COACHCARE · REMOTE CARE SERVICE LINE

Quality of Life Health Services

Care Management Service Line — Performance & Optimization

2026 Strategy Report

A CoachCare Remote Care Service Line (APCM · CCM · RPM) as the operating spine — and the CY2026 reimbursement change that makes care management billable now, separately from the health center's PPS visit.

Quality of Life Health Services, Inc. · Federally Qualified Health Center · Gadsden & Northeast Alabama

Purpose of this report

This report reads Quality of Life Health Services' starting position and makes a single, disciplined case: a managed care-management service line — APCM, CCM and RPM, staffed by CoachCare — is the highest-return operational move available to the health center in 2026. It is net-positive on its own economics from month two, with no negative-margin quarter, it is additive to the PPS visit rather than carved out of it, and it is the operating layer underneath the UDS quality measures, grant narratives and staffing constraints the center already carries.

Economics shown are illustrative and modeled from a CoachCare Value Analysis; every figure should be verified against the health center's own patient, payer and utilization data during discovery. Public organizational facts are sourced and date-stamped, and items that could not be verified are flagged as such.

Prepared for: Quality of Life Health Services leadership

Prepared by: CoachCare — Remote Patient Monitoring & Chronic Care Management

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Executive Summary

Quality of Life Health Services, Inc. (QOLHS) is a private nonprofit 501(c)(3) federally qualified health center and HRSA Health Center Program (§330) grantee, founded in Gadsden, Alabama in 1977 by Dr. Roberta O. Watts and self-described as the largest system of federally qualified community health centers in the state. It operates 25 UDS service sites across a roughly 18-county footprint in northeast Alabama — Gadsden, Sardis City, Cullman, DeKalb, Clay, Chambers and Wadley among the named clinic communities, plus school-based and behavioral-health sites — and served **20,272 unique patients in CY2024** (HRSA Uniform Data System). Service lines span adult medicine, pediatrics, women's health, behavioral health, dental, in-house pharmacy, vision, podiatry, school-based health and medication-assisted treatment. The center has operated as a Patient-Centered Medical Home model since 2013, has been Joint Commission accredited since 1998, and has been led by the same President/CEO since 1982. Total revenue was $35.4M in the fiscal year ended March 2026 (IRS Form 990), against $45.1M of net assets and a modest operating surplus — a stable balance sheet with capacity to fund a program launch. Its EHR is OCHIN-hosted Epic.

The starting position — and the CY2026 payment change. The single most consequential fact in QOLHS's near-term environment is a change in how federally qualified health centers get paid for care management. CMS sunset the bundled G0511 code — last billable September 30, 2025. Since January 1, 2026, health centers bill the individual CCM, RPM and APCM codes at Physician Fee Schedule rates — and each is separately payable on top of the health center's PPS visit, not carved out of it. For decades the between-visit work of chasing blood pressures, closing HbA1c gaps and following up after a discharge was an unfunded cost absorbed into the encounter rate. As of this year it is a billable service line.

> **Time-sensitive — verify before contracting**
>
> The G0511 sunset and the January 2026 move to individual-code billing at PFS rates are stated from public CY2026 final-rule summaries for health centers as of July 2026. New APCM behavioral-health add-on codes became billable by FQHCs and RHCs in 2026, and RPM remains separately billable in the same month as APCM. Confirm the exact CY2026 rates, the current concurrency guidance, and any Alabama-specific billing instruction with the center's Medicare Administrative Contractor before any contract language.

APCM is the FQHC-native hook — and RPM is the largest line. Advanced Primary Care Management (G0556 / G0557 / G0558) is the code family built for exactly the panel QOLHS already runs. It is **not time-based** — no minute thresholds, no stopwatch discipline imposed on a workforce-constrained team — it needs no device to start, and it pays the most for the population a safety-net health center has in the greatest volume: **QMB dual-eligibles carrying two or more chronic conditions**, billed under G0558. At CY2026 national non-facility PFS rates these are $16.37, $53.78 and $117.24 per patient per month across the three levels. With 98.7% of the panel at or below 200% of the federal poverty level, the dual-eligible share of QOLHS's Medicare book is almost certainly high — which is precisely what makes APCM worth more here than almost anywhere. What APCM is not is the biggest number. Because CCM and APCM are mutually exclusive for the same patient in the same month, the care-management share of the panel is a **split, not a stack**: APCM takes the QMB and dual-eligible slice (35% of the in-scope population) and CCM takes the remainder (40%), together covering 75% of the panel rather than being layered on top of each other. Modeled that way, APCM produces **$434,667** of net reimbursement across 24 months against

$823,020 for CCM and $1,260,407 for RPM — which sits on a separate 65% share, has the widest reach of the three, and is the largest single line in the model. APCM still leads the sequencing: it is the richest code per dual-eligible patient touched, it imposes no minute-tracking on QOLHS's staff, and it reaches its ceiling in month four — faster than either other program.

The central argument

A managed care-management service line delivers value two ways at once, and both should be read together.

Standalone. Recurring, subscription-like professional-fee revenue — $2,518,094 of modeled net reimbursement over 24 months and $1,066,045 net to the health center after all CoachCare fees, a 42.3% of net reimbursement (Year 1 41.7%, Year 2 42.8%) — additive to the PPS structure rather than a reallocation of it, and net-positive from month two onward.

Connective tissue. One shared engine — enrollment, connected devices, monitoring and alert triage, documented escalation, billing capture and analytics — simultaneously produces UDS clinical-measure performance, the documented longitudinal touch that §330 grant narratives are judged on, staffing leverage in a workforce-constrained rural footprint, and 340B pharmacy synergy. Build it once; every layer draws on it.

Stated plainly: no shared-savings claim is made. No MSSP ACO participation was found for QOLHS in public sources, so APCM is framed in this report strictly as a fee-schedule service in Original Medicare — no ACO or shared-savings performance is assumed or required for any dollar in the model. The accountability QOLHS does carry is the annual UDS clinical-measure report against its §330 grant, its Joint Commission accreditation and PCMH model, and the Alabama Coordinated Health Network care-coordination landscape on the Medicaid side — and those are the frames this report uses. Alabama's Medicare Advantage penetration of roughly 51% (among the highest in the nation) does not change the economics: MA plans reimburse these care-management codes at or above 100% of the Medicare Physician Fee Schedule, so the billing rail holds across both halves of the Medicare panel.

The panel, stated honestly. QOLHS served 20,272 unique patients in CY2024. This model does not run on that number. It runs on roughly **3,000** — the estimated Medicare and dual-eligible slice of the panel, which is where RPM, CCM and APCM bill at Medicare PFS rates. The center's published payer mix covers the other side of the book — 35.5% uninsured and 23.3% Medicaid (UDS 2024) — but the Medicare share itself is not exposed in public sources and is carried here as an estimate at the conservative end of a 15–20% planning band. The exact CY2024 payer mix and QMB dual-eligible count is the single highest-value number still outstanding — the forecast is ceiling-limited and scales roughly linearly with it — and it is carried as discovery item #1.

Workforce relief is the delivery model, not a side benefit. QOLHS runs a roughly 220-employee organization across 25 rural sites in a region where clinical recruiting is structurally hard. Against that reality, a tool that requires the health center to hire care managers to operate it solves the wrong problem. CoachCare supplies the enrollment and engagement labor — **16,923 staff-hours over 24 months, roughly an 8.1 FTE-equivalent of CoachCare-performed work**, plus a CoachCare-funded on-site enrollment specialist — with no new health-center headcount. QOLHS's clinicians retain protocol governance and every clinical decision.

And the field is clear. QOLHS already operates telehealth — Zoom-integrated virtual visits through its OCHIN MyChart portal, with a named Program Director of Telehealth and Telemedicine — so the virtual-care muscle exists. But nothing on the center's published services, locations or portal pages describes a remote patient monitoring, chronic care management or advanced primary care management program, and no care-manager or RPM job postings were surfaced. The whitespace is not telehealth; it is the monetized monitoring and care-management layer on top of it. There is no incumbent vendor to displace. (Absence of a program is an absence-based finding from public sources — [UNVERIFIED]; confirm no nascent internal effort exists.)

The modeled economics (illustrative). A CoachCare Value Analysis built on CY2026 national non-facility PFS rates and a ~3,000-patient Medicare and dual-eligible in-scope population projects, over 24 months: **$2,518,094** of net professional-fee reimbursement (Year 1 $1,014,603; Year 2 $1,503,491), **$1,066,045** net to the center after all CoachCare fees, **39,238** reimbursable claims, **135,773** physiologic readings, and roughly **86 avoided hospitalizations** (≈$1.29M of avoided acute cost — a system-level benefit, not health-center revenue). Stated the way the client asks for it: **24-month practice margin: 42.3% of net reimbursement (Year 1 41.7%, Year 2 42.8%).** Month 1 nets **−$3,693** because one-time implementation lands before the census ramps; the line turns positive in **month two** and stays positive — there is no negative-margin quarter — reaching a steady state near $53,566 per month. No claim of day-one profitability is made. All figures are **illustrative, modeled — verify against practice data.**

2026–2027 Priority Recommendations

1. **Stand up the care-management service line now, APCM first.** The reimbursement change is already in effect; every month without a program is a month of care-management labor absorbed rather than billed. Charter it as a named service line with an owner, a P&L and a scorecard — not a pilot bolted onto one clinic.
2. **Lead with APCM on the dual-eligible cohort, then layer RPM and scale CCM.** APCM enrolls fastest because it is not time-based and requires no device, so it is the right first wave and the cleanest early proof of capture rate and revenue per patient-month. RPM follows into the hypertension and diabetes cohorts where devices change management; CCM carries the multi-chronic Medicare patients outside the APCM arm.
3. **Set the APCM-versus-CCM attribution policy before go-live.** APCM is not billed in the same month as CCM (or PCM or TCM) for the same patient; RPM may be billed alongside APCM. One written rule — dual-eligible and multi-chronic patients run APCM + RPM, the remaining multi-chronic Medicare patients run CCM + RPM — keeps the model reimbursement-accurate and audit-ready.
4. **Confirm the CY2024 payer mix and QMB dual-eligible count, then re-run the forecast.** All three programs reach their eligible-population ceilings between months four and ten, so the forecast is bounded by the size of the confirmed Medicare and dual population rather than by enrollment pace. A larger confirmed population scales the whole forecast roughly linearly; this is the highest-leverage number in the entire analysis.
5. **Build it native to Epic from day one — through OCHIN.** QOLHS's Epic instance is hosted by OCHIN, and Epic is one of CoachCare's integrated EHRs: enrollment flags and trigger ordering, exchange of patient health history, discrete vitals into the chart, escalation tasks and automated claim generation all run inside the Epic environment the center's staff already use. Because

OCHIN governs the hosted instance and its interfaces, the integration path runs through OCHIN — confirm scope and timeline in contracting.

6. **Wire the output into UDS reporting and the grant narrative — deliberately.** The same enrolled patient produces a billable Medicare line, a UDS clinical-measure numerator and the documented longitudinal-touch evidence that §330 grant narratives are judged on. Assign that linkage to a named owner in the first 180 days.

1. Footprint & Operating Model

QOLHS operates as northeast Alabama's safety-net anchor. Its headquarters — the Quality of Life Health Complex at 1411 Piedmont Cutoff, Gadsden — anchors a network the center describes as 24 community health centers (25 service sites in UDS 2024) across an 18-county service area, with multiple locations in Calhoun, Etowah and Marshall counties and named clinics including the J.W. Stewart Neighborhood Health Center, the Roberta O. Watts Medical Center, Sardis City Medical Center, and county clinics in Cullman, DeKalb, Clay, Chambers and Wadley (Randolph County). The UDS service-area type is rural. The organization was founded in 1977, has been tax-exempt since 1979, and is a self-certified minority-owned entity. It is FTCA-deemed under the Health Center Program.

The operating model is deep rather than wide: adult medicine, pediatric and adolescent medicine, women's health, behavioral health, dental, an in-house pharmacy, vision and optometry, podiatry, school-based health services, telehealth, medication-assisted treatment and interpreting services — an integrated primary-care platform for a panel of which **98.7% live at or below 200% of the federal poverty level** (UDS 2024). Leadership is unusually stable: the founder-era President/CEO has led the organization since 1982, and the executive team spans operations, financial services, compliance, human resources, special populations and communications.

> **A note on entity, scale and data vintage**
>
> Patient counts in this report use the official CY2024 HRSA UDS figure of 20,272 unique patients across 25 service sites. The center's own website describes 24 community health centers; the difference is a site-definition artifact, not a discrepancy of substance. Financials use the IRS Form 990 for the fiscal year ended March 2026: total revenue $35.4M (58.5% contributions and grants, 32.7% program services), expenses $34.8M, net assets $45.1M. Workforce scale is cited in third-party sources at roughly 220 employees — [UNVERIFIED] precision — and current provider and FTE counts by type are discovery items. The ~35 referring providers assumed in the financial model is a working estimate to be validated; the forecast is ceiling-limited, so this input carries low sensitivity.
>
> QOLHS describes itself as a Patient-Centered Medical Home and has been patient-centered since 2013, with Joint Commission accreditation since 1998. Formal NCQA PCMH recognition level and HRSA Community Health Quality Recognition badges could not be verified from public sources and are not asserted anywhere in this report.

Remote-care posture: telehealth yes, monitoring no. QOLHS lists telehealth as a live service line, delivered through Zoom-integrated virtual visits in its OCHIN-hosted MyChart portal, and staffs a named Program Director of Telehealth and Telemedicine. What was not found — anywhere on qolhs.org, in news coverage, or in job postings — is any remote patient monitoring, chronic care management or advanced primary care management program, or any care-manager hiring for one. That is the classic FQHC whitespace profile: an Epic chassis and a PCMH care-team culture with no monetized remote care-management layer on top. The finding is absence-based from public sources ([UNVERIFIED] as a definitive negative) and should be confirmed in discovery.

Design principles for the service line

Principle	What it means for QOLHS
Longitudinal by default	The Medicare and dual-eligible patient is managed between visits, every month — not re-encountered episodically when something breaks.
Additive, never substitutive	Every care-management code is billed on top of the PPS visit. Nothing in this design reallocates encounter-rate revenue or changes how a visit is billed.
One service line, one scorecard	APCM, CCM and RPM run as a single named service line with one owner, one P&L and one scorecard — not three disconnected programs in three departments.
Staffed, not licensed	CoachCare supplies the enrollment and engagement labor, including a CoachCare-funded on-site enrollment specialist. In a rural recruiting market, a program that requires new hires to operate is a program that does not launch.
Clinical governance stays inside	Protocols, escalation preferences and every clinical decision remain QOLHS's. CoachCare executes to documented standard operating procedures and documents every touch.
Built where the work already happens	Enrollment, vitals, escalation tasks and claims live inside the OCHIN-hosted Epic environment, so clinicians and billers do not learn a second system.

2. The Remote Care Service Line — The Spine

This is the centerpiece. The care-management service line is not a point solution bolted onto the health center; it is the operating spine that carries recurring PPS-additive revenue, UDS quality performance, staffing leverage and grant-narrative evidence on one shared engine.

2.1 What It Is: The Care-Management Stack

QOLHS owns a longitudinal primary-care panel, which is what makes the full stack billable here. Three programs run together, each with a distinct job. There is no separate specialty arm at a health center — the primary-care panel owns everything, and transitional care management is a clinical touchpoint at discharge rather than a modeled program.

Layer	Codes	Role in the health-center stack
APCM	G0556 / G0557 / G0558	Advanced Primary Care Management — non-time-based monthly management of the longitudinal panel. G0558 covers QMB dual-eligibles with two or more chronic conditions. Richest per patient touched, fastest to its ceiling, and no minute-tracking.
CCM	99490 / 99439 (complex 99487 / 99489)	Chronic Care Management for Medicare patients with two or more chronic conditions who are not on the APCM arm — the longitudinal wrapper for hypertension, diabetes and depression in one panel.
RPM	99453 / 99454 / 99457 / 99458 (short-window 99445 / 99470)	Remote Physiologic Monitoring — blood pressure, weight and glucose. The continuous early-warning layer that makes chronic control measurable rather than episodic. Widest reach of the three, and the largest single line in the model.

The one coordination rule — and why the care-management pool is a split, not a stack

APCM bundles. It is not billed in the same month as CCM, PCM or TCM for the same patient — those services overlap with APCM by definition. RPM may be billed alongside APCM. Because each patient therefore sits on one management rail or the other, the two eligibility shares partition a single care-management pool rather than adding to each other: APCM takes the QMB and dual-eligible slice (35% of the in-scope panel) and CCM takes the remainder (40%), together covering 75% of the panel. RPM sits on its own 65% share because it pairs with either rail. So QOLHS sets one written attribution policy and the model follows it: dual-eligible and multi-chronic patients run APCM + RPM; the remaining multi-chronic Medicare patients run CCM + RPM. Clean rules like this keep the model reimbursement-accurate and audit-ready — and they are why the forecast never counts the same patient on two care-management rails. Confirm current concurrency guidance with the MAC before go-live.

2.2 Standalone Value: Five Value Layers

Before any quality or grant consideration, the service line pays for itself through five layers of value — the first of which is simply revenue that did not exist before January 2026.

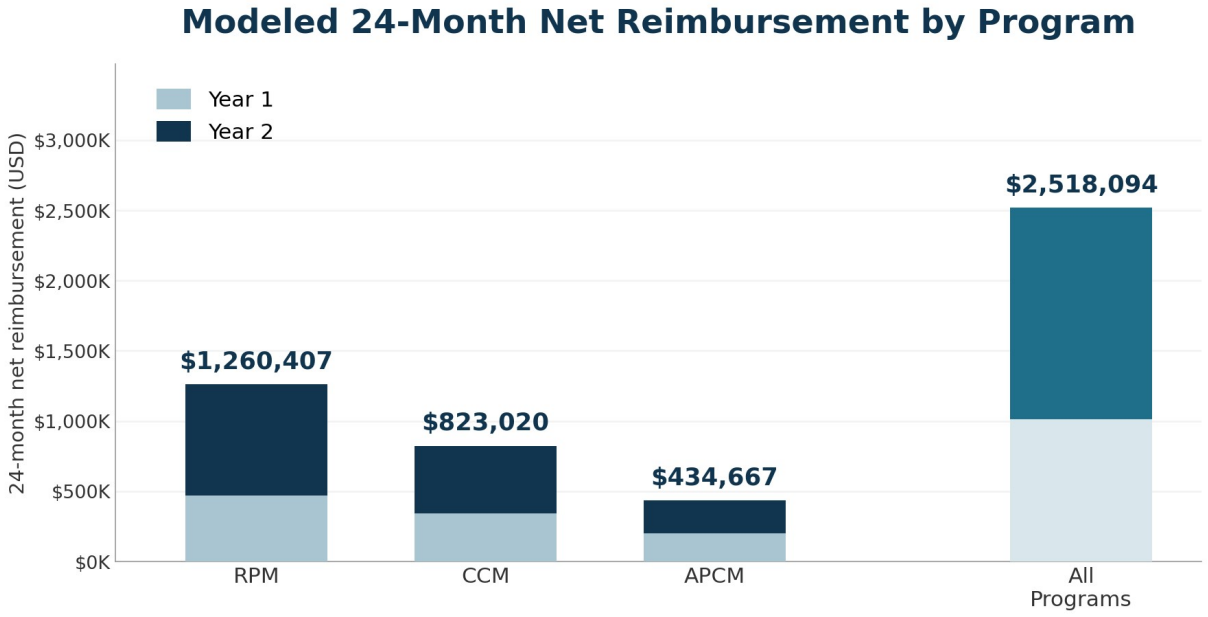
1. **Care-management revenue additive to the PPS structure.** Recurring monthly APCM, CCM and RPM billing at PFS rates, each separately payable on top of the encounter. A subscription-like revenue line the health center owns, on a population it already serves.
2. **UDS and HRSA quality performance.** Controlled blood pressure, HbA1c testing and control, and depression screening with follow-up are UDS clinical measures reported every year against the §330 grant — and they are precisely the measures structured monitoring and monthly contact move.
3. **Staffing leverage in a workforce-constrained setting.** 16,923 staff-hours of monitoring, outreach and documentation over 24 months — roughly an 8.1 FTE-equivalent of work — performed by CoachCare, not hired by QOLHS and not added to existing staff.
4. **Grant-narrative and health-equity alignment.** A documented longitudinal touch, month after month, for patients whose barriers are transportation, distance and phone continuity across an 18-county rural footprint. The §330 grant and every health-equity narrative the center writes are judged on exactly that evidence.
5. **340B pharmacy synergy.** Monthly care-management contact surfaces medication questions, adherence gaps and refill lapses and routes them to the prescriber, keeping more prescribing and refilling inside the health center's own in-house pharmacy relationship. No 340B effect is included in any modeled figure — it is structural upside.

The CY2026 billing stack (illustrative national non-facility rates)

Service / code	Type	Rate	Notes
APCM G0556	Monthly bundle	$16.37	Level 1 — zero or one chronic condition
APCM G0557	Monthly bundle	$53.78	Level 2 — two or more chronic conditions
APCM G0558	Monthly bundle	$117.24	Level 3 — QMB dual-eligible with two or more chronic conditions
CCM 99490 / 99439	Monthly	$66.13 / $50.44	Two or more chronic conditions; complex CCM 99487 / 99489 where applicable
RPM 99453 setup	One-time	$21.71	Requires at least 2 days of transmitted data
RPM 99454 / 99445	Monthly	$52.11	99454 = 16–30 days; 99445 = new CY2026 2–15 day short window
RPM 99457 / 99470	Monthly	$51.77 / $26.05	First 20 minutes / new CY2026 first-10-minute code

Service / code	Type	Rate	Notes
RPM 99458	Monthly	$41.42	Each additional 20 minutes

Rates are the CY2026 national non-facility Physician Fee Schedule amounts — the rail health centers bill these codes on since January 2026, with no geographic adjustment to the local MAC locality — and are the magnitudes used in the Value Analysis model — illustrative, not quotes. Payment for these codes is not locality-adjusted for health centers; verify the current-year national non-facility amounts with the regional MAC before contracting. Every rate is user-editable in the model. The short-window RPM codes (99445 / 99470) are not included in the modeled figures — they are upside on top, and a natural fit for the 2–15 day window after an emergency-department visit or hospitalization.



Illustrative, modeled — verify against practice data.

Figure 1. Modeled 24-month net professional-fee reimbursement by program, split Year 1 / Year 2. RPM leads on reach, while CCM and APCM split one care-management pool between them — the pattern that distinguishes a health-center panel from every other setting. Illustrative, modeled from a CoachCare Value Analysis on a ~3,000-patient Medicare and dual-eligible in-scope population — verify against practice data.

How the recurring-revenue math works

Each enrolled patient generates a predictable monthly professional fee for as long as they remain clinically appropriate and engaged. Scale that across the in-scope population and the line compounds: the model reaches 683 RPM, 360 CCM and 315 APCM active program enrollments between months four and ten and holds them — 1,358 enrolled services in total. CCM and APCM serve distinct patients (the two codes are mutually exclusive for the same patient in the same month), so those two cohorts are 675 care-management patients; roughly 473 of them also carry an RPM device and the remaining 210 RPM enrollments are monitoring-only patients — 885 enrolled patients in all. Blended net reimbursement per active patient-month, after denials and coinsurance bad debt, is modeled at approximately $97.47 for RPM, $110.75 for CCM and $62.25 for APCM.

Enrolled Patients versus Enrolled Services

A patient enrolled in APCM and RPM counts once as a patient and twice as a service. Program enrollments are never labeled “patients” anywhere in this report or in the companion workbook.

Modeling assumptions (read before quoting any number)

The forecast assumes a ~3,000-patient in-scope Medicare and dual-eligible population, roughly 35 referring providers, one CoachCare-funded on-site enrollment specialist plus telephonic outreach, enrollment beginning in month 1, and approximately 1.5% monthly attrition. Program eligibility within the in-scope population comes from the CY2026 FQHC / RHC row of the CoachCare eligibility table — a health-center-specific row rather than the general primary-care one — at 65% for RPM, 40% for CCM and 35% for APCM, with enrollment acceptance of 35% (RPM) and 30% (CCM and APCM), producing active-enrollment ceilings of 683 RPM, 360 CCM and 315 APCM. The CCM and APCM shares partition one care-management pool covering 75% of the panel; they are not stacked, because the two codes cannot be billed for the same patient in the same month.

The APCM tier mix is a modeled distribution, not a count from QOLHS's records: 15% Level 1, 55% Level 2, 30% Level 3, giving a blended $67.21 per patient-month before denials and coinsurance. The 35% APCM share of the in-scope panel is the CY2026 FQHC / RHC row's dual-eligible slice, and G0558 — the tier-3 code — is the one that pays richest for QMB duals. Given the depth of poverty in this panel (98.7% at or below 200% FPL), the actual QMB dual share is plausibly richer than the modeled 30% Level 3 — which would move the blended rate up, not down. The actual dual-eligible count moves this more than any other assumption on the page.

Not included anywhere in the financial figures: Alabama Medicaid care-management or remote-monitoring coverage, short-window RPM codes 99445 / 99470, transitional care management, any 340B pharmacy effect, and the ≈$1.29M of avoided acute cost. All are upside on top. All financial figures are illustrative, modeled — verify against practice data.

2.3 Connective Tissue: One Engine, Every Layer

The reason to build this as a service line rather than a series of disconnected point programs is that one shared engine carries every layer QOLHS cares about. Enroll a patient once, ship one device, run one monitoring and escalation protocol, capture one billing workflow — and the same activity shows up in the professional-fee line, the UDS numerator and the grant narrative.

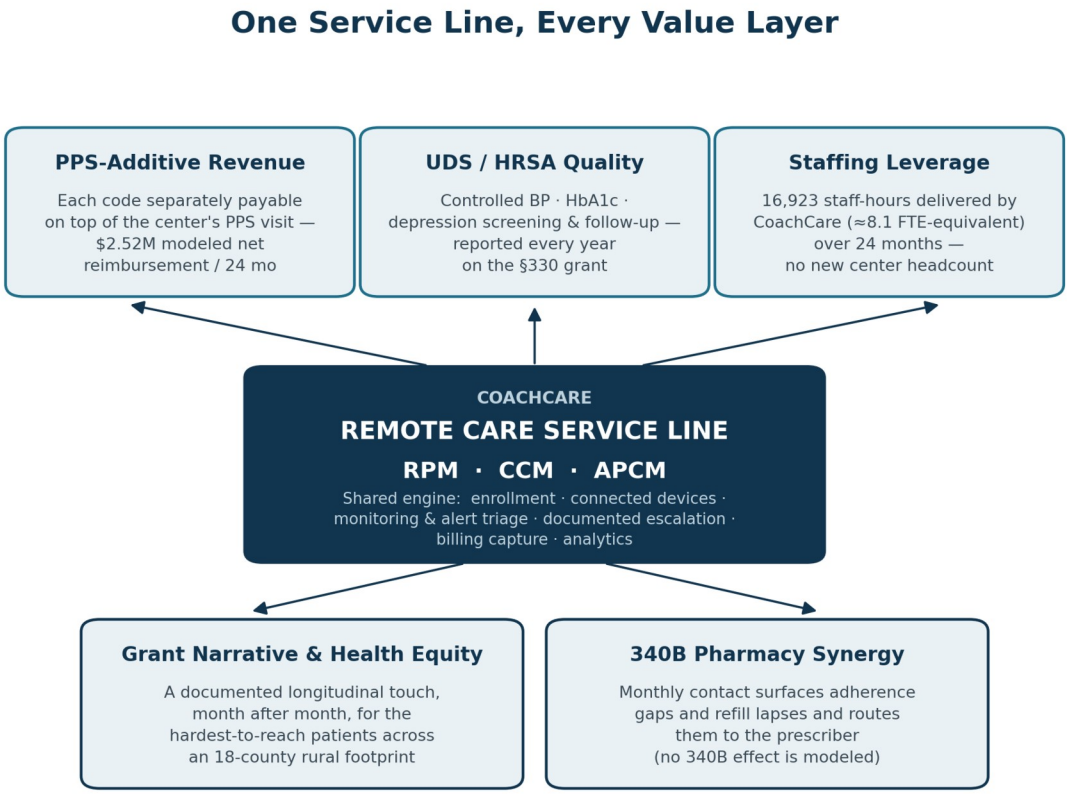


Figure 2. One service line, every value layer. Modeled figures are illustrative — verify against practice data. No 340B or Medicaid dollars are included in the modeled financials.

How the same infrastructure carries each layer

Value layer	What the shared engine contributes
PPS-additive revenue	Enrollment at scale, monthly documentation that satisfies the code requirements, and automated claim generation — the difference between a program and a result.
UDS / HRSA quality	Device-based home readings and monthly structured contact produce the numerators for controlled blood pressure, HbA1c testing and control, and depression screening with follow-up.
Staffing leverage	16,923 CoachCare-delivered staff-hours over 24 months absorb the enrollment, outreach, monitoring and documentation labor a rural health center cannot easily recruit.
Grant narrative & equity	A repeatable, documented outreach-and-escalation record for hard-to-reach patients — simultaneously the clinical goal, the quality numerator and the strongest grant language.
340B pharmacy	Monthly contact surfaces adherence gaps and refill lapses and routes them to the prescriber (structural upside; not modeled).
Avoided acute cost	Roughly 86 avoided hospitalizations over 24 months (≈$1.29M at

Value layer	What the shared engine contributes
	~$15,000 per admission) — a system-level benefit, never counted as health-center revenue in this report.

3. The CY2026 Payment Change — FQHC Care-Management Billing

This is the economic core of the report, and it is a policy fact rather than an opinion. For years, federally qualified health center care management was compressed into a single bundled code that paid roughly the same whether a center did a little or a lot. That structure is finished.

When	What changed	Why it matters at QOLHS
September 30, 2025	**The bundle sunset**	G0511 — the bundled FQHC/RHC general care-management code that aggregated roughly 22 distinct CCM, BHI and PCM services into one payment — was last billable 9/30/2025. Claims dated after that are denied.
January 1, 2026	**Individual codes, PFS rates**	Health centers bill the individual codes as separate line items at PFS-based rates: CCM (99490 / 99439, complex 99487 / 99489), RPM (99453 / 99454 / 99457 / 99458), PCM, BHI and APCM (G0556 / G0557 / G0558). Related unbundlings include G0512 (psychiatric collaborative care) and G0071 (virtual communication).
Ongoing	**Additive, not substitutive**	These are not carve-outs of the encounter. RPM, CCM and APCM are separately payable Medicare lines that sit on top of the health center's PPS visit — turning between-visit care management from an unfunded cost center into a revenue line. RPM remains separately billable in the same month as APCM.
From CY2026	**APCM behavioral-health add-ons**	New APCM behavioral-health add-on codes (general BHI and psychiatric CoCM add-ons) became billable by FQHCs and RHCs starting 2026 — a natural fit for a center with an integrated behavioral-health service line. Not modeled; upside.

APCM: the code family built for a safety-net panel

Advanced Primary Care Management began January 1, 2025 under the CY2025 PFS final rule, and federally qualified health centers may furnish and bill it. Three properties make it the right first wave at QOLHS. It is not time-based — there are no minute thresholds to track. It requires no device, so enrollment is not gated on logistics. And its top tier is aimed squarely at the population a Deep South health center has in the greatest volume.

Tier	Code	Who qualifies	Monthly rate	Modeled share
Level 1	G0556	Zero or one chronic condition	$16.37	15%
Level 2	G0557	Two or more chronic conditions	$53.78	55%
Level 3	G0558	QMB dual-eligible, two or more chronic conditions	$117.24	30%

Tier	Code	Who qualifies	Monthly rate	Modeled share
Blended		Across the modeled APCM cohort	**$67.21**	100%

CY2026 Physician Fee Schedule rates at the national non-facility amounts federally qualified health centers are paid on. The tier mix is a modeled distribution across the 315-patient APCM cohort, not a count from QOLHS's records — the actual QMB dual-eligible count is the single most important number still missing, and it moves this section more than any other assumption in the report. Illustrative, modeled — verify against practice data.

The Alabama frame — what is and is not in the model

- **Original Medicare, fee schedule only.** No MSSP ACO participation was found for QOLHS in public sources, and none is needed: every dollar in this model is fee-schedule reimbursement in Original Medicare. If the center does participate in, or later joins, a shared-savings arrangement, that performance sits on top of these numbers, not inside them. Definitive confirmation against the CMS ACO participant file is a discovery item.
- **Medicare Advantage at ~51% penetration.** Roughly half of Alabama's Medicare beneficiaries are in MA plans — among the highest penetration in the nation (September 2025 data). MA plans reimburse these care-management codes at or above 100% of the Medicare PFS, so the program economics hold across the MA half of the panel; the UDS payer counts used for the in-scope estimate already include MA. County-level MA penetration for Etowah, DeKalb and Cullman counties is [UNVERIFIED].
- **Alabama Medicaid: landscape context, zero modeled dollars.** Alabama has not expanded Medicaid, which is part of why 35.5% of QOLHS's panel is uninsured — and why Medicare care-management revenue is disproportionately strategic for Alabama health centers. The Alabama Coordinated Health Network (ACHN) runs regional Medicaid care-coordination entities with which primary-care providers, including FQHCs, hold agreements; QOLHS's specific ACHN agreements are [UNVERIFIED]. Any Alabama Medicaid remote-monitoring or care-management coverage is upside outside this model.

4. Operating System for Service Line Performance

Running the service line well means managing it like a service line — with a balanced scorecard that puts clinical, operational, financial and quality measures on one page and in front of one owner.

Dimension	Representative measures
Clinical	Percentage of enrolled hypertensive patients at goal; HbA1c testing and poor-control rates in the enrolled cohort; depression screening with documented follow-up; readings-per-patient-per-month adherence.
Service line	Enrolled patients and enrolled services by program; time-to-first-billable-enrollment; monthly capture rate (billable months ÷ eligible enrolled months); net revenue per patient per month; attrition.
Access & equity	Enrollment rate among transportation-limited and outlying-county patients; successful-contact rate; documented touches for patients with no completed visit in the prior six months.
Utilization	Emergency-department visits and admissions in the enrolled cohort; 30-day readmissions; completed post-discharge follow-up within 7–14 days.
Quality reporting	Annual UDS clinical-measure movement against the §330 grant; measure-level documentation completeness for controlled blood pressure, HbA1c and depression screening.
Governance	Escalations by category and time-to-resolution; protocol exceptions; documentation completeness; audit-readiness sampling.

Launch readiness checklist

- **In-scope population confirmed** — CY2024 payer mix and QMB dual-eligible count pulled from QOLHS's own records, and the forecast re-run against them.
- **Attribution policy written** — APCM versus CCM assignment rules, and the standing rule that RPM stacks with either.
- **Protocols signed off** — hypertension, diabetes and the behavioral-health overlay, plus QOLHS's stated escalation preferences for non-emergent findings.
- **OCHIN Epic integration scoped** — interface scope and timeline confirmed with OCHIN, and billing configuration tested end-to-end on a small cohort before scale.
- **Service-line governance named** — one owner, a monthly scorecard, and a standing slot in the existing quality or operations meeting rather than a new committee.
- **Reporting linkage assigned** — who carries service-line output into UDS reporting and the annual grant narrative.

5. The Panel — Who Is Actually In Scope

Being precise about the denominator is the difference between a forecast a chief financial officer can defend and a number that falls apart in the first finance meeting. This section states the panel honestly, including what is excluded and why.

QOLHS served **20,272 unique patients in CY2024** (HRSA Uniform Data System). The model does not run on that number. It runs on roughly **3,000** — the estimated Medicare and dual-eligible slice of the panel, which is where RPM, CCM and APCM bill at Medicare Physician Fee Schedule rates. The published UDS payer mix covers the rest of the book: 35.5% uninsured and 23.3% Medicaid (including CHIP). The Medicare share itself is not exposed in the public UDS mirror — by arithmetic, Medicare plus private plus other insurance is roughly 41% of patients, and a rural-Alabama FQHC Medicare share of 15–20% (roughly 3,000–4,000 patients) is a reasonable planning band. This model uses the conservative 15% end. That figure is a discovery-stage estimate to be validated against QOLHS's own chart and payer counts, not a count taken from them.

What is excluded, and why. Medicaid-only and uninsured / sliding-fee patients are excluded from the modeled billable core. Alabama Medicaid's remote-monitoring and care-management coverage for health centers is narrower than Medicare's, and FQHC Medicaid services largely bundle into the PPS encounter rate — so including them would inflate the forecast with revenue that is not clearly separately payable today. That exclusion is a deliberate conservatism, not an oversight: it means the number in this report is a floor built on the clearest billing rail, with the Medicaid side treated as upside.

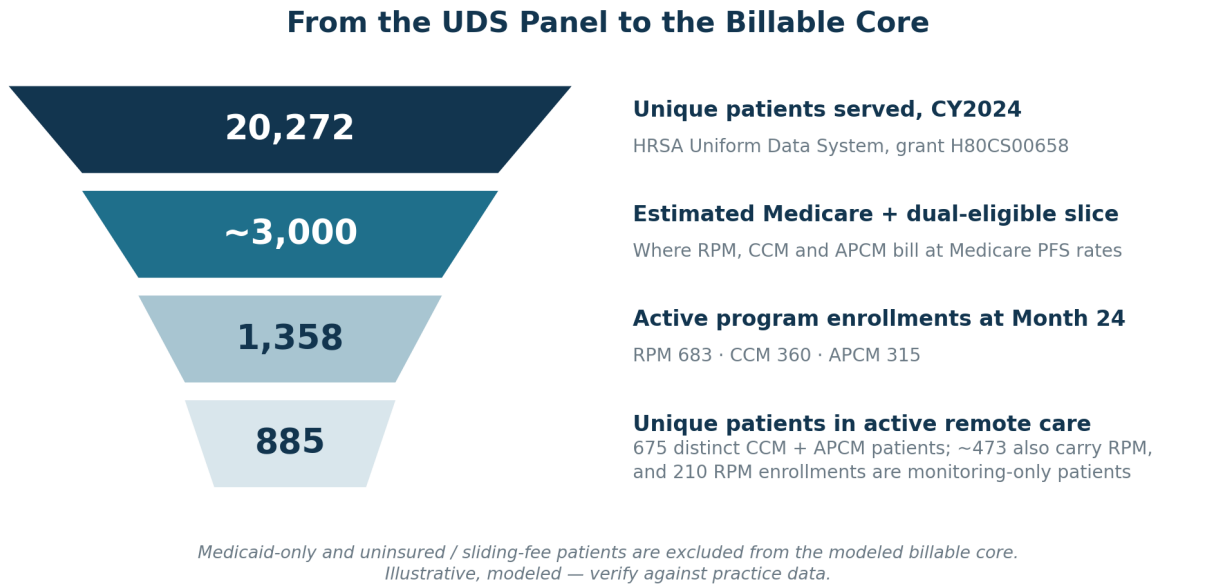


Figure 3. From the CY2024 UDS panel to the modeled billable core and the enrolled census at Month 24. The in-scope figure is a discovery-stage estimate, not a chart count. Illustrative, modeled — verify against practice data.

Upside deliberately left out of the model

- **Alabama Medicaid coverage.** Any separately payable Alabama Medicaid remote-monitoring or care-management revenue, and any ACHN care-coordination participation payments. Not in the forecast.

- **APCM behavioral-health add-ons.** The new 2026 BHI and CoCM add-on codes, a natural fit for QOLHS's integrated behavioral-health line. Not modeled.
- **Short-window RPM.** The new CY2026 codes 99445 and 99470 cover 2–15 day monitoring windows after an acute episode. Not modeled.
- **Transitional care management.** TCM at hospital discharge is a clinical touchpoint in the workflow, not a modeled revenue line.
- **340B pharmacy effect.** Structural, real, and deliberately excluded from every modeled figure.
- **Avoided acute cost. ≈$1.29M of avoided hospitalization cost accrues to payers** and the acute-care system, not to the center's income statement.

The honest constraint — and why it is good news

All three programs reach their eligible-population ceilings between months four and ten and stay flat: APCM 315 in month 4, CCM 360 in month 7 and RPM 683 in month 10. That is not an enrollment-pace problem. CoachCare's enrollment engine — roughly 35 referring providers plus one funded on-site enrollment specialist — fills the panel faster than the eligible population can absorb it. The forecast is therefore constrained by the size of the confirmed Medicare and dual-eligible population, not by how fast patients can be enrolled — which means the leverage runs one way: a larger confirmed population scales this entire forecast roughly linearly. If QOLHS's real Medicare-plus-dual slice is closer to the top of the planning band, or resembles peer health centers at ~24% of panel, the 24-month figures scale up by roughly 1.3–1.6×. Adding referring providers does not move the number; the ceiling binds first.

Discovery item #1 — the CY2024 payer mix and QMB dual-eligible count

QOLHS's center-specific UDS payer breakdown (Medicare %, Medicaid %, uninsured %, private %) and its QMB dual-eligible count are the single highest-value inputs still outstanding. They set the in-scope denominator, the APCM tier mix, and therefore the entire forecast. HRSA exposes them only in a browser-rendered per-center UDS profile, so they are [UNVERIFIED] here and stated as an estimate. Everything in this report is built to be re-run the moment those two numbers land. Related open items: center-specific CY2024 UDS clinical measures (controlled hypertension, HbA1c poor control, depression screening and follow-up) — no baseline or improvement is assumed anywhere in this report.

6. Powering Quality: UDS Measures & the Alabama Landscape

QOLHS is not choosing whether to be accountable for quality — it already is, every year. As a §330 grantee it reports Uniform Data System clinical measures to HRSA annually, it operates as a Patient-Centered Medical Home model, and it has carried Joint Commission accreditation since 1998. The measures the UDS report rewards — controlled blood pressure, HbA1c testing and control, depression screening with follow-up — are the measures a structured remote-care line moves fastest. And the disease burden here is not hypothetical: rural counties nationally carry hypertension prevalence of roughly 40.0% against 29.4% in large metros, rural Alabama's diabetes mortality runs roughly 30.4 per 100,000 against 20.8 in urban areas, and much of Alabama sits inside the U.S. Diabetes Belt. A panel that is 98.7% at or below 200% FPL, spread across 18 rural counties, is exactly the panel these measures are hardest to move by visit-based care alone.

What each measure is worth, and how the service line moves it

Measure	Where it counts	How the service line moves it
Controlled blood pressure	UDS clinical measure	Device-based RPM produces home readings between visits; out-of-range trends trigger protocolized outreach and titration support instead of waiting for the next appointment.
HbA1c testing and poor control	UDS clinical measure	Monthly APCM or CCM contact closes testing gaps and surfaces medication and adherence barriers; glucose RPM makes control continuous rather than quarterly.
Depression screening and follow-up	UDS clinical measure	Structured monthly outreach creates the documented follow-up touch the measure requires — and routes into QOLHS's existing integrated behavioral-health service.
30-day readmissions / ED use	Utilization scorecard; payer relationships	The post-discharge three-touch cadence (Day 1–2 / 5–8 / 12–14) triggered by any admission or ED visit in the previous 60 days converts avoidable acute episodes into same-week clinic touches.

The double-count that is not double-counting. The same enrolled patient generates a billable Medicare care-management line and improves a UDS numerator and produces the documented-engagement evidence a grant narrative is judged on. That is not stacking assumptions — it is one clinical activity that several payment and reporting structures happen to reward at the same time. It is also why a care-management line is unusually durable at a health center: it does not depend on any single one of them staying favorable.

The Medicaid side, kept in its lane. On the Medicaid book, Alabama's Coordinated Health Network provides the care-coordination scaffolding, and the same monitoring and outreach engine strengthens whatever role QOLHS plays in it — but no ACHN payment, quality pool or Medicaid

dollar appears anywhere in the model. The revenue thesis in this report is deliberately a Medicare and dual-eligible story.

What to confirm before citing any quality baseline

QOLHS's center-specific CY2024 UDS rates for controlled hypertension, HbA1c poor control and depression screening with follow-up are not published in machine-readable form and are [UNVERIFIED] in this report. The mapping above is directional — it describes mechanism, not measured lift. No baseline and no improvement percentage is assumed anywhere in the financial model. Pull the center-specific UDS profile in discovery and set targets against QOLHS's own starting point.

7. Staffing Leverage, Grant Narrative & 340B

The reimbursement is the reason the service line survives a budget review. These are the reasons it is worth running — the clinical work performed, the acute care avoided, and the labor a workforce-constrained health center does not have to hire.

Modeled 24-month output	Figure	What it means
Reimbursable claims	39,238	Recurring, subscription-like professional-fee volume generated automatically inside the Epic workflow.
Physiologic readings	135,773	A continuous picture of blood pressure, weight and glucose between visits — the raw material for chronic control and for quality-measure numerators.
Hospitalizations avoided	86	≈$1.29M of avoided acute cost at roughly $15,000 per admission. A system-level, indirect benefit — not health-center revenue, and not counted as such anywhere in this report.
Staff-hours delivered by CoachCare	16,923	≈8.1 FTE-equivalent of monitoring, outreach and documentation performed by CoachCare — not headcount QOLHS hires, and not hours added to existing staff.

Staffing leverage is the whole argument. QOLHS runs roughly 220 employees across 25 rural sites — a lean organization for a 20,272-patient panel spread over 18 counties, in a region where clinical recruiting is structurally difficult. Against a $35.4M revenue base built 58.5% on grants and contributions, the binding constraint on any new care-management program is people, not intent. CoachCare supplies the enrollment and engagement labor — telephonic outreach, a CoachCare-funded on-site enrollment specialist (CoachCare's expense, embedded in the service rather than billed to the center), device logistics, monitoring and documentation — which is the only version of this program a rural health center can actually staff. QOLHS's clinicians keep clinical governance and every clinical decision.

Grant narrative and health equity. QOLHS's §330 Health Center Program grant and every access-focused award it pursues are judged on documented engagement with hard-to-reach populations. A remote-care line produces exactly that evidence: a documented longitudinal touch, month after month, for patients whose barriers are transportation, distance and phone continuity rather than willingness. The escalation record described in Section 9 is grant-narrative material as much as it is clinical governance — a repeatable, auditable account of reaching people the system usually loses. For an organization whose public story is four decades of taking care to underserved northeast Alabama, this is the same mission with a billing rail underneath it.

340B pharmacy synergy. QOLHS operates in-house pharmacy services, and as a §330 grantee it is 340B-eligible by statute (specific covered-entity registrations and contract-pharmacy arrangements are [UNVERIFIED] and worth confirming in discovery). Monthly care-management contact surfaces medication questions, adherence gaps and refill lapses and routes them to the

prescriber, so more of the prescribing and refilling stays inside the health center's own pharmacy relationship. No 340B effect is included in any modeled figure in this report; it is structural upside.

Integrated behavioral health is a multiplier here, not a side line. QOLHS runs behavioral health, medication-assisted treatment and school-based health alongside primary care — and the new-for-2026 APCM behavioral-health add-on codes are built for exactly that integration. Remote care extends the same discipline to the physiologic side of the same patients: hypertension, type 2 diabetes, and depression with co-occurring conditions. The add-ons are not modeled; they are a named next step once the core line is running.

> **Scope discipline**
>
> The avoided-hospitalization figure is a system-level, indirect benefit — it accrues to payers and to the acute-care system, not to QOLHS's income statement, and it is excluded from every revenue number in this report. It is included because it is the clinical point of the exercise and because it is what moves the readmission and ED utilization the center's scorecard should track. Treat it as a quality argument, not a financial one.

8. Epic Integration — Through the OCHIN-Hosted Environment

QOLHS runs Epic, hosted by OCHIN — the center's MyChart portal sits on OCHIN's multi-tenant hosted-Epic domain, which is publicly verifiable. That matters more than it sounds. Epic is one of CoachCare's integrated EHRs, so this is a configured integration rather than a custom build, and the whole program lives in the Epic environment the center's staff already use. Clinicians and billers stay in Epic; enrollment flags, discrete vitals, escalation tasks, compliance documentation and claim generation move between the two systems automatically. One structural specific applies here: because OCHIN controls the hosted instance and its interface governance, the integration path runs through the OCHIN environment rather than directly against a locally managed Epic — a known, navigable step for OCHIN-member health centers, and a contracting confirmation item rather than a risk to the design.

Direction	What moves	Operational effect
From Epic	**Integrated enrollment and trigger ordering**	Enrollment flags and trigger ordering sit inside the clinical workflow; CoachCare's team enrolls qualified Medicare patients on the center's behalf, with enrollment status visible in Epic in real time.
From Epic	**Exchange of patient health history**	The monitoring team works from the same problem list, medication list and history the clinic sees, rather than a parallel record that drifts.
Back into Epic	**Integrated discrete vitals**	Home blood pressure, weight and glucose land in the chart as discrete, trendable vitals — not as PDFs attached to the record.
Back into Epic	**Compliance documentation and care summary**	Clinical changes route to a named member of QOLHS's care team, with audit-ready compliance documentation and an integrated care summary in the record.
Back into Epic	**Automated claim generation**	Claims are created automatically by the CoachCare billing engine, eliminating the manual claim-creation step for each patient every month. For a service line whose entire economics depend on monthly capture, that is the difference between a model and a result.

Three capabilities worth naming specifically

- **Speed to first service.** With integrated enrollment flags and trigger ordering, patients begin receiving CCM and RPM services in under five days from flag — the program starts delivering in days rather than after a long build.
- **Integrated discrete vitals and care summary.** Vitals arrive as structured chart data and escalations arrive with an integrated care summary, which is what makes the monitoring record usable for UDS reporting and audit rather than merely visible.

- **Automated claim generation.** CoachCare is the only care-management application integrated with Epic that provides automated claims creation. Monthly capture rate is the single operational variable that determines whether a care-management forecast is realized, and automating it removes the most common failure mode.

Confirm in discovery — and again at contracting

QOLHS's OCHIN-hosted Epic instance is inferred with high confidence from the center's own MyChart routing (an OCHIN-domain portal) and OCHIN's published telehealth model, which matches QOLHS's Zoom-in-MyChart virtual visits; a direct OCHIN member-roster listing was not located. Integration scope — which interfaces are in scope through the OCHIN environment, what configuration is required, OCHIN's interface governance process, and the implementation timeline — is a contracting confirmation item, not an assumption of this report. Confirm the instance details and interface scope with QOLHS and OCHIN before the integration statement of work.

9. Implementation Playbook

Goals & scope

Stand up a managed care-management service line that is self-funding on its own economics and wired into UDS reporting and the grant narrative within the first year. Scope: APCM + CCM + RPM, billed by QOLHS, on the Medicare and dual-eligible population, delivered full-service by CoachCare with no new health-center headcount. Chartered in 30 days; billing by day 90.

Target populations (in launch order)

- **QMB dual-eligibles with two or more chronic conditions (launch first)** — where the economics and the mission converge. No devices, no minute-tracking, first billable month inside the quarter, and the cleanest possible proof of capture rate and revenue per patient-month.
- **The hypertension and diabetes cohorts** — layered onto RPM second, because that is where device data actually changes management and where the UDS measures live.
- **Multi-chronic Medicare patients outside the APCM arm** — carried on CCM + RPM under the written attribution policy.
- **Post-discharge and post-ED patients** — any admission or emergency-department visit in the previous 60 days triggers the three-touch cadence, which is the concrete readmission-prevention loop behind the avoided-hospitalization figure.

Staffing, technology & billing architecture

- **CoachCare-delivered labor.** Telephonic enrollment, a CoachCare-funded on-site enrollment specialist, health coaches, monitoring and alert triage, and documentation — 16,923 staff-hours over 24 months, ≈8.1 FTE-equivalent, at CoachCare's expense. QOLHS adds no headcount to launch; the internal staffing model formalizes as census grows.
- **Devices that work in a rural safety-net panel.** Cellular-connected blood-pressure cuffs, scales and glucometers, shipped, provisioned and supported — no home Wi-Fi, no router credentials, no Bluetooth pairing for the patient to manage. For an 18-county panel with transportation and connectivity barriers, that is not a convenience feature.
- **Native Epic integration from day one.** Enrollment, orders, discrete vitals, escalation tasks and claims run inside the OCHIN-hosted Epic environment per Section 8, subject to the OCHIN scope confirmations noted there.
- **Billing architecture built for capture.** Care-plan coding and automated claim generation for every eligible patient, every month, with the APCM-versus-CCM attribution policy enforced in the workflow rather than remembered by a biller.

Clinical workflow & escalation governance

Steady state: enroll at a clinic visit, on provider referral, or through telephonic outreach → ship and activate connected devices where the program calls for them → daily physiologic data and monthly structured contact into a monitoring and triage layer → protocolized outreach on out-of-range trends → documentation and claim generation inside Epic → monthly scorecard to service-line governance. Every RPM, CCM and APCM finding runs through a documented protocol rather than ad hoc triage.

Routing	Trigger	What happens
Emergent	An active emergent symptom reported live during outreach — chest pain, new shortness of breath, stroke signs, syncope, worst-ever headache, sudden swelling	The care team calls 911 with the patient still on the line. If the patient refuses, CoachCare loops in the clinic; if the clinic is unavailable, CoachCare activates 911 itself. The urgent/emergent policy supersedes any local escalation preference — the response never waits on a callback.
Critical value	A critical reading, regardless of symptoms	Escalates regardless of symptoms. An out-of-range value first gets a retake plus a symptom check; a trend is defined objectively (three consecutive out-of-range readings at least an hour apart) rather than by a single stray number.
Non-critical clinical change	A confirmed trend or clinically meaningful change that is not emergent	Routed to a defined member of QOLHS's care team for review and follow-up — the right person, not a broadcast page across a 25-site network.
Stable or resolved	A reading that normalizes or a resolved finding	Documented as an FYI in the record — visible for continuity, without interrupting anyone.
Post-discharge	Any hospitalization or ED visit in the previous 60 days	A fixed three-touch sequence: Day 1–2 stabilize, reconcile medications and confirm a 7–14 day follow-up; Day 5–8 verify adherence, re-evaluate triggers and confirm the appointment happened; Day 12–14 review medications and risk and re-assess symptoms.

Every escalation documents the vital, the findings, the method of contact, who was reached, the outcome and the follow-up. A patient who cannot be reached is escalated to the clinic and re-escalated on a fixed cadence, and no change to a patient's monitoring status happens without the clinic informed. In an 18-county rural panel where patients move, change phone numbers and miss appointments, that record is what converts a hard-to-reach patient into a documented longitudinal touch — which is simultaneously the clinical goal, the quality-measure numerator and the strongest possible language for a grant narrative.

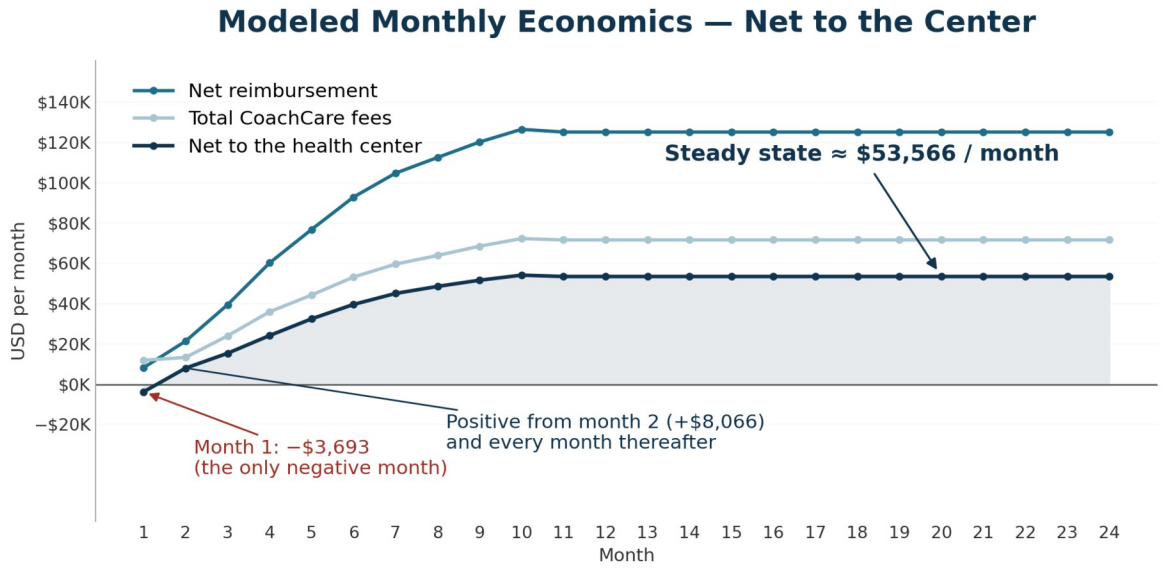
KPI dashboard

Clinical	Operational	Financial & quality
Percentage of enrolled hypertensives at goal; HbA1c testing and poor-control rates; depression screening with documented follow-up; readings per patient per month; admissions, ED visits and 30-	Enrolled patients and enrolled services by program; time-to-first-billable-enrollment; successful-contact rate and attrition; escalations by category and time-to-resolution; device provisioning and activation lead	Monthly capture rate (billable months ÷ eligible enrolled months); net revenue per patient per month, by program; net to the health center after all fees; UDS measure movement year over year

Clinical	Operational	Financial & quality
day readmissions	time	

Expected impact & 12-month roadmap

Modeled 24-month impact (illustrative; verify against practice data): $2,518,094 of net professional-fee reimbursement, $1,066,045 net to the center after all CoachCare fees, 39,238 reimbursable claims, 135,773 physiologic readings, roughly 86 avoided hospitalizations, and 16,923 staff-hours delivered by CoachCare. 885 enrolled patients and 1,358 enrolled services under active management at Month 24. 24-month practice margin: 42.3% of net reimbursement (Year 1 41.7%, Year 2 42.8%). Month 1 nets −$3,693; the line is positive from month two onward with no negative-margin quarter, and reaches a steady state near $53,566 per month.



Illustrative, modeled — verify against practice data. Fees include one-time implementation, EMR setup and telephonic enrollment.

Figure 4. Modeled monthly economics — net reimbursement, total CoachCare fees, and net to the center, drawn against a true zero baseline. Fees include one-time implementation, EMR setup and telephonic enrollment. Illustrative, modeled — verify against practice data.

- **Days 0–30 — Charter the service line.** Named owner, P&L and scorecard; OCHIN Epic integration and billing configuration; the APCM-versus-CCM attribution policy; protocol sign-off for hypertension, diabetes and the behavioral-health overlay; and confirm the CY2024 payer mix and dual-eligible count.
- **Days 31–90 — Launch APCM on the dual-eligible cohort.** Start where the economics and the mission converge. No devices, no minute-tracking, first billable month inside the quarter, and the cleanest early proof of capture rate and revenue per patient-month.
- **Days 91–180 — Layer RPM and scale CCM.** Extend device-based monitoring across the hypertension and diabetes cohorts; activate CCM for multi-chronic Medicare patients outside the APCM arm; extend from the Gadsden flagship sites across the county clinics; monthly scorecard reporting to service-line governance.

- **Days 181–365 — Wire it into quality and the grant narrative.** Connect service-line output to UDS reporting and the annual §330 narrative; formalize the behavioral-health referral loop and evaluate the APCM behavioral-health add-ons; and re-run the forecast against the now-confirmed Medicare and dual-eligible population.

References & Data Sources

- HRSA Health Center Program / Uniform Data System — Quality of Life Health Services, Inc., Health Center Program grant H80CS00658: CY2024 total unique patients 20,272; 25 service sites; rural service-area type; payer mix (35.5% uninsured; 23.3% Medicaid including CHIP; 98.7% at or below 200% FPL). Vintage: CY2024 reporting year, retrieved July 2026. Center-specific Medicare share, dual-eligible count and clinical-measure rates were not accessible in this pass and are carried as [UNVERIFIED] discovery items.
- QOLHS public website (qolhs.org) — organizational history (founded 1977; Joint Commission accredited since 1998; patient-centered / PCMH model since 2013; self-described largest FQHC system in Alabama), services, named clinic sites, 18-county service-area statement, telehealth service line and MyChart routing. Reviewed July 2026; absence of a published RPM / CCM / APCM program is an absence-based finding [UNVERIFIED].
- IRS Form 990, fiscal year ended March 2026 (via ProPublica Nonprofit Explorer) — total revenue $35.4M (contributions/grants 58.5%; program services 32.7%); expenses $34.8M; net assets $45.1M; the same President/CEO since 1982. Filed June 2026.
- CMS CY2026 Physician Fee Schedule — care-management and remote-monitoring codes (APCM G0556 / G0557 / G0558; CCM 99490 / 99439 and complex 99487 / 99489; RPM 99453 / 99454 / 99457 / 99458; new short-window codes 99445 / 99470), at CY2026 national non-facility PFS amounts, with no geographic adjustment. Illustrative magnitudes — verify against the current PFS and the health center's MAC.
- CY2026 final-rule summaries for federally qualified health centers and rural health clinics (NARHC CY26 summary; CMS CY2026 PFS final-rule fact sheet; industry explainers) — sunset of the bundled G0511 effective after 9/30/2025; individual-code billing at PFS-based rates from 1/1/2026; related unbundlings (G0512, G0071); APCM behavioral-health add-on codes billable by FQHCs/RHCs from 2026; RPM separately billable in the same month as APCM. Stated as of July 2026; confirm with the MAC before contracting.
- CMS — Advanced Primary Care Management (CY2025 PFS final rule): non-time-based monthly bundle, 13 service elements, billable by FQHCs and RHCs; G0558 scoped to QMB dual-eligible patients with two or more chronic conditions.
- CMS 2026 Medicare Advantage landscape and state fact sheets; healthinsurance.org Medicare-in-Alabama summary — roughly 51% of Alabama Medicare beneficiaries enrolled in MA (September 2025); ~1.13M total Alabama Medicare enrollees. County-level MA penetration [UNVERIFIED].
- Alabama Medicaid — Alabama Coordinated Health Network (ACHN) program pages and ALPHCA overview: regional PCCM care-coordination entities with which primary-care providers, including FQHCs, hold agreements. QOLHS's specific ACHN agreements [UNVERIFIED]. No MSSP ACO participation found for QOLHS in public sources; definitive confirmation against the CMS ACO participant file is a discovery item.
- Disease-burden context — CDC/peer-reviewed county-level hypertension prevalence (rural/noncore ~40.0% vs ~29.4% large-metro); Alabama Department of Public Health State Health Assessment and diabetes rankings (rural Alabama diabetes mortality ~30.4 vs ~20.8 per 100,000 urban; U.S. Diabetes Belt).

- OCHIN — hosted Epic for community health centers and Zoom-integrated MyChart telehealth; QOLHS MyChart routed on OCHIN's hosted-Epic domain (operative EMR evidence, high confidence; direct member-roster listing not located).
- CoachCare / Epic integration overview — integrated enrollment and trigger ordering, exchange of health history, integrated discrete vitals, compliance documentation and integrated care summary, automated claim generation; services beginning in under five days from flag; automated claims creation differentiator.
- CoachCare Care Management standard operating procedures — escalation decision logic, urgent/emergent policy, and the post-discharge three-touch cadence.
- CoachCare Value Analysis (2026) — modeled economics for Quality of Life Health Services on a ~3,000-patient Medicare and dual-eligible in-scope population at CY2026 national non-facility PFS rates; source of all illustrative financial, clinical and operational figures in this report. Companion workbook available; every rate and assumption is user-editable.

Verification & validation caveat

All financial figures in this report are illustrative, modeled outputs of a CoachCare Value Analysis under the stated assumptions — verify against practice data — and are not a guarantee of reimbursement or revenue. Verify all rates against the current CY Physician Fee Schedule national non-facility amounts and the health center's own billing rail before contracting. The modeled in-scope population is a discovery-stage estimate of the Medicare and dual-eligible slice of the panel, not a chart count; Medicaid-only and uninsured or sliding-fee patients are excluded from the modeled billable core.

CY2026 FQHC care-management billing rules, including the sunset of G0511 and the move to individual-code billing at PFS-based rates, are stated from public CMS and industry summaries as of July 2026 and must be confirmed with the health center's MAC. Organizational, financial, quality and market facts are sourced from HRSA, IRS Form 990, CMS and public reporting as of July 2026 and should be confirmed at the time of decision. Items marked [UNVERIFIED] could not be confirmed from public sources and are carried as discovery items rather than asserted.

Contact

Connor Knapp, CoachCare · connor.knapp@coachcare.com