COACHCARE · REMOTE CARE SERVICE LINE

Treasure Coast Community Health

Care Management Service Line — Performance & Optimization
2026 Strategy Report

A CoachCare Remote Care Service Line — **CCM first, full-service**, with **RPM quantified** as the recommended expansion — and the draft financial assessment promised in April, **with the variables called out**.

Treasure Coast Community Health, Inc. · Federally Qualified Health Center (§330) · Vero Beach & Indian River County, Florida

Purpose of this report

In April 2026, CoachCare committed to following our conversation with a draft financial assessment built on the panel counts your team shared, with the variables called out rather than buried in footnotes. **This report is that deliverable.** It presents the scenario your team asked for first — Chronic Care Management only, delivered full-service — alongside the paired CCM + RPM scenario CoachCare recommends, quantified so the comparison is a decision rather than a debate. Every element is designed around the two constraints your team named: patient cost-sharing sensitivity and staff burden.

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. Public organizational facts are sourced and date-stamped, and items that could not be verified are flagged as such.

Prepared for: Treasure Coast Community Health leadership
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Date: July 2026 · Confidential — prepared for Treasure Coast Community Health leadership

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Executive Summary

Treasure Coast Community Health, Inc. (TCCH) is a 501(c)(3) federally qualified health center and HRSA Health Center Program (§330) grantee — grant H80CS00187 — serving Indian River County from service sites across Vero Beach, Sebastian and Fellsmere, with a mobile medical unit extending reach across the county. It served **27,878 unique patients in CY2024** (HRSA Uniform Data System), a majority-minority panel, through an organization that spans family medicine, pediatrics, women's health, behavioral health and psychiatry, dental, vision, infectious disease, in-house pharmacy and county-jail medicine. Roughly fourteen adult-medicine providers anchor the Medicare panel this report models. The center is AAAHC re-accredited as of December 2025, recognized as a Patient-Centered Medical Home, holds HRSA Community Health Quality Recognition badges — including Advancing Health Information Technology for Quality and Addressing Social Risk Factors — and operates the Treasure Coast area's only ADCES-accredited diabetes education program. Its EHR is Epic, hosted through Health Choice Network (HCN), and it is a named participant in a Medicare Shared Savings Program ACO, Health Choice Care, LLC. It sits in one of America's most retirement-dense counties: more than a third of Indian River County residents are 65 or older.

What your team asked for — and what this report is. In April your team was specific: Chronic Care Management first, delivered **outsourced and full-service**; Remote Physiologic Monitoring deliberately deferred but not off the table; and a financial assessment honest enough to name its own variables. This report delivers exactly that. **Scenario A (CCM only) is presented first and in full — it is the program you asked for.** Scenario B (CCM + RPM, paired on the same patients) is presented alongside it as CoachCare's quantified recommendation, so the RPM conversation can happen on numbers rather than instinct.

Designed around the two constraints your team named. TCCH has run care-management plays before, and the lessons were clear. An in-house effort showed how quickly patient enthusiasm meets cost-sharing arithmetic on fixed incomes; a grant-funded monitoring program delivered devices and data but left TCCH's clinical staff as the first line on every abnormal reading — internal labor on top of a vendor relationship, with reporting that never quite answered the health center's questions. Neither experience argues against care management. Both argue for the specific model in this report: **cost-sharing and bad debt priced into every figure** (there are no rosy gross numbers here), **risk-stratified eligibility** that starts with the patients who feel the value most, and a **full-service operating model in which CoachCare's care team handles roughly 90% of patient interactions and escalations** — with only about 10% reaching the practice, through the channel TCCH chooses.

The CY2026 payment change makes the timing structural, not opportunistic. CMS sunset the bundled FQHC care-management code (G0511) on October 1, 2025. Since January 1, 2026, health centers bill the individual CCM and RPM code families at national non-facility Physician Fee Schedule rates — each separately payable **on top of the PPS visit**, not carved out of it. The between-visit work of chasing blood pressures and closing HbA1c gaps — work a PCMH-recognized health center already does — is now a billable service line.

The central argument

A full-service care-management line delivers value two ways at once — and both are goals TCCH has already named.

Standalone. Recurring, subscription-like professional-fee revenue, stated net of cost-sharing and bad debt: **Scenario A (CCM only) models $1,630,361 of net reimbursement over 24 months with $696,284 net to the health center after all CoachCare fees. Scenario B (CCM + RPM on the same patients) models $2,137,081 and $913,863 — plus 41 avoided hospitalizations.** Additive to the PPS structure, not a reallocation of it.

Connective tissue. One engine — outreach, enrollment, care-team pods, monitoring, documented escalation, billing capture, reporting — simultaneously produces UDS quality movement, care-gap closure with TCCH's quality team, and the chronic-disease control that feeds Health Choice Care's shared-savings performance. Build it once; every layer draws on it.

The panel, stated honestly. The model does not run on 27,878 patients. It runs on **~3,300 Medicare lives and ~2,700 CCM-eligible patients — TCCH's own counts**, shared in April — corroborated against the UDS panel (a Medicare share of ~11.8%, in line with the ~11.2% national FQHC average) but not yet chart-validated. Enrollment is modeled at **25% of eligible — the conservative end of the 25–35% range CoachCare typically sees**, with engaged practices reaching ~50%. Both scenarios hit their enrollment ceilings well before month 24, so stronger provider buy-in scales the whole forecast roughly linearly.

A meaningful contributor to a stated objective. TCCH's leadership has publicly committed to initiatives that add **$2.5 million to the health center's bottom line**. A care-management service line contributing roughly **$350,000–$460,000 per year of net** — Scenario A to Scenario B, averaged across the first 24 months — is a meaningful, recurring, compounding contributor to that publicly stated objective, and it arrives with **no new health-center headcount**: CoachCare delivers 14,772–18,167 staff-hours of program labor across the two scenarios (≈7.1–8.7 FTE-equivalent).

Month 1, stated plainly. Month 1 nets **−$4,550 (Scenario A) / −$4,238 (Scenario B)** because one-time implementation lands before the census ramps. The line turns positive in month 2 and stays positive — no claim of day-one profitability is made anywhere in this report. All figures are **illustrative, modeled — verify against practice data**.

2026–2027 Priority Recommendations

1. **Charter the CCM service line now — full-service, outsourced, no new headcount.** The reimbursement change is already in effect; every month without a program is between-visit labor absorbed rather than billed. Scenario A is designed to be live within 60–90 days of signature (integration-dependent).
2. **Risk-stratify enrollment from the ~2,700-patient list.** Heart-failure, kidney-disease and complex multimorbid patients first: they feel the value of monthly clinical attention most, object least to cost-sharing, and are where avoidable utilization concentrates.
3. **Set the cost-sharing posture before the first outreach call.** Every figure here assumes patients bear their cost-sharing; TCCH's exploration of donor-funded coverage — a play its own philanthropic infrastructure has run before for women's preventive health — is upside on top of these numbers, never a precondition for them.

4. **Hold the clinical working session with CoachCare's Chief Medical Officer.** Escalation protocols, diagnosis-specific care pathways and the care-team workflow deep-dive — the agreed next step from April, and the fastest way to convert your clinical leadership's questions into signed-off protocol.
5. **Bring Health Choice Network into integration scoping in the first 30 days.** CoachCare integrates with Epic and is delivering an FQHC engagement on an Epic aggregator today — and has not yet integrated with HCN specifically. Early scoping is how the 60–90-day launch window holds (§9).
6. **Put the RPM decision on the calendar — month 6, decided on program data.** Scenario B quantifies what pairing RPM adds on the same 675 patients: **+$506,720 of reimbursement, + $217,579 net, and 41 avoided hospitalizations** over 24 months. Make it a scheduled decision, not a standing question.

1. Footprint & Operating Model

TCCH operates as Indian River County's community-health anchor — by its own description the county's largest community health provider and its only §330-grantee health center. Founded in 1993 to serve the county's rural citrus, ranching and farmworker communities, it has grown into a multi-site system: the Fellsmere headquarters campus, a Vero Beach cluster that now includes the 18,000-square-foot West Health Center opened in September 2025, the Gifford Health Center, dental and vision hubs, a clinic co-located with United Against Poverty's opportunity center, a mobile medical unit, and an Oslo campus under construction — including a new 20,000-square-foot pediatric center. Service lines span family and internal medicine, pediatrics, gynecology and women's health, behavioral and mental health including psychiatry, substance-use disorder treatment, infectious disease, dental, vision, in-house pharmacies, and comprehensive medical care for the county jail with reentry continuity supported by a $1M HRSA quality-improvement award.

The adult-medicine core — where the Medicare panel lives — counts roughly **fourteen providers**: family-medicine and internal-medicine physicians supported by a deep APRN/DNP bench. Around them sit the assets a care-management program borrows credibility from: the area's **only ADCES-accredited diabetes education program** staffed by certified diabetes care and education specialists, a Medicare Annual Wellness Visit program, PCMH-style care coordination, and a quality team already organized around care-gap closure. Accreditation and recognition are current and public: **AAAHC re-accreditation earned December 2025**, Patient-Centered Medical Home recognition, and HRSA Community Health Quality Recognition badges including Access Enhancer, Advancing HIT for Quality and Addressing Social Risk Factors.

> **A note on scale, counts and data vintage**
>
> Patient counts in this report use the official **CY2024 HRSA Uniform Data System figure of 27,878 unique patients** (grant H80CS00187). Larger figures — “about 30,000” and “approximately 35,000” — appear in the center's public materials and are best read as total individuals touched, including outreach and screening contacts, rather than the countable UDS panel. Provider counts are taken from TCCH's own published directory (July 2026): roughly fourteen adult-medicine providers, with pediatrics, behavioral health and dental counted separately. The **~3,300 Medicare lives and ~2,700 CCM-eligible patients are TCCH's own counts**, shared in April 2026 and treated throughout as the panel basis — corroborated but not yet chart-validated (§4).

Remote-care posture. TCCH's public services and portal pages describe no active remote patient monitoring or chronic care management program today. What exists is adjacent muscle, not a competing program: PCMH care coordination, the diabetes education team, a care-gap quality function, and an Epic/MyChart patient portal via Health Choice Network. The health center has already proven it can do the hard parts — outreach, engagement, chronic-disease education; what it has not had is a billing rail and a staffing engine underneath that work. That is the gap this service line fills.

Design principles for the service line

Principle	What it means at TCCH
Longitudinal by default	The Medicare patient is managed between visits, every month — not re-encountered episodically when something breaks.
Additive, never substitutive	Every care-management code bills on top of the PPS visit. Nothing in this design reallocates encounter revenue or changes how a visit is billed.
Full-service means full-service	CoachCare's care team carries ~90% of patient interactions and escalations; roughly 10% reaches the practice — through the channel TCCH chooses. No first-line triage burden returns to TCCH staff.
Affordability engineered in	Cost-sharing and bad debt are priced into every figure; eligibility is risk-stratified toward patients who feel the value; donor-funded coverage is upside, never an assumption.
Clinical governance stays inside	Protocols, escalation preferences and every clinical decision remain TCCH's. CoachCare executes to documented standard operating procedures and documents every touch.
Built where the work already happens	Enrollment flags, evidence-of-care documentation and claims live inside Epic via Health Choice Network — no second system for clinicians or billers (§9).

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 an operating spine that carries recurring PPS-additive revenue, quality and care-gap performance, and staffing leverage on one shared engine — shaped, at TCCH, by a deliberate deal design: **CCM first, full-service, with RPM quantified and waiting**.

2.1 What It Is: CCM First, Full-Service, Outsourced

TCCH owns a longitudinal primary-care panel, which is what makes chronic care management billable here. The stack below reflects the sequence your team chose — not a vendor's default.

Layer	Codes	Role in the TCCH stack
CCM — live at launch	99490 / 99439; complex 99487 / 99489 where documentation supports it	Chronic Care Management for Medicare patients with two or more chronic conditions — the longitudinal wrapper for hypertension, diabetes, heart failure and kidney disease in the adult panel. The program TCCH asked for first, delivered full-service by CoachCare's care team under TCCH's protocols.
RPM — deferred by design, quantified	99453 / 99454 / 99457 / 99458	Remote Physiologic Monitoring — blood pressure, weight, glucose through cellular-connected devices. The continuous early-warning layer, and the entire avoided-hospitalization line in Scenario B. Deferred at TCCH's direction; modeled in full so the month-6 decision is made on numbers (§5.2).

Billing integrity, stated up front

CCM at TCCH is **fee-for-service under Medicare Part B**. It is confirmed as not capitated into any TCCH population-health arrangement — no prospective primary-care capitation applies (per CMS program files) — so every properly documented month is a payable claim, and nothing modeled here is absorbed into a per-member payment.

When RPM is added, **RPM and CCM bill together for the same patient in the same month** — discrete time, discrete documentation, one written attribution policy set before go-live. Where a plan-level rule makes a specific payer problematic, that plan is removed from eligibility rather than argued with (§5.3).

2.2 Designed Around the Two Constraints Your Team Named

Care-management programs earn durability by being designed around the constraints that actually bind. In April your team named the two that matter here with unusual clarity — named from experience, not theory. Both are design inputs to everything in this report, not caveats appended to it.

Constraint 1 — Patient cost-sharing sensitivity

TCCH serves a fixed-income population in which even modest recurring cost-sharing changes enrollment behavior — a lesson the health center learned directly. Three design answers, in order of importance:

- **Priced in, everywhere.** Every figure in this report is net of expected patient cost-sharing and bad debt. There are no gross numbers to walk back later in a finance meeting — the modeled net is the number.
- **Risk-stratified eligibility.** Enrollment starts with heart-failure, kidney-disease and complex multimorbid patients — the patients who feel the value of monthly clinical attention and object least to its cost. A meaningful share of an FQHC Medicare panel is also dually eligible, and for qualified Medicare beneficiaries, Part B cost-sharing is not the patient's to pay — the objection simply does not arise for that segment.
- **Donor coverage as upside, never as assumption.** TCCH is exploring donor-funded coverage of patient cost-sharing — and it owns the machinery to do it: a dedicated supporting foundation, a professional development office, and a documented precedent of local philanthropy funding patient assistance for women's preventive health. Every figure in this report stands without that fund. If it materializes, it adds enrollment and retention on top of these numbers. Structure and compliance review belong with TCCH's counsel.

Constraint 2 — Staff burden from first-line triage

TCCH's prior monitoring experience put its own staff first in line for every abnormal reading — full-time internal work layered on top of a vendor relationship. The full-service operating model inverts that arrangement, and the commitments below are the operating standards CoachCare shared with your team in April:

- **~90/10.** CoachCare's licensed care team handles roughly **90% of patient interactions and escalations** end-to-end; only about 10% reaches the practice — routed to a named team member through the channel TCCH chooses (§8).
- **A dedicated outreach and enrollment team** runs recruitment, separate from the care managers — so care managers manage care rather than chase sign-ups.
- **Care-team pods with roster continuity.** The same care manager works the same patient roster month over month — patients hear a voice they know.
- **Caseloads capped at 165 patients per care manager**; the current book of business runs near **133:1**.
- **45–60 minutes of care-management work per patient per month**, delivered by CoachCare's team and documented to billing standard.
- **Every call recorded and quality-assured** against documented standards.

Hold us to these numbers

The standards above are operating discipline, not marketing. The monthly program report (§10) shows escalation rates, contact rates, per-provider attribution and time-in-program — so TCCH can watch the ~90/10 split and the caseload caps actually happening, month over month.

2.3 Connective Tissue: One Engine, Every Layer

The reason to build this as a service line rather than a disconnected pilot is that one shared engine carries every layer TCCH cares about. Enroll a patient once, run one documented monitoring-and-escalation protocol, capture one billing workflow — and the same activity shows up in the professional-fee line, the UDS numerator, the care-gap worklist and the ACO's quality story.

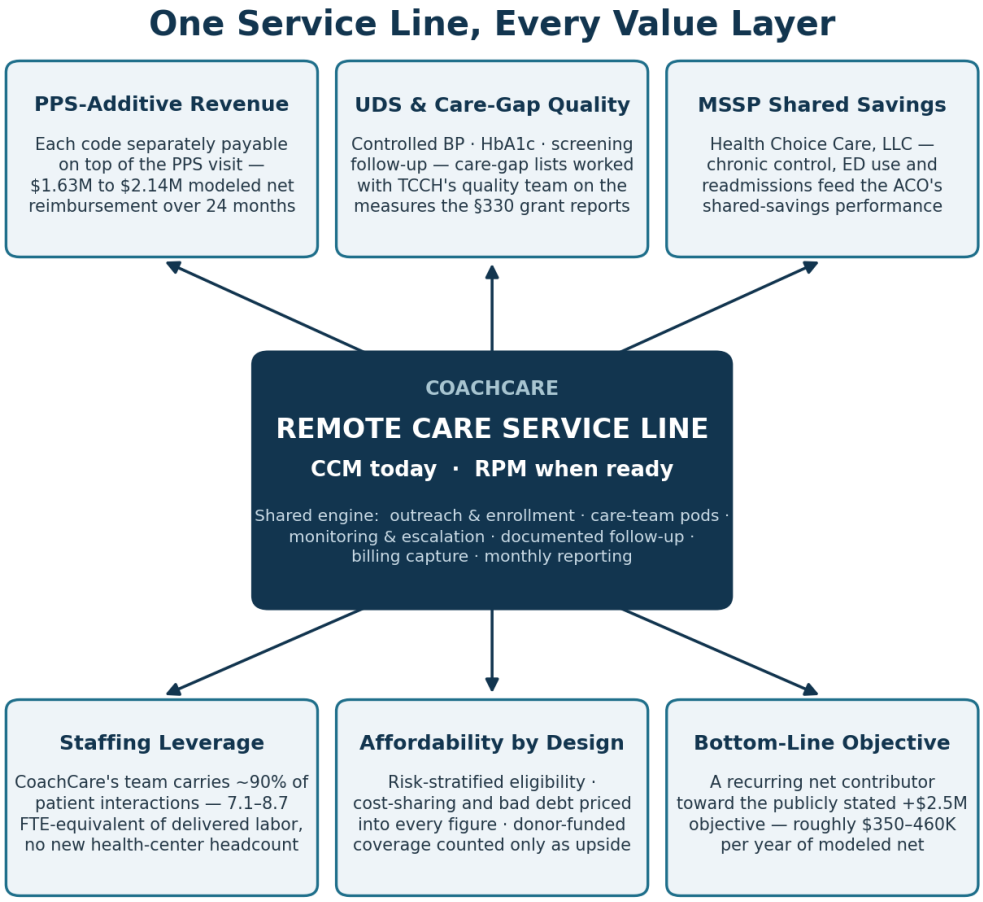


Figure 1. One service line, every value layer. Modeled figures are illustrative — verify against practice data. No shared-savings or donor dollars are included in any modeled financial figure.

How the same infrastructure carries each layer

Value layer	What the shared engine contributes
PPS-additive revenue	Enrollment at scale, monthly documented care that satisfies code requirements, automated claim generation — $1.63M–$2.14M modeled net reimbursement across the two scenarios.
UDS & care-gap quality	Home blood-pressure and glucose data plus monthly structured contact produce numerators for controlled blood pressure and HbA1c — and close testing gaps worked jointly with TCCH's quality team (§7).
MSSP shared savings	Chronic control, early decompensation detection and post-discharge follow-up move ED use and readmissions — the levers Health Choice Care's shared-savings performance rides on (§7).
Staffing leverage	14,772–18,167 CoachCare-delivered staff-hours over 24 months (≈7.1–8.7 FTE-equivalent) — labor TCCH does not hire, recruit or backfill.
Affordability by design	Risk-stratified eligibility and priced-in cost-sharing keep the program aligned with the population's economics; the donor pathway adds on top (§2.2).
The bottom-line objective	Roughly $350–460K per year of modeled net — a recurring, no-new-headcount contributor to the publicly stated $2.5M objective.

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

This is the economic backdrop of the report, and it is a policy fact rather than an opinion. For years, FQHC 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 — and the timing favors a health center that moves in 2026.

When	What changed	Why it matters at TCCH
October 1, 2025	The bundle sunset	G0511 — the bundled FQHC general care-management code that compressed many distinct care-management services into one flat payment — was last billable September 30, 2025.
January 1, 2026	Individual codes at national PFS rates	Health centers now bill the individual CCM and RPM code families as separate line items at national non-facility Physician Fee Schedule rates — code-level work now earns code-level payment.
Ongoing	Additive, not substitutive	These are separately payable Medicare lines that sit on top of the health center's PPS visit. Between-visit chronic care moves from unfunded cost to revenue line — without touching how a visit is billed.
From CY2027	The billable surface widens	New Physician Fee Schedule care-management codes are set to auto-add for FQHCs at national non-facility rates — the code set grows rather than shrinks.

★ 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. Confirm the exact CY2026 rates, current concurrency guidance and any Florida-specific billing instruction with the health center's Medicare Administrative Contractor (First Coast Service Options) before any contract language.

What it means on TCCH's panel is simple: the between-visit work a PCMH-recognized health center already performs — monthly telephonic management, medication reconciliation, care-plan maintenance, care-gap chasing — becomes a compounding revenue line when it is delivered systematically, documented to billing standard, and captured every month. The financial assessment

in §5 does not use list rates as its headline: it models **realized net per enrolled patient-month** — after expected cost-sharing, bad debt and plan behavior — which is the number a finance team can actually plan against.

4. The Panel — Who Is Actually In Scope

Being precise about the denominator is the difference between a forecast a finance team can defend and a number that falls apart in the first meeting. This model runs on TCCH's own counts, stated as exactly that.

TCCH served **27,878 unique patients in CY2024** (HRSA Uniform Data System, official). The model does not run on that number. It runs on **~3,300 Medicare lives**, of which **~2,700 are CCM-eligible** — both **TCCH's own counts**, shared with CoachCare in April 2026. The corroboration is straightforward: 3,300 ÷ 27,878 is a Medicare share of ~11.8%, essentially identical to the ~11.2% national Medicare share of FQHC patients — exactly what a health center in a county where more than a third of residents are 65+ should show. The ~2,700 eligible figure (about 82% of Medicare lives carrying two or more chronic conditions) is consistent with FQHC multimorbidity patterns. Both counts deserve the credit of being treated as real — and the discipline of chart validation during implementation.

One structural fact about the county book: roughly **43% of Indian River County Medicare beneficiaries are enrolled in Medicare Advantage**, leaving a **traditional-Medicare majority (~57%)** that bills cleanly under the individual-code structure. Plan-level MA behavior is a named variable in this model — handled in §5.3 — not a surprise discovered in month four.

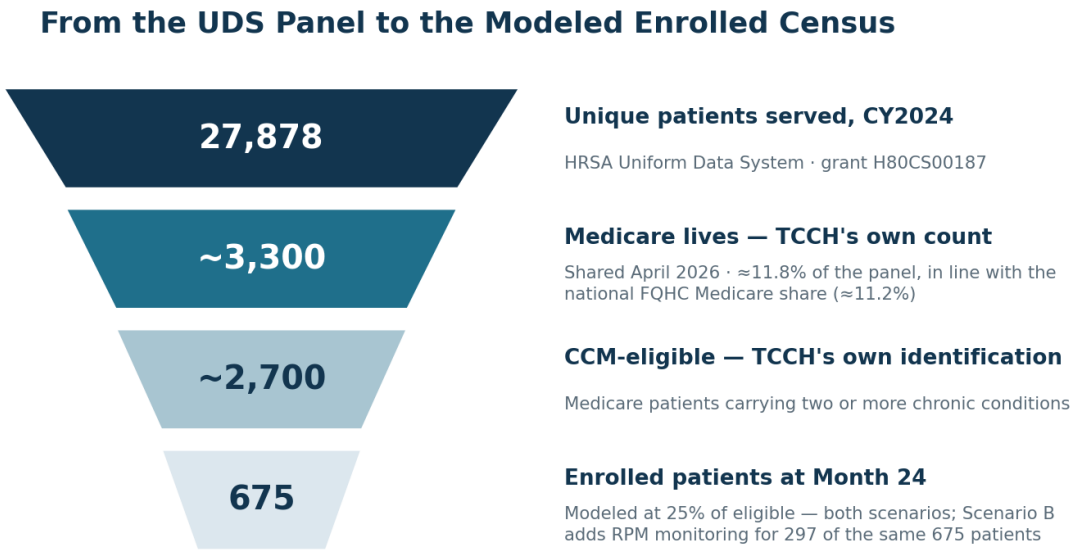


Figure 2. From the CY2024 UDS panel to TCCH's own Medicare and CCM-eligible counts, to the modeled enrolled census. Illustrative, modeled — verify against practice data.

Enrollment is modeled at 25% of eligible — deliberately conservative. CoachCare typically sees **25–35%** of eligible patients enroll, and up to **~50%** where provider buy-in is strong — when the recommendation comes from the patient's own provider at the point of care, conversion roughly

doubles. This model takes the bottom of that band. At 25%, the CCM census reaches its **675-patient ceiling at month 6** in Scenario A (month 9 in Scenario B, where outreach runs two programs), and Scenario B's RPM census tops out at **297 by month 7**.

The honest constraint — and why it is good news

Both scenarios are **ceiling-limited, not pace-limited**: the outreach engine fills the eligible pool faster than the pool can absorb, then holds flat with ~1.5% monthly attrition backfilled. The forecast is therefore bounded by the size of the eligible list and the 25% conversion floor — not by outreach capacity. The leverage runs one way: **stronger provider buy-in scales this entire forecast roughly linearly.** A 35% conversion is ~40% more program; ~50% is roughly double. That is a leadership lever, not a vendor promise.

★ Discovery item #1 — validate the list

Implementation begins by running the eligibility definition — Medicare coverage, two or more chronic conditions, attribution rules, plan screening per §5.3 — against Epic to convert the ~2,700 into a named, validated enrollment list. The forecast re-runs on the confirmed count. Related: the payer split of the ~3,300 (traditional Medicare vs Medicare Advantage, by plan) sets the clean-billing denominator, and the dual-eligible share sizes the segment for whom cost-sharing is not a barrier at all.

5. The Financial Assessment — Two Scenarios, Variables Called Out

This is the draft financial assessment promised in April. It is built from a CoachCare Value Analysis on TCCH's own counts (§4) at the health center's Florida Medicare locality, with **every CoachCare fee reflected** in the net-to-health-center figures, and with realized net per enrolled patient-month modeled at **≈$114.51 for CCM and ≈$99.92 for RPM** — after expected cost-sharing, bad debt and plan behavior. Scenario A comes first because it is what you asked for. Scenario B is the same program with monitoring depth added to 297 of the same patients — presented so the comparison is a decision, not a pitch.

5.1 Scenario A — CCM Only: What You Asked For

Full-service Chronic Care Management on the risk-stratified eligibility list: CoachCare runs outreach, enrollment, monthly care management, escalation per protocol, documentation and claims support; TCCH's providers govern clinically and bill the revenue.

Scenario A — modeled 24-month results	Figure
Net reimbursement, 24 months	**$1,630,361** (Year 1 $702,866 · Year 2 $927,495)
Net to the health center, after all CoachCare fees	**$696,284**
Enrolled patients at Month 24	675 — CCM census at its 25%-of-eligible ceiling from month 6
Reimbursable claims, 24 months	29,544
CoachCare-delivered staff-hours	14,772 (≈7.1 FTE-equivalent — no TCCH headcount)
Steady-state monthly net to the health center	≈$33,653 per month from month 7
Month 1	−$4,550 — the only negative month; positive from month 2 (+$5,918) onward

Scenario A is a complete, self-justifying program: it funds itself from month 2, reaches steady state inside three quarters, and delivers the care-gap and quality collaboration described in §7 — with zero device logistics. What it deliberately does not do is watch physiology between calls: with no monitoring data, **no avoided hospitalizations are claimed** — the model only credits avoided admissions where continuous vitals make the detection mechanism real. That honesty is what makes Scenario B's comparison meaningful.

5.2 Scenario B — CCM + RPM: What CoachCare Recommends

The same 675 patients, with cellular-connected blood-pressure cuffs, scales and glucometers added for the 297 highest-acuity among them — heart failure, uncontrolled hypertension, diabetes on the ADCES team's radar. Same escalation engine, same pods, same reporting; RPM claims stack

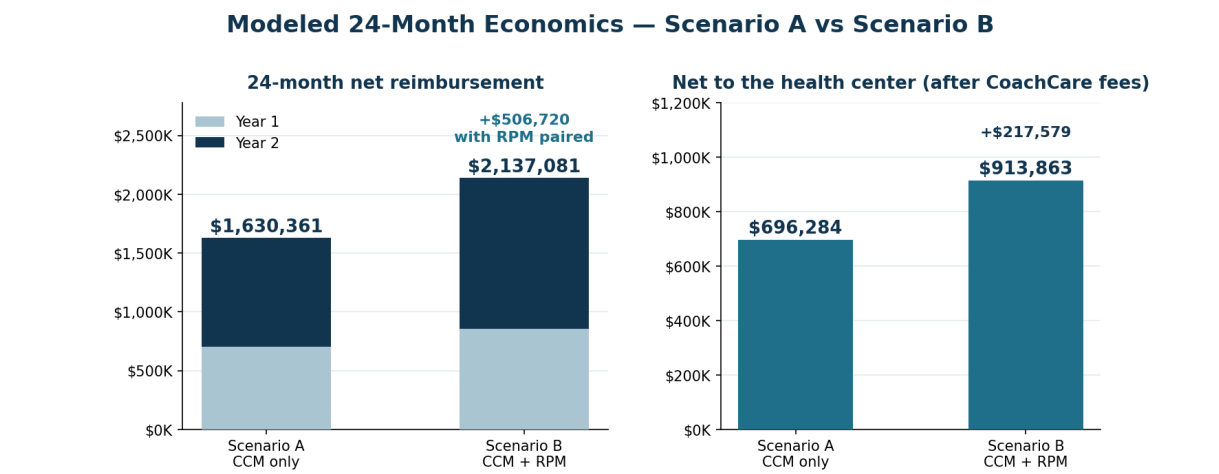
alongside CCM for those patients. **Scenario B adds depth, not headcount — for TCCH or for the patient list.**

Scenario B — modeled 24-month results	Figure
Net reimbursement, 24 months	**$2,137,081** (Year 1 $856,990 · Year 2 $1,280,092)
Net to the health center, after all CoachCare fees	**$913,863**
Enrolled patients at Month 24	675 — the same patients as Scenario A; 297 of them also on RPM (972 enrolled services)
Reimbursable claims, 24 months	38,891
Vitals readings captured	65,134
Hospitalizations avoided	**41** (≈$615K of avoided acute cost at roughly $15,000 per admission — system-level value, not health-center revenue)
CoachCare-delivered staff-hours	18,167 (≈8.7 FTE-equivalent)
Steady-state monthly net to the health center	≈$46,161 per month from month 10
Month 1	−$4,238 — the only negative month; positive from month 2 (+$6,316) onward

The RPM delta — the April argument, quantified

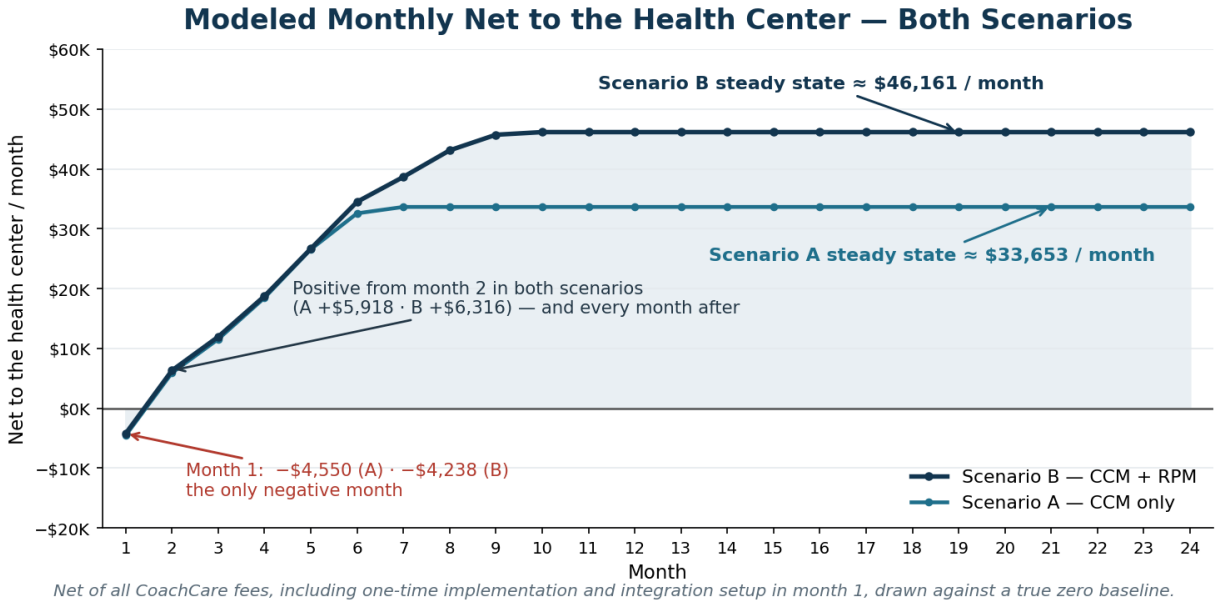
Pairing RPM with CCM on the same 675 patients adds **+$506,720 of net reimbursement, +$217,579 of net to the health center, and 41 avoided hospitalizations (≈$615K of avoided acute cost)** over 24 months — with **no additional outreach burden**, because every RPM patient is already enrolled, consented and known inside the CCM cohort.

The avoided-hospitalization engine is specifically RPM's continuous signal: a weight trend that precedes a heart-failure admission, a blood-pressure run that precedes a stroke, a glucose pattern the phone alone cannot see. That is why Scenario A honestly shows zero on that line — and why the recommendation is to schedule the RPM decision for month 6, made on TCCH's own program data.



Same 675 enrolled patients in both scenarios at Month 24 — Scenario B adds RPM depth for 297 of them, plus 41 avoided hospitalizations (system-level; not in these bars). Illustrative, modeled — verify against practice data.

Figure 3. Modeled 24-month economics, Scenario A vs Scenario B — net reimbursement (Year 1 / Year 2) and net to the health center after all CoachCare fees. Same 675 enrolled patients in both scenarios; Scenario B adds RPM monitoring for 297 of them. Illustrative, modeled — verify against practice data.



Net of all CoachCare fees, including one-time implementation and integration setup in month 1, drawn against a true zero baseline. Illustrative, modeled — verify against practice data.

Figure 4. Modeled monthly net to the health center, both scenarios, drawn against a true zero baseline so the month-1 position is visible rather than hidden. Positive from month 2 onward in both scenarios. Illustrative, modeled — verify against practice data.

5.3 The Variables, Called Out

A forecast is only as honest as its named variables. These are the five that move this one — what the model assumes, and what changes the answer.

Variable	Where this model sets it	What moves it — and how it is managed
Enrollment rate	25% of eligible — the conservative end of the 25–35% CoachCare typically sees; engaged practices reach ~50%	Ceiling-limited scenarios scale roughly linearly with conversion. Provider endorsement at the point of care is the single biggest lever — and it is TCCH's lever.
Patient cost-sharing & bad debt	Priced into every net figure — no gross numbers appear anywhere in this report	Risk-stratified eligibility reduces objection-driven attrition; dually eligible patients carry no Part B cost-sharing of their own; donor-funded coverage (§2.2) adds back as pure upside if TCCH stands it up.
Medicare Advantage plan behavior	~43% of county Medicare is MA; known plan-level CCM nuances exist among Florida plans	Managed three ways: pre-checking claims experience with CoachCare's regional Florida accounts; monitoring the first payment reports in the months-4–6 collaborative review (§10); removing problem plans from eligibility. The traditional-Medicare majority (~57%) bills cleanly.
Attrition & tenure	~1.5% monthly attrition; engagement normalizes around month 6; ~18-month average tenure once a patient passes three months	Roster continuity and the familiar-voice outreach model (§10) are the retention mechanics; cost-sharing transparency at consent prevents the classic surprise-driven drop-off.
The eligibility list itself	~2,700 — TCCH's own identification, corroborated against UDS arithmetic but not chart-validated	Validated against Epic during implementation (§4); the forecast re-runs on the confirmed list and scales close to proportionally with it.

Read before quoting any number

Not included in any figure in this report: shared-savings distributions from Health Choice Care; donor-funded cost-sharing coverage; diabetes self-management training and Annual Wellness Visit adjacencies; and the ≈$615K of avoided acute cost (system-level, not health-center revenue). All are upside on top of the modeled numbers.

Time in program is modeled at 45–60 minutes per patient per month, delivered by CoachCare and documented to billing standard. All financial figures are **illustrative, modeled outputs of a CoachCare Value Analysis — verify against practice data** — and none constitute a guarantee of reimbursement. Confirm current-year rates and billing rules with the health center's MAC (First Coast Service Options) before contracting.

6. The Payer Pre-Check — Verified Before Anyone Is Enrolled

In the April conversation, Medicare Advantage participation came up as a known concern — some plans handle care-management codes differently, and the health center has seen that firsthand. CoachCare committed to pre-checking the Florida plans that actually hold this market. That review is complete; this section summarizes what it found.

Indian River County's Medicare population splits roughly 57% traditional fee-for-service — which pays these codes at standard Medicare rates with no plan dependency — and roughly 43% Medicare Advantage (CMS enrollment files, July 2026). Within the MA book, enrollment concentrates heavily at the top:

Parent organization	Approx. share of county MA	Pre-check status
UnitedHealthcare (incl. Preferred Care Partners, Care Improvement Plus)	~39%	Verified standard payer
Humana (incl. CarePlus, Emphesys)	~29%	Verified standard payer
Florida Blue (GuideWell)	~8%	Confirmation in progress
Aetna / CVS	~7%	Verified for CCM; remote-monitoring criteria noted for Scenario B
All other plans	~17% combined	Plan-by-plan verification before enrollment

The two dominant carriers — roughly 68% of the county's Medicare Advantage book — are standard, verified payers for these codes. A small number of smaller plans carry routine confirmation items (contract-structure and policy checks) that resolve with a billing-office answer or a brief plan call; that is normal pre-launch diligence, not an obstacle. Taken together, roughly 86% of the modeled program sits on rails with no open questions even before the remaining confirmations complete (illustrative, modeled — verify against practice data).

How this is enforced: the verification runs in three passes. Published-policy review across every plan family in the county (complete). Early payment-report monitoring in the first three months after launch, worked collaboratively with the billing office (§5.3). And a standing rule above all of it: any plan with an unresolved issue is removed from the eligibility list — no patient is ever enrolled into a denial.

One finding that strengthens the cost-sharing plan: members with QMB dual-eligible status cannot legally be charged Medicare cost-sharing. Donor-funded coverage — the pathway the health center is already exploring — therefore only needs to reach non-QMB members. The cost-sharing challenge is smaller than it first appears.

7. Powering Quality: UDS, the ACO & Care-Gap Collaboration

Quality accountability at TCCH is not hypothetical. The health center reports UDS clinical measures to HRSA every year against grant H80CS00187, and it is a **named participant in Health Choice Care, LLC** — a Medicare Shared Savings Program ACO organized within the Health Choice Network family of community health centers — verified in the CMS PY2026 MSSP participant file. Health Choice Care's public reporting describes a decade of Medicare cost savings, more than $32M earned across its member centers.

As the ACO evolves along CMS's performance-based tracks (per CMS program files), the connection between chronic-disease control and health-center economics tightens: better blood-pressure and HbA1c control and fewer avoidable ED visits and readmissions in the attributed panel accrue real shared-savings value — **on top of, not instead of**, the fee-for-service care-management revenue modeled in §5. Two facts are worth stating plainly. First, **CCM at TCCH bills fee-for-service; no prospective capitation applies to it** (confirmed against CMS program files), so nothing in this model is absorbed into a population-health payment. Second, none of this report's figures include any shared-savings dollars — that value accrues on top. As the program stands up, it is worth **aligning with Health Choice Care on current track status** and on how care-management documentation and monitoring data should flow into the ACO's quality reporting.

One forward option, noted and deliberately not modeled: Medicare's **Advanced Primary Care Management** code family replaces minute-tracking with flat monthly management tiers and is billable by FQHCs — for a health center inside a shared-savings ACO, it can become an attractive evolution of the same care-management chassis this report builds. Nothing in this report's figures depends on it. The disciplined path is to stand up CCM now, let the program prove its capture rate, and evaluate that code family later, jointly with Health Choice Care, once attribution and quality-reporting linkages are in place.

What your team told us — and what we corroborated

In the April introduction, the arrangement was described as not yet risk-bearing from the health center's seat, with chronic care management billed fee-for-service rather than capitated into any population-health payment. Our verification corroborates the billing point: CMS program files show no capitation flags for the health center's participation — everything the health center bills remains fee-for-service, which is why every figure in this report stands on FFS rails.

What the public record adds — to confirm together

Per CMS Shared Savings Program files (reviewed July 2026), the health center has participated in Health Choice Care, LLC since 2016. The ACO's record is genuinely strong: eleven performance years without a loss year, roughly $81.8 million in gross savings generated and $38.9 million earned, and the ACO's own disclosures show the majority of earned savings distributed to participating health centers in recent years. The same files show the ACO moved to the Shared Savings Program's ENHANCED track effective January 2025 — a two-sided arrangement at the ACO level. What that means for an individual health center depends on its participation agreement; it is a discovery item to confirm together, not a conclusion.

The discovery agenda

· How does Health Choice Care distribute earned savings — and allocate any future losses — to participating centers?

· What did the health center receive for the most recent performance years?

· Who at the health center reviews the ACO's expenditure and utilization reports?

· Which quality-measure pathway applies for 2026?

· How does the ACO view care-management billing by member centers?

These are working questions for the clinical session with CoachCare's Chief Medical Officer — answers that sharpen the program design, none of which gate the launch.

Why the program matters under any answer

Care-management services strengthen beneficiary attribution by regulation — care-management codes count toward Medicare's assignment methodology, and services on an FQHC claim count as primary care. The program's clinical results map directly onto the ACO's quality measures — and blood-pressure control is publicly the ACO's softest measure, which remote monitoring (Scenario B) directly addresses. Avoided hospitalizations accrue to shared-savings performance. The program pays on fee-for-service rails today and contributes to ACO performance however the risk question resolves.

What your quality team asked about — answered in the operating model

Question area	How the program answers it
Care-gap collaboration	Monthly contact is a standing opportunity: the care team works TCCH's care-gap lists — screenings due, labs overdue, control targets — as part of routine outreach, with closure activity attributed per provider in the monthly report.
Diagnosis-specific care pathways	Each enrolled condition runs a protocolized pathway — hypertension, diabetes, heart failure, kidney disease — reviewed and signed off by TCCH's clinicians before launch, in the clinical working session with CoachCare's Chief Medical Officer.
SDOH resource integration	TCCH's community-resource relationships are embedded in the care team's workflows, so social barriers surfaced on calls route to the resources TCCH already uses. The center's HRSA recognition for addressing social risk factors is exactly the muscle this extends between visits.

Question area	How the program answers it
BP data and quality reporting	Home readings are kept **separate from office vitals by design** — the office-vitals record stays clean — while remaining available and exportable for quality reporting. The separation is a feature, not a limitation: clinicians see monitoring data in context, and the quality team can still use it.
UDS measures	Controlled blood pressure, HbA1c testing and poor-control, and screening follow-up are the UDS measures structured monthly contact and home monitoring move fastest — the same activity that produces the revenue line in §5.

No quality baseline is assumed

This section describes mechanism, not measured lift. No UDS baseline, no improvement percentage and no shared-savings dollars appear in any financial figure in this report. Set targets against TCCH's own measure set once the program is live, with the quality team at the table.

8. Clinical Governance & Escalation

The first question clinical leadership should ask of any care-management partner is the one your nursing leadership asked in April: **when the abnormal reading arrives, who owns it?** The answer is a single documented escalation engine — every RPM and CCM finding routes through it, it is the same engine across every CoachCare client, and it is the reason the ~90/10 split holds in practice rather than only in a proposal.

One engine, objectively defined. Critical values escalate **regardless of symptoms** — a critical reading is never talked down by a symptom checklist. Out-of-range readings that are not critical get a structured retake plus symptom check. A trend is defined objectively — **three consecutive out-of-range readings at least one hour apart** for blood pressure or glucose, or **three readings within seven days** for heart rate — so no single stray number triggers an escalation, and no real deterioration hides between monthly calls. Every escalation documents the vital, the findings, the method of contact, who was reached, the outcome and the follow-up.

Routing	Trigger	What happens
Emergent — 911	An active emergent symptom reported live during any touch: 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, the clinic is looped in immediately; if the clinic is unavailable, CoachCare activates 911 itself. **CoachCare's urgent/emergent policy supersedes any local escalation preference** — the response never waits on a callback.
Critical value	A critical reading, regardless of symptoms	Escalates on the value alone. Non-critical out-of-range readings get a retake plus symptom check before any escalation — discipline in both directions.
Non-critical clinical change	A confirmed trend or clinically meaningful change that is not emergent	Routed to a **named member of TCCH's care team** for review and follow-up, through TCCH's chosen channel — the right person, not a broadcast page across the 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. This is most of the ~90%.

Routing	Trigger	What happens
Post-discharge	Any hospitalization or emergency-department visit reported within the previous 60 days	A fixed three-touch cadence: **Day 1–2** — stabilize, reconcile medications, confirm a timely follow-up appointment; **Day 5–8** — verify adherence, re-evaluate triggers, confirm the appointment happened; **Day 12–14** — review medications and risk, re-assess symptoms. The concrete readmission-prevention loop behind Scenario B's avoided-hospitalization figure.

Continuity is a clinical control, not a courtesy. Care-team pods keep the same care manager on the same roster; caseloads are capped at **165:1** (currently running near **133:1**); calls are recorded and quality-assured. 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 and phone numbers change, that documented record is what converts a hard-to-reach patient into a managed one.

All of it — protocols, escalation preferences, the named routing contact, the pathway sign-offs — is reviewed and adopted with TCCH's clinicians in the working session with CoachCare's Chief Medical Officer, so the engine runs TCCH's medicine, executed by CoachCare's team.

9. Epic via Health Choice Network — Integration, Stated Honestly

TCCH runs Epic hosted through **Health Choice Network (HCN)** — publicly verifiable through the health center's MyChart portal — which means the integration counterpart is HCN's hosted environment, and any build is scoped **with** HCN rather than around it. The program is designed to live inside the chart and billing workflows TCCH's staff already use:

Direction	What moves	Operational effect
From Epic	Enrollment flags at the point of care	Qualified patients are flagged at appointment check-in, so clinical and front-office staff see program status inside the schedule they already work — and enrollment conversations happen where trust already exists.
From Epic	Patient health history	The care team works from the problem list, medications and history the clinic sees — not a parallel record that drifts out of sync.
Into Epic	Monitoring data — kept separate by design	Home vitals live in the program record, deliberately not written into office vitals, and surface to clinicians in context — with export available for quality reporting (§7).
Into Epic	Monthly evidence-of-care documents	A monthly per-patient record of care delivered, time and clinical activity files to the chart — audit-ready documentation without chart-building labor for TCCH staff.
Into Epic	Automated claim generation	Claims generate automatically each month; TCCH's billing team receives a **reconciliation-only monthly CSV** — verification work, not creation work. For a program whose economics depend on monthly capture, this is the difference between a model and a result.

Where CoachCare's Epic experience actually stands

CoachCare integrates with Epic today, and an FQHC engagement is underway on **OCHIN — a national Epic host for community health centers and the closest analog to HCN's hosted model**. CoachCare **has not yet integrated with HCN specifically**, and this report does not pretend otherwise.

The plan follows from that honesty: **HCN joins integration scoping in the first 30 days**, the workplan is built through HCN's third-party process, and the 60–90-day launch window flexes with that scoping — which is exactly why it starts first. Integration scope, sequence and cost are contracting items; no integration figures appear in this report. One structural upside: an integration built once on HCN's hosted Epic follows a pattern shared across the HCN family of health centers.

10. Implementation Playbook

Goals & scope

Stand up a full-service CCM line billed by TCCH — live within **60–90 days of signature** (integration-dependent, §9) — designed to the two constraints in §2.2, reporting monthly from the first billable month, with the RPM decision scheduled at month 6 on program data. **No new TCCH headcount at any point.**

Target populations, in launch order

- **The risk-stratified core** — heart-failure, kidney-disease and complex multimorbid patients from the validated eligibility list: highest clinical need, strongest perceived value, least cost-sharing friction.
- **The diabetes program's patients** — the ADCES-accredited team's roster is a natural care-management cohort now, and the glucose/blood-pressure-ready on-ramp when RPM turns on.
- **Post-discharge and post-ED patients** — any admission or emergency visit in the previous 60 days triggers the three-touch cadence (§8).
- **The remainder of the validated ~2,700** — enrolled in waves as capacity and provider endorsement build toward and past the modeled 25%.

Outreach & enrollment — in TCCH's name

A dedicated outreach team runs enrollment under TCCH's brand: co-branded brochures and posters in the clinics, a patient-facing program webpage, outbound calls presenting the practice's caller ID, and voicemails recorded in a familiar voice — all included within implementation. Enrollment happens at appointments (prompted by Epic flags, §9) and telephonically; consent includes plain-language cost-sharing disclosure so no patient is surprised later — the single most important retention control this population needs.

Reporting & the claims-review partnership

A monthly automated program-performance report lands with TCCH leadership: census and enrollments by program and provider, billable percentage, activation sources, deactivation reasons, escalation rate, task and vitals volumes, and engagement channels — with custom cuts (blood-pressure trend distributions, demographics, plan-level views) available on request. In **months 4–6**, CoachCare and TCCH's billing team jointly review the first payment reports — the checkpoint where plan-level Medicare Advantage behavior is verified against actual remittances and any problem plan exits eligibility (§5.3).

KPI dashboard

Clinical	Operational	Financial & quality
% of enrolled hypertensive patients at goal · HbA1c testing and poor-control rates in the enrolled cohort · escalations by category and time-to-resolution · post-discharge touches completed on cadence · readings per patient per month (Scenario B)	Enrolled patients and enrolled services, by program · time-to-first-billable-enrollment · successful-contact rate and attrition vs the ~1.5%/month expectation · caseload ratio vs the 165:1 cap · share of interactions resolved without practice involvement (the ~90/10 discipline)	Monthly capture rate (billable months ÷ eligible enrolled months) · net revenue per enrolled patient-month · net to the health center after all fees · care gaps closed through program outreach · UDS measure movement year over year

The 12-month roadmap

- **Days 0–30 — Contract, charter, scope.** Named TCCH program owner and scorecard; HCN into integration scoping (§9); eligibility definition and plan screening against Epic; protocol and pathway sign-off; **the clinical working session with CoachCare's Chief Medical Officer**; cost-sharing posture decided, with the donor pathway on its own parallel track (§2.2).
- **Days 31–90 — Build, integrate, launch.** Integration build with HCN; outreach materials in TCCH branding; enrollment waves begin on the risk-stratified list; first billable months land inside the window.
- **Months 4–6 — Prove and tune.** Collaborative payment-report reviews with the billing team; plan-level verification and any eligibility pruning; engagement normalization (~month 6); capture-rate and attrition review against the §5.3 variables.
- **Months 6–12 — Decide RPM, align the ACO.** The scheduled RPM decision, made on TCCH's own program data with Scenario B as the quantified case; alignment with Health Choice Care on track status and quality-data flow (§7); forecast re-run on the validated list; care-gap collaboration formalized into the quality team's routine.

Contract shape

The working structure discussed in April: a **one-year initial term** with termination on **90 days' notice**, written around an orderly unwind — patient transition, device return and documentation handover — rather than lock-in. Commercial terms are carried in the contract template being shared separately; none appear in this report.

Expected impact — both scenarios, restated

Scenario A (CCM only): **$1,630,361** modeled 24-month net reimbursement; **$696,284** net to the health center; 675 enrolled patients; 29,544 claims; 14,772 CoachCare staff-hours. Scenario B (CCM + RPM on the same patients): **$2,137,081** and **$913,863**; 972 enrolled services across 675 unique patients; 38,891 claims; 65,134 readings; **41 avoided hospitalizations (≈$615K of avoided acute cost)**; 18,167 staff-hours. Month 1 is negative in both (−$4,550 / −$4,238); both are positive from month 2 onward. Illustrative, modeled — verify against practice data.

References & Data Sources

- HRSA Health Center Program / Uniform Data System — Treasure Coast Community Health, Inc., grant H80CS00187: CY2024 total unique patients 27,878; service-site registry; majority-minority panel share. Vintage: CY2024 reporting year, retrieved July 2026.
- Practice-provided panel counts (April 2026) — ~3,300 Medicare lives; ~2,700 CCM-eligible patients. TCCH's own identification, treated as the panel basis and flagged for chart validation during implementation.
- NACHC analysis of 2024 UDS — national FQHC Medicare share ≈11.2% of patients, used to corroborate the practice-provided Medicare count.
- CMS Medicare Shared Savings Program, PY2026 ACO Participants public use file — Treasure Coast Community Health Inc listed as a participant of Health Choice Care, LLC; CMS program files on track structure and the absence of prospective primary-care capitation. Retrieved July 2026.
- Health Choice Care, LLC public reporting — savings history across member health centers (as published; verify current-year results directly with the ACO).
- CMS Medicare Advantage State/County penetration file, July 2026 — Indian River County: ~43% MA penetration; ~57% of beneficiaries in traditional Medicare.
- CY2026 final-rule summaries for FQHC/RHC care management — sunset of bundled G0511 effective October 1, 2025; individual-code billing at national non-facility PFS rates from January 1, 2026; CY2027 auto-add provision. Stated as of July 2026; confirm with the health center's MAC (First Coast Service Options) before contracting.
- TCCH public website and announcements, reviewed July 2026 — services and locations; West Health Center opening (September 2025); Oslo campus and pediatric center construction; MyChart via Health Choice Network; ADCES-accredited diabetes program; AAAHC re-accreditation (December 2025); HRSA Community Health Quality Recognition badges; the publicly stated $2.5M bottom-line objective; jail-medicine program and HRSA quality-improvement award.
- IRS filings via ProPublica Nonprofit Explorer — 501(c)(3) status; the Supporting Organization of Treasure Coast Community Health Inc. (the health center's philanthropic support entity) and documented donor-funded patient-assistance precedent.
- County demographic data — Indian River County age structure (36.1% of residents 65+), retrieved July 2026.
- Health Choice Network public materials — HCN as an FQHC-owned network hosting Epic for member health centers; context for the integration pathway in §9.
- CoachCare Care Management standard operating procedures (v. March 2026) — escalation decision logic, urgent/emergent policy, post-discharge three-touch cadence, unreachable-patient and discharge governance. Source of the §8 protocol content.
- CoachCare operating standards shared with TCCH (April 2026) — ~90/10 interaction split; dedicated outreach team; care-team pods; 165:1 maximum caseload (currently ~133:1); 45–60 minutes per patient per month; recorded, quality-assured calls; 25–35% typical enrollment (up to ~50% with strong provider buy-in); ~1.5% monthly attrition; ~18-month average tenure.
- CoachCare Epic integration overview — enrollment flags, health-history exchange, monitoring data kept separate from office vitals, monthly evidence-of-care documents, automated claim generation with reconciliation-only CSV.

- CoachCare Value Analysis (2026) — modeled economics for TCCH on the practice-provided panel at the Florida locality; source of all illustrative financial, clinical and operational figures in this report. Companion workbook available on request.
- CoachCare program-scale references — 400+ managed conditions for 500,000+ patients; 10,000+ providers; 1,000+ implementations; care-plan coding and billing generating over 5 million claims; 100+ million vitals recorded; 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 and billing rules against the current-year Physician Fee Schedule and the health center's Medicare Administrative Contractor (First Coast Service Options) before contracting. The modeled panel is built on practice-provided counts that remain subject to chart validation; enrollment, attrition and engagement parameters are CoachCare operating expectations, not guarantees.

Organizational, quality and market facts are sourced from HRSA, CMS, IRS filings and public reporting as of July 2026 and should be confirmed at the time of decision. Items that could not be verified from public sources are flagged in the text and carried as discovery items rather than asserted.