COACHCARE | SERVICE LINE STRATEGY

South Central Primary Care

South Central Primary Care Center, Inc. · a Section 330 federally qualified health center serving 15,921 patients across sixteen sites in six south Georgia counties, from its Ocilla headquarters, with a mobile unit that carries care into a seventh

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line — remote physiologic monitoring, chronic care management and advanced primary care management — for the Medicare panel that has grown every year since 2021, billed under the CY2026 rules that pay health centers for those codes separately from the PPS visit

Purpose of this document

Prepared by CoachCare, August 2026, as a discussion document for the leadership of South Central Primary Care. It brings together the health center's published clinical quality record, the shape of its Medicare panel, the CY2026 rules governing how health centers bill care management, the two-sided accountable-care position it holds, the market its patients live in, and a 24-month financial forecast.

The argument is short. This health center already screens at the national frontier — first quartile on depression, tobacco and BMI screening, with two 2026 National Quality Leader badges — and it already reaches patients others cannot, through a mobile unit, school-based sites and outreach staff. The measure that stays stubborn is blood-pressure control, and it is stubborn because it is decided between visits. Since October 2025, Medicare pays health centers for exactly that between-visit work, code by code.

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Executive Summary

South Central Primary Care — legally South Central Primary Care Center, Inc., founded in 1992 — is a HRSA Section 330 federally qualified health center headquartered in Ocilla, Georgia, with sixteen registered sites across Irwin, Coffee, Ben Hill, Atkinson, Berrien and Lowndes Counties and a mobile unit that extends care into Cook County. It has been a 340B covered entity since 2014, dispenses through its own pharmacy with home delivery, carries AAAHC accreditation and patient-centered medical home recognition, and runs its clinical operation on eClinicalWorks. Its 2025 Uniform Data System report counts **15,921 patients**.[1]

The panel that matters to this report is small and moving fast. The health center served **1,432 Medicare-primary patients in 2025** — up 41% from 1,017 in 2021, and the line grew every single year, including the one year total patients did not. Patients 65 and over grew from 810 to 1,302 over the same period. Inside the Medicare line sits the number that shapes the enrollment economics: **524 of the 1,432 — 36.6% — are dually eligible** for Medicare and Medicaid.[2]

This is also a health center that performs where a visit can settle the measure. 2025 UDS quality places it in the **first national quartile on depression screening and follow-up (96.89%), tobacco screening and cessation (95.04%), BMI screening (94.52%) and HIV screening**, and its 2026 Community Health Quality Recognition badges name it a **National Quality Leader in Diabetes Health and in Behavioral Health**. One measure runs the other way: controlling high blood pressure stands at **58.69% — the bottom national quartile — with 3,045 hypertension patients** on the registry.[3]

> **The observation this report is built on**
>
> **The screening engine is national-class. The measure still stuck is the one that lives between visits.**
>
> A health center that screens 96.89% of its patients for depression and holds two National Quality Leader badges does not have an engagement problem. Blood-pressure control is different in kind: it is won in the weeks between appointments — whether the medication gets taken, whether anyone sees the reading that says a dose is wrong, whether the titration happens this month or at the next visit. Since October 2025, Medicare pays health centers for exactly that between-visit work, code by code, on top of the PPS visit.

The reason to act now is a billing change that has already happened. Health centers billed care coordination through one bundled code, G0511, until CMS retired it: the code was payable only through **September 30, 2025**, and claims after that date deny.[4] In its place, a health center reports the individual CPT and HCPCS codes for chronic care management, remote physiologic monitoring, advanced primary care management and the related families, paid at the **national non-facility physician fee schedule amount, in addition to the PPS visit payment** when both occur — CMS's health-center billing booklet, March 2026 edition, states the rule directly.[5] South Central Primary Care has to run code-level care-

[1] HRSA Health Center Program: Uniform Data System awardee profile, grant H80CS00836, 2025 reporting year (retrieved August 2026); HRSA Health Center Service Delivery Sites file (sixteen registered sites across Irwin, Coffee, Ben Hill, Atkinson, Berrien and Lowndes Counties, plus the mobile unit; the mobile unit's coverage including Cook County per scpccga.org). 340B Office of Pharmacy Affairs Information System covered-entity record: participating since July 1, 2014, recertified February 4, 2026; in-house pharmacy registered in NPPES. Section 330 project period through February 28, 2030, no program conditions. AAAHC accreditation and PCMH recognition per the health center's published history.

[2] HRSA Uniform Data System, 2021–2025: Medicare-primary patients 1,017 (2021), 1,174 (2022), 1,228 (2023), 1,308 (2024), 1,432 (2025); patients 65 and over 810 to 1,302; dually eligible 524, reported within the Medicare line, equal to 36.6% of it. UDS counts each patient once by primary coverage, so Medicare Advantage members sit on the Medicare line.

[3] HRSA Uniform Data System, 2025 clinical quality with HRSA adjusted quartile rankings (quartile 1 is the best-performing quartile nationally): depression screening and follow-up 96.89%, tobacco use screening and cessation 95.04%, BMI screening and follow-up 94.52%, HIV screening 58.80% — all first quartile; controlling high blood pressure 58.69%, fourth quartile, on 3,045 hypertension patients (39.6% of medical patients); diabetes registry 1,552 patients. 2026 Community Health Quality Recognition badges: National Quality Leader — Diabetes Health; National Quality Leader — Behavioral Health.

[4] Medicare Administrative Contractor notices and CMS MLN Connects, June 5, 2025: G0511 payable for dates of service through September 30, 2025; later claims deny.

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

management billing from now on whether or not it starts anything new. The open question is who carries that work.

Today the program does not exist. All eighteen clinicians on the health center's roster were queried against the remote monitoring and care-management code families in the CY2024 Medicare claims file, and **no Medicare remote-care or care-management program at meaningful scale is visible in CY2024 claims or public materials**. The bundled G0511 billed institutionally, outside that file's scope, so whatever volume ran through September 2025 is a number to pull from the health center's own billing system — Section 3.3 bounds the claim honestly.[6]

What the Value Analysis returns

	Year 1	Year 2	24 months
Net reimbursement	**$457,469**	**$675,632**	**$1,133,102**
CoachCare fees	$268,374	$383,651	$652,025
Net to the health center	**$189,095**	**$291,981**	**$481,077**
Margin to the health center	41.34%	43.22%	**42.46%**

CoachCare Value Analysis: 1,432 Medicare-primary patients (2025 UDS), RPM + CCM + APCM, CY2026 fee schedule at the Georgia locality amounts.

One market fact sits underneath every number above. Medicare Advantage covers 56.1% of the beneficiaries in the seven-county footprint, and MA plans must reimburse at least 100% of the Medicare rate for a health center's covered services — a floor; individual contracts set their own terms for the care-management code families. The plan-by-plan read is the first item in Section 8.4.

1. **The service line pays for itself from its second month.** Month 1 nets −$5,288, because implementation and the eClinicalWorks integration setup land in that month. The first positive month is M2, at $3,684, and the program runs at $24,332 a month net to the health center from M11.
2. **Nobody is hired.** CoachCare delivers 8,086 hours of care-management labor over 24 months — about 3.9 full-time equivalents — including an on-site enrollment specialist carried at CoachCare's expense. Against an eleven-prescriber adult-medicine roster and a three-person executive team, that is the difference between a program and a plan.
3. **The dual-eligible mix makes APCM work harder here than at almost any practice CoachCare serves.** 36.6% of the Medicare panel is dually eligible. Dual status maps those patients to the highest advanced primary care management tier — $111.80 a month at the Georgia amount — and Qualified Medicare Beneficiary protections mean the coinsurance objection that stalls enrollment elsewhere does not exist for them.
4. **The binding constraint is the size of the Medicare panel, not enrollment capacity.** All three programs reach their enrollment ceiling — advanced primary care management in M4, chronic care management in M7, remote monitoring in M10. At M24 the program holds 648 active program enrollments across 423 unique patients, which is every patient the three programs can take. The panel has grown every year since 2021, so the ceiling rises every year.
5. **The ACO position turns clinical results into benchmark defense.** The health center has carried two-sided risk in the Medicare Shared Savings Program since January 1, 2024. Under a two-sided

[6] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024 (released May 2026), queried per National Provider Identifier across all eighteen roster clinicians for the remote monitoring (99453, 99454, 99457, 99458, 99091), chronic care management (99490 family), advanced primary care management (G0556–G0558) and transitional care management families: zero rows. CMS suppresses clinician-and-code lines under 11 beneficiaries; G0511 billed on institutional claims, outside this file's scope.

agreement, the admissions this program prevents are spending that never reaches the benchmark reconciliation — Section 5 sizes that at the admission rates a targeted chronic cohort actually runs.

6. **Medicare is the billable rail.** Georgia Medicaid pays a health center nothing separately for remote monitoring or chronic care management — that work sits inside the PPS encounter. The 7,142 Medicaid patients, 44.9% of the panel, are the quality and equity dividend of the same infrastructure, and Section 7 frames them that way.

1. The Health Center, and the Panel That Grew Every Year

1.1 The footprint

South Central Primary Care has operated since 1992 and holds a Section 330 grant with a project period running through February 2030, with no program conditions on its record. Sixteen registered sites span six counties: the Ocilla headquarters and clinic in Irwin County, service sites in Douglas, Fitzgerald, Nashville, Pearson and Valdosta, five school-affiliated sites, and a mobile unit based in Pearson that carries screenings and primary care across the footprint and into Cook County. The organization runs lean: $11.6 million of revenue in its 2025 fiscal year and a cost per patient of $648.07, roughly a fifth of what an urban health center spends.[7]

The footprint in numbers	2025	What it means for this program
Patients	**15,921**	Up 46% from 10,922 in 2021 — growth across every payer line
Registered sites	16 across six counties, plus a mobile unit	Enrollment can run where patients already are, including the towns with no other adult primary care
Children under 18	50.68% of the panel	Half the panel is pediatric — the adult chronic-disease book concentrates in a handful of sites and prescribers
Adult-medicine prescribers	**11**	One family-medicine physician and ten nurse practitioners — the referral engine for this forecast
Patients at or below 200% of poverty	**91.18%**	65.92% live at or below 100% of the poverty guideline — cost-sharing friction decides enrollment here
Agricultural workers and families	1,145 — 7.19% of patients	A migratory panel that a mobile unit and cellular devices can hold onto between moves
Limited English proficiency	1,637 patients — 10.28%	Outreach and enrollment run in the patient's own language

HRSA Uniform Data System 2025; HRSA service-delivery-sites file; scpccga.org site listing.

The clinician roster deserves one sentence of precision. The adult-medicine core that can order and refer remote care runs to **eleven prescribers — one family-medicine physician and ten nurse practitioners** — spread across the adult sites. The three pediatricians, the pediatric nurse practitioner, the behavioral-health clinicians and the pharmacist sit outside that core, and the forecast in Section 4 does not count them.[8]

1.2 The Medicare panel: 1,432 patients, 36.6% dually eligible

Measure	2021	2023	2025	Direction
Total patients	10,922	14,067	**15,921**	+46% over the period
Medicare-primary patients	1,017	1,228	**1,432**	**+41% — grew every year**
— of whom dually eligible	398	454	**524**	**now 36.6% of Medicare**
Patients 65 and over	810	1,149	**1,302**	+61% over the period

[7] HRSA Health Center Service Delivery Sites file and scpccga.org site listing (sixteen registered sites; mobile unit based in Pearson); HRSA UDS 2025 (total cost $10,317,915; cost per patient $648.07); IRS Form 990 series via public filings (FY2025 revenue $11.6 million); Section 330 project period through February 2030 with no program conditions.

[8] Practice-published clinician roster cross-checked to NPPES, the CMS Doctors & Clinicians file and CMS Quality Payment Program records: eighteen clinicians in all — one family-medicine physician, ten adult-capable nurse practitioners, three pediatricians, one pediatric nurse practitioner, two behavioral-health clinicians and one pharmacist. The adult-medicine referral core used in the forecast is eleven prescribers.

Measure	2021	2023	2025	Direction
Medicaid / CHIP patients	4,671	5,778	7,142	44.9% of the panel
Uninsured patients	2,383	2,643	2,703	17.0% of the panel

HRSA Uniform Data System, 2021–2025. UDS counts each patient once by primary coverage; Medicare Advantage members sit on the Medicare line, and the dually-eligible count is reported within it.

Three things stand out in that table. First, the Medicare line is the steadiest growth story the health center has — it rose in 2022, 2023, 2024 and 2025, including the year the total panel pulled back. Second, the growth is structural: the 65-and-over population grew 61% in four years, faster than any age band. Third, the chronic-disease registries behind the panel are deep for an organization this size: **3,045 patients with hypertension — 39.6% of medical patients — and 1,552 with diabetes**. The Medicare slice of those registries is the population this service line enrolls.[9]

1.3 Quality: national-class screening, one measure left between visits

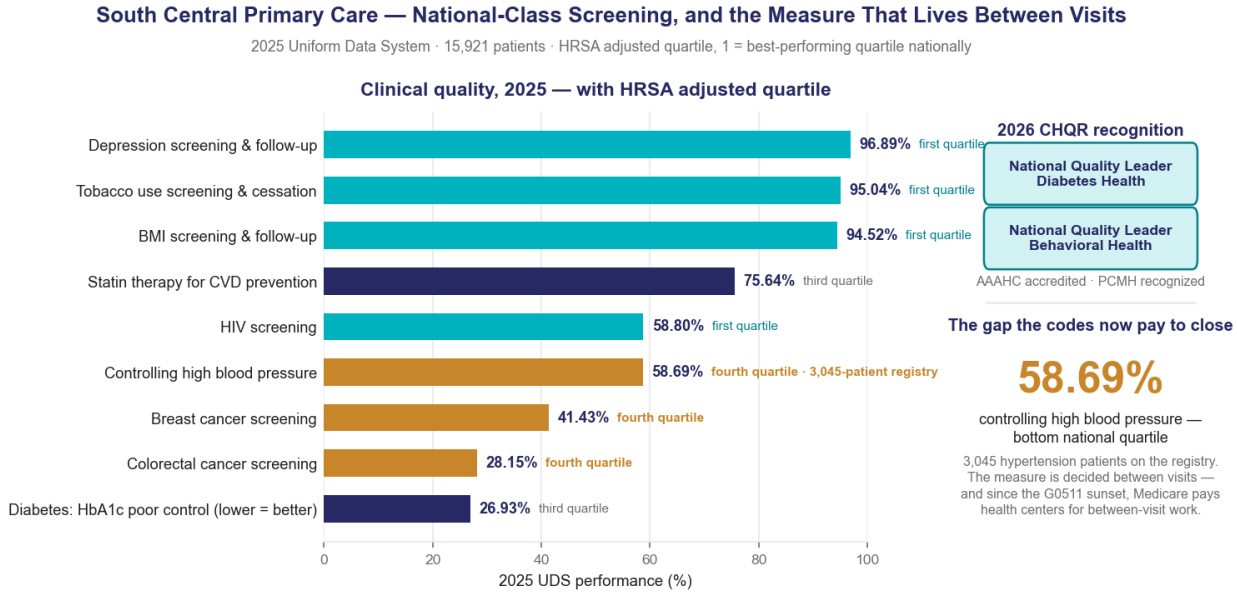

Figure 1 — 2025 Uniform Data System clinical quality with HRSA adjusted quartile position (quartile 1 is the best-performing quartile nationally), the 2026 CHQR National Quality Leader badges, and the blood-pressure gap.

Give the credit first, because it is earned. Four measures sit in the first national quartile — depression screening and follow-up at 96.89%, tobacco screening and cessation at 95.04%, BMI screening at 94.52%, and HIV screening. The 2026 Community Health Quality Recognition cycle awarded the health center two National Quality Leader badges, in **Diabetes Health** and **Behavioral Health** — recognition given to a small fraction of health centers nationally. The operation knows how to find a patient, screen a patient and follow up.[10]

Then the gap. **Controlling high blood pressure stands at 58.69% — the bottom national quartile** — on a registry of 3,045 hypertension patients. Diabetes control and statin therapy sit in the third quartile. The pattern is precise: the measures the health center leads are settled inside the visit, and the measures that lag are settled between visits — whether the pills get taken, whether a climbing reading gets seen in

[9] HRSA Uniform Data System, 2021–2025, payer-mix and age tables as published on the awardee profile. Chronic-disease registries, 2025: hypertension 3,045 (39.6% of medical patients); diabetes 1,552 (20.9%).

[10] HRSA Uniform Data System, 2025 quality measures and HRSA adjusted quartiles; 2026 Community Health Quality Recognition badge display on the awardee profile: National Quality Leader — Diabetes Health and National Quality Leader — Behavioral Health.

time, whether the dose changes this week or in three months. A health center cannot staff its way to daily blood-pressure surveillance out of an eleven-prescriber roster. Since January 2026, Medicare pays for that surveillance code by code, which makes the quality case and the revenue case the same case.

1.4 The market around it

County	Medicare beneficiaries	Enrolled in Medicare Advantage	Dually eligible
Irwin (HQ)	1,899	60.2%	29.1%
Coffee	7,679	60.7%	30.4%
Ben Hill	4,045	65.6%	32.1%
Atkinson	1,491	**67.7%**	34.1%
Berrien	4,144	58.0%	30.4%
Cook (mobile unit)	3,692	59.7%	31.3%
Lowndes	21,646	50.6%	24.2%
Seven-county footprint	**44,596**	**56.1%**	27.7%

CMS Medicare Monthly Enrollment, CY2025 annual. Excluding Lowndes — the one urban county, where three of the health center's sites are pediatric — the core-county Medicare Advantage share is 61.3%.

Two facts in that table shape the program. First, the footprint holds **44,596 Medicare beneficiaries** against the health center's 1,432 — the panel the ceilings in Section 4.4 are built on is a small share of the seniors within reach of its own sites and mobile unit. Second, **Medicare Advantage is the majority payer environment**: 56.1% across the footprint, 61.3% in the core counties, reaching 67.7% in Atkinson. MA plans must reimburse at least 100% of the Medicare rate for a health center's covered services — a floor; individual contracts set their own terms for the care-management code families — so the plan-by-plan read of the health center's own MA mix sits in the confirmation list in Section 8.4, not in the forecast.[11]

The counties themselves explain why the panel is worth defending. Poverty runs 17% to 23% across the core counties and the uninsured rate reaches 26.1% in Atkinson, against roughly 8% nationally; Atkinson County is 27.5% Hispanic, aligned with the health center's farmworker program. This is a service area where the alternative to the health center is usually nothing, which is exactly the population HRSA's quality measures — and Section 7's equity argument — care most about.[12]

[11] CMS Medicare Monthly Enrollment, CY2025 annual: county Medicare beneficiary totals, Medicare Advantage and Other shares, and dual shares for Irwin, Coffee, Ben Hill, Atkinson, Berrien, Cook and Lowndes Counties; seven-county footprint 44,596 beneficiaries, 56.1% MA, 61.3% excluding Lowndes. Federal Medicare Advantage payment rules require MA plans to pay a federally qualified health center at least what original Medicare would pay for covered services.

[12] U.S. Census Bureau, American Community Survey 2020–2024 five-year estimates, profiles DP03 and DP05: poverty 17.4%–23.2% and uninsured 14.9%–26.1% across the core counties; Atkinson County 27.5% Hispanic and 9.1% limited English proficiency.

2. The 2026 Billing Change for Health Centers

2.1 One bundled code became many individual ones

For years a health center billed Medicare care management through a single bundled HCPCS code, G0511, at one blended rate regardless of what was delivered. CMS ended that. Health centers were directed to bill the individual care-coordination codes, with G0511 permitted during a transition that ran **through September 30, 2025**. Claims carrying G0511 after that date deny. Every health center in the country now reports the individual CPT and HCPCS codes for chronic care management, remote physiologic monitoring, advanced primary care management, behavioral health integration and the related families.[13]

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

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

- **Care management does not cannibalize the PPS rate.** It is paid in addition to it. A patient seen face to face and enrolled in remote monitoring generates the PPS payment and the monitoring payment.
- **The compliance work now exists whether or not a program does.** One bundled code required one time log. The individual codes require per-program time capture, documentation, consent and claim construction, each family with its own thresholds. That work landed on every health-center billing office on October 1, 2025.

2.2 What the codes pay, and the rate basis of this report

CY2026 also widened what remote monitoring can bill. Two new codes matter for this panel: **99445**, which pays for 2 to 15 days of device supply in a month, and **99470**, which pays for the first 10 minutes of treatment management. Before these codes, a month with fewer than 16 days of readings or under 20 minutes of management produced nothing billable; now it produces a claim. Across the 24-month forecast the two codes contribute **$101,175 of gross reimbursement — about 8.9% of net reimbursement**. Partial months are exactly where a newly enrolled rural panel lives, which makes these codes worth more to this health center than to a typical practice.[15]

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

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[13] Medicare Administrative Contractor G0511 transition notices and CMS MLN Connects, June 5, 2025.

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

[15] CY2026 Medicare Physician Fee Schedule: 99445 (remote physiologic monitoring device supply, 2–15 days in 30) and 99470 (treatment management, first 10 minutes). Contribution of $101,175 gross over 24 months, about 8.9% of 24-month net reimbursement: CoachCare Value Analysis for South Central Primary Care, 2026.

The rate basis of this report — conservative on purpose

Every figure in this report is priced at the Georgia locality amounts — the Palmetto GBA Rest-of-Georgia fee schedule — which sit below the national non-facility amounts health centers are entitled to bill.

Re-priced at the national amounts, the same 24 months return $1,203,160 of net reimbursement and $551,135 net to the health center, at a 45.81% margin — CoachCare's fees are flat per-patient-month prices, so the entire difference falls to the health center. The forecast keeps the lower basis.

On the Medicare Advantage side, plans must reimburse at least 100% of the Medicare rate for covered services — a floor; individual contracts set their own terms for the care-management code families.

2.3 The work the change creates, and who carries it

The change gives with one hand and takes with the other. The individual codes pay more, and they demand more: per-program time capture, per-program documentation, per-program consent and per-program claim construction, every enrolled patient, every month. At South Central Primary Care that work would land on a three-person executive team and an eleven-prescriber clinical roster that already carries six counties. Nobody on either list has spare hours.

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

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

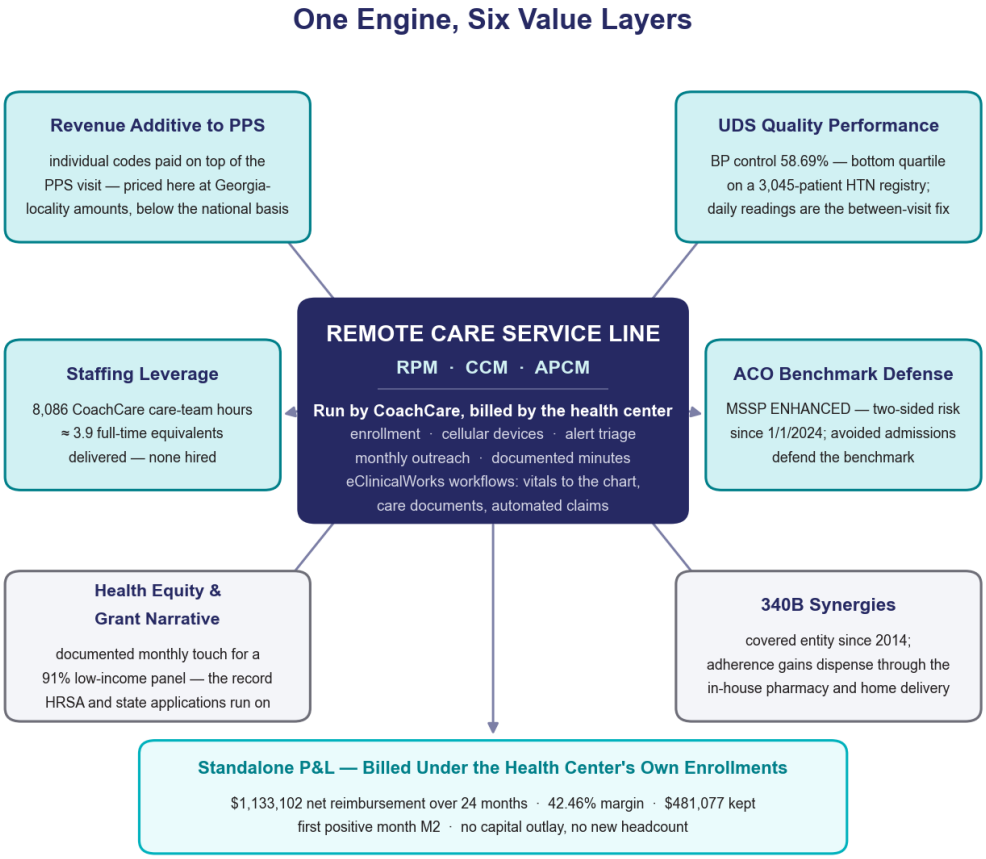

Figure 2 — one operating spine, six value layers, and the standalone profit and loss underneath it. Figures from the CoachCare Value Analysis and the 2025 Uniform Data System.

3.1 The clinical and billing stack

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

Program	What it does clinically	Who it fits in this panel	Net reimbursement per enrolled patient-month
Remote physiologic monitoring (RPM)	A connected cuff, scale or glucometer transmits readings between visits, reviewed against thresholds the health center sets	The Medicare slice of the 3,045-patient hypertension and 1,552-patient diabetes registries — the control measures are computed from exactly the values these devices transmit	**$90.58**
Chronic care management (CCM)	A documented care plan for patients with two or more chronic conditions, with at least 20 minutes of non-face-to-face coordination each month	The multi-morbid core of the Medicare panel	**$105.73**

Program	What it does clinically	Who it fits in this panel	Net reimbursement per enrolled patient-month
Advanced primary care management (APCM)	A monthly per-patient payment for continuous primary-care management — no minute threshold, tiered by complexity and dual-eligible status	The 36.6%-dual panel. Dual status maps patients to the highest tier, G0558 — Section 3.2	**$59.36**

Blended net reimbursement per enrolled patient-month, CoachCare Value Analysis, CY2026 Georgia locality amounts.

Chronic care management and advanced primary care management draw on one care-management pool and are mutually exclusive in a given patient-month. Remote monitoring runs alongside either. The forecast enrolls each patient in the combination that pays for the work their condition actually needs.

3.2 APCM and the dual-eligible panel

Advanced primary care management is priced in three tiers, and the third — **G0558, for patients who are Qualified Medicare Beneficiaries with two or more chronic conditions** — pays the most: $111.80 a month at the Georgia amount, every month, with no minute threshold to document. At South Central Primary Care, 36.6% of the Medicare panel is dually eligible — 524 patients — roughly twice what a typical community practice carries, and the five-year range has never dropped below 34.9%.[16]

Dual eligibility also solves the enrollment problem. Care-management programs stall on the coinsurance conversation: a patient living at or below the poverty line, asked to take on a monthly copay for a program they have not experienced yet, declines. Qualified Medicare Beneficiary protections prohibit billing those patients Medicare cost-sharing. For the dual third of this panel — on a panel where 65.92% of all patients live at or below 100% of poverty — the objection does not exist.

The wedge, stated as one sentence

The dual-eligible mix makes advanced primary care management worth more at this health center than at almost any practice CoachCare works with — and the enrollment and engagement labor that earns it is ours.

APCM contributes $198,446 of the 24-month forecast on 150.3 active enrollments at $59.36 per enrolled patient-month blended across the tiers, with the dual share driving the top-tier weighting. It saturates in month 4 — the fastest of the three programs — because the eligible population is concentrated and already in the building. It is the cleanest first yes in the enrollment conversation.

3.3 The starting position: whitespace, honestly bounded

Every clinician on the health center's roster — eighteen in all, including the pediatric and behavioral-health staff — was queried against the remote monitoring, chronic care management, advanced primary care management and transitional care management code families in the CY2024 Medicare claims file. None appears on any of them: **no Medicare remote-care or care-management program at meaningful scale is visible in CY2024 claims or public materials**. Two structural facts bound what those zeros can prove, and both belong in the open.[17]

[16] HRSA UDS 2025 (524 dually eligible of 1,432 Medicare-primary, 36.6%; five-year range 34.9%–40.6%); CY2026 physician fee schedule, Georgia locality amount for G0558, $111.80 per month; CMS MLN006397, March 2026, for the G0556–G0558 tiers; Qualified Medicare Beneficiary billing protections under federal law prohibit charging QMB patients Medicare cost-sharing.

[17] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024, per-clinician query across the eighteen-clinician roster; query mechanics validated against a known-positive control, so the nulls are absences rather than query failures. Services and after-hours descriptions: scpccga.org, reviewed August 2026.

- **CMS suppresses any clinician-and-code line under 11 beneficiaries.** A code billed to ten patients is invisible. The supportable statement is the one above — at meaningful scale — not that no patient was ever billed.
- **G0511 billed institutionally and is structurally absent from the clinician file.** Through September 2025, health-center care management ran through the bundled code on institutional claims, which the clinician-level file does not capture. Whatever G0511 volume ran historically is a number to pull from the health center's own billing system, and it is the first number worth pulling — it decides whether this program starts from zero or from a base worth migrating.

The public record adds two corroborating facts: the health center's services pages describe no remote monitoring, telehealth platform or care-management program, and its after-hours pathway is an answering service reaching an on-call clinician. What the record does show is an organization built to reach people — which is the subject of Section 3.5.

3.4 Staffing: 3.9 full-time equivalents, none of them hired

Over 24 months the forecast carries **8,086 hours of CoachCare care-team labor — about 3.9 full-time equivalents** — covering enrollment calls, monthly outreach, alert triage, documentation and claim preparation. The health center hires nobody, buys no devices and stocks nothing. The care-management families operate under general supervision, so the work runs under the health center's billing without adding to any prescriber's schedule — and without adding a fourth name to a three-person executive team's payroll requests.[18]

One staffing line deserves its own sentence: the on-site enrollment specialist, carried at CoachCare's expense. Run the same forecast without that person and 24-month net reimbursement falls to $945,518 — the specialist is worth **$187,584** over 24 months, not by enrolling more patients but by reaching the same ceilings months sooner. On a rural panel spread across six counties, enrollment lives or dies in person, at the site the patient already visits.

3.5 The enrollment chassis this health center already owns

Most organizations buy enrollment infrastructure. This one already owns it, built for other purposes and pointed at exactly the right population.

Asset already in place	What it does for this service line
The mobile unit	Routes through Atkinson, Ben Hill, Berrien, Coffee, Cook and Lowndes Counties doing screenings and vaccines — a rolling enrollment venue that reaches the seniors least likely to travel
Outreach staff who enroll for a living	The health center's outreach workers are certified application counselors who sign neighbors up for coverage; program enrollment is the same conversation with a shorter form
School-based sites in three counties	Family relationships that reach grandparents — the panel's Medicare growth is happening inside households the health center already knows
340B pharmacy with home delivery	A covered entity since 2014, dispensing from its own pharmacy with home delivery. A monitoring program's core clinical products — adherence and timely titration — show up as prescriptions filled, and here those fills stay in-house
The grant file	A panel 91.18% at or under 200% of poverty, 1,145 agricultural workers, documented monthly touch for every enrolled patient — the longitudinal engagement record HRSA submissions and state applications are built on

HRSA 340B covered-entity record; scpccga.org services pages; HRSA UDS 2025. Section 7 returns to the state-funding angle.

[18] CoachCare Value Analysis for South Central Primary Care, 2026: 8,086 care-team hours over 24 months, 3.9 full-time equivalents; removing the enrollment specialist lowers 24-month net reimbursement from $1,133,102 to $945,518, a difference of $187,584. The specialist is carried at CoachCare's expense.

3.6 eClinicalWorks integration: the program lives in the chart

The health center runs eClinicalWorks — verified by the vendor-hosted patient portal linked from its own website. CoachCare uses built-in eClinicalWorks workflows, so the care team enrolls and monitors patients without learning a second system and without a parallel portal to check. The program lives in the chart the prescribers already use.[19]

Integration pillar	What it does in the record
Integrated enrollment and ordering	Enrollment flags and trigger ordering by service sit inside the clinical workflow. The CoachCare team enrolls qualified Medicare patients on the health center's behalf, and enrollment status is visible in real time
Enrollment by services and devices	Each patient is routed to the program combination and connected device their diagnoses call for
Exchange of health history	Care plans start from what is already in the chart instead of from a blank form
Integrated vital reports	**Device readings land in the chart as vitals a clinician can trend — the same values the blood-pressure control measure is computed from**
Compliance documentation and integrated care summary	Evidence of Care, vitals and care-plan documents attach to the patient's chart monthly — the audit trail the per-code rules in Section 2.3 require
Automated claim generation	**Claims created through the CoachCare billing engine. CoachCare is the only care management application integrated with eClinicalWorks that generates claims automatically, which removes the manual per-patient, per-month claim step entirely**

Two consequences carry into the forecast. Patients begin receiving chronic care management and remote monitoring services in **under five days** from the enrollment flag, which is why the census climbs as steeply as it does in the first quarter. And because claim construction is automatic, the **18,740 claims** the program generates over 24 months never land on the billing office as manual work.

On what the integration is for

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

CoachCare

[19] eClinicalWorks verification: the patient portal linked from scpccga.org is hosted on eClinicalWorks' own cloud domain, which serves only eClinicalWorks instances. Integration detail: CoachCare eClinicalWorks integration overview — integrated enrollment and ordering, enrollment by services and devices, exchange of health history, integrated vital reports, compliance documentation and integrated care summary, and automated claim generation via the CoachCare billing engine, with CCM and RPM services beginning in under five days from the enrollment flag.

4. Value Analysis: The 24-Month Forecast

4.1 The headline economics

The forecast covers remote physiologic monitoring, chronic care management and advanced primary care management across the 1,432 Medicare-primary patients in the 2025 Uniform Data System count, priced at the CY2026 Georgia locality amounts, with eleven referring adult-medicine prescribers and one on-site enrollment specialist.[20]

	Year 1	Year 2	24 months
Net reimbursement	**$457,469**	**$675,632**	**$1,133,102**
CoachCare fees	$268,374	$383,651	$652,025
Net to the health center	**$189,095**	**$291,981**	**$481,077**
Margin to the health center	41.34%	43.22%	**42.46%**

The margin moves from 41.34% in year one to 43.22% in year two because the one-time implementation and integration costs fall out and the census is full from the first month of the year. Year two is the steady state: **$675,632 of net reimbursement, $291,981 of it kept, at 43.22%**.

4.2 Where the revenue comes from

Program	Year 1	Year 2	24 months	Per enrolled patient-month
Remote physiologic monitoring	$207,287	$350,481	**$557,768**	$90.58
Chronic care management	$158,791	$218,096	**$376,887**	$105.73
Advanced primary care management	$91,391	$107,055	**$198,446**	$59.36

Net reimbursement by program and year, CoachCare Value Analysis.

Remote monitoring carries just under half the revenue on the largest enrolled population — 325.85 active enrollments at M24 — which is why this report leads with the blood-pressure registry rather than with any single code. Chronic care management earns the most per patient-month across 171.9 enrollments. Advanced primary care management is the smallest line and the fastest to fill, and the dual mix does the most work there, per Section 3.2. The **648 active program enrollments at M24 belong to 423 unique patients**, because a patient can hold a monitoring enrollment and a care-management enrollment at the same time.

[20] CoachCare Value Analysis for South Central Primary Care, 2026. All Section 4 figures. Inputs: 1,432 Medicare-primary patients (2025 UDS), eleven referring adult-medicine prescribers, one on-site enrollment specialist, CY2026 fee schedule at Georgia locality amounts, RPM + CCM + APCM.

4.3 The ramp, month by month

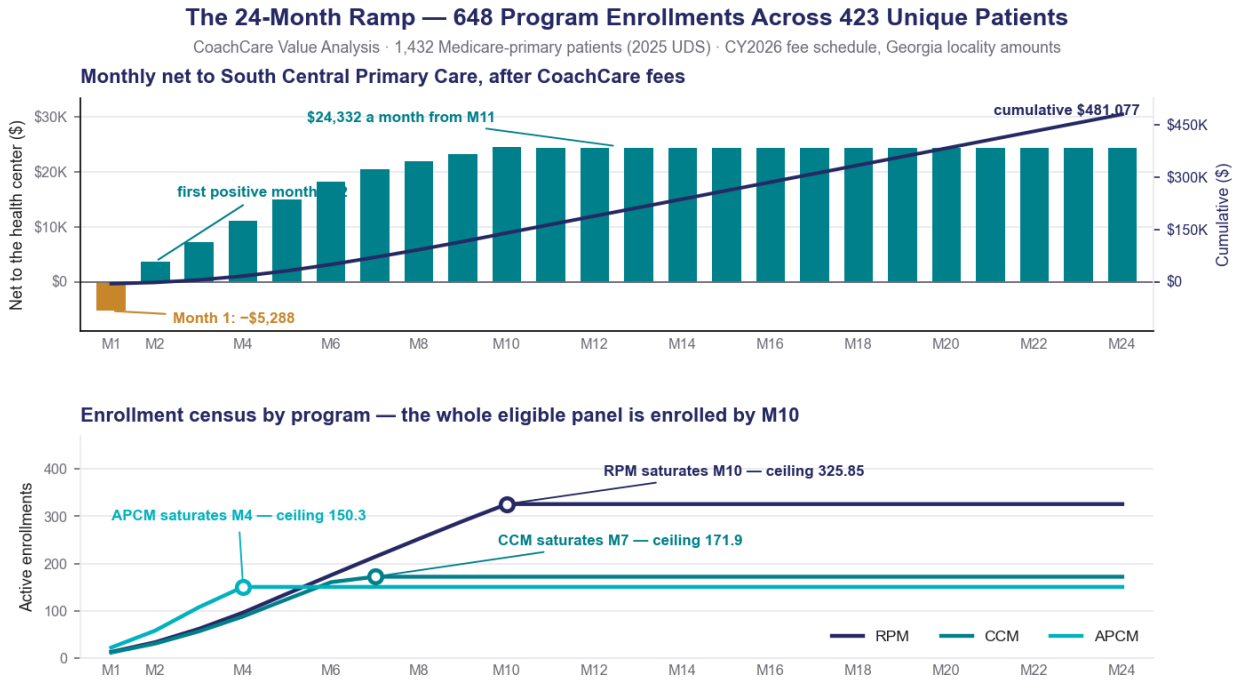

Figure 3 — monthly net to the health center after CoachCare fees, with cumulative net overlaid, and the enrollment census by program with saturation months marked. CoachCare Value Analysis.

Month 1 nets **−$5,288**, because the one-time implementation fee and the eClinicalWorks integration setup land in that month against a census still building. The first positive month is **M2**, at $3,684, and month 1's shortfall is repaid by M3. The program peaks at M10 — the month the last remote-monitoring enrollments land — and holds a steady state of $24,332 a month from M11.

Month	Net reimbursement	CoachCare fees	Net to the health center
M1	$3,843	$9,131	**−$5,288**
M2	$9,954	$6,270	**$3,684**
M3	$18,369	$11,199	$7,170
M6	$42,285	$24,014	$18,271
M8	$50,384	$28,393	$21,991
M10	$56,946	$32,326	$24,620
M11 onward	**$56,303**	$31,971	**$24,332**

The commercially important number in that table is not the 24-month total. It is that the program is cash-positive in its second month and self-funding from then on. A service line that pays its own way from M2 competes with nothing else in an $11.6 million budget, and there is no capital to compete for anyway — no devices purchased, no software licensed, no headcount added.

4.4 Ceilings: the Medicare panel is the constraint, and it rises

Program	Eligible share of the 1,432	Acceptance	Ceiling	Saturates
Remote physiologic monitoring	65% — 931 patients	35%	**325.85**	**M10**
Chronic care management	40% — 573 patients	30%	**171.9**	**M7**

Program	Eligible share of the 1,432	Acceptance	Ceiling	Saturates
Advanced primary care management	35% — 501 patients	30%	**150.3**	**M4**

Say the constraint out loud

The binding constraint on this program is the size of the Medicare panel, not enrollment capacity. By M10 every patient the three programs can take is enrolled — the fastest full saturation of any health center CoachCare has sized this year — and the same infrastructure has nowhere further to go on that year's panel.

The panel rises to meet it. Medicare-primary patients grew every year from 2021 to 2025, 1,017 to 1,432, and the 65-and-over line grew 61% over the same period. Each year's growth raises every ceiling in the table above. Built on a 1,550-patient panel, the same 24-month forecast returns $1,210,177.

4.5 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Readings received	**64,658**	Blood pressure, weight and glucose values arriving between visits, against a control measure currently computed from office readings alone
Claims generated	**18,740**	Constructed, coded and submitted automatically through the eClinicalWorks integration
Care-management tasks completed	37,481	Outreach attempts, care-plan updates, medication reviews and follow-up actions
Patient conversations	5,622	Live contacts across 312 hours of call time
Chart updates	9,370	Documentation written back for the care team to act on
Care-team hours delivered by CoachCare	**8,086**	**About 3.9 full-time equivalents of care-management labor the health center does not employ**
Hospitalizations avoided	**41.1**	At $15,000 per admission, roughly $616,000 of cost that never lands on a payer or a patient — computed at a 20% annual admission rate; Section 5 shows the figure at the rates a targeted cohort actually runs

CoachCare Value Analysis, 24-month totals.

The avoided-admission line belongs to the patient and the payer rather than to the health center's income statement, and it is not part of the $481,077. It is the number that matters to Medicare Advantage plans in counties where 56.1% of beneficiaries are enrolled in one — and it is the number that matters to an ACO carrying two-sided risk, which is where Section 5 picks up.

5. The ACO Layer: Two-Sided Risk and Benchmark Defense

South Central Primary Care participates in the Medicare Shared Savings Program through **Accountable Care Coalition of Georgia, LLC** — ACO A1596 in the PY2026 participant file, a professionally managed ACO that has operated in the program since 2013 and is now in its fourth agreement period. The terms that matter: the current agreement period began **January 1, 2024**, on the **ENHANCED track — two-sided risk**, with retrospective beneficiary assignment, low-revenue status, and no participation in the prospective primary-care payment model some health-center ACOs use — so every code in this report pays fee-for-service, claim by claim.[21]

Two-sided risk changes the meaning of chronic-disease control. Under an upside-only agreement, weak blood-pressure control is a missed bonus. Under ENHANCED, the ACO shares losses when spending runs over benchmark — an avoidable admission is a bad clinical outcome and money the ACO's participants can owe. Since January 2024, the 58.69% blood-pressure control figure in Section 1.3 has been a live financial exposure as well as a quality score.

- **Assignment runs on primary-care touch.** Retrospective assignment follows where beneficiaries actually receive their primary care. A documented monthly care-management relationship with 423 patients is the strongest signal the health center can send that these beneficiaries belong on its assignment list rather than drifting to whoever saw them last.
- **Performance runs on the benchmark.** Care-management billing adds Part B spending, which counts inside the ACO's total cost of care — and the admissions the same program prevents subtract from it. For a two-sided participant, the avoided-admission line is the more important number, and it deserves to be sized honestly.

The forecast's own avoided-admission figure is deliberately conservative: 41.1 admissions over 24 months, computed at a **20% annual admission rate** — a generic Medicare-population figure. This program does not enroll a generic population. It enrolls from a registry of 3,045 hypertension and 1,552 diabetes patients, a third of them dually eligible — and avoided admissions scale with the rate the enrolled cohort would actually run.[22]

Annual admission rate on the enrolled cohort	Admissions avoided, 24 months	Value at $15,000 per admission
20% — the forecast's basis	41.1	$616,500
30%	61.6	$924,000
40% — realistic for this cohort	**82.1**	**$1,231,500**
50%	102.6	$1,539,000

CoachCare Value Analysis avoided-admission engine. Avoided admissions scale in proportion to the underlying admission rate; the forecast ships the 20% basis.

[21] CMS Medicare Shared Savings Program PY2026 participant file, data.cms.gov, retrieved August 2026: South Central Primary Care Center, Inc., participant in Accountable Care Coalition of Georgia, LLC (ACO A1596); ENHANCED track; agreement period four, current period beginning January 1, 2024; ACO initial program start January 1, 2013; low-revenue; retrospective assignment; prospective primary-care payment model participation: none.

[22] CoachCare Value Analysis avoided-admission engine: 41.1 avoided hospitalizations over 24 months at a 20% annual admission rate and $15,000 per admission; avoided admissions scale in proportion to the underlying admission rate, giving 61.6 at 30%, 82.1 at 40% and 102.6 at 50%. Cohort basis: HRSA UDS 2025 registries, 3,045 hypertension and 1,552 diabetes patients.

Where the fee forecast stops, stated plainly

The financial forecast in this report is fee-for-service. It does not include shared-savings distributions or loss allocations under the ACO agreement — those settle at the ACO level, on the ACO's benchmark.

That distinction cuts in a specific direction under two-sided risk. The program bills $1,133,102 of Part B reimbursement over 24 months, which counts toward total cost of care. At the realistic 40% admission rate, the admissions it prevents are worth $1,231,500 against that benchmark — the program defends the benchmark while it pays for itself. The number to bring into the first working session is the health center's assigned-beneficiary count and its distribution history, both of which the ACO's manager holds.

6. Clinical Governance & Escalation

Section 4 shows the service line pays. This section shows it is safe. Every reading a patient takes routes through one shared escalation engine with defined thresholds, a defined trend rule, defined routing and a defined documentation standard, so the health center never carries surveillance liability it did not agree to. Thresholds and routing are set with the health center's clinical leadership rather than by default, and signed off before the first patient enrolls.[23]

6.1 One shared escalation engine

Branch	The rule	Why it is written this way
Critical value	**Escalate immediately, regardless of symptoms**	A reading at a critical threshold escalates whether or not the patient reports symptoms. There is no wait-and-see branch on a critical value, and no client preference can suppress it
Out of range, not critical	Retake, then a structured symptom check	A non-critical out-of-range reading is worked rather than forwarded: confirm technique, request a repeat, then run the symptom check. Most out-of-range readings resolve here, which is why the prescribers' inboxes stay clean
Trend	**Three consecutive readings at least one hour apart for blood pressure or glucose; three readings within seven days for heart rate**	A trend is a definition rather than a judgment call. A confirmed trend escalates on the same footing as a single threshold breach
Patient unreachable	Document the attempt, leave a voicemail with the callback line and advice to seek care if symptoms worsen — and escalate anyway if the reading was critical or a confirmed trend	Silence never downgrades a clinical finding. This is the branch that separates a monitoring program from a data-collection exercise
Documentation	**Six fields on every escalation: vital · findings · method · contact · outcome · follow-up**	The same six fields every time, so any episode can be reconstructed end to end. Parameter changes are documented in the same record

Outreach, symptom checks and escalation conversations run in the patient's own language — which the 1,637 patients with limited English proficiency, concentrated in the farmworker counties, make a patient-safety requirement rather than a service preference.

6.2 The emergent pathway

Non-negotiable, and stated as such

Triggers. Chest pain · new shortness of breath · signs of stroke · syncope · worst-ever headache · sudden swelling. Any of these reported during an outreach call activates the emergent protocol immediately.

Action. 911 is called with the patient still on the line. The call is not ended and handed off.

If the patient refuses. The health center's care team is called with the patient still on the line and directs care. If the care team cannot be reached, CoachCare activates emergency services regardless. Either way the clinic is notified and the chart records the symptoms, the 911 status, the contact made and the instructions given.

The floor. CoachCare's urgent and emergent policy supersedes any client-specific escalation preference. The health center shapes routing for everything else. It cannot lower the floor on an emergency, and neither can we.

[23] CoachCare Care Management Programs standard operating procedures, March 2026: alert and escalation decision logic, trend definitions, emergent and urgent communication protocol, escalation routing, post-discharge cadence and discharge governance, as reproduced in this section.

Recent or changing symptoms that are not actively emergent — inside a 72-hour window — route as an escalation under the health center's stated preference, documented the same way.

6.3 Three-way routing

The failure mode of a monitoring program inside a busy clinic is not a missed alert. It is an inbox nobody reads, because everything arrives as an alert. Escalations route three ways, and the split is agreed before the first patient enrolls.

Route	What goes there	Who sees it
Emergency	Emergent symptoms, or a critical value with clinical instability	911 activated, with the care team notified
Non-critical	A confirmed out-of-range reading or trend without emergent features	The defined care-team member named in the escalation matrix, within the agreed window
Stable or resolved	**Worked, retaken, resolved, patient asymptomatic**	**Documented in the record as a note rather than pushed as an alert. This is the branch that keeps the program sustainable across sixteen sites and an eleven-prescriber roster**

Across six counties the matrix is agreed per site, not once centrally — the covering clinician in Ocilla is not the covering clinician in Valdosta — and the after-hours branch is defined alongside the health center's existing on-call arrangement, so night and weekend readings have a route that does not depend on anyone's memory.

6.4 The post-discharge three-touch cadence

Triggered automatically by any emergency room visit or hospitalization reported in the previous 60 days — the readmission-prevention spine, and the mechanism behind the avoided admissions in Sections 4.5 and 5.

Touch	Window	What happens
1 · Stabilize	**Day 1–2**	Identify what precipitated the admission; reconcile discharge medications against what is actually in the house; confirm the follow-up appointment exists within 7 to 14 days; symptom assessment, documented and escalated per the engine above
2 · Detect	**Day 5–8**	The window in which post-discharge decompensation usually declares itself. Verify medication adherence; re-evaluate the original triggers; confirm the appointment was attended; verify ordered labs were completed
3 · Secure	**Day 12–14**	Medication and risk review; review the outcome of the completed visit; final symptom assessment; hand the patient into the longitudinal monitoring panel so the window closes with continuity rather than a cliff

6.5 Continuity and discharge governance

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

1. **An unreachable patient escalates on a fixed cadence.** A monitoring patient unreachable 45 days from enrollment is escalated to the care team; non-compliance at 90 days triggers a second escalation plus 90 more days of monitoring. Care management runs a longer clock: first escalation at six months.
2. **There is a hard backstop.** If no instruction comes back from the care team, discharge proceeds at 180 days for monitoring. The clinic is notified in every case and discharges process in the first week of the following month.
3. **The health center always decides.** Clinical discharge criteria, escalation thresholds and routing belong to South Central Primary Care. CoachCare executes them consistently and documents the

execution. It does not overrule clinical judgment, with the single exception of the emergent floor in Section 6.2.

4. **Auditable by design.** Because every escalation carries the same six documented fields, any episode can be reconstructed end to end — which is what the per-code documentation rules in Section 2.3 require in any case.

7. The Georgia Medicaid Rail, and Why Medicare Comes First

Medicaid and CHIP cover 7,142 of this health center's patients — five times the Medicare panel — so the question of what Georgia Medicaid pays for this work deserves a straight answer. The state's telehealth guidance, effective January 2024, gives one: across its 85 pages there is no provision for remote patient monitoring, no chronic-care-management code, and no care-management billing route for a health center — the health-center section addresses telehealth visit rules and nothing else, and the national policy tracker's current read of the April 2026 handbook confirms that remote patient monitoring is not a covered Medicaid service in Georgia. That work sits inside the PPS encounter, however well it is done. A Medicaid patient enrolled in monitoring generates no separate Medicaid claim.[24]

Whether any of the state's Medicaid managed-care organizations would recognize remote monitoring as a value-added service is a plan-by-plan conversation, and this report treats it that way: no Medicaid revenue appears anywhere in the forecast. Medicare — including Medicare Advantage at its rate floor — is the rail that pays for the work code by code, which is why the 1,432-patient Medicare panel is the whole of Section 4.

That is not the same as saying the Medicaid panel gets nothing. Quality measures are payer-blind: the 58.69% blood-pressure figure is computed across the whole 3,045-patient registry, most of which is not Medicare. The protocols, thresholds, titration cadences and staff disciplines this program installs for the Medicare panel become the standard of care for the building — and every point of panel-wide improvement shows up in the UDS submission, the quartile rankings and the badge cycle that HRSA reads. The Medicare panel funds the infrastructure; the whole panel inherits it.

There is also a state-momentum reason to move now. Georgia's Rural Health Transformation Program — the GREAT Health Program — carries **$218.8 million in approved federal funding for its first year**, and its July 2026 awards put $30.6 million into 26 organizations, seventeen of them rural hospitals, with telemedicine and school-based health among the funded uses. No health center has been funded yet, and application phases continue across the five-year program. A health center that walks into that process with a running remote-care program, measured outcomes on 3,045 hypertension patients and a documented equity record is carrying evidence, not a proposal.[25]

So the sequencing writes itself. Medicare first, because it pays now and builds the machine. The Medicaid panel inherits the clinical standard. The state program becomes the expansion vehicle, applied for from strength.

[24] Georgia Department of Community Health, Telehealth Guidance effective January 1, 2024 (85 pages): no remote patient monitoring, chronic care management or G0511 payment provision for any provider type; the FQHC/RHC section addresses originating- and distant-site telehealth encounter rules only. Center for Connected Health Policy, Georgia profile, current to the April 2026 Georgia Medicaid telehealth handbook: remote patient monitoring — not covered.

[25] Georgia Department of Community Health: GREAT Health Program (Georgia's Rural Health Transformation Program) — CMS-approved $218.8 million first-year amount; Phase 2 awards announced July 16, 2026, $30.6 million to 26 organizations including seventeen rural hospitals, with telemedicine and school-based health among funded uses; application phases continuing across the five-year program.

8. Implementation and the First 90 Days

8.1 Who runs what

Function	CoachCare	South Central Primary Care
Patient identification	Registry query against the agreed inclusion criteria — starting from the 3,045-patient hypertension and 1,552-patient diabetes registries	Approves the criteria and the target list
Enrollment	**On-site enrollment specialist, at CoachCare's expense; eClinicalWorks enrollment flags and trigger ordering**	Provider referral at the point of care — eleven adult-medicine prescribers
Devices	Sourced, configured, cellular-paired, shipped, replaced	Nothing purchased, nothing stocked
Monitoring and escalation	Reading review, monthly outreach, alert triage, post-discharge cadence, protocol execution and documentation	**Sets thresholds, routing and after-hours cover; receives escalations**
Documentation and billing	Time logs, monthly care documents to the chart, automated claim generation	**Bills under its own enrollments; keeps the revenue**
Reporting	Monthly enrollment, engagement, escalation and revenue reporting, including the view the ACO needs	Standing monthly operating call

About CoachCare

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

8.2 The model inputs

Input	Value in this forecast
Medicare panel	**1,432 Medicare-primary patients** — 2025 UDS; 36.6% dually eligible
Referring prescribers	11 adult-medicine prescribers (one family-medicine physician, ten nurse practitioners)
Enrollment staffing	1 on-site enrollment specialist, CoachCare-funded, plus provider referral and telephonic outreach
EHR	eClinicalWorks — integration per Section 3.6
Rates	CY2026 physician fee schedule at the Georgia locality amounts (Palmetto GBA, Rest of Georgia) — below the national health-center basis, per Section 2.2. MA plans must reimburse at least 100% of the Medicare rate — a floor; individual contracts set their own terms for the care-management code families
Program pricing	21% program pricing, reflected in the extended per-patient-month fees: **RPM $52.04 · CCM $52.46 · APCM $32.98**
Programs	RPM + CCM + APCM; each patient enrolled in the combination their condition needs, one care-management program per patient-month

8.3 The 90-day plan

Window	What happens	Result at the end of it
Days 0–15 Decide	Pull the payer detail behind the 1,432 and the G0511 history from the billing system. Request the assigned-beneficiary count from the ACO. Agree the clinical targets from the hypertension and diabetes registries. Open the eClinicalWorks integration request	Scope signed, target cohorts defined, integration scheduled
Days 16–30 Design	eClinicalWorks build: enrollment flags, trigger ordering, vitals and document write-back. Escalation thresholds, routing and after-hours cover agreed per site. Enrollment scripts and materials finalized, including Spanish-language versions for the farmworker counties	Clinical protocol signed by the health center's leadership
Days 31–60 Enroll	Enrollment specialist on site, starting at the highest-volume adult sites. Flags live in the clinical workflow. Cellular devices shipped and paired — no patient WiFi, smartphone or app required, which matters in these counties	First claims generated automatically; month 2 turns cash-positive
Days 61–90 Scale	Roll across the remaining adult sites and put enrollment on the mobile unit's route. Post-discharge cadence on. Monthly operating and ACO reporting views live	All three programs ramping toward ceiling; APCM saturates in month 4

8.4 What we would confirm together

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

1. **The payer detail behind the 1,432.** A chart-count pull in week one — traditional Medicare versus Medicare Advantage, plan by plan. MA plans must reimburse at least 100% of the Medicare rate — a floor; individual contracts set their own terms for the care-management code families — so the plan mix sets each program's target list and the order the sites come online.
2. **The G0511 history, and what has been billed since.** Whatever bundled care-management volume ran through September 2025 is invisible in public claims. The billing system knows, and the answer decides whether the program starts from zero or migrates an existing base onto the individual codes.
3. **The ACO numbers.** The health center's assigned-beneficiary count, its benchmark position and its distribution history under the current two-sided agreement — held by the ACO's manager, and the frame for Section 5's arithmetic.
4. **The eClinicalWorks configuration.** Version, module set and interface path, so the integration in Section 3.6 is scheduled against the instance as it actually runs.

9. Recommendations

1. **Point the program at the blood-pressure gap first.** 3,045 hypertension patients, 58.69% control, bottom national quartile — and a control measure computed from exactly the readings a connected cuff transmits. Enroll the Medicare slice of that registry first, because it is where the clinical gap, the quality exposure and the reimbursement all point at the same patients.
2. **Treat the G0511 transition as the forcing function it is.** Code-level care-management billing became mandatory for health centers on October 1, 2025. The compliance work now exists whether or not a program does. Run it through a system that captures time, writes documentation into eClinicalWorks and generates the claims automatically, rather than building that machinery by hand.
3. **Lead the enrollment conversation with APCM on the dual panel.** 524 dually eligible patients map to the highest tier, $111.80 a month at the Georgia amount, with no minute threshold and no coinsurance friction under Qualified Medicare Beneficiary protections. It is the fastest program to saturate — month 4 — and the cleanest first yes.
4. **Let CoachCare carry the labor.** The program runs on 8,086 care-team hours over 24 months — 3.9 full-time equivalents an eleven-prescriber, three-executive organization should not hire for. The on-site enrollment specialist alone is worth $187,584 of 24-month net reimbursement, and CoachCare funds that role.
5. **Size the program to the panel it will have, not the panel it had.** Every program hits ceiling by M10 on the 2025 panel. That panel grew every year for four years, and the 65-and-over line grew 61%. Re-run the ceilings annually; at 1,550 Medicare patients the same 24 months return $1,210,177.
6. **Make the service line the ACO strategy.** Under a two-sided agreement, the avoided admissions in Section 5 defend the benchmark the health center settles against — $1,231,500 at the realistic 40% admission rate. Bring the assigned-beneficiary count and the distribution history into the first working session.
7. **Read the Medicare Advantage contracts early.** 56.1% of the footprint's beneficiaries carry MA. Plans must reimburse at least 100% of the Medicare rate — a floor; individual contracts set their own terms for the care-management code families — so the plan-by-plan read in Section 8.4 decides how far past traditional Medicare the program reaches.
8. **Run enrollment on the chassis the health center already owns.** The mobile unit's route, the outreach staff who already enroll neighbors in coverage, the school-based family relationships and the pharmacy's home-delivery footprint are the enrollment plan. The specialist rides them; nothing new is built.
9. **Let the Medicaid panel inherit the standard, and say so in applications.** Georgia Medicaid pays nothing separately for this work, but the protocols the Medicare program installs raise the payer-blind quality measures the whole panel is scored on — and a running program with measured outcomes is the strongest evidence a health center can put in front of the state's rural-health funding phases.

The Medicare panel is 9% of this health center's patients, and it supports a $1,133,102 service line at a 42.46% margin inside 24 months — because the codes now pay on top of the PPS visit, because a 36.6% dual mix loads the highest APCM tier, and because the between-visit work the codes pay for is precisely the work the health center's one lagging measure needs. The panel that supports it has grown every year since 2021, the ACO position turns the clinical results into benchmark defense, and the whole thing runs on staff the health center does not have to hire.

References & Data Sources

- **HRSA Health Center Program records** (retrieved August 2026): the Uniform Data System awardee profile for grant H80CS00836, reporting years 2021 through 2025, for total patients, payer mix, the Medicare-primary and dually-eligible counts, age distribution, poverty and special-population counts, cost per patient, the full clinical quality measure set with HRSA adjusted quartile rankings, and the 2026 Community Health Quality Recognition badges; and the HRSA Health Center Service Delivery Sites file, for the sixteen registered sites and the mobile unit. 2025 is the most recent published reporting year.
- **CMS provider and claims files** (retrieved August 2026): NPPES and PECOS organization records for the health center's enrollments; the CMS Doctors & Clinicians file and the practice's own published roster for the eighteen-clinician count and the eleven-prescriber adult-medicine core; and the Medicare Physician & Other Practitioners by Provider and Service file, CY2024, queried per clinician across the full roster for the remote monitoring, chronic care management, advanced primary care management and transitional care management code families. CMS suppresses clinician-and-code lines under 11 beneficiaries, and G0511 billed institutionally, outside that file's scope.
- **Medicare payment rules for health centers:** CMS MLN006397, the Federally Qualified Health Center booklet, March 2026 edition, for payment of the individual care-coordination codes at national non-facility physician fee schedule rates alone or with other payable services, the general-supervision rule and the absence of a face-to-face requirement; the Medicare contractor and CMS newsletter notices for the G0511 transition ending September 30, 2025; and the CY2026 physician fee schedule — national amounts and Palmetto GBA Rest-of-Georgia locality amounts — for the 99445 and 99470 remote-monitoring codes and the G0556–G0558 advanced primary care management tiers.
- **Medicare Shared Savings Program PY2026 participant file** (data.cms.gov, retrieved August 2026): South Central Primary Care Center, Inc. as a participant in Accountable Care Coalition of Georgia, LLC (ACO A1596); ENHANCED track; current agreement period beginning January 1, 2024; fourth agreement period, ACO in the program since 2013; low-revenue; retrospective assignment; not a participant in the prospective primary-care payment model.
- **Market and population sources:** CMS Medicare Monthly Enrollment, CY2025 annual, for county Medicare beneficiary counts, Medicare Advantage shares and dual-eligibility shares across the seven-county footprint; and the U.S. Census Bureau American Community Survey 2020–2024 five-year estimates for county poverty, uninsured and demographic figures.
- **Georgia Medicaid authority:** the Georgia Department of Community Health Telehealth Guidance effective January 1, 2024, which contains no remote-monitoring or care-management payment provision for any provider type including health centers; and the Center for Connected Health Policy's Georgia profile, current to the April 2026 state telehealth handbook, recording remote patient monitoring as not covered by Georgia Medicaid.
- **Georgia rural-health funding:** Georgia Department of Community Health announcements for the GREAT Health Program — Georgia's Rural Health Transformation Program — including the $218.8 million approved first-year federal amount and the July 16, 2026 Phase 2 awards of $30.6 million to 26 organizations.
- **340B and pharmacy records:** the HRSA 340B Office of Pharmacy Affairs Information System covered-entity record for the health center, participating since July 2014 and recertified February 2026, with its in-house pharmacy registration in NPPES.
- **The record system:** eClinicalWorks, verified by the vendor-hosted patient portal linked from the health center's own website. Integration detail is from the CoachCare eClinicalWorks integration overview: integrated enrollment and ordering, enrollment by services and devices, exchange of

health history, integrated vital reports, compliance documentation and integrated care summary, automated claim generation, and first services in under five days from the enrollment flag.

- **CoachCare Care Management Programs standard operating procedures, March 2026:** the shared clinical alert and escalation decision logic, the trend definitions, the emergent and urgent communication protocol, the three-way escalation routing, the post-discharge three-touch sequence and the discharge decision flow reproduced in Section 6.
- **CoachCare Value Analysis for South Central Primary Care, 2026:** every financial, enrollment, clinical-output and operational figure in Sections 4, 5 and 8, built on 1,432 Medicare-primary patients, eleven referring prescribers, one on-site enrollment specialist, and the CY2026 fee schedule at Georgia locality amounts for remote physiologic monitoring, chronic care management and advanced primary care management.
- **The health center's own published materials** (retrieved August 2026): scpccga.org, for the site listing, the services and after-hours descriptions, the mobile unit's county coverage, the certified-application-counselor outreach role, the pharmacy and home-delivery service, and the organization's founding and accreditation history.

A note on how this report handles counts

Unique patients and program enrollments are different numbers. At M24 the program holds 648 active program enrollments belonging to 423 unique patients, because a patient may hold 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.

Panel counts come from the Uniform Data System, not from claims. Health-center encounters bill institutionally under the health center's own certifications rather than clinician by clinician on the physician fee schedule, so clinician-level claims files systematically undercount a health-center panel. The 1,432 Medicare-primary figure used throughout is the measured 2025 UDS count, which includes Medicare Advantage members.

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