



Health Education, Assessment and Leadership, Inc. · Atlanta, Georgia

COACHCARE | SERVICE LINE STRATEGY

A Federally Qualified Health Center serving southwest Atlanta and Douglasville from six sites, a mobile unit and two school-based clinics, on eClinicalWorks

Remote Care Service Line Performance & Optimization 2026 Strategy Report

A chronic-disease service line for the health center's Medicare panel: remote physiologic monitoring, chronic care management and advanced primary care management, billed as individual codes on top of the PPS encounter since 2025 — with the enrollment and engagement labor funded by CoachCare.

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of HEALing Community Health: the Medicare structure of Fulton County, the billing rules a health center works under since 2025, a 24-month Value Analysis for a remote care service line on the Medicare panel, the clinical governance that would run it, the eClinicalWorks integration it lives in, and the health-equity design a safety-net program has to get right.

The argument is short. A safety-net center whose patients are overwhelmingly low-income carries a Medicare population that is heavily dual-eligible, and since 2025 Medicare pays a health center for the month of care between visits as its own codes, at national amounts, on top of every visit — and the dual mix makes the monthly code worth more here than almost anywhere. The Medicare book is small today; it is margin-positive now and it scales as the panel is confirmed and grows. The people to run it are ours.

**Prepared by CoachCare for discussion with HEALing Community Health. © 2026 CoachCare.
Illustrative, modeled figures — verify against practice data.**

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Executive Summary

HEALing Community Health is a Federally Qualified Health Center in Atlanta, Georgia — the operating brand of Health Education, Assessment and Leadership, Inc. Founded by a head-and-neck surgeon who began seeing uninsured patients around 2009, it became a Health Center Program grantee in 2013 and today runs six HRSA-registered sites across southwest Atlanta and Douglasville, plus a mobile medical unit and two school-based clinics, on the eClinicalWorks record.¹ Its 2024 Uniform Data System report counts 2,330 patients, 98% of them from racial or ethnic minorities and more than nine in ten living below the federal poverty level; the center is a registered 340B covered entity and offers family medicine, pediatrics, women's health, behavioral health and dental care, with telehealth live at every site.²

What the record does not yet show is a Medicare revenue line for the month between visits. There is **no evidence of any remote monitoring, chronic care management or advanced primary care management program** at the health center — no program page, no vendor, no care-manager posting — and a health center's care-management billing is structurally invisible in the public Medicare claims files in any case, so the honest reading is open whitespace, confirmed on the call.³ The chronic-disease burden the program would serve is high and documented; the registries already live in eClinicalWorks; the between-visit layer is missing.

Fulton County's Medicare population is heavily Medicare Advantage — about 55% in 2026 — so the traditional-Medicare, fee-for-service subset of any panel here is smaller than the headcount suggests, and sizing it is a discovery item.⁴ Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.

¹ HEALing Community Health is the operating brand of Health Education, Assessment and Leadership, Inc., a 501(c)(3) organization; Federally Qualified Health Center, HRSA Health Center Program grantee via a New Access Point award in 2013; clinic operations began around 2009. HRSA Health Center Program records; the health center's website, retrieved September 2026.

² HRSA Uniform Data System profile, 2024 reporting year: 2,330 total patients; 98% racial or ethnic minority; more than 90% below the federal poverty level. 340B OPAIS; registered covered entity since 2015. Services and telehealth as listed on the health center's website and HRSA site records, retrieved September 2026.

³ No remote monitoring, chronic care management or advanced primary care management program is evident from the health center's website, news or job postings (retrieved September 2026). CMS suppresses any provider-and-code line under 11 beneficiaries, and care management billed on a health-center claim does not appear in the public professional-claims files, so the whitespace is confirmed on the call rather than asserted from claims.

⁴ CMS Medicare Advantage county penetration, 2026: Fulton County, about 158,000 Medicare beneficiaries, about 55% enrolled in Medicare Advantage.

The observation this report is built on

A safety-net center whose patients are overwhelmingly low-income carries a Medicare population that is heavily dual-eligible. Since 2025, Medicare pays a health center for the month of care between visits as its own codes, at national amounts, on top of every visit — and the dual mix makes the monthly code worth more here than almost anywhere. The Medicare book is small today; this is margin-positive now and it scales as the panel is confirmed and grows. The people to run it are ours.

G0511, the bundled code health centers used for care management, was retired on September 30, 2025. From October 1, 2025 a health center bills chronic care management, remote physiologic monitoring and advanced primary care management as individual codes at national non-facility Physician Fee Schedule amounts, in addition to the PPS encounter.⁵ The short-window remote monitoring codes new for 2026 (99445, 99470) fit partial and post-visit months exactly.

What the Value Analysis returns

The forecast prices a service line for the health center's Medicare panel — modeled at an estimated 150 patients, the single most important number to confirm — referred by the three clinicians in adult medicine and delivered by CoachCare under the health center's clinical direction, priced at the national amounts a health center is paid for these codes. It is illustrative and modeled; the figures are to be verified against the health center's own data.⁶

	Year 1	Year 2	24 months
Net reimbursement	\$72,144	\$76,608	\$148,752
CoachCare fees	\$45,098	\$40,563	\$85,661
Net to the health center	\$27,046	\$36,046	\$63,092
Margin to the health center	37.49%	47.05%	42.41%

CoachCare Value Analysis. CY2026 national non-facility Physician Fee Schedule amounts, the rail a health center bills care-management codes on. 150 Medicare patients in scope (estimated); RPM + CCM + APCM. Margin is net to the health center divided by net reimbursement. Illustrative, modeled figures — verify against practice data. Figures are rounded to the nearest dollar.

- 1. This is a \$63,000 two-year net line on a roughly 150-patient panel, and it fills in the first quarter.** It is not a large program, and the report does not dress it as one. Every program reaches its ceiling early: APCM and CCM in month 2, RPM in month 3. At M24 the program holds 68 active program enrollments across 44 unique patients, the same census it holds at M12. The binding constraint is the size of the Medicare panel, not enrollment capacity or clinician count.
- 2. It funds itself from the second month, not the first.** Month 1 nets -\$5,519 to the health center, because implementation and the eClinicalWorks integration land before enrollment revenue does. The first positive month is M2, at \$2,390. From M4 the service

⁵ CY2025 Physician Fee Schedule Final Rule (CMS-1807-F): Federally Qualified Health Centers report the individual CPT and HCPCS codes for care management in place of G0511, paid at national non-facility Physician Fee Schedule amounts in addition to the PPS encounter; G0511 retired September 30, 2025 after a transition period; advanced primary care management adopted on the same basis. CY2026 Final Rule (CMS-1832-F) for 2026 dates of service, including the new codes 99445 and 99470.

⁶ CoachCare Value Analysis for HEALing Community Health, 2026. Basis: CY2026 national non-facility Physician Fee Schedule amounts; an estimated 150 Medicare patients in scope; 3 referring clinicians; RPM, CCM and APCM. Illustrative and modeled; to be verified against the health center's own data.

line runs at \$6,384 in monthly net reimbursement and \$3,004 net to the health center. It is margin-positive from the second month, not day one.

3. **The dual-eligible mix is the wedge.** Because more than nine in ten of the health center's patients live below the federal poverty level, its Medicare patients are far more likely than a typical panel to be dually eligible. Advanced primary care management pays its highest tier, G0558 at \$117.24 a month, for a Qualified Medicare Beneficiary — the best-paying monthly code on the page, and the reason APCM earns its place on a panel this size.
4. **Nobody is hired.** CoachCare delivers 995 hours of care-team work over 24 months, about 0.48 full-time-equivalent years, including CoachCare-funded enrollment support, for a health center of roughly 23 employees. No capital outlay and no new requisition; the enrollment and engagement labor is ours.
5. **The work compounds where the center's mission and quality reporting live.** A documented monthly touch for hard-to-reach chronic patients is exactly the care the center's Uniform Data System quality measures reward, and it pairs with the center's 340B medication access. The clinical return is concrete: the forecast projects about 5.2 avoided hospitalizations over 24 months, roughly \$78,000 of cost that accrues to payers, not to the health center's fee revenue.
6. **The panel is the number to confirm, and the growth is in it.** The 150-patient panel is an estimate; the current Medicare-primary count in eClinicalWorks is discovery item one, and it moves 24-month net reimbursement from about \$117,000 to \$205,000 across a credible range. The service line is margin-positive on the small book today and scales as the Medicare panel grows.

1. The Health Center Today

1.1 A founder-led safety-net center for southwest Atlanta and Douglas County

HEALing Community Health is the operating brand of Health Education, Assessment and Leadership, Inc., a 501(c)(3) organization that grew out of a free and mobile clinic and became a Health Center Program grantee, a full Federally Qualified Health Center, through a New Access Point award in 2013.⁷ HRSA lists six active service sites: a main and administrative campus on Cascade Road in southwest Atlanta, a dental site, a full medical and dental site in Douglasville, a mobile medical unit, and two school-based clinics; the health center has been a registered 340B covered entity since 2015.⁸ The patient base is low-income and almost entirely from racial and ethnic minority communities: the 2024 Uniform Data System report counts 2,330 patients, 98% minority, with more than nine in ten below the federal poverty level.

The health center, in its public record	Detail
Designation	Federally Qualified Health Center, HRSA Health Center Program grantee (New Access Point, 2013)
Total patients (UDS 2024)	2,330 · 98% racial or ethnic minority; more than 90% below the federal poverty level

⁷ HRSA Health Center Program grant record (New Access Point, 2013); the health center's website and public program narrative, retrieved September 2026. The organization is a 501(c)(3) corporation.

⁸ HRSA Health Center Service Delivery Sites file: six active sites (a main and administrative campus, a dental site, a Douglasville medical and dental site, a mobile medical unit and two school-based clinics), across Fulton and Douglas counties, with telehealth recorded at each. 340B OPAS: registered covered entity since 2015, recertified 2025.

The health center, in its public record	Detail
Sites	Six HRSA-registered sites, a mobile medical unit and two school-based clinics, across Fulton and Douglas counties
Services	Family medicine and adult health, pediatrics, women's health, behavioral health, dental, vaccinations, telehealth at every site
340B	Registered covered entity since 2015 ; discounted medication for eligible patients
EHR	eClinicalWorks, with the healow patient portal live on the health center's site
Team	About 23 employees; a small adult-medicine clinical roster

Sources: HRSA Health Center Program and Uniform Data System records (2024); the 340B OPAIS registry; the health center's website (2026). Counts are the health center's own reported figures.

Two things follow for a service line. The center already reaches hard-to-reach patients through channels most practices do not have — a mobile unit, school-based clinics, and social-needs screening — and it already runs on eClinicalWorks, one of CoachCare's named integration platforms, so the program can live inside the record the clinicians already use. A remote care service line adds a new, margin-positive revenue line without capital and without a new hire, on a panel the center already sees.

1.2 A high chronic-disease burden, and the month between visits

The population this program would serve carries a high and documented chronic-disease burden. The health center's own program narrative names diabetes, hypertension and cardiovascular disease as disproportionately prevalent among the community it serves, and those patients are seen a few times a year in the office.⁹ The registries that identify them — who has hypertension, whose diabetes is out of range, who was recently in the hospital — already live in eClinicalWorks. What is missing is the layer between visits: the monthly documented contact, the connected device, the reading worked before it becomes an admission.

That between-visit layer is also where a health center's quality performance is won. The same monthly, documented care-management work that generates the revenue in this report is the work the Uniform Data System clinical-quality measures reward: blood-pressure control and diabetes management move on continuous readings and a monthly touch, not on a quarterly office visit. This report makes no claim about the center's current measure rates, which are not public and are a discovery item; the point is structural. The program does not ask the center to fix a number. It builds the between-visit layer once, and the same work compounds into the center's quality reporting, its 340B medication management and its mission for hard-to-reach patients.

⁹ The health center's Health Center Program narrative and website, retrieved September 2026, naming diabetes, hypertension and cardiovascular disease as disproportionately prevalent in the community served. This report makes no claim about the health center's current Uniform Data System clinical-quality measure rates, which are not public.

2. What Changed: A Health Center Now Bills the Month Between Visits

2.1 G0511 is gone; the individual codes pay on top of the PPS encounter

Federally Qualified Health Centers are paid a prospective payment per qualifying encounter. For years, everything a health center did for chronic patients between those encounters was compressed into one bundled monthly code, G0511 — one flat payment regardless of how many services, minutes or programs a patient carried. That code was retired on September 30, 2025. From October 1, 2025 a health center reports the individual CPT and HCPCS codes, the CCM, RPM and APCM families among them, and Medicare pays each at the **national non-facility Physician Fee Schedule amount, in addition to the PPS encounter**.¹⁰

CY2026 also added two short-window codes: 99445 pays the device-supply month when a patient transmits 2 to 15 days of readings rather than 16 or more, and 99470 pays the first 10 minutes of monthly management time where 20 minutes is not reached. A patient who enrolls mid-month, or transmits only a handful of readings in a first partial month, used to produce an unbillable gap; now it bills. In this forecast the two codes carry about 9% of net reimbursement, revenue that did not exist a year ago.¹¹

The structural consequence is the point. Between-visit care stops being a flat bundled payment and becomes a per-service revenue line that scales with enrollment and delivered work, on a panel the health center already sees.

2.2 What the codes pay a health center

The Value Analysis is priced at the national amounts a health center is paid for these codes: the CY2026 non-facility Physician Fee Schedule at the national conversion factor with no geographic adjustment. That is the rail a health center bills care-management codes on, and it is the only basis on any page of this report. Atlanta's own locality runs slightly above the national amounts, so the national rail is the conservative choice as well as the correct one.¹²

Code	What it pays for	Cadence	CY2026 national amount
99453	RPM setup and patient education	One-time	\$21.71
99454	Device supply, 16–30 days of readings	Monthly	\$52.11
99445	Device supply, 2–15 days of readings (new 2026)	Monthly	\$52.11
99457	RPM management, first 20 minutes	Monthly	\$51.77
99470	RPM management, first 10 minutes (new 2026)	Monthly	\$26.05
99458	RPM management, each additional 20 minutes	Monthly	\$41.42
99490	CCM, first 20 minutes of clinical staff time	Monthly	\$66.13
99439	CCM, each additional 20 minutes	Monthly	\$50.44

¹⁰ CMS-1807-F (see note 5): G0511 retired with a transition period through September 30, 2025; from October 1, 2025 the individual codes are the standing requirement. CMS-1832-F added the advanced primary care management and remote monitoring code updates for 2026.

¹¹ CoachCare Value Analysis, Financial Value detail: 99445 and 99470 together carry about 9% of the forecast's net reimbursement on this account's code frequencies.

¹² CY2026 Physician Fee Schedule national non-facility amounts (CMS RVU26A, January 2026 release): total non-facility relative value units times the \$33.4009 conversion factor, with every geographic practice cost index at 1.000. Health centers bill the care-management codes at the national amount regardless of the locality their ZIP code falls in; Atlanta's own locality runs slightly above the national amounts, so the national rail is the conservative basis.

Code	What it pays for	Cadence	CY2026 national amount
G0556	APCM, level 1: one chronic condition	Monthly	\$16.37
G0557	APCM, level 2: two or more chronic conditions	Monthly	\$53.78
G0558	APCM, level 3: Qualified Medicare Beneficiary	Monthly	\$117.24
99495	Transitional care management, moderate complexity	Per discharge	\$220.11 (named, not in the forecast)
99496	Transitional care management, high complexity	Per discharge	\$298.60 (named, not in the forecast)
99484	Behavioral health integration, first 20 minutes	Monthly	\$57.45 (named, not in the forecast)

CY2026 national non-facility Physician Fee Schedule amounts, the Value Analysis basis. The APCM tiers are weighted toward level 3 by the dual-eligible mix (see 3.2); APCM returns \$68.12 per patient-month of net reimbursement in the forecast. Illustrative, modeled figures — verify against practice data.

These are Original Medicare amounts. Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families. With Medicare Advantage carrying the majority of Fulton County's Medicare, that contract check is a discovery item, not a load-bearing assumption.

2.3 The work the change creates, and who carries it

Individual-code billing pays more and asks more. Each code carries its own eligibility test, consent, time capture and documentation standard, and the claim volume is real: this forecast generates about 2,310 claims over 24 months. In the operating model of Section 11, CoachCare carries the load — enrollment, device logistics, monitoring documentation and billing-ready claim generation inside eClinicalWorks. The health center's own billing team files the FQHC claims with the care-management codes, and the clinicians keep the clinical decisions.

One structural note, because the deal design has to respect it. **Georgia Medicaid does not reimburse remote monitoring, chronic care management or advanced primary care management on a fee-for-service basis**, so Medicare is the only billable rail in this forecast and it carries no Medicaid dollar.¹³ The Medicaid and uninsured majority of the panel is served by the same clinical infrastructure as reach and mission, not as revenue; Section 5 sets that out.

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

3.1 The clinical and billing stack

Three programs, one infrastructure. Remote physiologic monitoring supplies the daily signal; chronic care management and advanced primary care management supply the monthly coordination wrapper. Enrollment, devices, monitoring, escalation, documentation and claims run on the same CoachCare engine for all three. Principal care management is off: a primary-care panel bills CCM or APCM, not the single-condition specialist code.

¹³ Georgia Department of Community Health Medicaid policy: remote physiologic monitoring, chronic care management and advanced primary care management are not reimbursed on a fee-for-service basis. The Value Analysis carries no Medicaid dollar.

Program	Who qualifies (of ~150 Medicare patients)	What it is	Billing
RPM	About 98 (65%): hypertension, diabetes, heart failure, COPD	Cellular-connected devices (blood-pressure cuff, glucose meter, scale, pulse oximeter); readings monitored against clinical thresholds; monthly management time	99453 setup; 99454/99445 supply; 99457/99470/99458 management
CCM	About 60 (40%): two or more chronic conditions expected to last twelve months or more	Monthly non-face-to-face coordination: comprehensive care plan, medication reconciliation, referrals, outreach	99490 + 99439
APCM	About 52 (35%): ongoing primary-care relationship; level set by condition count and Qualified Medicare Beneficiary status	Monthly bundle of thirteen practice-capability elements; no minute tracking	G0556 / G0557 / G0558
TCM	Any inpatient discharge home to a health-center patient	Contact within two business days, medication reconciliation, a face-to-face visit within 7 or 14 days	99495 / 99496, named and not in the forecast

Eligible-pool counts from the Value Analysis eligibility model on the estimated 150-patient Medicare panel; pools overlap, billing does not (see the coordination rule below). Illustrative, modeled figures — verify against practice data.

One coordination rule, set at enrollment

APCM and CCM never bill for the same patient in the same month; a patient carries one care-management wrapper, not two. RPM stacks with either. A transitional care episode runs for 30 days after a discharge and does not overlap APCM for that patient in that month. The enrollment workflow assigns each patient a wrapper (CCM or APCM) plus RPM where clinically indicated, so the code families never collide on a claim.

3.2 The dual-eligible mix: why APCM pays more here

Advanced primary care management is a monthly bundle with three tiers, and the tier is set by the patient, not the minutes. Level 1 (G0556, \$16.37) covers one chronic condition; level 2 (G0557, \$53.78) covers two or more; level 3 (G0558, \$117.24) applies to a Qualified Medicare Beneficiary with two or more conditions. In most panels the level-3 tier is a small minority. Here it is not likely to be. Because more than nine in ten of the health center's patients live below the federal poverty level, its Medicare patients are far more likely than a typical panel to be dually eligible — and the dual-eligible share is the single input that sets how much of the panel lands on G0558.¹⁴ Confirming it is a discovery item; the forecast weights the tiers toward level 3 on that structural expectation — about 15% level 1, 45% level 2 and 40% level 3 — and APCM returns \$68.12 per patient-month of net reimbursement, with G0558 the single best-paying monthly code on the page.

The service line pays the health center three ways. First, additive revenue: every care-management dollar lands on top of the PPS encounter, not inside it. Second, the quality

¹⁴ CMS Advanced Primary Care Management: G0556 level 1 (one chronic condition), G0557 level 2 (two or more), G0558 level 3 (a Qualified Medicare Beneficiary with two or more); CY2026 national non-facility amounts \$16.37 / \$53.78 / \$117.24. The dual-eligible and Qualified Medicare Beneficiary share of this panel is unverified and is a discovery item; the forecast weights the tiers toward level 3 (about 15% / 45% / 40%) on the structural expectation given more than 90% of patients below the federal poverty level, and APCM returns \$68.12 per patient-month.

measures the center reports to HRSA move on continuous readings and a monthly documented touch, so the same work compounds into its Uniform Data System performance. Third, avoided admissions: a patient whose fluid weight climbs for four days is treated by phone and in clinic, not admitted three weeks later. That is where the forecast's 5.2 avoided hospitalizations come from.

3.3 The Medicare panel it runs on: an estimate to confirm

The forecast is built on **an estimated 150 Medicare-primary patients, and this is the single most important number to confirm**. Unlike a published patient count, the health center's current Medicare-primary figure is not public. The last payer mix in the public record put Medicare near 5% of the panel; against the 2,330 patients in the 2024 Uniform Data System report that implies roughly 117. The forecast uses 150 — about 6% of the panel, still below the roughly 9% Medicare share typical across health centers nationally — as a deliberately conservative central estimate.¹⁵ From that panel the eligibility model carves the program pools: about 98 patients RPM-eligible (65%), 60 CCM-eligible (40%), 52 APCM-eligible (35%). The pools overlap; the coordination rule keeps the billing disjoint.

Say plainly what this means. The Medicare-primary chart count in eClinicalWorks is the first discovery item, and it moves the whole forecast: across a credible range of 117 to 210 Medicare patients, 24-month net reimbursement runs from about \$117,000 to \$205,000, and the margin holds above 40% throughout (Section 12 prices each step). Two further unknowns sit on top of the panel count and are discovery items in their own right: the dual-eligible and Qualified Medicare Beneficiary share, which sets the APCM tier blend, and the fee-for-service versus Medicare Advantage split, since Fulton County's Medicare is majority Medicare Advantage. Medicare Advantage members are already inside the 150 count, with no gross-up.

3.4 Transitional care and behavioral health, named and not in the forecast

Two adjacent programs are named here and carry no dollars in the forecast. Each discharge home to a health-center patient opens a transitional care management episode — an interactive contact within two business days, medication reconciliation, and a face-to-face visit within 14 days (99495, \$220.11) or 7 days (99496, \$298.60).¹⁶ TCM is on the recommended stack because a discharge is the highest-yield moment to enroll a patient in monitoring, but it carries no dollars here: the center's discharge volume is a discovery item, and every episode billed later is upside. Behavioral health integration (99484, \$57.45 a month) is the natural next arm for a center with an in-house behavioral health division: the same infrastructure, the same monthly cadence, applied to a population the center already treats. It, too, is named at zero dollars.

¹⁵ The last payer mix in the public record put Medicare near 5% of the panel; against the 2,330 patients in the 2024 Uniform Data System report that implies roughly 117. The forecast uses 150 (about 6% of the panel), below the roughly 9% Medicare share typical across health centers nationally (HRSA national Uniform Data System context). The current Medicare-primary count is a discovery item; the sensitivity analysis in Section 12 models a credible range of 117 to 210.

¹⁶ CPT 99495 and 99496 requirements (interactive contact within two business days of discharge; face-to-face visit within 14 or 7 days; moderate or high medical decision-making); CY2026 national non-facility amounts \$220.11 and \$298.60. CPT 99484, CY2026 national non-facility amount \$57.45. TCM and behavioral health integration are carried at zero dollars in every figure in this report.

3.5 Built the way the codes work, and nobody is hired

The health center's adult-medicine bench is small — three clinicians carry the forecast's referrals — and for this service line that shape is right. CCM, APCM and RPM are general-supervision code families: qualified clinical staff deliver the monthly work under a billing clinician's overall direction, without that clinician in the room. The referral motion is one step — a clinician flags a qualifying patient in the chart — and the program runs from there. Section 12 shows the clinician count barely moves the result.¹⁷

CoachCare delivers 995 hours of care-team work across the 24 months, about **0.48 full-time-equivalent years**, without the health center hiring anyone. At this panel the enrollment resource is a shared, CoachCare-funded one, not a dedicated on-site full-time position — the enrollment and engagement labor is ours, and it is not a program cost to the center. For a health center of roughly 23 employees, the service line adds working capacity and a new revenue line with no capital outlay and no new requisition. The health center's clinicians contribute the two things only they can: the referral flag that starts each enrollment, and clinical judgment at the escalation points.

4. Value Analysis: The 24-Month Forecast

4.1 Headline economics

Over 24 months the service line produces **\$148,752 in net reimbursement** to HEALing Community Health. CoachCare's fees total \$85,661, including \$12,944 of ancillary items: implementation, the eClinicalWorks integration and telephonic outreach. Net to the health center is **\$63,092, a 42.41% margin** on the program — 37.49% in Year 1 and 47.05% in Year 2.¹⁸

¹⁷ CoachCare Value Analysis eligibility and referral model: three referring clinicians in adult medicine; general-supervision code families (CCM, APCM, RPM). Section 12 recalculations show the result changing by less than \$700 of 24-month net reimbursement between two and four referring clinicians.

¹⁸ CoachCare Value Analysis, 24-month forecast: monthly net reimbursement, fees and net-to-health-center series; Year 1 margin 37.49%, Year 2 margin 47.05%, 24-month margin 42.41%, each defined as net to the health center divided by net reimbursement. Ancillary fees of \$12,944 over 24 months: implementation \$2,500; eClinicalWorks integration \$4,000 setup, \$150 a month and \$1.50 per patient-month; telephonic outreach. Figures are rounded to the nearest dollar.

The 24-Month Ramp: Every Program Reaches Its Ceiling in the First Quarter

CoachCare Value Analysis (illustrative, modeled) · 150 Medicare patients in scope (estimated) · at M24: 68 active enrollments across 44 unique patients

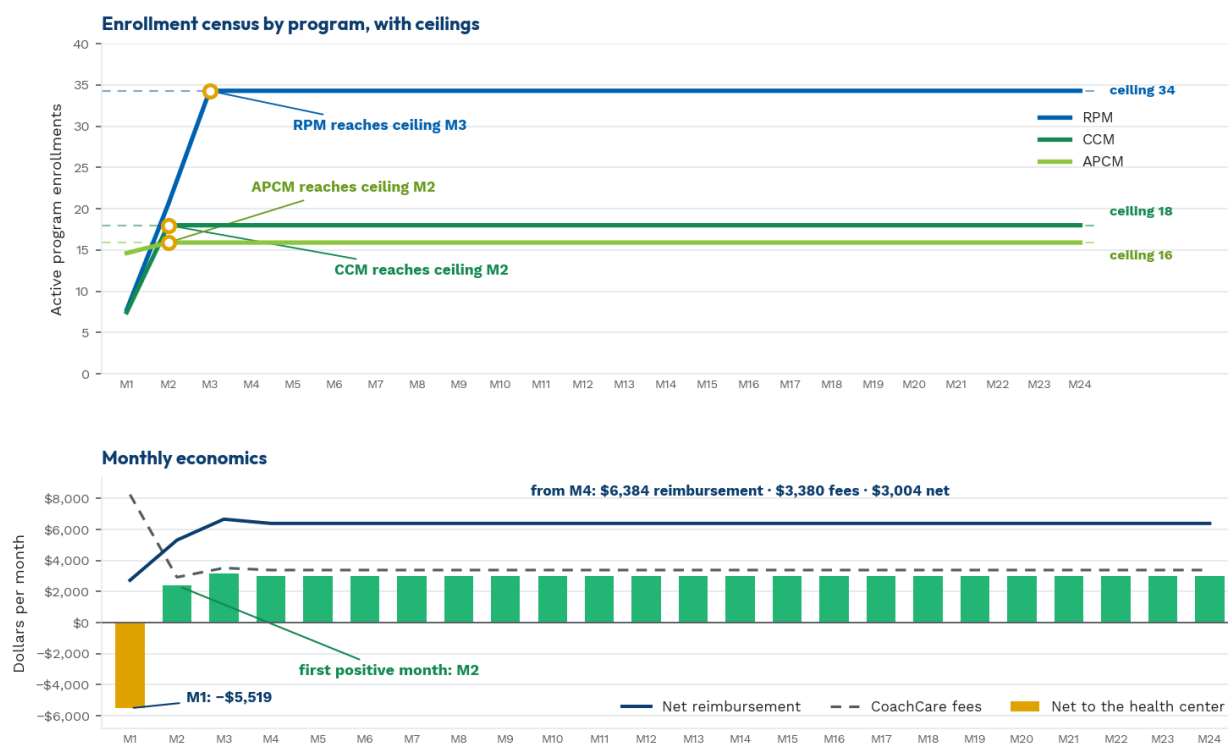


Figure 1. The 24-month ramp: enrollment census by program with ceilings (above) and monthly net reimbursement, CoachCare fees and net to the health center (below). Month 1 nets -\$5,519; the first positive month is M2; from M4 the line holds at \$3,004 net per month. Illustrative, modeled figures — verify against practice data.

The shape of the curve is worth reading precisely. Month 1 is negative, -\$5,519, because implementation and the eClinicalWorks integration land before the first full billing months do. Month 2 turns positive at \$2,390, month 3 nets \$3,141, and the line settles quickly: M3 is the peak at \$6,657 of net reimbursement, and from M4 the line runs at \$6,384 of net reimbursement, \$3,380 of fees and \$3,004 net a month once the setup codes fall away and the census holds at its ceiling. Month 12 and month 24 are the same month.

4.2 Program economics by year

Program	Year 1 net reimbursement	Year 2 net reimbursement	24-month net reimbursement	24-month fees	24-month net
RPM	\$36,479	\$39,688	\$76,168	\$38,679	\$37,489
CCM	\$22,754	\$23,922	\$46,676	\$20,988	\$25,687
APCM	\$12,911	\$12,998	\$25,909	\$13,050	\$12,859
Ancillary (implementation, integration, outreach)	—	—	—	\$12,944	-\$12,944
All programs	\$72,144	\$76,608	\$148,752	\$85,661	\$63,092

CoachCare Value Analysis, per-program economics by contract year. Ancillary items: implementation \$2,500; eClinicalWorks integration \$4,000 setup plus \$150 a month and \$1.50 per patient-month; telephonic outreach.

Illustrative, modeled figures — verify against practice data. Figures are rounded to the nearest dollar and rows may not sum exactly.

Program	Year 1 fees	Year 1 net	Year 2 fees	Year 2 net
RPM	\$18,343	\$18,136	\$20,336	\$19,353
CCM	\$10,232	\$12,522	\$10,757	\$13,165
APCM	\$6,503	\$6,408	\$6,547	\$6,451

Per-program fees and net to the health center by contract year, before ancillary items. Illustrative, modeled figures — verify against practice data.

RPM is the volume engine at about 783 patient-months and \$76,168 of net reimbursement. CCM is the yield engine at \$110.75 of net reimbursement per patient-month across roughly 421 patient-months, against \$97.29 for RPM and \$68.12 for APCM over its 380. APCM earns its place a different way, as Section 3.2 sets out: no minute-tracking, a bundled monthly payment, and the level-3 tier on a panel where the dual-eligible share is structurally high. Year 2 outruns Year 1 by about \$4,500 of net reimbursement because Year 1 carries the ramp and Year 2 runs all three programs at ceiling from its first month.

Service-Line Composition: RPM \$76,168 · CCM \$46,676 · APCM \$25,909

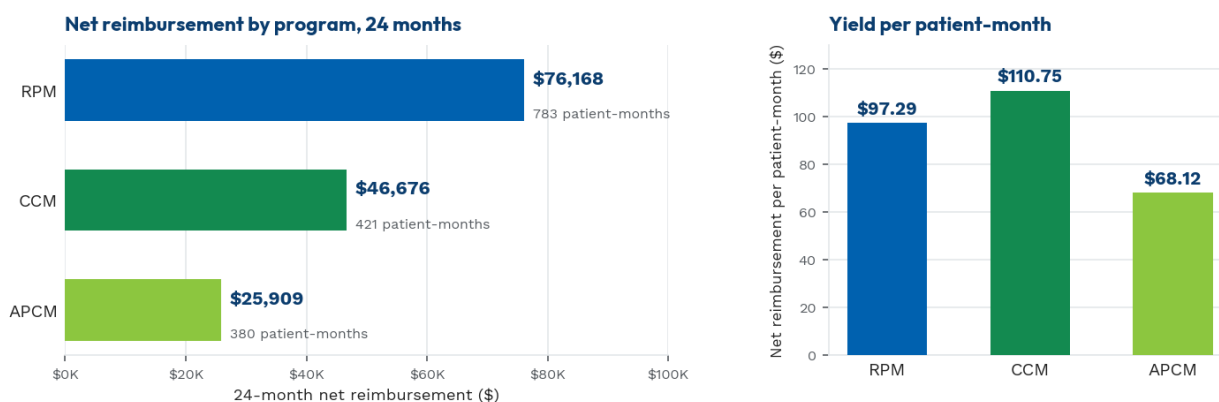


Figure 2. Service-line composition: per-program 24-month net reimbursement and net reimbursement per patient-month. Illustrative, modeled figures — verify against practice data.

4.3 The ramp: every ceiling reached in the first quarter

This account is ceiling-limited in all three programs inside the first quarter. APCM reaches its ceiling of 16 enrollments in month 2, CCM its 18 in month 2, and RPM its 34 in month 3. From month 4 the forecast is flat because there is no one left to add.¹⁹ The first 90 days move fast: about 30 new enrollments across the three programs in month 1, 25 in month 2, 15 in month 3.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
RPM	98	34	Month 3	34
CCM	60	18	Month 2	18

¹⁹ CoachCare Value Analysis enrollment model: program ceilings 34 (RPM), 18 (CCM), 16 (APCM); ceilings reached in months 3, 2 and 2; 68 active enrollments across 44 unique patients at month 24 and at month 12.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
APCM	52	16	Month 2	16
All programs		68		68 enrollments · 44 unique patients

Enrollment counts are program enrollments, not unique patients; the 68 enrollments at M24 belong to 44 unique patients (44 at M12), because a patient may carry a monitoring enrollment and a care-management enrollment at the same time. Illustrative, modeled figures — verify against practice data.

Say the constraint out loud: what binds this program is the size of the Medicare panel, not enrollment capacity, and not clinician count. That cuts two ways. It caps the near-term forecast at a two-year net line near \$63,000, and it de-risks it, because the model asks the clinicians for no heroic enrollment performance, only a panel that exists. Two things move the ceiling upward, and both are in the health center's own hands: confirming and then growing the Medicare panel, and adding the behavioral-health arm once the first three programs are full. The CoachCare-funded enrollment support cannot raise a ceiling, but it reaches every ceiling months sooner, and Section 12 prices what that is worth.

4.4 What the program produces

24-month output	Volume
Claims generated, billing-ready	2,310
Device readings monitored	8,220
Care-management tasks completed	4,619
Chart updates written to eClinicalWorks	1,155
Patient conversations held	693 (38 hours of call time)
Care-team hours delivered	995 (≈ 0.48 FTE-years)
Hospitalizations avoided	5.2 · ≈ \$78,000 at \$15,000 per admission

CoachCare Value Analysis operational and clinical outputs, 24 months. Illustrative, modeled figures — verify against practice data.

The avoided-admission line deserves its own sentence. About 5.2 avoided hospitalizations over 24 months is roughly \$78,000 of cost that never lands — and it accrues to the payers and the hospitals, not to the health center's fee revenue.²⁰ It is also the entry requirement for any future value-based arrangement: a consented, documented, monthly-managed panel with continuous readings, which this service line builds under fee-for-service first.

5. The Growth Story: The Panel Is the Constraint, and It Can Grow

The honest headline of this report is also its growth story. The service line is margin-positive today on a small Medicare book, and the one thing that limits it is the size of that book — not

²⁰ CoachCare Value Analysis clinical-outcomes module: about 5.2 avoided hospitalizations over 24 months, valued at \$15,000 per avoided admission (about \$78,000). The avoided cost accrues to payers and hospitals, not to the health center's fee revenue.

the clinicians, not the enrollment engine, not the acceptance rate. That is why the first move is to confirm the panel, and the second is to grow it.

Confirm the panel first

The 150-patient estimate is the model's most sensitive input. The current Medicare-primary count in eClinicalWorks settles it, and the range is wide enough to matter: from about 117 patients (24-month net reimbursement near \$117,000) to about 210 (near \$205,000), with the margin holding above 40% across the whole range. Nothing else in the forecast moves the number as much, and it is the health center's own data to pull.

Then grow it

The panel grows two ways. Patients already in the center's care age into Medicare every year, and the payer reconciliation itself typically surfaces patients whose Medicare coverage sits behind another payer in the record. As the Medicare panel grows, the program scales on the same infrastructure — the sensitivity table in Section 12 prices each step — with no change to the operating model.

The larger population is served clinically, not billed

The center's chronic-disease volume mostly sits outside Medicare — in a Medicaid and uninsured population that is the majority of the panel. **Georgia Medicaid does not pay remote monitoring, chronic care management or advanced primary care management on a fee-for-service basis**, so this forecast carries no Medicaid dollar and makes no Medicaid revenue claim. But the same devices, the same escalation engine and the same eClinicalWorks workflow serve those patients clinically at no additional platform cost. That is reach and mission — a documented monthly touch for the hard-to-reach patients the center exists to serve — and it is where the health-equity value of the program sits, distinct from its Medicare revenue.

6. eClinicalWorks Integration: The Program Lives in the Record

The health center runs on eClinicalWorks, one of CoachCare's named integration platforms, and the forecast prices the integration at the catalog tier: \$4,000 setup, \$150 a month and \$1.50 per patient-month.²¹ The program operates inside the record rather than beside it, so the health center's clinicians and billing staff learn no new system.

- **Out of the chart: enrollment flags and orders.** Qualifying patients are flagged and orders triggered inside the eClinicalWorks workflow; CoachCare enrolls flagged Medicare patients on the health center's behalf, and clinicians see enrollment status in real time in the chart they already use. Patients begin receiving services within a few days of the flag.
- **Back into the chart: device data, care plans and status.** Cellular device readings land as integrated vital reports; the care plan, the monthly evidence of care and the integrated care summary attach to the chart each month; enrollment status and time capture write back to the record, so the documentation the codes require is in eClinicalWorks, not in a side system.

²¹ EHR as stated by the health center (eClinicalWorks), September 2026; the healow patient-portal link on the health center's site corroborates it. CoachCare integration pricing for eClinicalWorks as carried in the Value Analysis: \$4,000 setup, \$150 a month, \$1.50 per patient-month.

- **Automated, billing-ready claims.** The CoachCare billing engine assembles the monthly care-management claim lines automatically, the step that makes individual-code billing workable at about 2,310 claims over 24 months. The health center's own billing team files the FQHC claims with the care-management codes.
- **Registry-driven enrollment.** Enrollment lists are pulled from the chronic-disease registries already in eClinicalWorks — hypertension, diabetes, heart failure, COPD — screened by diagnosis and tagged by payer, so the Medicare panel is identified from the record rather than by hand.

7. Clinical Governance and Escalation

7.1 A monitoring program is a clinical operation first

A monitoring program is a clinical operation before it is a revenue line. This section sets out the machinery the health center inherits on the first day: CoachCare's Care Management Programs standard operating procedures, rendered as process maps covering qualification, monitoring, escalation and discharge.²² The purpose is keeping a patient with heart failure or uncontrolled diabetes at home, managed between visits, rather than in a hospital bed.

7.2 One shared escalation engine

Every program — RPM and the care-management wrappers alike — routes through one alert-and-escalation decision logic. A critical value escalates immediately, regardless of symptoms. An out-of-range reading that is not critical gets worked before it escalates: the patient retakes the reading and answers a symptom check, so the clinic hears clinical signal rather than cuff artifacts. Trend rules are explicit. Three consecutive out-of-range blood-pressure or glucose readings at least an hour apart, or three abnormal heart-rate readings inside seven days, count as a trend and draw clinical review even when no single reading is critical.

7.3 The emergent pathway

An active emergent symptom reported during any outreach contact triggers the 911 pathway. That policy supersedes any site-specific escalation preference: whichever site the patient belongs to and whatever day of the week it is, the emergent floor does not move.

7.4 Qualification, device assignment and routing

Enrollment starts with the panel, not the device inventory. The population is screened by diagnosis and routed to the right program and device, and device assignment follows a fixed, ordered hierarchy in which the highest-acuity qualifying condition wins: a patient with heart failure and diabetes gets the device the higher-acuity condition needs. Once monitoring runs, escalations route three ways: emergencies to the emergent pathway, non-critical clinical items to the clinic for direction, and informational items documented to the chart. Cellular devices matter here: a cuff or meter that transmits the moment it is used needs no smartphone, no app and no home broadband, which is the difference between a reading and a device in a drawer for a low-income panel.

²² CoachCare Care Management Programs standard operating procedures and the derived process maps: qualification and device assignment; the RPM patient lifecycle; the care-management lifecycle; alert-and-escalation decision logic; the emergent communication protocol; and the discharge decision flow.

7.5 Discharge governance and continuity

Discharge from the program is governed, not ad hoc. Discharge criteria and unreachable-patient timelines are defined per program, and the clinic is notified in every case. For monitoring patients the sequence is explicit: a recommended discharge first escalates to the clinic for instructions, re-escalates every 30 days, and if the clinic has given no instruction by 180 days the discharge proceeds. Processed discharges post in the first week of the following month. Nobody quietly falls out of the program, and nobody quietly stays in it either.

8. Built for HEALing Community Health: Health Equity and Operational Design

A remote care program for a safety-net panel has to be built for that panel, not adapted to it afterward. The center's patients are overwhelmingly low-income, almost entirely from minority communities, and reached through a mobile unit, school-based clinics and social-needs screening as much as through a main clinic. Six design decisions follow.

- **Cellular devices, not app-dependent.** A cellular cuff or glucose meter transmits the moment it is used: nothing to pair, no smartphone, no app, no password, no home broadband. For a panel where many households do not carry a smartphone or reliable internet, that is the difference between a reading and a device in a drawer.
- **Enrollment through the channels the center already runs.** The mobile medical unit, the school-based clinics and the center's social-needs screening are enrollment channels a typical practice does not have. CoachCare-funded enrollment support works those channels, meeting patients where the center already reaches them.
- **Enrollment lists pulled by condition, not by age.** Enrollment lists come from the hypertension, diabetes, heart-failure and COPD registries in eClinicalWorks, screened by diagnosis with payer attached, so the Medicare and clinical-only populations stay distinct from the first list.
- **A documented monthly touch for the hard-to-reach.** The core of the health-equity case is simple: the program creates a documented, monthly, longitudinal contact with exactly the chronic patients a safety-net center exists to serve and an office schedule reaches least. That is clinical value first, and it also strengthens what the center can show for the population it is accountable to.
- **The work compounds into UDS quality reporting.** Blood-pressure control, diabetes management and the other Uniform Data System measures the center reports move on continuous readings and a monthly documented touch. The same work that bills the Medicare codes compounds into the center's quality performance, with no separate effort.
- **Paired with 340B.** The between-visit medication work — reconciliation, adherence follow-up, refill coordination — pairs directly with the center's 340B medication access for chronic patients, so the monthly touch and the discounted medication reinforce each other.

9. Market Context: Atlanta and Fulton County Medicare

Two market facts shape the program. The first is Medicare Advantage penetration. Fulton County had about 158,000 Medicare beneficiaries in 2026, and roughly 55% of them were enrolled in Medicare Advantage — so a little under half of the county's Medicare is still Original Medicare.²³ Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families. Because the panel is counted by primary payer, Medicare Advantage members are already inside the 150-patient estimate; the fee-for-service versus Medicare Advantage split matters for contract terms, and it is a discovery item, not a reason to discount the panel.

Fulton County and the service area	Value
Medicare beneficiaries, 2026	About 158,000
Medicare Advantage penetration, 2026	About 55% — a little under half of Medicare here is Original Medicare
The health center's patients below the federal poverty level	More than 90%
The health center's patients from racial or ethnic minorities	98%
Service area	Southwest Atlanta (Fulton County) and Douglasville (Douglas County)

Sources: CMS Medicare Advantage county penetration (2026); the health center's Uniform Data System profile (2024). Beneficiary and penetration figures are rounded.

The second market fact is need. The health center's service area is high-need by any measure, and its own panel is more so — more than nine in ten patients below the federal poverty level, in a metropolitan area dense with community health centers. In that market a monthly documented touch in the patient's own community, on a device that needs no broadband, does the work an office schedule cannot.

10. The CY2027 Proposed Rule, Repriced on This Forecast

CMS published its proposed CY2027 Physician Fee Schedule in July 2026; the changes take effect January 1, 2027, and a statutory phase-in caps how far any code's payment can fall in a single year. The proposal that matters here is a reduction to the remote monitoring device-supply codes. Every code in this forecast was repriced at the national amounts on this account's own billing mix, with enrollment held constant; the forecast's basis and the repricing use the same national amounts on both sides.²⁴

²³ CMS Medicare Advantage county penetration, 2026: Fulton County, about 158,000 Medicare beneficiaries, about 55% enrolled in Medicare Advantage, leaving a little under half in Original Medicare.

²⁴ CMS-1848-P, proposed CY2027 Physician Fee Schedule (July 2026). CoachCare repricing at the national non-facility amounts on this forecast's code frequencies and APCM tier weights: device supply 99454 and 99445 from \$52.11 to \$41.38 (–20.6%); the remote monitoring arm –9.5% (–\$7,252); chronic care management –2.1%; advanced primary care management –0.6%; the whole service line –5.7% (–\$8,409, from \$148,752 to \$140,344). Enrollment held constant; a modeling exercise on the proposed amounts, not a final rule.

The cascade: one code, one arm, one line

Device supply, 99454 and 99445: \$52.11 → \$41.38 a month, –20.6%. The code CMS proposes to cut.

The remote monitoring arm: \$76,168 over 24 months, –9.5%, –\$7,252. Device supply is 32% of the remote monitoring basket; management time moves little.

Chronic care management: \$46,676, –2.1%. Advanced primary care management: \$25,909, –0.6%. Conversion-factor and relative-value movement only; the proposal does not target these codes. The care-management movement is \$1,157 of the total.

The whole service line: \$148,752 over 24 months, –5.7%, –\$8,409, to \$140,344. Remote monitoring is 51% of the line, and two of the three programs are not the one being repriced.

The CY2027 Proposed Rule on This Forecast: One Code Cut, One Shared Dollar Scale

Device supply 99454 and 99445: \$52.11 → \$41.38 a month (–20.6%) · the RPM arm –9.5% · the line –5.7%, –\$8,409 of \$148,752

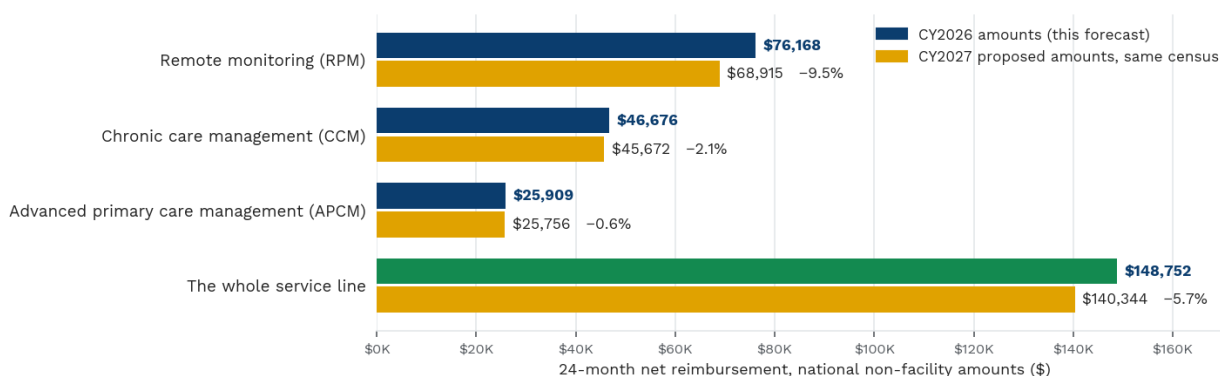


Figure 3. The CY2027 proposed rule on this forecast, at the national amounts on both sides: each arm and the whole line, CY2026 against the CY2027 proposed amounts, same census. Illustrative, modeled figures — verify against practice data.

The proposal is a comment-and-final process, and this is a modeling exercise on the proposed amounts, not a final rule. The point for the executive team is proportion: the cut lands on one code, flows through one arm, and moves the whole service line by a single-digit percentage, because two of the three programs are untouched. The pricing of the program against the final rule is a matter for the working session.

11. Implementation and the First 90 Days

11.1 Who runs what

CoachCare delivers	HEALing Community Health keeps
Telephonic and in-community enrollment; the enrollment support is CoachCare-funded	Referral flags in eClinicalWorks; clinical oversight under general supervision
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans and escalation preferences
Monitoring, documentation and the escalation protocol of Section 7	Responses to clinic-routed escalations
Automated claim creation inside eClinicalWorks	Filing the FQHC claims with the care-management codes; billing review; the revenue

CoachCare delivers	HEALing Community Health keeps
Monthly operating reports against the dashboard in 11.3	Program governance; the community-outreach relationship

11.2 Model inputs

Input	Value
Medicare panel in scope	150 patients (estimated); confirmed against the eClinicalWorks Medicare-primary chart count in the first 30 days
Referring clinicians	3 in adult medicine
Programs	RPM + CCM + APCM; TCM and BHI named, not in the forecast; PCM off
Program-eligible pools	RPM about 98 · CCM about 60 · APCM about 52
Enrollment ceilings	RPM 34 (M3) · CCM 18 (M2) · APCM 16 (M2)
Acceptance	RPM 35% · CCM and APCM 30% of the eligible pool
Enrollment engine	Provider referrals at 80% acceptance; CoachCare-funded enrollment support (a shared, fractional resource at this panel); telephonic outreach on; 1.5% monthly attrition
Rate basis	CY2026 national non-facility Physician Fee Schedule amounts, the rail a health center bills care-management codes on
APCM tiers	Weighted toward level 3 by the dual-eligible mix; \$68.12 per patient-month of net reimbursement
Medicare Advantage	About 55% of Fulton County's Medicare (2026). Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.
EHR	eClinicalWorks, priced at the catalog integration tier (\$4,000 setup, \$150 a month, \$1.50 per patient-month)

Illustrative, modeled figures — verify against practice data.

11.3 The 90-day plan and the operating dashboard

Days 0–30: foundation. Program agreement and the eClinicalWorks integration workplan. The Medicare-primary chart count pulled and the panel confirmed — the one input that moves the model most — with the dual-eligible and Qualified Medicare Beneficiary share and the fee-for-service split alongside it. Diagnosis-based screening of the Medicare panel, device logistics staged, escalation routing set, and clinician orientation to the general-supervision workflow.

Days 31–60: enrollment live. Telephonic, in-clinic and in-community enrollment running; first devices in homes; first billable service months. Month 1 nets –\$5,519 as implementation lands; month 2 turns positive. The forecast carries about 30 new enrollments in month 1 and 25 in month 2.

Days 61–90: scale and file. About 15 new enrollments in month 3, RPM at its ceiling, CCM and APCM already there. First monthly operating report against the dashboard, and the first read on the panel growth and behavioral-health arm that follow.

The operating dashboard from month one:

- Enrollment census by program against ceiling (34 / 18 / 16)

- Time from referral flag to first billable enrollment (target: under five days from flag to first service)
- Device-reading days per patient-month against the 16-day 99454 threshold, with 99445 capturing 2- to 15-day months
- Escalations by pathway: emergent, clinic-routed, documented
- Claims generated against expected claims, and claims filed on the FQHC claim
- Enrolled-patient measures that feed the center's Uniform Data System quality reporting
- Net to the health center per month against the \$3,004 steady-state line

12. Recommendations

1. **Stand up the Medicare service line now, sized honestly.** The individual-code rail has been live since 2025. This is a \$63,092 two-year net line that fills in the first quarter and is margin-positive from the second month; each month of delay pushes it one month further out, and nothing about it waits on a hire.
2. **Confirm the Medicare-primary count in the first 30 days.** The 150-patient figure is an estimate and drives every ceiling in the forecast. The current Medicare-primary chart count in eClinicalWorks is the single largest lever in this report — it moves 24-month net reimbursement from about \$117,000 to \$205,000 — and the table below prices each step.
3. **Lead with APCM on the dual-eligible core of the panel.** The panel is structurally dual-eligible-heavy, and G0558 at \$117.24 a month is the best-paying monthly code on the page. Confirm the dual and Qualified Medicare Beneficiary share, and set the wrapper rule at enrollment so those patients land on APCM level 3.
4. **Add the capacity without adding headcount.** CoachCare delivers about 0.48 full-time-equivalent years of care-team work and funds the enrollment support, for a health center of roughly 23 employees. No capital outlay, no new requisition, and the enrollment and engagement labor is ours.
5. **Let the work compound into quality and mission.** A documented monthly touch for hard-to-reach chronic patients is the health-equity core of the program; the same work compounds into the center's Uniform Data System quality reporting and pairs with its 340B medication access. Build the between-visit layer once and reuse it everywhere.
6. **Plan for panel growth and the larger clinical population.** The service line is margin-positive on the small book today and scales as the Medicare panel grows. The Medicaid and uninsured majority is served by the same infrastructure clinically, at no additional platform cost, even though Georgia Medicaid does not pay these codes.
7. **Set the attribution rule at enrollment.** Each patient carries one care-management wrapper, CCM or APCM, never both in a month, plus RPM where indicated and a transitional care episode after a discharge. One rule, set once in the enrollment workflow, prevents every double-billing collision the code families allow.

What moves the number

Scenario	24-month net reimbursement	Net to the health center	Margin	Ceiling reached RPM / CCM / APCM
Base: 150 panel, 3 clinicians, CoachCare-funded enrollment support	\$148,752	\$63,092	42.41%	M3 / M2 / M2

Scenario	24-month net reimbursement	Net to the health center	Margin	Ceiling reached RPM / CCM / APCM
No enrollment support	\$133,252	\$55,467	41.63%	M8 / M6 / M4
Added (second) enrollment support	\$151,410	\$64,392	42.53%	M2 / M2 / M1
2 referring clinicians	\$148,438	\$62,939	42.40%	M3 / M2 / M2
4 referring clinicians	\$149,067	\$63,244	42.43%	M3 / M2 / M2
Panel 117 (Medicare at 5% of the 2,330-patient panel)	\$116,531	\$47,252	40.55%	M3 / M2 / M1
Panel 170	\$167,775	\$72,455	43.19%	M4 / M3 / M2
Panel 210 (Medicare at the ~9% national health-center share)	\$204,663	\$90,609	44.27%	M4 / M3 / M2

CoachCare Value Analysis recalculations at the same pricing. The binding constraint is the size of the Medicare panel, not enrollment capacity or clinician count; the enrollment support changes when each ceiling is reached, not where it sits. Illustrative, modeled figures — verify against practice data.

Read the table from the bottom up. The clinician-count rows barely move the result, because every program fills inside the first quarter on three referrers. The enrollment-support rows move the timing, not the ceilings: the support is worth about \$15,500 of 24-month net reimbursement against the no-support case, and without it the programs fill in months 8, 6 and 4 rather than 3, 2 and 2. The panel rows are the only rows that move the ceilings, and the panel is the health center's own number to confirm.²⁵

13. The Ask: A Working Session

CoachCare asks for one working session with the health center's executive team, clinical leadership and billing lead. The forecast stands on the figures in Section 4; the session is about the inputs that would move it, in the order they matter.

1. **The Medicare-primary count.** The current number of patients with Medicare as primary payer in eClinicalWorks. This one number sets every ceiling, and it moves 24-month net reimbursement across a range from about \$117,000 to \$205,000.
2. **The dual-eligible and QMB share, and the fee-for-service split.** The dual and Qualified Medicare Beneficiary share sets the APCM tier blend; the fee-for-service versus Medicare Advantage split sizes the billable subset in a county that is majority Medicare Advantage.
3. **The chronic-disease registries by payer.** The hypertension, diabetes and heart-failure counts in eClinicalWorks, with payer attached, size the RPM cohort and confirm the larger clinical population the same infrastructure serves.
4. **The eClinicalWorks product line and interfaces, and who owns care management.** Which eClinicalWorks products the center runs and which interfaces are available, so the integration workplan can be written; and who on the current team owns care coordination and quality day to day.

²⁵ CoachCare Value Analysis recalculations at the same pricing: no enrollment support \$133,252 / \$55,467 / 41.63%; added enrollment support \$151,410 / \$64,392 / 42.53%; two referring clinicians \$148,438 / \$62,939 / 42.40%; four clinicians \$149,067 / \$63,244 / 42.43%; panel 117 \$116,531 / \$47,252 / 40.55%; panel 170 \$167,775 / \$72,455 / 43.19%; panel 210 \$204,663 / \$90,609 / 44.27%. The enrollment support is worth about \$15,500 of 24-month net reimbursement against the no-support case.

5. **Value-based-care participation.** Whether the center takes part in any value-based-care arrangement today is a discovery topic that would shape the roadmap beyond the fee-for-service service line this report sizes.

Everything else in this report — the Medicare Advantage contract terms, the behavioral health arm, and the growth path as the panel is confirmed and grows — is a workplan item that follows the session rather than a condition of it.

About CoachCare

CoachCare runs remote care programs for health centers, specialty practices and health systems: the enrollment, the devices, the clinical monitoring, the documentation and the claims, inside the EHR the organization already uses.²⁶

Measure	CoachCare, 2026
Patients managed	over 400 managed conditions for 500,000+ patients
Clinicians on the platform	10,000+ providers running remote care programs day to day
Implementations	1,000+ programs stood up and running in market
Claims generated	care-plan coding and billing behind more than 5 million claims
Vitals recorded	over 100 million vitals recorded; 4 million+ care actions enabled

References and Data Sources

- **HRSA Health Center Program records:** the Uniform Data System profile for the health center (2024 reporting year, retrieved September 2026), the Health Center Service Delivery Sites file (six active sites), and the Health Center Program grant record (New Access Point, 2013).
- **340B OPAIS registry:** the health center as a registered 340B covered entity, participating since 2015, recertified 2025.
- **The health center's website,** retrieved September 2026: the services, locations and leadership pages and the site's brand assets; the EHR (eClinicalWorks) corroborated by the healow patient-portal link on the site.
- **CMS Medicare Physician & Other Practitioners public files:** the basis for the whitespace reading in Section 1. CMS suppresses any provider-and-code line under 11 beneficiaries, and care management billed on a health-center claim is not in this professional-claims file, so the absence of a program there is not by itself proof; the whitespace is confirmed on the call.
- **The CY2025 Physician Fee Schedule Final Rule (CMS-1807-F) and CY2026 Final Rule (CMS-1832-F):** retirement of G0511 on September 30, 2025; individual-code reporting for health-center care management from October 1, 2025; payment at national non-facility amounts in addition to the PPS encounter; APCM adopted for health-center payment; the CY2026 additions 99445 and 99470.
- **CY2026 Physician Fee Schedule rate files (CMS RVU26A, January 2026 release):** national non-facility amounts for the forecast codes, the two transitional care codes and the

²⁶ CoachCare company statistics, 2026: patients served, managed conditions, providers on the platform, implementations completed, claims generated and vitals recorded.

behavioral health integration code, at the \$33.4009 conversion factor with no geographic adjustment.

- **CMS-1848-P, the proposed CY2027 Physician Fee Schedule (July 2026):** the proposed national non-facility amounts used in the Section 10 repricing.
- **CMS Medicare Advantage county penetration, 2026:** Fulton County's Medicare beneficiary count and Medicare Advantage penetration used in Sections 3, 9 and 11.
- **Georgia Department of Community Health Medicaid policy:** Georgia Medicaid does not reimburse remote monitoring, chronic care management or advanced primary care management on a fee-for-service basis; the forecast carries no Medicaid dollar.
- **CoachCare Care Management Programs standard operating procedures** and the derived process maps: the shared alert-and-escalation decision logic, trend definitions, the emergent communication protocol, three-way routing, and the discharge decision flow reproduced in Section 7.
- **CoachCare eClinicalWorks integration overview:** integrated ordering and enrollment, enrollment status in the clinical workflow, integrated vital reports, monthly evidence-of-care, vitals and care-plan documents, and automated claims creation through the CoachCare billing engine.
- **CoachCare Value Analysis for HEALing Community Health, 2026, and the CY2027 repricing of the same forecast:** every financial, enrollment, clinical-output and operational figure in Sections 2, 4, 10, 11 and 12, built on an estimated 150 Medicare patients in scope, 3 referring clinicians, CoachCare-funded enrollment support, and CY2026 national non-facility amounts for RPM, CCM and APCM. The figures are illustrative and modeled, to be verified against the health center's own data.

How this report counts

Patients and program enrollments are different numbers. At M24 the program holds 68 active program enrollments belonging to 44 unique patients, because a patient may carry a monitoring enrollment and a care-management enrollment at the same time. Wherever this report gives a patient count it says patients; wherever it gives an enrollment count it says enrollments.

The panel figure is an estimate. The health center's current Medicare-primary count is not public, and health-center visits bill on the FQHC claim rather than under individual clinicians, so clinician-level claims files structurally undercount a health-center panel. The 150-patient figure is a conservative estimate, and the first implementation step confirms it against the eClinicalWorks Medicare-primary chart count.

The figures are illustrative and modeled. Every financial and operational figure is a CoachCare Value Analysis output, to be verified against the health center's own data before contracting. No individual is named anywhere in this report; governance, leadership and clinician composition are described by count and role only.