COACHCARE | SERVICE LINE STRATEGY

Community Health Care Systems

Community Health Care Systems, Inc. · a Section 330 federally qualified health center serving 20,188 patients through 24 service-delivery sites across 14 middle-Georgia counties, from Wrightsville and the Sandersville specialty hub

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line — remote physiologic monitoring, chronic care management and advanced primary care management — for the Medicare panel underneath a hypertension registry of 7,732 patients, billed under the CY2026 rules that pay health centers for those codes separately from the PPS visit

Purpose of this document

Prepared by CoachCare, August 2026, as a discussion document for the leadership of Community Health Care Systems. It brings together the health center's published clinical quality record, the shape of its Medicare panel, the CY2026 rules governing how health centers bill care management, the accountable-care position it entered in 2024, the market its patients sit in, and a 24-month financial forecast.

The argument is short. Hypertension control here has climbed nineteen points in four years and now runs above the national health-center average. Gains of that size come from better visits. The points after them are won in the weeks between visits — and since January 1, 2026, Medicare pays a health center for that work code by code.

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Executive Summary

Community Health Care Systems is a HRSA Section 330 federally qualified health center, established in 1993, operating 24 active service-delivery sites across 14 middle-Georgia counties — clinic, school-based and mobile — from its Wrightsville headquarters and its Sandersville administration and specialty hub. It is Joint Commission accredited, an active 340B covered entity recertified in February 2026, and carries five 2026 Community Health Quality Recognition badges, among them National Quality Leader for Diabetes Health. CY2025 Uniform Data System reporting counts **20,188 patients**.[1]

The panel this report is about is the Medicare one. CY2025 UDS counts **5,299 Medicare-primary patients** — 26.25% of the whole panel, and a line that has held between 5,155 and 5,299 for three straight reporting years while the panel ages into it: patients 65 and over went from 16.7% in 2021 to 23.2% in 2025. Inside that Medicare line sits the number that shapes the economics of everything that follows: **2,099 of the 5,299 — 39.6% — are dually eligible** for Medicare and Medicaid.[2]

This is a health center that performs. CY2025 UDS quality places it in the **first national quartile on aspirin or antiplatelet therapy for ischemic vascular disease, on depression screening with follow-up, and on BMI screening with follow-up**. Blood-pressure control stands at 73.27% against a 69.08% national health-center average, up from 54.10% in 2021. Diabetes control also beats the national average: 25.30% of diabetic patients carry poor HbA1c control against 26.28% nationally, down from 34.02% four years ago. The registries behind those rates hold **7,732 hypertension patients and 4,063 diabetes patients**.[3]

The observation this report is built on

A nineteen-point climb in blood-pressure control came from better visits. The next points come from between them.

Past the national average, the marginal point stops coming from the exam room, because the disease is decided in the ninety days between appointments — whether the medication gets taken, whether anyone sees the reading that says a dose is wrong, whether the titration happens this month or at the next visit. One flagship measure already sits in the bottom national quartile for exactly that reason: colorectal cancer screening, at 35.82%, which runs on between-visit outreach rather than exam-room care. Since January 1, 2026, Medicare pays a health center for between-visit work code by code.

The reason to act now is a billing change that has already happened. Health centers billed care coordination through one bundled code, G0511, until CMS retired it. In its place a health center reports the individual codes for chronic care management, remote physiologic monitoring, advanced primary care management and the related families, paid at the **physician fee schedule amount, in addition to the PPS visit payment** when both occur. CMS states the rule directly in its health-center billing booklet, March 2026 edition.[4] Code-level care-management billing is now the health center's job whether or not it starts anything new. The open question is who carries that work.

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[1] HRSA Health Center Program: Uniform Data System awardee profile, grant H80CS00507, CY2025 (retrieved August 2026): 20,188 patients; total cost $23.58 million; 2026 Community Health Quality Recognition badges for National Quality Leader – Diabetes Health, Advancing Health Information Technology for Quality, High Value Care, Preventive Health and Patient-Centered Medical Home. HRSA Health Center Service Delivery and Look-Alike Sites file: 24 active service-delivery sites across 14 Georgia counties. HRSA 340B Office of Pharmacy Affairs Information System: active covered entity, last recertified February 16, 2026.

[2] HRSA Uniform Data System, CY2021–CY2025: Medicare-primary patients 5,783 (2021), 5,155 (2023), 5,299 (2025), equal to 26.25% of the CY2025 panel; dually eligible 2,099, reported within the Medicare line, equal to 39.6% of it; patients 65 and over 4,290 (16.7%) in 2021 to 4,687 (23.2%) in 2025. UDS counts each patient once by primary coverage.

[3] HRSA Uniform Data System, CY2025 clinical quality with HRSA adjusted quartile rankings (quartile 1 is the best-performing quartile nationally): aspirin or antiplatelet therapy for ischemic vascular disease 90.56%, depression screening with follow-up 89.83%, and BMI screening with follow-up 87.50%, all first quartile; controlling high blood pressure 73.27% against a 69.08% national health-center average, second quartile; diabetes HbA1c poor control 25.30% against 26.28% nationally, lower being better. Chronic-condition registries: 7,732 hypertension (48.35% of patients), 4,063 diabetes (27.26%).

[4] CMS MLN006397, Federally Qualified Health Center booklet, March 2026 edition: care-coordination services including TCM, CCM, APCM (G0556–G0558), BHI, PCM, remote physiologic monitoring and RTM are paid at the physician fee schedule rate, alone or with other payable services; no face-to-face visit is required; auxiliary personnel furnish under general supervision.

Today nothing is running on the rail. Every clinician enrolled under the organization was queried against the remote monitoring, chronic care management, principal care management, advanced primary care management and transitional care management code families in the CY2024 Medicare Part B claims file. The supportable reading, stated precisely, is that there is **no Medicare remote-care program at meaningful scale visible in CY2024 claims**. Section 3.3 sets out what the file can and cannot show.[5]

What the Value Analysis returns

	Year 1	Year 2	24 months
Net reimbursement	**$776,302**	**$1,946,667**	**$2,722,969**
CoachCare fees	$458,006	$1,103,350	$1,561,356
Net to the health center	**$318,296**	**$843,317**	**$1,161,613**
Margin to the health center	41.00%	43.32%	**42.66%**

CoachCare Value Analysis, CY2026 Medicare physician fee schedule at MAC locality 10212/99 (Rest of Georgia), 5,299 Medicare-primary patients (CY2025 UDS), RPM + CCM + APCM.

1. **The service line pays for itself from its second month.** Month 1 nets −$5,070, because implementation and the eClinicalWorks integration setup land in that month against a census still building. The first positive month is M2, at $4,295, and the program is still climbing at M24, when it returns $79,691 for the month.
2. **Nobody is hired.** CoachCare delivers 18,521 hours of care-management labor over 24 months — about 8.9 full-time equivalents — including an on-site enrollment specialist carried at CoachCare's expense. The health center is recruiting physicians and a nurse practitioner; this program adds care capacity without competing for either hire.
3. **The dual-eligible mix makes APCM worth more here than almost anywhere.** 39.6% of the Medicare panel is dually eligible. Dual status maps those patients to the highest advanced primary care management tier, G0558, and Qualified Medicare Beneficiary protections remove the coinsurance conversation for that slice. The enrollment and engagement labor that earns those payments is CoachCare's.
4. **The binding constraint is enrollment throughput, not the size of the panel.** Advanced primary care management reaches its ceiling of 556.5 in month 9 and chronic care management its 636.0 in month 18. Remote monitoring is still enrolling at month 24 — 952.8 against a ceiling of 1,205.4. Run the same panel at 5,500 patients and the 24-month number moves 1.4%; add a second enrollment specialist and it moves 22.4%.
5. **The ACO position compounds it.** Since January 1, 2024 the health center has participated in the Medicare Shared Savings Program through ACME Health Partners ACO, an all-health-center ACO of seven participants on the ENHANCED two-sided track, and it holds that ACO's board chair and executive seat. The ACO earned $941,298.81 in shared savings for PY2024, four-fifths of it distributed to participants.
6. **Traditional Medicare is the rail this forecast bills.** Georgia Medicaid does not reimburse remote patient monitoring under fee-for-service, so no Medicaid revenue appears in this document. Across the footprint, 62.4% of Medicare beneficiaries are in Medicare Advantage plans as of the May 2026 enrollment file; MA plans must pay a health center at least 100% of the Medicare rate for covered services, a floor, with each contract setting its own terms for the care-management code families.

[5] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024, queried per National Provider Identifier across every clinician reassigning to the organization's PAC identifier. Section 3.3 lists the code families and the two structural limits on what the nulls can show.

1. The Health Center, and the Panel Underneath It

1.1 The footprint

Community Health Care Systems has been a Section 330 grantee since 1993 and now runs 24 active service-delivery sites across Baldwin, Bibb, Glascock, Hancock, Jefferson, Johnson, Jones, Laurens, Taliaferro, Telfair, Twiggs, Warren, Washington and Wilkinson counties. The mix is unusual for an organization this size: clinic sites, six school-based wellness centers, two mobile units, a dental clinic and a retail pharmacy. Total cost of care in CY2025 was $23.58 million, and cost per patient has risen 66% in four years against a panel that is flat. That last fact is the finance case in one line — a health center absorbing 66% cost growth on a flat panel needs revenue lines that are additive to the PPS structure rather than inside it.[6]

The footprint in numbers	CY2025	What it means for this program
Patients	**20,188**	Up 2.8% on 2024 after three years of decline, with the Medicare line stable throughout
Service-delivery sites	24, across 14 counties	Enrollment can run where patients already are, including school-based sites and two mobile units
Adult-medicine prescribers	**15** referring clinicians	Six Medicare-enrolled adult-medicine physicians plus the nurse practitioner and physician-assistant bench — the referral engine for this forecast
Hypertension registry	**7,732 patients** (48.35%)	The single largest identified cohort in the organization, and the one remote monitoring is built for
Diabetes registry	**4,063 patients** (27.26%)	Roughly a thousand of them still sit above 9% HbA1c
Patient support and enabling services	2,522 patients (12.5%)	Quadrupled since 2021 — outreach is already a discipline here, just not a billed one
Patients at or below 100% of poverty	**81.89%** of known-income patients	Cellular-connected devices are a requirement rather than a preference, and CoachCare ships them that way

HRSA Uniform Data System CY2025; HRSA Health Center Service Delivery Sites file; CMS Doctors & Clinicians file, retrieved August 2026.

The referral input deserves one sentence of precision. The CMS Doctors & Clinicians file lists 13 Medicare-enrolled clinicians under the organization's identifier, six of them adult-medicine physicians. That file systematically undercounts health-center staff, because health-center visits bill institutionally and nurse practitioners and physician assistants often never appear in it; a national-registry cross-check against the organization's own site addresses surfaces a further bench of 17. The forecast in Section 4 uses **15 referring adult-medicine prescribers**, the midpoint of the two counts, and Section 4.4 prices what the endpoints are worth.[7]

1.2 The Medicare panel: 5,299 patients, 39.6% dually eligible

Measure	2021	2023	2025	Direction
Total patients	25,734	19,980	**20,188**	Turned back up in 2025

[6] HRSA Uniform Data System CY2021–CY2025 (total cost $18.09 million in 2021 to $23.58 million in 2025; cost per patient $702.80 to $1,168.16; federal Section 330 cluster $7.38 million in 2025); HRSA Health Center Service Delivery and Look-Alike Sites file, retrieved August 2026, for the 24 active sites, the school-based clinics and the two mobile units; national provider registry for the dental clinic and retail pharmacy registrations.

[7] CMS Doctors & Clinicians national file (retrieved August 2026), rolled up on the organization's PAC identifier: 13 Medicare-enrolled clinicians, of whom 6 are adult-medicine physicians (3 family or general practice, 3 internal medicine). The file undercounts health-center staff because health-center visits bill institutionally; a national provider registry address-match against the organization's site addresses surfaces a further 17 nurse-practitioner and physician-assistant records at adult-medicine sites. The forecast uses 15 referring prescribers, with the 6 and 23 endpoints priced in Section 4.4.

Measure	2021	2023	2025	Direction
Medicare-primary patients	5,783	5,155	**5,299**	**Stable, and 26.25% of the panel**
— of whom dually eligible	2,092	2,021	**2,099**	**39.6% of the Medicare line**
Patients 65 and over	4,290 (16.7%)	4,178 (20.9%)	**4,687 (23.2%)**	**A point a year, every year**
Medicaid and CHIP patients	4,502	4,289	3,324	16.5% of the panel
Uninsured patients	7,623	4,226	4,191	20.8% of the panel

HRSA Uniform Data System, CY2021–CY2025. UDS counts each patient once by primary coverage; the dually-eligible line is reported within the Medicare line.

Three things stand out. First, the Medicare line is stable in a panel that is not — total patients fell for three years and recovered in 2025, while Medicare held between 5,155 and 5,299 throughout. Second, the age structure underneath it is moving in one direction: the 65-and-over share has gained six and a half points in four years and gains about a point a year, so every enrollment ceiling in Section 4.4 rises on its own. Third, **39.6% of the Medicare panel is dually eligible** — the single most important input to the advanced primary care management economics in Section 3.2.[8]

The 3,324 Medicaid-only patients and 4,191 uninsured patients sit outside the billable core of this forecast. Section 7 explains why, and what the same infrastructure does for them once the Medicare program is running.

1.3 The quality record, and the one gap in it

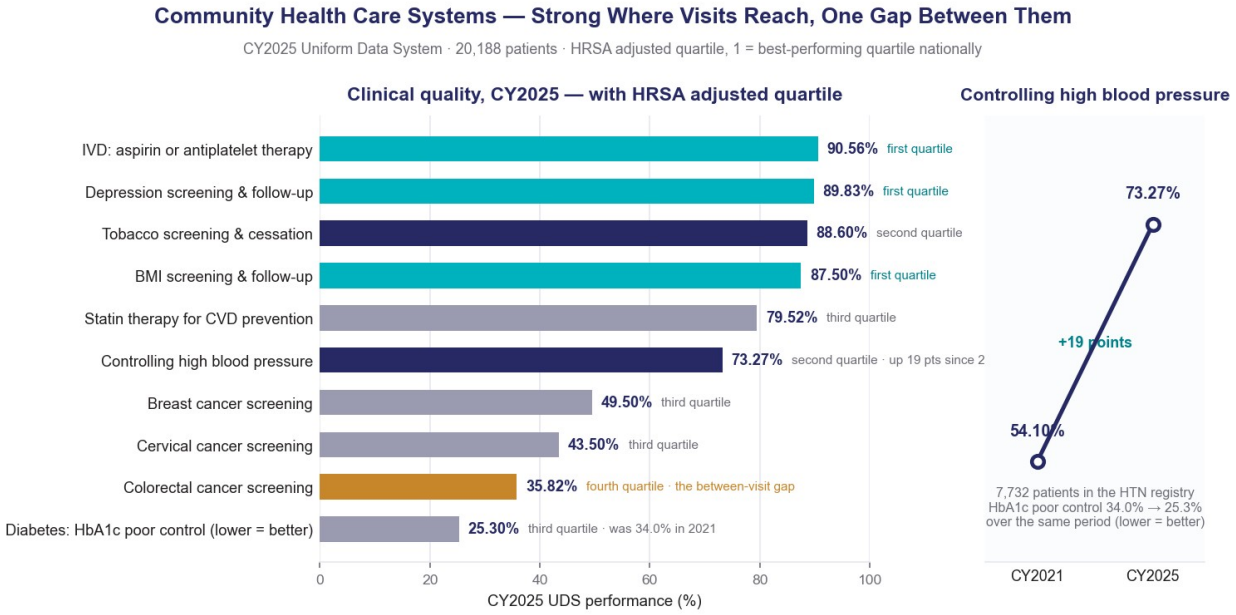

Figure 1 — CY2025 Uniform Data System clinical quality with HRSA adjusted quartile position (quartile 1 is the best-performing quartile nationally). Right panel: blood-pressure control, CY2021 to CY2025.

[8] HRSA Uniform Data System, CY2021–CY2025, payer-mix and age tables as published on the awardee profile: Medicaid and CHIP 3,324 (16.5%); uninsured 4,191 (20.8%); other third-party 7,374 (36.5%).

Three measures sit in the first national quartile: aspirin or antiplatelet therapy for ischemic vascular disease at **90.56%**, depression screening with follow-up at **89.83%**, and BMI screening with follow-up at **87.50%**. Blood-pressure control at 73.27% runs more than four points above the 69.08% national health-center average and has climbed from 54.10% since 2021. HbA1c poor control has fallen from 34.02% to 25.30%, better than the 26.28% national figure, and HRSA named the organization a National Quality Leader for Diabetes Health in 2026.[9]

One flagship measure sits in the bottom national quartile: **colorectal cancer screening at 35.82%**, up from 26.96% in 2021 but still fourth-quartile. The pattern across the whole scorecard is consistent and worth naming. Where the measure is decided inside the visit, this health center is at or near the national frontier. Where the measure is decided between visits, by outreach that has to be initiated and followed up, it is behind. A monthly care-management touch is a screening reminder with a billing rail under it.

The strategic point follows from the arithmetic. A health center at 73.27% blood-pressure control has already captured what visit-based care can deliver; the distance between 73.27% and 80% is decided in the weeks between appointments. The same is true of the roughly one thousand diabetic patients still above 9%. The registries name the cohorts: 7,732 patients with hypertension, 4,063 with diabetes. The quality case and the revenue case are the same case.

1.4 The market around it

Market fact	Figure	What it means for this service line
Medicare Advantage is the majority	**62.4%** of the 84,727 Medicare beneficiaries across the 14-county footprint, May 2026 enrollment file[10]	MA plans must pay a health center at least 100% of the Medicare rate for covered services — a floor. How each contract handles the care-management code families is settled contract by contract, which is why that read sits in the implementation plan rather than in the forecast
The footprint is dual-heavy	21,701 of those beneficiaries are dually eligible — 25.6%, against a 39.6% dual share inside the health center's own Medicare panel[11]	The panel is meaningfully more dual than the counties around it, which is what drives the APCM tier mix in Section 3.2
Rural, poor and aging	22.1% footprint poverty; 17.9% of residents 65 or over (ACS 2024 five-year estimates)[12]	Home broadband runs 63% to 70% in Warren, Glascock and Taliaferro counties, so devices ship cellular-connected and need no patient WiFi, app or smartphone

CMS Medicare Monthly Enrollment file, May 2026; U.S. Census Bureau American Community Survey 2024 five-year estimates; CY2025 UDS.

One consequence of that MA share is worth stating plainly, because it decides how far beyond this forecast the program reaches. The UDS Medicare line counts each patient once by primary coverage, so Medicare Advantage members already sit inside the 5,299; the forecast does not gross the panel up for them. The traditional-Medicare subset inside that 5,299 is the first number to pull from the practice-management system, and Section 4.4 carries the conservative case in the sensitivity table.

[9] HRSA Uniform Data System, CY2025 quality measures and HRSA adjusted quartiles, with the five-year trajectory from the CY2021–CY2025 profile series: controlling high blood pressure 54.10% (2021) to 73.27% (2025); HbA1c poor control 34.02% to 25.30%; colorectal cancer screening 26.96% to 35.82%, fourth quartile; cervical cancer screening 43.50% and breast cancer screening 49.50%, both third quartile. HRSA 2026 Community Health Quality Recognition: National Quality Leader – Diabetes Health.

[10] CMS Medicare Monthly Enrollment file, May 2026, aggregated across the 14 footprint counties: 84,727 total beneficiaries, 52,893 in Medicare Advantage and other plans, 62.4%. County-level Medicare Advantage shares range from 56.5% to 72.1%.

[11] CMS Medicare Monthly Enrollment file, May 2026: 21,701 dually eligible beneficiaries across the 14 counties, 25.6% of the footprint total, against a 39.6% dual share within the health center's own CY2025 UDS Medicare line.

[12] U.S. Census Bureau, American Community Survey 2024 five-year estimates, profiles DP02, DP03 and DP05, aggregated across the 14 footprint counties: population 369,762; 17.9% aged 65 or over; 22.1% below poverty; household broadband subscription 84.8% footprint-wide, and 63.2%, 66.0% and 70.1% in Warren, Glascock and Taliaferro counties respectively.

2. The 2026 Billing Change for Health Centers

2.1 One bundled code became many individual ones

For years a health center billed Medicare care management through a single bundled HCPCS code, G0511, at one blended rate regardless of what was delivered. CMS ended that. Since **January 1, 2026**, health centers report the individual CPT and HCPCS codes for chronic care management, remote physiologic monitoring, advanced primary care management, behavioral health integration and the related families, each separately payable.[13]

> **The load-bearing rule, from CMS's own health-center booklet**
>
> **Care-coordination services — including CCM, APCM and remote physiologic monitoring — are paid at the physician fee schedule rate, "either alone or with other payable services,"** meaning on top of the PPS visit payment when both occur on a claim.
>
> The same booklet settles the operating questions: no face-to-face visit is required for these services, and auxiliary personnel may furnish them under general supervision — which is what lets a contracted care team do the work under the health center's billing.
>
> *CMS MLN006397, Federally Qualified Health Center booklet, March 2026 edition.*

Two consequences are worth stating plainly, because both run against what many health-center finance teams assume.[14]

- **Care management does not cannibalize the PPS rate.** It is paid in addition to it. A patient seen face to face and enrolled in remote monitoring generates the PPS payment and the monitoring payment.
- **The revenue is additive to the grant structure too.** None of it is a Section 330 draw, none of it competes with the federal cluster award, and none of it depends on a new funding cycle. It is fee-for-service revenue earned against work the clinical registries already justify.

2.2 Two rate rails, and the one this forecast uses

Health centers bill these codes at CY2026 national non-facility rates. This forecast is built on the lower of the two available bases — the Medicare physician fee schedule at **MAC locality 10212/99, Rest of Georgia** — so every rate in it traces to a published locality schedule and sits beneath what the health-center rail actually pays.[15]

[13] CMS MLN006397, Federally Qualified Health Center booklet, March 2026 edition, and the CY2026 Medicare Physician Fee Schedule final rule, for the transition from the bundled G0511 payment to individual care-coordination codes for federally qualified health centers.

[14] CMS MLN006397, March 2026 edition. The booklet lists the payable care-coordination families for health centers and states payment at the physician fee schedule rate, either alone or with other payable services.

[15] Rate basis: CY2026 Medicare Physician Fee Schedule resolved to MAC locality 10212/99, Rest of Georgia, from the health center's headquarters ZIP code. Measured spread from that basis to the CY2026 national non-facility schedule, code by code: 99453 +10.9%; 99445 and 99454 +11.9%; 99470 and 99457 +6.1%; 99458 +4.7%; 99490 +4.5%; 99439 +5.1%; G0556 +4.3%; G0557 +4.9%; G0558 +4.9%.

The rate gap, quantified

Measured code by code, the CY2026 national non-facility rate runs above the Rest of Georgia locality basis used here:

99453 +10.9% · 99445 and 99454 +11.9% · 99470 and 99457 +6.1% · 99458 +4.7% · 99490 +4.5% · 99439 +5.1% · G0556 +4.3% · G0557 +4.9% · G0558 +4.9%

CoachCare's fees are per-patient-month prices that do not move with reimbursement, so essentially all of that difference falls to the health center. It sits outside every number in this report.

Payer scope. The forecast bills traditional Medicare. Across the footprint, 62.4% of beneficiaries are enrolled in Medicare Advantage plans as of the May 2026 enrollment file; MA plans must pay a health center at least 100% of the Medicare rate for covered services, a floor, with individual contracts setting their own terms for the care-management code families.

CY2026 also widened what remote monitoring can bill. Two new codes matter for this panel: **99445**, which pays for 2 to 15 days of device supply in a month, and **99470**, which pays for the first 10 minutes of treatment management. Before these codes, a month with fewer than 16 days of readings or under 20 minutes of management produced nothing billable; now it produces a claim. Across the 24-month forecast the two contribute **$193,413 of gross reimbursement, about $179,000 net — 6.6% of total net reimbursement**. Partial months are exactly where a newly enrolled rural panel lives, which makes these codes worth disproportionately more here than to a typical practice.[16]

Advanced primary care management entered health-center billing in the same reform: three tiers — G0556, G0557 and G0558 — priced by patient complexity and dual-eligibility status, with no minute threshold. Section 3.2 explains why the third tier is the one that matters here.

2.3 The work the change creates, and who carries it

The change gives with one hand and takes with the other. One bundled code required one time log. The individual codes require per-program time capture, per-program documentation, per-program consent and per-program claim construction, each family with its own minute thresholds and add-on rules. That work landed on every health-center billing office in the country, and it lands whether or not the organization enrolls a single new patient.

This is the operating argument for running the program with CoachCare rather than assembling it internally. The enrollment conversations, the monthly outreach minutes, the device logistics, the documentation and the claim files are CoachCare's work product, delivered inside the health center's own eClinicalWorks environment — readings land as discrete vital reports, documentation attaches to the chart monthly, and claims generate automatically rather than being assembled by hand for every enrolled patient every month. Section 3.6 sets out the mechanics. The health center bills under its own enrollments and keeps the margin.

[16] CY2026 Medicare Physician Fee Schedule: 99445 (remote physiologic monitoring device supply, 2–15 days in 30) and 99470 (treatment management, first 10 minutes). Contribution of $193,413 gross and approximately $179,000 net over 24 months, 6.6% of total net reimbursement: CoachCare Value Analysis for Community Health Care Systems, 2026.

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

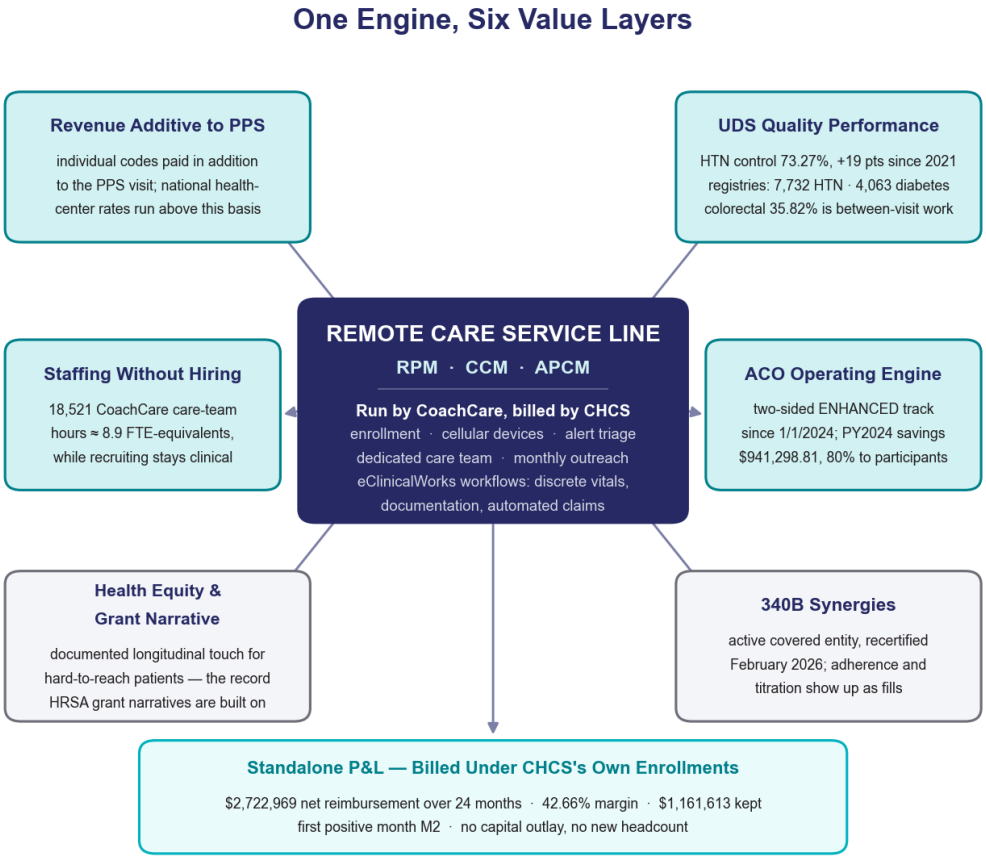

Figure 2 — one operating spine, six value layers, and the standalone profit and loss underneath it. Figures from the CoachCare Value Analysis and the CY2025 Uniform Data System.

3.1 The clinical and billing stack

Three programs, one enrollment conversation, one care team, one billing pipeline. Each program answers a different clinical question and each is separately payable to a health center.

Program	What it does clinically	Who it fits in this panel
Remote physiologic monitoring (RPM)	A cellular blood-pressure cuff, scale or glucometer transmits readings between visits, reviewed against thresholds the health center sets. 99453, 99454, 99457, 99458, plus the CY2026 codes 99445 and 99470	The 7,732-patient hypertension registry and 4,063-patient diabetes registry. Both control measures are computed from exactly the values these devices transmit
Chronic care management (CCM)	A documented care plan for patients with two or more chronic conditions, with at least 20 minutes of non-face-to-face coordination each month. 99490 and 99439	The multi-morbid core of the Medicare panel — in a population where 48% carry hypertension and 27% diabetes, that is most of it
Advanced primary care management (APCM)	A monthly per-patient payment for continuous primary-care management, with no minute threshold, tiered by complexity and dual-eligible status. G0556, G0557 and G0558	The 39.6%-dual panel. Dual status maps patients to the highest tier, G0558 — Section 3.2

Chronic care management and advanced primary care management draw on one care-management pool and cannot both be billed for the same patient in the same month, so the forecast treats them as a partition rather than a stack: APCM takes the dual-heavy slice where the top tier pays most, and CCM takes the remainder. Remote monitoring runs alongside either. That is why **2,145 active program enrollments at M24 resolve to 1,311 unique patients**.

3.2 APCM and the dual-eligible panel

Advanced primary care management is priced in three tiers, and the third — **G0558, for patients who are Qualified Medicare Beneficiaries with two or more chronic conditions** — pays the most. Here, 39.6% of the Medicare panel is dually eligible against 25.6% across the surrounding counties, so the tier mix skews toward the top of the schedule in a way almost no other kind of practice can match. A specialty group might qualify a tenth of its panel for the top tier.[17]

Dual eligibility solves the other half of the enrollment problem. Care-management programs stall on the coinsurance conversation: a patient asked to take on a monthly copay for a program they have not experienced yet often declines. Qualified Medicare Beneficiary protections prohibit billing those patients Medicare cost-sharing. For that slice of the panel, the objection does not exist.

The wedge, stated as one sentence

This dual-eligible mix makes advanced primary care management worth more here than at almost any other organization CoachCare works with — and the enrollment and engagement labor that earns it is ours.

APCM contributes $618,163 of the 24-month forecast on 556.5 active enrollments, at $56.55 per enrolled patient-month, with no minute threshold to document. It reaches its ceiling in month 9 — the fastest of the three programs — because the eligible population is concentrated and already in the building.

3.3 The starting position: whitespace, honestly bounded

Every clinician who reassigns Medicare billing to the organization was queried against the remote monitoring, chronic care management, principal care management, advanced primary care management and transitional care management code families in the CY2024 Medicare Part B claims file. None appears on any of them. Two structural facts about that file bound what the nulls can prove, and both belong in the open.[18]

- **CMS suppresses any clinician-and-code line under 11 beneficiaries.** A code billed to ten patients is invisible. The supportable statement is that there is no Medicare remote-care program at meaningful scale visible in CY2024 claims.
- **G0511 billed institutionally and is structurally absent from the physician file.** Health-center care management under the old bundled code reported on institutional claims, which this file does not capture, and no public CMS file exposes health-center claim-line detail. Whatever G0511 volume the organization ran is a number to pull from its own billing system, and it is worth pulling early.

[17] HRSA UDS CY2025 (2,099 dually eligible of 5,299 Medicare-primary, 39.6%); CMS Medicare Monthly Enrollment file, May 2026, for the 25.6% footprint dual share; CMS MLN006397, March 2026, for the G0556 through G0558 advanced primary care management tiers; Qualified Medicare Beneficiary billing protections under federal law prohibit charging those patients Medicare cost-sharing.

[18] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024, per-clinician query across the full roster reassigning to the organization's PAC identifier; query mechanics validated against a known-positive control, so the nulls are absences rather than query failures.

Three independent signals point the same way. The organization's website carries no remote monitoring, chronic care or care-management program page anywhere in its services navigation. Its careers page is advertising physicians, a nurse practitioner and an optometrist, with no care-manager or care-coordinator role posted. Its news feed has been dormant since 2021. Taken with the claims result, the read is a health center with deep registries, a billing rail opened at the start of this year, and nothing running on it.[19]

The organization is not starting from zero capability, though. Patient support and enabling services reached 2,522 patients in CY2025, four times the 2021 count. School-based clinics, two mobile units and a 340B pharmacy program all run today. The work of this service line is work the organization already knows how to do. The move is to point that outreach discipline at the one payer that pays for it code by code.

3.4 Staffing: 8.9 full-time equivalents, none of them hired

Over 24 months the forecast carries **18,521 hours of CoachCare care-team labor — about 8.9 full-time equivalents** — covering enrollment calls, monthly outreach, alert triage, documentation and claim preparation. The health center hires nobody, buys no devices and stocks nothing. The care-management families operate under general supervision, so the work runs under the health center's billing without adding to any clinician's schedule.[20]

That matters more here than it would elsewhere. The organization is currently recruiting physicians and a nurse practitioner across its sites, which is the ordinary condition of rural primary care in middle Georgia. A care-management layer that requires new hires competes with those searches. This one does not compete with them; it adds 8.9 full-time equivalents of care capacity while the recruiting stays clinical.

One staffing line deserves its own sentence: the on-site enrollment specialist, carried at CoachCare's expense. Run the same forecast with no enrollment specialist and 24-month net reimbursement falls to $1,786,291 — that person is worth **$936,678** over 24 months. Add a second and it rises to $3,332,371, another $609,402. On an account where enrollment pace rather than panel size sets the number, this is the largest single lever in the forecast, and it is on CoachCare's side of the ledger.

3.5 Two quieter layers: 340B and the grant file

Two value layers sit outside the profit-and-loss statement and are worth naming. First, **340B**. The organization is an active covered entity, recertified in February 2026, and holds its own retail pharmacy registration. A monitoring program's core clinical products are medication adherence and timely titration, and both show up as prescriptions filled.[21]

Second, **the grant file**. A Section 330 health center competes for federal and foundation funding on its ability to document longitudinal engagement with hard-to-reach populations — and 81.89% of this organization's known-income patients live at or below the federal poverty guideline, across 14 rural counties. A remote-care program produces, as a by-product, a dated record of monthly contact, readings and outreach for exactly those patients. Every UDS submission and grant narrative the organization writes gets stronger the month this program turns on.

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[19] chcsga.org services navigation, careers page and news archive, retrieved August 2026: no remote monitoring, chronic care or care-management program page; open positions for physicians, a nurse practitioner and an optometrist, with no care-manager or care-coordinator role posted; most recent news post October 2021. HRSA UDS CY2021–CY2025 for patient support and enabling services, 2,522 patients in CY2025 against roughly a quarter of that in 2021.

[20] CoachCare Value Analysis for Community Health Care Systems, 2026: 18,521 care-team hours over 24 months, 8.9 full-time equivalents. Scenario recomputations: 24-month net reimbursement of $1,786,291 with no enrollment specialist and $3,332,371 with two, against $2,722,969 in the base case.

[21] HRSA 340B Office of Pharmacy Affairs Information System covered-entity record, registered October 2016, participating since January 2017, last recertified February 16, 2026; national provider registry listing for the organization's retail pharmacy. Poverty share: HRSA UDS CY2025, 81.89% of known-income patients at or below 100% of the federal poverty guideline.

3.6 eClinicalWorks integration: the program lives in the chart

The organization runs on eClinicalWorks. CoachCare uses eCW's built-in workflows, so the care team enrolls and monitors patients without learning a second system and without a parallel portal to check. The program lives in the record the clinicians already work in.[22]

Integration pillar	What it does in the record
Integrated enrollment	Enrollment flags and trigger ordering by service sit inside the clinical workflow. The CoachCare team enrolls qualified Medicare patients on the health center's behalf, and enrollment status is visible in eCW in real time
Exchange of health history	Bi-directional at intake, so the care plan starts from the same problem list, medications and history the clinic holds
Integrated vital reports	**Device readings land in the chart as discrete vital reports rather than as scanned attachments — a blood-pressure series a clinician can trend, in the same structured data the quality measures read from**
Compliance documentation and integrated care summary	Evidence of Care, vitals and care plans attach to the patient's chart monthly — which is what the per-code rules in Section 2.3 now require of every program, every month
Automated claim generation	**Claims created through the CoachCare billing engine. CoachCare is the only care management application integrated with eClinicalWorks providing automated claims creation, which removes the manual per-patient, per-month claim step entirely**

Two consequences carry into the forecast. Patients begin receiving chronic care management and remote monitoring services in **under five days** from the enrollment flag, which is why the census climbs as steeply as it does in the first quarter. And because claim construction is automatic, the **42,277 claims** the program generates over 24 months never land on the billing desk as manual work — which matters for a lean billing team already absorbing the conversion from one bundled code to nine individual ones.

> **On what the integration is for**
>
> *"Key to achieving a program that is efficient, effective and sustainable, is creating a seamless, intuitive user experience for the patient and provider, and that's what our integration with eCW accomplishes."*
>
> **CoachCare**

[22] Record system evidenced by the organization's eCW-hosted patient-portal instance, retrieved August 2026. Integration detail: CoachCare eClinicalWorks integration overview — integrated enrollment with flags and trigger ordering by service, bi-directional health-history exchange, integrated vital reports, compliance documentation and integrated care summary attached to the chart monthly, and automated claim generation, with first services in under five days from the enrollment flag.

4. Value Analysis: The 24-Month Forecast

4.1 The headline economics

The forecast covers remote physiologic monitoring, chronic care management and advanced primary care management across the 5,299 Medicare-primary patients in the CY2025 Uniform Data System count, at CY2026 Medicare physician fee schedule rates for MAC locality 10212/99, with 15 referring adult-medicine prescribers and one on-site enrollment specialist.[23]

	Year 1	Year 2	24 months
Net reimbursement	**$776,302**	**$1,946,667**	**$2,722,969**
CoachCare fees	$458,006	$1,103,350	$1,561,356
Net to the health center	**$318,296**	**$843,317**	**$1,161,613**
Margin to the health center	41.00%	43.32%	**42.66%**

The margin moves from **41.00% in year one to 43.32% in year two** because the one-time implementation and integration costs fall out and the census is far larger across the second twelve months. Over the full window the margin to the health center is **42.66%**. Year two is not a steady state here: the program is still adding remote-monitoring enrollments in its final month, so year three starts from a higher census than year two did.

4.2 Where the revenue comes from

Program	Year 1	Year 2	24 months	Share
Remote physiologic monitoring	$263,736	$808,428	**$1,072,164**	39.4%
Chronic care management	$272,059	$760,583	**$1,032,642**	37.9%
Advanced primary care management	$240,507	$377,656	**$618,163**	22.7%
Total net reimbursement	**$776,302**	**$1,946,667**	**$2,722,969**	100%

Net reimbursement by program and year, CoachCare Value Analysis. Rows and columns sum as printed.

Remote monitoring and chronic care management run nearly even. Monitoring reaches the widest slice of the panel — 952.8 active enrollments at M24, at $91.08 per enrolled patient-month — while chronic care management earns the most per patient-month at $105.73 across 636.0 enrollments. Advanced primary care management adds $56.55 across 556.5 enrollments, the smallest line and the one the dual mix makes stronger here than anywhere else. The revenue mix shifts across the two years: in year one the three programs are within $32,000 of each other, and by year two monitoring is pulling ahead because it is the only program still enrolling.

[23] CoachCare Value Analysis for Community Health Care Systems, 2026. All Section 4 figures. Inputs: 5,299 Medicare-primary patients (CY2025 UDS), 15 referring adult-medicine prescribers, one on-site enrollment specialist, CY2026 Medicare physician fee schedule rates at MAC locality 10212/99, RPM + CCM + APCM.

4.3 The ramp, month by month

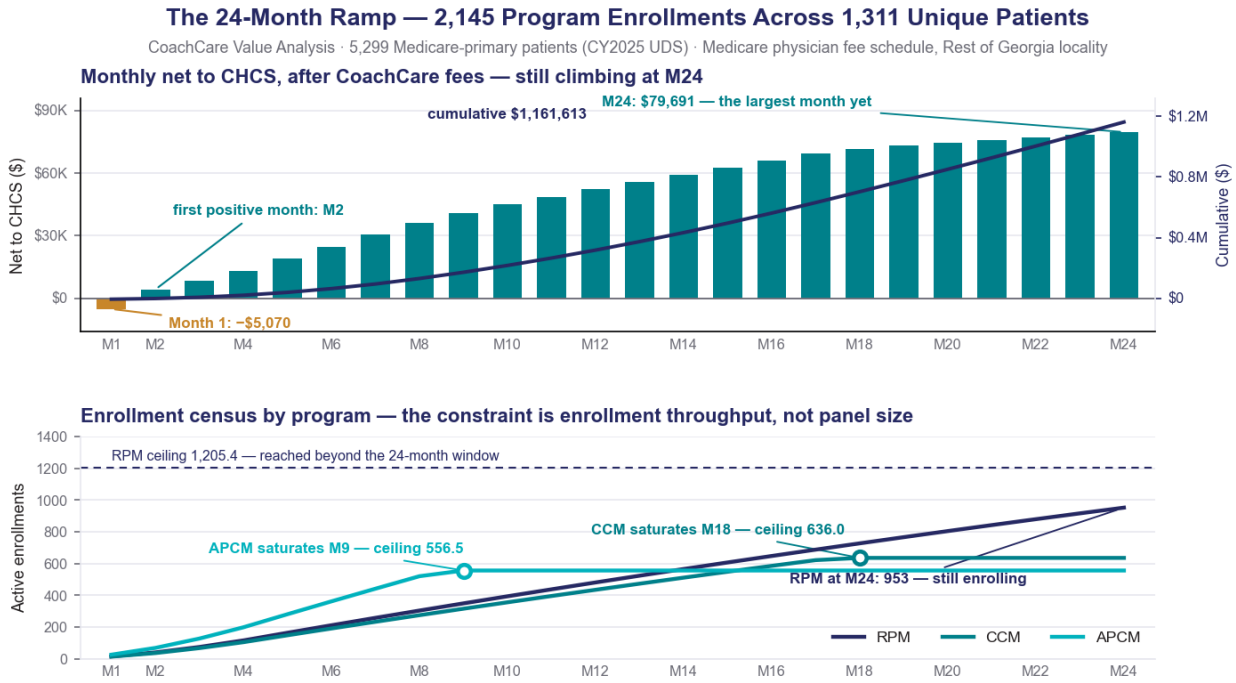

Figure 3 — monthly net to the health center after CoachCare fees, with cumulative net overlaid, and the enrollment census by program with saturation months marked. CoachCare Value Analysis.

Month 1, stated precisely

Month 1 nets −$5,070. It is the only negative month.

Implementation and the eClinicalWorks integration setup are one-time costs that land in month 1 against a census still building. The first positive month is

M2, at $4,295, and month 1's shortfall is repaid inside the first quarter. From there every month is larger than the one before it, through M24.

Month	Net reimbursement	CoachCare fees	Net to the health center
M2	$11,758	$7,463	**$4,295**
M3	$21,648	$13,323	$8,325
M6	$60,494	$35,715	$24,779
M9	$97,000	$55,929	$41,071
M12	$121,381	$69,106	$52,275
M18	$164,650	$93,011	$71,639
M24	**$184,763**	$105,072	**$79,691**

CoachCare Value Analysis, selected months. Net to the health center is net reimbursement less CoachCare fees, row by row.

The commercially important number in that table is not the 24-month total. It is that the program is cash-positive in its second month and self-funding from then on. A service line that pays its own way from M2 competes with nothing else in the budget for capital, and there is no capital to compete for — no devices

purchased, no software licensed, no headcount added. The second important number is the last row: M24 is the largest month in the forecast, which is a different shape from a program that has finished ramping.

4.4 The constraint is enrollment throughput, not panel size

Program	Eligible share of the 5,299	Acceptance	Ceiling	Position at M24
Remote physiologic monitoring	65% — 3,444 patients	35%	**1,205.4**	**952.8 enrolled, still climbing**
Chronic care management	40% — 2,120 patients	30%	**636.0**	**ceiling reached in M18**
Advanced primary care management	35% — 1,855 patients	30%	**556.5**	**ceiling reached in M9**

Say the constraint out loud

The binding constraint on this program is enrollment throughput, not the size of the Medicare panel.

Advanced primary care management fills its eligible population in month 9 and chronic care management in month 18. Remote monitoring, the largest revenue line, holds 952.8 of a 1,205.4 ceiling at month 24 and is still adding patients — the panel supports more enrollment than 24 months of outreach capacity can reach. Every additional unit of enrollment capacity converts directly into revenue, which is why the enrollment specialist and the referring-prescriber count are the two levers that move this forecast and panel size is not.

Scenario	24-month net reimbursement	Change
Base — 5,299 panel, 15 prescribers, 1 enrollment specialist	**$2,722,969**	—
No enrollment specialist	$1,786,291	**−34.4%**
Two enrollment specialists	**$3,332,371**	**+22.4%**
6 referring prescribers	$2,035,743	−25.2%
23 referring prescribers	$3,193,560	+17.3%
Panel at 5,500	$2,761,141	**+1.4%**
In-scope panel at 2,100	$1,582,167	−41.9%

CoachCare Value Analysis, each scenario recomputed in full. The margin to the health center holds between 42.0% and 42.7% across every row, including the 2,100-patient case at 42.04%.

Two rows in that table carry the argument. Moving the panel from 5,299 to the top of its credible range changes the 24-month number by 1.4%, because the panel is not what is binding. Removing the enrollment specialist changes it by 34.4%. The last row is the conservative case: if the traditional-Medicare subset of the 5,299 turns out to be 2,100 patients, the 24-month forecast is $1,582,167 and the margin holds at 42.04%. That number is confirmed in week one from the practice-management system, per Section 8.4.

4.5 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Readings received	**123,606**	Blood pressure, weight and glucose values arriving between visits, against control measures currently computed from office readings alone
Claims generated	**42,277**	Constructed, coded and submitted automatically through the eClinicalWorks integration
Care-management tasks completed	84,554	Outreach attempts, care-plan updates, medication reviews and follow-up actions
Patient conversations	12,683	Live contacts across roughly 705 hours of call time
Chart updates	21,138	Documentation written back for the care team to act on
Care-team hours delivered by CoachCare	**18,521**	**About 8.9 full-time equivalents of care-management labor the health center does not employ**
Hospitalizations avoided	**78**	At a conservative $15,000 per avoided admission, roughly $1.18 million of cost that never lands on a payer or a patient

CoachCare Value Analysis, 24-month totals.

The avoided-admission figure belongs to the patient and the payer rather than to the health center's income statement, and it is not part of the $1,161,613. It is the number that matters to Medicare Advantage plans in a footprint where 62.4% of beneficiaries are enrolled in one, and it is the number that matters most to a two-sided ACO — which is where Section 5 picks up.

5. The ACO Layer: Two-Sided Risk on the Work This Program Does

Since **January 1, 2024**, Community Health Care Systems has participated in the Medicare Shared Savings Program through **ACME Health Partners ACO**, an accountable care organization built entirely of Georgia community health centers, with seven participants. The terms, from the PY2026 participant file: third agreement period, **ENHANCED track** — the two-sided option, carrying the highest sharing rate in the program alongside real downside — low-revenue status, and retrospective beneficiary assignment. The health center holds the chair of that ACO's governing board and its executive seat.[24]

The ACO reported **$941,298.81 in shared savings for performance year 2024**, distributed 80% to the participating health centers. A care-management service line is not adjacent to that position. It is the operating engine of it, three ways over.

- **Attribution runs on primary-care services.** Medicare assigns beneficiaries to an ACO based on where they receive their primary care, and advanced primary care management is among the qualifying services. A documented monthly care-management relationship is primary care recorded twelve times a year. A patient managed monthly is a patient whose attribution stays home.
- **Performance runs on total cost of care, in both directions.** ENHANCED is the deep end of the program. What earns savings there is exactly what remote care produces: blood pressure that stays controlled, decompensation caught early, and the post-discharge cadence in Section 6.4 behind the 78 avoided hospitalizations in the forecast.
- **The flagged quality measure is a between-visit measure.** The ACO's own public quality reporting and the UDS report card point at the same gap: colorectal cancer screening. That number moves through outreach between visits, which is what a care-management layer does every month, with a billing rail under it.

One payment mechanic is worth confirming rather than assuming. The ACO does not participate in the ACO Primary Care Flex model — checked against the PY2026 participant file and against the CMS list of participating ACOs — so there is no prospective primary-care payment substituting for claim-by-claim billing. Every code in this forecast pays as ordinary fee-for-service, on assigned and unassigned patients alike, and the shared-savings position sits on top of it rather than in place of it.[25]

The number to bring into the room early is the health center's assigned-beneficiary count, which the ACO holds. It sizes the traditional-Medicare floor inside the 5,299 and it is second on the list in Section 8.4.

[24] CMS Medicare Shared Savings Program PY2026 participant file, data.cms.gov, retrieved August 2026: participation in ACME Health Partners ACO, ACO identifier A5460, service area Georgia; ENHANCED track; low-revenue; retrospective assignment; third agreement period, initial and current start date January 1, 2024. The ACO's public reporting, retrieved August 2026, records seven health-center participants, a governing board of eight with equal votes, and PY2024 shared savings of $941,298.81 distributed 10% to infrastructure, 10% to care redesign and 80% to participants.

[25] ACO Primary Care Flex status recorded as zero in the PY2026 Medicare Shared Savings Program participant file, and the ACO does not appear in the CMS ACO Primary Care Flex PY2026 participant notice of January 2026 listing the 23 participating organizations. Consequently the care-management and monitoring codes pay as ordinary fee-for-service, with no prospective primary-care payment substitution.

6. Clinical Governance & Escalation

Section 4 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 the health center never carries surveillance liability it did not agree to. Thresholds and routing are set with its clinical leadership rather than by default, and signed off before the first patient enrolls.[26]

6.1 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, then run the symptom check. Most out-of-range readings resolve here, which is why the care team's inbox stays clean
Trend	**Three consecutive readings at least one hour apart for blood pressure or glucose; three readings within seven days for heart rate**	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. That record is also what substantiates the billed time

6.2 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.

If the patient refuses. The 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. The health center 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 health center's stated preference, documented the same way.

[26] 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.

6.3 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 care team notified
Non-critical	A confirmed out-of-range reading or trend without emergent features	The defined care team member named in the 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 across 24 sites**

Across 24 sites in 14 counties the matrix is agreed per site rather than once centrally, because the covering clinician in Sandersville is not the covering clinician in McRae-Helena, and the mobile units cover differently again.

6.4 The post-discharge three-touch cadence

Triggered automatically by any emergency room visit or hospitalization reported in the previous 60 days — the readmission-prevention spine, and the mechanism behind the 78 avoided hospitalizations in the forecast.

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

6.5 Continuity and discharge governance

Patients do not quietly fall out of the program, and the care team is notified at every decision point.

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: 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 clinic is notified in every case and discharges process in the first week of the following month.
3. **The health center always decides.** Clinical discharge criteria, escalation thresholds and routing belong to the health center. CoachCare executes them consistently and documents the execution. It does not overrule clinical judgment, with the single exception of the emergent floor in Section 6.2.
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 in Section 2.3 require in any case.

7. The Georgia Rail, and Why Medicare Comes First

Medicaid covers 3,324 of the health center's patients and another 4,191 are uninsured, so the question of what Georgia pays for this work deserves a straight answer. The Department of Community Health's Physician Services Manual and its FQHC/RHC Services Handbook, April 2026 editions, give one: **Georgia Medicaid does not reimburse remote patient monitoring** under fee-for-service, and care management otherwise sits inside the encounter rate. A Medicaid patient enrolled in monitoring generates no separate Georgia Medicaid claim, however good the care is. Live-video telehealth is covered, and a health center may act as originating or distant site, but not bill both fees on one encounter.[27]

So the sequencing writes itself. Medicare is the billable rail, and the 24-month forecast in Section 4 bills the 5,299-patient Medicare panel and nothing else. No Medicaid revenue appears anywhere in this report, because none exists to bill. What changes over time is not the infrastructure but how much of the footprint it serves and who pays for it — the same device fleet, the same enrollment staff and the same escalation engine reach every site in all 14 counties from month one.

What sits outside this forecast	Why it is worth watching
Georgia's rural health transformation program	The state holds a $218.86 million first-year CMS award, part of a $1.43 billion five-year plan, with funded strategies that name federally qualified health centers, value-based-care readiness, care coordination, telehealth, and clinical technology that supports care coordination. No subaward to this health center exists and none is assumed anywhere in this report. A running remote-care service line is the kind of infrastructure those strategies describe
The demographic escalator	Patients 65 and over went from 16.7% of the panel in 2021 to 23.2% in 2025, about a point a year. Every program ceiling in Section 4.4 is set by the Medicare line, and that line's future is already in the waiting room
The national rate rail	The forecast is built at the Rest of Georgia locality basis. Health centers bill these codes at national non-facility rates, 4.3% to 11.9% higher code by code, and essentially all of that difference falls to the health center because CoachCare's fees do not move with reimbursement
340B dispensing	Better adherence and faster titration fill prescriptions, and this organization holds its own retail pharmacy registration under an active covered-entity record

Georgia Department of Community Health and CMS award announcements, December 2025 through July 2026; HRSA UDS CY2021–CY2025; CMS MLN006397, March 2026.

[27] Georgia Department of Community Health Physician Services Manual and FQHC/RHC Services Handbook, April 2026 editions, as summarized in the Center for Connected Health Policy state profile retrieved August 2026: remote patient monitoring is not reimbursed under Georgia Medicaid fee-for-service; live-video telehealth is covered, and a health center may serve as originating or distant site but may not bill both fees on one encounter. The state telemedicine guidance issued through the Medicaid management information system contains no remote physiologic monitoring codes.

8. Implementation and the First 90 Days

8.1 Who runs what

Function	CoachCare	Community Health Care Systems
Patient identification	Registry query against the agreed inclusion criteria — starting from the 7,732-patient hypertension and 4,063-patient diabetes registries	Approves the criteria and the target list
Enrollment	**On-site enrollment specialist, at CoachCare's expense; eCW enrollment flags and trigger ordering; telephonic outreach across the remaining counties**	Provider referral at the point of care — 15 adult-medicine prescribers
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	**Sets thresholds, routing and after-hours cover; receives escalations**
Documentation and billing	Time logs, discrete vital reports and documentation attached to the chart monthly, automated claim generation	**Bills under its own enrollments; keeps the revenue**
Reporting	Monthly enrollment, engagement, escalation and revenue reporting, including the view the ACO needs	Standing monthly operating call

About CoachCare

CoachCare operates remote care and care-management programs for more than 500,000 patients across 400+ managed conditions, with over 10,000 clinicians on the platform. Its teams have stood up more than 1,000 programs, generated over 5 million claims through care-plan coding and billing, and recorded more than 100 million patient vitals.

8.2 The model inputs

Input	Value in this forecast
Medicare panel	**5,299 Medicare-primary patients** — CY2025 UDS; 2,099 of them (39.6%) dually eligible
Referring prescribers	15 adult-medicine prescribers — the midpoint of a 6-to-23 range between the CMS clinician file and the national provider registry
Enrollment staffing	1 on-site enrollment specialist, CoachCare-funded, plus provider referral and telephonic outreach
EHR	eClinicalWorks — integration per Section 3.6. Catalog integration pricing is $4,000 setup, $150 per month and $1.50 per patient, confirmed in contracting
Rates	CY2026 Medicare physician fee schedule, MAC locality 10212/99 (Rest of Georgia). Health centers bill these codes at national non-facility rates, 4.3% to 11.9% above this basis
Payer scope	Traditional Medicare. Across the footprint, 62.4% of beneficiaries are enrolled in Medicare Advantage as of the May 2026 enrollment file; MA plans pay a health center at least 100% of the Medicare rate for covered services, a floor, with individual contracts setting their own terms for the care-management code families
Program pricing	20% program pricing, reflected in the extended per-patient-month fees: **RPM $52.70 · CCM $53.12 · APCM $31.80**
Programs	RPM + CCM + APCM. Each patient is enrolled in the combination their condition needs, with one care-management program per patient-month

8.3 The 90-day plan

Window	What happens	Result at the end of it
Days 0–15 Decide	Pull the traditional-Medicare and dual-eligible split behind the 5,299 from eClinicalWorks, and the assigned-beneficiary count from the ACO. Agree the clinical targets from the hypertension and diabetes registries and pick the launch sites	Scope signed, target cohorts defined, launch sites named
Days 16–30 Design	eCW build: enrollment flags, trigger ordering by service, discrete vital reports mapped to the chart, documentation templates mapped to the individual-code requirements. Escalation thresholds, routing and after-hours cover agreed per site	Clinical protocol signed by the health center's leadership
Days 31–60 Enroll	Enrollment specialist on site at the highest-Medicare clinics and the Sandersville specialty hub, with telephonic outreach covering the other counties from the start. Cellular devices shipped and paired — no patient WiFi, app or smartphone required	First claims generated automatically; month 2 turns cash-positive
Days 61–90 Scale	Roll across the remaining sites, the school-based clinics and the two mobile units. Post-discharge cadence on. Monthly operating and ACO reporting views live	All three programs ramping; APCM reaches its ceiling in month 9

8.4 What we would confirm together

Five items sharpen the plan, and every one lives in the health center's own systems or one call away. None of them holds up the start — the 90-day plan above collects them in its first two windows.

1. **The traditional-Medicare split behind the 5,299.** A payer-mix pull from eClinicalWorks in week one. It sets each program's target list and the order sites come online, and it replaces the conservative 2,100-patient row in Section 4.4 with a measured number.
2. **The assigned-beneficiary count, from the ACO.** It establishes the verified traditional-Medicare floor inside the panel and sizes the shared-savings position described in Section 5.
3. **The Medicare Advantage lineup and its care-management terms.** With 62.4% of footprint beneficiaries in MA plans, a contract-by-contract read of how the care-management code families are paid decides how far beyond traditional Medicare this program reaches. The 100%-of-Medicare requirement is the floor those conversations start from.
4. **The record system, confirmed.** eClinicalWorks is evidenced by the organization's own patient-portal instance. Confirming version and hosting sets the integration build date in the 90-day plan.
5. **Whatever bundled care-management volume ran under G0511.** Organization-side volume on that code is not visible in any public file. The number sits in the billing system, and it is the cleanest baseline for measuring what this program adds.

9. Recommendations

1. **Point the existing outreach discipline at the Medicare panel.** This organization already runs enabling services for 2,522 patients, school-based clinics and two mobile units. Start with the 7,732-patient hypertension registry and the 4,063-patient diabetes registry, because both cohorts are already identified, and bill the work to the one payer that pays for it code by code.
2. **Treat the G0511 conversion as the forcing function it is.** Code-level care-management billing became the health center's job on January 1, 2026. The compliance work exists whether or not a program does. Run it through a system that captures time, attaches documentation to the chart and generates the claims automatically, rather than building that machinery by hand on a lean billing team.
3. **Lead the enrollment conversation with APCM on the dual panel.** With 39.6% of the Medicare panel dually eligible, a large share of patients map to the highest APCM tier and face no Medicare cost-sharing. It is the fastest program to reach its ceiling — month 9 — and the cleanest first yes.
4. **Buy enrollment capacity, not panel size.** Panel growth moves the 24-month number by 1.4%. A second CoachCare-funded enrollment specialist moves it by 22.4%, and the prescriber count moves it by up to 17.3%. On a pace-limited account, every decision that widens the enrollment funnel converts directly into revenue.
5. **Make the service line the ACO strategy.** Attribution runs on primary-care services, and the ENHANCED track settles on total cost of care in both directions. The 1,311 patients this program touches, the 78 admissions it avoids and the colorectal screening number the ACO's own reporting flags are the shared-savings case rather than a side effect of it. Bring the assigned-beneficiary count into the first working session.
6. **Read the Medicare Advantage contracts early.** 62.4% of footprint beneficiaries are in MA plans as of the May 2026 enrollment file. Those plans pay a health center at least 100% of the Medicare rate for covered services, and each contract sets its own terms for the care-management code families. A contract-by-contract read in the first month decides how much of the panel beyond traditional Medicare this program can reach.
7. **Ship cellular devices from day one.** Home broadband runs between 63% and 70% in Warren, Glascock and Taliaferro counties. Cellular-paired devices need no patient WiFi, no app and no smartphone, which is the difference between a program that works across 14 rural counties and one that works in the two with the best connectivity.
8. **Sign the escalation matrix at leadership level before the first patient.** Thresholds, per-site routing and after-hours cover in Section 6 are governance decisions. Agreeing them once, in writing, is what lets 24 sites across 14 counties run one program safely.
9. **Sequence Georgia's rails correctly.** Georgia Medicaid does not pay for remote monitoring under fee-for-service, so the second act is not a Medicaid billing play. It is the state's rural-health investment, the ACO's next performance year and the panel that ages into Medicare a point a year — all of which the same infrastructure serves once the Medicare program is running.

The Medicare panel is a quarter of this health center's patients, and it supports a $2,722,969 service line at a 42.66% margin inside 24 months — because the codes now pay on top of the PPS visit, because the dual-eligible mix puts a large share of the panel in the highest APCM tier, and because the outreach discipline the program needs is one the organization already practises. The forecast is still climbing in its final month, which means the number above is the floor on what the second 24 months look like.

References & Data Sources

- **HRSA Health Center Program records** (retrieved August 2026): the Uniform Data System awardee profile for grant H80CS00507, CY2021 through CY2025, for total patients, payer mix, the Medicare-primary and dually-eligible counts, age distribution, poverty and special-population counts, chronic-disease registries, total cost and cost per patient, the 2026 Community Health Quality Recognition badges, and the full clinical quality measure set with HRSA adjusted quartile rankings; and the HRSA Health Center Service Delivery and Look-Alike Sites file, for the 24 active service-delivery sites across 14 counties. CY2025 is the most recent published reporting year.
- **CMS provider and claims files** (retrieved August 2026): the Doctors & Clinicians national file, rolled up on the organization's PAC identifier, for the Medicare-enrolled clinician roster and the specialty composition behind the referring-prescriber input; the national provider registry, address-matched against the organization's own site addresses, for the nurse-practitioner and physician-assistant bench that the clinician file does not capture; and the Medicare Physician & Other Practitioners by Provider and Service file, CY2024, queried per clinician across the remote monitoring, chronic care management, principal care management, advanced primary care management and transitional care management code families, with a known-positive control validating the query.
- **Medicare payment rules for health centers:** CMS MLN006397, the Federally Qualified Health Center booklet, March 2026 edition, for payment of the individual care-coordination codes at physician fee schedule rates alone or with other payable services, the general-supervision rule and the absence of a face-to-face requirement; and the CY2026 physician fee schedule for the 99445 and 99470 remote-monitoring codes, the 99453, 99454, 99457 and 99458 families, the 99490 and 99439 chronic care management codes, and the G0556 through G0558 advanced primary care management tiers, resolved at MAC locality 10212/99 and compared code by code against the national non-facility schedule.
- **Medicare Shared Savings Program PY2026 participant file** (data.cms.gov, retrieved August 2026): participation in ACME Health Partners ACO, ACO identifier A5460, third agreement period beginning January 1, 2024, ENHANCED track, low-revenue, retrospective assignment, with ACO Primary Care Flex status recorded as zero; the CMS ACO Primary Care Flex PY2026 participant notice, January 2026, in which the ACO does not appear; and the ACO's own public reporting for the seven-participant composition, the governing-board structure and the PY2024 shared savings of $941,298.81 distributed 80% to participants.
- **Market and population sources:** the CMS Medicare Monthly Enrollment file, May 2026, for the 84,727 footprint beneficiaries, the 62.4% Medicare Advantage share and the 21,701 dually-eligible beneficiaries across the 14 counties; and the U.S. Census Bureau American Community Survey 2024 five-year estimates for county population 65 and over, poverty and household broadband subscription.
- **Georgia payment authority:** the Georgia Department of Community Health Physician Services Manual and FQHC/RHC Services Handbook, April 2026 editions, for the non-coverage of remote patient monitoring under Medicaid fee-for-service and the treatment of care management inside the encounter rate; and the state telemedicine guidance issued through the Medicaid management information system.
- **Georgia rural health transformation program:** the Governor's award announcement of December 2025 and the Department of Community Health approval announcement of February 2026 for the $218.86 million first-year CMS award and the $1.43 billion five-year plan; and the Georgia Hospital Association strategy summary of January 2026 for the funded strategy weightings covering value-based-care readiness, care coordination, telehealth and care-coordination technology.

- **340B records:** the HRSA 340B Office of Pharmacy Affairs Information System covered-entity record for the organization, recertified February 2026, and the national provider registry listing for its retail pharmacy.
- **The record system:** eClinicalWorks, evidenced by the organization's own eCW-hosted patient-portal instance. Integration detail is from the CoachCare eClinicalWorks integration overview: the five pillars in Section 3.6, the under-five-days interval from enrollment flag to first service, the monthly attachment of Evidence of Care, vitals and care plans, and automated claim creation through the CoachCare billing engine.
- **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 6.
- **CoachCare Value Analysis for Community Health Care Systems, 2026:** every financial, enrollment, clinical-output and operational figure in Sections 3, 4, 5 and 8, built on 5,299 Medicare-primary patients, 15 referring prescribers, one on-site enrollment specialist, and CY2026 Medicare physician fee schedule rates at MAC locality 10212/99 for remote physiologic monitoring, chronic care management and advanced primary care management. Each scenario in Section 4.4 is a full recomputation rather than a scaled estimate.
- **The organization's own published materials** (retrieved August 2026): chcsga.org, for the county list, the site and service inventory, the Joint Commission accreditation and FTCA deeming statements, the patient-portal instance, and the open clinical positions cited in Section 3.3.

A note on how this report handles counts

Unique patients and program enrollments are different numbers. At M24 the program holds 2,145 active program enrollments belonging to 1,311 unique patients, because a patient may hold a monitoring enrollment and a care-management enrollment at the same time, while chronic care management and advanced primary care management cannot both be billed for one patient in one month. Wherever this report gives a patient count it says patients; wherever it gives an enrollment count it says enrollments.

Panel counts come from the Uniform Data System, not from claims. Health-center encounters bill institutionally under the organization's own certifications rather than clinician by clinician on the physician fee schedule, so physician-file claims systematically undercount a health-center panel. The 5,299 Medicare-primary figure used throughout is the measured CY2025 UDS count, and Medicare Advantage members already sit inside it.

No individual is named anywhere in this report. Clinicians, executives, board members and ACO personnel are described by count and by the role the organization holds.