



SERVICE LINE STRATEGY • Connected Care, by CoachCare.

ODA Primary Health Care Network

A federally qualified health center serving Williamsburg, Brooklyn since 1974: ten Brooklyn sites and two summer sites in the Catskills, 90,063 patients in 2025, 5,858 of them on Medicare, and one eClinicalWorks system

Remote Care Service Line Optimization Report

2026 Strategy Report

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

Purpose of this document

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

The case is short. ODA already ranks in HRSA's best quartile on diabetes control, keeps cardiology, endocrinology, nutrition and social work under the same roof as primary care, and runs its own care management department. Most of its Medicare patients also qualify for Medicaid, which makes advanced primary care management worth more at ODA than at almost any other kind of practice. What ODA does not yet have is daily readings from home and a monthly care team for every eligible Medicare patient. This report shows what that program returns, who does the work, and how it starts without capital or a hire.

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Executive Summary

ODA Primary Health Care Network is an HRSA Section 330 health center that has served Williamsburg, Brooklyn since 1974. It runs ten Brooklyn sites and two summer sites in the Catskills, with urgent care at its main Wallabout Street center until midnight every day of the year. Four sites carry adult primary care, and a cardiologist, an endocrinologist, nutrition counseling and social work sit in the same buildings. Every site runs on one eClinicalWorks system.¹

ODA served 90,063 patients in 2025. 5,858 of them were on Medicare, up 26% since 2022, and 59% of those Medicare patients, 3,433 people, also qualify for Medicaid. HRSA ranks ODA in its best quartile on diabetes control, and blood-pressure control has climbed more than ten points since 2021. **We found no remote monitoring program at ODA, and no Medicare chronic care management or advanced primary care management billing.** ODA does run its own care management department, which has followed up with patients with diabetes and asthma since at least 2017.²

The observation this report is built on

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

Since January 1, 2026 a health center bills remote monitoring, chronic care management and advanced primary care management as individual Medicare codes, each paid in addition to the PPS encounter. The top tier of advanced primary care management, \$117.24 a month, is reserved for Qualified Medicare Beneficiaries, and 59% of ODA's Medicare patients are dual-eligible. ODA has the panel, the clinicians and the record system. What it lacks is the monthly care team and the daily readings, and CoachCare supplies both, billed under ODA's NPIs from inside eClinicalWorks.

What the Value Analysis returns

Full service line	Year 1	Year 2	24 months
Net reimbursement	\$1,062,607	\$2,535,053	\$3,597,660
CoachCare fees	\$625,520	\$1,443,974	\$2,069,494
Net to ODA	\$437,087	\$1,091,079	\$1,528,166
Practice margin	41.1%	43.0%	42.5%

CoachCare Value Analysis: 5,858 Medicare patients, all in scope; remote monitoring, chronic care management and advanced primary care management; 22 referring clinicians; one CoachCare-funded on-site enrollment specialist; CY2026 national non-facility amounts. Practice margin is net to ODA divided by net reimbursement.

ODA can take this two ways, and both are net-positive. CoachCare can run remote monitoring on its own, with care management left with ODA's own department: **\$1,467,446 of net reimbursement and \$621,975 to ODA over 24 months**, a 42.4% margin, for 1,212 patients. Or CoachCare can run all three programs, the forecast of record above, for 1,607 unique patients. Every dollar is Medicare, paid on top of the PPS encounter. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families.

1. **Care management fills first; remote monitoring sets the pace.** Advanced primary care management reaches its eligible ceiling of 615 patients by month 8 and chronic care management its 703 by month 16. Remote monitoring is still climbing at month 24, 1,212 of 1,333, because 22 referring clinicians and one

¹ odahealth.org, retrieved October 26, 2026: history, locations, services and care team pages; HRSA Health Center Program site file for grant H80CS00064; New York State Department of Health facility records. The patient portal is eClinicalWorks healow, configured for ODA.

² HRSA Uniform Data System, 2025, health center H80CS00064: 90,063 patients; 5,858 Medicare patients (4,638 in 2022); 3,433 dual-eligible; controlling high blood pressure 67.97% (57.19% in 2021); HbA1c above 9% 18.32%, quartile 1.

enrollment specialist set how fast patients join. A second CoachCare enrollment specialist adds \$573,108 of net reimbursement.

2. **Net-positive from month 2.** Month 1 runs -\$4,381 while implementation and the eClinicalWorks setup post against a census still ramping. Every month after is positive, and the monthly net climbs to \$102,174 in month 24.
3. **No ODA hires.** CoachCare brings on 7 care managers by month 12 and 10 by month 24, at 165 patients each, and delivers 22,558 care-team hours over 24 months.
4. **The program lives in eClinicalWorks.** CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically, and a flagged patient reaches the first day of service in under five days.
5. **Medicare only.** New York Medicaid pays remote monitoring only to health centers that bill under APGs; ODA's Medicaid visits are paid under PPS, so the forecast counts Medicare only.
6. **The CY2027 proposed rule takes 4.8% off this line.** A 20.6% cut to device supply is 9.5% on the remote-monitoring arm and \$171,906 on the whole line over 24 months (Section 9).
7. **Transitional care and behavioral health integration are named, at zero dollars.** The same care team can run both once the program is live.

The ask is a working session with ODA's leadership to confirm the Medicare chart count by payer (traditional Medicare, Medicare Advantage and dual-eligible), walk through how the care management department runs today, settle the language plan for Yiddish- and Spanish-speaking patients, and scope the eClinicalWorks workflow for the four adult-medicine sites.

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

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

The shift	What it means for ODA
1. From visits to panels	Four visits a year leave 361 days without a reading. Blood pressure drifts in those days, glucose climbs in them, and the urgent-care visit at eleven at night starts in them. Managing the panel means knowing which of ODA's 5,858 Medicare patients are trending the wrong way before they reach the urgent-care desk or an emergency department.
2. Quality scored every year	HRSA ranks every health center each year on blood-pressure control, diabetes control, statin therapy and depression screening. In 2025 ODA ranked in the best quartile on diabetes control and the third on blood-pressure control at 68.0%. Each of those measures moves with what happens between visits.
3. Paid for the month	Since January 1, 2026 health centers bill remote monitoring, chronic care management and advanced primary care management as individual codes, each paid on top of the PPS encounter. The highest level of advanced primary care management is reserved for Qualified Medicare Beneficiaries, and 59% of ODA's Medicare patients are dual-eligible.
4. Codes for the work between visits	Remote monitoring pays when a patient takes readings on 16 or more days in a month, and two codes new in 2026, 99445 and 99470, pay for the shorter months; in this forecast they carry 17% of remote-monitoring reimbursement. ³ One hypertensive patient on remote monitoring and chronic care management is worth \$170.01 a month in Medicare allowed charges; a Qualified Medicare Beneficiary on remote monitoring and advanced primary care management level 3 is worth \$221.12 .

³ CoachCare Value Analysis for ODA, 2026: 99445 \$234,013 and 99470 \$38,995 of \$1,584,287 remote-monitoring gross reimbursement over 24 months (17.2%).

Each shift pays for, or measures, what happens between visits. A remote care service line is how ODA covers that time for every eligible Medicare patient, and all three programs bill for it today, on top of the PPS encounter, under ODA's own NPIs.

2. ODA Today: A Williamsburg Health Center Since 1974

ODA is a federally qualified health center by grant and by design: an HRSA Health Center Program grantee, deemed under the Federal Tort Claims Act and licensed by New York State as a diagnostic and treatment center. It grew from one primary care and dental facility in Williamsburg into a network that keeps specialists, social work, nutrition and a pharmacy under the same roof as primary care.⁴

2.1 Ten Brooklyn sites, four with adult primary care

Site	Address	What it offers	Role in this program
Wallabout Health Center	74 Wallabout Street	Adult and pediatric primary care; cardiology, endocrinology, GI, allergy, dermatology, podiatry, nutrition; urgent care until midnight, 365 days a year	The adult-medicine hub, where most adult clinicians and both in-house specialists practice
Park Avenue	517 Park Avenue	Pediatrics, internal and family medicine, GI, wound care, nutrition, urgent care	Adult primary care; social work integrated
Quality Health Center	432 Bedford Avenue	Pediatrics, internal medicine, nutrition, podiatry, urgent care	Adult primary care; social work integrated
ODA East	251 Wallabout Street	Internal and family medicine, pediatrics, dermatology, podiatry, eye care; opened spring 2026	New adult-medicine capacity, ODA's fourth adult primary care site
Six more Brooklyn sites	Heyward Street, Rutledge Street, Flushing Avenue, Crown Heights and others	Rehabilitation and social work, vision, dental, women's health, a therapy and wellness center, pediatrics and podiatry in Crown Heights, and a mobile unit	Referral sources and shared services; social work at Heyward Street
Two Catskills sites	Woodridge and Monticello	Pediatrics, primary and urgent care, July and August only	Outside the program's launch

odahealth.org locations and services pages, October 26, 2026. Twelve locations in all: ten in Brooklyn and two seasonal sites in the Catskills.

The adult-medicine bench is 22 prescribers: 6 physicians in internal and family medicine and 16 nurse practitioners and physician assistants who see adults, most of them at Wallabout. ODA keeps a cardiologist and an endocrinologist in house, both at Wallabout, so most heart and diabetes patients never leave ODA. It has 27 social workers on staff, with behavioral health integrated into primary care at Heyward, Bedford and Park, and nutrition counseling for diabetes, high blood pressure and high cholesterol at three sites.⁵

2.2 The patients ODA serves

Patients, HRSA UDS 2025	Count	Chronic conditions and access	Count
Patients served, all ages and payers	90,063	Patients with hypertension	4,690
Patients served in 2021	74,938	Patients with diabetes	2,991
Medicare patients, traditional and Medicare Advantage	5,858	Patients with diabetes above 9% A1c or untested	548

⁴ HRSA Health Center Program, grant H80CS00064, project period through March 31, 2030; ODA compliance page, retrieved October 26, 2026; New York State Department of Health facility records, operating certificate 7001254R.

⁵ ODA health care team directory and services pages, retrieved October 26, 2026: 6 adult-medicine physicians (5 internal medicine, 1 family medicine), 16 family and urgent-care nurse practitioners and physician assistants, 1 cardiologist, 1 endocrinologist, 27 social workers.

Patients, HRSA UDS 2025	Count	Chronic conditions and access	Count
Medicare patients in 2022	4,638 (up 26% since)	Best served in a language other than English	4,684
Dual-eligible Medicare patients	3,433 (59%)	Patients under 18	44%
Patients 65 and older	6,251	Languages spoken by clinicians and staff	English, Yiddish, Hebrew, Spanish and others

HRSA Uniform Data System, 2025 and prior years, health center H80CS00064. Condition counts cover patients of all ages.

Two facts shape the program. The Medicare panel is growing, from 4,638 patients in 2022 to 5,858 in 2025, and it is mostly dual-eligible: 59% of ODA's Medicare patients also qualify for Medicaid, one of the highest shares among health centers. That share is what makes advanced primary care management pay well here, and dual-eligible patients tend to carry more chronic conditions and more barriers to getting to a visit. A program that reaches them at home, by phone, fits the panel.

2.3 How ODA scores where remote care helps

ODA's 2025 HRSA Uniform Data System report card places it against every health center in the country. Quartile 1 is the best-performing quarter on HRSA's adjusted ranking.⁶

Clinical quality measure, UDS 2025	Population	ODA	HRSA quartile
Diabetes: HbA1c poor control (> 9%)	Patients with diabetes · lower is better	18.32%	Quartile 1
BMI screening and follow-up	Adults 18 and older · higher is better	72.14%	Quartile 2
Controlling high blood pressure	Hypertensive patients under 140/90 · higher is better	67.97%	Quartile 3
Colorectal cancer screening	Adults 45–75 · higher is better	36.88%	Quartile 3
Statin therapy for cardiovascular disease	Patients at high cardiovascular risk · higher is better	66.46%	Quartile 4
Depression screening and follow-up	Patients 12 and older · higher is better	61.20%	Quartile 4

ODA has added more than ten points of blood-pressure control in four years, from 57.2% in 2021 to 68.0%, and sits in the third quartile; across 4,690 hypertensive patients the next points come from home readings and medication changes between visits. Poor A1c control is already lower than at three in four health centers, yet 548 patients with diabetes were still above 9% or untested in 2025. Statin therapy and depression screening, both in the fourth quartile, are monthly-call work: a statin started or restarted, a PHQ screen done by phone and routed to ODA social work the same week.

2.4 Fifty years of growth in Williamsburg

Year	What happened
1974	ODA is founded to serve Williamsburg's immigrant community, beginning with one primary care and dental facility. Its first site, on Heyward Street, joins HRSA's Health Center Program in 1978
2011–2014	The Park Avenue Health Care Center opens; ODA takes on the Quality Health Center on Bedford Avenue and opens its dental center on Rutledge Street
2019	The Wallabout Street health center opens as the main site: adult and pediatric primary care, cardiology, endocrinology and urgent care until midnight, 365 days a year. The vision center and a mobile unit follow
2022	A Crown Heights site for pediatrics and podiatry, ODA's first outside Williamsburg

⁶ HRSA Uniform Data System, 2025, H80CS00064, clinical quality measures and adjusted quartile rankings.

Year	What happened
2025	90,063 patients, up from 74,938 in 2021; a therapy and wellness center opens on Flushing Avenue; the Medicare panel reaches 5,858
2026	ODA East opens at 251 Wallabout Street with internal medicine, family medicine, pediatrics, dermatology, podiatry and eye care, the fourth site for adult primary care
Next	Daily readings and monthly care management for every eligible Medicare patient at the four adult-medicine sites, run by a CoachCare care team inside eClinicalWorks and billed under ODA's NPIs

2.5 What ODA already runs, and the gap

What exists	Status	What it means for this program
eClinicalWorks and the healow portal	Live at every site	The program's host: flags, orders, readings, care documents and claims (Section 4)
A care management department	Since at least 2017	Credited and kept. Its care managers follow up with patients with diabetes and asthma; CoachCare adds home readings and carries the monthly Medicare minutes
Chronic disease and care coordination measured by site	Every quarter	Monthly reporting from the care team lands in the same review
Cardiology and endocrinology	In house at Wallabout	Home weight, blood pressure and glucose reach the specialist with the referral
Social work and behavioral health	27 social workers; integrated at Heyward, Bedford and Park	A positive PHQ screen on the monthly call routes to ODA social work the same week
Nutrition counseling	Three sites	Home glucose and weight show whether the diet plan is working between counseling visits
On-site pharmacy, including 340B	In house	Missed refills surface on the monthly call before they show up as a high reading
Remote monitoring	We found no program	Devices, daily readings and business-hours alert triage come from CoachCare
Medicare chronic care management and APCM billing	We found no program	Billed under ODA's NPIs, claims built in eClinicalWorks

The gap is specific. ODA's care management department already follows up with patients with diabetes and asthma, ODA measures chronic disease by site every quarter, and cardiology, endocrinology and nutrition are in house. What ODA does not have yet is daily readings from home and a monthly care team for every eligible Medicare patient, with the claims built in eClinicalWorks automatically.⁷

2.6 The market, the rate basis and Medicaid

57.8% of Medicare beneficiaries in Kings County were in a Medicare Advantage plan in October 2026. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The 5,858 Medicare patients in ODA's UDS count already include its Medicare Advantage and dual-eligible patients, so the forecast needs no gross-up; the split by payer is the first thing to confirm.⁸

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

⁷ New York State Department of Health primary care plan update, September 2017: ODA's care management department and its diabetes and asthma follow-up. ODA quality page, retrieved October 26, 2026: chronic disease and care coordination measured quarterly by site.

⁸ CMS Medicare Advantage State/County Penetration, October 2026: Kings County, 241,058 of 417,294 eligible beneficiaries (57.8%).

the Medicare amount. New York Medicaid pays remote monitoring only to health centers that bill under APGs; ODA's Medicaid visits are paid under PPS, so the forecast counts Medicare only.⁹

3. The Service Line: RPM, CCM and APCM

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

Health centers are paid a prospective payment per qualifying visit. For years the between-visit work for chronic patients was billed under one flat monthly code, G0511, whatever the services, minutes or programs behind it. **Since January 1, 2026 health centers bill remote monitoring, chronic care management and advanced primary care management as individual codes, each paid in addition to the PPS encounter.** Each code carries its own eligibility test, consent, time capture and documentation standard. That is more work for a billing office and more revenue for a health center that does the work; the claims in this forecast are built in eClinicalWorks, not by hand.¹⁰

3.2 The clinical and billing stack

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

Program	What it does clinically	Who it fits on this panel	Net reimbursement per patient-month
Remote physiologic monitoring (RPM)	Cellular cuffs, glucometers and scales send readings between visits against thresholds ODA's clinicians set; 99453, 99454 or 99445, 99457, 99458, 99470	Hypertension and diabetes first, then kidney disease and heart failure; 3,808 eligible	\$98.03
Chronic care management (CCM)	A documented care plan and at least 20 minutes of clinical staff time a month for patients with two or more chronic conditions; 99490, 99439	The multi-chronic core: hypertension with diabetes, kidney disease, heart disease or depression; 2,343 eligible	\$110.75
Advanced primary care management (APCM)	A monthly amount for running the patient's primary care, with no minute count, tiered by complexity; G0556, G0557, G0558	Patients with an ongoing primary-care relationship; level 3 for Qualified Medicare Beneficiaries; 2,050 eligible	\$69.86

One coordination rule, set at enrollment

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

3.3 Advanced primary care management and the dual-eligible panel

Advanced primary care management pays a monthly amount per patient for the work of running a primary-care panel: access, care planning, coordination and population management, without a minute count. Level 1 (G0556) covers patients with one chronic condition or none, level 2 (G0557) two or more, and level 3 (G0558) Qualified Medicare Beneficiaries with two or more.¹¹

⁹ CY2026 Medicare Physician Fee Schedule final rule, national non-facility amounts, conversion factor \$33.4009. New York State Medicaid Telehealth Policy Manual, updated July 2026, section 9.8; New York State Department of Health list of health centers billing under APGs, updated October 29, 2025.

¹⁰ CY2026 Medicare Physician Fee Schedule final rule: G0511 retired for health centers; RPM, CCM and APCM billed under their individual codes, paid at the national non-facility amount in addition to the PPS encounter.

¹¹ CY2025 and CY2026 Physician Fee Schedule final rules: APCM (G0556 to G0558) effective January 1, 2025, billed in place of chronic care management for the same patient and month.

That last tier is why ODA's panel matters. 59% of ODA's Medicare patients are dual-eligible, and Qualified Medicare Beneficiaries are a group within them. The forecast sets the tier mix at 10% level 1, 50% level 2 and 40% level 3, anchored to the dual-eligible share and held below it, because not every dual-eligible patient is a Qualified Medicare Beneficiary. At \$117.24 a month, a level 3 patient-month pays more than twice a level 2 patient-month at \$53.78. Advanced primary care management fills first in the forecast, reaching its ceiling of 615 patients in month 8. Which patients carry it rather than chronic care management is a program decision to make together, and the Medicare chart count by payer settles the tier mix.

3.4 The care team, and the hours it keeps

CoachCare hires, trains and manages the care managers, at 165 patients each: 7 care managers at month 12, for 1,159 unique patients, and 10 by month 24, for 1,607. An on-site enrollment specialist on CoachCare's payroll works beside ODA's medical assistants at the adult-medicine sites and enrolls patients during the visit, and telephonic outreach reaches the rest. Devices are cellular, with no Wi-Fi, smartphone or pairing needed. Monitoring runs on business hours: devices transmit daily, and care managers review readings, run outreach and send escalations Monday to Friday, 8 a.m. to 5 p.m. in the patient's time zone. Patients are told at consent to call 911 for an emergency, and ODA, whose Wallabout urgent care is open until midnight every day, for anything urgent.

3.5 Transitional care, behavioral health and community health

Transitional care management (99495 at \$220.11, 99496 at \$298.60) pays for the month after a hospital or observation stay: contact within two business days, medication reconciliation and an ODA visit within 14 days, or 7 for high-complexity patients. The post-discharge cadence in Section 5.4 is that episode: CoachCare makes the first call and books the visit, and ODA furnishes the visit and bills the code. The forecast carries no dollars for it. The trigger is the hard part: whether a discharge notice reaches ODA from the hospitals where ODA's patients are admitted is a discovery item.

Behavioral health integration (99484, \$57.45 a month) fits the same care-manager calls and the same chart. ODA already places social workers inside primary care, and behavioral health integration is the program built for depression follow-up. **Community health integration** (G0019, \$86.17) pays for time spent on the social needs that get in the way of treatment. Both run on the same care team and carry no dollars in this forecast.

3.6 Two deployments, and what ODA keeps

ODA has already built part of the answer to build-versus-partner: a care management department that follows its diabetes and asthma patients. CoachCare can take on as much or as little of the care management as ODA wants.

Deployment	What CoachCare runs	What ODA keeps
RPM alongside ODA's own care management	Remote monitoring for the hypertension, diabetes and heart-failure patients	Care management as its department runs it today, with home readings in the chart
Full service line, RPM + CCM + APCM (the forecast of record)	All three programs, enrolling every eligible patient into a care-management program as well as monitoring	The patients its own care managers already follow, if it chooses

- **ODA keeps clinical governance, the patients and the revenue.** Its clinicians set thresholds, routing and discharge criteria and sign the care plans; claims go out under ODA's billing entity and NPIs, separate from the PPS encounter, and in the full service line ODA keeps 42.5% of net reimbursement after CoachCare's fees.
- **CoachCare supplies the program.** Devices, an on-site enrollment specialist, care managers, business-hours alert triage, monthly documentation and automated claims, priced per active patient per month. None of it is ODA's headcount, inventory or capital.

- **Today's patients stay where they are.** The forecast counts care management from zero against the whole eligible panel, so how the work divides with the patients ODA's care managers follow today is a discovery item.

3.7 What the codes pay

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

How the rates apply

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

One device code (99454 or 99445), one first-tier management code (99457 or 99470) and one care-management program (chronic care management or advanced primary care management) bill per patient per month. A Qualified Medicare Beneficiary on remote monitoring and advanced primary care management level 3 (99454, 99457 and G0558) is worth \$221.12 a month.

Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The forecast prices every patient at the Medicare amount.

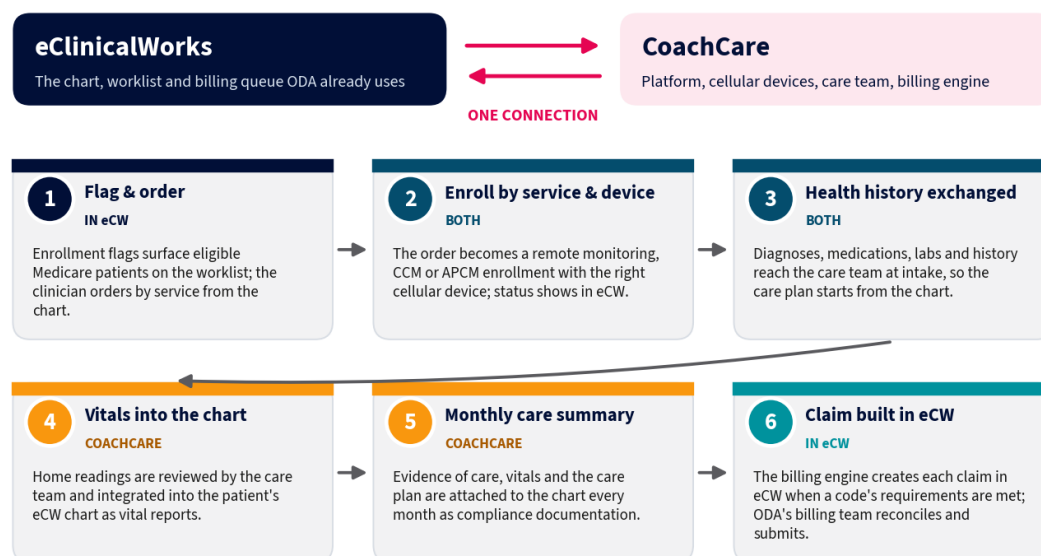
4. eClinicalWorks: The Program Lives in the Chart

CoachCare works inside eClinicalWorks' own workflows, so ODA's clinicians and staff do not learn a second system. Evidence of care, vitals and care plans are attached to each chart every month, enrollment status is visible at every site, and a flagged patient reaches the first day of service in under five days.¹² CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically.

Integration pillar	What happens in eClinicalWorks
Integrated enrollment	Flags in the chart prompt the order for patients who meet criteria ODA's clinicians approve, at a chronic-care visit, an annual wellness visit or on an outreach list
Enrollment by services and devices	The clinician orders by service and by device (cuff, glucometer, scale), the way a lab is ordered
Exchange of health history	Diagnoses, medications, vitals and lab results pass to the care team at intake; the care plan comes back
Integrated vital reports	Home readings land in the chart, so the clinician sees home averages at the next visit
Compliance documentation and care summary	Evidence of care, vitals and the care plan attached monthly for every enrolled patient

¹² CoachCare eClinicalWorks integration overview, 2026: the six integration pillars; patients begin chronic care management and remote monitoring in less than five days.

Integration pillar	What happens in eClinicalWorks
Automated claim generation	Claims built for every patient, every month, once a code's requirements are met; ODA's billing team reconciles and files them under ODA's NPIs, separate from the PPS encounter



Repeats every month for every enrolled patient, at all four adult-medicine sites, from the same chart. Source: CoachCare eClinicalWorks integration overview.

Figure 1. From a flag in the chart to a claim: the six steps CoachCare and eClinicalWorks run every month for every enrolled patient. CoachCare eClinicalWorks integration overview.

The integration costs \$4,000 for setup, \$150 a month and \$1.50 per enrolled patient-month. With implementation and telephonic outreach the ancillary items total \$86,922 over 24 months, inside the \$2,069,494 of CoachCare fees. The build runs alongside onboarding, so it does not hold up the first enrollments.

5. Clinical Governance & Escalation

Every reading routes through one escalation engine with defined thresholds, trend rules, routing and documentation, so ODA never carries surveillance liability it did not agree to. Thresholds and routing are set with ODA's clinicians, for each site, before the first patient enrolls.¹³

5.1 One shared escalation engine

Branch	The rule	Why
Critical value	Escalate to the health center, regardless of symptoms	No site preference can suppress it. A critical reading on its own goes to ODA, not to 911
Out of range, not critical	Retake, then a structured symptom check	Most out-of-range readings resolve here, which keeps inboxes usable
Trend	Three consecutive readings an hour or more apart for blood pressure or glucose; three within seven days for heart rate; weight gain past the agreed threshold	A confirmed trend escalates like a single threshold breach
Patient unreachable	Document, leave a callback message, and escalate anyway if the reading was critical or a confirmed trend	Silence never downgrades a clinical finding

¹³ CoachCare Care Management Programs standard operating procedures, March 2026: escalation logic, trend definitions, emergent protocol, care-management hours (Monday to Friday, 8:00 a.m. to 5:00 p.m. local patient time), post-discharge sequence and discharge governance.

Branch	The rule	Why
Documentation	Six fields: vital • findings • method • contact • outcome • follow-up	Any episode can be reconstructed end to end

5.2 The emergent pathway

Non-negotiable, and stated as such

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

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

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

The floor. CoachCare's emergent policy supersedes any site escalation preference. This cannot be configured away. ODA shapes routing for everything else.

5.3 Three-way routing, on business hours

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

The matrix is agreed for each of the four adult-medicine sites. Care managers work readings and escalations Monday to Friday, 8 a.m. to 5 p.m. local patient time, and Wallabout, the adult-medicine hub, is open from 8 a.m. to midnight every day, so every escalation lands while clinicians are in the building. A reading that arrives on a weekend or overnight is worked the next business day, and the patient's standing instruction for anything urgent is ODA's own line, or 911.

5.4 The post-discharge cadence

Any emergency visit or hospitalization in the previous 60 days triggers the cadence. After a hospital or observation stay it is also the transitional care episode ODA can bill, and for a health center whose main site runs urgent care until midnight, it is how a patient who is struggling at home gets a call before the next trip to the urgent-care desk.

Touch	Window	What happens
1 • Stabilize	Day 1–2	What led to the visit; discharge medications reconciled against what is in the house; a follow-up visit confirmed within 7 to 14 days
2 • Detect	Day 5–8	Adherence verified, triggers re-checked, appointment and ordered labs confirmed
3 • Secure	Day 12–14	Medication and risk review, visit outcome, and a handoff into monthly monitoring

5.5 Language access and a phone-first design

ODA's clinicians and staff speak English, Yiddish, Hebrew, Spanish and other languages, and HRSA counts 4,684 of ODA's patients as best served in a language other than English. Language is a design requirement here, not an

add-on: enrollment, device instructions and outreach are scoped with ODA for Yiddish- and Spanish-speaking patients before the first patient enrolls, and the welcome call covers how to take a reading that counts.

The rest of the design is phone-first. Devices are cellular and arrive ready to use, with no home internet, smartphone or pairing. The welcome call, the monthly care-management call and every escalation call are made by phone, so no patient has to learn an app. Patients who already use the healow portal can keep using it, and nothing in the program depends on it. A monitoring patient unreachable 45 days from enrollment is escalated to ODA; without an instruction from ODA, discharge from monitoring follows at 180 days, and discharge criteria always belong to ODA's clinicians.

6. Value Analysis: The 24-Month Forecast

6.1 The headline economics

The forecast covers remote monitoring, chronic care management and advanced primary care management across ODA's 5,858 Medicare patients, all in scope, at the CY2026 national amounts, with 22 referring clinicians and one CoachCare-funded on-site enrollment specialist. Every dollar is Medicare fee-for-service reimbursement, paid in addition to the PPS encounter. No transitional care, behavioral health integration, Medicaid or grant dollars are in these numbers.¹⁴

Full service line	Year 1	Year 2	24 months
Remote physiologic monitoring	\$361,094	\$1,106,352	\$1,467,446
Chronic care management	\$356,407	\$913,130	\$1,269,537
Advanced primary care management	\$345,106	\$515,571	\$860,677
Net reimbursement	\$1,062,607	\$2,535,053	\$3,597,660
CoachCare fees, including eClinicalWorks integration and implementation	\$625,520	\$1,443,974	\$2,069,494
Net to ODA	\$437,087	\$1,091,079	\$1,528,166
Practice margin	41.1%	43.0%	42.5%

Year two is more than twice year one because remote monitoring keeps climbing all the way through and chronic care management fills in month 16: the program enters year two with 1,159 unique patients and ends it with 1,607. The margin rises from 41.1% to 43.0% as the one-time setup falls away. Year two returns **\$2,535,053 of net reimbursement, \$1,091,079 of it kept by ODA.**

6.2 Two deployments, side by side

Each deployment is priced on its own, and the full service line is the forecast of record. Remote monitoring on its own leaves care management with ODA's department and returns \$621,975 to ODA at a 42.4% margin. The full line adds chronic care management and advanced primary care management for 1,318 patients by month 24 and returns \$906,191 more to ODA over 24 months.

24 months	RPM alongside ODA's own care management	Full service line, RPM + CCM + APCM
Net reimbursement	\$1,467,446	\$3,597,660
Net to ODA after fees	\$621,975	\$1,528,166
Practice margin	42.4%	42.5%
Unique patients at month 24	1,212	1,607
Hospitalizations avoided	About 100	About 100

¹⁴ CoachCare Value Analysis for ODA, 2026, the source of all Section 6 figures; sensitivity runs change one input at a time on the same workbook.

6.3 Where the revenue comes from

24 months	Net reimbursement	CoachCare fees	Net to ODA
Remote physiologic monitoring	\$1,467,446	\$838,180	\$629,266
Chronic care management	\$1,269,537	\$646,975	\$622,562
Advanced primary care management	\$860,677	\$497,417	\$363,260
Implementation, eClinicalWorks integration, per-patient EMR fee, telephonic outreach		\$86,922	-\$86,922
Total	\$3,597,660	\$2,069,494	\$1,528,166

Remote monitoring is the largest program, \$1,467,446 on 1,212 enrollments at month 24, and it produces the readings, alerts and avoided admissions. Chronic care management carries \$1,269,537 on 703 enrollments, because the multi-chronic core of the panel is large and the 99439 add-on is earned in most months. Advanced primary care management carries \$860,677 on 615, with the level 3 tier doing most of the work. The **2,530 active program enrollments at month 24 belong to 1,607 unique patients**, because most care-management patients are also monitored. The two codes new in 2026 carry 17% of remote-monitoring reimbursement on this mix.

6.4 The ramp, month by month

Month 1 nets -\$4,381, because the one-time implementation fee and the eClinicalWorks setup post against 69 enrollments. The program is positive from month 2, with \$6,142 on 181 enrollments, and cumulative net to ODA is above zero by the end of month 2. New enrollments arrive at about 111 a month through the first year, so the monthly net climbs every month of the forecast, to \$102,174 in month 24. Cumulative net to ODA passes \$93,531 at month 6, \$437,087 at month 12 and \$1,528,166 at month 24.

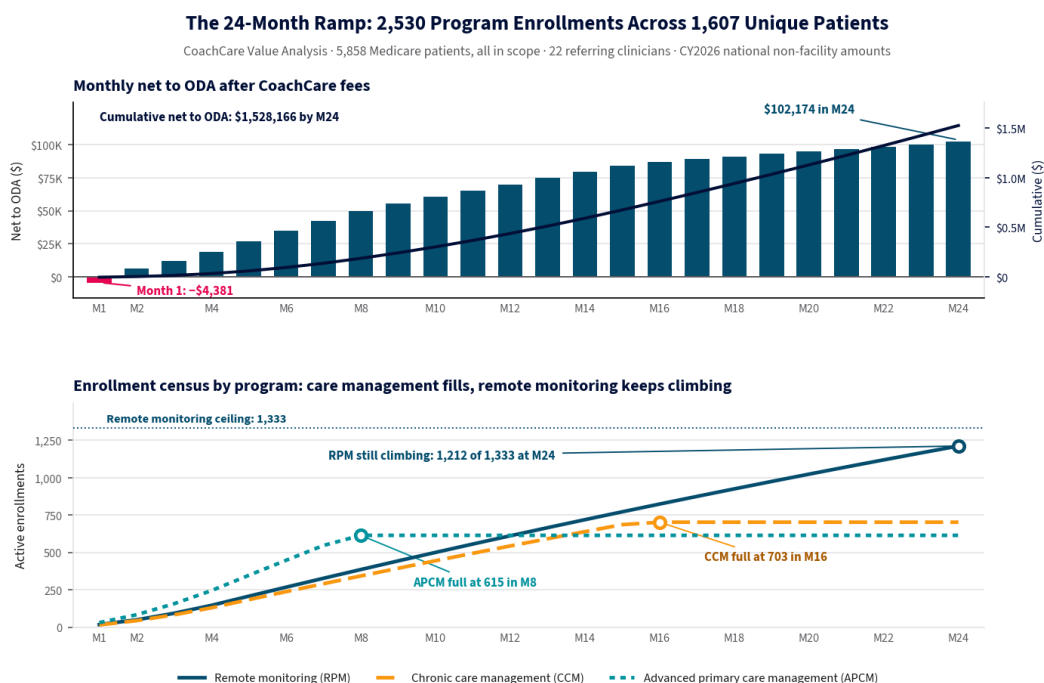


Figure 2. Monthly net to ODA after CoachCare fees, with cumulative net, and the enrollment census by program against the eligible ceilings. CoachCare Value Analysis, full service line.

Month	Active enrollments	Net reimbursement	CoachCare fees	Net to ODA
M1	69	\$6,385	\$10,766	–\$4,381
M2	181	\$16,493	\$10,351	\$6,142
M3	337	\$30,376	\$18,594	\$11,782
M6	956	\$84,924	\$50,241	\$34,683
M8	1,346	\$119,496	\$69,655	\$49,841
M12	1,771	\$163,337	\$93,338	\$69,999
M16	2,142	\$201,305	\$114,265	\$87,040
M24	2,530	\$238,563	\$136,389	\$102,174

6.5 Enrollment pace, not the panel, holds back remote monitoring

Program	Eligible share of the 5,858 in scope	Acceptance	Ceiling	Reached
Advanced primary care management	35%, 2,050 patients	30%	615	M8
Chronic care management	40%, 2,343 patients	30%	703	M16
Remote physiologic monitoring	65%, 3,808 patients	35%	1,333	1,212 at M24, still climbing

Say the constraint out loud

The two care-management programs are limited by the size of ODA's Medicare panel: advanced primary care management is full by month 8 and chronic care management by month 16. Remote monitoring is different. At month 24 it holds 1,212 of the 1,333 patients it can reach, so enrollment pace, not the size of ODA's Medicare panel, is what holds it back. With 22 referring clinicians and one on-site enrollment specialist, patients join at the rate the visits and the outreach allow.

A second CoachCare enrollment specialist cannot raise the ceiling, but reaches it sooner. Remote monitoring fills in month 20 instead of climbing past month 24, and the forecast gains \$573,108 of net reimbursement over 24 months (\$4,170,768 against \$3,597,660), on CoachCare's payroll, not ODA's.

What Moves the Forecast: Enrollment Pace More Than Panel Size

CoachCare Value Analysis recalculations, one input changed at a time; every run keeps the whole panel in scope and 22 referring clinicians

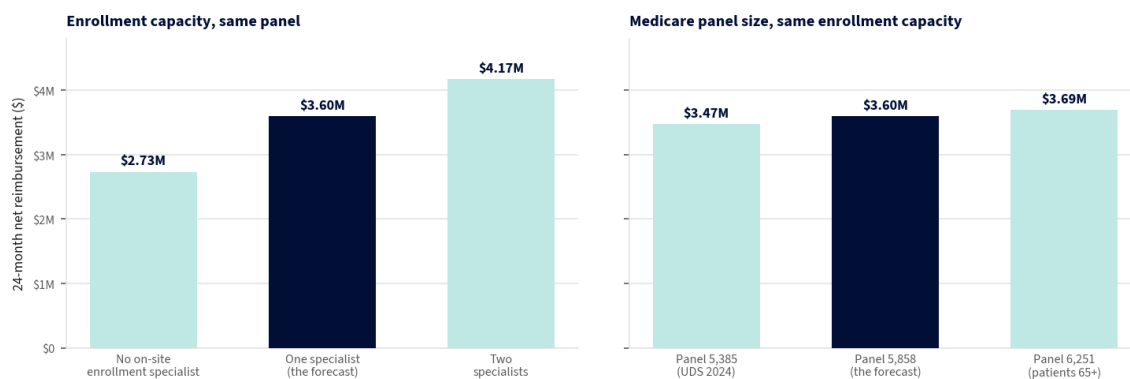


Figure 3. 24-month net reimbursement with no, one or two on-site enrollment specialists, against the Medicare panel at the 2024 UDS count, the 2025 count and the count of patients 65 and older. CoachCare Value Analysis recalculations.

Scenario	24-month net reimbursement	Net to ODA	Unique patients at M24	Ceilings: RPM · CCM · APCM
Base: panel 5,858, 22 referring clinicians, one enrollment specialist	\$3,597,660	\$1,528,166	1,607	climbing · M16 · M8
No on-site enrollment specialist	\$2,733,445	\$1,153,895	1,310	climbing · climbing · M12
A second on-site enrollment specialist	\$4,170,768	\$1,770,635	1,728	M20 · M12 · M6
The 6 physicians referring alone	\$2,316,573	\$974,854	1,203	climbing · climbing · M13
15 referring clinicians	\$3,114,576	\$1,321,880	1,350	climbing · M20 · M10
30 referring clinicians	\$4,042,505	\$1,715,656	1,728	M21 · M13 · M7
Panel 5,385, the 2024 UDS count	\$3,474,375	\$1,474,722	1,573	climbing · M15 · M8
Panel 6,251, ODA's patients 65 and older	\$3,694,268	\$1,569,779	1,635	climbing · M17 · M9

CoachCare Value Analysis sensitivity runs, one input changed at a time, every panel fully in scope. "Climbing": the program has not reached its ceiling by month 24.

Panel size moves this forecast less than pace does. From the 2024 count of 5,385 to the 6,251 patients 65 and older, 24-month net reimbursement runs from \$3,474,375 to \$3,694,268. Taking the on-site enrollment specialist away costs \$864,215, and the nurse practitioners' and physician assistants' referrals matter: with the 6 physicians referring alone the forecast is \$2,316,573. The margin barely moves in any run, because the fee scales with the census.

6.6 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	157,176	Blood pressure, glucose and weight values arriving between visits
Claims and billable units	51,774	Created in eClinicalWorks for ODA's billing team
Care-management tasks	103,548	Outreach, care-plan updates and medication reviews
Patient conversations	15,532	Live contacts across 863 hours of call time
Care-team hours	22,558	About 10.8 full-time-equivalent years of work ODA does not have to hire for
Hospitalizations avoided	About 100	Admissions, and the emergency visits before them, that do not happen

Annual admission rate among enrolled patients	20% (the workbook's baseline)	30%	40%	50%
Hospitalizations avoided over 24 months	100	150	200	249

CoachCare Value Analysis, full service line. The workbook counts avoided admissions at a 20% annual admission rate; the first patients enrolled, uncontrolled hypertension with diabetes, kidney disease or heart failure, run closer to 40%, which puts the figure near 200.

6.7 Published results from CoachCare programs

- **Blood pressure.** Cardiac Solutions, a physician-owned cardiology practice with three offices, put 2,738 patients on CoachCare remote monitoring. Stage 2 hypertension patients saw a 29.1 mmHg average systolic drop, and 94.8% improved. Patients who took readings consistently dropped 8.53 mmHg against 3.54 mmHg for those who did not.¹⁵

¹⁵ Cardiac Solutions case study, April 2026: 2,738 remote-monitoring patients enrolled 12 months or more.

- **Readmissions, at the same practice.** Across 26,689 patients, the 30-day readmission rate was 7% for CoachCare patients against 15% for the rest.¹⁶
- **Heart failure.** Iowa Heart enrolled 450 advanced heart-failure patients and recorded zero readmissions over six months.¹⁷

7. Quality: The UDS Measures HRSA Counts

ODA reports clinical quality to HRSA every year, and most of the measures it is ranked on depend on work this program does every month. The documented result for each is in eClinicalWorks, where the care team's work is recorded.¹⁸

Measure	ODA 2025	What the program does each month
CMS165 Controlling high blood pressure	68.0%, quartile 3	Home averages give an accurate reading of control and a monthly chance to act; the documented status reflects home data, not one rushed office reading
CMS122 Diabetes: A1c poor control (> 9%)	18.3%, quartile 1	Care management keeps A1c testing and medication changes on schedule; home glucose shows slippage before the next lab, with ODA's endocrinologist in the building
CMS347 Statin therapy for cardiovascular disease	66.5%, quartile 4	The monthly call reviews the medication list against the care plan; a patient at risk without a statin is flagged for the clinician to order or document the reason
CMS2 Depression screening and follow-up	61.2%, quartile 4	A PHQ screen on the monthly call for every enrolled patient, documented in eClinicalWorks, with a positive screen routed to ODA social work the same week
CMS130 Colorectal cancer screening	36.9%, quartile 3	An overdue screening is flagged on the call, the FIT kit or referral drafted for the clinician to sign, and completion documented
CMS69 BMI screening and follow-up	72.1%, quartile 2	Cellular scales put a weight in the chart every month, and the care team books nutrition counseling when the plan calls for it

ODA already sits in HRSA's best quartile on diabetes control. The program's job there is to hold that standing across 2,991 patients with diabetes with home data behind every documented result. Statin therapy and depression screening, both in the fourth quartile, are where a monthly call has the most room to move a score, and blood-pressure control, at 68.0% across 4,690 hypertensive patients, is where home readings do the most.

8. What the Service Line Adds for a Health Center

The forecast counts claims. A health center gets more from this program than the claims, and each of the five returns below is one ODA already works toward.

What it adds	How it works at ODA
Revenue on top of the PPS encounter	Every code in the forecast is paid in addition to the PPS visit, so the program adds \$3,597,660 of net reimbursement over 24 months without displacing a visit, and \$1,528,166 stays with ODA after fees.
UDS quality	Blood-pressure control, diabetes control, statin therapy, depression screening and colorectal screening all move with monthly work between visits (Section 7).
Staffing in a tight market	10 CoachCare care managers by month 24 and 22,558 care-team hours, recruited, trained and managed by CoachCare, at a time when every health center is competing for the same nurses. ODA's clinicians keep doing clinical work.

¹⁶ Cardiac Solutions readmissions case study: 7% against 15% across 26,689 patients.

¹⁷ Iowa Heart case study, 2026: 450 NYHA class III to IV patients over six months.

¹⁸ HRSA Uniform Data System clinical quality measures, 2025 reporting year: CMS165, CMS122, CMS347, CMS2, CMS130 and CMS69, as filed by ODA.

What it adds	How it works at ODA
The Health Center Program's purpose	ODA holds an HRSA Health Center Program award and a 2024 Behavioral Health Service Expansion award, and the Health Center Program exists for patients who are hard to reach. A monthly call and daily readings document a longitudinal touch with those patients between visits, and the monthly reports show it by site.
The pharmacy	ODA fills prescriptions on site, including through the 340B program. The monthly call confirms refills and dose changes before a patient runs out, so medication changes made between visits are filled where the patient already goes.

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

CMS published its proposed CY2027 physician fee schedule in July 2026. The comment period closed September 14, 2026, the final rule is expected in early November 2026, and the changes take effect January 1, 2027. The proposal cuts the remote-monitoring device-supply codes. Every code in this forecast was repriced at the proposed national amounts, the rail health centers bill on, on the forecast's own billing mix, with enrollment held constant.¹⁹

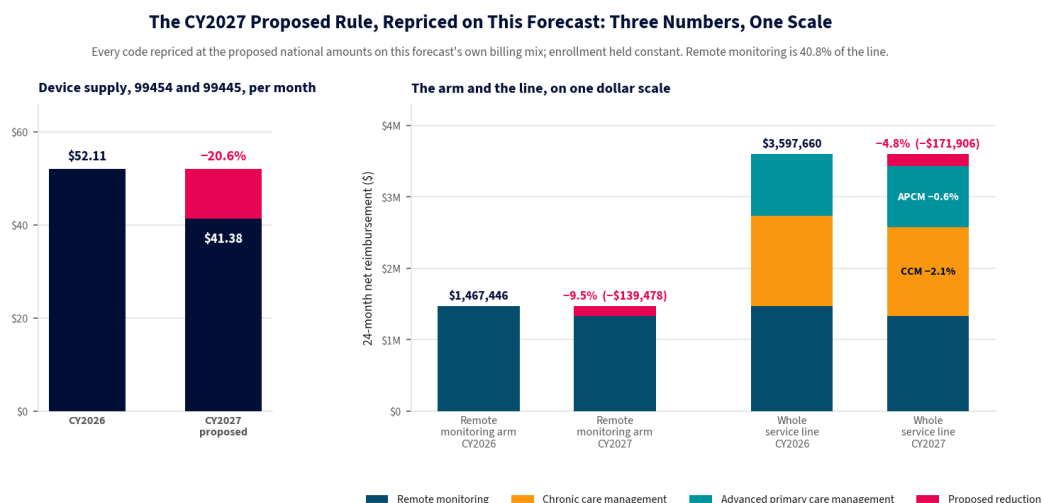


Figure 4. The CY2027 cascade on this forecast: the one code CMS proposes to cut, then the remote-monitoring arm and the whole service line on one dollar scale, with the proposed reduction in coral. CoachCare repricing at the proposed CY2027 national amounts.

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
Device supply, 99454 and 99445	\$52.11 a month	\$41.38 a month, -20.6%	The code CMS proposes to cut
The remote monitoring arm	\$1,467,446 over 24 months	-9.5%, -\$139,478	Device supply is 32.0% of the remote monitoring basket
Chronic care management	\$1,269,537 over 24 months	-2.1%, -\$27,293	Routine rate changes only; not targeted
Advanced primary care management	\$860,677 over 24 months	-0.6%, -\$5,135	Routine rate changes only; not targeted
The whole service line	\$3,597,660 over 24 months	-4.8%, -\$171,906, to \$3,425,754	Remote monitoring is 40.8% of the line

¹⁹ CMS-1848-P, published July 2026. CoachCare repricing at the CY2027 proposed national non-facility amounts, conversion factor \$32.8409 against \$33.4009: device supply 32.0% of the remote-monitoring basket; remote monitoring 40.8% of the line.

Each number is smaller than the last only because its base is larger: this line rests on three programs, and only one holds the code being repriced. Care management, 59.2% of the line, barely moves. CoachCare will rerun the forecast at the final rates.

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

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

10. Implementation Roadmap

10.1 Who runs what

Function	CoachCare	ODA
Identification and enrollment	Registry query in eClinicalWorks starting with uncontrolled hypertension, diabetes and Qualified Medicare Beneficiaries with two or more conditions; an on-site enrollment specialist; telephonic outreach; devices shipped, cellular-paired and replaced	Approves the criteria and target list; clinicians order at the visit or the annual wellness visit
Care management	Monthly chronic care management or advanced primary care management calls, care-plan updates and medication reviews, coordinated with ODA's care management department	Decides which patients its own care managers keep
Monitoring and escalation	Reading review, monthly outreach, business-hours alert triage and the post-discharge cadence, at 165 patients per care manager	Sets thresholds and routing for each site; receives escalations
Transitional care	Two-business-day contact and medication reconciliation after each discharge ODA learns of; visit booked inside the 7- or 14-day window	Furnishes the visit and bills 99495 or 99496
Documentation, billing, reporting	Monthly care documents in eClinicalWorks, claims created automatically, operational and clinical outcomes reports by site and clinician	Reconciles and files under its own NPIs; keeps the revenue; names a program lead

10.2 The model inputs

Input	Value in this forecast
Medicare panel	5,858 patients, the HRSA UDS 2025 Medicare count: traditional Medicare and Medicare Advantage, dual-eligible patients inside it, no gross-up; all in scope

Input	Value in this forecast
Medicare Advantage	57.8% of Kings County Medicare beneficiaries. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families.
Referring clinicians	22: 6 physicians in internal and family medicine and 16 nurse practitioners and physician assistants who see adults
Programs	Remote monitoring, chronic care management and advanced primary care management; transitional care, behavioral health integration and community health integration at zero dollars
Eligibility and acceptance	Remote monitoring 65% eligible, 35% accept; chronic care management 40%, 30%; advanced primary care management 35%, 30%; chronic care management and advanced primary care management never billed for the same patient in the same month; 1.5% monthly attrition
APCM tiers	10% level 1, 50% level 2, 40% level 3 (Qualified Medicare Beneficiaries), set against a 59% dual-eligible Medicare panel
Enrollment staffing	One on-site CoachCare enrollment specialist plus telephonic outreach, CoachCare's expense
EMR	eClinicalWorks integration: \$4,000 setup, \$150 a month, \$1.50 per patient-month; scope confirmed in contracting
Rates	CY2026 Medicare Physician Fee Schedule, national non-facility amounts; every patient priced at the Medicare amount; Medicare only

10.3 The first 90 days, across four adult-medicine sites

Window	What happens	Result
Weeks 0–6 Integrate and charter	eClinicalWorks workshop with ODA's IT and billing leads; Medicare chart count by payer; the care management department's caseload mapped so nobody is called twice; the language plan; thresholds and routing for each site agreed	Integration live, protocol signed, language plan set
Weeks 6–12 Launch at Wallabout	Enrollment from the first week at the adult-medicine hub, where most adult clinicians practice; remote monitoring for hypertension and diabetes, advanced primary care management for Qualified Medicare Beneficiaries; the post-discharge cadence live	69 enrollments in month 1, 181 by month 2, 337 by month 3
Months 3–12 Park Avenue, Bedford Avenue and ODA East	Same protocols at every adult-medicine site; heart-failure and kidney-disease cohorts added; care managers added as the census grows; advanced primary care management full by month 8	1,771 enrollments, 1,159 unique patients at month 12
Months 13–24 Scale	Chronic care management full by month 16; remote monitoring keeps climbing; behavioral health integration and transitional care scoped on the same team	Year 2: \$1,091,079 to ODA at 43.0%

Remote monitoring and care management carry Part B coinsurance, so the consent conversation explains the monthly cost plainly before the device ships. Qualified Medicare Beneficiaries owe no Medicare cost-sharing.

10.4 What we would confirm together

1. **The Medicare chart count by payer.** Traditional Medicare, Medicare Advantage and dual-eligible, with Qualified Medicare Beneficiaries counted. It settles the panel and the advanced primary care management tier mix.
2. **Which clinicians refer, by site.** The forecast assumes 22; referring clinicians are the pace lever for remote monitoring.
3. **How the care management department runs today.** Its staff, caseload and conditions, how it documents in eClinicalWorks, and which patients it keeps.
4. **Medicare Advantage plans and their terms.** Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code

families. Which plans ODA's patients hold, and how each pays the care-management code families, is confirmed plan by plan.

5. **The language plan.** Yiddish, Spanish and the other languages ODA's patients speak, for enrollment, device instructions and outreach.
6. **Hospitals and discharge notices.** The hospitals where ODA's Medicare patients are admitted, and whether their discharge notices reach ODA in time for transitional care.
7. **The eClinicalWorks configuration.** The version, the healow and care-management modules licensed, and the integration scope.

11. Recommendations

1. **Launch the full service line.** \$1,528,166 to ODA over 24 months at a 42.5% margin (41.1% in year one, 43.0% in year two), positive from month 2, with no ODA hires.
2. **Lead with advanced primary care management for Qualified Medicare Beneficiaries.** It is the program that fits ODA's dual-eligible panel best, and it fills first.
3. **Staff enrollment to the pace remote monitoring needs.** A second CoachCare enrollment specialist reaches the remote-monitoring ceiling inside 24 months and adds \$573,108 of net reimbursement.
4. **Pull the Medicare chart count by payer in week one.** It confirms the ceilings and the tier mix. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families.
5. **Start at Wallabout.** Most adult clinicians and both in-house specialists practice there; Park Avenue, Bedford Avenue and ODA East follow on the same protocols.
6. **Keep ODA's care management department at the center.** CoachCare adds the readings and the monthly minutes; ODA decides which patients its own care managers keep.
7. **Aim the monthly work at the UDS measures.** Blood-pressure control, statin therapy and depression screening have the most room to move.
8. **Set the language plan before launch.** Enrollment, device instructions and outreach in Yiddish, Spanish and the other languages ODA's patients speak.
9. **Add transitional care and behavioral health integration once running.** Both run on the same care team and the same chart.

The Medicare panel ODA already serves supports a \$3,597,660 service line at a 42.5% practice margin over 24 months, on staff ODA does not hire and devices it does not buy, paid on top of every PPS visit. Care management fills inside the first year and a half; how fast remote monitoring grows depends on enrollment capacity, which is CoachCare's to supply.

About CoachCare

The experience to get it right

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

- **It builds on what ODA already does.** ODA ranks in HRSA's best quartile on diabetes control, keeps cardiology, endocrinology, nutrition and social work under the same roof as primary care, and runs its own care management department. Remote monitoring adds daily readings to that work.
- **It runs inside the chart ODA already uses.** Readings, documentation and claims live in eClinicalWorks, and enrollment status is visible at every site.

- **Fully staffed, no hiring.** Care managers at 165 patients each, enrollment, devices, business-hours alert triage and billing preparation on CoachCare's payroll, with fees per active patient per month and no capital outlay.
- **Clinicians stay in charge.** ODA's physicians, nurse practitioners and physician assistants set the protocols, sign the care plans and make every clinical decision.
- **Designed for ODA's patients.** Cellular devices with nothing to pair, outreach by phone, and a language plan for Yiddish- and Spanish-speaking patients set with ODA before the first patient enrolls.
- **Published results.** A 29.1 mmHg drop in Stage 2 hypertension across 2,738 patients at Cardiac Solutions, half the 30-day readmission rate across 26,689 patients at the same practice, and zero readmissions among 450 advanced heart-failure patients at Iowa Heart.

The ask is a working session with ODA's leadership to confirm the Medicare chart count by payer, walk through how the care management department runs today, settle the language plan for Yiddish- and Spanish-speaking patients, and scope the eClinicalWorks workflow for the four adult-medicine sites.

Contact

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Prepared by CoachCare for discussion with ODA Primary Health Care Network. © 2026 CoachCare.

References & Data Sources

- **ODA Primary Health Care Network:** odahealth.org, retrieved October 26, 2026, for history, locations, services, the care team directory, quality and compliance pages, and the eClinicalWorks healow patient portal.
- **HRSA:** Uniform Data System, 2021 to 2025, health center H80CS00064; Health Center Program service delivery sites file, October 2026.
- **New York State:** Department of Health facility records; list of health centers billing under APGs, October 2025; Medicaid Telehealth Policy Manual, July 2026; primary care plan update, 2017.
- **Medicare payment rules:** the CY2026 Physician Fee Schedule final rule and Addendum B, national non-facility amounts; CMS-1848-P, the CY2027 proposed rule.
- **Market:** CMS Medicare Advantage State/County Penetration, October 2026.
- **CoachCare:** eClinicalWorks integration overview, 2026; Care Management Programs standard operating procedures, March 2026; Cardiac Solutions and Iowa Heart case studies; and the Value Analysis for ODA, 2026, the source of every financial, enrollment, clinical-output and operational figure in Sections 6 to 11.

Unique patients and program enrollments are different numbers. At month 24 the program holds 2,530 active program enrollments belonging to 1,607 unique patients, because a patient may hold a remote-monitoring enrollment and a care-management enrollment at once. The 5,858-patient panel is ODA's 2025 UDS Medicare count, traditional Medicare and Medicare Advantage together.