FOSTER CITY MEDICAL CENTER

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line — RPM + CCM + PCM, with TCM at every discharge — as the operating spine of an independent primary-care practice

Purpose of this report

This report maps Foster City Medical Center's starting position — a verified Medicare Shared Savings Program participant carrying two-sided risk, with no visible remote-care infrastructure — to a concrete 2026 build plan: a managed Remote Care Service Line that generates recurring professional-fee revenue from the panel the practice already manages, strengthens shared-savings performance, and preserves the practice's independence. All modeled figures are illustrative, modeled — verify against practice data.

Prepared July 2026 · In collaboration with CoachCare

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Executive Summary

Foster City Medical Center is an independent, physician-owned primary-care and walk-in urgent-care practice operating from a single site at 1241 E. Hillsdale Blvd., Suite 270, Foster City, California (San Mateo County). The clinical roster is six providers — three physicians (internal medicine and family medicine) and three advanced-practice providers — serving Medicare and a broad commercial payer panel. The practice is led by its owner-physician CEO, which means the decision path for a new service line runs through a single clinical owner rather than a committee. (Practice website and NPPES, retrieved July 27, 2026.)

The starting position is unusual and, for this strategy, decisive. Foster City Medical Center appears in the CMS PY2026 Medicare Shared Savings Program participant file under ACO A2098, "The Accountable Care Organization, Ltd.", on the **ENHANCED track — the program's two-sided risk track**, in a low-revenue ACO with retrospective beneficiary assignment[1]. At the same time, the practice shows **no visible remote-care infrastructure**: no remote patient monitoring, chronic care management, or principal care management program is mentioned anywhere on its website (site sweep, July 27, 2026). The practice is carrying accountability for total cost of care with none of the between-visit machinery that programs of this kind are built to provide. One structural advantage is already in place: the practice runs on Epic (confirmed July 27, 2026), which gives the build a direct, bi-directional integration path from the first enrolled patient (Section 7.4).

> **The central argument**
>
> **Standalone value:** a managed Remote Care Service Line — RPM + CCM as the workhorse, PCM for the highest-risk single-condition patients, TCM at every discharge — converts the panel the practice already manages into recurring, subscription-like professional-fee revenue. Modeled at a 2,000-patient Medicare panel estimate, the program produces $1,096,276 in 24-month net reimbursement and $515,854 in practice profit at a 47.1% margin, margin-positive from month two (illustrative, modeled — verify against practice data).
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> **Connective tissue:** the same infrastructure — enrollment, connected devices, 24/7 alert-and-triage, nurse navigation, billing capture, analytics — is the practice's most direct operational lever on MSSP shared-savings performance under two-sided risk, defends MIPS quality scores, and positions the practice for APCM (G0556–G0558), for which its value-model eligibility is already verified. Build once, reuse everywhere.

The narrative for 2026 is simple: **turn the panel you already manage into a profit-generating service line** — without hiring, without selling the practice, and without waiting on infrastructure the practice does not have today. CoachCare funds and staffs the on-site enrollment specialist, operates the monitoring and documentation layer, and the practice bills under its own provider numbers. Independence is preserved; the economics diversify away from visit volume.

The CY2026 Physician Fee Schedule strengthens the case: new RPM codes 99445 (2–15 days of device data in a month) and 99470 (first 10 minutes of management time) make short and light-touch monitoring windows billable for the first time, widening the billable base beyond the classic 16-day/20-minute thresholds. Rates in this report are illustrative national and Noridian JE (locality 05) magnitudes — verify against the current fee schedule.

[1] CMS PY2026 MSSP ACO Participants file (modified February 4, 2026): participant legal business name "FOSTER CITY MEDICAL CENTER" under ACO A2098. The match is name-based — the public participant file carries no TIN or practice address — and the name matches the practice's NPPES legal business name exactly, with the ACO's service area including California. Confirm TIN-level participation in discovery.

2026–2027 Priority Recommendations

1. **Validate the Medicare panel with a chart count — discovery item #1.** The 2,000-patient panel figure is a method-based estimate (credible range 1,600–2,700) and the forecast's most sensitive input; the 24-month numbers scale roughly linearly with it.
2. **Stand up the RPM + CCM core** on the hypertension, diabetes, and multi-chronic cohorts — running inside the practice's Epic environment through CoachCare's direct integration — the modeled ramp reaches the RPM ceiling (180 enrolled) by month 6 and the CCM ceiling (200) by month 7, with one CoachCare-funded on-site enrollment specialist.
3. **Layer PCM** for the small high-risk single-condition cohort (modeled ceiling: 25 patients, reached by month 3) and wire **TCM at every hospital discharge** to capture transitions and feed the monitoring programs.
4. **Point the program at ACO A2098 performance:** route avoided admissions, medication adherence, and blood-pressure/glucose control data into the ACO's quality and total-cost-of-care workflow. Under ENHANCED-track two-sided risk, every avoided admission is both a clinical win and a financial one.
5. **Make the CCM-versus-APCM program-mix decision within two quarters.** APCM eligibility is verified via MSSP participation, but APCM cannot be billed with CCM, PCM, or TCM for the same patient in the same month — it is a per-patient program-mix choice, presented here as incremental upside and intentionally not modeled in the forecast.
6. **Re-run the Value Analysis after discovery** (panel count, payer mix) and set the 12-month KPI dashboard: enrolled census, time-to-first-billable-enrollment, capture rate, and revenue per patient per month.

1. Practice Footprint & Operating Model

Foster City Medical Center operates one clinic in Foster City, California, combining longitudinal primary care (internal medicine and family medicine) with walk-in urgent care, women's health, lab and allergy testing, telehealth visits, occupational and immigration exams, mental-health screening, and medical weight-loss management (practice website, retrieved July 27, 2026). NPPES lists the organization under NPI 1255731980 with urgent-care and general-practice taxonomies; the practice describes itself as physician-owned. Practice physicians hold admitting affiliations with hospitals on the mid-Peninsula (public physician directories, retrieved July 27, 2026).

Provider	Role
Rajan Dave, MD	Internal Medicine — CEO, owner-physician (NPPES authorized official)
Amanda L. Howard, MD	Internal Medicine
Ka Wai Tam, MD	Family Medicine
Balsharan Dhillon, PA-C	Physician Assistant
Angela Chen, NP	Family Medicine Nurse Practitioner
Kristina Sia, NP	Family Medicine Nurse Practitioner

Provider roster per the practice website, July 27, 2026.

Two structural facts shape the opportunity. First, the practice's panel is a classic adult internal-medicine mix — hypertension, type 2 diabetes, heart failure, CKD, and COPD live in one panel — which is exactly the population remote-care billing programs were designed around. Second, the walk-in urgent-care arm gives the practice steady acute demand but also competes for clinician time; a remote-care layer managed by a partner adds a longitudinal revenue stream without pulling providers away from the front door.

For an independent 3-physician practice in one of the country's most consolidated markets, the strategic frame is **independence preservation**: recurring service-line revenue is an alternative to the two default endgames for small practices — selling to a hospital system or to private-equity-backed aggregators. A remote-care service line diversifies revenue away from visit volume while keeping ownership and clinical control where they are today.

Design principles for the service line

Principle	What it means at Foster City Medical Center
Longitudinal by default	Every multi-chronic Medicare patient is assessed for RPM/CCM/PCM at the point of care; enrollment is the default pathway, not an exception
One front door	Urgent-care and primary-care encounters both feed the same enrollment funnel; a discharge or walk-in visit is an enrollment opportunity
Digital as care, not add-on	Connected devices and between-visit touches are part of the care plan, documented in the chart, and billed
Top-of-license staffing	CoachCare's enrollment specialist and monitoring staff do the outreach and documentation; practice clinicians review exceptions and sign orders
Single scorecard	One monthly view: enrolled census, capture rate, revenue per patient per

Principle	What it means at Foster City Medical Center
	month, alerts resolved, admissions avoided

2. The Remote Care Service Line — The Spine

2.1 What it is — the primary-care remote-care stack

The service line is a managed operating layer over the existing panel, built from four Medicare care-management programs that are designed to run together. CoachCare provides the devices, the 24/7 monitoring and alert-triage layer, the care-management staff time, the documentation and billing capture, and a funded on-site enrollment specialist; the practice provides clinical oversight and bills under its own provider numbers.

Program	Who it serves	Cadence & mechanics
RPM — Remote Physiologic Monitoring (99453/99454/99445, 99457/99470/99458)	Hypertension and diabetes cohorts; HF weight monitoring	Connected BP cuff, glucometer, or scale; monthly device-supply and management-time billing; 24/7 alert-and-triage
CCM — Chronic Care Management (99490/99439; 99491/99437; 99487/99489)	Patients with 2+ chronic conditions expected to last 12+ months — the core adult-IM panel	Monthly non-face-to-face care management: care plan, medication reconciliation, coordination, 20+ minutes staff time
PCM — Principal Care Management (99424/99425; 99426/99427)	High-risk patients managed around one dominant condition (e.g., HF) for 3+ months	Condition-specific care plan and monthly management; the small, sickest slice of the panel
TCM — Transitional Care Management (99495/99496)	Every patient discharged from hospital or SNF	Contact within 2 business days; face-to-face within 7/14 days; feeds RPM/CCM enrollment at the moment of highest risk

The primary-care remote-care stack. APCM (G0556–G0558) is a fifth, bundled alternative discussed in Section 6.

> **The one coordination rule that matters**
>
> APCM is a monthly bundle and **cannot be billed with CCM, PCM, or TCM for the same patient in the same month**. RPM, by contrast, stacks with all of them (discrete time and documentation). The design consequence: choose a per-patient program track — CCM + RPM for most multi-chronic patients today, with APCM + RPM as the alternative track once the practice makes its program-mix decision (Section 6). One care plan per patient in Epic, one program owner per patient per month.

2.2 Standalone value — four value layers and the CY2026 billing stack

Before any value-based upside, the service line stands on its own economics. Four value layers, in order of immediacy:

1. **Per-panel recurring revenue without adding headcount.** Enrollment, device logistics, monitoring, and documentation are CoachCare-operated, and the on-site enrollment specialist is CoachCare-funded — an embedded part of the program's value, not a cost the practice carries. Modeled steady-state practice profit is $25,054 per month from month 8 (illustrative, modeled — verify against practice data).
2. **MIPS and quality-score defense.** Continuous blood-pressure, glucose, and adherence data directly supports the control measures that drive MIPS scoring for a primary-care practice — evidence generated as a by-product of care, not chart abstraction.
3. **ACO shared-savings contribution.** As a verified MSSP ENHANCED-track participant, the practice shares in savings — and losses — on total cost of care. The modeled program avoids an estimated 25.2 hospitalizations over 24 months; under two-sided risk, avoided admissions flow to the ACO's bottom line and the practice's shared-savings position (Section 5).
4. **Independence preservation.** A recurring service-line P&L diversifies practice economics away from visit volume — a durable alternative to consolidation for a physician-owned group.

The CY2026 billing stack

Service / code	Type	~CY2026 magnitude	Notes
TCM 99495 / 99496	Per discharge	~$200 / ~$280	Contact within 2 business days; face-to-face within 14 / 7 days
RPM 99453	One-time setup	~$20	Device setup and patient education
RPM 99454 / 99445	Monthly	~$52	99454: 16–30 days of data; 99445 (new 2026): 2–15 days — short windows now billable
RPM 99457 / 99470	Monthly	$50.66 / ~$26	First 20 management minutes (99457, Noridian JE locality 05 rate); 99470 (new 2026): first 10 minutes
RPM 99458	Monthly	~$41	Each additional 20 minutes
CCM 99490 + 99439	Monthly	$62.10 + ~$47	First 20 staff minutes (99490, Noridian JE locality 05 rate); add-on per extra 20 minutes
PCM 99426 + 99427	Monthly	$66.08 + ~$50	First 30 staff minutes (99426, Noridian JE locality 05 rate); add-on per extra 30 minutes
APCM G0556 / G0557 / G0558	Monthly bundle	~$15 / ~$49 / ~$107	By patient complexity; no minute-tracking; eligibility verified via MSSP — not modeled (Section 6)

Illustrative rates. Values marked as Noridian JE locality 05 are drawn from the practice-specific Value Analysis workbook (ZIP 94404, carrier 01112, locality 05); all others are national non-facility magnitudes. Verify against the current CY2026 Physician Fee Schedule and local MAC pricing.

Recurring-revenue mechanics

Unlike fee-for-service visit revenue, care-management revenue behaves like a subscription: each enrolled patient generates predictable monthly billings across RPM device-supply, RPM management time, and CCM or PCM care-management codes — plus TCM at each discharge. At the modeled census plateau of 405 program enrollments (~248 unique patients), the practice's net reimbursement runs $52,420 per month. The revenue base is the panel, not the appointment book.

2.3 Connective tissue — one infrastructure, every value lever

The deeper argument for building the service line is that its infrastructure is reused by every strategic lever the practice cares about. One enrollment funnel, one device logistics chain, one 24/7 monitoring layer, one billing-capture engine — powering the standalone P&L, the ACO position, quality defense, and the APCM option simultaneously.

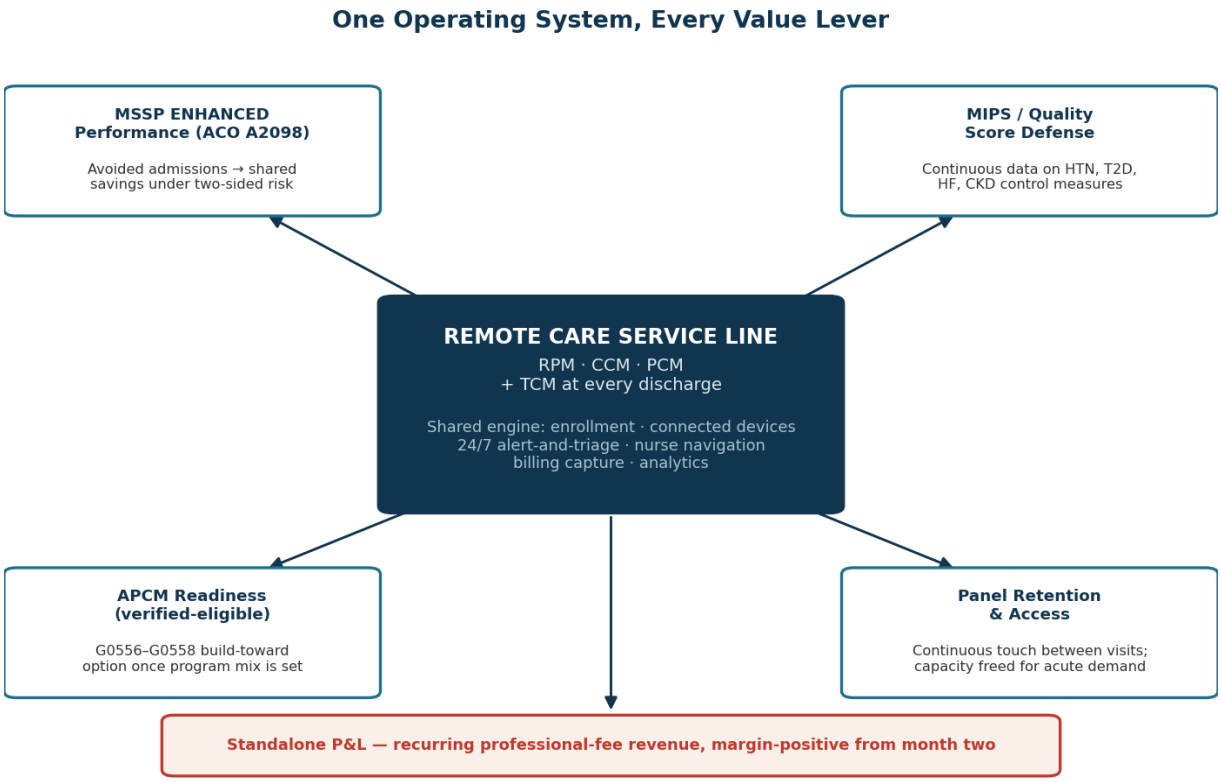

Figure 1. One operating system, every value lever: the same remote-care infrastructure powers the practice's standalone P&L, MSSP ENHANCED performance, MIPS defense, panel retention, and APCM readiness.

Value lever	How the same infrastructure powers it
MSSP ENHANCED performance (ACO A2098)	24/7 monitoring and nurse triage catch decompensation early; avoided admissions and ED visits lower total cost of care under two-sided risk; retrospective assignment rewards continuous engagement
MIPS / quality-score defense	Continuous BP, glucose, and adherence data feeds control measures;

Value lever	How the same infrastructure powers it
	documentation is generated in the normal course of monitoring
APCM readiness (verified-eligible)	The 13 APCM service elements map closely onto the CCM + RPM operating capabilities the service line builds; switching a patient track later is a billing decision, not a new build
Panel retention & access	Between-visit touches keep patients attached to the practice in a market dense with large-system alternatives; clinician time is freed for acute and complex visits
Standalone P&L	Billing capture across RPM/CCM/PCM/TCM converts the same monitoring work into recurring professional-fee revenue, margin-positive from month two

3. 2026 Policy & Payment Environment

3.1 MSSP ENHANCED track — verified participation, two-sided risk

Foster City Medical Center appears as a participant legal business name in the CMS PY2026 Medicare Shared Savings Program ACO Participants file (file modified February 4, 2026) under ACO **A2098 — "The Accountable Care Organization, Ltd."**[2] The ACO's characteristics, per the same CMS file: **ENHANCED track** (the program's highest risk-and-reward track — the ACO shares in savings and in losses), **low-revenue ACO** (a designation that generally corresponds to physician-led ACOs whose participants' Medicare fee-for-service revenue is a small share of their assigned beneficiaries' total spend), retrospective beneficiary assignment, agreement period 4 (current period start January 1, 2025), and use of the SNF 3-day-rule waiver. The ACO's service area spans eleven states including California.

Three practical consequences follow. First, **the downside is real**: under ENHANCED, if the ACO's assigned population runs over its benchmark, the ACO owes CMS a share of the losses. A practice with no between-visit monitoring capability is exposed to exactly the events — unmanaged hypertension, decompensating heart failure, missed post-discharge follow-up — that drive avoidable spend. Second, **retrospective assignment rewards engagement**: beneficiaries are assigned based on where they actually receive primary care, so continuous between-visit contact both improves care and stabilizes the assigned population. Third, **APCM's value-model requirement is already satisfied**: APCM billing requires participation in an advanced primary-care value model, and verified MSSP participation meets that test (Section 6). Participation in other CMS primary-care models has not been confirmed for this practice and is not assumed anywhere in this report.

3.2 The CY2026 remote-care billing tailwind

The CY2026 Physician Fee Schedule is the most remote-care-friendly in the program's history, and the changes map directly onto this practice's use cases:

- **99445 — RPM device supply, 2–15 days of data per month.** Previously, a month with fewer than 16 days of readings was unbillable. Short windows — a post-discharge blood-pressure run,

[2]Name-based legal-business-name match; see footnote 1. Dataset: data.cms.gov, Medicare Shared Savings Program — Accountable Care Organization Participants, PY2026.

a medication-titration check, a post-urgent-care follow-up — are now billable at approximately the same magnitude as the full-month code.

- **99470 — RPM management, first 10 minutes.** Light-touch monitoring months, previously below the 20-minute billing floor, now generate revenue. For a mixed-acuity primary-care panel this widens the billable base materially.
- **APCM behavioral-health add-ons (G0568–G0570).** New 2026 add-on codes attach behavioral-health integration to the APCM bundle — relevant to the Section 6 decision, given the practice already offers mental-health screening.

Scope note: this practice is primary care and urgent care only. The CMS models relevant to this report are MSSP (participation verified) and APCM eligibility (satisfied via that verified MSSP participation); no other model participation is assumed or asserted anywhere in this document.

4. Value Analysis — 24-Month Forecast

CoachCare's Value Analysis for Foster City Medical Center models an RPM + CCM + PCM program over 24 months, priced at Noridian JE locality 05 rates (ZIP 94404), held at CoachCare's list pricing with no discount, and carrying Epic's integration catalog fees ($4,000 one-time setup, $150 per month, $1.50 per patient). **APCM is intentionally not modeled** — it is a verified-eligible incremental upside pending the program-mix decision in Section 6. All figures in this section are **illustrative, modeled — verify against practice data.**

4.1 Inputs and assumptions

Input	Value	Basis
Medicare panel (in scope, year 1)	2,000 — ESTIMATE	~5–6 adult primary-care clinicians × ~450 Medicare patients each, with a haircut for the walk-in/urgent-care mix; credible range 1,600–2,700
Programs modeled	RPM + CCM + PCM	Primary-care/IM program set; TCM captured operationally at discharges; APCM not modeled
Eligibility rates	RPM 30% · CCM 40% · PCM 5%	Specialty-standard eligibility for a primary-care/IM panel
Conversion rates	RPM 30% · CCM 25% · PCM 25%	Program defaults, one funded on-site enrollment specialist
Enrollment staffing	1 on-site enrollment specialist	CoachCare-funded — CoachCare's expense, embedded in program value; never netted from practice margin
Pricing	List (0% discount)	24-month margin at list is 47.1%, above the 40% threshold — held at list
EMR integration	Epic — confirmed July 27, 2026	Catalog fees applied: $4,000 one-time setup + $150/month + $1.50/patient; exact instance/hosting configuration confirmed in contracting
MAC locality	Noridian JE, carrier 01112,	Resolved from ZIP 94404; locality-adjusted

Input	Value	Basis
	locality 05 (CA)	rates populated in the workbook

The panel estimate is the forecast's most sensitive assumption

There is no claims-data count for this practice; 2,000 Medicare patients is a method-based estimate (clinician-count build-up with an urgent-care haircut), with a credible range of 1,600–2,700. Because all three program ceilings bind by month 7, the 24-month forecast scales roughly linearly with this input. A chart count in discovery is validation item #1; budget a re-run of the Value Analysis once the real number is known.

4.2 Headline economics

	Year 1	Year 2	24-Month
Net reimbursement to the practice	$467,239	$629,037	$1,096,276
CoachCare fees (incl. one-time implementation)	$252,034	$328,389	$580,423
Practice profit	$215,206	$300,648	$515,854
Margin (profit ÷ net reimbursement)	46.1%	47.8%	47.1%

Modeled at list pricing, 2,000-patient panel estimate. Illustrative, modeled — verify against practice data.

Program (24-month)	Net reimbursement	Practice profit	Margin
RPM	$477,640	$228,864	47.9%
CCM	$554,795	$279,094	50.3%
PCM	$63,842	$31,016	48.6%
APCM	not modeled	not modeled	—

Month-1 economics — read before quoting

Month 1 is modeled at **−$4,696** for the practice: the one-time implementation fee ($2,500) and the Epic integration setup fee ($4,000) land in month 1, ahead of the enrollment ramp. The program turns **margin-positive in month 2** (~45% margin) and is cumulatively break-even within month 2 — narrowly, at +$268 cumulative — with cumulative profit reaching ~$9.4K by month 3 and a steady ~48% margin from month 3 onward.

4.3 Ramp, ceilings, and the enrollment plateau

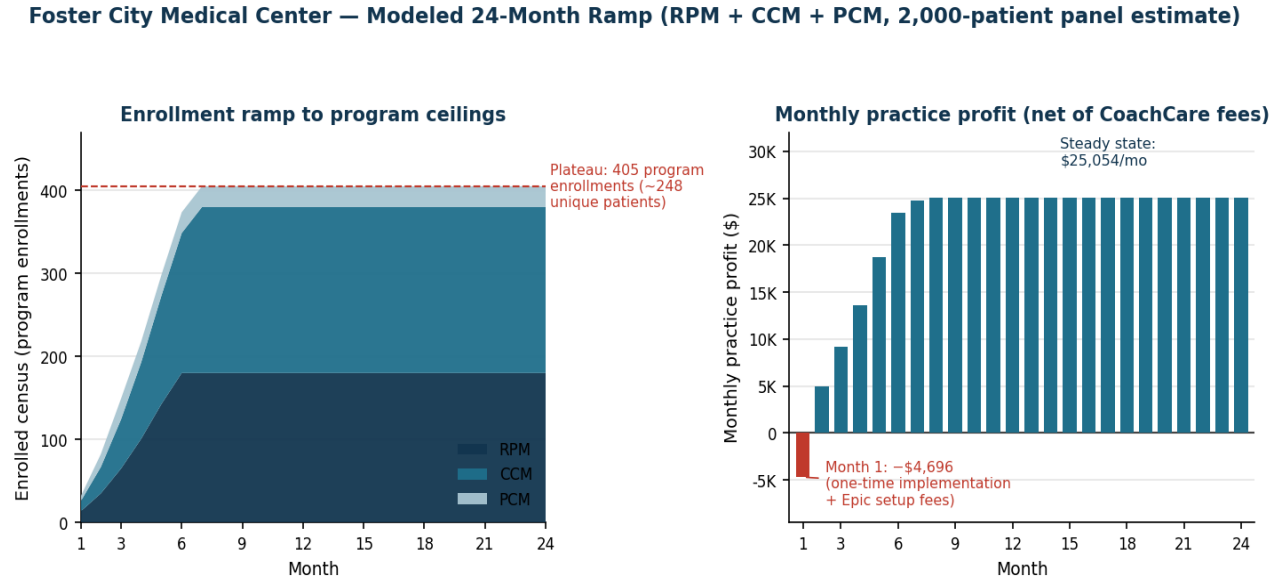

Figure 2. Modeled enrollment ramp and monthly practice profit. Illustrative, modeled — verify against practice data.

Program	Ceiling arithmetic	Ceiling	Saturates
RPM	2,000 × 30% eligible × 30% conversion	180 enrolled	Month 6
CCM	2,000 × 40% eligible × 25% conversion	200 enrolled	Month 7
PCM	2,000 × 5% eligible × 25% conversion	25 enrolled	Month 3

This is a **ceiling-limited account, not a pace-limited one**. Total active enrollment plateaus at 405 program enrollments from month 7 — approximately 248 unique patients, since roughly 70% of CCM/PCM patients are dual-enrolled in RPM. Adding providers or a second enrollment specialist does not move the forecast; the eligibility definition is the constraint. The practical implication cuts both ways: the ramp is fast (steady-state economics inside two quarters), and the honest lever for a bigger number is a bigger validated panel — which is why the chart count matters.

4.4 Clinical and operational value

Measure (24-month, modeled)	Value
Claims/billable units generated	16,335
Physiologic readings captured	39,653
Hospitalizations avoided	25.2 (~$378K at an illustrative $15K per admission)
Care-team hours saved	7,540 hours (≈3.62 FTE equivalents)
Care-management tasks completed	32,669
Chart updates	8,167
Patient–care-manager conversations	4,900

Operational by-products of the same monitoring work that generates the billing above. Illustrative, modeled — verify against practice data.

The staffing math deserves emphasis: 3.62 FTE-equivalents of care-management work are performed inside CoachCare's service — work a six-provider practice could not absorb internally without hiring. That capacity, plus the funded enrollment specialist, is embedded in the program fee; it is part of what the practice buys, not a cost line it carries.

5. Powering MSSP Performance: Shared Savings Under Two-Sided Risk

For most independent practices, remote-care programs are argued on fee-for-service economics alone. Foster City Medical Center's verified ENHANCED-track participation changes the calculus: the same avoided admissions that make the program clinically valuable also move the ACO's total-cost-of-care position, and under a two-sided model the practice participates in both directions of that movement.

- **The exposure side.** ENHANCED-track ACOs repay CMS a share of spending above benchmark. The events most likely to drive a small practice's assigned population over benchmark — hypertensive crises, HF decompensation, uncontrolled diabetes, post-discharge bounce-backs — are precisely the events a 24/7-monitored RPM/CCM layer is built to intercept. Today the practice has no such layer visible; the service line is the most direct operational hedge available.
- **The upside side.** The Value Analysis models 25.2 avoided hospitalizations over 24 months (~$378K at an illustrative $15K per admission). Those dollars are not practice fee-for-service revenue — they are total-cost-of-care savings of the kind that fund shared-savings distributions. The practice's ACO is low-revenue and physician-led in character, the configuration under which shared savings most directly reach participant practices. Actual distribution terms are set by the ACO's internal agreements — a discovery item, not an assumption.
- **Assignment stability.** With retrospective assignment, beneficiaries count toward the ACO based on where they receive the plurality of primary care. Monthly care-management touches keep patients attached to the practice — protecting both the assigned population and the panel itself in a market dense with large-system alternatives.
- **Quality reporting.** MSSP quality performance draws on the same control measures (blood pressure, HbA1c) that RPM generates continuously. The monitoring layer turns quality reporting from an annual abstraction exercise into a by-product of operations.

> **What this report does not claim**
>
> No ACO-level benchmark, savings-rate, or distribution figures for ACO A2098 are modeled or implied here; the practice's shared-savings economics depend on the ACO's internal participation agreement and performance, which are not public at practice level. The claim is narrower and operational: under two-sided risk, a monitored panel is a materially better position than an unmonitored one, and the service line is how a 6-provider practice gets there without hiring.

6. The APCM Decision: A Verified-Eligible, Unmodeled Upside

Advanced Primary Care Management (G0556/G0557/G0558) is Medicare's bundled alternative to minute-tracked care management: one monthly rate per patient, tiered by complexity (~$15 / ~$49 / ~$107, with G0558 for Qualified Medicare Beneficiary/dual-eligible patients), covering 13 defined service elements with no time-threshold documentation. From 2026, behavioral-health integration add-ons (G0568–G0570) can attach to the bundle.

APCM carries a gate that most independent practices fail: the billing practice must participate in an advanced primary-care value model. **Foster City Medical Center passes it today** — its verified PY2026 MSSP participation satisfies the requirement. Among independent primary-care practices, that is an uncommon and valuable position: the practice can choose APCM on the merits, not build toward eligibility.

> **Why APCM is not in the forecast**
>
> APCM cannot be billed with CCM, PCM, or TCM for the same patient in the same month — for each patient, the practice picks one care-management track. The CCM-versus-APCM mix is therefore a program-design decision the practice has not yet made, and modeling both would double-count patients. The Section 4 forecast models the CCM + RPM track only; whatever share of the panel ultimately moves to APCM + RPM (RPM stacks with APCM) is **incremental to, and partially substitutive of**, the modeled CCM economics. Present APCM as upside pending the program-mix decision — not as a second revenue stack.

The decision framework

Factor	Favors CCM + RPM (modeled track)	Favors APCM + RPM (alternative track)
Patient complexity	Moderate-complexity patients where 20–40 staff minutes/month is realistic and add-on codes accrue	High-complexity and QMB/dual patients — G0558 (~$107/mo) exceeds typical CCM realization without minute-tracking
Documentation burden	Minute-tracking required; CoachCare automates capture	No minute-tracking; 13 service elements must be in place as capabilities
TCM interaction	TCM billable at every discharge alongside CCM	TCM cannot be billed in an APCM month for that patient — discharge-heavy patients argue for the CCM track
Behavioral health	Standard BHI codes	G0568–G0570 add-ons attach cleanly to the bundle

A per-patient track decision, revisited quarterly once the program is live.

Recommended sequencing: launch on the modeled CCM + RPM track, then run a program-mix analysis at month 6 with real acuity and QMB-mix data — the 13 APCM service elements substantially overlap the capabilities the service line will already be operating, so a later track switch is a billing decision rather than an operational rebuild.

7. Implementation Playbook

7.1 Goals and scope

- Stand up an RPM + CCM + PCM service line across the Medicare panel, with TCM wired to every discharge, reaching modeled census ceilings (180/200/25) by month 7.
- Route monitoring outcomes into ACO A2098 quality and total-cost-of-care workflows from the first enrolled month.
- Reach the APCM program-mix decision by end of Q2 post-launch with real acuity and payer-mix data.

7.2 Target populations

Cohort	Primary programs	Modeled scale
Hypertension and diabetes (multi-chronic)	RPM + CCM	RPM ceiling 180; CCM ceiling 200 (overlapping)
High-risk single-condition (e.g., HF)	PCM + RPM	PCM ceiling 25
Every hospital/SNF discharge	TCM → RPM/CCM enrollment	Operational pathway; feeds the programs above
QMB/dual and highest-complexity patients	APCM candidates (Section 6)	Sized at the month-6 program-mix review

7.3 Staffing model

The practice adds no headcount. CoachCare provides: (1) one funded on-site enrollment specialist — CoachCare's expense, embedded value, never netted from practice margin; (2) the 24/7 monitoring and alert-triage layer; (3) care-management staff performing the equivalent of ~3.6 FTEs of work at modeled steady state; (4) billing-capture and documentation tooling. The practice provides clinical oversight: order signing, exception review (a clinician-defined alert escalation path), and care-plan approval — designed to fit inside existing clinic rhythms for a six-provider group.

7.4 Technology, data, and billing architecture — the Epic integration

Foster City Medical Center runs on **Epic** (confirmed by the practice, July 27, 2026) — the strongest integration scenario for this build. CoachCare maintains a direct, bi-directional Epic integration, so the whole program lives in the practice's Epic environment: clinicians never learn a second system, and remote-care data behaves like native chart data.

Integration pillar	What it does in Epic
Integrated enrollment	Enrollment flags and trigger ordering inside the clinical workflow; CoachCare enrolls qualified Medicare patients on the practice's behalf, with enrollment status visible in Epic in real time
Health-history exchange	Bi-directional exchange of health history at intake
Discrete vitals	Device readings land as discrete vitals in the chart — not PDFs
Compliance documentation	Audit-ready care summaries and time logs written to the record
Automated claim generation	Claims created automatically by the CoachCare billing engine — no manual claim step per patient per month

Two proof points matter for a practice this size: enrolled patients typically begin receiving CCM and RPM services within five days of an enrollment flag, and CoachCare is the only care-management application integrated with Epic that provides automated claims creation — eliminating the per-patient monthly billing step and accelerating reimbursement.

“Key to achieving a program that is efficient, effective and sustainable is creating a seamless, intuitive user experience for the patient and provider — and that's what our integration with Epic accomplishes.”

The one remaining configuration item is the normal contracting-stage one: confirming the practice's exact Epic instance and hosting arrangement (for example, a Community Connect relationship with a host system) and the practice-management configuration. The Value Analysis already carries Epic's integration catalog fees ($4,000 one-time setup, $150 per month, $1.50 per patient), so this confirmation refines workflow details, not the modeled economics.

Billing architecture: all professional fees are billed by the practice under its own provider numbers; CoachCare supplies the audit-ready time logs, device-supply evidence, and claim-line detail for each code, including the new 99445/99470 short-window codes, generated through the Epic integration's automated claim pipeline.

7.5 Clinical workflow

1. **Identify:** panel scrub against RPM/CCM/PCM eligibility (chart count doubles as the panel validation exercise).
2. **Enroll:** the on-site enrollment specialist consents patients at visits, at urgent-care encounters, and by outreach; devices ship or are handed off same-week.
3. **Monitor:** readings flow to CoachCare's 24/7 layer; alerts triage by protocol; escalations route to the practice's designated clinician.
4. **Manage:** monthly care-management touches, medication reconciliation, and care-plan updates documented against each program's requirements.
5. **Bill and report:** monthly claim files with supporting documentation; a single scorecard to the CEO; quality data routed to MIPS and ACO reporting.

7.6 KPI dashboard

Domain	KPIs
Financial	Enrolled census vs. ceiling; time-to-first-billable-enrollment; capture rate (billed ÷ billable patient-months); revenue per patient per month; monthly practice profit vs. the $25,054 modeled steady state
Clinical	BP and glucose control rates; alert resolution time; medication adherence; hospitalizations and ED visits vs. baseline
Operational	Enrollment velocity vs. ramp curve; device return/refresh rate; patient-contact completion; TCM 2-business-day contact rate
Strategic	ACO quality-measure completeness; panel retention among enrolled vs. unenrolled patients; APCM candidate count for the month-6 review

7.7 12-month roadmap

Phase	Months	Milestones
Discovery & contracting	0–1	Epic instance/hosting configuration confirmed; chart-count panel validation; Value Analysis re-run; BAA and program agreement; alert-escalation protocol signed
Launch	1–2	Enrollment specialist on site; first RPM/CCM cohorts enrolled; first billable month closed (month-1 net of one-time fees is modeled negative; margin-positive from month 2)

Phase	Months	Milestones
Ramp	2–7	PCM ceiling by month 3; RPM ceiling by month 6; CCM ceiling by month 7; TCM pathway live at admitting hospitals
Optimize	6–12	APCM program-mix review with real acuity/QMB data; ACO quality-data feed live; capture-rate tuning; panel re-validation and forecast refresh

7.8 Expected impact

At the modeled 2,000-patient panel: $515,854 in 24-month practice profit at a 47.1% margin, ~248 unique patients under continuous management, an estimated 25.2 hospitalizations avoided, and roughly 3.6 FTEs of care-management capacity added without a hire — alongside a materially stronger position under the ACO's two-sided risk arrangement. Every figure is illustrative, modeled — verify against practice data, and re-run the Value Analysis after the chart count.

References & Data Sources

- Foster City Medical Center website — services, provider roster, contact and payer information (retrieved July 27, 2026).
- NPPES NPI Registry — organization NPI 1255731980 and provider records (retrieved July 27, 2026).
- CMS, Medicare Shared Savings Program — Accountable Care Organization Participants, PY2026 file (data.cms.gov; file modified February 4, 2026): participant legal business name match under ACO A2098, "The Accountable Care Organization, Ltd." (ENHANCED track, low-revenue, retrospective assignment).
- CMS CY2026 Physician Fee Schedule — remote physiologic monitoring (including 99445/99470), care-management code families (TCM, CCM, PCM), and Advanced Primary Care Management (G0556–G0558; G0568–G0570). Rates cited are illustrative national or Noridian JE locality 05 magnitudes.
- CoachCare Value Analysis workbook — Foster_City_Medical_Center_CoachCare_Value_Analysis_2026.xlsx (built July 27, 2026; re-run with confirmed Epic integration catalog fees; Noridian JE carrier 01112, locality 05, ZIP 94404): all modeled census, reimbursement, fee, profit, and clinical-operations figures in Section 4.
- CoachCare platform statistics (About CoachCare, July 2026): 500,000+ patients across 400+ managed conditions; 10,000+ providers; 1,000+ implementations; 5 million+ claims supported; 100 million+ vitals recorded.

Global caveat

This report is a strategy document prepared for discussion. All financial figures are illustrative, modeled — verify against practice data; actual reimbursement is locality-adjusted and set by the regional MAC. The Medicare panel size is an estimate pending chart-count validation (credible range 1,600–2,700). The MSSP participation match is name-based (the public CMS file carries no TIN or address). The practice's EMR is Epic (confirmed July 27, 2026); the exact Epic instance, hosting arrangement, and configuration are confirmed in contracting. Confirm current-year rates against the CY2026 Physician Fee Schedule and program rules before operational or financial commitments.