COACHCARE | SERVICE LINE STRATEGY

Mercy Care

Saint Joseph's Mercy Care Services, Inc., d/b/a Mercy Care · a Section 330 federally qualified health center and Atlanta's Health Care for the Homeless grantee, serving 18,089 patients across eight clinics and two mobile units in Fulton and DeKalb counties

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line — remote physiologic monitoring, chronic care management and advanced primary care management — for the Medicare panel inside Mercy Care's mission, 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 Mercy Care. It brings together the organization's published clinical quality record, the shape and growth of its Medicare panel, the CY2026 rules governing how health centers bill care management, the market its patients sit in, and a 24-month financial forecast.

The argument is short. Mercy Care already finds and holds onto patients almost no one else reaches — street medicine that runs day and night, clinics inside the shelters, two mobile units, 33 medical respite beds, and social-needs screening structured in the chart for 7,173 patients. That engine has never been pointed at the one payer that pays for between-visit work code by code. Since January 2026, Medicare does exactly that.

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Executive Summary

Mercy Care — legally Saint Joseph's Mercy Care Services, Inc. — has been Atlanta's Health Care for the Homeless grantee since the Sisters of Mercy founded it in 1985. It operates eight service-delivery sites and two mobile units across Fulton and DeKalb counties, including clinics embedded inside Gateway Center, City of Refuge and a Salvation Army campus, and it runs street medicine teams day and night. CY2025 Uniform Data System reporting counts **18,089 patients**, of whom 11,891 — 65.7% — were homeless during the year, and 58.2% were uninsured.[1]

Inside that mission sits a smaller panel with a different payment rail. Mercy Care served **1,132 Medicare-primary patients in CY2025** — 6.3% of the total, up from 882 in 2021, a 28% increase in four years. **714 of them, 63.1%, are dually eligible for Medicare and Medicaid**. Behind that panel is a larger one arriving: 3,118 patients aged 55 to 64, nearly three times the current Medicare count.[2]

The clinical picture in Mercy Care's own CY2025 submission is specific. The organization performs strongly on what a visit controls — 90.2% on tobacco screening and cessation, 83.4% on depression screening with follow-up, 80.8% on statin therapy for patients at cardiovascular risk. The measures that depend on what happens between visits sit lower: **blood-pressure control at 62.1%** across a 3,819-patient hypertension registry, and **HbA1c poor control at 32.5%** across 1,939 diabetic patients. Inside the blood-pressure measure is a 19-point spread: 56.3% in the non-Hispanic Black cohort, which is 2,347 of the 3,605 hypertensive patients measured, against 75.3% in the Hispanic cohort.[3]

Since January 1, 2026, the between-visit work that moves those measures is separately payable. The bundled code that paid health centers one flat amount for care management has been replaced by the individual chronic care management, remote monitoring and advanced primary care management codes, paid at national non-facility physician fee schedule rates **in addition to** the PPS encounter rate. The encounter is untouched.[4]

The forecast in one paragraph

A remote care service line across Mercy Care's 1,132 Medicare patients — remote physiologic monitoring, chronic care management and advanced primary care management, delivered by CoachCare and billed by Mercy Care — produces

$1,020,160 of net reimbursement over 24 months, of which Mercy Care keeps $430,994, a margin of 42.25%.

The program reaches 334 unique patients in active remote care by month 24, adds the equivalent of 3.2 full-time care-management staff without Mercy Care hiring anyone, and requires no capital outlay. Month 1 nets −$4,929 because one-time setup lands before the census builds; every month from month 2 is positive.

Three things make this panel unusual, and all three point the same way.

- **The dual mix removes the enrollment objection.** Advanced primary care management pays its highest tier for qualified Medicare beneficiaries who also carry Medicaid, and those beneficiaries cannot be billed Medicare cost-sharing at all. For most of a 63.1%-dual panel, enrollment carries no out-of-pocket surprise — the objection that slows enrollment everywhere else.

[1] HRSA Uniform Data System, CY2025 reporting year, grant H80CS00022: 18,089 total patients; 11,891 patients experiencing homelessness (65.7%); 10,531 uninsured (58.2%).

[2] HRSA Uniform Data System, CY2021 and CY2025: Medicare-primary patients 882 to 1,132; dually eligible 508 to 714; dual share of the Medicare panel 57.6% to 63.1%. Patients aged 55 to 64 in CY2025: 3,118 (1,552 aged 55 to 59 and 1,566 aged 60 to 64).

[3] HRSA Uniform Data System, CY2025 clinical quality measures: controlling high blood pressure 62.08% of 3,605 measured hypertensive patients; HbA1c poor control 32.53% of 1,977; tobacco screening and cessation intervention 90.24%; depression screening with follow-up plan 83.44%; statin therapy for cardiovascular disease prevention 80.77% (2,234 of 2,766). Blood-pressure control by race and ethnicity: non-Hispanic Black 56.3% of 2,347; Hispanic 75.3%; white 73.4%.

[4] CMS Federally Qualified Health Center payment guidance current for CY2026: the individual care-coordination codes are paid at national non-facility physician fee schedule rates, alone or with other payable services, in addition to the PPS encounter rate.

- **The clinical gap is measured, not asserted.** The blood-pressure and diabetes numbers above are Mercy Care's own federal submission. Remote monitoring produces a reading a week from patients whose next appointment may be months away, and cellular devices need no smartphone, no home internet and no fixed address.
- **The infrastructure already exists.** 33 medical respite beds, two mobile units, street medicine, shelter-embedded clinics, social-needs screening structured in Epic for 7,173 patients. This is a health center that already does the hard part — finding people and keeping hold of them.

What is missing is the billing rail and the staffing to work it. A review of CY2024 Medicare claims across every clinician enrolled under Mercy Care found no remote monitoring, no chronic care management, no advanced primary care management and no transitional care management on any professional claim. Health-center care management bills institutionally and is not visible in that file, so the accurate statement is that **no Medicare remote-care program at meaningful scale is visible in CY2024 claims** — not that no patients received such care.[5]

This report sets out the service line, the CY2026 payment mechanics, the 24-month forecast, the clinical governance behind it, and a 90-day path to the first enrolled patient.

[5] Medicare Physician & Other Practitioners by Provider and Service, CY2024, queried per clinician across all 22 clinicians enrolled under the organization's PAC identifier for the RPM, CCM, PCM, APCM and TCM code families. No clinician returns a row in any family.

1. The Health Center, and the Panel Inside the Mission

1.1 The footprint

Mercy Care operates eight HRSA-scope service-delivery sites and two mobile units, all in Fulton and DeKalb counties. The Decatur Street headquarters clinic opened in 2001 and runs 50 hours a week. Chamblee runs 52. The rest of the network is embedded where the patients already are: a clinic inside Gateway Center, Atlanta's main shelter; a clinic on the City of Refuge campus; sites at a Salvation Army location and a youth-and-family services campus. Four sites carry Medicare provider numbers.[6]

Two clinical assets matter for what follows. Mercy Care runs **33 medical respite beds** — a 19-bed men's unit at Gateway Center and a 14-bed women's unit at City of Refuge — where patients discharged from hospital recover somewhere other than the street. And it runs street medicine teams that include a psychiatrist, a nurse practitioner, a registered nurse and a case manager, working encampments day and night. Both are post-discharge infrastructure that most health centers do not have.[7]

	CY2021	CY2024	CY2025
Total patients	16,193	19,029	**18,089**
Medicare-primary patients	882	1,172	**1,132**
Dually eligible	508	679	**714**
Dual share of Medicare panel	57.6%	57.9%	**63.1%**
Patients experiencing homelessness	8,205	13,869	**11,891**

Uniform Data System reporting for grant H80CS00022. CY2025 is the most recent published reporting year.

1.2 The Medicare panel: 1,132 patients, 63.1% dually eligible

Medicare is 6.3% of Mercy Care's patients and the fastest-growing slice of the organization by payer. The panel grew 28% between 2021 and 2025 while total patients grew 11.7%. Patients aged 65 and over number 1,398. Behind them, **3,118 patients are aged 55 to 64** — the cohort that ages into Medicare over the next decade.[8]

The payer mix around that panel explains why the Medicare slice is the right place to start. Medicaid covers 4,129 patients, 10,531 are uninsured, and 2,297 carry private coverage. Of patients whose income is known, 81.4% live at or below the federal poverty level. Medicare is the one line in that mix where care management and remote monitoring pay per code, per month, from the first patient enrolled.[9]

Why the dual share is the number to watch

714 of the 1,132 Medicare patients are dually eligible. That drives two things at once: advanced primary care management pays its highest tier for qualified Medicare beneficiaries who also carry Medicaid, and those same beneficiaries are protected from Medicare cost-sharing — so the coinsurance conversation that slows enrollment in most practices does not arise for most of this panel.

[6] HRSA Health Center Service Delivery Sites file, retrieved August 2026: eight active service-delivery sites and two mobile units, with operating hours per site; four sites carry Medicare provider numbers.
[7] Mercy Care service and location listings, and Saint Joseph's Health System reporting, retrieved August 2026: a 19-bed men's medical respite unit at Gateway Center and a 14-bed women's unit at City of Refuge; street medicine team composition and operating pattern.
[8] HRSA Uniform Data System, CY2025: 1,398 patients aged 65 and over; 3,118 aged 55 to 64.
[9] HRSA Uniform Data System, CY2025 Table 4: Medicaid or CHIP 4,129; uninsured 10,531; private 2,297. Of 12,772 patients with known income, 10,392 at or below 100% of the federal poverty level.

1.3 The quality record, and the gap inside it

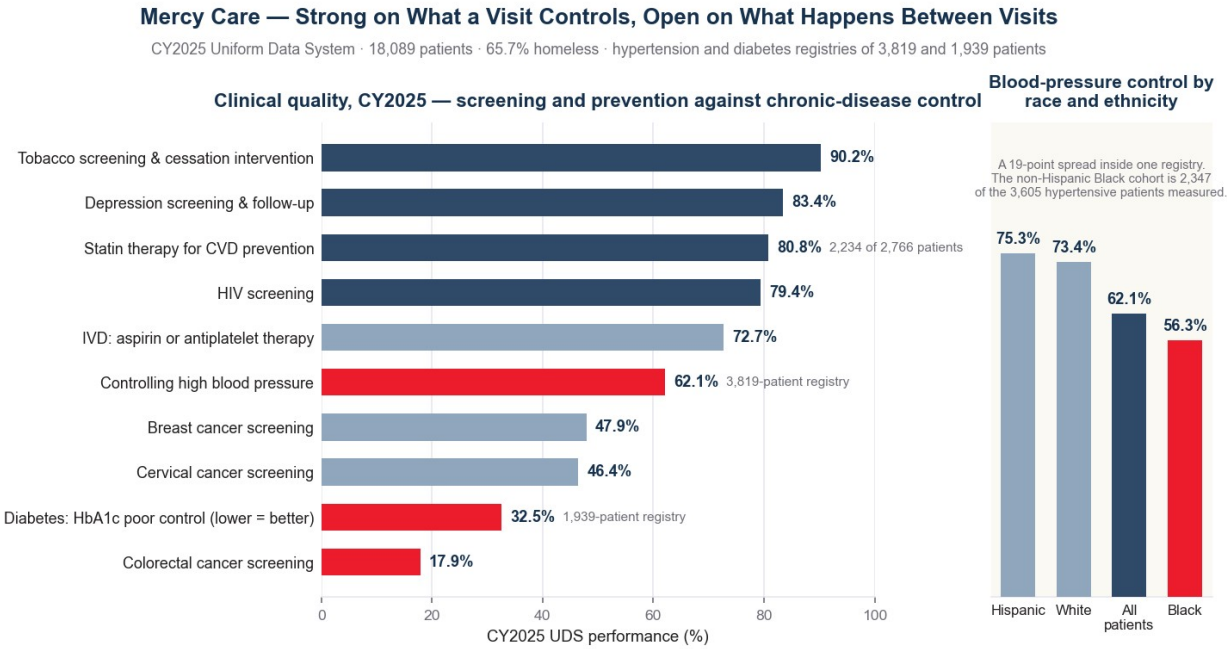

Figure 1 — CY2025 Uniform Data System clinical quality for Mercy Care, with blood-pressure control broken out by race and ethnicity.

Read the measures in two groups. The screening and prevention measures — the ones a structured visit controls — are strong: tobacco screening and cessation intervention at 90.2%, depression screening with a documented follow-up plan at 83.4%, HIV screening at 79.4%, and statin therapy for cardiovascular risk at 80.8%, covering 2,234 of 2,766 eligible patients. For a panel that is two-thirds homeless, those are the numbers of an organization with real clinical discipline.[10]

The chronic-disease control measures sit lower. Blood-pressure control reaches 62.1% of 3,605 measured hypertensive patients. HbA1c poor control — where lower is better — runs at 32.5%, meaning roughly one in three diabetic patients is above 9% or was never tested. Colorectal cancer screening reaches 17.9%.[11]

The difference between the two groups is not effort. It is what a visit can reach. Screening happens in the room. Blood-pressure and glucose control happen in the weeks between rooms — and for a patient sleeping in a shelter or an encampment, those weeks are where contact is lost. Section 5 takes the equity spread inside the blood-pressure measure and shows what a monitoring program does with it.

1.4 The market around it

Mercy Care's patients come from 117 ZIP codes across Fulton and DeKalb, concentrated downtown near Gateway Center, on the west side near City of Refuge, and in the Chamblee and Doraville corridor. Fulton County holds 161,656 Medicare beneficiaries and DeKalb 118,499.[12]

Medicare Advantage penetration runs 53.5% in Fulton and 58.9% in DeKalb. That matters for contracting rather than for this panel's size: Mercy Care's own UDS submission reports **zero Medicare managed-care member-months**, so the Medicare patients it serves sit on the traditional fee-for-service rail where

[10] HRSA Uniform Data System, CY2025 clinical quality measures, as in note 3.
[11] HRSA Uniform Data System, CY2025: colorectal cancer screening 17.87% of 5,702 eligible patients; HbA1c poor control 643 of 1,977 patients.
[12] HRSA Uniform Data System, CY2025 patient-origin ZIP table (117 ZIP codes); CMS Medicare Monthly Enrollment, CY2025: Fulton County 161,656 beneficiaries, DeKalb County 118,499.

these codes pay at published national rates. Where a Medicare Advantage plan does cover a patient, plans must pay at least the Medicare rate; individual contracts set their own terms for the care-management code families, which is a contracting item to confirm rather than a modeling assumption.[13]

[13] CMS Medicare Monthly Enrollment, CY2025: Medicare Advantage and other health-plan enrollment 53.5% in Fulton County and 58.9% in DeKalb County. HRSA Uniform Data System, CY2025 Table 4, line 13: Medicare managed-care member-months reported as zero.

2. The 2026 Billing Change for Health Centers

2.1 One bundled code became many individual ones

Until recently, a federally qualified health center billed care management through G0511 — a single bundled code paying one flat amount that covered roughly twenty distinct services, from chronic care management to remote monitoring to behavioral health integration. The rate was the same whether a health center delivered twenty minutes of care coordination or ran a full remote monitoring program.[14]

That code was retired on September 30, 2025. Since January 1, 2026, health centers bill the **individual** codes: 99490 and 99439 for chronic care management, the 99453 through 99458 family plus the CY2026 additions 99445 and 99470 for remote physiologic monitoring, and G0556 through G0558 for advanced primary care management.[15]

2.2 National rates, on top of the PPS visit

Two features of the new structure decide the economics. First, these codes pay at **national non-facility physician fee schedule rates** — the same amount at Decatur Street, at Chamblee, in a shelter clinic and on a mobile unit, with no geographic adjustment. Second, they are payable **in addition to** the PPS encounter rate rather than folded into it. A patient who comes in for a visit generates the encounter payment, and the care management delivered between visits generates its own payments on top.[16]

Code	What it pays for	CY2026 national rate
99453	Remote monitoring setup and patient education	$21.71
99454	Device supply, 16 or more days of readings	$52.11
99445	Device supply, 2 to 15 days of readings (new for CY2026)	$52.11
99457	First 20 minutes of remote monitoring management	$51.77
99458	Each additional 20 minutes	$41.42
99470	Remote monitoring management, 10 to 19 minutes (new for CY2026)	$26.05
99490	Chronic care management, first 20 minutes	$66.13
99439	Chronic care management, each additional 20 minutes	$50.44
G0556	Advanced primary care management, one chronic condition	$16.37
G0557	Advanced primary care management, two or more conditions	$53.78
G0558	**Advanced primary care management, QMB dual with two or more conditions**	**$117.24**

CY2026 national non-facility physician fee schedule rates, as used in the forecast in Section 4.

2.3 The work the change creates, and who carries it

Unbundling created revenue and work in the same stroke. Under one bundled code, one monthly entry sufficed. Under individual codes, each program carries its own time capture and its own documentation, every month, for every enrolled patient — and the time has to be substantiated when a payer asks. For a health center with a lean billing operation, that administrative load is the reason a program does not get started.

[14] CMS guidance on the G0511 care-management code for federally qualified health centers and rural health clinics, and the CMS notice of its transition ending September 30, 2025.

[15] CY2026 Medicare physician fee schedule: the 99453 through 99458 remote physiologic monitoring family with 99445 and 99470 added for CY2026; 99490 and 99439 for chronic care management; G0556 through G0558 for advanced primary care management.

[16] CMS Federally Qualified Health Center payment guidance current for CY2026, as in note 4: no geographic adjustment applies to these codes when billed by a health center, and payment is in addition to the PPS visit.

That load is what CoachCare absorbs. The enrollment, the devices, the monthly monitoring contact, the escalation handling, the documentation and the claim generation are delivered by CoachCare staff working inside Mercy Care's own Epic environment. Mercy Care supplies the panel and the clinical decisions, and bills under its own enrollments.

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

3.1 The clinical and billing stack

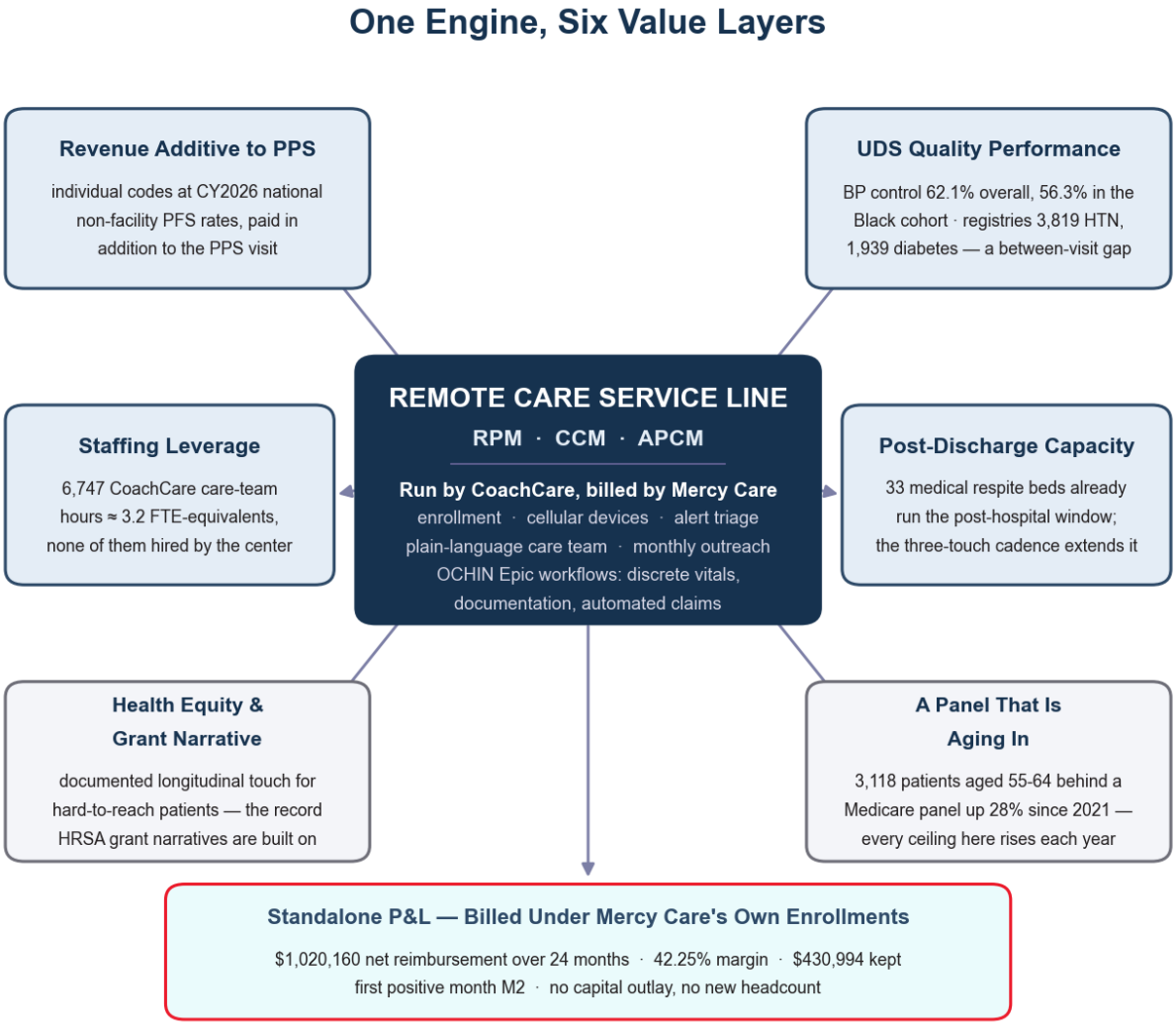

Figure 2 — the service line and the value layers it produces.

Three programs run on one enrollment engine and one care team.

- **Remote physiologic monitoring** puts a cellular blood-pressure cuff or glucose meter in the patient's hands. Readings transmit on their own. The care team reviews them, contacts the patient when a reading is out of range, and documents the monitoring time. It reaches 65% of the panel in the model and can be billed alongside either care-management program.
- **Chronic care management** is monthly non-face-to-face management for patients with two or more chronic conditions. In a panel carrying 3,819 hypertension and 1,939 diabetes diagnoses, that describes most of the Medicare population.
- **Advanced primary care management** pays a monthly per-patient amount tiered by complexity, with no minute thresholds and no time sheets. It is the newest of the three and the one this panel is built for.

Chronic care management and advanced primary care management do not stack

The two codes cannot be billed for the same patient in the same month. The forecast treats them as a partition rather than a layer: advanced primary care management takes the dual-eligible slice where the top tier pays most, chronic care management takes the remainder, and remote monitoring sits on its own share because it can be billed with either. That is why 512 program enrollments belong to 334 patients.

3.2 APCM and the dual-eligible panel

Advanced primary care management has three tiers. G0556 pays $16.37 a month for a patient with one chronic condition. G0557 pays $53.78 for two or more. G0558 pays **$117.24** for a qualified Medicare beneficiary — a dually eligible patient in the category where Medicaid covers Medicare cost-sharing — who also has two or more chronic conditions. The top tier pays more than seven times the bottom one.[17]

With 714 of 1,132 patients dually eligible, this panel sits where that tier concentrates. The forecast models a tier mix of 10% at the first tier, 50% at the second and 40% at the third, which produces a blended $69.86 per enrolled patient-month. The exact share of the 714 that falls in the qualified beneficiary category is a number Mercy Care can pull from its own eligibility file, and it is the single input most worth confirming before launch.

The cost-sharing protection matters as much as the rate. A qualified Medicare beneficiary cannot be billed Medicare deductibles or coinsurance. For most of this panel, enrolling in a monthly care-management program creates no patient bill — which removes the most common reason patients decline.

3.3 The starting position: whitespace, honestly bounded

Every clinician enrolled under Mercy Care's organizational identifier was swept against the CY2024 Medicare Physician & Other Practitioners files for remote monitoring, chronic care management, principal care management, advanced primary care management and transitional care management. **No clinician shows any of those code families**. Only one of the 22 enrolled clinicians appears in the file at all, with 11 beneficiaries and $152 of allowed charges across the year.[18]

That result needs its limits stated. Health-center services bill institutionally, under the organization rather than the individual clinician, and the bundled care management code returns no rows in this file for any provider in the country. CMS also suppresses any clinician-and-code line covering fewer than eleven patients. The defensible reading is that **no Medicare remote-care program at meaningful scale is visible in CY2024 claims**, not that no patient received such care.

One signal points the other way and is worth raising early. Mercy Care's own CY2025 HRSA submission lists remote patient monitoring among the telehealth modalities it uses, in primary care and behavioral health. No billing trace corresponds to it. Whatever sits behind that entry — a device-lending arrangement, a grant-funded pilot, a behavioral health tool — is the starting point for the program rather than a conflict with it, and it is the first question in Section 8.4.[19]

3.4 Staffing: 3.2 full-time equivalents, none of them hired

The program delivers **6,747 hours of care-team time over 24 months**, the equivalent of 3.2 full-time staff, without Mercy Care adding a position. That includes a CoachCare-funded on-site enrollment specialist who works the highest-volume sites, telephonic outreach covering the rest of the network, the monthly monitoring contacts, and the documentation behind every billed code.

[17] CY2026 Medicare physician fee schedule national non-facility rates: G0556 $16.37, G0557 $53.78, G0558 $117.24 per patient per month.

[18] Medicare Physician & Other Practitioners by Provider, CY2024: one of 22 enrolled clinicians appears, with 11 beneficiaries and $152.32 of Medicare allowed charges.

[19] HRSA Uniform Data System, CY2025 other-data-elements section: telehealth modalities in use include live videoconferencing and remote patient monitoring, across primary care and behavioral health.

The enrollment specialist is carried at CoachCare's expense. It is not a line item Mercy Care pays and it is not netted out of the margin figures in Section 4. Its value is measurable: running the same model with no enrollment specialist produces **$931,737 of net reimbursement instead of $1,020,160** — the funded position is worth $88,423 over the 24 months, because the same patient ceilings are reached sooner.

3.5 Devices built for a panel without stable housing

The devices are cellular. They transmit over their own built-in connection, so they need no smartphone, no home internet, no app and no fixed address — the four assumptions that make most remote monitoring programs unusable for a panel where 65.7% of patients experienced homelessness during the year and 2,212 were unsheltered.[20]

That fit is the difference between a program that enrolls this panel and one that screens it out. It also extends naturally to where Mercy Care already reaches patients: the respite beds, the shelter clinics, the mobile units and the street medicine rounds are all places a device can be issued and a reading can be reviewed.

3.6 OCHIN Epic integration: the program lives in the chart

Mercy Care runs OCHIN Epic at every site and for every provider, with a patient portal, kiosks, secure messaging and automated outreach for care-gap closure already in place. It also screens for social needs using a structured instrument, with 7,173 patients screened and results captured in the record.[21]

CoachCare builds on Epic's own workflows rather than beside them. Enrollment flags and trigger orders sit in the clinical workflow. Health history moves in both directions at intake. Device readings post as **discrete vitals on the chart**, not as scanned attachments, so they are filterable and usable in the quality reporting behind the UDS measures. An integrated care summary documents the monthly work, and claims are generated automatically by the CoachCare billing engine — the only care-management application integrated with Epic that does so. Patients begin receiving services in under five days from flag.[22]

> **One implementation note, stated plainly**
>
> Mercy Care's Epic instance is hosted by OCHIN, the community-health network, rather than run in-house. Interface work therefore goes through the OCHIN queue and OCHIN's integration governance. It is a well-travelled path and it is the first ticket in week one of the plan in Section 8.3.

[20] HRSA Uniform Data System, CY2025 Table 4: 11,891 patients experiencing homelessness, of whom 2,212 were unsheltered and 3,433 were in shelters.

[21] HRSA Uniform Data System, CY2025 health information technology section: an electronic health record installed at all service-delivery sites and used by all providers, identified as OCHIN Epic; patient portal, kiosks, secure messaging and automated care-gap outreach in use; 7,173 patients screened for social needs with results structured in the record.

[22] CoachCare Epic integration overview: integrated enrollment with flags and trigger ordering, bi-directional health-history exchange, discrete vitals posted to the chart, integrated care summaries, and automated claim generation; services begin within five days of flag.

4. Value Analysis: The 24-Month Forecast

4.1 The headline economics

The forecast covers remote physiologic monitoring, chronic care management and advanced primary care management across the 1,132 Medicare-primary patients in the CY2025 Uniform Data System count, at CY2026 national non-facility fee-schedule rates, with 14 referring adult-medicine prescribers and one on-site enrollment specialist.[23]

	Year 1	Year 2	24 months
Net reimbursement	**$441,878**	**$578,283**	**$1,020,160**
CoachCare fees	$260,042	$329,124	$589,166
Net to Mercy Care	**$181,835**	**$249,159**	**$430,994**
Margin to Mercy Care	41.15%	43.09%	**42.25%**

The margin moves from 41.15% in year one to 43.09% 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: **$578,283 of net reimbursement, $249,159 of it kept, at 43.09%**.

4.2 Where the revenue comes from

Program	Year 1	Year 2	24 months	Share
Remote physiologic monitoring	$209,142	$298,078	**$507,220**	49.7%
Chronic care management	$143,540	$180,612	**$324,152**	31.8%
Advanced primary care management	$89,195	$99,593	**$188,788**	18.5%
Total net reimbursement	**$441,878**	**$578,283**	**$1,020,160**	100%

Net reimbursement by program and year, CoachCare Value Analysis. Rows and columns sum as printed.

Remote monitoring carries just under half the revenue because it reaches the widest slice of the panel — 258 active enrollments at month 24, at $97.41 per enrolled patient-month. Chronic care management earns the most per patient-month, $110.75, across 136 enrollments. Advanced primary care management adds $69.86 across 119 enrollments; it is the smallest revenue line, and the one the dual mix makes stronger here than in most panels. The **512 active program enrollments at month 24 belong to 334 unique patients**, because a patient can hold a monitoring enrollment and a care-management enrollment at the same time.

Remote monitoring's total includes the two codes new for CY2026 — 99445 and 99470 — worth $94,969 of gross reimbursement over the 24 months, 9.3% of the program. Partial and short months produce claims now, and a newly enrolled panel has many of them.

[23] CoachCare Value Analysis, August 2026, built on the CY2025 Uniform Data System Medicare-primary count of 1,132 patients at CY2026 national non-facility physician fee schedule rates.

4.3 The ramp, month by month

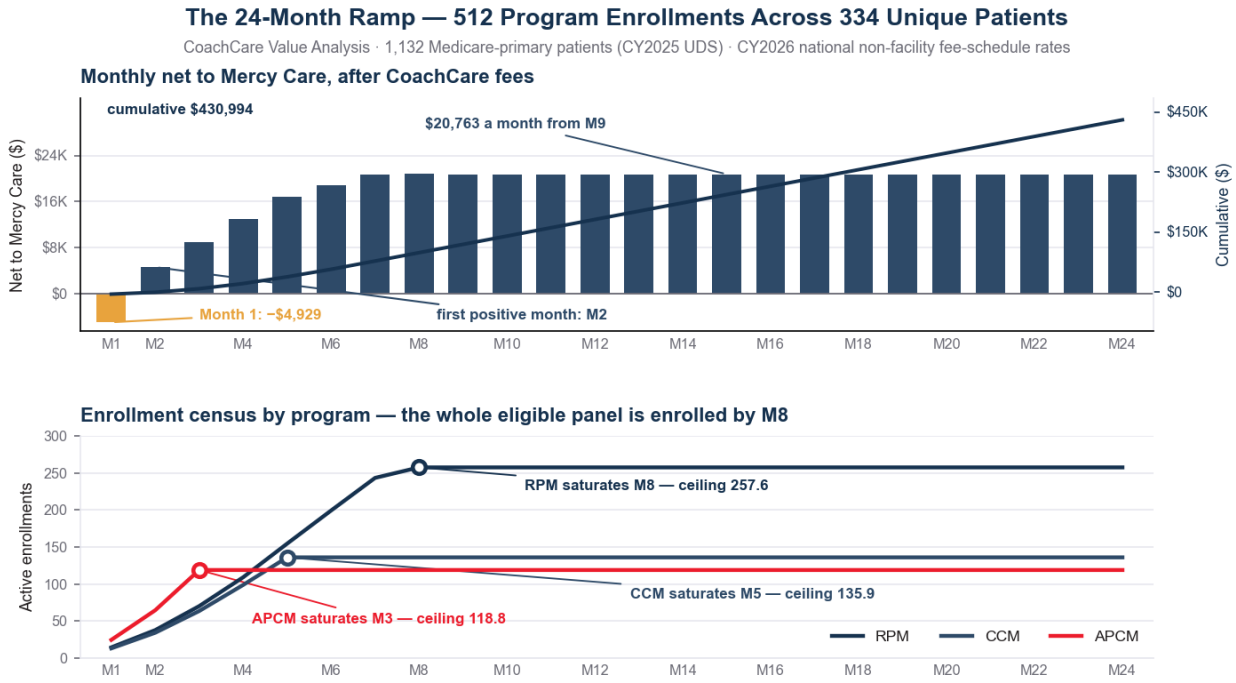

Figure 3 — monthly net to Mercy Care after CoachCare fees, with cumulative net overlaid, and the enrollment census by program with saturation months marked. CoachCare Value Analysis.

Month 1 nets **−$4,929**, because implementation and the Epic integration setup are one-time costs that land in that month against a census still building. The first positive month is **M2**, at $4,634, and month 1's shortfall is repaid inside the first quarter. The program reaches its steady state of $20,763 a month from M9, once the last remote-monitoring enrollments land.

Month	Net reimbursement	CoachCare fees	Net to Mercy Care
M1	$4,768	$9,698	**−$4,929**
M2	$12,352	$7,718	**$4,634**
M3	$22,710	$13,792	$8,918
M6	$43,455	$24,545	$18,909
M9	$48,190	$27,427	$20,763
M12	$48,190	$27,427	$20,763
M18	$48,190	$27,427	$20,763
M24	$48,190	$27,427	**$20,763**

Selected months from the 24-month series. Rows subtract as printed.

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

Every program in this forecast reaches its ceiling inside the first eight months. Advanced primary care management saturates at month 3 at 119 enrollments, chronic care management at month 5 at 136, and remote monitoring at month 8 at 258. After that the census is flat, and revenue is flat with it.

The binding constraint is worth naming plainly: **it is the size of the Medicare panel, not enrollment capacity**. Fourteen prescribers referring into a 1,132-patient panel exhaust the eligible population quickly.

Adding referral capacity or enrollment staff reaches the same ceilings sooner — worth real money, as Section 4.6 shows — but cannot raise them.

Two things raise them. The first is the panel itself, which grew 28% between 2021 and 2025 and has 3,118 patients aged 55 to 64 behind it; every ceiling in this model rises as that cohort ages in. The second is scope: the same devices, the same care team and the same escalation engine serve the rest of Mercy Care's 18,089 patients whenever a payment rail exists for them, which Section 7 takes up.

4.5 What the program produces clinically and operationally

Over 24 months	Value
Physiologic readings captured	**54,675**
Claims generated, coded and documented	**15,648**
CoachCare care-team hours delivered	**6,747**
Full-time-equivalent capacity added	**3.2**
Hospitalizations avoided	**34.7**
Value of avoided hospitalizations at $15,000 each	**≈ $520,700**

Clinical and operational output of the modeled program, CoachCare Value Analysis.

The avoided-hospitalization value belongs to payers and to the health system rather than to Mercy Care's revenue line, so it is excluded from every dollar figure in Sections 4.1 through 4.3. It is included here because it is what the program is clinically for, and because it is the number that matters in a grant narrative and in any future conversation about shared savings.[24]

4.6 What moves the forecast

Each of the following is a full re-run of the model with one input changed. The margin holds between 41.88% and 42.42% across all of them, so none requires repricing.

Change	24-month net reimbursement	Difference
Base case — 1,132 panel, 14 prescribers, 1 specialist	**$1,020,160**	—
No enrollment specialist	$931,737	**−8.7%**
Two enrollment specialists	$1,055,798	+3.5%
Panel of 1,398 — the current 65-and-over count	$1,226,206	**+20.2%**
In-scope 800 — a narrower billable slice	$744,873	**−27.0%**

Measured sensitivities, each a full recalculation of the Value Analysis.

Two of these deserve comment. The enrollment specialist is worth $88,423 even though the program is ceiling-limited — more enrollment capacity reaches the same ceilings sooner, and the extra patient-months are real revenue. And the in-scope figure is the input most worth pinning down: the model bills the full 1,132-patient Medicare count, and the share of that count actually available on the fee-for-service rail is a number Mercy Care's own eligibility file answers in an afternoon.

[24] CoachCare Value Analysis: 34.7 hospitalizations avoided over 24 months, valued at $15,000 each, derived from remote-monitoring patient-months. The value accrues to payers and to the health system and is excluded from all revenue and margin figures in this report.

5. The Equity Gap the UDS Already Measures

Mercy Care's CY2025 submission reports blood-pressure control by race and ethnicity. The overall figure is 62.1%. Underneath it: **56.3% in the non-Hispanic Black cohort**, which is 2,347 of the 3,605 hypertensive patients measured — the largest group in the registry — against 75.3% in the Hispanic cohort and 73.4% in the white cohort. A 19-point spread inside one measure, inside one organization, on one panel.[25]

That spread is not a statement about the care delivered in the exam room. The same clinicians, protocols and medications serve all three groups, and the screening measures show no comparable gap. It is a statement about what happens after the patient leaves — whether a medication gets filled and taken, whether a side effect gets reported before it becomes a reason to stop, whether a rising pressure is seen at all before the next appointment.

> **What a monitoring program does to that gap**
>
> A cellular cuff produces roughly a reading a week instead of a reading a quarter. A monthly care-management contact catches the medication that was never filled and the side effect that stopped it. Neither requires the patient to come in, own a smartphone, or have an address — which is precisely why the intervention lands hardest in the cohort where visit-based care reaches least.

The same argument applies to diabetes. HbA1c poor control runs at 32.5% across 1,939 patients, and that measure counts patients who were never tested alongside those above 9%. For an unstably housed panel, "never tested" and "out of contact" are frequently the same patient. Continuous glucose or blood-pressure data plus a monthly touch is the standard intervention for both, and under the CY2026 rules it is billable under all three programs modeled in Section 4.

Two practical consequences follow. The UDS measures are the scoreboard Mercy Care is already judged on, so improvement shows up where it is visible to HRSA. And the documented longitudinal touch a monitoring program produces — dated, coded, attributable contact with hard-to-reach patients — is exactly the evidence a health center's grant narrative is built from.

[25] HRSA Uniform Data System, CY2025 Table 7, controlling high blood pressure by race and ethnicity, as in note 3.

6. Clinical Governance & Escalation

The economics prove the service line pays. This section is what keeps it safe, and what lets 14 busy clinicians delegate monitoring without inheriting an alert queue.[26]

6.1 One shared escalation engine

Every reading from every device routes through one set of rules. There is no per-program logic and no per-clinician variation.

- An out-of-range reading is retaken and paired with a symptom check before anything escalates. A single high number is a measurement; a confirmed one is a finding.
- **Critical values escalate regardless of symptoms.** A patient who feels fine with a critical reading still escalates.
- Trends are defined objectively: three readings at least an hour apart for blood pressure or glucose, or three within seven days for heart rate. Not a judgment call, and not a different threshold depending on who is working.
- An unreachable patient still escalates. Voicemail and a callback attempt are logged, and a critical value or confirmed trend escalates anyway. Silence never closes a case — a discipline this panel demands more than most.
- Every escalation documents the same six things: the vital, the findings, the method of contact, who was reached, the outcome, and the follow-up. That record is also what substantiates the billed time.

6.2 The emergent pathway

Chest pain, new shortness of breath, stroke signs, syncope, a worst-ever headache or sudden swelling trigger a 911 call with the patient still on the line. If the patient refuses, the care team routes them to the clinic; if they refuse that, CoachCare activates 911.

> **The policy that is not configurable**
>
> **CoachCare's urgent and emergent policy supersedes any client-specific escalation preference.**
>
> It cannot be adjusted in configuration or waived by agreement. That is what allows a practice to delegate monitoring without inheriting the risk that comes with it.

6.3 Three-way routing

Findings route three ways so the clinic sees signal rather than noise. Emergencies go to 911. Non-critical findings go to a named member of the practice team, agreed during configuration. Stable and resolved findings go into the record as information, so no one is paged about a reading that resolved itself.

6.4 The post-discharge three-touch cadence

Any emergency-department visit or hospitalization in the previous sixty days triggers a fixed sequence: a call on day one or two, a second on day five to eight, and a third on day twelve to fourteen. Those three touches are where the 34.7 avoided hospitalizations in the forecast come from.

This is the part of the program that fits Mercy Care's existing operation most directly. The 33 medical respite beds already run the post-hospital window for the patients who need somewhere to recover; the

[26] 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.

three-touch cadence extends the same discipline to every monitored patient, including those who leave the hospital with nowhere to go.

6.5 Continuity and discharge governance

An unreachable patient is re-escalated on a fixed cadence rather than quietly dropped, and the practice is notified at every decision point — including the decision to discharge a patient from the program. For a panel where contact is genuinely hard to keep, a documented re-contact schedule is the difference between a patient who is unreachable this week and a patient who is lost.

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

Medicare is 6.3% of Mercy Care's patients. The obvious question is what happens to the other 93.7%, and the answer in Georgia is specific.

Georgia Medicaid does not reimburse remote patient monitoring as a separate service. The state's telehealth guidance contains no remote-monitoring provision and no chronic-care-management provision for health centers, and the current health-center manual treats telephone and electronic contact as not separately billable. A health center may serve as an originating site for a telehealth visit; that is a different thing from a monitoring program.[27]

So the sequencing is decided by the payment rules rather than by preference. **Medicare is the rail that pays code by code, from month one, at the same national rate at every Mercy Care site**. It funds itself from month two and requires no capital. Building there first means the devices, the enrollment workflow, the escalation engine and the documentation templates all exist and are proven before any conversation about extending them.

Two things then grow the footprint without a rule change. The Medicare panel itself is growing, with 3,118 patients aged 55 to 64 behind the current 1,132. And the infrastructure is payer-agnostic: a cuff issued at a respite bed, a reading reviewed by a care manager, an escalation routed to a clinician — none of that changes by payer. If Georgia's rules change, or if a managed-care contract creates a rail, the program extends rather than restarts.

[27] Georgia Department of Community Health telehealth guidance and the current Federally Qualified Health Center and Rural Health Clinic services manual: no separate remote-patient-monitoring or chronic-care-management payment for health centers; telephone and electronic communication do not constitute a separately billable visit; health centers may serve as originating sites for telehealth.

8. Implementation and the First 90 Days

8.1 Who runs what

CoachCare delivers	Mercy Care provides
Cellular devices, shipped and replaced as needed	The Medicare panel and the clinical decisions
On-site enrollment specialist, at CoachCare's expense	Agreement on which sites start
Telephonic enrollment across the rest of the network	A named clinical contact for escalations
Monthly monitoring contacts and care-management time	Access to the OCHIN Epic environment for the interface
Alert triage and escalation under the Section 6 rules	Billing under Mercy Care's own enrollments
Documentation and automated claim generation	Clinical oversight

8.2 The model inputs

Input	Value	Basis
Medicare panel	1,132	CY2025 UDS Medicare-primary count
Dually eligible	714 (63.1%)	CY2025 UDS
Referring prescribers	14	2 family practice and 3 internal medicine physicians, 9 family nurse practitioners
On-site enrollment specialists	1	CoachCare-funded
Rate basis	CY2026 national non-facility PFS	The statutory rail for health-center care-management billing
Electronic health record	OCHIN Epic	Verified in UDS reporting
Program eligibility	65% RPM, 40% CCM, 35% APCM	Health-center eligibility row
Enrollment acceptance	35% RPM, 30% CCM and APCM	Standard model assumption

8.3 The 90-day plan

Week 1 — confirm the panel and open the OCHIN ticket.

Pull the exact Medicare and dual-eligible counts from the practice management system, submit the interface request into the OCHIN queue, and agree which sites start. Decatur Street and Chamblee carry the deepest Medicare concentration and are the natural first two.

Weeks 2 and 3 — build the interface and configure.

Enrollment flags and trigger orders built into the existing workflow, discrete vitals mapped to the chart, escalation routing set to Mercy Care's own contacts, documentation templates mapped to the CY2026 individual-code requirements, plain-language enrollment materials prepared in the languages the panel needs, devices staged, and the on-site enrollment specialist placed.

Week 4 — first patients enrolled.

Enrollment begins in month 1; there is no dormant onboarding period. Telephonic outreach and the shelter clinics extend reach beyond the first sites immediately.

Months 2 through 8 — the eligible population enrolls.

Advanced primary care management reaches its ceiling in month 3, chronic care management in month 5, remote monitoring in month 8. From there the program grows with the panel, and the conversation turns to the respite beds, the mobile units and the rest of the mission.

8.4 What we would confirm together

- **The billable Medicare slice.** The forecast bills the full 1,132-patient Medicare count. The share genuinely available on the fee-for-service rail is the input that moves the answer most, and it comes from Mercy Care's own eligibility file.
- **The qualified-beneficiary share of the 714 duals.** This sets how much of the advanced primary care management census bills at the top tier rather than the middle one.
- **What sits behind the remote-monitoring entry in the UDS submission.** Whatever is already running becomes the starting point rather than something the program duplicates.
- **The OCHIN interface path.** Which queue, which governance step, and what the realistic build window is.

1. **The clinical escalation contact.** Which role receives non-critical findings, and during which hours.

9. Recommendations

1. Build the Medicare service line first, and start it this year.

It is the only rail in Georgia that pays for this work code by code today. It produces $1,020,160 of net reimbursement over 24 months with $430,994 retained, needs no capital and no new positions, and is positive from month 2. It is also recurring revenue that is not grant revenue, which is worth something on its own.

2. Start where the Medicare patients are concentrated, not everywhere at once.

Decatur Street and Chamblee first, with telephonic outreach covering the rest of the network from day one. The on-site specialist works the highest-volume site; the shelter clinics, respite beds and mobile units come in as the workflow settles.

3. Point the program at hypertension first.

The 3,819-patient hypertension registry is the largest chronic cohort, blood-pressure control is the measure with the widest equity gap, and blood pressure is the vital remote monitoring moves fastest. Diabetes follows on the same infrastructure.

4. Pull the eligibility detail before launch, not after.

The fee-for-service share of the 1,132 and the qualified-beneficiary share of the 714 duals are the two inputs that move the forecast most. Both come from files Mercy Care already holds.

5. Treat the avoided-admission figure as mission evidence, not revenue.

34.7 avoided hospitalizations over 24 months, worth roughly $520,700, accrue to payers rather than to Mercy Care. They belong in the grant narrative and in any future value-based conversation — which is where documented, dated, longitudinal contact with hard-to-reach patients carries the most weight.

References & Data Sources

- **HRSA Health Center Program records** (retrieved August 2026): the Uniform Data System awardee profile for grant H80CS00022, CY2021 through CY2025, for total patients, payer mix, the Medicare-primary and dually-eligible counts, age distribution, special-population counts, the language-access share, the chronic-disease diagnosis counts, the clinical quality measure set and its breakdown by race and ethnicity, the health information technology responses covering the electronic health record and telehealth modalities, and the social-needs screening counts; and the HRSA Health Center Service Delivery Sites file, for the eight active service-delivery sites, the two mobile units, their operating hours and the site-level Medicare certifications. CY2025 is the most recent published reporting year.
- **CMS provider and claims files** (retrieved August 2026): the Doctors & Clinicians national file, rolled up on the organization's PAC identifier, for the 22 Medicare-enrolled clinicians and the specialty composition behind the 14-prescriber referral input; and the Medicare Physician & Other Practitioners by Provider and by Provider and Service files, 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. CMS suppresses clinician-and-code lines under 11 beneficiaries, and health-center care management bills institutionally, so absence in this file bounds the claim rather than proving it.
- **Medicare payment rules for health centers:** the CMS Federally Qualified Health Center payment guidance current for CY2026, for payment of the individual care-coordination codes at national non-facility physician fee schedule rates in addition to the PPS visit; the CMS notice of the G0511 transition ending September 30, 2025; and the CY2026 physician fee schedule for the 99445 and 99470 remote-monitoring codes and the G0556 through G0558 advanced primary care management tiers.
- **Georgia Medicaid coverage:** the Georgia Department of Community Health telehealth guidance and the current Federally Qualified Health Center and Rural Health Clinic services manual, for the absence of separate remote-patient-monitoring and chronic-care-management payment for health centers, the originating-site rules, and the treatment of telephone and electronic communication.
- **Market and population sources:** CMS Medicare Monthly Enrollment data for CY2025, for the Fulton and DeKalb County beneficiary counts and Medicare Advantage penetration; and the American Community Survey five-year estimates for 2020 through 2024, for county population, age structure, poverty and uninsured rates.
- **CoachCare Value Analysis, August 2026:** the 24-month forecast, its per-program net reimbursement, fee and margin figures, the monthly enrollment census and economics series, the program ceilings and saturation months, the clinical and operational output figures, and the measured sensitivities in Section 4.6, each of which is a full recalculation of the model with one input changed.
- **CoachCare Care Management standard operating procedures, March 2026:** the alert and escalation decision logic, trend definitions, emergent and urgent communication protocol, escalation routing, post-discharge cadence and discharge governance reproduced in Section 6.