

Rosemark Women Care Specialists

An independent, physician-owned women's health practice in Idaho Falls, Idaho: fourteen clinicians under one roof on Potomac Way, with gynecology, urogynecology, bone health and primary care for women, and an older Medicare panel in which high blood pressure is the most common condition

Remote Care Service Line Optimization Report

2026 Strategy Report

A scalable, profitable remote care service line for Rosemark Women Care Specialists: remote monitoring and chronic care management for the Medicare women its clinicians already see, billed under Rosemark's own NPIs at Idaho's CY2026 Medicare rates, staffed by CoachCare and run inside Greenway

Purpose of this document

Prepared by CoachCare, October 2026, as a discussion document for the physician partners and leadership of Rosemark Women Care Specialists. It is the companion to Rosemark's remote care strategy page and makes the same argument at report length: why Medicare's payment rules make this the year, what Rosemark's own Medicare claims show, how the service line runs, what it returns over 24 months at Idaho's rates, and why CoachCare is the partner to run it.

The argument is short. Rosemark's Medicare patients are older women who come for gynecology, bone health and urogynecology, and most of them carry high blood pressure, high cholesterol or both. The claims show no program yet for the months between their visits. This report shows what that program returns, who does the work, and how it starts with no capital and no new hire.

Prepared by CoachCare for discussion with Rosemark Women Care Specialists. © 2026 CoachCare.

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Executive Summary

Rosemark Women Care Specialists is an independent, physician-owned women's health practice in Idaho Falls. Since 2025 all of its care sits under one roof, an expanded building on Potomac Way with bone density, ultrasound, lab and bladder testing in house, same-day appointments, and a clinical research program that has run trials since 1998. Fourteen clinicians bill Medicare through the practice: six physicians, one of them a urogynecologist, two certified nurse-midwives, three nurse practitioners and three physician assistants. The practice runs Greenway.¹

Rosemark's own CY2024 Medicare claims describe an older panel of women. The average traditional-Medicare patient is about 72, with a weighted risk score of 0.82 against a national 1.00. **High blood pressure appears in 59.8% of these patients and high cholesterol in 53.9%; osteoporosis, diabetes, depression and anxiety each sit near a quarter, and chronic kidney disease at about a fifth.** No remote monitoring, chronic care management or behavioral health integration program appears at meaningful scale.²

Rosemark already offers primary care for women of all ages, care for depression and anxiety, and in-house dietitians, and local readers have voted it Idaho Falls' best OB/GYN clinic nine times. Its Medicare patients see it once or twice a year. Between those visits their blood pressure, glucose and mood keep changing, and Medicare now pays for watching them.

The observation this report is built on

Turn the Medicare women Rosemark already sees into a profit-generating service line.

Rosemark has the patients, the conditions, the chart and the clinicians. What its claims do not show is daily readings for the women with high blood pressure or diabetes, or monthly care management for the women with two or more chronic conditions. This service line adds both: staffed by CoachCare, governed by Rosemark's clinicians, billed under Rosemark's NPIs from inside Greenway.

What the Value Analysis returns

Full service line	Year 1	Year 2	24 months
Net reimbursement	\$265,356	\$294,170	\$559,526
CoachCare fees	\$155,324	\$165,382	\$320,706
Net to Rosemark	\$110,031	\$128,788	\$238,819
Practice margin	41.5%	43.8%	42.7%

CoachCare Value Analysis: 650 Medicare patients, all 650 in scope, remote monitoring and chronic care management, 14 referring clinicians, one CoachCare-funded on-site enrollment specialist, CY2026 Idaho locality 00 amounts. Margin is net to Rosemark divided by net reimbursement.

Rosemark can start two ways, and both are net-positive. It can begin with remote monitoring alone, which a Rosemark clinician can order and bill even where another physician provides chronic care management: **\$282,008 of net reimbursement and \$119,739 to Rosemark over 24 months**, for 137 patients. Or CoachCare can run both programs for the women Rosemark manages, the forecast of record above, for 172 unique patients.

¹ rosemark.net, retrieved October 22, 2026: 3450 Potomac Way, Idaho Falls, ID 83404; expanded building with bone density, ultrasound, lab, bladder testing and same-day care. CMS Doctors and Clinicians, October 2026: 14 clinicians reassigned to the practice. The patient portal is Greenway's My Health Record.

² CMS Medicare Physician & Other Practitioners by Provider, CY2024, nine clinicians, chronic-condition shares weighted by patients: high blood pressure 59.8%, high cholesterol 53.9%, arthritis 48.4%, osteoporosis 25.3%, anxiety 25.0%, diabetes 24.6%, depression 24.1%, chronic kidney disease 20.4%; weighted HCC risk 0.82; average age about 72.

1. **Positive from month 2, with nobody hired.** Implementation and the Greenway setup post in month 1; every month after is positive, and from month 5 the program holds \$10,732 a month. CoachCare supplies 4,968 care-team hours over 24 months, about 2.4 full-time-equivalent years, with one care manager at the standard caseload of 165 patients.
2. **The binding constraint is the size of the eligible Medicare panel.** Remote monitoring reaches its ceiling of 137 in month 3 and chronic care management its ceiling of 117 in month 4, after which the program holds 254 active program enrollments across 172 unique patients. A larger chart count moves the forecast almost one for one, so the Medicare chart count by payer is discovery item number one.
3. **The margin holds whatever the panel turns out to be.** At a 400-patient panel the program returns \$148,138 to Rosemark over 24 months, and at 900 it returns \$325,578. The fee scales with the census, so the practice margin barely moves with panel size (Section 6.5).
4. **The program lives in Greenway.** The integration is built on Greenway's own Intergrity and Prime Suite workflows, claims are created automatically, and a flagged patient reaches the first day of service in under five days (Section 4).
5. **Advanced primary care management is the named next lever, at zero dollars.** For the women who use Rosemark as their primary care home, APCM bills in place of chronic care management. Whether and when to move patients from CCM to APCM is a program decision to make together.
6. **The CY2027 proposed rule takes 5.8% off this line.** A 20.7% cut to device supply is 9.6% on the remote-monitoring arm and \$32,702 over 24 months on the whole line. Section 8 draws the cascade.

The ask is a working session: confirm Rosemark's Medicare chart count by payer, map which of those patients Rosemark manages for blood pressure, diabetes and mood and which see an outside primary care physician, scope the Greenway integration, and choose the starting deployment before the first enrollment.

1. Why Now: Medicare Pays for the Months Between Visits

Medicare is changing what it pays for. Four shifts are under way at once, and each lands in the same place: the months between a patient's visits. For a women's practice whose Medicare patients carry high blood pressure, high cholesterol, osteoporosis and diabetes, those months decide how the year goes.

The shift	What it means for Rosemark
1. From visits to panels	A woman seen once a year spends 364 days between visits. Managing a panel means knowing which of Rosemark's roughly 650 Medicare patients are drifting before the next appointment comes around, and that takes readings from home and a care team assigned to act on them every month.
2. Women's care after 65 is chronic care	Rosemark's traditional-Medicare patients average about 72. About 60% have high blood pressure, 54% high cholesterol and a quarter each osteoporosis and diabetes. Those are the conditions Medicare's care-management codes were written for, and the women who carry them already trust Rosemark with the rest of their care.
3. Medicare pays for outcomes	CMS has set a goal of putting every Traditional Medicare beneficiary in an accountable care relationship by 2030, and Medicare's quality programs score blood-pressure control, diabetes control and depression screening. In Bonneville County 38.44% of Medicare beneficiaries are in Medicare Advantage, and Original Medicare enrollment rose from 11,658 in December 2025 to 14,109 in July 2026.

The shift	What it means for Rosemark
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 shorter months such as the first weeks after enrollment; in this forecast they carry 17% of remote-monitoring reimbursement. ³ At Idaho's CY2026 rates one hypertensive patient on remote monitoring and chronic care management (99454, 99457 and 99490) is worth \$158.92 a month in Medicare allowed charges.

Each shift pays for, or measures, what happens between visits. A remote care service line is how Rosemark covers that time for every eligible Medicare patient, and remote monitoring and chronic care management bill for it under Medicare fee-for-service today.

2. Rosemark Today: A Practice Built Around Women

Since 1994 Rosemark has cared for the women of Idaho Falls through every stage of life. For its Medicare patients that care is mostly gynecology, bone health and urogynecology, and the claims show those women carry the chronic conditions of their age.

2.1 One building, fourteen clinicians

Part of the practice	What Rosemark does today	What the program adds
Gynecology middle life and senior	Menopause care, screening exams and gynecologic problems for women past 65; blood pressure is taken at the visit and not seen again until the next one	A woman whose pressure runs high goes home with a cellular cuff, and her home averages are in the Greenway chart before she comes back
Urogynecology bladder testing in house	Bladder and pelvic-floor care; about three in four of these patients have high blood pressure in CY2024 claims	One care plan carries bladder medications, pelvic-floor therapy and the other conditions month to month
Bone density DXA in the building	About a quarter of the traditional-Medicare patients have osteoporosis	Treatment adherence, fall risk and the next scan tracked on the monthly care plan
Primary care for women	Annual exams, screening and health management for diabetes, hypertension and thyroid disease	For the women Rosemark manages, home readings and a monthly call make that management a documented, billable program
Depression and anxiety	Treated in the practice; about one in four Medicare patients carries one of the two	PHQ screening on the monthly call, with a positive screen routed back to the Rosemark clinician
Dietitians	Registered dietitians run the weight-management program	Home weight and blood pressure shared with the dietitian and the care team
Lab, ultrasound, same-day care	Lab draws and ultrasound on Potomac Way; same-day and urgent appointments	Home readings tell the care team when a test is due, and a flagged patient has a same-day slot to be seen in

rosemark.net, retrieved October 22, 2026; CMS Medicare Physician & Other Practitioners, CY2024.

Fourteen clinicians reassign their Medicare billing to the practice: six physicians, five MDs and one DO, among them the urogynecologist, plus two certified nurse-midwives, three nurse practitioners and three physician assistants. The billing entity is Women's Healthcare Associates, P.A., the professional corporation formed in 1994 that has practiced under the Rosemark name since 2002. The office is open Monday to Friday, 8 a.m. to 5 p.m.⁴

³ CoachCare Value Analysis for Rosemark Women Care Specialists, 2026: 99445 and 99470 carry 17.1% of 24-month remote-monitoring gross reimbursement.

⁴ Idaho Secretary of State: professional service corporation filed October 3, 1994; assumed business name filed August 28, 2002. CMS Doctors and Clinicians, October 2026: six physicians (five MD, one DO), two certified nurse-midwives, three nurse practitioners, three physician assistants. Office hours from *rosemark.net*.

2.2 What the CY2024 claims say

The CY2024 Medicare by-provider and by-provider-and-service files were queried for every clinician billing at Rosemark that year. Nine carry a row, and several clinicians joined after 2024, so the profile describes the fee-for-service patients Rosemark's CY2024 clinicians saw.⁵

Panel	CY2024	Condition	Share
Beneficiary-clinician pairs	662	High blood pressure	59.8%
Medicare allowed	\$127,522	High cholesterol	53.9%
Established-visit pairs (99212–99214)	336	Arthritis	48.4%
Average age	About 72	Osteoporosis	25.3%
Weighted HCC risk score	0.82	Anxiety	25.0%
Patients CMS attributed (PY2024 MIPS cost measure)	402	Diabetes	24.6%
Remote monitoring	No program at meaningful scale	Depression	24.1%
Chronic care management, behavioral health integration	No program at meaningful scale	Chronic kidney disease	20.4%

CMS Medicare Physician & Other Practitioners, CY2024, the nine clinicians billing at Rosemark. Shares are of traditional-Medicare patients, weighted by patients; pairs count a patient once per clinician seen. CMS suppresses lines under 11 beneficiaries.

This is the panel chronic care management was written for: high blood pressure and high cholesterol in the majority, and osteoporosis, diabetes, depression, anxiety and kidney disease each in a fifth to a quarter of patients. The billed mix is office visits, mostly 99212 and 99213, bone-density scans, screening exams, lab work and urogynecology procedures, and **no remote monitoring, chronic care management or behavioral health integration program appears at meaningful scale under any Rosemark clinician**. For its PY2024 MIPS cost measure CMS attributed 402 Medicare fee-for-service patients to the practice, the women for whom Rosemark is a regular source of care.⁶

2.3 Since 1994, independent and physician-owned

Year	What happened
1994	A group of Idaho Falls OB/GYNs opens a practice of its own in October; it takes the Rosemark name in 2002, and one of the founding physicians still sees patients there ⁷
1998	The first clinical trial runs inside the practice. ClinicalTrials.gov now lists 43 studies at Rosemark, from menopause and bladder care to vaccines
2015	Two of the practice's physicians take on its leadership, and a third joins the partnership a few years later; nurse-midwives, nurse practitioners and physician assistants join the roster
2025	Rosemark consolidates into an expanded Potomac Way building with bone density, ultrasound, lab, bladder testing, same-day appointments and its aesthetics practice in one place
Today	Fourteen clinicians, primary care for women, care for depression and anxiety, dietitians, and Greenway in every exam room
2027	Next: daily readings and monthly care management for every eligible Medicare patient, run by a CoachCare care team inside Greenway and billed under Rosemark's NPIs

⁵ CMS by Provider (8889d81e) and by Provider and Service (92396110), CY2024, queried by NPI for every clinician billing at Rosemark addresses: 662 beneficiary-clinician pairs, 336 with an established-patient visit, \$127,522 allowed.

⁶ CMS by Provider and Service, CY2021 to CY2024, searched for the remote monitoring, chronic care management, principal care management, behavioral health integration and APCM codes: no line at 11 or more beneficiaries under a Rosemark clinician. CMS Provider Data, PY2024 Group Public Reporting (0ba7-2cb0): 402 patients attributed for the total per capita cost measure.

⁷ rosemark.net About page; Idaho Secretary of State; ClinicalTrials.gov, queried October 22, 2026: 43 studies at Rosemark.

2.4 What Rosemark already does, and the gap

What exists	Status	What it means for this program
Greenway and its patient portal	Live	The program's host: flags, orders, readings, care documents and claims (Section 4)
Primary care for women of all ages	Offered	The women Rosemark manages for blood pressure and diabetes are the full-service-line cohort
Care for depression and anxiety	Offered	Mood screening fits the monthly call; behavioral health integration is a named next lever
Dietitians, bone density, lab and ultrasound	In the building	The care plan tracks the scan, the lab and the weight plan between visits
Remote monitoring and monthly care management	No program at meaningful scale	Devices, monitoring, business-hours alert triage and monthly care management come from CoachCare

The gap is specific: daily readings for the women with high blood pressure or diabetes, and monthly care management for the women with two or more chronic conditions. There is no remote-care program of Rosemark's own to credit or displace. The program builds on the primary care, bone health, mental-health care and nutrition care already in the building.

2.5 The market, and the rate basis

Bonneville County had 22,909 Medicare-eligible residents in October 2026, and 38.44% were in a Medicare Advantage plan. Original Medicare stood at 14,109 of 22,850 beneficiaries in July 2026, up from 11,658 in December 2025, and 15.7% of the county's beneficiaries are dual-eligible. 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. Rosemark's own payer mix is the third thing to confirm, after the chart count and who manages each patient's chronic conditions.⁸

The office ZIP, 83404, is the oldest in the area: 17.3% of its residents are 65 or older, and adult high blood pressure (32.5%) and high cholesterol (35.2%) run above the county (29.9% and 32.8%). About a quarter of adults county-wide report depression.⁹

Idaho is a single statewide payment locality, locality 00, under the Noridian JF contractor. Every dollar in this report is priced at those CY2026 amounts.¹⁰

3. The Service Line: Remote Monitoring and Chronic Care Management

3.1 The clinical and billing stack

Two monthly programs, one enrollment conversation, one care team and one billing pipeline into Rosemark's own billing through Greenway.

⁸ CMS Medicare Advantage State/County Penetration, October 2026: Bonneville County 38.44% (8,807 of 22,909 eligibles). CMS Medicare Monthly Enrollment: Original Medicare 14,109 of 22,850 in July 2026 and 11,658 in December 2025; dual-eligible 15.7%.

⁹ American Community Survey 2020–2024, ZCTA 83404: 17.3% aged 65 or older. CDC PLACES 2025, adults, crude: ZCTA 83404 high blood pressure 32.5%, high cholesterol 35.2%; Bonneville County 29.9% and 32.8%; county depression 25.3%.

¹⁰ CY2026 Physician Fee Schedule, Noridian JF carrier 02202, Idaho locality 00: geographic indices work 1.000, practice expense 0.920, malpractice 0.473; conversion factor \$33.4009.

Program	What it does clinically	Who it fits on this panel	Net reimbursement per patient-month
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	High blood pressure with high cholesterol, diabetes, osteoporosis, depression or kidney disease	\$104.49
Remote physiologic monitoring (RPM)	Cellular cuffs, glucometers and scales send readings between visits against thresholds Rosemark's clinicians set; 99453, 99454 or 99445, 99457, 99458, 99470	High blood pressure first, then diabetes	\$90.82

Codes	What they pay for	CY2026 Idaho locality 00
99490 · 99439	Chronic care management, first 20 minutes · each additional 20	\$62.47 · \$47.52
99453	Remote monitoring setup and education, once	\$19.68
99454 · 99445	Device supply, 16+ days · 2 to 15 days in 30 (99445 new in CY2026)	\$47.79 · \$47.79
99457 · 99458	Treatment management, first 20 minutes · each additional 20	\$48.66 · \$39.14
99470	Treatment management, 10 to 19 minutes (new in CY2026)	\$24.50

How the rates apply

CY2026 non-facility amounts, Idaho locality 00 (Noridian JF, carrier 02202), ZIP 83404. One device code (99454 or 99445) and one first-tier management code (99457 or 99470) bill per patient per month, alongside chronic care management.

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.

3.2 The care team, and the hours it keeps

CoachCare hires, trains and manages the care managers, at a caseload of 165 patients each: one care manager for the 172 unique patients the program holds from month 4. An on-site enrollment specialist on CoachCare's payroll works beside Rosemark's medical assistants 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, the same hours Rosemark's office keeps. Patients are told at consent to call 911 for an emergency and Rosemark for anything urgent.

3.3 Two deployments, and why there are two

Rosemark's claims show that its Medicare patients come for gynecology, bone health and urogynecology, and many of them also see a primary care physician who may manage their blood pressure and diabetes. That is why there are two deployments. Remote monitoring can start for any eligible patient, because a Rosemark clinician can order and bill it even where another physician provides chronic care management. The full service line adds chronic care management for the women Rosemark manages itself. It is also why the chart count, and the split between those two groups, are the first two things to confirm (Section 9.4).

Deployment	What CoachCare runs	What stays as it is
Remote monitoring only	Blood-pressure and glucose monitoring for eligible Medicare patients, with home readings in the Greenway chart	Chronic care management stays with whoever provides it today
Full service line, RPM + CCM (the forecast of record)	Both programs, enrolling every eligible patient Rosemark manages into chronic care management as well as monitoring	The outside physician's care for women who have one, with routing set at enrollment

3.4 The next levers: APCM, behavioral health and principal care

Advanced primary care management (G0556 to G0558) pays a monthly amount per patient, tiered by complexity, for running a patient's whole primary care. For the women who use Rosemark as their primary care home it bills in place of chronic care management, and the same staff and workflow carry over.¹¹ Whether and when to move patients from CCM to APCM is a program decision to make together. It carries no dollars in this forecast.

Behavioral health integration (99484) is the adjacency for mood. About one in four of Rosemark's Medicare patients carries depression and about one in four anxiety, and Rosemark already treats both. Monthly behavioral health integration fits the same care-manager calls and the same chart once the program is running. It carries no dollars here.

Principal care management (99424 to 99427) covers a woman whose care at Rosemark centers on one serious condition, billing the same monthly calls against that condition alone. It carries no dollars here either.

3.5 What Rosemark keeps

- **Rosemark keeps clinical governance, the patients and the revenue.** Its clinicians set thresholds, routing and exit criteria and sign the care plans; claims go out under Rosemark's billing entity and NPIs, and in the full service line Rosemark keeps 42.7% of net reimbursement after CoachCare's fee.
- **CoachCare supplies the program.** Devices, an on-site enrollment specialist, care managers, business-hours alert triage, monthly documentation and automated claims, all priced per active patient per month. None of it is Rosemark's headcount, inventory or software.
- **The outside physician stays in the picture.** For a woman whose blood pressure or diabetes is managed elsewhere, Rosemark's monitoring adds readings without moving her care. How readings reach that physician is agreed at enrollment (Section 5.4).
- **Independence is part of the return.** A physician-owned practice since 1994 adds Medicare revenue that does not depend on another procedure or another visit, without adding staff.

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

4. Greenway: The Program Lives in the Chart

Greenway already holds the diagnoses, vitals, labs and medications the program needs. CoachCare's integration is built on Greenway's own workflows for Intergy and Prime Suite, and Greenway offers it to its practices as Greenway Care Coordination Services, so Rosemark's clinicians and staff never leave the chart. Enrollment status is visible in the existing clinical workflow, and a flagged patient begins receiving chronic care management and remote monitoring in under five days.¹² Whether Rosemark runs Intergy or Prime Suite is discovery item number four; the integration covers both.

Area of focus	What happens in Greenway
Bidirectional enrollment by services	Enrollment flags prompt the order for patients who meet criteria Rosemark's clinicians approve, at a gynecology, bone-health or urogynecology visit or on an outreach list; the clinician orders by service, the way a lab is ordered
Exchange of health history	Diagnoses, medications, vitals and labs pass to the care team at intake, and the care plan comes back
Integrated discrete vitals	Home readings land in the chart as discrete values, so the clinician sees home averages at the next visit
Escalation tasks	A confirmed out-of-range reading or trend arrives as a task for the clinician or nurse Rosemark designates, with the readings attached
Compliance documentation and integrated care summary	Evidence of care, vitals and the care plan attached monthly for every enrolled patient
Automated claim generation	Claims built for every patient, every month, once a code's requirements are met; Rosemark's billing team reconciles and files them

Integration setup is a one-time \$2,500, with no monthly or per-patient fee, confirmed in contracting. With implementation and telephonic outreach the ancillary items total \$8,361 over 24 months, inside the \$320,706 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 Rosemark never carries surveillance liability it did not agree to. Thresholds and routing are set with Rosemark's clinicians before the first patient enrolls.¹³

5.1 One shared escalation engine

Branch	The rule	Why
Critical value	Escalate to the practice, regardless of symptoms	No client preference can suppress it. A critical reading on its own goes to the office, 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

¹² CoachCare Greenway Intergy and Greenway Prime Suite integration overviews: the six areas of focus; patients begin chronic care management and remote monitoring in less than five days.

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) and program-exit 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 Rosemark office the same day. A critical reading alone, without those symptoms, goes to the office instead.

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

The floor. CoachCare's emergent policy supersedes any client escalation preference. Rosemark 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 office notified
Needs the practice	A critical reading, or an out-of-range reading or trend confirmed after a retake	The clinician or nurse Rosemark designates, in Greenway, with readings and a recommended next step
Stable or resolved	Worked, retaken and resolved	Documented as an FYI in the chart, without paging anyone

Care managers work readings and escalations Monday to Friday, 8 a.m. to 5 p.m. local patient time, the hours Rosemark's office is open. 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 Rosemark's own line or 911. Rosemark's same-day appointments give a patient flagged during the week a place to be seen.

5.4 The treating clinician, when a patient has two

When a patient also sees a primary care physician outside Rosemark, her readings still go to the clinician Rosemark designates, who ordered the monitoring and signs the care plan. Whether and how readings are shared with the outside physician is set at enrollment, patient by patient, and recorded in Greenway. A woman on Rosemark's monitoring whose chronic care management sits elsewhere keeps one escalation path, so nobody calls her twice and no reading waits for an owner.

5.5 Around surgery

Gynecologic, pelvic-floor and bladder surgery takes place at the hospitals where Rosemark's surgeons operate, and some of those women carry high blood pressure or diabetes into the operating room. Patients already on monitoring keep their readings going through recovery, so a problem shows up before the follow-up visit instead of at it. This is continuity for enrolled patients; the forecast carries no separate billing for it.

When	What the program does
Before	Home averages in the chart give the surgeon a true blood-pressure baseline at the pre-operative visit

When	What the program does
Weeks 1–4 after	Readings continue at home; pain medicines and missed doses show up in the data, and a pressure that stays high or glucose that runs high gets a call
After	Monthly remote monitoring and chronic care management pick up where they left off; bladder symptoms after pelvic-floor surgery are asked about on the monthly call

5.6 Continuity, and leaving the program

1. **Unreachable patients escalate on a fixed clock.** A monitoring patient unreachable 45 days from enrollment goes to the office; non-compliance at 90 days triggers a second escalation; chronic care management's first escalation comes at six months.
2. **There is a hard backstop.** Without an instruction from the office, discharge from monitoring proceeds at 180 days, with the office notified.
3. **Rosemark always decides.** Exit criteria, thresholds and routing belong to Rosemark's clinicians, with the single exception of the emergent floor in Section 5.2.

6. Value Analysis: The 24-Month Forecast

6.1 The headline economics

The forecast covers remote monitoring and chronic care management across a Medicare panel of 650, all of it in scope, at the CY2026 Idaho locality 00 amounts, with 14 referring clinicians and one CoachCare-funded on-site enrollment specialist at 80 enrollments a month. No APCM, behavioral health integration or principal care management is in these numbers.¹⁴

Full service line	Year 1	Year 2	24 months
Remote physiologic monitoring	\$134,537	\$147,470	\$282,008
Chronic care management	\$130,818	\$146,700	\$277,518
Net reimbursement	\$265,356	\$294,170	\$559,526
CoachCare fees, including Greenway integration and implementation	\$155,324	\$165,382	\$320,706
Net to Rosemark	\$110,031	\$128,788	\$238,819
Practice margin	41.5%	43.8%	42.7%

The margin rises from 41.5% in year one to 43.8% in year two as the one-time setup falls away and the census is full all year. Year two is the steady state: **\$294,170 of net reimbursement, \$128,788 of it kept by Rosemark.**

6.2 Two deployments, side by side

Each deployment is priced on its own, and the full service line is the forecast of record. The avoided admissions are the same in both because they come from the monitoring. The full line adds chronic care management for 117 patients, 35 of them women the monitoring does not reach, and \$119,080 more to Rosemark over 24 months.

24 months	Remote monitoring only	Full service line, RPM + CCM
Net reimbursement	\$282,008	\$559,526
Net to Rosemark after fees	\$119,739	\$238,819

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

24 months	Remote monitoring only	Full service line, RPM + CCM
Unique patients at month 24	137	172
Hospitalizations avoided	About 21	About 21

6.3 Where the revenue comes from

24 months	Net reimbursement	CoachCare fees	Net to Rosemark
Remote physiologic monitoring	\$282,008	\$167,731	\$114,276
Chronic care management	\$277,518	\$144,614	\$132,904
Implementation, Greenway integration setup, telephonic outreach		\$8,361	-\$8,361
Total	\$559,526	\$320,706	\$238,819

The two programs carry close to equal shares: remote monitoring \$282,008 on 137 enrollments and chronic care management \$277,518 on 117. Care management earns more per patient-month, \$104.49 against \$90.82, because the 99439 add-on is earned in most months; monitoring produces the readings, the alerts and the avoided admissions. The **254 active program enrollments at month 24 belong to 172 unique patients**, because most women in chronic care management also take readings. The two codes new in 2026 carry 17% of remote-monitoring gross reimbursement on this mix.¹⁵

6.4 The ramp, month by month

Month 1 nets -\$2,842, because the one-time implementation fee and the Greenway setup post against 51 enrollments. The program is positive from month 2, with \$5,719 on 136 enrollments; new enrollments peak at about 80 patients a month during the launch, and from month 5 the program holds \$10,732 a month. The first month's draw is repaid in month 2, and cumulative net to Rosemark passes \$45,637 at month 6, \$110,031 at month 12 and \$238,819 at month 24.

Month	Net reimbursement	CoachCare fees	Net to Rosemark
M1	\$5,441	\$8,284	-\$2,842
M2	\$13,919	\$8,199	\$5,719
M3	\$25,368	\$14,780	\$10,588
M4	\$24,514	\$13,807	\$10,707
M5 onward	\$24,514	\$13,782	\$10,732

¹⁵ CoachCare Value Analysis: 99445 \$44,518 and 99470 \$7,608 of \$304,462 remote-monitoring gross reimbursement over 24 months.

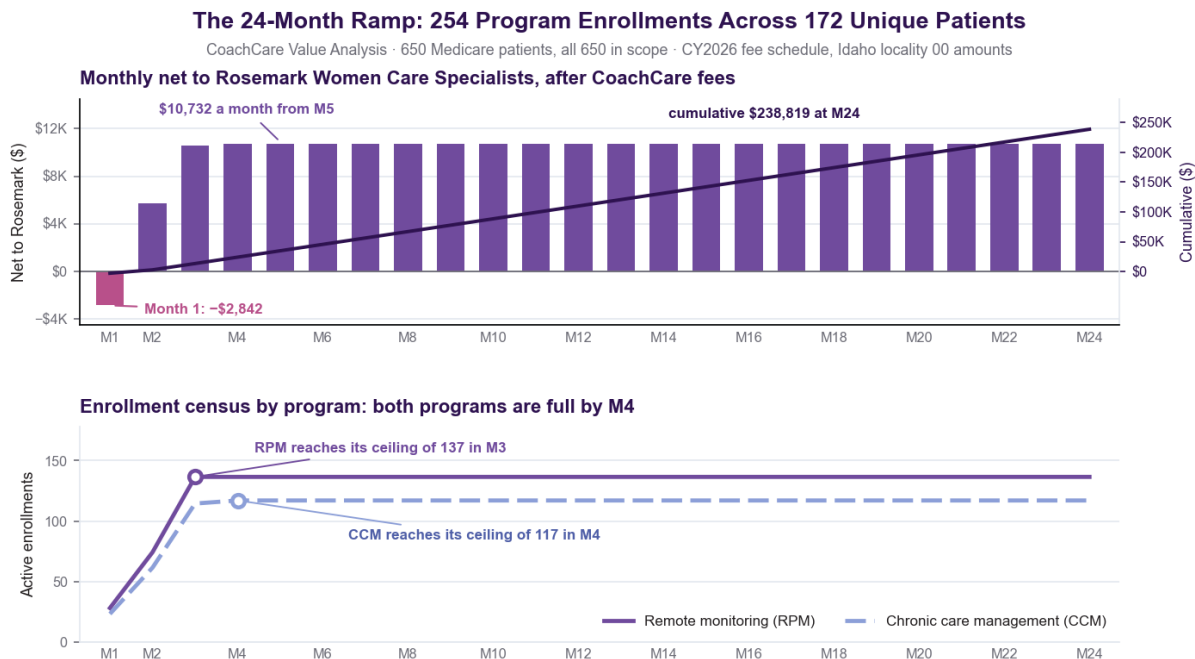


Figure 1. Monthly net to Rosemark after CoachCare fees, with cumulative net, and the enrollment census by program with the two ceiling months marked. CoachCare Value Analysis, full service line.

6.5 Ceilings, and what moves them

Program	Eligible share of the 650 in scope	Acceptance	Ceiling	Reached
Remote physiologic monitoring	60%, 390 patients	35%	137	M3
Chronic care management	60%, 390 patients	30%	117	M4

Say the constraint out loud

The binding constraint is the size of the eligible Medicare panel, not enrollment capacity. By month 4 every patient the two programs can take is enrolled. A second on-site enrollment specialist cannot raise the ceiling but reaches it sooner, with chronic care management full in month 3, and adds \$8,790 of net reimbursement over 24 months (\$568,316 against \$559,526). With no on-site specialist the forecast falls to \$535,125 and both ceilings move out to month 5.

The chart count is discovery item number one. The 650 is sized from Rosemark's own CMS claims. A chart pull by payer replaces it, and a larger chart count moves the forecast almost one for one.

What moves the answer	24-month net reimbursement	Net to Rosemark	Unique patients at M24	Ceilings reached
Base: panel 650, all in scope, 14 clinicians, one enrollment specialist	\$559,526	\$238,819	172	M3 / M4
Panel 400, all in scope	\$351,389	\$148,138	106	M3 / M3
Panel 500, all in scope	\$434,750	\$184,461	132	M3 / M3
Panel 750, all in scope	\$639,285	\$273,560	198	M4 / M4
Panel 900, all in scope	\$758,692	\$325,578	238	M4 / M4
Panel 650 with 80% in scope (520)	\$451,422	\$191,726	137	M3 / M3

What moves the answer	24-month net reimbursement	Net to Rosemark	Unique patients at M24	Ceilings reached
Panel 650 with 60% in scope (390)	\$343,053	\$144,506	103	M3 / M3

CoachCare Value Analysis sensitivity runs, one input changed at a time. Ceilings reached: remote monitoring / chronic care management.

Revenue is close to linear in the panel because both programs are ceiling-limited: from 400 to 900 patients, 24-month net to Rosemark runs from \$148,138 to \$325,578 at about the same margin. Clinician count changes timing only. With nine referring clinicians the forecast is \$551,758, and with the six physicians referring alone it is \$547,005. The panel is the lever.

6.6 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	32,604	Blood pressure, glucose and weight values arriving between visits
Claims and billable units	11,204	Created in Greenway for Rosemark's billing team
Care-management tasks	22,408	Outreach, care-plan updates and medication reviews
Patient conversations	3,361	Live contacts across 187 hours of call time
Care-team hours	4,968	About 2.4 full-time-equivalent years of work Rosemark does not employ
Hospitalizations avoided	About 21	About \$310,000 at \$15,000 per admission

CoachCare Value Analysis, 24-month totals, full service line.

Two ledgers, kept separate

Fee margin funds the program. \$238,819 to Rosemark over 24 months, paid claim by claim.

Avoided admissions and quality measures speak to the patients. About 21 admissions avoided, about \$310,000 at \$15,000 each, plus monthly work on the five MIPS measures in Section 7.¹⁶

6.7 Published results from CoachCare programs

- **Blood pressure.** Cardiac Solutions, a physician-owned cardiology practice, put 2,738 patients on CoachCare remote monitoring with home blood-pressure readings. 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.¹⁷
- **Readmissions, at the same practice.** Across 26,689 patients, the 30-day readmission rate was 7% for CoachCare patients against 15% for the rest.¹⁸
- **Heart failure.** Iowa Heart enrolled 450 advanced heart-failure patients and recorded zero readmissions over six months.¹⁹

High blood pressure is the most common condition in Rosemark's Medicare panel, and it is the condition the first result measures. The result followed the patients who kept taking readings, so the care team's monthly work is outreach and engagement, and clinician time goes to the escalations that need it.

¹⁶ CoachCare Value Analysis: 20.7 hospitalizations avoided over 24 months at the workbook's baseline admission rate, \$15,000 each.

¹⁷ Cardiac Solutions case study, April 2026: 2,738 remote-monitoring patients enrolled 12 months or more.

¹⁸ Cardiac Solutions readmissions case study: 7% against 15% across 26,689 patients.

¹⁹ Iowa Heart case study, 2026: 450 NYHA class III to IV patients over six months.

7. Quality: Five MIPS Measures the Monthly Work Moves

Medicare's Merit-based Incentive Payment System scores clinicians on quality measures, and Rosemark can report as a group. Five measures that fit a women's practice depend on work this program does every month.²⁰

Measure	What it counts	What the program does each month
Q236 Controlling high blood pressure	Hypertensive patients whose latest blood pressure is under 140/90	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
Q001 Diabetes: A1c poor control (> 9%)	Patients with diabetes whose latest A1c is above 9%; lower is better	Care management keeps A1c testing and medication changes on schedule; home glucose shows slippage before the next lab
Q039 Screening for osteoporosis, women 65–85	Women 65 to 85 screened for osteoporosis	Rosemark scans bone density in the building; the care plan tracks who is due, who is on treatment and who has missed a scan
Q048 Urinary incontinence assessment, women 65+	Women 65 and older assessed for urinary incontinence	The monthly call asks the same bladder questions every month, and a woman who needs a urogynecology visit is booked into one
Q134 Depression screening and follow-up	Patients screened, with a follow-up plan when the screen is positive	PHQ-2 and PHQ-9 in monthly care management; positives routed to the Rosemark clinician

With high blood pressure in about 60% of Rosemark's Medicare patients and diabetes in a quarter, Q236 and Q001 cover most of the women the program enrolls. Q039 and Q048 track care Rosemark already gives in its own building, and the monthly call turns that care into documentation.

8. 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 Idaho locality 00 on Rosemark's own billing mix, with enrollment held constant.²¹

²⁰ CMS Quality Payment Program eligibility, 2026: the practice is eligible to report MIPS as a group. Quality measures 001, 039, 048, 134 and 236.

²¹ CMS-1848-P, published July 2026. CoachCare repricing at Idaho locality 00, conversion factor \$32.8409 against \$33.4009: device supply 31.8% of the remote monitoring basket; remote monitoring 50.4% of the line.

The CY2027 Proposed Rule, Repriced on This Forecast: Three Numbers, One Scale

Every code repriced at Idaho locality 00 on Rosemark's own billing mix; enrollment held constant. Device supply is 32% of the remote-monitoring basket; remote monitoring is 50% of the line.

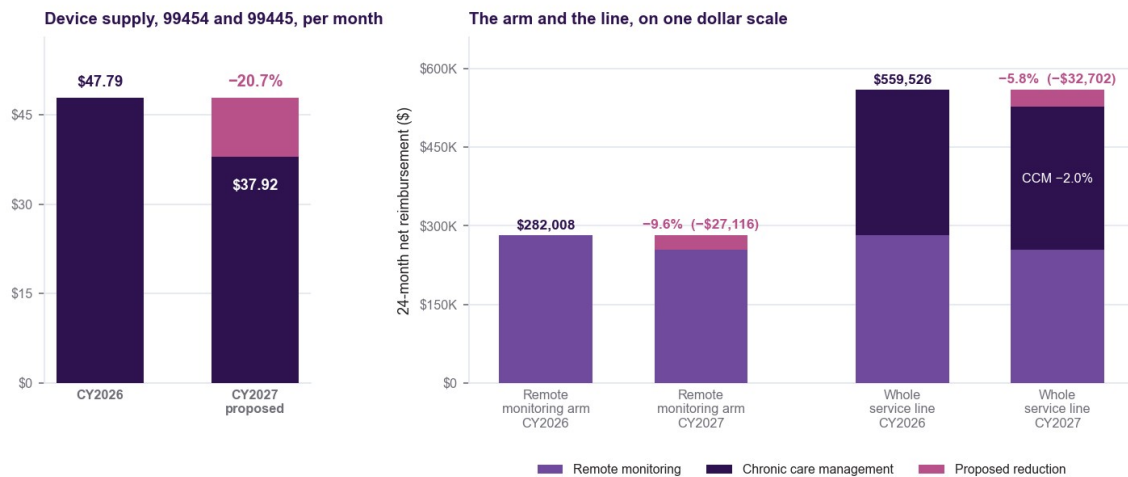


Figure 2. The CY2027 cascade on this forecast: the one code CMS proposes to cut, then the remote-monitoring arm and the whole service line on one dollar scale, with the proposed reduction in rose. CoachCare repricing at the proposed CY2027 amounts.

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
Device supply, 99454 and 99445	\$47.79 a month	\$37.92 a month, -20.7%	The code CMS proposes to cut
The remote monitoring arm	\$282,008 over 24 months	-9.6%, -\$27,116	Device supply is 32% of the remote monitoring basket
Chronic care management	\$277,518 over 24 months	-2.0%, -\$5,586	Routine rate changes only; not targeted
The whole service line	\$559,526 over 24 months	-5.8%, -\$32,702, to \$526,824	Remote monitoring is 50% of the line

Each number is smaller than the last only because its base is larger: this line rests on two programs of almost equal size, and only one holds the code being repriced. CoachCare will rerun the forecast at the final rates. Two contingencies are already in build: an unbundled arrangement, with the software platform, device logistics and program enablement priced separately, and one in which CoachCare manages the staffing while Rosemark owns the clinical program and the billing.

9. Implementation Roadmap

9.1 Who runs what

Function	CoachCare	Rosemark Women Care Specialists
Identification and enrollment	Registry query in Greenway starting with the high blood pressure, diabetes, kidney and osteoporosis patients; an on-site enrollment specialist at 80 enrollments a month; telephonic outreach; devices shipped, cellular-paired and replaced	Approves the criteria and target list; clinicians order at the gynecology, bone-health, urogynecology or primary care visit
Shared primary care	Routing to an outside physician recorded at enrollment, patient by patient	Decides which women enter the full service line and which take monitoring only
Monitoring and escalation	Reading review, monthly outreach and business-hours alert triage, at 165 patients per care manager	Sets thresholds and routing; receives escalations

Function	CoachCare	Rosemark Women Care Specialists
Documentation, billing, reporting	Monthly care documents in Greenway, claims created automatically, operational and clinical outcomes reports	Reconciles and files under its own NPIs; keeps the revenue; names a program lead

9.2 The model inputs

Input	Value in this forecast
Medicare panel	650 patients, all in scope; traditional Medicare and Medicare Advantage
Referring clinicians	14: six physicians, two certified nurse-midwives, three nurse practitioners, three physician assistants
Programs	Remote monitoring and chronic care management; APCM, behavioral health integration and principal care management at zero dollars
Eligibility and acceptance	Eligibility set from Rosemark's own CY2024 claims profile: remote monitoring 60% eligible, 35% accept; chronic care management 60%, 30%; 8 referrals per clinician a month at 80% acceptance; 70% of chronic care management patients also on monitoring; 1.5% monthly attrition
Enrollment staffing	One CoachCare-funded on-site enrollment specialist at 80 a month, plus telephonic outreach
EMR	Greenway: \$2,500 one-time setup, no monthly or per-patient fee
Rates	CY2026 fee schedule, non-facility, Idaho locality 00, ZIP 83404; every patient priced at the Medicare amount

9.3 The first 90 days, and after

Window	What happens	Result
Weeks 0–6 Integrate and charter	Greenway workshop with the practice and billing leads; Medicare chart count by payer; the women Rosemark manages for chronic conditions separated from those with an outside physician; thresholds and routing agreed	Integration live, protocol signed, starting deployment chosen
Weeks 6–12 Launch	The enrollment specialist working the clinic schedule; remote monitoring for high blood pressure and diabetes, care management for two-plus conditions	51 enrollments in month 1, 136 by month 2, 251 by month 3
Months 3–4 Fill to the ceiling	Remote monitoring reaches 137 in month 3 and chronic care management 117 in month 4	254 enrollments, 172 unique patients
Months 5–24 Widen the definition	Eligibility re-checked against chart data; the APCM mix decided together; behavioral health integration and principal care management scoped; documentation aligned with the five MIPS measures	Year 2: \$128,788 to Rosemark at 43.8%

Remote monitoring and chronic care management carry Part B coinsurance, so the consent conversation explains the monthly cost plainly.

9.4 What we would confirm together

- 1. The Medicare chart count, by payer.** Traditional Medicare against each Medicare Advantage plan, and how many women carry high blood pressure, diabetes or two or more chronic conditions. Every ceiling in Section 6 moves with it.
- 2. Which women Rosemark manages for blood pressure, diabetes and mood.** And which see an outside primary care physician for them. The first group can take the full service line; the second can take remote monitoring.

3. **The payer and Medicare Advantage 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. Bonneville County runs at 38.44%.
4. **The Greenway product and version.** Intergy or Prime Suite, the version, and any care-management or device module already licensed.
5. **Any care management billed today in small numbers.** CMS does not publish lines under 11 beneficiaries, so a small program would not show in the public files.
6. **Coinsurance at consent.** How the monthly Part B coinsurance is explained to each woman before she enrolls.

10. Recommendations

1. **Launch the full service line for the women Rosemark manages, with remote monitoring for every eligible patient.** \$238,819 to Rosemark over 24 months at a 42.7% margin, positive from month 2, with nobody hired.
2. **Pull the Medicare chart count by payer in week one.** The eligible panel is the binding constraint, and the registry sets the number.
3. **Map who manages each woman's blood pressure, diabetes and mood.** That split decides which deployment each patient enters.
4. **Start with high blood pressure.** A cellular cuff for the readings, care management for the plan, and the gynecology or bone-health visit as the enrollment conversation.
5. **Use the building.** Same-day slots for flagged patients, bone density and lab results on the care plan, and the dietitians working from home weight and blood pressure.
6. **Aim the monthly work at the five MIPS measures.** Blood pressure, A1c, osteoporosis screening, incontinence assessment and depression screening all move with the monthly call.
7. **Hold APCM as the next lever, and scope behavioral health integration and principal care management once running.** All three run on the same care team and the same chart.
8. **Keep clinical governance where it is.** Rosemark's clinicians decide; CoachCare does the work and documents it.

The Medicare women Rosemark already sees support a \$559,526 service line at a 42.7% practice margin over 24 months, on staff Rosemark does not hire and devices it does not buy. What remains is to build it once, with a partner, and run it as Rosemark's own.

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 care Rosemark already gives.** Rosemark already offers primary care, bone health, mental-health care and dietitians for women of all ages. Remote monitoring and monthly care management put that care on a schedule between visits, for the Medicare women who qualify.
- **It runs inside the Greenway chart Rosemark already uses.** Built on Greenway's own workflows. Readings, documentation and claims live in the chart, and enrollment status is visible to every clinician in the building.

- **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.** Rosemark's physicians and advanced practice clinicians set the protocols, sign the care plans and make every clinical decision.
- **Independent, with a new revenue line.** A physician-owned practice since 1994 adds Medicare revenue at a 42.7% margin over 24 months, without adding staff.
- **Published results.** A 29.1 mmHg drop in Stage 2 hypertension across 2,738 patients at Cardiac Solutions, half the 30-day readmission rate at the same practice, and zero readmissions among 450 advanced heart-failure patients at Iowa Heart.

The ask is a working session to confirm Rosemark's Medicare chart count by payer, map which of those patients Rosemark manages for blood pressure, diabetes and mood and which see an outside primary care physician, scope the Greenway integration, and choose the starting deployment before the first enrollment.

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Prepared by CoachCare for discussion with Rosemark Women Care Specialists. © 2026 CoachCare.

References & Data Sources

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- **CMS claims and quality files:** Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024; CMS Provider Data, PY2024 Group Public Reporting, MIPS measures; Quality Payment Program eligibility, 2026.
- **Medicare payment rules:** the CY2026 Physician Fee Schedule final rule, Addendum B, RVU file and Idaho locality 00 geographic indices; CMS-1848-P, the CY2027 proposed rule.
- **Market:** CMS Medicare Advantage State/County Penetration, October 2026; CMS Medicare Monthly Enrollment, July 2026; American Community Survey 2020–2024; CDC PLACES 2025.
- **CoachCare:** Greenway Intergy and Greenway Prime Suite integration overviews; Care Management Programs standard operating procedures, March 2026; Cardiac Solutions and Iowa Heart case studies; and the Value Analysis for Rosemark Women Care Specialists, 2026, the source of every financial, enrollment, clinical-output and operational figure in Sections 6 to 10.

Unique patients and program enrollments are different numbers. At month 24 the program holds 254 active program enrollments belonging to 172 unique patients, because a patient may hold both a care-management and a monitoring enrollment. The 650-patient panel counts traditional Medicare and Medicare Advantage; the 662 beneficiary-clinician pairs in the CY2024 claims are fee-for-service only and count a patient once per clinician seen.