COACHCARE | SERVICE LINE STRATEGY

Carbon Health

A technology-enabled urgent care and primary care operator headquartered in San Francisco: 81 clinics across eight states, primary care at 25 of them, about 480 clinicians, and its own ONC-certified electronic health record, CarbyOS

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line for the Medicare primary care panel: remote physiologic monitoring, chronic care management and transitional care at every discharge, billed under the CY2026 rules at California locality 05 amounts, built once on CarbyOS and switched on at each of the 25 primary-care sites

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of Carbon Health. It brings together the shape of the Medicare panel at Carbon's primary-care sites as the CY2024 claims files show it, the accountable-care position the Massachusetts billing entity holds, the markets its patients live in, the record system the program would live in, and a 24-month financial forecast priced at Carbon's home locality.

The argument is short. Carbon Health built a remote-monitoring and chronic-care line once, retired it, and kept the two assets that matter most: a certified, FHIR-capable record and a patient app. The CY2024 claims show the panel still carries the conditions that line was built for. This report shows what a partner-run service line returns on that panel, who does the work, and how it switches on site by site without capital or headcount from Carbon.

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Executive Summary

Carbon Health is a technology-enabled urgent care and primary care operator, founded in 2015 and headquartered in San Francisco. As of September 2026 it runs 81 clinics across eight states: 54 in California, 11 in New Jersey, 5 in Massachusetts, 3 each in Colorado, Texas and Washington, and 2 in the Kansas City area. Primary care is offered at 25 of those sites: 13 in the Bay Area, 1 in Roseville, 5 in Boston, 5 in central New Jersey and 1 in Puyallup. About 480 clinicians work across the footprint, most of them physician assistants and nurse practitioners; the CMS Doctors & Clinicians file lists 457 distinct clinician identifiers affiliated with a Carbon billing entity, about 45 of them physicians. Carbon runs its own ONC-certified electronic health record, CarbyOS, and licenses it to outside clinics.[1]

The panel that matters here is the Medicare primary care panel across the 25 primary-care sites. The CY2024 Medicare fee-for-service claims at Carbon addresses describe it. The address-matched beneficiaries average 73.5 years of age and carry an average HCC risk score of 1.05; **64% have hypertension, 24% diabetes, 18% chronic kidney disease and 13% heart failure**. The same file shows an urgent-care visit pattern around that panel: 4,468 established-visit beneficiary-clinician pairs against 2,845 new-patient pairs, no annual wellness visits, and no longitudinal-care add-on. The forecast in Section 5 models a Medicare panel of 5,500 across the 25 sites, 4,400 of them in scope.[2]

Two facts set this account apart from the usual primary care workup. In 2021 Carbon acquired a remote-monitoring platform and a CGM-integrated diabetes clinic and said at the time that remote monitoring should serve a majority of its primary-care patients; both lines were retired in 2023, and the CY2024 claims show no remote-monitoring code on any Carbon clinician. And the record system that would host a program is already modern and certified: **CarbyOS v3 was ONC-certified in September 2025 with a (g)(10) FHIR R4 API**, which is the interface CoachCare integrates over. The Massachusetts billing entity is also a verified PY2026 participant in a Shared Savings Program ACO in the BASIC track, which opens one further lever for the five Boston sites.[3]

The observation this report is built on

They built it. They retired it. The panel still carries the conditions.

Carbon Health has already decided, once, that remote monitoring and chronic care management belong in its primary care. What it does not have in 2026 is the program: the CY2024 claims show no remote-monitoring or care-management program at meaningful scale at any Carbon address, with one nurse practitioner at one site billing chronic care management for 27 beneficiaries. What it does have is the panel, the record system, the patient app and 25 primary-care sites. The service line in this report is the missing piece, supplied and staffed by a partner and switched on per site.

What the Value Analysis returns

	Year 1	Year 2	24 months
Net reimbursement	**$2,085,859**	**$3,113,042**	**$5,198,901**

[1] carbonhealth.com location listings and primary-care site picker, retrieved September 11, 2026: 81 clinics (California 54, New Jersey 11, Massachusetts 5, Colorado 3, Texas 3, Washington 3, Kansas City area 2, the last spanning Kansas and Missouri); primary care at 25 sites. CMS Doctors & Clinicians national file: 457 distinct clinician identifiers affiliated with a Carbon Health billing entity; physician assistant 247, nurse practitioner 140, physician 45. ONC Certified Health IT Product List: CarbyOs EHR v3, Drummond Group, certified September 25, 2025.

[2] CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024, clinicians whose practice address is a Carbon Health clinic: 8,335 beneficiary-clinician pairs; established-visit beneficiaries 4,468 (99214 3,000; 99213 1,295; 99215 133; 99212 40); new-patient beneficiaries 2,845 (99204 2,159; 99203 636); G0438 and G0439 none; G2211 none; average age 73.5; average HCC risk score 1.05; hypertension 64%; diabetes 24%; chronic kidney disease 18%; heart failure 13%; COPD 13%.

[3] Company press releases and trade coverage, 2021 to 2023, on the acquisition of a remote-monitoring platform (October 2021) and a CGM-integrated virtual diabetes clinic (June 2021), the stated remote-monitoring thesis, and the 2023 retirement of both lines. CMS by Provider and Service, CY2024: no 99453, 99454, 99457, 99458 or 99091 row for any of the 457 Carbon-affiliated identifiers. ONC Certified Health IT Product List, CarbyOs EHR v3, criterion 170.315(g)(10). CMS Medicare Shared Savings Program PY2026 participant file: Carbon Health Medical Group of Massachusetts PC, BASIC track.

	Year 1	Year 2	24 months
CoachCare fees	$1,093,158	$1,608,870	$2,702,028
Net to the practice	**$992,701**	**$1,504,172**	**$2,496,873**
Practice margin	47.6%	48.3%	**48.0%**

CoachCare Value Analysis: 5,500 Medicare patients across 25 primary-care sites, 4,400 in scope, RPM + CCM, 40 referring clinicians, one CoachCare-funded on-site enrollment specialist at 80 enrollments a month, list pricing, CY2026 fee schedule at the California locality 05 amounts. Margin is net to the practice divided by net reimbursement. Transitional care management is recommended and is not in the forecast.

One market fact sits under every number above. Medicare Advantage covers about 51% of the Bay Area's beneficiaries, where 13 of the 25 primary-care sites are. 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 Boston and central New Jersey counties run mostly fee-for-service.

1. **The service line is positive from the first month, by $325.** Month 1 nets $325 on 103 enrollments because the one-time implementation and CarbyOS setup land in that month. M2 nets $17,729, M3 $32,690, and the program holds $125,347 a month from M10 once both programs are full.
2. **Nobody at Carbon is hired.** CoachCare delivers 34,581 care-team hours over 24 months, about 16.6 full-time-equivalent years of care-management labor. The on-site enrollment specialist, the care managers and the device logistics are CoachCare's payroll, embedded in the fee, never deducted from practice margin. Carbon's 40 primary-care clinicians refer and supervise; Carbon's own revenue cycle files the claims through CarbyOS.
3. **The margin holds at 48% whatever the panel turns out to be.** At a 3,000-patient panel the program returns $1,462,241 to the practice; at 8,000 it returns $3,361,873; the Bay Area sites alone return $1,385,257. The margin is between 47.9% and 48.1% in every case, because the fee scales with the census. Section 5.4 is the table.
4. **The binding constraint is the longitudinal Medicare panel, not outreach.** Remote monitoring reaches its ceiling of 1,001 active enrollments in month 7 and chronic care management reaches 990 in month 9. At M24 the program holds 1,991 active program enrollments across 1,298 unique patients, which is every patient the two programs can take on a 4,400-patient in-scope panel. Every urgent-care patient 65 or older who converts to a primary-care relationship raises the ceiling.
5. **Transitional care management belongs on the stack, and is not in the forecast.** Carbon has no hospital; its patients are discharged from the hospitals they use, and the urgent-care visit that follows is often how Carbon learns of it. The two-business-day contact and the 7- or 14-day visit that 99495 and 99496 pay for, $274.86 and $373.26 per discharge at California locality 05, are the cadence the program already runs.
6. **Built once, switched on per site.** One CarbyOS integration, one protocol, one staffing model, 25 primary-care sites. The program starts at the 13 Bay Area sites and is switched on in Boston and central New Jersey as the professional corporation that bills in each state contracts for it. Section 6 is the shape of that.
7. **Advanced primary care management is the named next lever for Boston.** The Massachusetts entity's verified Shared Savings Program participation clears the eligibility gate for the APCM codes at the five Boston sites. This forecast carries them at zero dollars; the choice between chronic care management and APCM there is Carbon's, once the program is running. Section 3.2 frames it.
8. **The CY2027 proposed rule takes 6.2% off this line and leaves the case intact.** A 20.7% cut to device supply is a 10.5% change to the remote-monitoring arm and 6.2% to the whole line, $323,855 over 24 months. Section 7 draws the cascade.

1. The Organization, and the Panel It Already Manages

1.1 The footprint: 81 clinics, 25 with primary care

Carbon Health began in 2015 as a software company and opened its first clinics in 2017. The 2026 footprint is 81 clinics in eight states, urgent-care-led, with primary care as a second service line at 25 of them. The primary-care sites cluster in four markets, and the program in this report is scoped to those four.[4]

Region	Clinics	Primary-care sites	What it means for this program
Bay Area, California	15	**13** Corte Madera, Campbell, San Mateo, Stonestown, Novato, Berkeley, Santa Clara, Civic Center, Oakland, Market Park, Albany, Irving Street, Market Street	The largest cluster and the launch market. Billed under the California professional corporation at California locality 05, the basis of every dollar in this report
Sacramento, California	4	**1** Roseville	Joins the California launch on the same integration and the same entity
Boston, Massachusetts	5	**5** Brighton, Fenway, Back Bay, West Roxbury, Downtown	Every clinic offers primary care. The billing entity is inside a Shared Savings Program ACO in the BASIC track; the counties are mostly fee-for-service
Central New Jersey	11	**5** Montgomery, Lawrenceville, Somerset, Eatontown, Marlboro	Mostly fee-for-service counties; switched on after Boston under the New Jersey entity
Puyallup, Washington	3	**1** Puyallup	One site; switched on with the Washington entity when the census justifies it
Rest of California, Colorado, Texas, Kansas City	43	0	Urgent care only. Every patient 65 or older seen at these sites is a candidate for a primary-care relationship at a site that has one

carbonhealth.com location and primary-care listings, retrieved September 11, 2026. The two Kansas City clinics span the Kansas and Missouri sides of the metro.

Two other pieces of the footprint matter to enrollment. Carbon's patient app carries booking, messaging, records and virtual visits for every patient, so the enrollment conversation, the device instructions and the monthly check-in have a channel the patient already uses. And every one of the 81 clinics runs on CarbyOS, so one integration covers all 25 primary-care sites and any urgent-care site that later adds primary care.[5]

1.2 What the CY2024 claims say

The CY2024 Medicare by-provider and by-provider-and-service files were queried for all 457 clinician identifiers affiliated with a Carbon billing entity, and the results narrowed to clinicians whose practice address is a Carbon clinic. That address-matched set describes the fee-for-service population Carbon's clinicians already see.[6]

[4] carbonhealth.com/locations and the primary-care page, retrieved September 11, 2026. Company history per the company's own about page and trade coverage: software company founded 2015, first clinics 2017.

[5] carbonhealth.com and the CarbyOS product page, retrieved September 11, 2026: the patient app's booking, messaging, records and virtual-visit functions; CarbyOS deployed across all Carbon clinics since 2023.

[6] CMS Medicare Physician & Other Practitioners by Provider (dataset 8889d81e-2ee7-448f-8713-f071038289b5) and by Provider and Service (dataset 92396110-2aed-4d63-a6a2-5d6207d46a29), CY2024 vintage, retrieved September 2026. Of the 457 Carbon-affiliated identifiers, 307 appear in the by-provider file and 73 carry a practice ZIP that is a Carbon clinic ZIP; the table reports the 73. The by-provider file reports each clinician's full-year Medicare billing at that clinician's enrolled practice address.

CY2024 Medicare fee-for-service at Carbon addresses	Value
Beneficiary-clinician pairs	**8,335**
Established-patient visits, 99212 to 99215 (beneficiaries)	4,468
New-patient visits, 99202 to 99205 (beneficiaries)	2,845
Annual wellness visits, G0438 and G0439	none at a Carbon address
Longitudinal-care add-on, G2211	none at a Carbon address
Remote monitoring, 99453 to 99458	none on any Carbon clinician
Chronic care management	one nurse practitioner at one site, 27 beneficiaries
Average beneficiary age	**73.5**
Average HCC risk score	**1.05**
Hypertension	**64%**
Diabetes	24%
Chronic kidney disease	18%
Heart failure	13%
COPD	13%

CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024; clinicians whose practice address is a Carbon clinic. CMS suppresses counts under 11. Pairs count a patient once per clinician seen.

Read the two halves of that table together. The lower half is the profile remote care is built for: an older panel where two in three beneficiaries carry hypertension, a quarter are diabetic, and a sixth have chronic kidney disease. The chronic care management codes require two or more chronic conditions expected to last a year; the remote monitoring codes want a condition whose readings change treatment between visits. Hypertension and diabetes are the largest such cohorts on this panel, and heart failure and kidney disease are the ones a connected scale and cuff catch earliest.

The upper half is the shape of the business around that panel. New-patient visits nearly equal established visits, there are no annual wellness visits, and the longitudinal-care add-on is absent: the Medicare volume at Carbon addresses is mostly episodic urgent care. That is the point of this report rather than an objection to it. The patients who carry the conditions are already in the building; what the claims do not show is a monthly, staffed relationship with them, and **no remote-care or care-management program at meaningful scale is visible in CY2024 claims at any Carbon address**. Section 3.3 bounds that claim and credits what did run.[7]

1.3 The accountable-care position: Boston

Carbon Health Medical Group of Massachusetts PC, the entity that bills for the five Boston primary-care sites, is listed in the CMS PY2026 Medicare Shared Savings Program participant file as a participant in **a Shared Savings Program ACO in the BASIC track**, at the track's highest level, in its fourth agreement period with the current period beginning January 1, 2025, with retrospective beneficiary assignment and without the prospective primary-care payment option. The California, New Jersey and Washington entities are not confirmed in any value model: not in the Shared Savings Program file, not in ACO REACH, not in any primary-care model.[8]

[7] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024, all 1,415 clinician-and-code rows for the 457 identifiers searched for 99453, 99454, 99457, 99458, 99445, 99470, 99490, 99491, 99439, 99424 to 99427, 99487, 99489, 99484, 99091, G0556 to G0558, 99495 and 99496. At a Carbon address: one nurse practitioner, 99491, 27 beneficiaries, 143 services. CMS suppresses clinician-and-code lines under 11 beneficiaries. Query mechanics were validated against positive rows for the same codes at non-Carbon addresses in the same file.

[8] CMS Medicare Shared Savings Program PY2026 participant file, data.cms.gov, retrieved September 2026: participant legal business name Carbon Health Medical Group of Massachusetts PC; BASIC track, Level E; agreement period 4; current start January 1, 2025;

Three consequences follow, and all three are scoped to Boston. First, the ACO's savings arithmetic rewards exactly what remote monitoring and chronic care management produce on an older, hypertensive panel: fewer emergency visits and admissions among attributed beneficiaries. Second, the Massachusetts entity's verified participation clears the value-model gate for the advanced primary care management codes at the five Boston sites, which Section 3.2 takes up. Third, the remote monitoring and care-management claims billed there are Part B spending against the ACO's benchmark. The Value Analysis in Section 5 is fee-for-service across all 25 sites and does not model the ACO's shared-savings economics. For the entities outside the ACO, the same monthly care-management work also supports the quality and improvement-activity categories of the practice's MIPS reporting.

1.4 The markets around the primary-care sites

Market	County	Medicare beneficiaries	Medicare Advantage share	Fee-for-service share
Bay Area	San Francisco	159,577	51.4%	48.6%
	San Mateo	143,457	50.9%	49.1%
	Santa Clara	312,786	50.3%	49.7%
	Alameda	278,052	52.5%	47.5%
	Contra Costa	228,656	52.0%	48.0%
	Marin	64,872	45.1%	54.9%
Sacramento	Placer	102,498	56.3%	43.7%
Boston	Suffolk	115,029	42.2%	**57.8%**
	Middlesex	308,208	34.1%	**65.9%**
	Norfolk	152,523	32.5%	**67.5%**
Central New Jersey	Mercer	72,465	45.8%	54.2%
	Somerset	66,549	35.6%	**64.4%**
	Middlesex	157,578	41.3%	**58.7%**
	Monmouth	148,379	31.2%	**68.8%**
Puyallup	Pierce	175,530	52.0%	48.0%

CMS Medicare Monthly Enrollment, county level, May 2026. Medicare Advantage share is Medicare Advantage and other plans divided by total beneficiaries.

About half of the Bay Area's Medicare beneficiaries are in a Medicare Advantage plan, and the Bay Area holds 13 of the 25 primary-care sites. 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 Boston and central New Jersey counties are the fee-for-service-rich pockets of the footprint: most of them are between 58% and 69% fee-for-service, and none is below 54%. That is the reason the roadmap in Section 8 switches Boston on second, ahead of the census a single site would justify.

The rate basis follows the geography. ZIP 94103, Carbon's home ZIP, falls in California locality 05 under the Noridian JE contractor, one of the higher-rate localities in the country: 99490 pays $80.42, 99454

retrospective assignment; high-revenue ACO; prospective primary-care payment option = 0. No California, New Jersey, Washington, Colorado, Texas or Kansas Carbon entity in the file. ACO REACH PY2025 and PY2026 participant and provider lists: no Carbon entity. Primary Care First and Making Care Primary: not confirmed.

pays $73.14 and 99457 pays $65.26 at the CY2026 non-facility amounts, against national amounts of $66.13, $52.11 and $51.77. Every dollar in this report is priced at the locality 05 amounts.[9]

2. Why This Year

Three things line up in 2026 that did not line up in 2023, and one of them has a calendar attached.

What changed	Why it matters to Carbon Health
CY2026 opened the short-window remote monitoring codes	99445 pays for device supply when a patient transmits on 2 to 15 days of a 30-day period, at the same $73.14 as the 16-day code, and 99470 pays $32.81 for 10 to 19 minutes of treatment management. Before 2026 a patient who transmitted on twelve days earned nothing for the month. On a panel that averages 73.5 years, partial-month adherence is the normal case, and this is the first year it is billable. Post-discharge and titration windows are now payable next to the monthly stack, and transitional care management pays for the hand-off at the discharge itself
The care-management economics at a high-rate locality	Chronic care management pays $80.42 for the first 20 minutes and $62.10 for each additional 20 at California locality 05, and advanced primary care management pays $19.79, $66.08 or $143.79 a month by complexity tier where the value-model gate is cleared. On a panel where two in three carry hypertension and a quarter are diabetic, most patients qualify for a monthly code, and the locality amounts are 20 to 40% above the national figures
No capital and no headcount are required	Under the partner model the on-site enrollment specialist, the care managers, the cellular devices, the 24/7 alert triage and the claim construction are CoachCare's payroll and CoachCare's inventory, priced per active patient per month. Carbon adds a referral order to CarbyOS and a supervising clinician per site. The line is margin-positive from the first month
The record system is ready	CarbyOS v3 was certified in September 2025 with a FHIR R4 patient-and-population API, application access, transitions of care and Direct messaging. Integration does not wait on a record-system project; Section 3.5 is the path

3. The Service Line: RPM, CCM and TCM on the Medicare Panel

3.1 The clinical and billing stack

Two monthly programs and one episode code for the primary care panel. One enrollment conversation, one care team, one billing pipeline into Carbon's own revenue cycle through CarbyOS. Each answers a different clinical question and each is separately payable under the CY2026 fee schedule. The forecast in Section 5 carries the two monthly programs; transitional care management is recommended and not in the forecast.[10]

[9] CY2026 Medicare Physician Fee Schedule, non-facility amounts, MAC 01112 locality 05 (San Francisco–Oakland–Berkeley: San Francisco, San Mateo, Alameda and Contra Costa counties; Noridian JE); geographic indices work 1.095, practice expense 1.410, malpractice 0.425; conversion factor $33.4009: 99490 $80.42; 99439 $62.10; 99453 $29.95; 99454 and 99445 $73.14; 99457 $65.26; 99458 $50.66; 99470 $32.81; G0556 $19.79; G0557 $66.08; G0558 $143.79. National non-facility: 99490 $66.13; 99454 $52.11; 99457 $51.77. ZIP 94103 maps to this locality; the Marin County sites map to California locality 52 and the Santa Clara sites to locality 09.

[10] CoachCare Value Analysis for Carbon Health, 2026: blended net reimbursement per enrolled patient-month, remote physiologic monitoring $126.52 and chronic care management $135.47, on the code frequencies in the forecast at the California locality 05 amounts. Transitional care management 99495 $274.86 and 99496 $373.26 per discharge, CY2026 relative value units priced at the locality 05 indices (national $220.11 and $298.60); not in the forecast.

Program	What it does clinically	Who it fits on this panel	Net reimbursement per enrolled patient-month
Remote physiologic monitoring (RPM)	A cellular blood pressure cuff and scale transmit readings between visits, reviewed against thresholds Carbon's clinical leadership sets; 99453 setup, 99454 or 99445 device supply, 99457, 99458 and 99470 treatment management	The hypertension, diabetes, heart-failure and kidney-disease cohorts: 64% of the panel carries hypertension, and the readings that change a dose are the readings a cuff sends	**$126.52**
Chronic care management (CCM)	A documented care plan for patients with two or more chronic conditions, with at least 20 minutes of care-management time each month; 99490 and 99439	The multi-chronic core of the panel: hypertension with diabetes, kidney disease, heart failure or COPD in one patient	**$135.47**
Transitional care management (TCM)	Contact within two business days of discharge, medication reconciliation, and a face-to-face visit within 14 days (99495, moderate complexity) or 7 days (99496, high complexity); one payment per discharge	Every panel patient discharged from a hospital or observation stay. Carbon learns of most of them at the urgent-care visit or the app message that follows	**$274.86 / $373.26 per discharge; not in the forecast**

Blended net reimbursement per enrolled patient-month for the two monthly programs, CoachCare Value Analysis, CY2026 California locality 05 amounts at list pricing. Transitional care management is the CY2026 locality 05 amount per discharge and carries no dollars in the forecast.

Code	What it pays for	CY2026 California locality 05 amount
99453	Remote monitoring setup and patient education, once	$29.95
99454	Device supply with daily recording or alerts, 16 or more days in 30	$73.14
99445	**Device supply, 2 to 15 days in 30 (new in CY2026)**	**$73.14**
99457	Treatment management, first 20 minutes, with interactive communication	$65.26
99458	Each additional 20 minutes	$50.66
99470	**Treatment management, 10 to 19 minutes (new in CY2026)**	**$32.81**
99490	Chronic care management, first 20 minutes of clinical staff time	$80.42
99439	Each additional 20 minutes	$62.10
99495	Transitional care management, moderate complexity, visit within 14 days of discharge	$274.86
99496	Transitional care management, high complexity, visit within 7 days of discharge	$373.26
G0556	Advanced primary care management, level 1, per month	$19.79
G0557	Advanced primary care management, level 2, two or more chronic conditions	$66.08
G0558	Advanced primary care management, level 3, qualified Medicare beneficiary	$143.79

CY2026 Medicare Physician Fee Schedule, non-facility amounts, California locality 05 (Noridian JE). National amounts for the transitional care codes are $220.11 and $298.60. The Boston and New Jersey sites bill at their own localities.

A patient can hold a monitoring enrollment and a care-management enrollment in the same month, and on this panel most monitored patients qualify for both. Transitional care management is billed once per discharge and sits alongside either. Advanced primary care management is a pathway decision for Boston, taken up next; it carries no dollars here.

3.2 Advanced primary care management: the next lever for Boston

Advanced primary care management (G0556, G0557 and G0558) pays a monthly per-patient amount for continuous primary-care management with no minute threshold, tiered by complexity. CMS ties the codes to participation in a value-based arrangement, and the Massachusetts entity's verified Shared Savings Program participation clears that gate for the five Boston sites. It is not cleared anywhere else in the footprint, which is why APCM appears in this report for Boston only.[11]

It appears at zero dollars. Advanced primary care management and chronic care management cannot both be billed for the same patient in the same month, so moving the Boston multi-chronic panel from one to the other is a pathway decision: which patients, at which tier, with what documentation, and how the ACO's own care-coordination arrangements interact with a participant billing APCM. Those are Carbon's decisions and the ACO's, and this forecast does not pre-empt them. Remote monitoring bills alongside either, so the monitoring arm in Boston is unchanged whichever way the decision goes. The decision belongs in months 9 to 24 of the roadmap, once the Boston chronic care management census and the documentation workflow are real.

3.3 What exists today, stated plainly

This is the build-versus-partner section, and it starts with credit. Carbon Health built more of a remote care line than almost any primary care operator its size. It acquired a remote-monitoring platform with connected devices and a CGM-integrated virtual diabetes clinic in 2021, launched an at-home CGM diabetes program in 2022, and shipped ambient AI charting across every clinic in 2023 inside a record system it wrote itself. The thesis behind the 2021 acquisitions was that remote monitoring should serve a majority of ongoing primary-care patients.[12]

Asset	Status in 2026	What it means for this program
CarbyOS	**Live; ONC-certified v3, September 2025**	The program's host. FHIR R4 reads, application access, transitions of care, Direct messaging. Section 3.5
Patient app	**Live**	Booking, messaging, records and virtual visits. The channel for enrollment consent, device instructions and the monthly check-in
Ambient AI charting	**Live**	The clinician's documentation burden is already low; a referral order and a monthly care document add little to it
Remote-monitoring platform (acquired 2021)	Retired 2023	Devices, the monitoring workflow, alert triage and the care team are supplied by CoachCare
CGM-integrated diabetes clinic (acquired 2021) and the 2022 at-home CGM program	Retired 2023	The diabetes cohort, 24% of the panel, enrolls in remote monitoring and chronic care management on the same devices and the same care team
Chronic care management billing	One nurse practitioner at one site, 27 beneficiaries in CY2024	A local initiative, and evidence the work fits the panel. The program in this report is practice-wide and staffed

carbonhealth.com and carbyos.com, retrieved September 11, 2026; ONC Certified Health IT Product List; CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024.

- **What exists now is the record system and the app.** The monitoring platform and the diabetes clinic were retired in 2023 and the CY2024 claims show nothing replaced them: no remote-

[11] CY2026 Medicare Physician Fee Schedule, California locality 05 amounts for G0556, G0557 and G0558. CMS advanced primary care management requirements include participation in a qualifying value-based arrangement; the Massachusetts entity's Shared Savings Program participation (note 8) satisfies the gate for the Boston sites. Advanced primary care management and chronic care management may not be billed for the same patient in the same month; remote physiologic monitoring may be billed alongside either.

[12] Trade coverage of October 2021 on the remote-monitoring acquisition, including the company's stated view that remote monitoring should be used by a majority of patients for ongoing primary care; company release of April 13, 2022 on the at-home CGM diabetes program; company release of June 5, 2023 on ambient AI charting across all clinics; trade coverage of June and November 2023 on the retirement of the remote-monitoring, chronic-care and diabetes lines.

monitoring code on any Carbon clinician, and chronic care management at one site. CMS suppresses any clinician-and-code line under 11 beneficiaries, so the supportable statement is the one this report makes, no program at meaningful scale in CY2024, rather than a claim that no patient was ever billed.

- **What the partner model supplies is everything the retired lines used to.** Devices sourced, shipped and replaced; an on-site enrollment specialist; care managers at about 160 patients each; 24/7 alert triage under a written escalation protocol; monthly documentation into CarbyOS; claims constructed and landed billing-ready. None of it is Carbon's headcount, inventory or software to maintain, and all of it is priced per active patient per month.
- **What Carbon keeps is clinical governance and the revenue.** The physician-owned professional corporation that bills in each state sets the thresholds, the routing and the discharge criteria, supervises the program, files the claims under its own identifiers and keeps 48% of net reimbursement after CoachCare's fee. That division is a design principle of the partner model, and it is the reason the model fits a multi-state operator with a separate billing entity in each state.

3.4 The urgent-care visit: referral and transitional-care trigger

Carbon has no hospital, and the program does not need one. Its panel's admissions happen at the hospitals its patients use, and the urgent-care visit is where Carbon most often meets those patients on their worst days: a hypertensive 76-year-old with a blood pressure of 190 over 100, a diabetic with a foot wound, a heart-failure patient who has gained six pounds in a week. Each of those visits is an enrollment conversation. The clinician who saw the patient can place the referral order in CarbyOS before the patient leaves, the on-site enrollment specialist or the app carries the consent, and a cellular cuff and scale ship the same week. For a patient already enrolled, the visit is the trigger that tightens the monitoring cadence.

The urgent-care visit is also where Carbon learns of discharges. A patient who was admitted from an urgent-care visit, or who comes in after a hospital stay, is a transitional care episode: contact within two business days of the hospital or observation discharge, medication reconciliation, and a face-to-face visit within 7 or 14 days, at $373.26 or $274.86 per discharge at the California locality 05 amounts. The discharge itself is what qualifies the episode; an urgent-care visit is the signal that a discharge happened, and the 60-day post-discharge cadence in Section 4.4 is the mechanism. Those episodes carry no dollars in the forecast; the count of panel patients admitted in the last twelve months, which CarbyOS's transitions-of-care feed can produce, is the number that sizes them, and it is on the confirmation list.

The 56 urgent-care-only clinics are the third piece. Every patient 65 or older seen there carries a Medicare identifier and, on this panel's profile, a two-in-three chance of hypertension. A referral to a primary-care site with the program running is a new longitudinal patient and a new enrollment, and Section 6 treats that conversion as the growth lever it is.

3.5 CarbyOS: the program lives in the chart

CarbyOS EHR v3 was certified by Drummond Group on September 25, 2025 under the ONC Health IT Certification Program. The criteria that matter to this program are the (g)(10) standardized FHIR R4 API for patient and population services, the (g)(7) and (g)(9) application-access criteria, (b)(1) transitions of care, and (h)(1) Direct messaging. CoachCare integrates over FHIR for reads of the Patient, Condition, Observation and Encounter resources, and over Direct or document exchange for the monthly documentation. Write-back of care plans and charge capture into CarbyOS is scoped in the integration workshop with Carbon's clinical-informatics team, and the integration is priced as a custom integration in the forecast, with scope confirmed in contracting.[13]

[13] ONC Certified Health IT Product List, CarbyOs EHR v3, certification 15.04.04.3216.Carb.02.01.1.250925, Drummond Group, September 25, 2025, status active; criteria 170.315 (g)(10), (g)(7), (g)(9), (b)(1), (b)(10), (c)(1) to (c)(3), (h)(1). CarbyOS certification disclosures: FHIR service-base-URL publication endpoint, API documentation v1.2 (May 30, 2025), OAuth 2.0 registration. The certified API covers reads under the (g)(10) criterion; write-back is outside it and is scoped in the integration workshop.

Step	What happens in CarbyOS	Who does it
Eligibility	Patients meeting the agreed criteria are identified from the Condition and Encounter feeds and flagged; the flag is the enrollment prompt at the point of care	CoachCare configures the criteria Carbon's clinical leadership approves
Referral	The clinician places a referral order the way they would order a lab. The order is the enrollment	Any of the 40 primary-care clinicians, in the visit; any urgent-care clinician for a patient 65 or older
Device	A cellular blood pressure cuff and scale ship to the patient, pre-paired; no smartphone, WiFi or app required, though the Carbon app carries the instructions for patients who use it	CoachCare sources, ships, replaces
Outreach	The patient is reached, educated and consented; readings and monthly care documents return to the chart through the documented exchange path	CoachCare's on-site enrollment specialist and care team
Claims	Each month's codes are constructed from logged time and transmission days and land billing-ready for Carbon's revenue cycle	CoachCare generates; Carbon files and keeps the revenue

The custom integration carried in this forecast is $4,000 for setup, $150 a month and $1.50 per enrolled patient-month. Together with implementation and telephonic outreach, those ancillary items total $74,979 over 24 months, and they are inside the $2,702,028 of CoachCare fees, not on top of it.

4. Clinical Governance & Escalation

Section 5 shows the service line pays. This section shows it is safe. Every reading a patient takes routes through one shared escalation engine with defined thresholds, a defined trend rule, defined routing and a defined documentation standard, so Carbon never carries surveillance liability it did not agree to. Thresholds and routing are set with the physician-owned professional corporation's clinical leadership in each state, not by default, and signed off before the first patient enrolls.[14]

4.1 One shared escalation engine

Branch	The rule	Why it is written this way
Critical value	**Escalate immediately, regardless of symptoms**	A reading at a critical threshold escalates whether or not the patient reports symptoms. There is no wait-and-see branch on a critical value, and no client preference can suppress it
Out of range, not critical	Retake, then a structured symptom check	A non-critical out-of-range reading is worked rather than forwarded: confirm technique, request a repeat, run the symptom check. Most out-of-range readings resolve here, which is why the clinicians' inboxes stay usable
Trend	**Three consecutive readings at least one hour apart for blood pressure or glucose; three readings within seven days for heart rate; a weight gain over the agreed threshold in the agreed window**	A trend is a definition rather than a judgment call. A confirmed trend escalates on the same footing as a single threshold breach
Patient unreachable	Document the attempt, leave a voicemail with the callback line and advice to seek care if symptoms worsen, and escalate anyway if the reading was critical or a confirmed trend	Silence never downgrades a clinical finding. This is the branch that separates a monitoring program from a data-collection exercise
Documentation	**Six fields on every escalation: vital · findings · method · contact · outcome · follow-up**	The same six fields every time, so any episode can be reconstructed end to end. Parameter changes are documented in the same record

[14] CoachCare Care Management Programs standard operating procedures, March 2026: alert and escalation decision logic, trend definitions, emergent and urgent communication protocol, escalation routing, post-discharge cadence and discharge governance, as reproduced in this section.

4.2 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. Any of these reported during an outreach call activates the emergent protocol immediately.

Action. 911 is called with the patient still on the line. The call is not ended and handed off. The escalation record follows the patient, and the Carbon site that manages them is notified the same day.

If the patient refuses. The site's care team is called with the patient still on the line and directs care. If the care team cannot be reached, CoachCare activates emergency services regardless. Either way the clinic is notified and the chart records the symptoms, the 911 status, the contact made and the instructions given.

The floor. CoachCare's urgent and emergent policy supersedes any client-specific escalation preference. Carbon shapes routing for everything else. It cannot lower the floor on an emergency, and neither can we.

Recent or changing symptoms that are not actively emergent, inside a 72-hour window, route as an escalation under the site's stated preference and are documented the same way. A patient told to seek same-day care is directed to the nearest Carbon urgent care where one is open, which keeps the visit, the record and the follow-up inside the same system.

4.3 Three-way routing

The failure mode of a monitoring program inside a busy clinic is not a missed alert. It is an inbox nobody reads, because everything arrives as an alert. Escalations route three ways, and the split is agreed before the first patient enrolls.

Route	What goes there	Who sees it
Emergency	Emergent symptoms, or a critical value with clinical instability	911 activated, with the site's care team notified
Non-critical	A confirmed out-of-range reading or trend without emergent features	The defined care-team member named in the site's escalation matrix, within the agreed window
Stable or resolved	**Worked, retaken, resolved, patient asymptomatic**	**Documented in the record as a note rather than pushed as an alert. This is the branch that keeps the program sustainable for clinicians who also carry an urgent-care schedule**

The matrix is agreed per site, because the covering clinician in Oakland is not the covering clinician in Back Bay, and the after-hours branch is defined alongside Carbon's existing virtual-care and on-call arrangements, so night and weekend readings have a route that does not depend on anyone's memory. Each site switched on adds a row, not a redesign.

4.4 The post-discharge three-touch cadence, and the TCM episode

Triggered by any emergency visit or hospitalization in the previous 60 days. For Carbon the trigger usually fires from an urgent-care visit, an app message or the transitions-of-care feed in CarbyOS, and when the event was a hospital or observation admission the cadence is also the transitional care episode: the first touch is the two-business-day contact 99495 and 99496 require, and the confirmed follow-up is the 7- or 14-day visit. This cadence is the mechanism behind the avoided admissions in Section 5.5.

Touch	Window	What happens
1 · Stabilize	**Day 1–2**	Identify what precipitated the visit; reconcile discharge medications against what is in the house; confirm a follow-up appointment exists within 7 to 14 days; symptom assessment, documented and escalated per the engine above

Touch	Window	What happens
2 · Detect	**Day 5–8**	The window in which post-discharge decompensation usually declares itself. Verify medication adherence; re-evaluate the original triggers; confirm the appointment was attended; verify ordered labs were completed
3 · Secure	**Day 12–14**	Medication and risk review; review the outcome of the completed visit; final symptom assessment; hand the patient into the longitudinal monitoring panel so the window closes with continuity rather than a cliff

4.5 Continuity and discharge governance

1. **An unreachable patient escalates on a fixed cadence.** A monitoring patient unreachable 45 days from enrollment is escalated to the care team; non-compliance at 90 days triggers a second escalation plus 90 more days of monitoring. Care management runs a longer clock, with the first escalation at six months.
2. **There is a hard backstop.** If no instruction comes back from the care team, discharge proceeds at 180 days for monitoring. The site is notified in every case and discharges process in the first week of the following month.
3. **Carbon always decides.** Clinical discharge criteria, escalation thresholds and routing belong to the physician-owned professional corporation that bills in each state. CoachCare executes them consistently and documents the execution. It does not overrule clinical judgment, with the single exception of the emergent floor in Section 4.2.
4. **Auditable by design.** Because every escalation carries the same six documented fields, any episode can be reconstructed end to end, which is what the per-code documentation rules require in any case and what an ACO quality review in Boston asks for.

5. Value Analysis: The 24-Month Forecast

5.1 The headline economics

The forecast covers remote physiologic monitoring and chronic care management across a Medicare panel of 5,500 at the 25 primary-care sites, with 4,400 in scope, priced at the CY2026 California locality 05 amounts at list, with 40 referring primary-care clinicians and one CoachCare-funded on-site enrollment specialist at 80 enrollments a month. Transitional care management is recommended in Section 3 and carries no dollars here.[15]

	Year 1	Year 2	24 months
Net reimbursement	**$2,085,859**	**$3,113,042**	**$5,198,901**
CoachCare fees, including the CarbyOS integration and implementation	$1,093,158	$1,608,870	$2,702,028
Net to the practice	**$992,701**	**$1,504,172**	**$2,496,873**
Practice margin	47.6%	48.3%	**48.0%**

The margin moves from 47.6% in year one to 48.3% in year two because the one-time implementation and CarbyOS setup fall out and the census is full from the first month of the year. Year two is the steady state: **$3,113,042 of net reimbursement, $1,504,172 of it kept, at 48.3%**.

[15] CoachCare Value Analysis for Carbon Health, 2026. All Section 5 figures. Inputs: 5,500 Medicare patients, 4,400 in scope; 40 referring clinicians; one on-site enrollment specialist at 80 enrollments a month; remote monitoring 65% eligible and 35% acceptance; chronic care management 75% eligible and 30% acceptance; 8 referrals per clinician per month at 80% acceptance; telephonic outreach on; list pricing; CY2026 fee schedule at California locality 05 amounts; custom integration $4,000 setup, $150 a month, $1.50 per enrolled patient-month. Sensitivity runs on the same workbook with one input changed at a time.

5.2 Where the revenue comes from

Program	Year 1	Year 2	24 months	Per enrolled patient-month
Remote physiologic monitoring	$1,078,820	$1,503,603	**$2,582,422**	$126.52
Chronic care management	$1,007,039	$1,609,440	**$2,616,479**	$135.47
Total	**$2,085,859**	**$3,113,042**	**$5,198,901**	

Net reimbursement by program and year, CoachCare Value Analysis.

24 months	Net reimbursement	CoachCare fees	Net to the practice
Remote physiologic monitoring	$2,582,422	$1,344,639	**$1,237,783**
Chronic care management	$2,616,479	$1,282,410	**$1,334,069**
Implementation, CarbyOS integration setup and monthly, per-patient EMR, telephonic outreach		$74,979	−$74,979
Total	**$5,198,901**	**$2,702,028**	**$2,496,873**

Fees and net to the practice by program, 24 months, CoachCare Value Analysis.

The two programs are nearly equal. Chronic care management is the larger line, $2,616,479 on 990 active enrollments at M24, because the multi-chronic core of this panel is large and the 99439 add-on is earned in most months. Remote monitoring carries $2,582,422 on 1,001 enrollments and is the program that produces the readings, the alerts and the avoided admissions. The **1,991 active program enrollments at M24 belong to 1,298 unique patients**, because most monitored patients also hold a care-management enrollment.

5.3 The ramp, month by month

Month 1 nets **$325**, because the one-time implementation fee and the CarbyOS setup land in that month against 103 enrollments. M2 nets $17,729 on 271 enrollments and M3 nets $32,690 on 506. Remote monitoring fills in M7, chronic care management fills in M9, and the program holds $125,347 a month from M10.

Month	Net reimbursement	CoachCare fees	Net to the practice
M1	$14,887	$14,562	**$325**
M2	$37,813	$20,084	$17,729
M3	$69,172	$36,482	$32,690
M4	$106,402	$55,896	$50,506
M6	$191,363	$100,081	$91,282
M7	$232,502	$121,431	$111,071
M8	$246,442	$128,974	$117,468
M9	$259,420	$135,023	$124,397
M10 onward	**$259,420**	$134,073	**$125,347**

The commercially important number in that table is not the 24-month total. It is that the program is self-funding in its first month and every month after, with no devices purchased, no software licensed and no

headcount added by Carbon. Cumulative net to the practice passes $263,721 at M6, $992,701 at M12 and $2,496,873 at M24. A service line that pays its own way from the first month competes with nothing else on the capital plan.

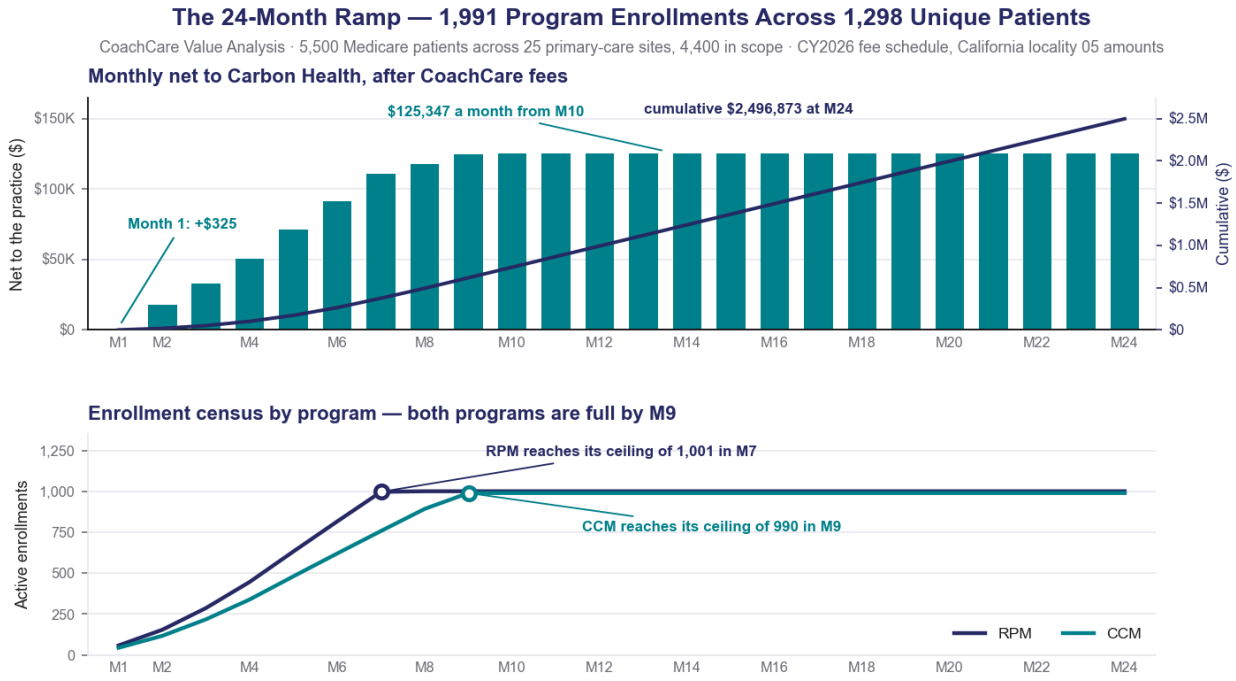


Figure 1 — monthly net to the practice after CoachCare fees, with cumulative net overlaid, and the enrollment census by program with the two ceiling months marked. CoachCare Value Analysis.

5.4 Ceilings, and what moves them

Program	Eligible share of the 4,400 in scope	Acceptance	Ceiling	Reached
Remote physiologic monitoring	65% — 2,860 patients	35%	**1,001**	**M7**
Chronic care management	75% — 3,300 patients	30%	**990**	**M9**

Say the constraint out loud

The binding constraint on this program is the size of the longitudinal Medicare panel and the eligibility definition, not outreach capacity. By M9 every patient the two programs can take is enrolled, and the enrollment specialist has nowhere further to go on this year's panel. That is why the sensitivity table below reads the way it does: more clinicians or a second enrollment specialist cannot raise the ceiling, only reach it sooner. The panel raises it, and the panel grows one way, by converting patients 65 and older from episodic urgent care into a primary-care relationship.

Chart counts are discovery item number one. The 5,500 is the forecast's basis across all 25 sites and all payers. CarbyOS's own registry, pulled in week one, replaces it, and every ceiling in this report moves with it.

Scenario	24-month net reimbursement	Net to the practice	Margin	Ceilings reached
Base: panel 5,500, 4,400 in scope, 40 clinicians, one enrollment specialist	**$5,198,901**	**$2,496,873**	**48.0%**	M7 / M9
Panel 3,000, 2,400 in scope	$3,051,385	$1,462,241	47.9%	M5 / M6

Scenario	24-month net reimbursement	Net to the practice	Margin	Ceilings reached
Panel 8,000, 6,400 in scope	$6,997,849	$3,361,873	48.0%	M10 / M13
25 referring clinicians	$4,862,572	$2,333,655	48.0%	M10 / M12
60 referring clinicians	$5,432,363	$2,610,364	48.1%	M6 / M7
A second on-site enrollment specialist	$5,369,635	$2,580,363	48.1%	M7 / M8
Bay Area sites only: panel 3,000, 2,400 in scope, 20 clinicians	$2,892,582	$1,385,257	47.9%	M7 / M8

CoachCare Value Analysis sensitivity runs. Ceilings reached: remote monitoring / chronic care management.

Read across the rows. Moving the panel from 3,000 to 8,000 moves 24-month net to the practice from $1,462,241 to $3,361,873 at the same margin; revenue is close to linear in the panel because both programs are ceiling-limited. Twenty more referring clinicians are worth about $114,000 and fifteen fewer cost about $163,000, in both cases through timing alone. A second enrollment specialist adds about $83,000 and brings the care-management ceiling a month sooner. The Bay Area row is the smallest program that still works: 13 sites, 20 clinicians, $1,385,257 at 47.9%. The panel is the lever; everything else is timing.

5.5 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	**214,326**	Blood pressure and weight values arriving between visits from a panel where two in three beneficiaries carry hypertension
Claims and billable units generated	**77,599**	Constructed, coded and landed billing-ready for Carbon's revenue cycle through the CarbyOS integration
Care-management tasks completed	155,197	Outreach attempts, care-plan updates, medication reviews and follow-up actions
Patient conversations	23,280	Live contacts across 1,293 hours of call time
Chart updates	38,799	Documentation returned to CarbyOS for the care team to act on
Care-team hours delivered by CoachCare	**34,581**	**About 16.6 full-time-equivalent years of care-management labor Carbon does not employ**
Hospitalizations avoided	**136.1**	About $2,041,000 at $15,000 per admission, cost that never lands on a payer, a patient or, in Boston, the ACO's benchmark

CoachCare Value Analysis, 24-month totals.

The two layers, kept separate

Fee margin funds the program. $2,496,873 to the practice over 24 months, positive from the first month, paid claim by claim by Medicare and by Medicare Advantage plans at their contracted terms.

Avoided admissions speak to the payers, and in Boston to the ACO. About 136 over 24 months on this census, about $2,041,000 at $15,000 each, plus the documented monthly relationship with 1,298 patients that retrospective assignment reads as primary care delivered here. The Massachusetts entity's assigned-beneficiary count and its distribution history under the current agreement are the numbers to bring to the first working session; the ACO holds both.

6. Built Once, Switched On per Site

Twenty-five primary-care sites in four markets and four billing entities, all on one record system, is a different shape from the usual single-practice program, and the partner model is built for it. The integration, the protocol and the staffing model are built once. Each site is switched on with a routing row and a supervising clinician; each state is switched on with a contract between CoachCare and the physician-owned professional corporation that bills there.

What is built once	What each site inherits
The CarbyOS integration	Every clinic runs on the same record system. A site switched on inherits the eligibility flag, the referral order, the documentation path and the claim construction from the first day, and an urgent-care site that adds primary care inherits them the same way
The clinical protocol	Thresholds, trend rules, the emergent floor and the three-touch cadence are the same everywhere. Each site adds a routing row naming its covering clinician and its after-hours path; each state's clinical leadership signs the protocol for its own entity
The staffing model	The care team scales by census at the same care-manager ratio, and the on-site enrollment specialist works each market's launch in turn. None of it is Carbon's headcount
The contracting shape	One agreement per billing entity: California first, then Massachusetts, New Jersey and Washington. Each entity supervises its own program, files under its own identifiers and keeps its own margin. Clinical governance stays with the physician-owned professional corporation in each state by design
The economics	Every site is a new ceiling. A primary-care site with a 300-patient Medicare panel is sized in the Scenario Explorer on the companion microsite in about a minute, at its own locality's amounts

The growth lever is conversion, not acquisition. Carbon sees hundreds of thousands of patients a year, most of them in urgent care and most of them younger than Medicare; the ones 65 and older who leave with a diagnosis of hypertension, diabetes or heart failure and no primary-care relationship at Carbon are the panel this program has not yet reached. A referral from the urgent-care visit to a primary-care site with the program running turns an episodic patient into a longitudinal one and an unreimbursed month into a billable one. At the 3,000-to-8,000 range in the sensitivity table, every thousand patients converted is worth about $380,000 of 24-month net to the practice at the same 48% margin.

The order matters. The Bay Area first, because 13 of the 25 sites are there, the California entity is the largest, and the launch market should be the one where the enrollment specialist can reach every site in a day. Boston second, because the counties are mostly fee-for-service and the ACO position adds a layer nowhere else has. Central New Jersey third, on the same fee-for-service logic. Puyallup when its census justifies a routing row of its own.

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

CMS published its proposed CY2027 physician fee schedule in July 2026. Comments close September 14, 2026; the final rule arrives in early November; the changes take effect January 1, 2027. The proposal that matters here is a reduction to the remote monitoring device-supply codes. Every code in this forecast was repriced at California locality 05 on this account's own billing mix, with enrollment held constant.[16]

[16] CMS-1848-P, CY2027 Medicare Physician Fee Schedule proposed rule, published July 2026; comment deadline September 14, 2026. CoachCare repricing of this forecast at the proposed CY2027 amounts, California locality 05 (conversion factor $32.8409 versus $33.4009): 99454 and 99445 $73.14 to $58.02 (−20.7%); remote monitoring arm −10.5% (−$271,427) with device supply 34.9% of that basket; chronic care management −2.0% (−$52,428); service line −6.2% (−$323,855), $5,198,901 to $4,875,046, with remote monitoring 49.7% of the line. Enrollment held constant.

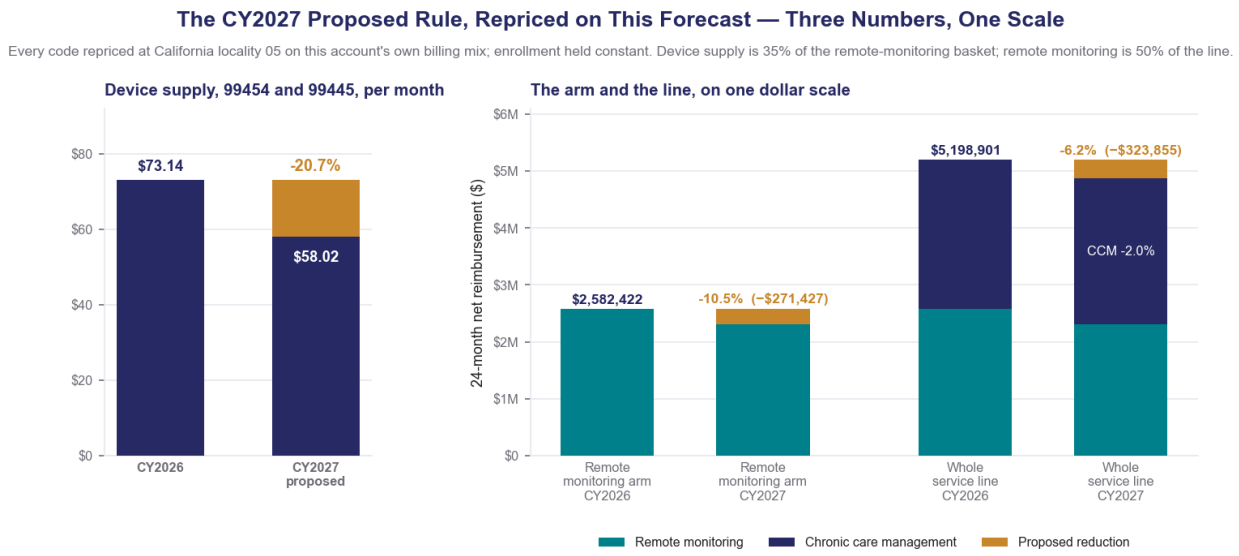


Figure 2 — the CY2027 cascade on this forecast. Left: the one code CMS proposes to cut, per month at California locality 05. Right: the remote-monitoring arm and the whole service line on one dollar scale, with the proposed reduction in one colour and absolute dollars beside each percentage. CoachCare repricing of the Value Analysis at the proposed CY2027 amounts.

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
Device supply, 99454 and 99445	$73.14 a month	**$58.02 a month, −20.7%**	The code CMS proposes to cut
The remote monitoring arm	$2,582,422 over 24 months	**−10.5%, −$271,427**	Device supply is 35% of the remote monitoring basket; treatment management moves little
Chronic care management	$2,616,479 over 24 months	−2.0%, −$52,428	Conversion-factor and relative-value churn only; the proposal does not target these codes
The whole service line	$5,198,901 over 24 months	**−6.2%, −$323,855, to $4,875,046**	Remote monitoring is 50% of the line; the rest moves two points

CoachCare repricing of this forecast at the CY2027 proposed amounts, California locality 05, on the code frequencies in this Value Analysis.

Three numbers, each smaller than the last only because its base is larger. A 20.7% cut to one code is a 6.2% change to the service line, because this line is built on two programs of nearly equal size and only one of them holds the code being repriced. The comment window is open until September 14, and CoachCare is filing.

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%

Code	What it pays for	CY2026 national	Proposed CY2027 national	Change
G0556	Advanced primary care management, level 1	$16.37	$16.09	−1.7%
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 repricing above uses California locality 05 amounts and this table uses national amounts; the two bases do not reconcile to the dollar, by design.

8. Implementation Roadmap

8.1 Who runs what

Function	CoachCare	Carbon Health
Patient identification	Registry query in CarbyOS against the agreed inclusion criteria, starting from the hypertension, diabetes, heart-failure and kidney-disease cohorts on the Medicare panel	Approves the criteria and the target list, per billing entity
Enrollment	**One on-site enrollment specialist at 80 enrollments a month, on CoachCare's payroll; CarbyOS eligibility flag and referral order**	Clinician referral at the point of care, in primary care and at the urgent-care visit; 40 primary-care clinicians
Transitional care	Discharge captured from the visit, the app or the transitions-of-care feed; two-business-day contact and medication reconciliation completed and documented; visit scheduled inside the 7- or 14-day window	Furnishes the face-to-face visit and bills 99495 or 99496
Devices	Sourced, configured, cellular-paired, shipped, replaced	Nothing purchased, nothing stocked
Monitoring and escalation	Reading review, monthly outreach, alert triage, post-discharge cadence, protocol execution and documentation, at about 160 patients per care manager	**Sets thresholds, routing and after-hours cover per site; receives escalations**
Documentation and billing	Time logs, monthly care documents to CarbyOS, claims constructed and landed billing-ready	**Files under its own identifiers through its own revenue cycle; keeps the revenue**
Reporting	Monthly enrollment, engagement, escalation and revenue reporting per site and per entity, including the view the Boston ACO needs	Standing monthly operating call; a named program lead per entity

8.2 The model inputs

Input	Value in this forecast
Medicare panel	**5,500 patients across the 25 primary-care sites, 4,400 in scope**; all payers
Referring clinicians	40 primary-care physicians, nurse practitioners and physician assistants across the 25 sites
Eligibility and acceptance	Remote monitoring 65% eligible, 35% accept; chronic care management 75% eligible, 30% accept; 8 referrals per clinician per month at 80% acceptance
Enrollment staffing	One CoachCare-funded on-site enrollment specialist at 80 enrollments a month, plus clinician referral and telephonic outreach; the specialist, care managers and device logistics are CoachCare's payroll, embedded in the fee

Input	Value in this forecast
EMR	CarbyOS; custom integration per Section 3.5 at $4,000 setup, $150 a month and $1.50 per enrolled patient-month, scope confirmed in contracting
Rates	CY2026 physician fee schedule, non-facility, California locality 05 (Noridian JE), ZIP 94103. 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.
Pricing	List pricing, reflected in the per-patient-month fees: **RPM $65.87 · CCM $66.40**
Programs	RPM + CCM in the forecast; transitional care management recommended at every hospital or observation discharge, not in the forecast; advanced primary care management named as the next lever for the Boston sites at zero dollars

8.3 The roadmap

Window	What happens	Result at the end of it
Weeks 0–4 Integration workshop and charter	Integration workshop with Carbon's clinical-informatics team: FHIR read scope, the documentation path, write-back and charge capture. Chart counts and the MA/FFS split pulled from CarbyOS by site and by entity. Escalation thresholds, per-site routing and after-hours cover agreed with the California entity's clinical leadership. Billing configuration with Carbon's revenue cycle. Protocol sign-off for the hypertension, diabetes, heart-failure and kidney-disease pathways. A named program lead	Scope signed, cohorts defined, integration live, protocol signed
Weeks 4–12 First cohorts at the Bay Area sites	The on-site enrollment specialist working the 13 Bay Area sites and Roseville. Chronic care management wave across the multi-chronic panel; remote monitoring for the hypertension, diabetes and heart-failure cohorts. Cellular cuffs and scales shipped and paired. Transitional care, the urgent-care-visit trigger and the three-touch cadence live from the first week	103 enrollments by month 1, 271 by month 2, 506 by month 3; positive from month 1
Months 3–9 Reach the ceilings	Both programs climb to ceiling on the California panel: remote monitoring 1,001 in M7, chronic care management 990 in M9. Monthly operating views live per site. Urgent-care referral of patients 65 and older to primary care running at every California clinic	1,991 active enrollments across 1,298 unique patients; $125,347 a month from M10
Months 9–24 Boston and New Jersey	The Massachusetts entity contracts and the five Boston sites switch on, with the ACO in the room and the chronic care management versus advanced primary care management decision on the agenda. The New Jersey entity follows. Chart-data eligibility widens the in-scope panel everywhere; Puyallup when its census justifies it	Year 2 at $3,113,042 net reimbursement, $1,504,172 to the practice, 48.3%, before the Boston and New Jersey panels are counted

8.4 What we would confirm together

These are the discovery items, and every one lives in CarbyOS or one call away. None of them holds up the start; the first window of the roadmap collects them.

1. **Chart counts and the payer split behind the 5,500.** A registry pull in week one, by site and by billing entity: active primary-care patients 65 and older, traditional Medicare versus Medicare Advantage plan by plan, and how many carry hypertension, diabetes or two or more chronic conditions. 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 plan mix sets each program's target list.
2. **The clinician count behind the 40.** The number of physicians, nurse practitioners and physician assistants who carry a primary-care panel at each of the 25 sites, as distinct from the urgent-care schedule. Between 25 and 60, the sensitivity table in Section 5.4 moves the ceiling months, not the ceilings.

3. **Who signs for each billing entity.** The physician-owned professional corporation that bills in each state is the counterparty for its own program and the owner of its clinical governance. The California entity comes first; the signatory and the supervising clinical lead for each entity are confirmed in the charter window.
4. **The accountable-care arrangements in Boston.** Whether the ACO places a care coordinator at any of the five sites, whether it restricts or claims chronic care management or advanced primary care management billing for participants, and the Massachusetts entity's assigned-beneficiary count and distribution history.
5. **CarbyOS write access for partners.** The certified API covers reads. Whether care-plan notes, time logs and charge capture can be written into CarbyOS directly, or travel by Direct and document exchange, is settled in the integration workshop and sets the final integration scope and fee.
6. **Any Medicare Advantage delegated-risk arrangement.** None was found in the public record. If any part of the panel sits under capitation, the fee-for-service forecast is scoped to the part that does not.
7. **The one site already billing chronic care management.** Whether the CY2024 program at that site is still running and on what workflow, so it is folded into the practice-wide program rather than run beside it.
8. **Hospital and observation admissions on the panel.** The count of primary-care patients admitted in the last twelve months, from the transitions-of-care feed, sizes the transitional care episodes this forecast carries at zero.
9. **Urgent-care patients 65 and older without a Carbon primary-care relationship.** The count at the 56 urgent-care-only clinics and at the 25 primary-care sites is the conversion pool in Section 6, and the number that sets how far the ceiling can move.

9. Recommendations

1. **Launch the partner-run service line at the Bay Area sites.** $2,496,873 to the practice over 24 months at a 48.0% margin on the full panel, positive from the first month, with nobody hired and nothing bought. The Bay Area alone returns $1,385,257 at 47.9%. Contract with the California entity first.
2. **Build the integration in the workshop, on the certified API.** FHIR reads of Patient, Condition, Observation and Encounter; Direct or document exchange for the monthly documentation; write-back scoped with Carbon's clinical-informatics team. Every site switched on afterwards inherits it.
3. **Point the first enrollment wave at the multi-chronic hypertensive core.** Two in three beneficiaries carry hypertension, a quarter are diabetic, a sixth have kidney disease. Chronic care management for the care plan, a connected cuff and scale for the readings, and the urgent-care visit as the trigger.
4. **Make the urgent-care visit the referral engine it already is.** Every patient 65 or older who leaves an urgent-care visit with hypertension, diabetes or heart failure and no Carbon primary-care relationship is a referral to a primary-care site with the program running. Order the device before they leave; hand the enrolled patient to the site with a plan.
5. **Bill transitional care management at every hospital or observation discharge Carbon learns of.** The two-business-day contact and the 7- or 14-day visit are the cadence the program already runs; 99495 and 99496 pay $274.86 and $373.26 per discharge at the California locality 05 amounts. Not in the forecast; sized by the panel's own admission count.
6. **Pull the chart counts in week one.** The binding constraint is the longitudinal Medicare panel. Between 3,000 and 8,000 patients, 24-month net to the practice runs from $1,462,241 to $3,361,873 at the same margin; the registry, not the estimate, sets the number.

7. **Switch Boston on second, with the ACO in the room.** The Massachusetts counties are 58% to 68% fee-for-service, the entity is inside a Shared Savings Program ACO in the BASIC track, and the avoided admissions, about 136 over 24 months on the full census, are the layer the ACO rewards. The assigned-beneficiary count, the distribution history and any coordinator or billing arrangement the ACO runs shape how the Boston program is drawn.
8. **Hold advanced primary care management as the named next lever for Boston, and decide it in months 9 to 24.** The gate is cleared at the five Boston sites and nowhere else. The pathway choice between chronic care management and APCM is Carbon's, made with the ACO, once the Boston care-management census and documentation workflow are real.
9. **Read the Medicare Advantage contracts early.** About half of the Bay Area's Medicare is in a plan. 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 plan-by-plan read decides how far past traditional Medicare the California program reaches.
10. **Contract per billing entity, and keep clinical governance where it is.** One agreement with the physician-owned professional corporation in each state; each sets its own thresholds and routing, files under its own identifiers and keeps its own margin. The program travels; the governance does not.
11. **Treat every converted patient and every site as a new ceiling.** The Scenario Explorer on the companion microsite prices a site's panel at its own locality's amounts in a minute. A thousand converted patients are worth about $380,000 of 24-month net to the practice at 48%.

The Medicare panel Carbon Health already manages supports a $5,198,901 service line at a 48.0% practice margin inside 24 months, positive from its first month, on staff Carbon does not have to hire and devices it does not have to buy. The panel is old and multi-chronic, the urgent-care visit sees its sickest patients first, the Massachusetts entity sits inside a contract that pays for the same outcomes, and the record system is certified and ready. Carbon decided once that this belonged in its primary care. What remains is to build the service line once, with a partner, and switch it on at every site that offers primary care.

About CoachCare

> **About CoachCare**
>
> CoachCare operates remote care and care-management programs for more than 500,000 patients, with over 10,000 clinicians on the platform. Its teams have completed more than 1,000 implementations, generated over 5 million claims through care-plan coding and billing, and recorded more than 100 million patient vitals.

Six reasons this partnership fits Carbon Health specifically, not remote care in general.

- **A certified record, integrated once.** CoachCare integrates with a certified FHIR R4 API for the reads the program needs and with Direct or document exchange for the documentation it returns. Eligibility flags and referral orders stay in CarbyOS; vitals, monthly care documents and billing-ready claims come back to it. There is no second system for the clinicians and no re-keying for the revenue cycle.
- **Full service, priced per patient.** The on-site enrollment specialist, care managers at about 160 patients each, device logistics, 24/7 alert triage and claim construction are CoachCare's payroll. Every site switched on inherits a running program at a 48% margin, without a hiring cycle or a capital line. Fees are per active patient per month; if the census does not build, CoachCare is not paid, with implementation and integration fees the exceptions.

- **The urgent-care visit.** Every visit by an enrolled patient fires the three-touch cadence the same day, and every discharge Carbon learns of becomes a transitional care episode. Critical readings escalate through one engine whose urgent policy supersedes any preference. An urgent-care network beside a primary-care panel is a referral engine most practices do not have.
- **Governance that stays with the professional corporation.** The physician-owned entity that bills in each state sets thresholds, routing and discharge criteria, supervises the program and keeps the revenue. CoachCare executes and documents. The division is the same in every state, which is what a multi-state operator needs.
- **Boston's contract sees the same outcomes.** Under the Shared Savings Program, fewer emergency visits and admissions among attributed patients are shared savings. The same monthly touches produce both ledgers: the fee-for-service margin funds the program while the savings-side benefit accrues to the ACO contract.
- **Aligned with what Carbon already believes.** Carbon said in 2021 that remote monitoring belongs in the majority of ongoing primary care. The forecast, the workbook and the companion documents are Carbon's to keep, and the program is the operating version of that thesis, run by a partner whose only business it is.

The ask is a working session with Carbon's clinical and operating leadership: validate the panel against CarbyOS chart counts, hold the integration workshop with the clinical-informatics team, and set go-live for the Bay Area cohorts.

References & Data Sources

- **Carbon Health's own published materials** (retrieved September 11, 2026): carbonhealth.com, for the location listings by region, the primary-care site picker, the service lines, the insurance and pricing page and the patient app; carbyos.com and the CarbyOS certification-disclosures page, for the record system's modules and its ONC certification details; company press releases from 2021 to 2023 on the remote-monitoring and diabetes acquisitions, the at-home CGM program and ambient AI charting.
- **ONC Certified Health IT Product List** (chpl.healthit.gov, retrieved September 2026): CarbyOs EHR v3, certified September 25, 2025 by Drummond Group, status active, with criteria 170.315 (g)(10), (g)(7), (g)(9), (b)(1), (b)(10), (c)(1) to (c)(3) and (h)(1); the published FHIR service-base-URL endpoint and API documentation.
- **CMS provider and claims files** (data.cms.gov, retrieved September 2026): NPPES organization records for the Carbon billing entities; the CMS Doctors & Clinicians national file for the 457 clinician identifiers affiliated with a Carbon entity and their credential mix; the Medicare Physician & Other Practitioners by Provider file, CY2024, for beneficiary counts, age, chronic-condition prevalence and risk scores of the address-matched clinicians; and the by Provider and Service file, CY2024, queried for every one of the 457 identifiers across the evaluation-and-management, annual wellness, remote monitoring, chronic care management, transitional care and advanced primary care management code families. CMS suppresses lines under 11 beneficiaries.
- **Medicare Shared Savings Program PY2026 participant file** (data.cms.gov, retrieved September 2026): Carbon Health Medical Group of Massachusetts PC as a participant in a BASIC-track ACO at the track's highest level, agreement period four, current period beginning January 1, 2025, retrospective assignment, without the prospective primary-care payment option. ACO REACH participant and provider lists, PY2025 and PY2026: no Carbon entity.
- **Medicare payment rules:** the CY2026 Medicare Physician Fee Schedule final rule and Addendum B, for the remote monitoring family including the new 99445 and 99470, the chronic care management family, the transitional care codes and the G0556 to G0558 advanced primary care management tiers; CMS-1848-P, the CY2027 proposed rule published July 2026, for the proposed device-supply repricing and the comment deadline; and the CY2026 RVU file and Addendum E

geographic indices for California locality 05 under the Noridian JE contractor, used for every dollar in this report.

- **Market sources:** CMS Medicare Monthly Enrollment, county level, May 2026, for beneficiary counts and the Medicare Advantage share in every county with a Carbon primary-care site.
- **CoachCare Care Management Programs standard operating procedures, March 2026:** the shared clinical alert and escalation decision logic, the trend definitions, the emergent and urgent communication protocol, the three-way escalation routing, the post-discharge three-touch sequence and the discharge decision flow reproduced in Section 4.
- **CoachCare Value Analysis for Carbon Health, 2026:** every financial, enrollment, clinical-output and operational figure in Sections 5, 6, 7, 8 and 9, including the sensitivity runs, built on 5,500 Medicare patients with 4,400 in scope, 40 referring clinicians, one on-site enrollment specialist at 80 enrollments a month, list pricing, and the CY2026 fee schedule at the California locality 05 amounts for remote physiologic monitoring and chronic care management.
- **Transitional care management amounts:** CY2026 Medicare Physician Fee Schedule relative value units for 99495 and 99496, priced with the Addendum E geographic indices for California locality 05: $274.86 and $373.26 per discharge (national $220.11 and $298.60). Transitional care management carries no dollars in the Value Analysis.

A note on how this report handles counts and names

Unique patients and program enrollments are different numbers. At M24 the program holds 1,991 active program enrollments belonging to 1,298 unique patients, because a patient may hold a monitoring enrollment and a care-management enrollment at the same time. Wherever this report gives a patient count it says patients; wherever it gives an enrollment count it says enrollments.

The panel figure is the forecast's basis; the claims describe its shape. The 5,500 covers all 25 primary-care sites and all payers. The 8,335 beneficiary-clinician pairs in the CY2024 claims file are fee-for-service only, count a patient once per clinician seen, and include urgent-care visits, so the two numbers describe different things and are not in conflict.

No individual is named anywhere in this report. Clinicians, executives and ACO personnel are described by count and role only, and the Massachusetts entity's ACO by its program track rather than by name.