid live-video parity.** Idaho reimburses live-video visits at parity and health centers may bill virtual-care encounters. Not in the forecast.
- **Medicare shared savings.** The shared-savings dollars a better-managed chronic panel earns through the ACO are not in these numbers either.
- **Short-window RPM.** The new CY2026 codes 99445 and 99470 cover 2–15 day monitoring windows after an acute episode. Not modeled.
- **Panel growth.** The Phase II build and the Coeur d'Alene Pediatrics alliance both add capacity in 2026. Neither is modeled as panel growth.
- **340B pharmacy effect.** Structural, real, and deliberately excluded from every modeled figure.

The honest constraint — and why it is good news

All three programs reach their eligible-population ceilings well before Month 24 and stay flat: 450 RPM, 500 CCM and 1,000 APCM active program enrollments. **That is not an enrollment-pace problem.** CoachCare's enrollment engine fills the panel faster than the eligible population can absorb it. The forecast is therefore **constrained by the size of the confirmed Medicare and dual-eligible population, not by how fast patients can be enrolled** — which means the leverage runs one way: a larger confirmed population scales this entire forecast close to proportionally. Adding referring providers or a second on-site enrollment specialist does not move the number; the ceiling binds first.

★ Discovery item #1 — the CY2024 payer mix and QMB dual-eligible count

Heritage's center-specific UDS payer breakdown (Medicare %, Medicaid %, uninsured %, private %) and its **QMB dual-eligible count** are the single highest-value inputs still outstanding. They set the in-scope denominator, the APCM tier mix, and therefore the entire forecast. HRSA exposes them only in a browser-rendered per-center UDS profile, so they are **[UNVERIFIED]** here and stated as an estimate. Everything in this report is built to be re-run the moment those two numbers land. Related open items: center-specific CY2024 UDS clinical measures (controlled hypertension, HbA1c poor control, depression screening and follow-up) and the FPL bands — no baseline or improvement is assumed anywhere in this report.

6. Powering Quality: UDS, the ACO, and Idaho Value Care

Heritage is not choosing whether to be accountable for quality — it already is, in three places at once. It reports Uniform Data System clinical measures to HRSA every year against the §330 grant. It participates in a Medicare Shared Savings Program ACO through the Community Health Center Network of Idaho, a network of Idaho health centers formed in 2012 that has held Medicare contracts since 2018 and earned its first shared savings in 2020. And it sits inside Idaho Medicaid's Healthy Connections Value Care model, where health centers enroll as accountable primary care organizations and per-member-per-month care-management fees are paid on top of fee-for-service, with downside limited to those fees so the PPS rate is protected. The measures all three reward are the measures remote care moves fastest.

What each measure is worth, and how the service line moves it

Measure	Where it counts	How the service line moves it
Controlled blood pressure	UDS clinical measure · ACO quality	Device-based RPM produces home readings between visits; out-of-range trends trigger protocolized outreach and titration support instead of waiting for the next appointment.
HbA1c testing and poor control	UDS · ACO quality · Idaho value-care measure set	Monthly APCM or CCM contact closes testing gaps and surfaces medication and adherence barriers; glucose RPM makes control continuous rather than quarterly.
Depression screening and follow-up	UDS clinical measure	Structured monthly outreach creates the documented follow-up touch the measure requires — and routes into Heritage's existing integrated behavioral-health service.
30-day readmissions	ACO shared savings · Idaho value-care measure set	The post-discharge three-touch cadence (Day 1 –2 / 5–8 / 12–14) triggered by any admission or ED visit in the previous 60 days.

Measure	Where it counts	How the service line moves it
Emergency-department utilization	ACO shared savings · Idaho value-care measure set	Early detection of decompensation plus a live clinical phone line converts avoidable ED trips into a same-week clinic touch.

The double-count that is not double-counting. The same enrolled patient generates a billable Medicare care-management line **and** improves a UDS numerator **and** contributes to shared-savings performance **and** counts toward Idaho's value-care quality pool. That is not stacking assumptions — it is one clinical activity that four different payment and reporting structures happen to reward at the same time. It is also why a care-management line is unusually durable at a health center: it does not depend on any single one of them staying favorable.

> **What to confirm before citing any quality baseline**
>
> Heritage's center-specific CY2024 UDS rates for controlled hypertension, HbA1c poor control and depression screening with follow-up are not published in machine-readable form and are **[UNVERIFIED]** in this report. The mapping above is **directional** — it describes mechanism, not measured lift. **No baseline and no improvement percentage is assumed anywhere in the financial model**, and no shared-savings or value-care dollars are included in any figure. Pull the center-specific UDS profile in discovery and set targets against Heritage's own starting point.

7. Staffing Leverage, Grant Narrative & 340B

The reimbursement is the reason the service line survives a budget review. These are the reasons it is worth running — the clinical work performed, the acute care avoided, and the labor a workforce-constrained health center does not have to hire.

Modeled 24-month output	Figure	What it means
Reimbursable claims	37,860	Recurring, subscription-like professional-fee volume generated automatically inside the athenahealth workflow.
Physiologic readings	97,811	A continuous picture of blood pressure, weight and glucose between visits — the raw material for chronic control and for quality-measure numerators.
Hospitalizations avoided	62	≈$932K of avoided acute cost at roughly $15,000 per admission. A system-level, indirect benefit — not health-center revenue, and not counted as such anywhere in this report.
Staff-hours delivered by CoachCare	17,008	≈8.2 FTE-equivalent of monitoring, outreach and documentation performed by CoachCare — not headcount Heritage hires, and not hours added to existing staff.

Staffing leverage is the whole argument. Kootenai County is a federal primary-care, dental and mental-health shortage area; North Idaho is projected roughly 50 primary-care physicians short by 2030; and Heritage's own behavioral-health provider-to-population ratio across Kootenai and Shoshone counties sits materially below the Idaho average. Against $27.3M of annual salaries and wages in an FY2024 expense base of $51.2M, the binding constraint on any new care-management program is people, not intent. **CoachCare supplies the enrollment and engagement labor** — telephonic outreach, a funded on-site enrollment specialist, device logistics, monitoring and documentation — which is the only version of this program a shortage-area health center can actually staff. Heritage's clinicians keep clinical governance and every clinical decision.

Grant narrative and health equity. Heritage's §330 Health Center Program grant, its Health Care for the Homeless program and its behavioral-health expansion awards are all judged on access and on documented engagement with hard-to-reach populations. A remote-care line produces exactly that evidence: **a documented longitudinal touch, month after month, for patients whose barriers are transportation, housing and phone continuity rather than willingness**. The escalation record described in Section 9 is grant-narrative material as much as it is clinical governance — a repeatable, auditable account of reaching people the system usually loses.

340B pharmacy synergy. Heritage is a registered 340B covered entity with in-house pharmacies in Coeur d'Alene and Rathdrum, and net inventory sales contributed roughly **$4.4M** — about 8.4% — of FY2024 revenue. Monthly care-management contact surfaces medication questions, adherence gaps and refill lapses and routes them to the prescriber, so more of the prescribing and refilling stays inside the health center's own pharmacy relationship. **No 340B effect is included in any modeled figure in this report**; it is structural upside, and it sits alongside Idaho's newer 340B financial-reporting requirements as a compliance backdrop rather than a threat to eligibility.

Integrated behavioral health is a multiplier here, not a side line. Heritage is North Idaho's largest behavioral-health provider, with outpatient therapy, psychiatry, neurobehavioral services, substance-use recovery, Assertive Community Treatment and a Certified Community Behavioral Health Clinic platform operating since 2022. A published collaboration with the University of Idaho reported improved depression scores, weight loss and improved diabetes measures — evidence that this panel already responds to structured longitudinal management. Remote care extends the same discipline to the physiologic side of the same patients: hypertension, type 2 diabetes, asthma and COPD, and depression with co-occurring conditions.

> **Scope discipline**
>
> The avoided-hospitalization figure is a **system-level, indirect benefit** — it accrues to payers and to the acute-care system, not to Heritage's income statement, and it is excluded from every revenue number in this report. It is included because it is the clinical point of the exercise and because it is what moves the readmission and ED measures Heritage is already accountable for. Treat it as a quality argument, not a financial one.

8. athenahealth Integration

Heritage runs **athenahealth** — the patient portal is athenahealth-hosted, which is publicly verifiable. That matters more than it sounds. athenahealth is one of CoachCare's **integrated** EHRs, so this is a

configured integration rather than a custom build, and the program lives inside the chart and the billing workqueues Heritage's staff already use. Clinicians and billers stay in athenahealth; enrollment flags, discrete vitals, escalation tasks, compliance documentation and claim generation move between the two systems automatically.

Direction	What moves	Operational effect
From athenahealth	Bidirectional enrollment by service; trigger ordering	Care teams enroll qualified Medicare patients on the health center's behalf, prompted by enrollment flags and trigger ordering by service — with enrollment status visible in real time inside the existing clinical workflow.
From athenahealth	Exchange of patient health history	The monitoring team works from the same problem list, medication list and history the clinic sees, rather than a parallel record that drifts.
Back into athenahealth	Integrated discrete vitals	Home blood pressure, weight and glucose land in the flowsheet as discrete, trendable data — not as PDFs attached to the chart.
Back into athenahealth	Escalation tasks and integrated care summary	Clinical changes route to a named member of Heritage's care team as a task in the inbox they already work, with compliance documentation attached.
Back into athenahealth	Automated claim generation	Claims are created automatically by the CoachCare billing engine, eliminating the manual claim-creation step for each patient every month. For a service line whose entire economics depend on monthly capture, that is the difference between a model and a result.

Three capabilities worth naming specifically

- **Integrated ordering and enrollment.** Enrollment is prompted by flags and trigger ordering by service inside athenahealth, and enrollment status is visible in real time in the existing clinical workflow — so the program starts delivering services in days rather than after a long build.
- **Integrated discrete vitals and care summary.** Vitals arrive as structured flowsheet data and escalations arrive as tasks with an integrated care summary, which is what makes the monitoring record usable for UDS reporting and audit rather than merely visible.
- **Automated claim generation.** The billing engine creates the claim for each patient each month. Monthly capture rate is the single operational variable that determines whether a care-management forecast is realized, and automating it removes the most common failure mode.

Confirm in discovery — and again at contracting

Heritage's athenahealth patient portal is public and verified. **Whether the center runs athenaOne (cloud) or athenaPractice (legacy) is [UNVERIFIED]** and determines the exact integration path and timing. **Integration scope — which interfaces are in scope, what configuration is required, and the implementation timeline — is a contracting confirmation item**, not an assumption of this report. Confirm the product state and interface scope before the integration statement of work.

9. Implementation Playbook

Goals & scope

Stand up a managed care-management service line that is self-funding on its own economics and wired into UDS, shared-savings and Idaho value-care reporting within the first year. Scope: APCM + CCM + RPM, billed by Heritage, on the Medicare and dual-eligible population, delivered full-service by CoachCare with no new health-center headcount. Chartered in 30 days; billing by day 90.

Target populations (in launch order)

- **QMB dual-eligibles with two or more chronic conditions (launch first) —** where the economics and the mission converge. No devices, no minute-tracking, first billable month inside the quarter, and the cleanest possible proof of capture rate and revenue per patient-month.
- **The hypertension and diabetes cohorts —** layered onto RPM second, because that is where device data actually changes management and where the UDS measures live.
- **Multi-chronic Medicare patients outside the APCM arm —** carried on CCM + RPM under the written attribution policy.
- **Post-discharge and post-ED patients —** any admission or emergency-department visit in the previous 60 days triggers the three-touch cadence, which is the concrete readmission-prevention loop behind the avoided-hospitalization figure.

Staffing, technology & billing architecture

- **CoachCare-delivered labor.** Telephonic enrollment, a CoachCare-funded on-site enrollment specialist, health coaches, monitoring and alert triage, and documentation — 17,008 staff-hours over 24 months, ≈8.2 FTE-equivalent, at CoachCare's expense. Heritage adds no headcount to launch; the internal staffing model formalizes as census grows.
- **Devices that work in a safety-net panel.** Cellular-connected blood-pressure cuffs, scales and glucometers, shipped, provisioned and supported — no home Wi-Fi, no router credentials, no Bluetooth pairing for the patient to manage. For a panel that includes housing-insecure and transportation-limited patients, that is not a convenience feature.
- **Native athenahealth integration from day one.** Enrollment, orders, discrete vitals, escalation tasks and claims run inside athenahealth per Section 8, subject to the deployment and scope confirmations noted there.

- **Billing architecture built for capture.** Care-plan coding and automated claim generation for every eligible patient, every month, with the APCM-versus-CCM attribution policy enforced in the workflow rather than remembered by a biller.

Clinical workflow & escalation governance

Steady state: enroll at a clinic visit, on provider referral, or through telephonic outreach → ship and activate connected devices where the program calls for them → daily physiologic data and monthly structured contact into a monitoring and triage layer → protocolized outreach on out-of-range trends → documentation and claim generation inside athenahealth → monthly scorecard to service-line governance. Every RPM, CCM and APCM finding runs through a documented protocol rather than ad hoc triage.

Routing	Trigger	What happens
Emergent	An active emergent symptom reported live during outreach — chest pain, new shortness of breath, stroke signs, syncope, worst-ever headache, sudden swelling	The care team calls 911 with the patient still on the line. If the patient refuses, CoachCare loops in the clinic; if the clinic is unavailable, CoachCare activates 911 itself. The urgent/emergent policy supersedes any local escalation preference — the response never waits on a callback.
Critical value	A critical reading, regardless of symptoms	Escalates regardless of symptoms. An out-of-range value first gets a retake plus a symptom check; a trend is defined objectively (three consecutive out-of-range readings at least an hour apart) rather than by a single stray number.
Non-critical clinical change	A confirmed trend or clinically meaningful change that is not emergent	Routed to a defined member of Heritage's care team for review and follow-up — the right person, not a broadcast page to a shortage-area provider panel.
Stable or resolved	A reading that normalizes or a resolved finding	Documented as an FYI in the record — visible for continuity, without interrupting anyone.
Post-discharge	Any hospitalization or ED visit in the previous 60 days	A fixed three-touch sequence: Day 1–2 stabilize and reconcile medications and confirm a 7–14 day follow-up; Day 5–8 verify adherence, re-evaluate triggers and confirm the appointment happened; Day 12–14 review medications and risk and re-assess symptoms.

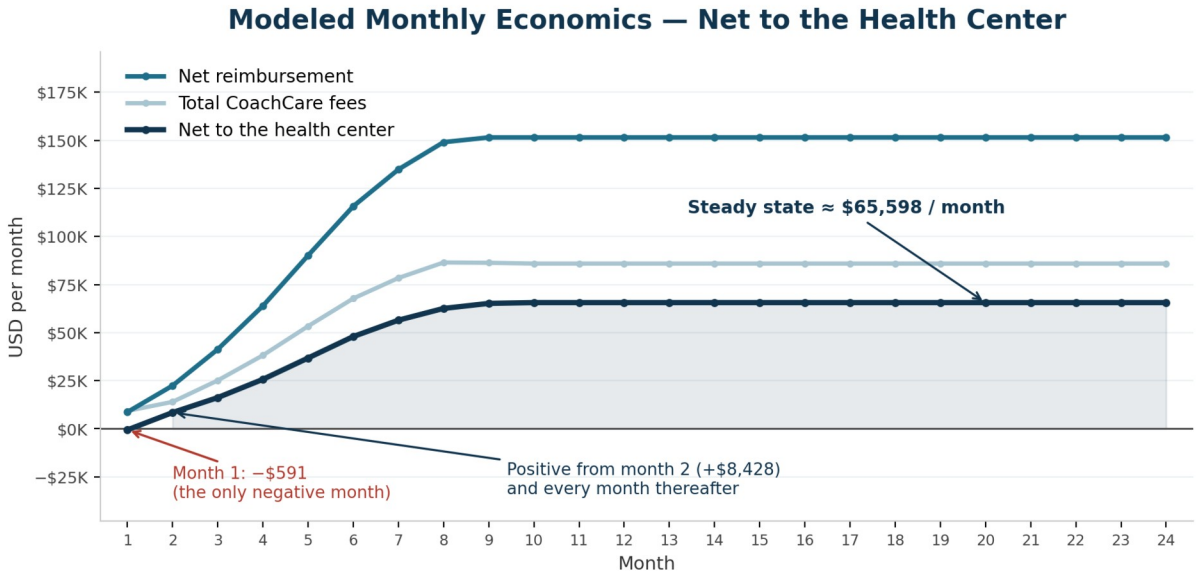
Every escalation documents the vital, the findings, the method of contact, who was reached, the outcome and the follow-up. A patient who cannot be reached is escalated to the clinic and re-escalated on a fixed cadence, and no change to a patient's monitoring status happens without the clinic informed. In a safety-net panel where patients move, change phone numbers and miss appointments, that record is what converts a hard-to-reach patient into a documented longitudinal touch — which is simultaneously the clinical goal, the quality-measure numerator and the strongest possible language for a grant narrative.

KPI dashboard

Clinical	Operational	Financial & quality
Percentage of enrolled hypertensives at goal	Enrolled patients and enrolled services by program	Monthly capture rate (billable months ÷ eligible enrolled months)
HbA1c testing and poor-control rates in the enrolled cohort	Time-to-first-billable-enrollment	Net revenue per patient per month, by program
Depression screening with documented follow-up	Successful-contact rate and attrition	Net to the health center after all fees
Readings per patient per month	Escalations by category and time-to-resolution	UDS measure movement year over year
Admissions, ED visits and 30-day readmissions in the enrolled cohort	Device provisioning and activation lead time	Shared-savings and Idaho value-care quality measure performance

Expected impact & 12-month roadmap

Modeled 24-month impact (illustrative; verify against practice data): **$3,049,666** of net professional-fee reimbursement, **$1,302,634** retained by the health center after all CoachCare fees, 37,860 reimbursable claims, 97,811 physiologic readings, roughly 62 avoided hospitalizations, and 17,008 staff-hours delivered by CoachCare. **900 enrolled patients** and **1,950 enrolled services** under active management at Month 24. Month 1 nets −$591; the line is positive from month 2 onward and reaches a steady state near $65,598 per month.



Illustrative, modeled — verify against practice data. Fees include one-time implementation, EMR setup and telephonic enrollment.

Figure 4. Modeled monthly economics — net reimbursement, total CoachCare fees, and net to the health center, drawn against a true zero baseline so the month-1 position is visible rather than hidden. Fees include one-time implementation, EMR setup and telephonic enrollment. Illustrative, modeled — verify against practice data.

- **Days 0–30 — Charter the service line.** Named owner, P&L and scorecard; athenahealth integration and billing configuration; the APCM-versus-CCM attribution policy; protocol sign-off for hypertension, diabetes and the behavioral-health overlay; and confirm the CY2024 payer mix and dual-eligible count.
- **Days 31–90 — Launch APCM on the dual-eligible cohort.** Start where the economics and the mission converge. No devices, no minute-tracking, first billable month inside the quarter, and the cleanest early proof of capture rate and revenue per patient-month.
- **Days 91–180 — Layer RPM and scale CCM.** Extend device-based monitoring across the hypertension and diabetes cohorts; activate CCM for multi-chronic Medicare patients outside the APCM arm; extend across the Coeur d'Alene, Hayden, Rathdrum and outlying sites; monthly scorecard reporting to service-line governance.
- **Days 181–365 — Wire it into quality and value.** Connect service-line output to UDS reporting, shared-savings performance and Idaho value-care quality submissions; formalize the behavioral-health referral loop; and re-run the forecast against the now-confirmed Medicare and dual-eligible population.

References & Data Sources

- HRSA Health Center Program / Uniform Data System — Heritage Health (Dirne Health Centers, Inc.), grant H80CS02331: CY2024 total unique patients 21,042; service-site registry; grantee status. Vintage: CY2024 reporting year, retrieved July 2026.
- HRSA / HHS TAGGS — §330 Health Center Program awards (FY2025–FY2026 ≈$9.2M combined); SAMHSA CCBHC Expansion award H79SM086463 (9/30/2022–9/29/2026) and the CCBHC Implementation award posted February 2026; HRSA behavioral-health, early-childhood and NP-residency awards. Retrieved July 2026.
- HRSA 340B OPAIS — Heritage Health registered covered-entity record; in-house pharmacy sites. Retrieved July 2026.
- IRS Form 990, FY2024 (via ProPublica Nonprofit Explorer) — total revenue $52.8M (FY2022 $39.0M; FY2023 $45.9M); expenses $51.2M; salaries and wages $27.3M; net inventory sales $4.4M. Vintage: FY2024 filing.
- CMS CY2026 Physician Fee Schedule — care-management and remote-monitoring codes (APCM G0556 / G0557 / G0558; CCM 99490 / 99439 and complex 99487 / 99489; RPM 99453 / 99454 / 99457 / 99458; new short-window codes 99445 / 99470), resolved to Heritage's Idaho locality (Noridian, 02202-00). Illustrative magnitudes — verify against the current PFS and the health center's MAC.
- CY2026 final-rule summaries for federally qualified health centers and rural health clinics — sunset of the bundled G0511 effective 10/1/2025; individual-code billing at national non-facility PFS rates from 1/1/2026; related unbundlings (G0512, G0071); CY2027 auto-add provision. Stated as of July 2026; confirm with the MAC before contracting.
- CMS — Advanced Primary Care Management (CY2025 PFS final rule): non-time-based monthly bundle, 13 service elements, billable by FQHCs and RHCs; G0558 scoped to QMB dual-eligible patients with two or more chronic conditions.
- Community Health Center Network of Idaho — Medicare Shared Savings Program ACO participation (network formed 2012; Medicare contracts since 2018; first shared savings 2020), with Heritage Health named as a participant. Retrieved July 2026.

- Idaho Medicaid — Healthy Connections Value Care: value-based payment model for health centers enrolling as accountable primary care organizations; per-member-per-month care-management fees on top of fee-for-service with downside limited to those fees; quality set including readmissions, ED visits, HbA1c testing, cancer screening and well-child visits.
- Center for Connected Health Policy — Idaho telehealth and remote patient monitoring policy summary (RPM covered for established patients; store-and-forward not reimbursed; live video at parity). Policy vintage July 2026. Exact Idaho Medicaid RPM code set and rates for health centers remain [UNVERIFIED] pending the current state FQHC/RHC provider handbook.
- HRSA shortage-designation data and regional reporting — Kootenai County primary-care, dental and mental-health HPSA status; North Idaho projected ~50 primary-care physicians short by 2030; Heritage's behavioral-health provider-to-population ratio below the Idaho average. Retrieved July 2026.
- Local and regional press (Coeur d'Alene Press, Prism News, Spokane Journal of Business) — Phase II Center for Healthy Living groundbreaking, February 8 2026 ($4M / 60,000 sq ft, completion late 2026); Coeur d'Alene Pediatrics alliance announced February 22 2026; NP residency graduation November 2024; historical workforce and patient-volume figures (2019 — stale, [UNVERIFIED] for 2026).
- Heritage Health public website — services, locations, patient portal (athenahealth-hosted), sliding-fee program, organizational history. Reviewed July 2026; absence of a published RPM / CCM / APCM program is an absence-based finding [UNVERIFIED].
- CoachCare / athenahealth integration overview — bidirectional enrollment by service, trigger ordering, exchange of health history, integrated discrete vitals, escalation tasks, compliance documentation and integrated care summary, automated claim generation.
- CoachCare Care Management standard operating procedures — escalation decision logic, urgent/emergent policy, and the post-discharge three-touch cadence.
- CoachCare Value Analysis (2026) — modeled economics for Heritage Health on a ~5,000-patient Medicare and dual-eligible in-scope population at the Idaho locality; source of all illustrative financial, clinical and operational figures in this report. Companion workbook available.
- CoachCare — program scale references: over 400 managed conditions for 500,000+ patients; 10,000+ providers; 1,000+ implementations; care-plan coding and billing generating over 5 million claims; over 100 million vitals recorded and 4 million+ care actions enabled.

Verification & validation caveat

All financial figures in this report are **illustrative, modeled outputs of a CoachCare Value Analysis under the stated assumptions — verify against practice data** — and are not a guarantee of reimbursement or revenue. Verify all rates against the current CY Physician Fee Schedule and the health center's actual MAC locality before contracting. The modeled in-scope population is a discovery-stage estimate of the Medicare and dual-eligible slice of the panel, not a chart count; Medicaid-only and uninsured or sliding-fee patients are excluded from the modeled billable core.

CY2026 FQHC care-management billing rules, including the sunset of G0511 and the move to individual-code billing at national non-facility PFS rates, are stated from public CMS and industry summaries as of **July 2026** and must be confirmed with the health center's MAC. Organizational, financial, quality and market facts are sourced from HRSA, IRS Form 990, CMS and public reporting as of July 2026 and should be confirmed at the time of decision. Items marked **[UNVERIFIED]** could not be confirmed from public sources and are carried as discovery items rather than asserted.