Closing the Capture-Rate Gap:

Making Remote Patient Monitoring Work in Rural Communities

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THE ROADMAP

Agenda

01	**The Hidden Metric**	What capture rate is, and why most dashboards never show it
02	**Why Rural Is Harder**	Distance, dead zones, and the numbers behind them
03	**Where We Sit in the Funnel**	What we run, what our clients run, and the handoff between
04	**How a Payer Sees It**	The number a health plan uses to decide renewal · Pramod Gaur, PhD
05	**Three Fixes That Move the Number**	Referrals, enrollment, and the first fourteen days
06	**What We Learned**	Lessons from three telehealth companies and one payer · Pramod Gaur, PhD
07	**What Changed This Year**	New billing codes, new rural funding, and what ten points is worth

First, two programs that show it done right: TIPS in Westchester and STATS at Shinnecock.

Then the seven sections above, with time for your questions after each section, and at the end.

About Us

Christopher Gaur

CO-FOUNDER AND MANAGING PARTNER, VCS

- Has run remote monitoring and community health programs in eight states, currently active in New York, New Jersey and Michigan
- Health systems, county aging services, and a community health partnership with the Shinnecock Indian Nation since 2015
- Executive MBA, Active New York State licensed EMT Volunteer, NASM Certified Personal Trainer
- Co-founded his first company as a freshman at Pace University. It is still operating

Pramod Gaur, PhD

BOARD ADVISOR, VCS

- Coordinated telehealth at the enterprise level for UnitedHealth Group
- Founding President and CEO of two telehealth companies, Viterion and Healthanywhere
- Twenty years in management at Bayer Healthcare, Baxter International and Eli Lilly
- American Telemedicine Association Class of Fellows, 2013. Adjunct professor, Pace University
- Has presented on digital health to the US Congress, the White House Conference on Aging, and delegates at the United Nations

TIPS · WESTCHESTER COUNTY, SINCE 2014

Three levels, one program

LEVEL 1 · HEALTH FAIRS

- Screenings at senior events and cultural fairs
- Blood pressure, pulse, oxygen and weight on the spot
- Finds the people who do not know their numbers

LEVEL 2 · WEEKLY VISITS

- Student technicians at senior centers, housing and houses of worship
- A nurse reviews every reading and calls on high-risk results within 24 hours
- Everyone leaves with a TIPS Sheet explaining their numbers

LEVEL 3 · DAILY AT HOME

- A home kit for people who need more than weekly checks
- 95 participants referred up from the weekly sites
- Same nurses, now with daily readings

With the Westchester Public/Private Partnership for Aging Services: 1,760 enrolled in New York through 2023, across 14 sites. A published study found self-reported hospital visits fell 28.9%, and 50% among Medicare participants.

5:00

TIPS in five minutes

TIPS trailer · youtu.be/Dy-ExBl-PnM

WHO PAYS FOR IT?

Each level has a different payer

1

Level 1 is paid for by the community

Grants, county aging budgets, hospital community benefit, and now Rural Health Transformation integration dollars. There is no claim to file. Its job is to find people: stages 1 and 2 of the funnel.

2

Level 2 is where the relationship gets built

In TIPS it has been funded by the county and foundations. This is where people get referred and say yes, stages 3 and 4. A Guidehouse analysis of TIPS pointed to health plans and ACOs as its natural funders.

3

Level 3 is where Medicare pays

Daily readings at home are billable remote patient monitoring: setup, device, and clinical time. This is stages 5 through 7, and where capture rate decides whether the whole model pays for itself.

WHAT WE LEARNED AT SHINNECOCK · Senior Total Population Assisted Telehealth Services (STATS)

Start where the community already gathers

STATS was a federally funded telehealth demonstration with the Shinnecock Indian Nation. The Nation set the priorities, a tribal member led it, and tribal members ran the screenings. It was the Nation's program. We brought the technology and operations. Dominican Sisters Family Health Service brought the nurses.

351

people screened at the Shinnecock Pow Wow, where the program launched. Community health events kept the door open after that.

79

enrolled in weekly monitoring at the Senior Center, three churches, and through home visits. About 790 encounters in six months, roughly double the goal.

WHAT WE LEARNED

- Trust came from the Nation, not from us. The liaison opened every door
- A screening at a gathering finds people a clinic never sees
- Weekly visits turned a one-time reading into a relationship
- Once the Clinic and Southampton Hospital saw the data, they joined. The doctor wrote to patients asking them to enroll

A federal grant paid for it. Grants build reach, but they end. The partnership with the Nation is now in its second decade.

Shinnecock Indian Nation STATS Program Report, August 2015 to January 2016, and STATS Program Summary. Funded by an HHS Office of the National Coordinator innovation challenge grant. Partners: Vital Care Services, Dominican Sisters Family Health Service, Stony Brook University.

01

The Hidden Metric

What capture rate is, and why your dashboard hides it.

ADHERENCE VS CAPTURE RATE · LEVELS 1 TO 3

Two questions to ask at every level

LEVEL 1 · HEALTH FAIRS

THE USUAL QUESTION

How many people did we screen?

CAPTURE RATE ASKS

Of the people in our community who needed a screening, how many did we reach?

LEVEL 2 · WEEKLY VISITS

THE USUAL QUESTION

How many people come every week?

CAPTURE RATE ASKS

Of everyone screened with a high reading, how many joined weekly visits?

LEVEL 3 · DAILY AT HOME

THE USUAL QUESTION

Adherence: of the patients who made it in, how many are transmitting?

CAPTURE RATE ASKS

Of the patients who needed home monitoring, how many are monitored and billed?

The usual question counts the people who made it in. Capture rate counts the ones you missed. A vendor dashboard will often show you the first. It almost never shows you the second.

THE PROCESS · LEVELS 1 TO 3

Seven stages across three levels

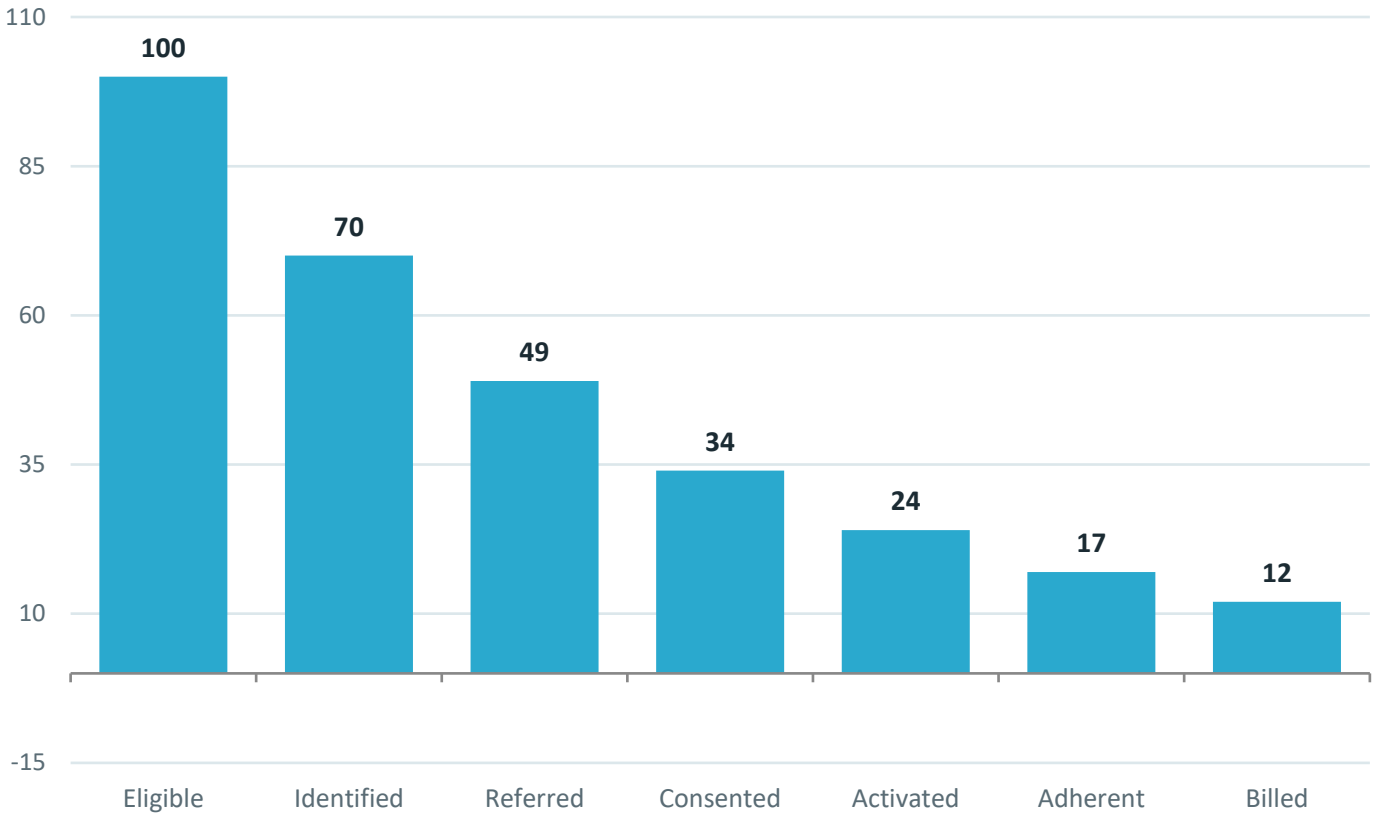
1	**Eligible**	Panel patients meeting clinical criteria and coverage	LEVEL 1 · HEALTH FAIRS
2	**Identified**	Surfaced by a registry, report, or EHR flag	LEVEL 1 · HEALTH FAIRS
3	**Referred**	Order placed or referral accepted by the program	LEVEL 2 · WEEKLY VISITS
4	**Consented**	Patient agreed and consent is documented	LEVEL 2 · WEEKLY VISITS
5	**Activated**	Device in hand and first transmission received	LEVEL 3 · DAILY AT HOME
6	**Adherent**	Enough transmission days to bill: 2 to 15, or 16 and up	LEVEL 3 · DAILY AT HOME
7	**Billed**	Claim submitted and paid, not just billable	LEVEL 3 · DAILY AT HOME

Count the same group moving forward, across all three levels. Counting each stage on its own hides the compounding, which is the whole effect.

Stage 6 changed in 2026. A patient with 2 to 15 transmission days is now billable under CPT 99445, where previously only 16 or more days counted.

ILLUSTRATIVE MODEL

Where the losses compound



THE TRAP

Every stage here is running at 70 percent. Managers could call that acceptable.

Six of them in a row produce a program that reaches one patient in eight.

This is why capture-rate problems survive quarterly reviews. Rarely does someone own the compounding, because rarely does someone own more than one stage.

02

Why Rural Is Harder

The same seven stages, with geography pulling on every one of them.

BY THE NUMBERS

Rural programs are already behind

2 to 240

RPM claims per 100,000 Medicare beneficiaries, 2018 to 2020. The category grew fast.

7.85

Monthly RPM users per 100,000 by which urban growth outran rural after March 2020.

73.6%

Average adherence in a year-long heart failure telemonitoring program, falling 1.4% a month.

One finding worth carrying into a rural senior population

In that same heart failure study, older patients were more adherent than younger ones, and stayed that way over twelve months. Age is not the adherence problem. **Onboarding and connectivity are.**

Mahashabde et al., Telemedicine and e-Health, November 2025 (Medicare fee-for-service claims, 2018 to 2020). Ware et al., JMIR mHealth and uHealth, 2019. Full citations on the last slide.

DEAD ZONES · STAGE 5

No signal, no patient

A cellular device that cannot find a tower is not a slow start. It is a patient who consented, received equipment, and never produced a single transmission. On paper they enrolled. In the funnel they are gone.

11,430

North Country households still unserved by high-speed internet. That is about one in five of the 53,005 unserved locations left in the whole state.

~9,000

of those are slated for satellite service rather than fiber or fixed wireless. Satellite works. It works less predictably under tree canopy and in weather.

WHAT TO DO

- Test signal at the address before the kit ships, not after
- Know your carrier's coverage, not the coverage map
- Have a store-and-forward or wifi fallback ready before you need it
- Ask whether the vendor will swap carriers on a per-patient basis. Most will not, and you need to know that before you sign

The Adirondack Park Agency requires new towers to meet a substantial invisibility standard.

Adirondack Explorer, July 2026, reporting New York ConnectALL deployment figures. NYS Adirondack Park Agency, Towers Policy, updated February 2026.

03

Where We Sit in the Funnel

We do not bill. Our clients do. Here is what we hand them so they can.

THE SYNERGY

Strategic Partnership: Billable is our job. Billing is theirs.

WHAT VCS RUNS

- Device setup and first transmission
- Daily monitoring and outreach
- Management time and live contacts, logged
- Escalation to the patient's care team

WHAT OUR CLIENTS RUN

- The order and the enrollment decision
- Clinical review and sign-off
- Claim submission
- Payment, denials and appeals

Stage 7 lives in our clients' claims, not in our system.

WHAT WE HAND OVER · STAGE 6 TO 7

The record that turns adherent into billed

A claim is only as good as the documentation behind it. For every monitored patient, every month, the billing team needs four things, and it needs them before the billing cycle closes.

Transmission days per patient, per 30-day period

Decides which monthly device code applies: 99454 at 16 or more days, 99445 at 2 to 15.

Management minutes, with the live contact logged

99470 starts at 10 minutes, 99457 at 20. Both need an interactive contact on record.

Vitals reports and alert history

The clinical record the ordering provider reviews and signs.

Device activation date and daily usage

Supports the 99453 setup claim, and flags the patient who goes quiet.

04

How a Payer Sees It

The number a health plan uses to decide whether your program continues.

Presented by Pramod Gaur, PhD

THE PAYER'S MATH

A plan is not reading your clinical results first

WHAT YOU REPORT

- Adherence rate
- Patient satisfaction
- Clinical outcomes
- Readmission reduction

WHAT THE PLAN CALCULATES

- Cost per enrolled member
- Utilization avoided
- Members reached against members eligible
- Program cost against the delta

Both columns matter. Only one of them decides whether the contract is renewed, and it is not the one most programs build their reporting around.

05

Three Fixes That Move the Number

Where to spend the next ninety days.

FIX 1 · REFERRAL DESIGN · STAGE 2 TO 3

A Proactive Approach to the Referral Process

Referral volume that depends on clinic-day recall will always track provider workload, never patient need. Consider replacing the ask with a query.

Run a standing registry query against your eligibility criteria

Monthly at minimum. Weekly if your electronic health record will schedule it.

Route the output to one named person who owns outreach

Not a team. One person, by name, with the list in their hands.

Opt-out beats opt-in for eligible patients

Same clinical criteria, different default. The patient can still say no.

Measure referrals generated per registry run, not per provider

Per-provider counts measure your providers. Per-run counts measure your process.

FIX 2 · ENROLLMENT FRICTION · STAGE 4 TO 5

Close the gap between yes and first transmission

Consent and activation get treated as one event and they are not. The days between them are where rural programs bleed hardest.

Target under seven days from consent to first transmission

Pick a number, publish it, and report against it monthly.

Somebody present the first time the device is used

In person, on video, or on the phone. Not a printed card in the box.

Signal-check the address before the kit ships

Five minutes of work that prevents a four-week failure.

Track the 90th percentile, not the median

The median looks fine in every program that has this problem. The tail is the problem.

FIX 3 · EARLY ADHERENCE · STAGE 5 TO 6

Own the first fourteen days

Early adherence predicts late adherence. Patients who get into a rhythm in month one usually hold it. Patients who do not, mostly never do, and almost no program flags them in time.

Automatic trigger at 48 hours of no transmission

A rule in the platform, not a person remembering to look.

Live call on day three, from the person who did the setup

Familiar voice, familiar number. This is the highest-yield call in the program.

Second call on day seven regardless of adherence

Yes, even the ones who are doing fine. It is cheap and it holds the rhythm.

Escalate at day ten, do not wait for the month to close

By the time the month closes you are reporting the loss, not preventing it.

Early-adherence evidence: Vhaduri et al., PervasiveHealth 2019, and Ware et al., JMIR mHealth and uHealth, 2019. See last slide.

06

What We Learned

Three telehealth companies, one payer, and the lessons we learned.

Presented by Pramod Gaur, PhD

WHAT WE LEARNED

Three Companies, One Payer, and Lessons Learned

X

We built for the patient who wanted the technology

That patient was never the problem. The program only pays off on the patient who did not want it, and every design decision optimized for the wrong person.

X

We treated enrollment as a marketing problem

It is an operations problem. No amount of patient education fixes a seven-week gap between consent and a working device.

X

We measured what the platform could report

Not what the program needed to know. If your metric exists because the software emits it, you are being led by your vendor's engineering backlog.

07

What Changed This Year

Two new billing codes, and $212 million of rural health money already appropriated for New York.

EFFECTIVE JANUARY 1, 2026

Two codes that changed the rural math

99445

Pays for the device in a month when the patient sent readings on only 2 to 15 days

Mutually exclusive with 99454 in the same period. Roughly $47 nationally.

99470

Pays for the first 10 minutes of a clinician's time, with one live conversation

Half the 20 minutes 99457 requires. Roughly $26 nationally.

Until this year, a patient who transmitted nine days and received twelve minutes of management time was worth nothing. In a rural panel that patient is not an edge case. If your billing configuration has not been touched since January, you are writing off revenue that is now payable, and your capture rate is understated on paper as well as in practice.

TWO THINGS PEOPLE MISS

- The setup code 99453 now needs only 2 days of data, not 16
- RPM is not a Medicare telehealth service. The originating-site and geographic rules never applied to it, and the telehealth extension through December 31, 2027 is a separate question

CY2026 Medicare Physician Fee Schedule final rule, published November 5, 2025. Figures are national non-facility averages and vary by locality. Verify your own rates in the CMS Physician Fee Schedule Look-Up Tool before quoting them.

NEW YORK, FIRST-YEAR AWARD

The money is already allocated. The question is who is ready to use it.

$212M

to New York for year one of the federal Rural Health Transformation Program. Five years, $50 billion nationally, running through 2030.

90 awards

to 56 organizations were announced on September 4, less than four weeks before this summit. If you were not one of them, this is year one of five.

$79.5M	Technology innovation and cybersecurity, including telehealth access
$77.2M	Rural Community Health Integration, the care-coordination line
$30M	Technology-enhanced primary care, analytics and operations
$13M	Rural Roots, workforce recruitment and EMS training

A monitoring program does not have its own line in this award. It sits inside the technology line and the integration line, and both are written around partnerships rather than vendors. That favors anyone in this room over a national RPM company with no local presence.

Office of Governor Hochul and CMS, September 4, 2026. NYS Department of Health, December 30, 2025. Initiative totals as published; the balance of the award covers program administration.

Connect With Us

We’d love to help

Building a Rural Health Transformation partnership and need a monitoring partner? Please contact us.

We can help evaluate your current and prospective future programs. We’d love to explore helping you implement metric driven programs that help enhance patient care and access.

Email: Chris@myvics.com

or scan to start the email

Questions

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- CMS Physician Fee Schedule Look-Up Tool, for locality-adjusted rates.
- Consolidated Appropriations Act, 2026 (H.R. 7148), signed February 3, 2026. Extends Medicare telehealth flexibilities through December 31, 2027.

RURAL HEALTH FUNDING

- Office of Governor Kathy Hochul, $76 million for rural health care, September 4, 2026.
- CMS, Rural Health Transformation Program New York award announcement, September 2026.
- New York State Department of Health, first-year federal funding announcement, December 30, 2025.

UTILIZATION, ADHERENCE AND CONNECTIVITY

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