



YourTown Health

Palmetto Health Council, Inc.

COACHCARE | SERVICE LINE STRATEGY

A HRSA-funded Section 330 community health center serving six Georgia counties, from the south-metro Atlanta edge into rural West Georgia, through seven sites and an in-house 340B pharmacy

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line for the health center's Medicare panel of about 1,679 patients, accountable for its total cost of care through a two-sided-risk Medicare Shared Savings Program since 2013: remote physiologic monitoring, chronic care management and advanced primary care management, billed as individual codes at national amounts on top of every PPS encounter since October 2025, and staffed by CoachCare

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of YourTown Health. It brings together the health center's own HRSA record, the Medicare structure of the six counties it serves, the billing rules a health center works under since October 2025, a 24-month Value Analysis for a remote care service line on the Medicare panel, the way that service line sits on top of the health center's own accountable care participation, the clinical governance that would run it, the eClinicalWorks integration it lives in, and the rural, two-language design a program across this footprint has to get right.

The argument is short. The health center has been accountable for the total cost of its Medicare patients' care, at two-sided risk, since 2013. The one thing that moves total cost, documented management of the month between visits, is the one thing it does not yet bill for or staff. Since October 2025 Medicare pays a health center to do exactly that, as its own codes at national amounts on top of every visit, and it is the same work a shared-savings settlement rewards. The panel is about 1,679 patients and it fills early in the second year. The people to run it are ours.

Prepared by CoachCare for discussion with YourTown Health. © 2026 CoachCare.

Table of Contents

Executive Summary.....	3
1. The Health Center Today.....	5
1.1 A network built across six Georgia counties since 1978.....	5
1.2 Quality the record can verify.....	6
1.3 The gap: the month between visits.....	6
2. What Changed: A Health Center Now Bills the Month Between Visits.....	7
2.1 G0511 is gone; the individual codes pay on top of the PPS encounter.....	7
2.2 What the codes pay a health center.....	7
2.3 The work the change creates, and who carries it.....	8
3. The Service Line: RPM, CCM and APCM on the Medicare Panel.....	8
3.1 The clinical and billing stack.....	8
3.2 The dual-eligible share and the APCM tier.....	9
3.3 The Medicare panel it runs on.....	10
3.4 Transitional care at the hospital discharge, named and not in the forecast.....	10
3.5 Behavioral health integration: the next arm, named.....	10
3.6 Built the way the codes work: an eight-clinician bench.....	10
3.7 Staffing: nobody is hired.....	11
4. Value Analysis: The 24-Month Forecast.....	11
4.1 Headline economics.....	11
4.2 Program economics by year.....	12
4.3 The ramp: every ceiling reached by month 14.....	13
4.4 What the program produces.....	13
5. The Value Model: Accountable Care at Two-Sided Risk Since 2013.....	14
6. eClinicalWorks Integration: The Program Lives in the Record.....	15
7. Clinical Governance and Escalation.....	15
7.1 A monitoring program is a clinical operation first.....	15
7.2 One shared escalation engine.....	15
7.3 The emergent pathway.....	16
7.4 Qualification, device assignment and routing.....	16
7.5 The post-discharge cadence.....	16
7.6 Discharge governance and continuity.....	16
8. Built for YourTown Health: Rural and Multilingual Design.....	16
9. Market Context: The Six-County Medicare Population.....	17
10. The CY2027 Proposed Rule, Repriced on This Forecast.....	17
11. Implementation and the First 90 Days.....	18
11.1 Who runs what.....	18
11.2 Model inputs.....	19
11.3 The 90-day plan and the operating dashboard.....	19
12. Recommendations.....	20
13. The Ask: A Working Session.....	21
About CoachCare.....	22
References and Data Sources.....	22

Executive Summary

YourTown Health, the legal entity Palmetto Health Council, Inc., is a HRSA-funded Section 330 community health center founded in 1978 and now running seven sites across six Georgia counties, from the south-metro Atlanta edge into rural West Georgia, with an in-house 340B pharmacy.¹ Its 2025 Uniform Data System report counts 8,925 patients: 1,819 aged 65 or older, 1,679 with Medicare as primary payer, 381 of those dually eligible, 2,686 with hypertension and 1,428 with diabetes.² It serves patients in English and Spanish, and its record carries the earned compliment first: 93.16% of its patients screened for depression with follow-up, top quartile among health centers nationally, and 82.20% of its cardiovascular-risk patients on statin therapy.³

What the record does not yet show is a Medicare revenue line for the month between visits. Across the adult-primary-care roster, CY2023 Medicare fee-for-service claims show **no remote-monitoring, chronic-care-management or advanced-primary-care program at meaningful scale**; CMS suppresses any provider-and-code line under 11 beneficiaries, and care management an FQHC bills on its own institutional claim is not visible in that file either, so that is the precise claim.⁴ The careers page lists a family-practice opening and no care-manager or remote-monitoring role. The 2,686 patients with hypertension and 1,428 with diabetes are seen a few times a year; diabetes A1c poor control sits in HRSA's bottom quartile at 37.54%, and blood-pressure control has slipped to 62.17% from 66.87% in 2023.

The health center has been accountable for the total cost of its Medicare patients' care since 2013, through a Medicare Shared Savings Program on the Enhanced, two-sided-risk track.⁵ The one activity that moves total cost is documented, continuous management of the month between visits, and that is exactly what the service line in this report delivers. Most of the Medicare panel here is in Medicare Advantage, 53.9% to 67.1% across the six counties, so the slice this forecast prices cleanly under fee-for-service is the roughly one-third to 46% in Original Medicare. Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.

¹ YourTown Health is the d/b/a of Palmetto Health Council, Inc., a Georgia non-profit corporation founded in 1978. HRSA Health Center Program grant H80CS00460 (Section 330 grantee). The health center's own site: adult primary care, pediatrics, obstetrics and gynecology, dental, behavioral health, an urgent-care site and an in-house 340B pharmacy across seven locations.

² HRSA Uniform Data System, grant H80CS00460, reporting year 2025: total patients 8,925; aged 65 and over 1,819 (20.4%); Medicare as primary payer 1,679 (18.8%); dually eligible 381 (22.7% of the Medicare panel); Medicaid/CHIP 1,433 (16.1%); uninsured 3,126 (35.0%); hypertension 2,686; diabetes 1,428; patients with limited English proficiency 1,953 (21.9%).

³ HRSA Uniform Data System clinical quality measures, reporting year 2025, with HRSA's adjusted quartile rankings: depression screening and follow-up 93.16% (quartile 1); statin therapy for cardiovascular prevention 82.20% (quartile 2); diabetes A1c above 9% or untested 37.54% (quartile 4); controlling high blood pressure 62.17% (quartile 3), 66.87% in the 2023 report.

⁴ CMS Medicare Physician & Other Practitioners by Provider and Service, CY2023 (the most recent release), queried per National Provider Identifier for the organization and every clinician on the adult-primary-care roster for the remote-monitoring, care-management, advanced-primary-care, transitional-care and behavioral-health-integration codes. No lines returned. FQHC visits and care management billed on the FQHC institutional claim do not appear in this professional-claims file.

⁵ CMS Medicare Shared Savings Program participant file, performance year 2026: the health center is a participant on the Enhanced (two-sided-risk) track, with an initial start date of 2013. CMS Quality Payment Program eligibility records corroborate Advanced Alternative Payment Model participation for the adult-primary-care clinicians. Referenced only as the health center's own participation.

The observation this report is built on

The health center has carried two-sided risk on the total cost of its Medicare patients' care since 2013. The one thing that moves that number, documented management of the month between visits, is the one thing the health center does not yet bill for or staff. Since October 2025 Medicare pays a health center to do exactly that, as its own codes at national amounts on top of every visit, and it is the same work a shared-savings settlement rewards. The panel is about 1,679 patients and it fills early in the second year. 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.⁶ The short-window RPM codes new for 2026 (99445, 99470) fit post-discharge monitoring exactly.

What the Value Analysis returns

The forecast prices a service line for the health center's own Medicare panel, 1,679 patients as reported to HRSA for 2025, Original Medicare and Medicare Advantage together, referred by the eight physicians, nurse practitioners and physician assistants in adult primary care, and delivered by CoachCare under the health center's clinical direction, priced at the national amounts a health center is paid for these codes.⁷

	Year 1	Year 2	24 months
Net reimbursement	\$471,365	\$822,929	\$1,294,294
CoachCare fees	\$275,693	\$466,333	\$742,026
Net to the health center	\$195,672	\$356,596	\$552,268
Margin to the health center	41.51%	43.33%	42.67%

CoachCare Value Analysis. CY2026 national non-facility Physician Fee Schedule amounts, the rail a health center bills care-management codes on. 1,679 Medicare patients in scope; RPM + CCM + APCM. Margin is net to the health center divided by net reimbursement.

- 1. This is a \$552,268 two-year net line on a 1,679-patient Medicare panel, and it fills early in the second year.** It is not a seven-figure program, and the report does not dress it as one. Each program reaches its eligibility ceiling and stops: APCM in M5, CCM in M8, remote monitoring in M14. At M24 the program holds 760 active program enrollments across 495 unique patients. The binding constraint is the size of the Medicare panel, not enrollment capacity or clinician count.
- 2. The program funds itself from the second month.** Month 1 nets -\$5,443 to the health center, because implementation lands before enrollment revenue does. The first positive month is M2, at \$3,226. Remote monitoring is still filling through month 14, so the census and the monthly line keep climbing into the second year; from M15 the service line runs at \$68,572 in monthly net reimbursement and \$29,708 net to the health center.
- 3. The value model is the multiplier.** Because the health center's accountable care organization bills care management under fee-for-service rather than a primary-care capitation, every RPM, CCM and APCM claim is paid per claim. The service line earns that fee-for-service margin on its own, and the same documented monthly management holds the attribution the accountable care

⁶ CY2025 Physician Fee Schedule Final Rule (CMS-1807-F): rural health clinics and 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 and the 99445/99470 additions.

⁷ CoachCare Value Analysis for YourTown Health, 2026. Basis: CY2026 national non-facility Physician Fee Schedule amounts; 1,679 Medicare patients in scope; eight referring clinicians; RPM, CCM and APCM.

organization runs on and improves the cost and quality performance a two-sided settlement rewards (Section 5).

4. **Nobody is hired.** CoachCare delivers 8,870 hours of care-team work over 24 months, about 4.26 full-time-equivalent years, including an on-site enrollment specialist carried at CoachCare's expense. No capital outlay and no new requisition.
5. **The growth is in the panel, and the report says where.** The health center reports 1,819 patients aged 65 and over against 1,679 with Medicare as primary payer, and a Medicare panel that reached 2,545 as recently as 2023; reconciling those figures by payer is discovery item one, and it is the input that moves every ceiling. Behavioral health integration is the next arm once the first three programs are full.
6. **The clinical return is concrete.** The forecast projects 44.1 avoided hospitalizations over 24 months at its baseline admission rate, roughly \$661,000 at \$15,000 per admission, and about twice that for a chronic-disease cohort admitting at a realistic rate, from 69,407 device readings worked through one escalation protocol, with the discharge from the acute-care hospitals in the counties served as one trigger.

1. The Health Center Today

1.1 A network built across six Georgia counties since 1978

YourTown Health, the legal entity Palmetto Health Council, Inc., was founded in 1978 by Palmetto, Georgia residents seeking local access to a physician, opened its first medical center in 1980, and grew into a network of seven patient-facing sites. It is a HRSA-funded Section 330 community health center, enrolled with Medicare as a Federally Qualified Health Center under seven certification numbers, covered by the Federal Tort Claims Act, and a 340B covered entity with an in-house pharmacy that opened in 2021.⁸ The seven sites sit in six counties: two in Fulton, including the Palmetto headquarters, and one each in Coweta, Carroll, Meriwether, Lamar and Pike, reaching from the southern edge of metro Atlanta into rural West Georgia.⁹ The panel is largely uninsured or publicly insured and increasingly Spanish-speaking: about 35% of patients are uninsured, 16% carry Medicaid or CHIP, and 22% have limited English proficiency, most of them Spanish-speaking.

UDS 2025	Count	What it means for the service line
Total patients	8,925	Adult primary care, pediatrics, dental, behavioral health, pharmacy and urgent care across seven sites
Medicare patients	1,679 (18.8%)	The panel this forecast runs on; Medicare Advantage and the 381 duals are inside it
Aged 65 and over	1,819 (20.4%)	Above the Medicare-primary count; the payer reconciliation is discovery item one
Dually eligible	381	22.7% of the Medicare panel; the APCM level-3 tier
Medicaid and CHIP	1,433 (16.1%)	Outside the Medicare forecast; Georgia Medicaid does not pay for remote monitoring
Uninsured	3,126 (35.0%)	The sliding-fee population; the Section 330 mission the monthly touch serves
Hypertension	2,686	The RPM cohort; blood-pressure control 62.17%, down from 66.87% in 2023
Diabetes	1,428	Glucose monitoring; A1c poorly controlled in 37.54% (HRSA bottom quartile)

⁸ CMS Federally Qualified Health Center Enrollments (July 2026 vintage): seven Part A FQHC certification numbers under one PECOS associate identifier, a Georgia non-profit corporation. HRSA Health Center Program grant H80CS00460, Section 330 grantee, Federal Tort Claims Act deemed, 340B covered entity; in-house pharmacy opened 2021.

⁹ HRSA Health Center Service Delivery Sites file, retrieved September 2026: seven sites in six counties, two in Fulton (including the Palmetto headquarters) and one each in Coweta, Carroll, Meriwether, Lamar and Pike; four sites flagged rural.

HRSA Uniform Data System, grant H80CS00460, reporting year 2025.

1.2 Quality the record can verify

Start with what the record already does well, because it is verified and it is the compliment a monitoring program builds on. In the 2025 Uniform Data System the health center screened 93.16% of its patients for depression with follow-up, HRSA's top quartile among health centers, and put 82.20% of its cardiovascular-risk patients on statin therapy. It screens 88.59% of patients for tobacco use with a cessation intervention.¹⁰ Those are numbers a health center reaches only when it can find a patient and act between visits.

Two measures point the other way, and they are the ones a monitoring program moves most directly. Diabetes A1c poor control sits at 37.54%, HRSA's bottom quartile, meaning more than a third of diabetic patients have an A1c above 9% or untested. Blood-pressure control is 62.17%, down from 66.87% in 2023. Continuous readings and a documented monthly touch are how both of those move: a patient whose home blood pressure runs high for a week is called and adjusted, not left until the next appointment.

Clinical quality measure, UDS 2025	Result	HRSA quartile
Depression screening and follow-up	93.16%	1 (top)
Tobacco use screening and cessation intervention	88.59%	2
Statin therapy for cardiovascular prevention	82.20%	2
Colorectal cancer screening	44.57%	2
Controlling high blood pressure	62.17%	3
Aspirin or antiplatelet therapy for ischemic vascular disease	67.44%	4
Diabetes: A1c above 9% or untested (lower is better)	37.54%	4

HRSA Uniform Data System clinical quality measures, reporting year 2025, with HRSA's adjusted quartile ranking among health centers (1 is best). Blood-pressure control was 66.87% in the 2023 report.

1.3 The gap: the month between visits

Between-visit chronic care has no Medicare revenue line here yet. A sweep of CY2023 Medicare fee-for-service claims across the adult-primary-care roster returns no lines on any remote-monitoring code, any chronic-care-management code, any advanced-primary-care code, any transitional-care code or any behavioral-health-integration code under the health center.¹¹ CMS suppresses any provider-and-code line under 11 beneficiaries, and care management an FQHC bills on its own institutional claim does not appear in that professional-claims file at all, so the precise finding is that there is **no remote-care or care-management program at meaningful scale in CY2023 claims**.

¹⁰ HRSA Uniform Data System clinical quality measures, reporting year 2025, with HRSA's adjusted quartile rankings among health centers: depression screening and follow-up 93.16% (quartile 1); tobacco use screening and cessation 88.59% (quartile 2); statin therapy 82.20% (quartile 2); colorectal cancer screening 44.57% (quartile 2); controlling high blood pressure 62.17% (quartile 3); aspirin or antiplatelet therapy 67.44% (quartile 4); diabetes A1c above 9% or untested 37.54% (quartile 4).

¹¹ CY2023 Medicare Physician & Other Practitioners sweep (see note 4).

The rest of the record points the same way, and it is a structural observation rather than a criticism. The careers page in September 2026 advertised a family-practice opening and several support roles, and no care manager, care coordinator or remote-monitoring role.¹² The patients are here and the conditions are counted: 2,686 with hypertension and 1,428 with diabetes across a panel the health center already sees. What is missing is the paid, staffed layer that manages them in the weeks between appointments, and since October 2025 that layer has a revenue line.

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**.¹³

CY2026 also added two codes that matter for a health center whose patients are discharged from the acute-care hospitals in the counties it serves: 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 discharged on the 20th of the month used to produce an unbillable partial month; now it bills. In this forecast the two codes carry \$120,549 of gross reimbursement over 24 months, about 9.3% of net reimbursement, revenue that did not exist a year ago.¹⁴

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.¹⁵

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

¹² The health center's careers page, retrieved September 2026: a family-practice clinician opening and several support-staff roles; no care-manager, care-coordinator or remote-monitoring position posted.

¹³ CMS-1807-F (see note 6): G0511 retired with a transition period through September 30, 2025; from October 1, 2025 the individual codes are the standing requirement. CMS-1832-F set the CY2026 dates of service.

¹⁴ CoachCare Value Analysis, Financial Value detail: 99445 and 99470 together carry \$120,549 of gross reimbursement over 24 months against \$1,294,294 of net reimbursement (9.3%), on this forecast's code frequencies. CMS Hospital General Information, September 2026: CMS-certified acute-care hospitals operate in the counties the health center serves.

¹⁵ CY2026 Physician Fee Schedule national non-facility amounts (CMS RVU26A, January 2026 release): total non-facility relative value units times the national 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.

Code	What it pays for	Cadence	CY2026 national amount
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
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 tier blend in the forecast (15% level 1, 70% level 2, 15% level 3) yields \$57.68 per patient-month, with the level-3 weight set to the Qualified Medicare Beneficiary share implied by 381 duals in a panel of 1,679.

These are Original Medicare amounts, and most of this panel is in Medicare Advantage. 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 running from 53.9% to 67.1% across the six counties, that contract check is a discovery item that sizes how much of the panel prices exactly at the national amounts this forecast uses.

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 20,530 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 on Medicaid, because the deal design has to respect it. Georgia Medicaid does not pay for remote physiologic monitoring, and Georgia has not expanded Medicaid, so the working-age chronic-disease population that carries a reimbursable monitoring benefit is the Medicare panel.¹⁶ The Medicare forecast on these pages does not include a Medicaid dollar, and there is no separate Medicaid remote-monitoring rail to build here. The case runs on the Medicare rail, and it is ready to bill.

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

¹⁶ Center for Connected Health Policy, Georgia, and the Georgia Department of Community Health Telehealth Guidance effective January 1, 2024: remote patient monitoring is not a covered Georgia Medicaid modality. Georgia has not adopted full Medicaid expansion. HRSA Uniform Data System 2025: Medicaid/CHIP 1,433 patients (16.1%).

engine for all three. Principal care management is off: an adult-primary-care panel bills CCM or APCM, not the single-condition specialist code.

Program	Who qualifies	What it is	Billing
RPM	1,091 of the 1,679 Medicare patients (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	672 (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	588 (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 from an acute-care hospital in the counties served	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; pools overlap, billing does not (see the coordination rule below).

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 share and the APCM tier

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. Here 381 of the 1,679 Medicare patients, 22.7%, are dually eligible, so the level-3 tier is a real but minority share of the panel.¹⁷ The forecast weights the tiers 15% level 1, 70% level 2 and 15% level 3, which blends to \$57.68 per patient-month. APCM earns a place beside CCM without minute-tracking and with a bundled monthly payment, and it is the smallest of the three arms on a panel where most chronic patients carry two or more conditions rather than dual eligibility.

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 UDS measures the health center will defend next year, diabetes A1c poor control at 37.54% and blood-pressure control at 62.17%, move on continuous readings and a monthly documented touch. 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 avoided hospitalizations come from, and it is also what the health center's two-sided accountable care participation rewards (Section 5).

¹⁷ HRSA Uniform Data System 2025: 381 dually eligible of 1,679 Medicare patients (22.7%). Value Analysis APCM tier weights 15% level 1, 70% level 2, 15% level 3, blending to \$57.68 per patient-month at the national amounts, with the level-3 weight set to the Qualified Medicare Beneficiary share implied by the dual count.

3.3 The Medicare panel it runs on

The forecast is built on **1,679 Medicare patients**, the health center's own count as reported to HRSA for 2025, Original Medicare and Medicare Advantage together; Medicare Advantage and the 381 duals are already inside it, with no gross-up. From that panel the eligibility model carves the program pools: 1,091 patients RPM-eligible (65%), 672 CCM-eligible (40%), 588 APCM-eligible (35%). The pools overlap; the coordination rule keeps the billing disjoint.¹⁸

The same panel reached 2,545 Medicare patients as recently as the health center's 2023 report, and 1,819 patients are aged 65 and over today. Reconciling those figures by payer, how many of the 1,819 carry Medicare and where the panel settles between 1,679 and its recent high, is the first question of the working session in Section 13, because it is the input that moves every ceiling in Section 4.

3.4 Transitional care at the hospital discharge, named and not in the forecast

Each discharge home from an acute-care hospital in the counties served 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 at the national amount) or 7 days (99496, \$298.60).¹⁹ TCM is on the recommended stack for that reason, and it carries no dollars anywhere in this forecast: the health center's discharge volume, the share of discharges that come home to a health-center patient, and visit-scheduling capacity are all discovery items. What TCM does in the forecast is clinical. A discharge is the highest-yield moment to enroll a patient in monitoring, and the three-touch post-discharge cadence in Section 7.5 runs on the same contact the TCM code requires. It is the discharge-to-monitoring loop, never the revenue base.

3.5 Behavioral health integration: the next arm, named

A health center with an in-house behavioral-health division and a depression-screening rate in the national top quartile has an obvious fourth program waiting: behavioral health integration, 99484, \$57.45 a month at the national amount for the first 20 minutes of care-manager time under a treating clinician's plan.²⁰ It is the same infrastructure, the same monthly cadence and the same billing engine, applied to a population the health center already treats. This forecast carries it at zero dollars and names it once, here, as the natural next arm once the three Medicare programs are at ceiling.

3.6 Built the way the codes work: an eight-clinician bench

Adult primary care is roughly eight clinicians: four physicians, a nurse practitioner and physician assistants, with a family-practice requisition open.²¹ Those clinicians are the referring bench in the forecast; pediatrics, obstetrics, behavioral, dental and vision clinicians are excluded. That the bench is a mix of physicians, nurse practitioners and physician assistants is the right shape for this service line. 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. At eight referrals per clinician per month, the bench fills every program well inside the two years; Section 12 shows the clinician count barely moves the result.

¹⁸ HRSA Uniform Data System 2025 (see note 2). CoachCare Value Analysis eligibility model: RPM 65%, CCM 40%, APCM 35% of the in-scope panel.

¹⁹ 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. CMS Hospital General Information, September 2026: CMS-certified acute-care hospitals with emergency services operate in the counties served. TCM is carried at zero dollars in every figure in this report.

²⁰ The health center's behavioral-health division (site services). CPT 99484, CY2026 national non-facility amount \$57.45. BHI is carried at zero dollars in every figure in this report.

²¹ The health center's provider page, retrieved September 2026: four adult-primary-care physicians, a family nurse practitioner and physician assistants; a family-practice clinician requisition open on the careers page. The public roster under-lists, so the true adult-primary-care count is a discovery item; the forecast uses eight. Each name resolved against CMS enumeration and eligibility records.

3.7 Staffing: nobody is hired

CoachCare delivers 8,870 hours of care-team work across the 24 months, about **4.26 full-time-equivalent years**, without the health center hiring anyone. The on-site enrollment specialist is CoachCare's expense, not a program cost. For a health center recruiting a family-practice clinician and carrying no care-management staff, the service line adds the working capacity of roughly four full-time people and zero requisitions, in the two languages the panel speaks. 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 **\$1,294,294 in net reimbursement** to YourTown Health. CoachCare's fees total \$742,026, including \$37,235 of ancillary items: implementation, the eClinicalWorks integration and telephonic outreach. Net to the health center is **\$552,268, a 42.67% margin** on the program, 41.51% in Year 1 and 43.33% in Year 2.²²

The 24-Month Ramp: Every Program at Its Ceiling by Month 14

CoachCare Value Analysis · about 1,679 Medicare patients in scope · at M24: 760 active enrollments across 495 unique patients

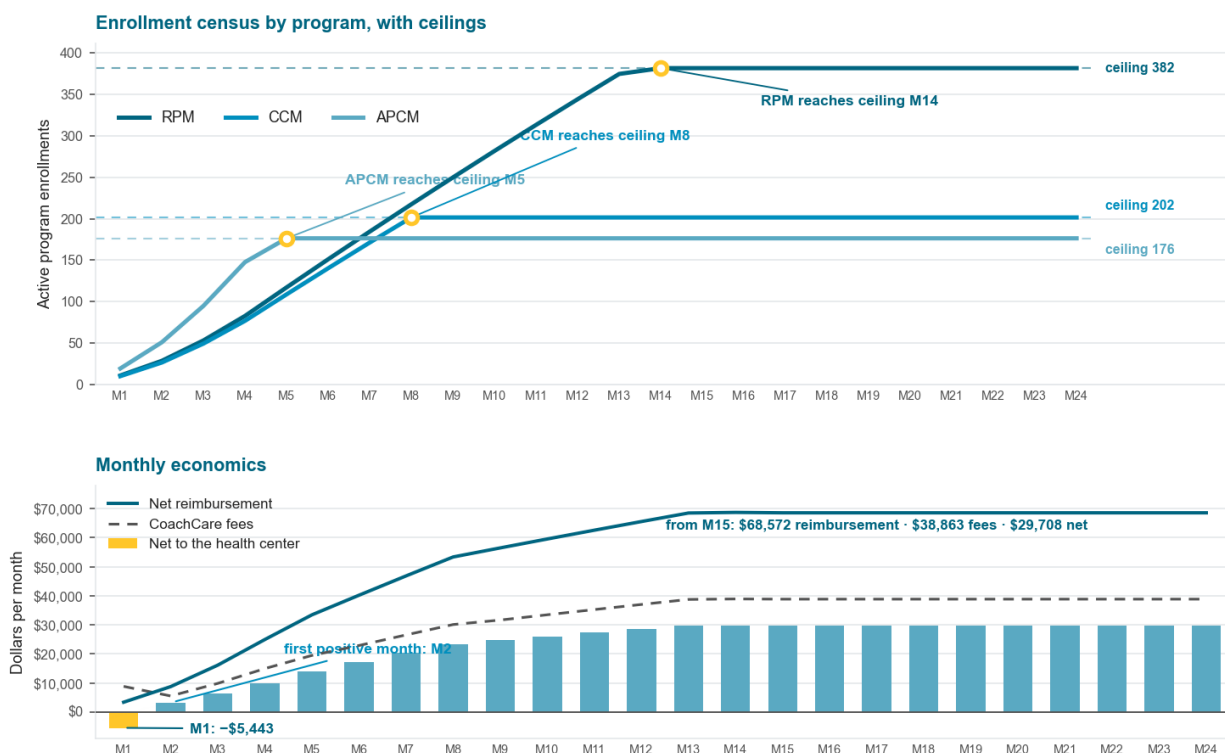


Figure 1. The 24-month ramp: enrollment census by program with ceilings (above) and monthly net reimbursement, CoachCare fees and net to the health center (below). Month 1 nets -\$5,443; the first positive month is M2; remote monitoring reaches its ceiling in month 14, and from M15 the line holds at \$29,708 net per month.

The shape of the curve is worth reading precisely. Month 1 is negative, -\$5,443, because implementation and enrollment effort land before the first full billing months do. Month 2 turns positive at \$3,226, month 3

²² CoachCare Value Analysis, 24-month forecast: monthly net reimbursement, fees and net-to-health-center series; Year 1 margin 41.51%, Year 2 margin 43.33%, 24-month margin 42.67%, each defined as net to the health center divided by net reimbursement. Ancillary fees of \$37,235 over 24 months: implementation \$2,500; eClinicalWorks integration \$4,000 setup, \$150 a month and \$1.50 per patient-month; telephonic outreach.

nets \$6,279, and the line climbs as the three programs fill. APCM reaches its ceiling in month 5 and CCM in month 8, but remote monitoring keeps filling through month 14, so the census at month 24 is higher than at month 12. M14, the month remote monitoring reaches its ceiling, is the peak at \$68,710 of net reimbursement and \$29,778 net; from M15 the line settles at \$68,572 of net reimbursement, \$38,863 of fees and \$29,708 net a month once setup codes fall away and the census holds at ceiling.

4.2 Program economics by year

Program	Year 1 net reimbursement	Year 2 net reimbursement	24-month net reimbursement	24-month CoachCare fees	24-month net to the health center
RPM	\$203,042	\$441,906	\$644,948	\$365,774	\$279,174
CCM	\$176,212	\$267,924	\$444,136	\$223,678	\$220,457
APCM	\$92,112	\$113,099	\$205,211	\$115,339	\$89,872
Ancillary (implementation, integration, outreach)	—	—	—	\$37,235	-\$37,235
All programs	\$471,365	\$822,929	\$1,294,294	\$742,026	\$552,268

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.

Program	Year 1 fees	Year 1 net	Year 2 fees	Year 2 net
RPM	\$112,605	\$90,437	\$253,169	\$188,737
CCM	\$88,745	\$87,467	\$134,933	\$132,990
APCM	\$51,772	\$40,340	\$63,568	\$49,531

Per-program fees and net to the health center by contract year, before ancillary items.

RPM is the volume engine at 6,610 patient-months and \$644,948 of net reimbursement. CCM is the yield engine at \$110.75 of net reimbursement per patient-month across 4,010 patient-months, against \$97.57 for RPM and \$53.43 for APCM over its 3,841. APCM earns its place a different way, as Section 3.2 sets out: no minute-tracking and a bundled monthly payment. Year 2 outruns Year 1 by \$351,564 of net reimbursement because Year 1 carries the ramp while Year 2 runs CCM and APCM at ceiling from its first month and remote monitoring reaches its own ceiling early in the year.

Service-Line Composition: RPM \$644,948 · CCM \$444,136 · APCM \$205,211

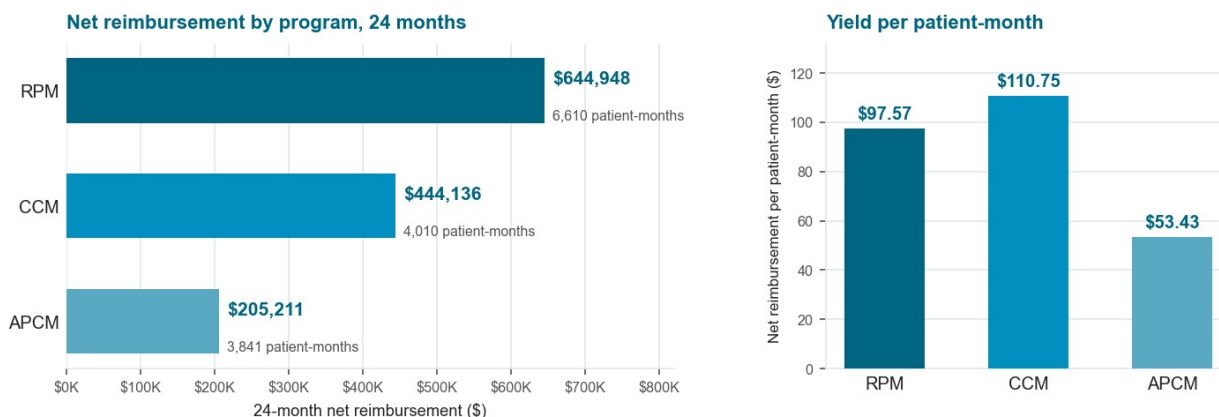


Figure 2. Service-line composition: per-program 24-month net reimbursement and net reimbursement per patient-month.

4.3 The ramp: every ceiling reached by month 14

This account is ceiling-limited in all three programs. APCM reaches its ceiling of 176 enrollments in month 5, CCM its 202 in month 8, and remote monitoring its 382 in month 14. Remote monitoring is the one that runs into the second year, which is why the month-24 census is above the month-12 census rather than flat against it.²³ The first 90 days move fast: 40 new enrollments across the three programs in month 1, 67 in month 2, 93 in month 3.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
RPM	1,091	382	Month 14	382
CCM	672	202	Month 8	202
APCM	588	176	Month 5	176
All programs		760		760 enrollments · 495 unique patients

Enrollment counts are program enrollments, not unique patients; the 760 enrollments at M24 belong to 495 unique patients (722 enrollments across 458 unique patients at M12), because a patient may carry a monitoring enrollment and a care-management enrollment at the same time.

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 forecast at a two-year net line near \$550,000, and it de-risks it, because the model asks the clinicians for no heroic enrollment performance, only a panel that exists. Three things move the ceiling upward: the Medicare payer reconciliation of the 1,819 patients aged 65 and over and the 2,545-patient panel of 2023 against the 1,679 Medicare-primary count; the behavioral health arm in Section 3.5 once the first three programs are full; and the performance of the health center's own accountable care participation in Section 5. The on-site enrollment specialist cannot raise a ceiling, but it is what reaches every ceiling, and Section 12 prices what it is worth.

4.4 What the program produces

24-month output	Volume
Claims generated, billing-ready	20,530
Device readings monitored	69,407
Care-management tasks completed	41,059
Chart updates written to eClinicalWorks	10,265
Patient conversations held	6,159 (342 hours of call time)
Care-team hours delivered	8,870 (≈ 4.26 FTE-years)
Hospitalizations avoided (baseline admission rate)	44.1 · ≈ \$661,000 at \$15,000 per admission

CoachCare Value Analysis operational and clinical outputs, 24 months.

²³ CoachCare Value Analysis enrollment model: program ceilings 382 (RPM), 202 (CCM), 176 (APCM); ceilings reached in months 14, 8 and 5; 760 active enrollments across 495 unique patients at month 24, 722 across 458 at month 12. Dedup: the care-management enrollments plus the RPM enrollments not already carrying a wrapper.

The avoided-admission line deserves its own sentence, and its own range. The model uses a conservative baseline admission rate for the enrolled population, which returns 44.1 avoided hospitalizations over 24 months, roughly \$661,000 of cost that never lands on anyone. A hypertension, diabetes and heart-failure cohort admits more often than that baseline; at a realistic rate the figure is about 88 avoided admissions and \$1.32 million of avoided cost. The table shows the range, and Section 5 is why the number matters beyond the fee line: avoided admissions are exactly what a two-sided total-cost-of-care settlement rewards.²⁴

Assumed annual admission rate, enrolled cohort	Avoided admissions, 24 months	Value at \$15,000 each
20% (the model's baseline)	44.1	≈ \$661,000
30%	66.1	≈ \$992,000
40% (realistic for this chronic-disease cohort)	88.1	≈ \$1,322,000
50%	110.2	≈ \$1,652,000

Avoided admissions scale with the enrolled cohort's underlying admission rate; 40% is the realistic figure for a hypertension, diabetes and heart-failure population.

5. The Value Model: Accountable Care at Two-Sided Risk Since 2013

YourTown Health has been accountable for the total cost of its Medicare patients' care for more than a decade. Since 2013 the health center has taken part in a Medicare Shared Savings Program accountable care organization, and it sits on the Enhanced track, the program's two-sided-risk option: the health center shares in savings when the total cost of care for its assigned Original-Medicare beneficiaries comes in under the benchmark, and it carries the downside when that cost runs over.²⁵

That participation changes what this service line is worth, in the health center's favor. The one activity that moves total cost of care is documented, continuous management of the month between visits, and that is the same activity these codes pay for. Because the health center's accountable care organization bills care management under fee-for-service rather than a primary-care capitation, each RPM, CCM and APCM claim is paid per claim, for assigned and unassigned beneficiaries alike. The service line earns that fee-for-service margin on its own, and the same documented monthly touch holds the attribution the accountable care organization runs on and improves the cost and quality performance the two-sided settlement rewards.

How the value model enters this report

The Value Analysis in Section 4 is a fee-for-service forecast. It prices the RPM, CCM and APCM claims at the national amounts and nothing else: no shared-savings dollar, no capitated payment, no total-cost-of-care settlement. The fee-for-service margin stands on its own, and the value-model effect sits on top of it.

The value-model effect is scoped in the working session, not carried in this forecast. The health center's count of assigned beneficiaries, its accountable care organization's current benchmark, and the way a documented monthly touch flows into the two-sided settlement are the first items on the Section 13 agenda. The assigned-beneficiary count is the number to confirm first.

²⁴ CoachCare Value Analysis clinical-outcomes module: 44.1 avoided hospitalizations over 24 months at the model's baseline 20% annual admission rate, valued at \$15,000 per avoided admission. Avoided admissions scale with the enrolled cohort's underlying admission rate: 66.1 at 30%, 88.1 at 40%, 110.2 at 50%.

²⁵ CMS Medicare Shared Savings Program participant and organization files, performance year 2026: the health center participates on the Enhanced (two-sided-risk) track, with an initial start date of 2013. Referenced only as the health center's own participation; no shared-savings dollar figure is asserted anywhere in this report.

The order of operations follows from that. The service line is built on the fee-for-service rail because the rail is explicit and ready to bill today, and it is net-positive to the health center on its own arithmetic. The accountable care performance is the layer on top: the avoided admissions in Section 4.4 and the chronic-disease measures in Section 1.2 are the cost and quality inputs a two-sided benchmark turns on, and the same monthly work produces all three.

6. eClinicalWorks Integration: The Program Lives in the Record

The health center runs on eClinicalWorks, and the forecast prices CoachCare's eClinicalWorks integration at the custom tier: \$4,000 setup, \$150 a month and \$1.50 per patient-month.²⁶ The program operates inside the record rather than beside it. CoachCare's integration uses the workflows already in eClinicalWorks, 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 by service 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 in under five days from the flag.
- **Back into the chart: vitals, documentation and status.** Device readings land as integrated vital reports; Evidence of Care, care plans and the integrated care summary attach to the chart monthly; enrollment status and time capture write back to the record.
- **Automated claims into the practice management system.** The CoachCare billing engine creates the monthly claim lines automatically in eClinicalWorks, the step that makes individual-code billing workable at 20,530 claims over 24 months. The health center's own billing team files the FQHC claims with the care-management codes.
- **The discharge feed.** Hospital discharges reach the program from the record, which arms the post-discharge cadence in Section 7.5 without anyone relaying a message; the interface from each acute-care hospital in the counties served is an integration-scope item.

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 of the program: CoachCare's Care Management Programs standard operating procedures, March 2026 edition, rendered as seven process maps covering qualification, monitoring, escalation and discharge.²⁷ The purpose is keeping a patient with heart failure or uncontrolled diabetes at home, managed in the language the family speaks, 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.

²⁶ EHR as indicated by the health center's healow patient portal (eClinicalWorks), September 2026. CoachCare integration pricing for eClinicalWorks as carried in the Value Analysis: \$4,000 setup, \$150 a month, \$1.50 per patient-month, the custom integration tier.

²⁷ CoachCare Care Management Programs standard operating procedures, March 2026 edition, and the seven derived process maps: qualification and device assignment; the RPM patient lifecycle; the care-management lifecycle; alert-and-escalation decision logic; the emergent/urgent communication protocol; the post-discharge follow-up sequence; and the discharge decision flow.

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 and any quiet window: whichever site the patient belongs to, whichever 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 ICD-10 code and routed to the right program and device, and device assignment follows a fixed, ordered hierarchy in which the highest-priority qualifying diagnosis wins: a patient with heart failure and diabetes gets the device that 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.

7.5 The post-discharge cadence

A hospitalization within the last 60 days fires a fixed three-touch follow-up sequence: a first contact on day 1 or 2, a second on days 5 to 8, and a third on days 12 to 14. Each touch is documented, and any clinical alert surfaced during a touch escalates under the same shared logic; the post-discharge window gets more contact, not a different rulebook. For a discharge from an acute-care hospital in the counties served, the first touch is also the interactive contact a transitional care episode requires, and the day-12-to-14 touch lands inside the 14-day visit window. One workflow serves both, and it is where most of the avoided hospitalizations in Section 4.4 are won.

7.6 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 YourTown Health: Rural and Multilingual Design

This footprint is not one place, and the program has to be built for it rather than adapted to it afterward. Seven sites span six counties, from the south-metro Atlanta edge at Palmetto to rural Meriwether, Lamar and Pike, and the panel is roughly one-in-five patients with limited English, most of them Spanish-speaking.²⁸ 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. Across rural West Georgia, where home internet is not a safe assumption, that is the difference between a reading and a device in a drawer.
- **Device instructions and call scripts in English and Spanish.** Patient-facing materials, enrollment scripts and outreach calls are prepared in both languages the health center serves, matched to the patient's language of record in eClinicalWorks.
- **A monthly touch that covers the distance an office schedule cannot.** Patients in the rural counties may be an hour from the nearest full-schedule site. A documented monthly contact and a continuous data feed reach them between visits, which is where the chronic-disease measures in Section 1.2 are won or lost.

²⁸ HRSA Uniform Data System 2025: patients with limited English proficiency 1,953 (21.9%), most Spanish-speaking. HRSA Health Center Service Delivery Sites file: seven sites across six counties, four flagged rural (Carroll, Meriwether, Lamar, Pike).

- **Enrollment lists pulled by condition, across all seven sites.** Enrollment lists come from the hypertension, diabetes, heart-failure and COPD registries, screened by ICD-10 code per the qualification map, with payer attached so the Medicare panel is worked first and the site of care travels with the patient.
- **A rural tailwind in the background.** Georgia is a funded participant in a federal rural-health transformation program, and the health center's rural sites sit inside its target geography. It is context for timing, not a billing source in this forecast.
- **340B alongside the fee line.** The in-house 340B pharmacy is a live margin engine; a chronic-care program that improves medication adherence and visit cadence lifts script capture there, a second financial effect beside the care-management fees.

9. Market Context: The Six-County Medicare Population

The health center's six counties run from dense, comparatively affluent south Fulton and Coweta on the metro edge to older, lower-income rural counties in Meriwether, Lamar and Pike.²⁹ The fact that shapes the forecast is the payer mix. Medicare Advantage penetration runs from 53.9% in Fulton to 67.1% in Meriwether, above half in every county and highest in the rural ones, so only about a third to 46% of the Medicare population in these counties is in Original Medicare. Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.

County (June 2026)	Medicare beneficiaries	Medicare Advantage penetration	Dual-eligible share
Fulton (south Fulton served)	164,273	53.9%	19.8%
Coweta	30,495	54.3%	11.0%
Carroll	25,369	58.7%	19.1%
Meriwether	5,652	67.1%	24.6%
Lamar	4,524	63.8%	21.0%
Pike	4,290	58.1%	14.5%

CMS Medicare Monthly Enrollment, June 2026, for the six counties the health center serves. Medicare Advantage penetration is MA and other health-plan enrollment as a share of total Medicare beneficiaries; dual-eligible share is duals as a share of Medicare beneficiaries. The health center serves the southern portion of Fulton County.

Two facts carry into the design. The Original Medicare slice the forecast prices cleanly is the minority payer here, so confirming how the dominant Medicare Advantage plans handle the care-management code families is the market question that sizes the rest. And the dual-eligible share, highest in the rural counties, is the population for whom a documented monthly touch in the patient's own language 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. Comments on CMS-1848-P closed September 14, 2026; the final rule arrives in early November; 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

²⁹ CMS Medicare Monthly Enrollment, June 2026, for the six counties: Medicare beneficiaries, Medicare Advantage penetration (Fulton 53.9%, Coweta 54.3%, Carroll 58.7%, Pike 58.1%, Lamar 63.8%, Meriwether 67.1%) and dual-eligible share (11.0% to 24.6%). U.S. Census Bureau American Community Survey 2019–2023 five-year estimates for the six counties: population, age, income, poverty and language.

was repriced at the national amounts on this account's own billing mix, with enrollment held constant; the forecast's basis and the repricing table use the same national amounts on both sides.³⁰

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: \$644,948 over 24 months, -9.5%, -\$61,375. Device supply is 32% of the remote monitoring basket; management time moves little.

Chronic care management: \$444,136, -2.1%, -\$9,548. Advanced primary care management: \$205,211, -0.9%, -\$1,770. Conversion-factor and relative-value movement only; the proposal does not target these codes. The care-management movement is \$11,318 of the total.

The whole service line: \$1,294,294 over 24 months, -5.6%, -\$72,693, to \$1,221,602. Remote monitoring is 50% 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 -5.6%, -\$72,693 of \$1,294,294

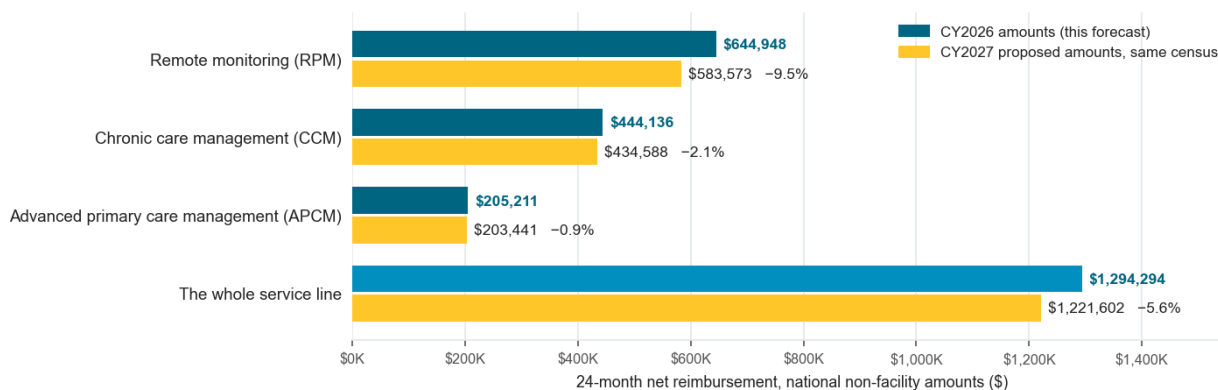


Figure 3. The CY2027 proposed rule on this forecast, at the national amounts on both sides: each arm and the whole line, CY2026 against the CY2027 proposed amounts, same census.

11. Implementation and the First 90 Days

11.1 Who runs what

CoachCare delivers	YourTown Health keeps
Telephonic and on-site enrollment in English and Spanish; the enrollment specialist is CoachCare's expense	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; the discharge feed from each hospital
Automated claim creation into the eClinicalWorks practice management system	Filing the FQHC claims with the care-management codes; billing review; the revenue
Monthly operating reports against the dashboard in 11.3	Program governance; the relationship with the accountable care organization

³⁰ CMS-1848-P, proposed CY2027 Physician Fee Schedule (July 2026); comment period closed September 14, 2026. CoachCare repricing at the national non-facility amounts on this forecast's code frequencies and APCM tier weights: 99454 and 99445 from \$52.11 to \$41.38 (-20.6%); RPM arm -9.5% (-\$61,375); CCM -2.1% (-\$9,548); APCM -0.9% (-\$1,770); service line -5.6% (-\$72,693, from \$1,294,294 to \$1,221,602). Enrollment held constant.

11.2 Model inputs

Input	Value
Medicare panel in scope	1,679 patients, the health center's UDS 2025 Medicare count; reconciled against the 1,819 patients aged 65 and over, and the 2,545-patient panel of 2023, by payer in the first 30 days
Referring clinicians	8 in adult primary care (four physicians, a nurse practitioner and physician assistants), with a family-practice requisition open
Programs	RPM + CCM + APCM; TCM and BHI named, not in the forecast; PCM off
Program-eligible pools	RPM 1,091 · CCM 672 · APCM 588
Enrollment ceilings	RPM 382 (M14) · CCM 202 (M8) · APCM 176 (M5)
Acceptance	RPM 35% · CCM and APCM 30% of the eligible pool
Enrollment engine	8 referrals per clinician per month at 80% acceptance; one CoachCare-funded on-site enrollment specialist at 80 enrollments a month; 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 tier blend	15% level 1 · 70% level 2 · 15% level 3 = \$57.68 per patient-month
Medicare Advantage	53.9%–67.1% of the six counties' Medicare (June 2026). Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.
EMR	eClinicalWorks, priced at the custom integration tier (\$4,000 setup, \$150 a month, \$1.50 per patient-month)

11.3 The 90-day plan and the operating dashboard

Days 0–30: foundation. Program agreement and the eClinicalWorks integration workplan. The Medicare payer reconciliation, 1,679 against 1,819 aged 65 and over and the 2,545 panel of 2023, and the hypertension and diabetes registries by payer, the inputs that move the model most. ICD-10 screening of the Medicare panel per the qualification map, device logistics staged, escalation routing set, materials and scripts finalized in English and Spanish, and clinician orientation to the general-supervision workflow.

Days 31–60: enrollment live. Telephonic and in-clinic enrollment running across the sites; first devices in homes; first billable service months. Month 1 nets –\$5,443 as implementation lands; month 2 turns positive. The forecast carries 40 new enrollments in month 1 and 67 in month 2.

Days 61–90: scale and file. 93 new enrollments in month 3, APCM at its ceiling, CCM two months from its own. First monthly operating report against the dashboard. Working session on the accountable care interplay, with the assigned-beneficiary count confirmed.

The operating dashboard from month one:

- Enrollment census by program against ceiling (382 / 202 / 176)
- Time from referral flag to first billable enrollment (target: under five days from flag to first service)
- Discharges captured: hospital discharges that entered the three-touch cadence
- 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, with the quiet-window log
- Claims generated against expected claims, and claims filed on the FQHC claim

- Blood-pressure control and A1c control among enrolled patients, against the UDS 2025 baseline of 62.17% and 37.54%
- Net to the health center per month against the \$29,708 steady-state line

12. Recommendations

1. **Stand up the Medicare service line now, sized honestly.** The individual-code rail has been live since October 2025. This is a \$552,268 two-year net line that fills early in the second year; each month of delay pushes it one month further out, and nothing about it waits on a hire.
2. **Reconcile the Medicare panel by payer in the first 30 days.** The 1,679-patient figure is the health center's own UDS count and drives every ceiling in the forecast. The 1,819 patients aged 65 and over, and the 2,545-patient panel of 2023, are the upper bounds; where the true Medicare count lands among them is the single largest lever in this report, and the table below prices each step.
3. **Confirm how the Medicare Advantage plans pay the care-management codes.** Most of the panel is in Medicare Advantage, from 53.9% to 67.1% across the six counties. Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families. Which plans dominate the panel, and on what terms they pay these code families, sizes how much of the forecast prices exactly at the amounts it uses.
4. **Run the service line as the operating arm of the accountable care participation.** The health center has carried two-sided risk since 2013. Build the fee-for-service service line first, because it is net-positive on its own, and treat the documented monthly management as what holds attribution and moves the cost and quality figures the two-sided settlement rewards.
5. **Lead with earned, recurring Medicare revenue on a panel you already see.** Every care-management dollar lands on top of the PPS encounter. This is new recurring revenue that requires no new clinic, no new site and no new patients, only the between-visit layer the health center does not yet staff.
6. **Keep the CoachCare-funded enrollment specialist in the plan.** The specialist cannot raise the ceilings, but is what reaches them, and is worth \$423,821 of 24-month net reimbursement against the no-specialist case in the table below; without it, remote monitoring stalls near 300 of its 382 ceiling inside 24 months.
7. **Make the hospital discharge the front door.** Wire the discharge feed from the acute-care hospitals in the counties served, enroll at the first post-discharge contact, and bill transitional care on every discharge home to a health-center patient. TCM is in the forecast at zero dollars; every episode billed is upside, and every episode enrolled is a monitoring patient from the day they most need it.
8. **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: 1,679 panel, 8 clinicians, 1 enrollment specialist	\$1,294,294	\$552,268	42.67%	M14 / M8 / M5
No on-site enrollment specialist	\$870,473	\$369,201	42.41%	not reached (300 of 382 at M24) / M19 / M10
Second on-site enrollment specialist	\$1,408,431	\$601,251	42.69%	M9 / M6 / M4

Scenario	24-month net reimbursement	Net to the health center	Margin	Ceiling reached RPM / CCM / APCM
6 referring clinicians	\$1,257,499	\$536,537	42.67%	M15 / M9 / M5
11 referring clinicians	\$1,336,451	\$570,271	42.67%	M12 / M8 / M5
Panel 1,629 (the health center's UDS 2024 Medicare count)	\$1,264,628	\$539,309	42.65%	M13 / M8 / M5
Panel 1,819 (every patient aged 65 and over; upper bound pending the payer reconciliation)	\$1,373,715	\$586,920	42.73%	M15 / M9 / M5
Panel 2,545 (the health center's UDS 2023 Medicare count)	\$1,715,840	\$736,915	42.95%	M20 / M12 / M6

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 specialist changes when each ceiling is reached, and whether remote monitoring reaches its ceiling at all inside 24 months.

Read the table from the bottom up. The clinician-count rows barely move the result, because every program fills on eight referrers. The specialist rows move the timing, and in the no-specialist case remote monitoring never reaches its ceiling inside 24 months. The panel rows are the ones that move the ceilings, and the panel is the health center's own number to confirm.³¹

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 four inputs that would move it, in the order they matter.

1. **The Medicare payer reconciliation.** 1,679 patients with Medicare as primary payer against 1,819 aged 65 and over and a panel that reached 2,545 in 2023: how many carry Medicare today, and where the panel settles among those figures. This one number sets every ceiling.
2. **The accountable care interplay.** The count of assigned beneficiaries in the health center's Medicare Shared Savings Program participation, the current benchmark, and how a documented monthly touch flows into the two-sided settlement, so the value-model layer on top of the fee-for-service forecast can be sized.
3. **The Medicare Advantage contract terms.** Which Medicare Advantage plans dominate the panel and how they pay the care-management code families, since most of the panel is in Medicare Advantage and the fee-for-service slice is the minority.
4. **The eClinicalWorks product line and interfaces.** Which eClinicalWorks products the health center runs and which interfaces are available, so the integration workplan and the hospital discharge feed can be written.

Everything else in this report, the hypertension and diabetes registries by payer, the discharge feed from each hospital, and the device logistics across seven sites, is a workplan item that follows the session rather than a condition of it.

³¹ CoachCare Value Analysis recalculations at the same pricing: no on-site enrollment specialist \$870,473 / \$369,201 / 42.41% (remote monitoring at 300 of 382 at month 24); second specialist \$1,408,431 / \$601,251 / 42.69%; 6 clinicians \$1,257,499 / \$536,537 / 42.67%; 11 clinicians \$1,336,451 / \$570,271 / 42.67%; panel 1,629 \$1,264,628 / \$539,309 / 42.65%; panel 1,819 \$1,373,715 / \$586,920 / 42.73%; panel 2,545 \$1,715,840 / \$736,915 / 42.95%. The enrollment specialist is worth \$423,821 of 24-month net reimbursement against the no-specialist case.

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.³²

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 for grant H80CS00460 (reporting year 2025, retrieved September 2026): total patients, payer and age mix, chronic-condition counts and the clinical quality measures with HRSA's adjusted quartile rankings; the Health Center Service Delivery Sites file (seven sites across six counties, four flagged rural); and the Section 330 grant record and project period.
- **CMS Federally Qualified Health Center Enrollments (July 2026 vintage):** seven Part A FQHC certification numbers under one PECOS associate identifier, a Georgia non-profit corporation, Federal Tort Claims Act coverage and 340B covered-entity status.
- **The health center's website,** retrieved September 2026: the provider, locations, services and careers pages and the site's brand assets; the EHR (eClinicalWorks) as indicated by the healow patient portal on every page.
- **CMS National Plan and Provider Enumeration System and Quality Payment Program eligibility records,** queried September 2026 for the clinicians billing under the health center's organization: the adult-primary-care roster by count and discipline, and Advanced Alternative Payment Model participation through the Medicare Shared Savings Program.
- **CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2023** (the most recent release): the sweep of every remote-monitoring, care-management, advanced-primary-care, transitional-care and behavioral-health-integration code across the adult-primary-care roster. CMS suppresses any provider-and-code line under 11 beneficiaries; care management an FQHC bills on its own institutional claim is not in this file.
- **CMS Medicare Shared Savings Program participant file, performance year 2026:** the health center's participation on the Enhanced (two-sided-risk) track, with an initial start date of 2013, referenced only as the health center's own participation.
- **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.

³² CoachCare company statistics, 2026: patients served, managed conditions, providers on the platform, implementations completed, claims generated and vitals recorded.

- **CY2026 Physician Fee Schedule rate files (CMS RVU26A, January 2026 release):** national non-facility amounts for the eleven forecast codes, the two transitional care codes and the behavioral health integration code, at the national 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; comment period closed September 14, 2026.
- **CMS Medicare Monthly Enrollment, June 2026:** Medicare beneficiary counts, Medicare Advantage penetration (53.9% to 67.1%) and dual-eligible share for the six counties the health center serves.
- **U.S. Census Bureau American Community Survey 2019–2023 five-year estimates,** for the six counties: population, age, income, poverty and language, distinguishing the metro-edge counties from the rural ones.
- **CMS Hospital General Information and Care Compare,** September 2026: the CMS-certified acute-care hospitals in the counties served, referenced by county only.
- **CoachCare Care Management Programs standard operating procedures, March 2026,** and the seven process maps derived from them: the shared alert-and-escalation decision logic, trend definitions, the emergent communication protocol, three-way routing, the post-discharge three-touch sequence 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 into the practice management system through the CoachCare billing engine.
- **CoachCare Value Analysis for YourTown 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 1,679 Medicare patients in scope, eight referring clinicians, one on-site enrollment specialist, and CY2026 national non-facility amounts for RPM, CCM and APCM.

How this report counts

Patients and program enrollments are different numbers. At M24 the program holds 760 active program enrollments belonging to 495 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 the health center's own. Health-center visits bill on the FQHC claim rather than under individual clinicians, so clinician-level Medicare claims files structurally undercount a health-center panel. The 1,679-patient figure is the Medicare count the health center reported to HRSA for 2025, and the first implementation step reconciles it against the 1,819 patients aged 65 and over by payer.

No individual is named anywhere in this report. Governance, leadership, clinician composition and the accountable care relationship are described by count, role and organization only.