COACHCARE | SERVICE LINE STRATEGY

MedCura Health

MedCura Health, Inc. · a Section 330 federally qualified health center serving 36,741 patients across 16 sites in DeKalb, Fulton, Rockdale and Cobb counties, from its Stone Mountain headquarters

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 — built on the Medicare panel this health center already serves, 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 MedCura Health. It brings together the organization's published clinical quality record, the shape of its Medicare panel, the CY2026 rules governing how health centers bill care management, the accountable-care position it has held since 2013, the market its patients sit in, and a 24-month financial forecast.

The argument is short. MedCura already runs the infrastructure a remote care program needs — one enterprise record system at every site, a 340B pharmacy rail that delivers to the patient's door, multilingual staff, and two chronic-disease registries holding 5,140 hypertensive and 2,713 diabetic patients. None of it is currently pointed at the one payer that pays for between-visit work code by code. Since October 2025, Medicare does exactly that.

Table of Contents

Executive Summary

MedCura Health, Inc. — the name Oakhurst Medical Centers took in 2020, after four decades under the original one — is a HRSA Section 330 federally qualified health center operating 16 sites across DeKalb, Fulton, Rockdale and Cobb counties. It is FTCA-deemed, a 340B covered entity that delivers prescriptions to the patient's door at no charge, and runs one enterprise record system across every site. In February 2026 the three health sites of Whitefoord, Inc. entered its HRSA scope, bringing eastside Atlanta into the panel. CY2025 Uniform Data System reporting, MedCura and Whitefoord combined, counts **36,741 patients** — up 9.5% in two years.[1]

The panel this report is about is the smallest, and the only one Medicare pays for this work on. MedCura served **2,935 Medicare-primary patients in CY2025** — 2,716 of its own plus the 219 who arrived with Whitefoord — about 8% of the total panel. Inside that line sits the number that shapes everything that follows: **1,034 of the 2,935 — 35.2% — are dually eligible** for Medicare and Medicaid. Patients 65 and over number 2,969, more than the Medicare line itself, so a real share qualified through disability or end-stage renal disease rather than age.[2]

The clinical case sits in the organization's own federal quality filing. CY2025 UDS identifies **5,140 hypertensive and 2,713 diabetic patients**. Blood-pressure control is **61.9% against a 69.1% national health-center average**, and the share of diabetic patients with HbA1c above 9% is **38.0% against 26.3% nationally**, six points worse than the year before. Neither measure is decided in the exam room.[3]

The observation this report is built on

The infrastructure for between-visit care already exists here. It has never been pointed at Medicare.

One enterprise record system at every site and for every provider, a 340B pharmacy rail that reaches patients at home, care in more than a dozen languages, thirteen years inside a Medicare accountable care organization, and two registries holding 7,853 chronic-disease patients. The rail none of it bills is Medicare care management — which, since October 2025, pays health centers for this work code by code.

The reason to act now is a billing change that has already happened. Health centers billed care coordination through one bundled code, G0511, until CMS retired it: 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 each care-management family, paid at the **national non-facility physician fee schedule amount, in addition to the PPS visit payment** when both occur.[5] MedCura runs code-level care-management billing from now on whether or not it starts anything new. The question is who carries that work.

Today, on the evidence available, nobody does. All 15 clinicians who reassign Medicare billing to the organization were swept against the care-management and remote-monitoring code families in the

[1] HRSA Health Center Program: Uniform Data System awardee profiles, grant H80CS00179 (MedCura Health) and grant H80CS00884 (Whitefoord), CY2025 (retrieved August 2026); combined total patients 36,741 against 33,545 in CY2023. HRSA Health Center Service Delivery Sites file: 16 active sites, DeKalb 11, Fulton 3, Rockdale 1, Cobb 1, of which three are school-based and one is a dental satellite; the three sites that came from the merger entered scope February 20, 2026. The organization is FTCA-deemed and an active 340B covered entity. Renamed from Oakhurst Medical Centers effective November 1, 2020.

[2] HRSA Uniform Data System, CY2023–CY2025, both filings summed: Medicare-primary patients 3,033, 3,032 and 2,935; dually eligible 947, 828 and 1,034, reported within the Medicare line and equal to 35.2% of it in CY2025; patients 65 and over 2,854 in CY2024 and 2,969 in CY2025. UDS counts each patient once by primary coverage, so Medicare Advantage members are inside the Medicare line.

[3] HRSA Uniform Data System, CY2025 clinical quality: controlling high blood pressure 61.9% (3,184 of 5,140 identified hypertensive patients) against a 69.1% national health-center average; diabetes HbA1c above 9% at 38.0% (1,032 of 2,713 identified diabetic patients) against 26.3% nationally, lower being better. National comparators computed from the same CY2025 awardee workbook across all reporting health centers.

[4] CMS notices ending the transition period for G0511 billing by federally qualified health centers and rural health clinics: claims with dates of service after September 30, 2025 deny.

[5] CMS MLN006397, Federally Qualified Health Center booklet, March 2026 edition: care-coordination services including TCM, CCM, APCM (G0556–G0558), BHI, PCM, remote physiologic monitoring and RTM are paid at the 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.

CY2024 Medicare Part B claims file, and none appears on any of them: **no Medicare remote-care program visible in CY2024 physician claims**. Section 3.3 bounds that finding and adds the three signals pointing the same way.[6]

What the Value Analysis returns

	Year 1	Year 2	24 months
Net reimbursement	**$744,799**	**$1,449,409**	**$2,194,208**
CoachCare fees	$433,155	$828,885	$1,262,040
Net to the health center	**$311,644**	**$620,524**	**$932,168**
Margin to the health center	41.84%	42.81%	**42.48%**

1. **The service line pays for itself from its second month.** Month 1 nets −$1,878, because implementation and the integration setup land in that month. The first positive month is M2, at $4,783. From M18 the program runs at $52,404 a month net.
2. **Nobody is hired.** CoachCare delivers 14,562 hours of care-management labor over 24 months — about 7.0 full-time equivalents — including an on-site enrollment specialist at CoachCare's expense. Outreach runs in the languages the panel speaks.
3. **A third of the Medicare panel is dually eligible, and G0558 pays $117.24 a month for exactly those patients.** Dual status maps a patient to the top advanced primary care management tier, and Qualified Medicare Beneficiary protections remove the coinsurance conversation. The labor that earns it is CoachCare's.
4. **The binding constraint is the size of the Medicare panel, not enrollment capacity.** All three programs reach their ceiling — advanced primary care management in M6, chronic care management in M10, remote monitoring in M16. At M24 it holds 1,328 active program enrollments across 866 unique patients, every patient the three can take on this year's panel.
5. **The accountable-care position compounds it.** MedCura has been in the Medicare Shared Savings Program since 2013, today through Accountable Care Coalition of Georgia, LLC on an ENHANCED-track agreement — the two-sided kind, where total cost is real money in both directions. The 71 avoided hospitalizations here are roughly $1.07 million of acute cost that never reaches that result.
6. **Medicare Advantage sits inside the 2,935, and the payer split is the first number to confirm.** UDS counts each patient once by primary coverage, so MA members are already in that line. Site-weighted MA penetration across the four counties runs about 58% (CMS May 2026 enrollment data), putting the fee-for-service subset at roughly 1,200 to 1,500. MA plans must reimburse a health center at least 100% of the Medicare rate — that is the floor — and each plan's contract sets its own terms for these code families. Built on 1,350 in-scope patients the same 24 months return $1,178,165 at 42.12%.
7. **Medicare is the billable rail.** Georgia Medicaid pays no separate amount for remote monitoring or chronic care management in fee-for-service, so the 14,542 Medicaid patients sit outside the billable core. No Medicaid revenue appears anywhere. Section 7 draws the boundary.

[6] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024 (released May 2026), queried per National Provider Identifier across all 15 clinicians reassigning to the organization's PAC identifier, for the remote monitoring (99453, 99454, 99457, 99458, 99091, 99445, 99470), chronic care management (99490, 99439, 99487, 99489), principal care management (99424–99427), advanced primary care management (G0556–G0558), G0511 and transitional care management (99495, 99496) families. Zero rows returned; an unfiltered control query on 99490 returned national biller rows, so the nulls are absences rather than query failures.

1. The Health Center, and the Panel It Bills Medicare For

1.1 The footprint

MedCura Health has been metro Atlanta's community health center for 45 years, under the Oakhurst name until 2020 and under its own since. It operates 16 HRSA-scoped sites — eleven in DeKalb County, three in Fulton, one in Rockdale and one in Cobb — of which three are school-based health centers and one is a dental satellite, leaving about twelve clinics delivering adult medicine. The organization holds HRSA health center grant H80CS00179 through the end of 2028, is FTCA-deemed, and reported $106.1 million of revenue for FY2024. In February 2026 it took the three health sites of Whitefoord, Inc. into its scope, adding eastside Atlanta clinics and a school-based center to the footprint.[7]

The footprint in numbers	CY2025	What it means for this program
Patients	**36,741**	MedCura and Whitefoord combined, up 9.5% in two years
Service-delivery sites	16 across four counties	Enrollment runs where patients already are; roughly twelve of the sixteen deliver adult medicine
Adult-medicine clinicians	**16** — 4 physicians, 10 nurse practitioners, 2 physician assistants	The referral engine for this forecast. Only 8 of the 16 are individually enrolled in Medicare, which is what a PPS-era billing history looks like
Medicaid patients	**14,542**	Four times the Medicare panel, and outside the billable core of this forecast — Section 7
Patients best served outside English	**10.3%** — 3,399 patients	Care is delivered in Spanish, French and more than a dozen African dialects; CoachCare staffs outreach to match
Panel composition	67.2% Black or African American	A population where hypertension and diabetes prevalence run high, which is where the two registries in Section 1.3 come from
Record system	**athenaOne, every site, every provider**	Attested in the organization's own federal health-IT filings two years running — Section 3.6

HRSA Uniform Data System CY2025 (MedCura and Whitefoord filings combined); HRSA Health Center Service Delivery Sites file; CMS Doctors & Clinicians file; the organization's own provider roster.

The clinician bench deserves one sentence of precision, because the forecast in Section 4 is built on it. The published roster runs to 47 providers across family medicine, pediatrics, women's health and specialty care. The adult-medicine core that can order and refer remote care is **16 clinicians** — four family medicine physicians, ten nurse practitioners and two physician assistants. Of those, eight are individually enrolled in Medicare. That gap is the signature of an organization that has billed everything institutionally under the PPS rate, which is exactly what the CY2026 rules change.[8]

1.2 The Medicare panel: 2,935 patients, 35.2% dually eligible

Measure	CY2023	CY2024	CY2025	What it tells us
Total patients	33,545	36,047	**36,741**	+9.5% in two years
Medicare-primary patients	3,033	3,032	**2,935**	**the panel this forecast bills on**

[7] HRSA Health Center Service Delivery Sites file (retrieved August 2026) for the 16 sites, their counties and their settings; HRSA award records for grant H80CS00179, project period through December 31, 2028; IRS business master file for FY2024 revenue of $106.1 million; the organization's own merger announcements of November 2025 and January 2026, and the February 20, 2026 scope-addition dates in the HRSA file.

[8] CMS Doctors & Clinicians national file (retrieved August 2026), rolled up on the organization's PAC identifier: 15 Medicare-enrolled clinicians, of whom 8 are adult-medicine (5 family practice, 3 nurse practitioners). The organization's published provider roster lists 47 providers in total, of which the adult-medicine bucket is 16 — 4 physicians, 10 nurse practitioners and 2 physician assistants. The 16-clinician figure is the referral input used in Section 4.

Measure	CY2023	CY2024	CY2025	What it tells us
— of whom dually eligible	947 (31.2%)	828 (27.3%)	**1,034 (35.2%)**	**the highest dual share in three years**
Patients 65 and over	—	2,854	**2,969**	more than the Medicare line, so a real under-65 disability and ESRD slice sits inside it
Medicaid patients	13,892	14,137	14,542	40% of the panel

HRSA Uniform Data System, CY2023–CY2025, MedCura (grant H80CS00179) and Whitefoord (H80CS00884) filings summed; Whitefoord reported separately through CY2025. UDS counts each patient once by primary coverage.

Three things in that table matter to the forecast. First, the Medicare panel is stable rather than growing — 3,033 to 2,935 across three years — so this is a service line sized to a known population rather than a projected one. Second, **35.2% of the Medicare panel is dually eligible**, the highest share in three reporting years, and the single most important input to the advanced primary care management economics in Section 3.2. Third, the 65-and-over count sits slightly above the Medicare-primary count, which tells you a meaningful part of this Medicare population qualified through disability or end-stage renal disease. Those patients carry chronic-condition burden earlier and heavier, and they widen rather than narrow the eligible pool.[9]

1.3 Two flagship measures, both decided between visits

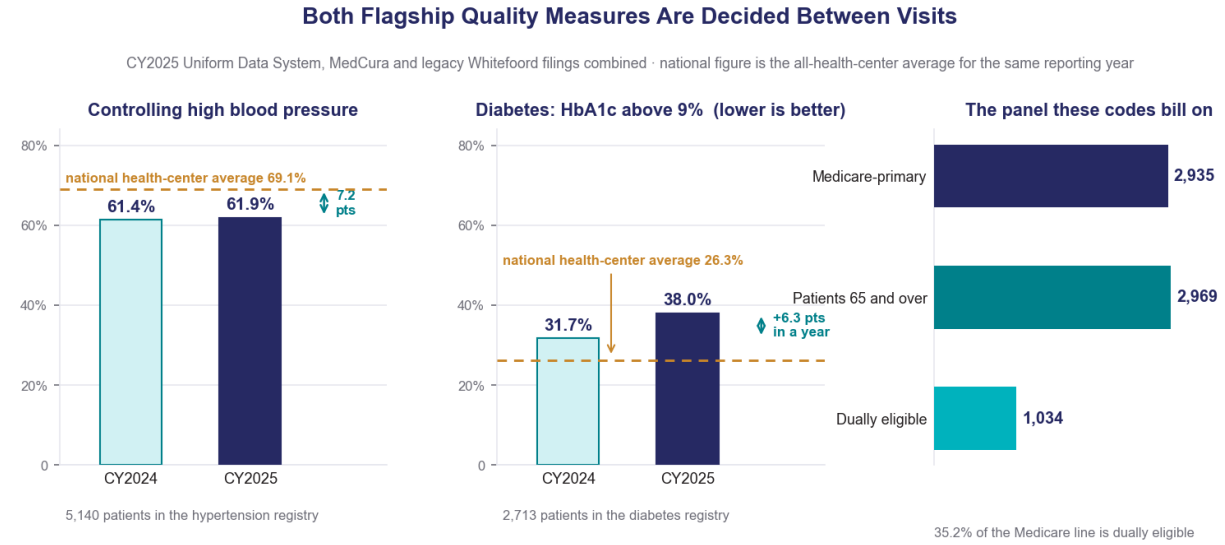

Figure 1 — CY2025 Uniform Data System clinical quality on the two flagship outcome measures, against the all-health-center national average for the same reporting year, with the Medicare panel the forecast is built on.

Start with what the record earns. This is a health center that has served metro Atlanta for 45 years, grew its panel 9.5% in two years while absorbing another organization's clinics, runs one enterprise record system across sixteen sites, has held a place in a Medicare accountable care organization since 2013, and delivers care in more than a dozen languages. Very few organizations of this size do all five.

[9] HRSA Uniform Data System, CY2023–CY2025, payer-mix tables as published on both awardee profiles. Dual share of the Medicare line: 31.2%, 27.3%, 35.2%.

Now the gap, stated as the record states it. Blood-pressure control is **61.9%** against a 69.1% national health-center average, effectively flat on the prior year. The share of diabetic patients with HbA1c above 9% is **38.0%** against 26.3% nationally, and that measure moved six points the wrong way in a single year. Both figures come from MedCura's own CY2025 UDS filing, computed over **5,140 identified hypertensive patients and 2,713 identified diabetic patients**.[10]

The registries are the asset. Identifying 7,853 patients with hypertension or diabetes and holding them in a single record system is the expensive half of a chronic-disease program, and MedCura has already done it. What neither measure responds to is more clinic time: blood pressure and HbA1c move when a reading arrives between appointments, when someone notices a dose is wrong before the next visit, when the titration happens this month rather than next quarter. That is the between-visit layer, and as of January 2026 Medicare pays a health center for it code by code. The quality case and the revenue case are the same case — and UDS quality also feeds HRSA recognition and the accountable-care quality gate in Section 5, so the work compounds three ways.

1.4 The market around it

County	Medicare beneficiaries	Medicare Advantage share	MedCura sites
DeKalb	120,272	**59.6%**	**11**
Fulton	163,879	54.1%	3
Rockdale	18,131	65.2%	1
Cobb	123,628	49.1%	1
Site-weighted average	**—**	**about 58%**	**16**

CMS Medicare enrollment data, May 2026; HRSA Health Center Service Delivery Sites file.

Two facts follow from that table, and both belong in the open before contracting. First, Medicare Advantage is the majority choice across MedCura's footprint, and UDS counts patients by primary coverage — so MA members are already inside the 2,935 rather than additional to it. On a site-weighted 58% penetration the traditional fee-for-service subset of that panel is plausibly **1,200 to 1,500 patients**, and the organization's own split is the first number to pull. Second, an MA plan must reimburse a health center at least 100% of the Medicare rate for covered services, which sets the floor; how each plan handles the care-management code families is settled contract by contract. Section 4.6 prices the conservative case directly, and Section 8.4 puts the payer-mix pull in week one.[11]

The counties themselves are aging into this program. DeKalb County, where eleven of the sixteen sites sit, has 105,276 residents aged 65 and over, 13.8% of its population, and 13.7% of the county lives below the poverty line. Rockdale runs older still at 15.8%. Those are the demographics behind a dual-eligible share that has climbed from 27.3% to 35.2% in two reporting years.[12]

[10] HRSA Uniform Data System, CY2024 and CY2025 quality measures for both filings: controlling high blood pressure 61.4% then 61.9%; diabetes HbA1c above 9% 31.7% then 38.0%. Registry denominators CY2025: 5,140 hypertensive patients, 2,713 diabetic patients.

[11] CMS Medicare Monthly Enrollment data, May 2026: DeKalb County 120,272 beneficiaries with 59.6% in Medicare Advantage, Fulton 163,879 at 54.1%, Rockdale 18,131 at 65.2%, Cobb 123,628 at 49.1%; site-weighted across the 16 sites, about 58%. The organization's own fee-for-service versus Medicare Advantage split is not published at organization level; the 1,200–1,500 range is derived from county penetration applied to the 2,935.

[12] U.S. Census Bureau, American Community Survey 2024 five-year estimates: DeKalb County population 765,351 with 105,276 aged 65 and over (13.8%) and 13.7% below the poverty line; Rockdale County 15.8% aged 65 and over; Fulton 12.7%; Cobb 13.7%.

2. The CY2026 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 on a claim.
>
> The same booklet settles the operating questions: no face-to-face visit is required for these services, and auxiliary personnel may furnish them under general supervision — which is what lets a contracted care team do the work under the health center's billing.
>
> *CMS MLN006397, Federally Qualified Health Center booklet, March 2026 edition.*

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

- **Care management does not cannibalize the PPS rate.** It is paid in addition to it. A patient seen face to face and enrolled in remote monitoring generates the PPS payment and the monitoring payment.
- **The rates are national.** The care-management and monitoring lines pay at national non-facility amounts for every health center in the country, with no geographic adjustment. Stone Mountain, Smyrna and the school-based sites all bill the same rate card, and the forecast in Section 4 is built on those national rates throughout.

2.2 National rates, on top of the PPS visit

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 **$194,787 of gross reimbursement — 17.3% of the remote-monitoring line and 8.9% of total net reimbursement**. Partial months are exactly where a newly enrolled, hard-to-reach panel lives, which makes these codes worth disproportionately more to a health center than to a typical practice.[15]

Advanced primary care management entered health-center billing in the same reform: three tiers priced by patient complexity and dual-eligibility status, with no minute threshold to document.

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[13] CMS transition notices for G0511 billing by federally qualified health centers and rural health clinics, with the transition ending September 30, 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 $194,787 gross over 24 months, 17.3% of gross remote-monitoring reimbursement and 8.9% of total net reimbursement: CoachCare Value Analysis for MedCura Health, 2026.

Code	CY2026 national rate	Who it covers	Why it matters here
G0556	$16.37 per month	One chronic condition	The base tier; a small share of this panel
G0557	$53.78 per month	Two or more chronic conditions	The multi-morbid core of the Medicare panel
G0558	**$117.24 per month**	**Two or more chronic conditions and Qualified Medicare Beneficiary status**	**1,034 of MedCura's Medicare patients are dually eligible — Section 3.2**

CY2026 Medicare Physician Fee Schedule, national non-facility amounts; CMS MLN006397, March 2026 edition.

One rate-rail point completes the picture. Because these codes pay a national amount with no locality adjustment, the forecast prices every enrolled patient at the same figure regardless of site. Within the 2,935, Medicare Advantage is the majority coverage across this footprint; an MA plan must pay a health center at least 100% of the Medicare rate for covered services, and each plan's contract sets its own terms for these code families. That is a contracting conversation with a known floor, and Section 8.4 schedules it.

2.3 The work the change creates, and who carries it

The change gives with one hand and takes with the other. One bundled code required one time log. The individual codes require per-program time capture, per-program documentation, per-program consent and per-program claim construction, each family with its own minute thresholds and add-on rules. That work landed on every health-center billing office in the country on October 1, 2025, and it lands whether or not the organization enrolls a single new patient.

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

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

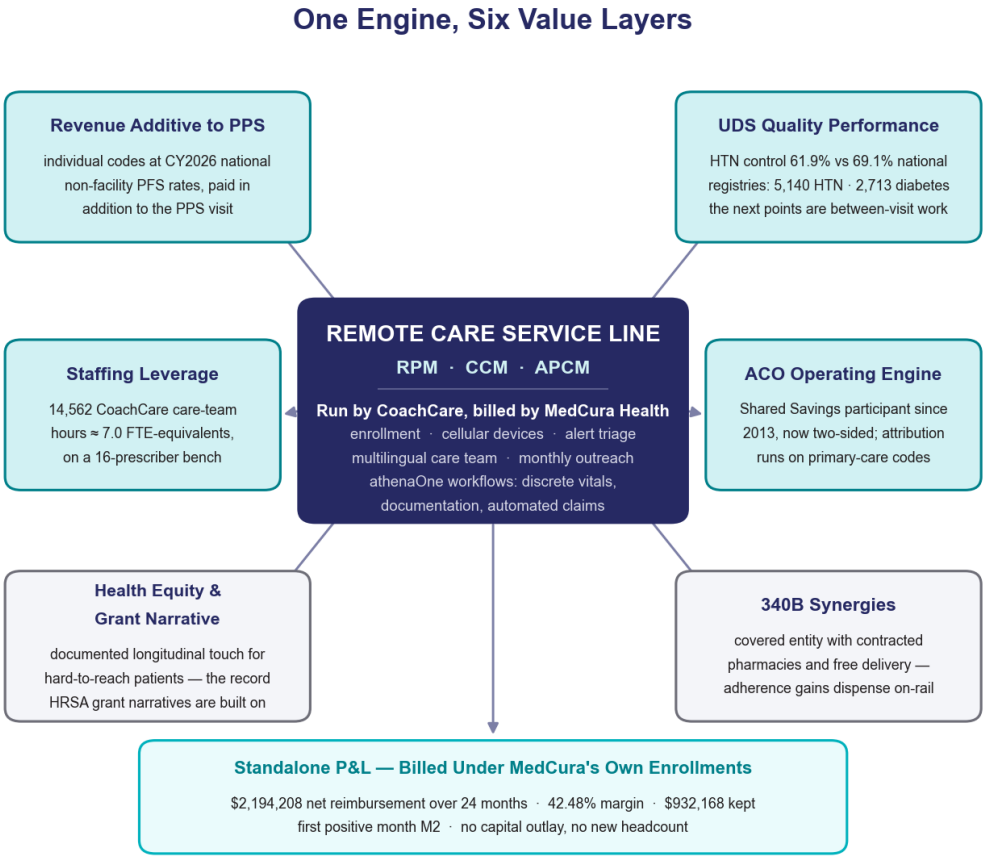

Figure 2 — one operating spine, six value layers, and the standalone profit and loss underneath it. Figures from the CoachCare Value Analysis and the CY2025 Uniform Data System.

3.1 The clinical and billing stack

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

Program	What it does clinically	Who it fits in this panel
Remote physiologic monitoring (RPM)	A connected cuff, scale or glucometer transmits readings between visits, reviewed against thresholds MedCura sets. Codes 99453, 99454, 99457, 99458, plus the CY2026 short-window codes 99445 and 99470	The 5,140-patient hypertension registry and 2,713-patient diabetes registry. Both UDS control measures are computed from exactly the values these devices transmit
Chronic care management (CCM)	A documented care plan for patients with two or more chronic conditions, with at least 20 minutes of non-face-to-face coordination each month. Codes 99490 and 99439	The multi-morbid core of the Medicare panel, including the under-65 disability and ESRD slice
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. Codes G0556, G0557 and G0558	The 35.2%-dual panel. Dual status maps patients to the highest tier, G0558 — Section 3.2

Chronic care management and advanced primary care management draw on one care-management pool and cannot be billed for the same patient in the same month. They are treated here as a partition rather than a stack: advanced primary care management takes the dual-heavy slice where the top tier pays most, chronic care management takes the multi-chronic remainder, and remote monitoring runs alongside either.

3.2 APCM and the dual-eligible third of the 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 $117.24 a month. At MedCura, 1,034 patients, 35.2% of the Medicare panel, are dually eligible, and that share has risen in each of the last two reporting years. A specialty group might qualify a tenth of its panel for the top tier. A health center in DeKalb County qualifies a third of it, which is why the tier mix used in the forecast puts 30% of enrolled patients at G0558 and 55% at G0557.[16]

Dual eligibility solves the other half of the enrollment problem too. Care-management programs stall on the 20% coinsurance conversation: a patient asked to take on a monthly copay for a program they have not experienced yet often declines. Qualified Medicare Beneficiary protections prohibit billing those patients Medicare cost-sharing. For a third of MedCura's Medicare panel — and this is the third least able to absorb a copay — the coinsurance objection does not exist.

The wedge, stated as one sentence

A third of MedCura's Medicare panel is dually eligible, and G0558 pays $117.24 a month for exactly those patients — while the enrollment and engagement labor that earns it is ours.

Advanced primary care management contributes $408,948 of the 24-month forecast across 308.1 active enrollments, at $62.25 per enrolled patient-month, with no minute threshold to document. It saturates in month 6 — the fastest of the three programs — because the eligible population is concentrated and already in the building.

3.3 The starting position: whitespace, honestly bounded

Every one of the 15 clinicians who reassigns Medicare billing to MedCura was queried against the remote monitoring, chronic care management, principal care management, advanced primary care management and transitional care management code families in the CY2024 Medicare Part B claims file. None appears on any of them, and a known-positive control confirms the query works. Two structural facts about that file bound what the zeros can prove, and both belong in the open.[17]

- **G0511 billed institutionally and is structurally absent from the physician file.** Whatever bundled care-management volume MedCura ran through September 2025 is invisible in this dataset. The supportable statement is that no Medicare remote-care program is visible in CY2024 physician claims — not that no patient was ever served. Whatever G0511 volume the organization billed is a number to pull from its own billing system, and it is the first number worth pulling.
- **CMS suppresses any clinician-and-code line under 11 beneficiaries.** A code billed to ten patients is invisible. Small-scale activity cannot be ruled out from this file alone.

Three independent signals point the same direction. The organization's own website lists no remote monitoring or care-management service anywhere; its chronic-condition offering is a patient education class. No care-management vendor relationship, job posting or announcement surfaced in searches. And

[16] HRSA UDS CY2025 (1,034 dually eligible of 2,935 Medicare-primary, 35.2%); CMS MLN006397, March 2026, and the CY2026 physician fee schedule for the G0556 ($16.37), G0557 ($53.78) and G0558 ($117.24) national non-facility amounts; Qualified Medicare Beneficiary billing protections under federal law prohibit charging QMB patients Medicare cost-sharing. Tier mix used in the forecast: 15% G0556, 55% G0557, 30% G0558, giving a blended $62.25 per enrolled patient-month.

[17] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024, per-clinician query across the 15-clinician roster; query mechanics validated against a known-positive control. G0511 returns no rows in this file for any health center, because it billed on the institutional claim.

only 8 of the 16 adult-medicine clinicians are individually enrolled in Medicare, which is what you would expect of a health center that has billed everything institutionally under the PPS rate. Taken together, the starting position is whitespace.

MedCura is not starting from zero capability, though. It runs one enterprise record system with a patient portal, secure messaging and automated care-gap outreach already live; it operates a pharmacy rail that delivers prescriptions to patients' homes; it screens for social needs at the eastside sites; and it staffs care in more than a dozen languages. The work of this service line is work the organization already knows how to do. The move is to point it at the one payer that pays for it code by code.

3.4 Staffing: 7.0 full-time equivalents, none of them hired

Over 24 months the forecast carries **14,562 hours of CoachCare care-team labor — about 7.0 full-time equivalents** — covering enrollment calls, monthly outreach, alert triage, documentation and claim preparation. MedCura hires nobody, buys no devices and stocks nothing. The care-management families operate under general supervision, so the work runs under MedCura's billing without adding to any clinician's schedule. On a 16-clinician adult-medicine bench with no slack clinical time, that distinction is the whole operating case.[18]

One staffing line deserves its own sentence: the on-site enrollment specialist, carried at CoachCare's expense. Run the same forecast with no enrollment specialist and 24-month net reimbursement falls from $2,194,208 to $1,715,330 — the specialist is worth **$478,878** over 24 months, purely by reaching the same enrollment ceilings sooner. Run it with two and the total rises to $2,390,488. The ceilings are identical in all three cases; what changes is how fast the program gets there.

3.5 Two quieter layers: 340B and the grant file

Two value layers sit outside the profit-and-loss statement and are worth naming. First, **340B**. MedCura is an active covered entity that dispenses through contracted pharmacies and delivers prescriptions to patients at no charge. A monitoring program's core clinical products — medication adherence and timely titration — show up as prescriptions filled, and at MedCura those fills already run on a rail the organization controls and that reaches the patient's home, which is where remote care lives.[19]

Second, **the grant file**. A Section 330 health center competes for federal and foundation funding on its ability to document longitudinal engagement with hard-to-reach populations — and MedCura's panel is 67.2% Black or African American, 40% Medicaid-covered, and one in ten best served outside English. A remote-care program produces, as a by-product, a dated record of monthly contact, readings and outreach for exactly those patients. Every UDS submission and grant narrative the organization writes gets stronger the month this program turns on.

3.6 athenaOne integration: the program lives in the chart

MedCura runs athenaOne enterprise-wide. Its own federal health-IT filings state, two years running, that the system is installed at all service-delivery sites and used by all providers, with a patient portal, secure messaging and automated care-gap outreach already in service. CoachCare builds on athenahealth's own workflows, so the care team enrolls and monitors patients without learning a second system and without a parallel portal to check. The program lives in the record the clinic already works in.[20]

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[18] CoachCare Value Analysis for MedCura Health, 2026: 14,562 care-team hours over 24 months, 7.0 full-time equivalents; removing the enrollment specialist lowers 24-month net reimbursement from $2,194,208 to $1,715,330, and adding a second raises it to $2,390,488, with identical enrollment ceilings in all three cases. Language need: HRSA UDS CY2025, 3,399 patients (10.3%) best served in a language other than English.

[19] HRSA 340B Office of Pharmacy Affairs Information System covered-entity record for the organization and its child sites (retrieved August 2026); the organization's own published description of its 340B program, contracted pharmacies and no-cost prescription delivery. Panel composition: HRSA UDS CY2025, 67.2% Black or African American, 14,542 Medicaid-covered patients.

[20] HRSA Uniform Data System health-information-technology sections, CY2024 and CY2025, filed by the organization: athenaOne installed at all service-delivery sites and used by all providers, certified product 0015CQK52LC975C, with patient portal, secure messaging, automated care-gap outreach, application programming interface patient access and health information exchange also reported. Integration detail: CoachCare athenahealth integration overview — bidirectional enrollment by services, exchange of health history,

Integration pillar	What it does in the record
Bidirectional enrollment by services	Enrollment flags and trigger ordering sit inside the clinical workflow. The CoachCare team enrolls qualified Medicare patients on MedCura's behalf, and enrollment status is visible in athenaOne in real time
Exchange of health history	Bi-directional at intake, so the care plan starts from the problem list, medications and history already in the chart rather than from a blank form
Integrated discrete vitals	**Device readings land in the chart as discrete vitals, not as scanned PDFs — a blood-pressure series a clinician can trend, in the same structured fields the UDS quality measures read from**
Escalation tasks	Alerts route to the named member of MedCura's team as a task in the workflow, under the routing agreed in Section 6.3
Compliance documentation and integrated care summary	Audit-ready documentation written into the record — which is what the per-code rules in Section 2.3 now require for every program, every month
Automated claim generation	**Claims created through the CoachCare billing engine. CoachCare is the only care-management partner integrated with athenahealth 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 **33,680 claims** the program generates over 24 months never land on the billing desk 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 athenahealth accomplishes.”*
>
> **CoachCare**

One sequencing note, settled in the first call rather than discovered later. The three sites that came across in the Whitefoord merger reported eClinicalWorks through CY2025, so their move onto the enterprise system is either in flight or scheduled. That sets the order sites come online rather than the start date: the enterprise athenaOne sites integrate first and enroll while the eastside consolidation completes. It is an implementation-plan step with a known path, and Section 8.3 places it.[21]

integrated discrete vitals, escalation tasks, compliance documentation and integrated care summary, and automated claim generation, with first services in under five days from the enrollment flag.

[21] Uniform Data System health-information-technology sections filed for the three sites that joined in February 2026, CY2024 and CY2025, which reported eClinicalWorks V12 at those sites through CY2025. CY2026 is the first consolidated reporting year for the combined organization.

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 2,935 Medicare-primary patients in the CY2025 Uniform Data System count, at CY2026 national non-facility fee-schedule rates, with 16 referring adult-medicine clinicians and one on-site enrollment specialist funded by CoachCare.[22]

Program	Year 1	Year 2	24 months
RPM net reimbursement	$291,919	$751,183	**$1,043,102**
CCM net reimbursement	$274,083	$468,075	**$742,158**
APCM net reimbursement	$178,797	$230,151	**$408,948**
Total net reimbursement	**$744,799**	**$1,449,409**	**$2,194,208**
CoachCare fees (incl. one-time)	$433,155	$828,885	$1,262,040
Net to the health center	**$311,644**	**$620,524**	**$932,168**
Margin to the health center	41.84%	42.81%	**42.48%**

CoachCare Value Analysis. Every row and every column sums exactly as printed.

The margin moves from 41.84% in year one to 42.81% in year two because the one-time implementation and integration costs fall out and the panel is fully enrolled. Year two is the steady state: **$1,449,409 of net reimbursement, $620,524 of it kept, at 42.81%**. The enrollment specialist is inside the fee line above, at CoachCare's expense — never a separate cost to the health center.

4.2 Where the revenue comes from

Program	Enrollments at M24	Net reimbursement per patient-month	24 months	Share
Remote physiologic monitoring	667.8	$97.67	**$1,043,102**	47.5%
Chronic care management	352.2	$110.75	**$742,158**	33.8%
Advanced primary care management	308.1	$62.25	**$408,948**	18.7%
Total	**1,328**	—	**$2,194,208**	100%

Net reimbursement by program, CoachCare Value Analysis, 24 months.

Remote monitoring carries just under half the revenue on the largest enrolled population, because it reaches the widest slice of the panel — 65% eligibility against 40% and 35% for the two care-management programs. Chronic care management earns the most per patient-month, $110.75. Advanced primary care management adds $62.25 across 308.1 enrollments, the smallest line and the one the dual mix makes stronger here than at most organizations. The **1,328 active program enrollments at M24 belong to 866 unique patients**, because a patient can hold a monitoring enrollment and a care-management enrollment at the same time.

[22] CoachCare Value Analysis for MedCura Health, 2026. All Section 4 figures. Inputs: 2,935 Medicare-primary patients (CY2025 UDS, both filings summed), 16 referring adult-medicine clinicians, one on-site enrollment specialist funded by CoachCare, CY2026 national non-facility fee-schedule rates, RPM + CCM + APCM.

Remote monitoring's total includes the two codes new for CY2026 — 99445 and 99470 — worth $194,787 of gross reimbursement over the 24 months, 17.3% of the remote-monitoring line. Partial and short months produce claims now, and a newly enrolled panel has many of them.

4.3 The ramp, month by month

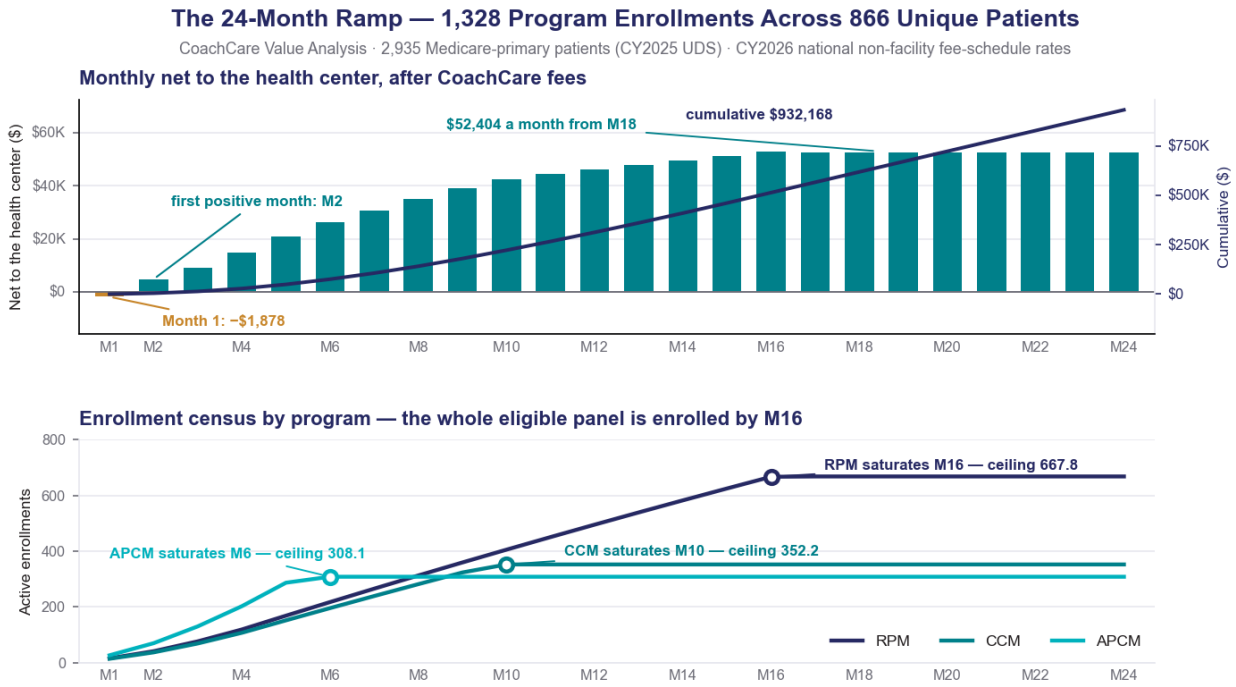

Figure 3 — monthly net to the health center after CoachCare fees, with cumulative net overlaid, and the enrollment census by program with saturation months marked. CoachCare Value Analysis.

Month 1 nets **−$1,878**, because implementation and the athenahealth integration setup are one-time costs that land in that month against a census still building. The first positive month is **M2**, at $4,783, and month 1's shortfall is repaid inside the first quarter. Net reimbursement peaks at $123,295 in M16, the month the last remote-monitoring enrollments and their one-time setup billing land, then settles at $122,580 a month from M18.

Month	Net reimbursement	CoachCare fees	Net to the health center
M1	$4,994	$6,872	**−$1,878**
M2	$12,909	$8,126	**$4,783**
M3	$23,793	$14,569	$9,224
M6	$62,766	$36,401	$26,365
M10	$98,167	$55,774	$42,393
M12	$106,798	$60,653	$46,145
M16	$123,295	$70,520	$52,775
M17	$122,604	$70,188	$52,416
M18 onward	**$122,580**	$70,176	**$52,404**

CoachCare Value Analysis, selected months. The 24 printed monthly rows sum to $932,168.

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

4.4 Ceilings: the panel is the constraint

Program	Eligible share of the 2,935	Acceptance	Ceiling	Saturates
Remote physiologic monitoring	65% — 1,908 patients	35%	**667.8**	**M16**
Chronic care management	40% — 1,174 patients	30%	**352.2**	**M10**
Advanced primary care management	35% — 1,027 patients	30%	**308.1**	**M6**

Say the constraint out loud

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

All three programs are ceiling-limited. By M16 every patient the three programs can take is enrolled — 1,328 program enrollments across 866 unique patients — and the same infrastructure has nowhere further to go on that year's panel. Adding a second enrollment specialist does not raise a single ceiling; it only reaches them faster.

Which makes act two a scope question, not a capacity question. The total panel grew 9.5% in two years and the Whitefoord merger added an eastside population that has not yet been through a full combined reporting year. Built on 3,050 Medicare patients, the top of the measured range, the same 24 months return $2,252,712.

4.5 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Readings received	**112,143**	Blood pressure, weight and glucose values arriving between visits, against control measures currently computed from office readings alone
Claims generated	**33,680**	Constructed, coded and submitted automatically through the athenahealth integration
Care-management tasks completed	67,361	Outreach attempts, care-plan updates, medication reviews and follow-up actions
Patient conversations	10,104	Live contacts across 561 hours of call time, in the patient's own language
Chart updates	16,840	Documentation written back for the care team to act on
Care-team hours delivered by CoachCare	**14,562**	**About 7.0 full-time equivalents of care-management labor MedCura does not employ**
Hospitalizations avoided	**71.2**	At a conservative $15,000 per avoided admission, roughly $1.07 million of cost that never lands on a payer or a patient

CoachCare Value Analysis, 24-month totals.

The avoided-admission figure belongs to the patient and the payer rather than to MedCura's income statement, and it is not part of the $932,168. It is the number that matters to Medicare Advantage plans in counties where about 58% of beneficiaries are enrolled in one, and it is the number that matters to a two-sided accountable care organization — which is where Section 5 picks up.

4.6 What moves the forecast

Six inputs were re-run end to end rather than scaled. The margin holds between 42.12% and 42.55% across every one of them, because the pricing is proportional to the work rather than to the total.

Scenario	24-month net reimbursement	Change
Base — 2,935 in scope, 16 clinicians, 1 enrollment specialist	**$2,194,208**	—
No enrollment specialist	$1,715,330	−21.8%
Two enrollment specialists	$2,390,488	+8.9%
Referrals from the 8 individually Medicare-enrolled clinicians only	$1,903,479	−13.2%
Panel at 3,050, the top of the measured range	$2,252,712	+2.7%
1,350 in scope — the fee-for-service billable subset	**$1,178,165**	**−46.3%, margin 42.12%**

CoachCare Value Analysis, full recalculation per scenario.

The last row is the one to sit with. If the traditional fee-for-service share of the 2,935 turns out to be 1,350 patients, the service line still returns $1,178,165 of net reimbursement over 24 months at a 42.12% margin, with no change to the operating model. That is the floor this program is being built on, and Section 8.4 puts the payer-mix pull in week one so the real number replaces the estimate before anything is signed.

One clinical input is worth its own scenario. The forecast prices avoided admissions off a 20% baseline annual admission rate, which is the generic assumption and the conservative one for a panel this complex.

Baseline annual admission rate	Hospitalizations avoided	Value at $15,000 each
20% — the figure used in this forecast	**71**	**$1.07 million**
30%	107	$1.60 million
40% — realistic for a dual-heavy, multi-chronic panel	**142**	**$2.14 million**
50%	178	$2.67 million

CoachCare Value Analysis, avoided-admission sensitivity. None of this value appears in the revenue figures in Section 4.1.

A third of this Medicare panel is dually eligible, a meaningful part of it qualified through disability or end-stage renal disease, and 38% of its diabetic patients carry HbA1c above 9%. On that population a 40% baseline annual admission rate is the realistic figure, which puts avoided acute cost nearer $2.14 million than $1.07 million. All of it accrues to payers and to the accountable-care result rather than to MedCura's revenue line.

5. The ACO Layer: Thirteen Years In, and Now Two-Sided

MedCura Health has participated in the Medicare Shared Savings Program since **January 1, 2013**, today through **Accountable Care Coalition of Georgia, LLC**. The terms, from the PY2026 participant file: fourth agreement period, current period beginning January 1, 2024, **ENHANCED track — the two-sided model, where the organization shares in savings and carries downside**, low-revenue status, and retrospective beneficiary assignment. The ACO is not a participant in the primary-care prospective payment model, so the care-management and monitoring codes in this report pay claim by claim, in full, with no primary-care fee reduction to net against them.[23]

Thirteen years is a long tenure, and it means the organization already knows what an accountable-care agreement asks of it. What has changed is the stakes: a two-sided agreement makes the total cost of attributed patients real money in both directions. A care-management service line is not adjacent to that position. It is the operating engine of it, three ways over.

- **Attribution runs on primary-care service codes.** Retrospective assignment means the beneficiary list is settled after the fact by where patients actually received their primary-care services — and the care-management families count. A documented monthly care-management relationship with 866 patients is the most direct instrument MedCura has for holding and growing its assigned population.
- **Downside exposure is defended by avoided admissions.** The 71 hospitalizations this forecast avoids are worth roughly $1.07 million of acute cost that never reaches the total-cost result — and on a 40% baseline admission rate, nearer $2.14 million. Under an upside-only agreement that value is an opportunity. Under a two-sided one it is protection.
- **Savings only pay out through the quality gate.** Shared savings are contingent on quality performance, and the gate scores blood-pressure control and diabetes control. Those are the same two measures in Section 1.3, computed over the same two registries, moved by the same between-visit work this service line delivers.

One number to bring into the room early: MedCura's assigned-beneficiary count, which the ACO holds. It sizes how much of the 2,935 sits inside the accountable-care population and therefore how much of the avoided-cost argument lands on MedCura's own reconciliation rather than on the ACO's aggregate. It is first on the list in Section 8.4.

[23] CMS Medicare Shared Savings Program PY2026 participant file, data.cms.gov, retrieved August 2026: MedCura Health Inc, participant in Accountable Care Coalition of Georgia, LLC (ACO ID A1596); agreement period 4; initial start January 1, 2013; current period start January 1, 2024; ENHANCED track; low-revenue ACO; retrospective beneficiary assignment; no participation in the primary-care prospective payment model, so no primary-care fee reduction applies to the care-management or monitoring code lines.

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 MedCura never carries surveillance liability it did not agree to. Thresholds and routing are set with MedCura's clinical leadership and signed off before the first patient enrolls.[24]

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 resolve here, which is why the care team's inbox stays clean
Trend	**Three consecutive readings at least one hour apart for blood pressure or glucose; three readings within seven days for heart rate**	A trend is a definition rather than a judgment call. A confirmed trend escalates on the same footing as a single threshold breach
Patient unreachable	Document the attempt, leave a voicemail with the callback line and advice to seek care if symptoms worsen — and escalate anyway if the reading was critical or a confirmed trend	Silence never downgrades a clinical finding — 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. Where one patient in ten is best served outside English, that is 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 care team is called with the patient still on the line and directs care. If it 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. MedCura shapes routing for everything else. It cannot lower the floor on an emergency, and neither can we.

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

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

6.3 Three-way routing

The failure mode of a monitoring program inside a busy clinic is not a missed alert. It is an inbox nobody reads, because everything arrives as one. Escalations route three ways, 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 lets a 16-clinician bench delegate monitoring without inheriting noise**

Across sixteen sites in four counties the matrix is agreed per site rather than once centrally — and the school-based sites cover differently again.

6.4 The post-discharge three-touch cadence

Triggered automatically by any emergency room visit or hospitalization in the previous 60 days — the mechanism behind the 71 avoided hospitalizations in the forecast.

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

6.5 Continuity and discharge governance

Patients do not quietly fall out of the program. 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; 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. **MedCura always decides.** Clinical discharge criteria, escalation thresholds and routing belong to MedCura. 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. Scope: The Medicare Rail, and What Sits Outside It

Medicaid covers 14,542 of MedCura's patients — five times the Medicare panel — so the question of what Georgia Medicaid pays for this work deserves a straight answer. Three editions of the state's telehealth policy were read end to end: the current guidance dated October 1, 2025, the January 2024 edition, and the provider presentation issued in December 2024. Across all three there is **no occurrence of any remote monitoring, chronic care management or advanced primary care management code**. The policy authorizes a health center to serve as an originating or distant site for the telehealth visit itself and pays for that visit; it does not pay these code families at all.[25]

So the boundary is drawn plainly. **This forecast books Medicare only.** Not one dollar of Medicaid revenue appears anywhere in Section 4. The 14,542 Medicaid patients sit outside the billable core of this program. Georgia's managed-care plans set their own policy contract by contract, which belongs in a contracting conversation rather than in a forecast.

What does cross the boundary is clinical, not financial. The UDS quality measures are all-payer. The blood-pressure pathways, the escalation engine, the multilingual outreach and the documentation standard that the Medicare line funds are the same ones every MedCura patient meets, whoever pays for their care. Quality movement shows up in HRSA reporting either way. That is the case for building the Medicare service line first: it is federal, it pays the same rate at all sixteen sites, it funds itself from month two, and every extension beyond it inherits a running program rather than a pilot.

[25] Georgia Department of Community Health, Part II Policies and Procedures for Telehealth Guidance, version dated October 1, 2025, together with the January 1, 2024 edition and the December 2024 provider presentation. A code-level read of all three returns no occurrence of 99453, 99454, 99457, 99458, 99091, 99490, G0511, G0556, G0557 or G0558. Section 618 of the current edition sets out the health-center originating-site and distant-site provisions and the payment that attaches to the visit itself.

8. Implementation and the First 90 Days

8.1 Who runs what

Function	CoachCare	MedCura Health
Patient identification	Registry query against the agreed inclusion criteria — starting from the 5,140-patient hypertension and 2,713-patient diabetes registries	Approves the criteria and the target list
Enrollment	**On-site enrollment specialist, at CoachCare's expense; athenaOne enrollment flags and trigger ordering**	Provider referral at the point of care — 16 adult-medicine clinicians
Devices	Sourced, configured, cellular-paired, shipped, replaced	Nothing purchased, nothing stocked
Monitoring and escalation	Reading review, monthly outreach in the patient's language, alert triage, post-discharge cadence, protocol execution and documentation	**Sets thresholds, routing and after-hours cover; receives escalations**
Documentation and billing	Time logs, discrete-vitals and documentation write-back to athenaOne, 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	**2,935 Medicare-primary patients** — CY2025 UDS, MedCura and Whitefoord combined; 1,034 dually eligible, 35.2%
Payer basis	Traditional Medicare fee-for-service rates applied across the in-scope panel. Medicare Advantage runs about 58% site-weighted across the four counties and sits inside the 2,935; MA plans pay a health center at least 100% of the Medicare rate, with care-management terms set contract by contract. The 1,350 in-scope scenario in Section 4.6 prices the conservative case
Referring clinicians	16 adult-medicine clinicians (4 physicians, 10 nurse practitioners, 2 physician assistants)
Enrollment staffing	1 on-site enrollment specialist, CoachCare-funded, plus provider referral and telephonic outreach
Record system	athenaOne — integration per Section 3.6, at catalog pricing of $1,000 setup, $150 a month and $1.50 per patient, confirmed in contracting
Rates	CY2026 national non-facility physician fee schedule — the health-center rail, no geographic adjustment
Program pricing	15% program pricing, reflected in the extended per-patient-month fees: **RPM $55.99 · CCM $56.44 · APCM $35.49**
Programs	RPM + CCM + APCM; each patient enrolled in the combination their condition needs, one care-management program per patient-month
Enrollment behavior	Eligibility 65% RPM / 40% CCM / 35% APCM; acceptance 35% RPM and 30% on each care-management program; monthly attrition 1.5%

8.3 Live in 30 days

Window	What happens	Result at the end of it
Week 1 Confirm	Pull the exact Medicare count and the fee-for-service versus Medicare Advantage split from athenaOne. Agree which sites start and in what order. Set the escalation contacts per site. Pull the historical G0511 volume from the billing system	Scope signed, target cohorts defined, payer split known
Weeks 2–3 Build	athenaOne build: enrollment flags, trigger ordering, discrete-vitals write-back, escalation tasks routed to MedCura's own team. Clinical thresholds and after-hours cover agreed. Multilingual enrollment scripts finalized	Clinical protocol signed by MedCura leadership; integration live
Week 4 Enroll	Enrollment specialist on site, starting at the highest-volume adult-medicine clinics. Flags live in the clinical workflow. Cellular devices shipped and paired — no patient WiFi or app required	First patients enrolled inside month one; first claims generated automatically
Months 2–16 Scale	Roll across the remaining sites, sequencing the three eastside sites as they complete their move onto the enterprise record system. Post-discharge cadence on. Monthly operating and accountable-care reporting views live	Month 2 turns cash-positive; APCM saturates M6, CCM M10, RPM M16

8.4 What we would confirm together

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

1. **The fee-for-service versus Medicare Advantage split inside the 2,935.** A payer-mix report out of athenaOne in week one. Site-weighted MA penetration across the four counties runs about 58%, which puts the traditional fee-for-service subset somewhere between 1,200 and 1,500 — but the organization's own split is not published anywhere and only MedCura can produce it. It sets each program's target list and the order sites come online, and Section 4.6 already prices the conservative end of the range.
2. **The historical G0511 volume, and whether individual-code billing started in CY2025.** The CY2024 physician claims file cannot see institutional bundled billing, and the CY2025 file does not publish until 2027. Both answers sit in MedCura's own billing system and take one query.
3. **The assigned-beneficiary count, from the ACO.** It sizes how much of the Medicare panel sits inside the accountable-care population, and therefore how much of the avoided-cost argument in Section 5 lands on MedCura's own reconciliation.
4. **The Medicare Advantage lineup and its care-management terms.** MA plans must pay at least 100% of the Medicare rate for covered services; how each plan treats the care-management code families is settled plan by plan. A contract-by-contract read decides how far beyond traditional Medicare the program reaches, and it belongs in a contracting conversation rather than in a forecast.

9. Recommendations

1. **Start with the two registries you already have.** 5,140 identified hypertensive patients and 2,713 identified diabetic patients are the expensive half of a chronic-disease program, and MedCura has already built them. Point remote monitoring and care management at the Medicare slice of those registries and bill the work to the one payer that pays for it code by code.
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 athenaOne and generates the claims automatically, rather than building that machinery by hand.
3. **Lead the enrollment conversation with APCM on the dual panel.** A third of the Medicare panel is dually eligible, G0558 pays $117.24 a month for those patients, and Qualified Medicare Beneficiary protections remove the coinsurance objection entirely. It is the fastest program to saturate — month 6 — and the cleanest first yes.
4. **Size the program to the panel, and say the constraint out loud.** Every program hits ceiling by M16 on the CY2025 panel: 1,328 enrollments across 866 unique patients. Adding enrollment capacity does not raise a ceiling. Re-run the ceilings each year against the combined post-merger panel, the first full reporting year of which has not yet published.
5. **Make the service line the accountable-care strategy.** Thirteen years of tenure now sits on a two-sided agreement. Attribution runs on primary-care service codes, the quality gate scores blood-pressure and diabetes control, and the reconciliation runs on total cost. The 866 patients this program touches and the 71 admissions it avoids are the accountable-care case rather than a side effect of it. Bring the assigned-beneficiary count into the first working session.
6. **Pull the payer split in week one and let it size the launch.** Medicare Advantage is the majority coverage across all four counties — about 58% site-weighted — and those members sit inside the 2,935 rather than beside it. MA plans pay a health center at least 100% of the Medicare rate; the care-management terms are contract by contract. Confirm the split out of athenaOne before contracting, and note that even at 1,350 fee-for-service patients the program returns $1,178,165 over 24 months at a 42.12% margin.
7. **Keep the program multilingual from the first call.** One patient in ten is best served outside English, and care here is delivered in Spanish, French and more than a dozen African dialects. Enrollment scripts, outreach, symptom checks and device instructions run in the patient's language, with the on-site specialist matched to the sites they cover.
8. **Sequence the eastside sites, do not wait for them.** The three sites that came across in the merger reported a different record system through CY2025. Start enrollment at the enterprise athenaOne clinics in week four and bring the eastside sites on as their consolidation completes. The integration is not on the critical path for the first patient.
9. **Sign the escalation matrix at leadership level before the first patient.** Thresholds, per-site routing and after-hours cover in Section 6 are governance decisions. Agreeing them once, in writing, is what lets sixteen sites run one program safely on a bench of sixteen adult-medicine clinicians.

The Medicare panel is 8% of MedCura's patients, and it supports a $2,194,208 service line at a 42.48% margin inside 24 months — because the codes now pay at national rates on top of the PPS visit, because a third of the panel is dually eligible and maps to the highest APCM tier, and because the record system, the registries and the pharmacy rail the program needs are the ones MedCura already runs. The same work moves the two UDS measures the organization reports to HRSA and the accountable-care gate scores. One build, three returns.

References & Data Sources

- **HRSA Health Center Program records** (retrieved August 2026): the Uniform Data System awardee profiles for grant H80CS00179 (MedCura Health) and grant H80CS00884 (Whitefoord), CY2023 through CY2025, for total patients, payer mix, the Medicare-primary and dually-eligible counts, age distribution, language need, race and ethnicity, and the clinical quality measure set; and the HRSA Health Center Service Delivery Sites file, for the 16 active service-delivery sites, their counties and their scope-addition dates. CY2025 is the most recent published reporting year, and the last in which the two organizations reported separately.
- **CMS provider and claims files** (retrieved August 2026): the Doctors & Clinicians national file, rolled up on the organization's PAC identifier, for the 15 Medicare-enrolled clinicians and their specialty composition; the organization's own published provider roster, for the 16-clinician adult-medicine bench used as the referral input; and the Medicare Physician & Other Practitioners by Provider and Service file, CY2024 (released May 2026), queried per clinician across the full roster for the remote monitoring, chronic care management, principal care management, advanced primary care management and transitional care management code families, with a known-positive control validating the query. 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 CMS notices ending the G0511 transition on September 30, 2025; and the CY2026 physician fee schedule for the 99445 and 99470 remote-monitoring codes and the G0556, G0557 and G0558 advanced primary care management tiers.
- **Medicare Shared Savings Program PY2026 participant file** (data.cms.gov, retrieved August 2026): MedCura Health's participation in Accountable Care Coalition of Georgia, LLC (ACO ID A1596), fourth agreement period, initial start January 1, 2013, current period start January 1, 2024, ENHANCED track, low-revenue, retrospective assignment, and no participation in the primary-care prospective payment model.
- **Market and population sources:** CMS Medicare Monthly Enrollment data, May 2026, for the county beneficiary counts and Medicare Advantage shares in DeKalb (59.6%), Fulton (54.1%), Rockdale (65.2%) and Cobb (49.1%), and for county dual-eligible and Qualified Medicare Beneficiary counts; and the U.S. Census Bureau American Community Survey 2024 five-year estimates for county population 65 and over, poverty and language.
- **Georgia Medicaid authority:** the Georgia Department of Community Health telehealth guidance, version dated October 1, 2025, together with the January 2024 edition and the December 2024 provider presentation, read in full for the remote monitoring, chronic care management and advanced primary care management code families, and for the health-center originating-site and distant-site provisions.
- **340B and pharmacy records:** the HRSA 340B Office of Pharmacy Affairs Information System covered-entity record for the organization and its child sites, and the organization's own published description of its 340B program and prescription-delivery service.
- **The record system:** the organization's Uniform Data System health-information-technology sections for CY2024 and CY2025, which state that athenaOne is installed at all service-delivery sites and used by all providers, with the certified product identifier, alongside the patient portal, secure messaging, automated care-gap outreach and health information exchange it reports; and the separate CY2024 and CY2025 filings for the three sites that joined in February 2026, which reported a different system through CY2025. Integration detail is from the CoachCare athenahealth

integration overview: the six pillars in Section 3.6, the under-five-days interval from enrollment flag to first service, and automated claim creation through the CoachCare billing engine.

- **CoachCare Care Management Programs standard operating procedures, March 2026:** the shared clinical alert and escalation decision logic, the trend definitions, the emergent and urgent communication protocol, the three-way escalation routing, the post-discharge three-touch sequence and the discharge decision flow reproduced in Section 6.
- **CoachCare Value Analysis for MedCura Health, 2026:** every financial, enrollment, clinical-output and operational figure in Sections 3, 4, 5 and 8, built on 2,935 Medicare-primary patients, 16 referring adult-medicine clinicians, one on-site enrollment specialist funded by CoachCare, and CY2026 national non-facility fee-schedule rates for remote physiologic monitoring, chronic care management and advanced primary care management. Each scenario in Section 4.6 is a full recalculation rather than a scaled estimate.
- **The organization's own published materials** (retrieved August 2026): medcura.org, for the site list, the provider roster, the 340B program and prescription-delivery service, the languages of care, the 2020 renaming, the merger announcements of November 2025 and January 2026, and the organization's own description of its chronic-condition education offering; and IRS records for the FY2024 revenue figure.

A note on how this report handles counts

Unique patients and program enrollments are different numbers. At M24 the program holds 1,328 active program enrollments belonging to 866 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 physician-file claims systematically undercount a health-center panel. The 2,935 Medicare-primary figure used throughout is the measured CY2025 UDS count, MedCura's 2,716 plus Whitefoord's 219, summed because the two organizations reported separately through that year.

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