



Jackson-Hinds Comprehensive Health Center

A Federally Qualified Health Center serving central Mississippi since 1970

COACHCARE | SERVICE LINE STRATEGY

The largest health center in Mississippi: 49,054 patients in 2025 across Hinds, Warren, Copiah, Rankin and Sharkey-Issaquena counties, from permanent clinics, a homeless clinic, mobile units and school-based clinics

Remote Care Service Line Performance & Optimization

2026 Strategy Report

Remote physiologic monitoring, chronic care management and advanced primary care management for the health center's 6,578 Medicare patients, billed on top of the PPS encounter at national amounts and staffed by CoachCare, for a health center that has carried two-sided accountable-care risk since 2020

Purpose of this document

Prepared by CoachCare, October 2026, as a discussion document for the leadership of Jackson-Hinds Comprehensive Health Center. It brings together the health center's own HRSA record, the Medicare structure of Hinds County and its neighbors, the billing rules a health center has worked under since January 2025, a 24-month Value Analysis for a remote care service line on the Medicare panel, the accountable-care risk the health center already carries, the clinical governance that would run the program, the eClinicalWorks integration it lives in, the Mississippi Medicaid rail beside it, and the access design a five-county footprint calls for.

The argument is short. Jackson-Hinds is the largest health center in the state, 44% of its Medicare patients are dually eligible, and it has carried two-sided accountable-care risk for six years. Since 2025 Medicare pays a health center for the month of care between visits as its own codes, at national amounts, on top of every visit. Two of the three programs fill inside fifteen months; remote monitoring is still enrolling at month 24, so enrollment capacity is the lever. The enrollment and engagement labor is ours.

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Table of Contents

Executive Summary.....	3
1. The Health Center Today.....	5
1.1 Fifty-five years in Jackson and central Mississippi.....	5
1.2 A national quality leader on heart and diabetes health.....	5
1.3 Two-sided accountable-care risk, and the month between visits.....	6
2. What Changed: A Health Center Now Bills the Month Between Visits.....	6
2.1 G0511 is gone; the individual codes pay on top of the PPS encounter.....	6
2.2 What the codes pay a health center.....	7
2.3 The work the change creates, and who carries it.....	8
3. The Service Line: RPM, CCM and APCM on the Medicare Panel.....	8
3.1 The clinical and billing stack.....	8
3.2 A dual-eligible panel, and what APCM pays for it.....	9
3.3 The accountable-care layer: why the same engine matters twice.....	9
3.4 The Medicare panel it runs on.....	10
3.5 Transitional care at the hospital discharge, named and not in the forecast.....	10
3.6 Behavioral health integration: the next arm, named.....	10
3.7 Built the way the codes work: a bench led by nurse practitioners.....	11
3.8 Staffing: nobody is hired.....	11
4. Value Analysis: The 24-Month Forecast.....	11
4.1 Headline economics.....	11
4.2 Program economics by year.....	12
4.3 The ramp: two programs fill, remote monitoring is still enrolling.....	13
4.4 What the program produces.....	14
5. The Second Rail: Mississippi Medicaid Covers Remote Monitoring.....	14
6. eClinicalWorks Integration: The Program Lives in the Record.....	15
7. Clinical Governance and Escalation.....	16
7.1 A monitoring program is a clinical operation first.....	16
7.2 One shared escalation engine.....	16
7.3 The emergent pathway.....	16
7.4 Qualification, device assignment and routing.....	16
7.5 The post-discharge cadence.....	16
7.6 Discharge governance and continuity.....	17
8. Built for Five Counties: Community and Access Design.....	17
9. Market Context: Hinds County Medicare.....	18
10. The CY2027 Proposed Rule, Repriced on This Forecast.....	19
11. Implementation and the First 90 Days.....	20
11.1 Who runs what.....	20
11.2 Model inputs.....	20
11.3 The 90-day plan and the operating dashboard.....	20
12. Recommendations.....	21
13. The Ask: A Working Session.....	22
About CoachCare.....	23
References and Data Sources.....	23

Executive Summary

Jackson-Hinds Comprehensive Health Center has served Jackson and central Mississippi since 1970 and is the largest health center in the state. Its 2025 Uniform Data System report counts 49,054 patients across 42 sites serving Hinds, Warren, Copiah, Rankin and Sharkey-Issaquena counties: permanent clinics, a homeless clinic, six mobile units and about 20 school-based clinics.¹ 6,578 of those patients carry Medicare as their primary coverage, and 2,869 of them, 43.6%, are dually eligible for Medicare and Medicaid. 12,435 patients carry a hypertension diagnosis and 5,857 diabetes.² Controlled blood pressure reached 63.1% in 2025, up from 49.0% in 2021, and HRSA lists the health center as a 2026 National Quality Leader for heart health, diabetes health and behavioral health.³

Two facts sit next to each other. Since 2020 the health center has been part of the statewide health-center Medicare Shared Savings Program ACO, on the two-sided-risk ENHANCED track, which makes it accountable for both the quality and the total cost of care of the Medicare patients assigned to it.⁴ And between visits, its 2025 report to HRSA lists real-time video as its telehealth technology and reports no remote patient monitoring, and no chronic care management or advanced primary care management program appears on its site. The care-management codes pay for exactly the between-visit work the ACO's cost line depends on. This is a structural observation, not a criticism.

Hinds County's Medicare is 54.5% Medicare Advantage (June 2026) and the share rises about a point a year.⁵ Medicare Advantage plans reimburse these code families at no less than the Medicare amount; that floor is set by law, and individual contracts set their own terms for the care-management code families.

The observation this report is built on

Jackson-Hinds is the largest health center in Mississippi, and 44% of its Medicare patients are dually eligible, the panel Medicare's advanced primary care management codes pay most for. It has carried two-sided accountable-care risk since 2020 and moved blood-pressure control fourteen points in four years. Since 2025 Medicare pays a health center for the month between visits as its own codes, at national amounts, on top of every visit, and those amounts sit above what a Mississippi physician office is paid for the same work. The enrollment and engagement labor is ours.

G0511, the bundled code health centers used for care management, was retired on a 2025 transition. Since January 1, 2025 a health center bills chronic care management, remote physiologic monitoring and advanced primary care management as individual codes at national non-facility Physician Fee Schedule amounts, in addition to the PPS encounter.⁶ The short-window remote monitoring codes new for 2026 (99445, 99470) fit the weeks after a hospital discharge. Mississippi Medicaid covers remote patient monitoring for chronic conditions in the patient's home.⁷

¹ HRSA Uniform Data System, 2025 reporting year (per-center file, May 2026 release): 49,054 patients, the largest health center in Mississippi by patients. HRSA Health Center Service Delivery Sites file, October 2026: 42 active sites. Counties served per the health center's own site.

² HRSA Uniform Data System 2025: Medicare as primary coverage 6,578 (13.4% of patients), of whom 2,869 dually eligible (43.6%); patients with a hypertension diagnosis 12,435; with diabetes 5,857.

³ HRSA Uniform Data System clinical quality measures: controlling high blood pressure 63.1% (2025), 49.0% (2021). HRSA health center profile, 2026 National Quality Leader recognitions: heart health, diabetes health, behavioral health.

⁴ CMS Medicare Shared Savings Program participant records, performance year 2026, and the annual participant lists from 2020: the health center (by its legal entity) is a named participant on the ENHANCED track, the program's two-sided-risk track, continuously since 2020. No shared-savings, benchmark or quality figure is asserted or modeled in this report.

⁵ CMS Medicare Monthly Enrollment, Hinds County, June 2026: 45,715 beneficiaries; Medicare Advantage and other 24,931 (54.5%); Original Medicare 20,784 (45.5%). Medicare Advantage share 53.4% (2025), 52.2% (2024), 49.3% (2023).

⁶ CY2025 Physician Fee Schedule Final Rule (CMS-1807-F, 89 FR 97710) and CY2026 Final Rule (CMS-1832-F): health centers report the individual codes for care management, remote monitoring and advanced primary care management in place of G0511, paid at national non-facility Physician Fee Schedule amounts in addition to the PPS encounter, from January 1, 2025.

⁷ 23 Miss. Admin. Code Pt. 225, Ch. 2: remote patient monitoring coverage for chronic conditions, delivered in the beneficiary's residence; coverage rule last revised effective July 1, 2021.

What the Value Analysis returns

The forecast prices a service line for the full Medicare panel in the health center's 2025 report, 6,578 patients, all in scope from the first month, referred by the 27 physicians and nurse practitioners in adult primary care and delivered by CoachCare under the health center's clinical direction, priced at the national amounts a health center is paid for these codes.⁸ Medicare Advantage members are already inside the 6,578, because the Uniform Data System counts patients by primary payer.

	Year 1	Year 2	24 months
Net reimbursement	\$1,181,393	\$2,836,688	\$4,018,082
CoachCare fees	\$691,716	\$1,611,720	\$2,303,436
Net to the health center	\$489,677	\$1,224,969	\$1,714,646
Margin to the health center	41.45%	43.18%	42.67%

CoachCare Value Analysis. CY2026 national non-facility Physician Fee Schedule amounts, the rail a health center bills care-management codes on. 6,578 Medicare patients in scope; RPM + CCM + APCM. Margin is net to the health center divided by net reimbursement.

- 1. A \$1,714,646 two-year net line on the full Medicare panel, at a 42.67% margin.** Two of the three programs reach their ceilings inside the forecast: advanced primary care management in month 8 (691 enrollments) and chronic care management in month 15 (789). Remote monitoring, the largest arm at 42% of net reimbursement, is still enrolling at month 24, with 1,398 of a 1,497-enrollment ceiling filled. At M24 the program holds 2,878 active program enrollments across 1,842 unique patients.
- 2. Enrollment capacity is the lever, and CoachCare pays for it.** Because remote monitoring is limited by enrollment pace rather than by the size of the panel, the on-site enrollment specialist moves the forecast more than any other input. Without one the line is \$814,995 smaller over 24 months. A second specialist adds \$564,496 of net reimbursement and \$239,066 net to the health center, and brings remote monitoring to its ceiling in month 20. Both specialists are on CoachCare's payroll.
- 3. The dual-eligible panel makes APCM worth more here.** With 43.6% of the Medicare panel dually eligible, the advanced primary care management tiers blend to \$69.11 per patient-month, and the arm fills in eight months.
- 4. It pays for itself from the second month, on the fee schedule.** Month 1 nets -\$4,121 because implementation lands before enrollment revenue. Month 2 nets \$6,868, month 12 nets \$78,613 and month 24 nets \$114,835 on \$267,459 of net reimbursement. The line runs on the Medicare fee schedule rather than a grant cycle: every month of care bills on its own claim, and CoachCare carries the staffing and the devices.
- 5. The accountable-care layer is why the same engine matters twice.** The forecast projects 115.1 avoided hospitalizations over 24 months, about \$1.73 million at \$15,000 per admission, the total-cost-of-care line a two-sided ACO is graded on. A documented monthly care-management service also keeps each patient's primary-care relationship on the record every month.
- 6. Nobody is hired.** CoachCare delivers 25,774 hours of care-team work over 24 months, about 12.4 full-time-equivalent years, including the on-site enrollment specialist. The program extends the health center's case-management team rather than replacing it.

⁸ CoachCare Value Analysis for Jackson-Hinds Comprehensive Health Center, 2026. Basis: CY2026 national non-facility Physician Fee Schedule amounts; 6,578 Medicare patients in scope; 27 referring clinicians; RPM, CCM and APCM.

1. The Health Center Today

1.1 Fifty-five years in Jackson and central Mississippi

Jackson-Hinds Comprehensive Health Center marked its 55th year in 2025. By the health center's own history it began with one bus and a Sunday-school classroom, and it was the first community health center in Mississippi to run a homeless clinic and school-based clinics and to deliver care through nurse practitioners.⁹ It is a Federally Qualified Health Center with community health center and health care for the homeless designations. HRSA's current scope lists 42 sites: the main health center on West Northside Drive and permanent clinics across Jackson, Utica, Edwards, Hazlehurst, Vicksburg and Flowood, a homeless clinic, six mobile units and about 20 school-based clinics, including two in Sharkey County added in 2026.¹⁰ Every site runs on eClinicalWorks.

UDS 2025	Count	What it means for the service line
Total patients	49,054	Adults 35,984 · children 13,070; the largest health center in Mississippi
Medicare as primary coverage	6,578 (13.4%)	The forecast base, all in scope from the first month
Dually eligible	2,869 (43.6% of Medicare)	Sets the advanced primary care management tier mix (Section 3.2)
Hypertension	12,435 patients	The core remote monitoring and care-management cohort
Diabetes	5,857 patients	Glucose monitoring and a monthly touch
Heart disease · COPD	1,517 · 910 patients	Weight and pulse-oximetry monitoring; care-management candidates
Medicaid and CHIP	15,497 (31.6%)	Outside the Medicare forecast; Mississippi Medicaid covers remote monitoring (Section 5)
Uninsured	14,897 (30.4%)	Outside the forecast; part of the equity case for a documented monthly touch
Patients experiencing homelessness	4,168	Served through the homeless clinic and its case managers (Section 8)

HRSA Uniform Data System, 2025 reporting year. Chronic-condition rows count patients with the diagnosis.

1.2 A national quality leader on heart and diabetes health

The compliment is earned and on the record. HRSA lists Jackson-Hinds as a 2026 National Quality Leader in three areas, heart health, diabetes health and behavioral health, with 2026 recognitions for preventive health and for advancing health information technology for quality.¹¹ Controlled blood pressure among hypertensive adults rose from 49.0% in 2021 to 63.1% in 2025, fourteen points in four years, and 5,751 of 9,111 hypertensive adults were controlled in 2025.¹² That is a team that can move a number. Continuous readings and a documented monthly touch are how the number keeps moving between visits.

⁹ The health center's own published history: incorporated in 1970; began with one bus and a Sunday-school classroom; the first community health center in Mississippi to operate a homeless clinic and school-based clinics and to deliver care through nurse practitioners. 55th anniversary, 2025.

¹⁰ HRSA Health Center Service Delivery Sites file, October 2026: 42 active sites, including permanent clinics, a homeless clinic, six mobile units and school-based clinics; two South Delta school sites in Sharkey County added in June 2026. HRSA Uniform Data System 2025: community health center and health care for the homeless funding streams; eClinicalWorks installed at all sites.

¹¹ HRSA health center profile, 2026 recognitions: National Quality Leader for heart health, diabetes health and behavioral health; preventive health; advancing health information technology for quality.

¹² HRSA Uniform Data System 2025, Table 7: 5,751 of 9,111 hypertensive adults aged 18 to 85 controlled (63.1%). Controlled-blood-pressure series 2021–2024 from HRSA's health center quality files: 49.0%, 51.3%, 54.5%, 56.3%.

Clinical quality measure, UDS 2025	Rate	Relevance to the service line
Controlling high blood pressure	63.1%	Up from 49.0% (2021) · 51.3% (2022) · 54.5% (2023) · 56.3% (2024); the cohort remote monitoring and CCM work every month
Statin therapy for cardiovascular prevention	82.0%	The cardiovascular cohort the service line manages between visits
Aspirin or antiplatelet therapy for vascular disease	81.0%	The same cohort, where medication reconciliation is a monthly CCM task
Depression screening and follow-up	88.4%	The behavioral-health population behind the named next arm (Section 3.6)
Adult BMI screening and follow-up	88.4%	Weight is a monitored reading for heart-failure patients
Tobacco screening and cessation	87.3%	Part of the care plan a CCM or APCM month documents

HRSA Uniform Data System clinical quality measures, 2025 reporting year; controlled-blood-pressure series from HRSA's health center quality files, 2021–2025.

1.3 Two-sided accountable-care risk, and the month between visits

Jackson-Hinds has been part of the statewide health-center Medicare Shared Savings Program ACO since 2020, on the two-sided-risk ENHANCED track, and every health center in Mississippi takes part in it. On that track the ACO shares in savings and in losses, so the total cost of care of the assigned Medicare patients is a real number on the health center's side of the ledger. Assignment is retrospective and follows primary-care services.¹³ Six years in, the health center has the accountable-care infrastructure: a population-health toolset, data exchange with insurers and ACOs, and automated outreach for care-gap closure.¹⁴

What sits between visits is the opening. The health center's 2025 report to HRSA lists real-time video as its telehealth technology and reports no remote patient monitoring, and no chronic care management or advanced primary care management program appears on its site.¹⁵ The 12,435 patients in the hypertension registry and the 5,857 in the diabetes registry are seen a few times a year. The care-management codes pay for the month in between, and that month is where admissions are avoided and blood pressure is controlled. The service line in this report bills that month under fee-for-service, margin-positive on its own, and it is the same work the ACO's cost line depends on.

2. What Changed: A Health Center Now Bills the Month Between Visits

2.1 G0511 is gone; the individual codes pay on top of the PPS encounter

Federally Qualified Health Centers are paid a prospective payment per qualifying encounter. For years, everything a health center did for chronic patients between those encounters was compressed into one bundled monthly code, G0511: one flat payment regardless of how many services, minutes or programs a patient carried. Since January 1, 2025 a health center reports the individual CPT and HCPCS codes instead, and Medicare pays each at the **national non-facility Physician Fee Schedule amount, in addition to the PPS encounter**. CMS allowed G0511 through September 30, 2025 and deleted it for

¹³ CMS Medicare Shared Savings Program participant records, performance year 2026 (see note 4): ENHANCED track, retrospective assignment, participant since 2020; all Mississippi health centers participate in the same ACO.

¹⁴ HRSA Uniform Data System 2025, health information technology fields: data used for population health management and quality improvement; electronic exchange with insurers and ACOs and a health information exchange; automated outreach for care-gap closure.

¹⁵ HRSA Uniform Data System 2024 and 2025, telehealth fields: real-time telehealth selected; remote patient monitoring not selected. The health center's site, as retrieved October 2026.

2026.¹⁶ Advanced primary care management opened to health centers in the same 2025 rule, also paid in addition to the PPS encounter, and the CY2026 rule added behavioral-health add-on codes to it.¹⁷

CY2026 also added two remote monitoring codes that matter after a hospital discharge: 99445 pays the device-supply month when a patient transmits 2 to 15 days of readings rather than 16 or more, and 99470 pays the first 10 minutes of monthly management time where 20 minutes is not reached. A patient discharged on the 20th of the month used to produce an unbillable partial month; now it bills. In this forecast the two codes carry \$314,931 of gross reimbursement over 24 months, about 7.8% of net reimbursement, revenue that did not exist two years ago.¹⁸

The structural consequence is the point. Between-visit care stops being a flat bundled payment and becomes a per-service revenue line that scales with enrollment and delivered work, on a panel the health center already sees, and it accrues on top of every PPS encounter rather than inside it.

2.2 What the codes pay a health center

The Value Analysis is priced at the national amounts a health center is paid for these codes: the CY2026 non-facility Physician Fee Schedule at the national conversion factor with no geographic adjustment. That is the rail a health center bills care-management codes on, and those national amounts sit above what a physician office in Mississippi is paid for the same codes.¹⁹

Code	What it pays for	Cadence	CY2026 national amount
99453	RPM setup and patient education	One-time	\$21.71
99454	Device supply, 16–30 days of readings	Monthly	\$52.11
99445	Device supply, 2–15 days of readings (new 2026)	Monthly	\$52.11
99457	RPM management, first 20 minutes	Monthly	\$51.77
99470	RPM management, first 10 minutes (new 2026)	Monthly	\$26.05
99458	RPM management, each additional 20 minutes	Monthly	\$41.42
99490	CCM, first 20 minutes of clinical staff time	Monthly	\$66.13
99439	CCM, each additional 20 minutes	Monthly	\$50.44
G0556	APCM, level 1: one chronic condition or none	Monthly	\$16.37
G0557	APCM, level 2: two or more chronic conditions	Monthly	\$53.78
G0558	APCM, level 3: two or more chronic conditions, Qualified Medicare Beneficiary	Monthly	\$117.24
99484	Behavioral health integration, first 20 minutes	Monthly	\$57.45 (named, not in the forecast)
99495 / 99496	Transitional care management, moderate / high complexity	Per discharge	Paid as a health-center visit under the PPS encounter (named, not in the forecast)

CY2026 national non-facility Physician Fee Schedule amounts, the Value Analysis basis and the rail a health center bills care-management codes on regardless of the locality its ZIP code falls in. Transitional care management is paid to a health center as a billable visit under the PPS.

¹⁶ CY2025 Physician Fee Schedule Final Rule (CMS-1807-F): individual-code reporting for health-center care management from January 1, 2025, paid at national non-facility amounts in addition to the PPS encounter. CMS MLN Connects, June 5, 2025: G0511 permitted through September 30, 2025. CMS CY2026 RHC/FQHC payment rate file: G0511 deleted for CY2026.

¹⁷ CY2025 Physician Fee Schedule Final Rule: APCM codes G0556–G0558 adopted for health centers, paid in addition to the PPS encounter. CY2026 Final Rule: APCM behavioral-health add-on codes G0568–G0570 adopted for health centers.

¹⁸ CoachCare Value Analysis, Financial Value detail: 99445 and 99470 together carry \$314,931 of gross reimbursement over 24 months against \$4,018,082 of net reimbursement (about 7.8%), on this forecast's code frequencies.

¹⁹ CY2026 Physician Fee Schedule national non-facility amounts: total non-facility relative value units times the national conversion factor of \$33.4009, with every geographic practice cost index at 1.000. Health centers bill the care-management codes at the national amount regardless of the locality their ZIP code falls in.

These are the Medicare amounts, and the forecast prices the whole Medicare panel at them. Hinds County's Medicare is 54.5% Medicare Advantage. Medicare Advantage plans reimburse these code families at no less than the Medicare amount; that floor is set by law, and individual contracts set their own terms for the care-management code families.

2.3 The work the change creates, and who carries it

Individual-code billing pays more and asks more. Each code carries its own eligibility test, consent, time capture and documentation standard, and the claim volume is real: this forecast generates 59,227 claims over 24 months. In the operating model of Section 11, CoachCare carries the load: enrollment, device logistics, monitoring, documentation and claim creation inside eClinicalWorks. The health center's billing team files the claims, and its clinicians keep the clinical decisions.

One structural note on Medicaid, because the deal design has to respect it. Mississippi Medicaid covers remote patient monitoring and does not pay chronic care management, principal care management, transitional care management, behavioral health integration or advanced primary care management.²⁰ Medicaid and CHIP cover 31.6% of the health center's patients and the uninsured another 30.4%, and none of that population is in this forecast. The Medicare forecast on these pages does not include a Medicaid dollar. Section 5 sets out the Medicaid remote monitoring rail as its own line, scoped separately.

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

3.1 The clinical and billing stack

Three programs, one infrastructure. Remote physiologic monitoring supplies the daily signal; chronic care management and advanced primary care management supply the monthly coordination wrapper. Enrollment, devices, monitoring, escalation, documentation and claims run on the same CoachCare engine for all three. Principal care management is off: a primary-care panel bills CCM or APCM, not the single-condition specialist code.

Program	Who qualifies	What it is	Billing
RPM	4,276 of the 6,578 Medicare patients (65%): hypertension, diabetes, heart failure, COPD	Cellular-connected devices (blood-pressure cuff, glucose meter, scale, pulse oximeter); readings monitored against clinical thresholds; monthly management time	99453 setup; 99454/99445 supply; 99457/99470/99458 management
CCM	2,631 (40%): two or more chronic conditions expected to last twelve months or more	Monthly non-face-to-face coordination: comprehensive care plan, medication reconciliation, referrals, outreach	99490 + 99439
APCM	2,302 (35%): an ongoing primary-care relationship; level set by condition count and Qualified Medicare Beneficiary status	Monthly bundle of practice-capability elements; no minute tracking	G0556 / G0557 / G0558
TCM	A discharge home from one of the Jackson acute-care hospitals	Contact within two business days, medication reconciliation, a face-to-face visit within 7 or 14 days	99495 / 99496 as a PPS visit, named and not in the forecast

Eligible-pool counts from the Value Analysis eligibility model; pools overlap, billing does not (see the coordination rule below).

²⁰ Mississippi Division of Medicaid fee schedule, non-covered codes (rows effective July 1, 2025): chronic care management, principal care management, behavioral health integration and collaborative care, transitional care management and advanced primary care management codes are not covered for any line of service. HRSA Uniform Data System 2025: Medicaid and CHIP 31.6%, uninsured 30.4%.

One coordination rule, set at enrollment

APCM and CCM never bill for the same patient in the same month; a patient carries one care-management wrapper, not two. RPM stacks with either. A transitional care episode runs for 30 days after a discharge and does not overlap APCM for that patient in that month. The enrollment workflow assigns each patient a wrapper (CCM or APCM) plus RPM where clinically indicated, so the code families never collide on a claim.

3.2 A dual-eligible panel, and what APCM pays for it

2,869 of the health center's 6,578 Medicare patients, 43.6%, are dually eligible for Medicare and Medicaid.²¹ That matters most for advanced primary care management, which pays by complexity tier rather than by the minute. Level 3 (G0558, \$117.24 a month) is the tier for patients with two or more chronic conditions who are Qualified Medicare Beneficiaries, a group drawn from the dual-eligible population. The Value Analysis weights the three tiers at 15%, 52% and 33% of APCM months, a blended **\$69.11 per patient-month** at the national amounts; after the model's collection adjustments the arm nets \$64.01 of reimbursement per patient-month.²²

APCM is the first program to fill. Its 691-enrollment ceiling is reached in month 8, and from then on the arm runs at full census for the remaining sixteen months of the forecast: \$887,441 of net reimbursement over 24 months with no minute-tracking burden on the care team. For a health center whose adult primary care is led by nurse practitioners and whose Medicare panel is this dual-heavy, APCM is the wrapper that pays most for the least administrative friction.

3.3 The accountable-care layer: why the same engine matters twice

The three programs are ordinary Original-Medicare fee-schedule services paid per claim, and that is the base case in Section 4: a recurring, margin-positive revenue line billed on top of every PPS encounter. The ACO does not take prospective primary-care payments, so the care-management codes bill per claim like any other Medicare service.²³ The reason they matter twice here is the risk the health center already carries. On the two-sided ENHANCED track, the cost of an avoided admission is a cost the ACO does not have to absorb.

- **A recurring, additive-to-PPS revenue line.** Every care-management dollar lands on top of the PPS encounter, not inside it: \$1,714,646 net to the health center over 24 months, positive from the second month, before any accountable-care effect is counted.
- **Total cost of care, as avoided admissions.** The forecast projects 115.1 avoided hospitalizations over 24 months, about \$1.73 million at \$15,000 per admission. On a two-sided track that is the line the ACO is measured on.
- **Attribution, held every month.** Shared Savings Program assignment follows primary-care services, and chronic care management and advanced primary care management count among them. A documented monthly care-management service keeps each enrolled patient's primary-care relationship with the health center on the record every month, between visits as well as at them.
- **The measures the health center is recognized on.** Blood-pressure control and diabetes care are where the health center holds its 2026 National Quality Leader recognitions, and they are the measures continuous readings and a monthly documented touch move directly.

²¹ HRSA Uniform Data System 2025, Table 4: Medicare 6,578; dually eligible 2,869 (43.6%).

²² CoachCare Value Analysis: APCM tier weights 15% (G0556, \$16.37), 52% (G0557, \$53.78) and 33% (G0558, \$117.24) of APCM patient-months, a blended \$69.11 per patient-month at the CY2026 national amounts; APCM net reimbursement \$64.01 per patient-month across 13,864 patient-months.

²³ CMS Medicare Shared Savings Program records, performance year 2026: the health center's ACO is not under the program's prospective primary-care payment option. Remote monitoring, chronic care management and advanced primary care management are Original-Medicare fee-schedule services billed in addition to the PPS encounter.

None of this asks the reader to believe a shared-savings projection, and the report makes none. CoachCare sits outside the ACO's own arrangements and works alongside the population-health tooling the health center already uses.

3.4 The Medicare panel it runs on

The forecast is built on **the 6,578 Medicare-primary patients** in the health center's 2025 Uniform Data System report, all in scope from the first month. The Uniform Data System counts patients by primary payer, so Medicare Advantage members are already inside that number and no gross-up is applied.²⁴ From that panel the eligibility model carves the program pools: 4,276 patients RPM-eligible (65%), 2,631 CCM-eligible (40%) and 2,302 APCM-eligible (35%). The pools overlap; the coordination rule keeps the billing disjoint.

Hinds County's Medicare is 54.5% Medicare Advantage and the share has risen about a point a year since 2023, while Rankin County, where the health center opened two Flowood sites in 2025 and 2026, is about two-thirds Original Medicare. Medicare Advantage plans reimburse these code families at no less than the Medicare amount; that floor is set by law, and individual contracts set their own terms for the care-management code families.

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

Each discharge home from one of the Jackson acute-care hospitals opens a transitional care management window: an interactive contact within two business days, medication reconciliation, and a face-to-face visit within 14 days (99495, moderate complexity) or 7 days (99496, high complexity). For a health center, Medicare pays transitional care management as a billable visit under the PPS encounter rather than as a separate fee-schedule amount.²⁵ TCM carries no dollars anywhere in this forecast; the health center's share of discharges and its visit capacity are discovery items. What TCM does here is clinical. A discharge is the highest-yield moment to enroll a patient in monitoring, the short-window codes 99445 and 99470 pay for the partial month that follows, and the three-touch post-discharge cadence in Section 7.5 runs on the same contact the TCM visit requires.

3.6 Behavioral health integration: the next arm, named

Behavioral health is already integrated here. The health center is a 2026 National Quality Leader for behavioral health, screens 88.4% of eligible patients for depression with follow-up, counts 1,615 patients with depression and other mood disorders and 1,941 with anxiety, and in 2026 opened a primary-care site on a psychiatric hospital campus in Flowood.²⁶ The obvious fourth program is behavioral health integration, 99484, \$57.45 a month at the national amount for the first 20 minutes of care-manager time under a treating clinician's plan. It runs on the same infrastructure, the same monthly cadence and the same billing engine. This forecast carries it at zero dollars and names it once, here, as the next arm.

²⁴ HRSA Uniform Data System 2025, Table 4 (patients by primary payer): Medicare 6,578. HRSA's 2025 Uniform Data System guidance places Medicare Advantage within the Medicare payer category. CoachCare Value Analysis eligibility model: RPM 65%, CCM 40%, APCM 35% of the in-scope panel.

²⁵ Medicare Benefit Policy Manual, Chapter 13, §230 and §230.1 (rev. effective January 1, 2026): care management services are paid separately, except transitional care management, which is a health-center billable visit paid under the PPS. CPT 99495 and 99496 requirements: interactive contact within two business days of discharge; face-to-face visit within 14 or 7 days. Transitional care management is carried at zero dollars in every figure in this report.

²⁶ HRSA health center profile, 2026: National Quality Leader for behavioral health. HRSA Uniform Data System 2025: depression screening and follow-up 88.4%; depression and other mood disorders 1,615 patients; anxiety disorders 1,941 patients. HRSA Health Center Service Delivery Sites file: a Flowood primary-care site added to scope in March 2026. CPT 99484, CY2026 national non-facility amount \$57.45; carried at zero dollars in every figure in this report.

3.7 Built the way the codes work: a bench led by nurse practitioners

The forecast refers from the 27 physicians and nurse practitioners in adult primary care: 7 physicians and 20 nurse practitioners whose Medicare records place them at a Jackson-Hinds site.²⁷ Most adult primary care here is delivered by nurse practitioners; the health center's staffing report counts about 30 nurse-practitioner FTEs against about 6 family and internal medicine physician FTEs. For this service line that is the right shape. CCM, APCM and RPM are general-supervision code families: qualified clinical staff deliver the monthly work under a billing clinician's overall direction, without that clinician in the room. The referral motion is one step, a clinician flags a qualifying patient in eClinicalWorks, and the program runs from there.

Clinician count moves this forecast, because remote monitoring is still enrolling at month 24. At 20 referring clinicians the 24-month net reimbursement is \$3,549,107; at the broader roster of 45 it is \$4,816,963 and remote monitoring reaches its ceiling in month 17. Section 12 sets out each case.

3.8 Staffing: nobody is hired

CoachCare delivers 25,774 hours of care-team work across the 24 months, about **12.4 full-time-equivalent years**, without the health center hiring anyone. The on-site enrollment specialist is CoachCare's expense, not a program cost: embedded value rather than a line the health center carries.²⁸ The health center already employs a case-management team of about a dozen and community health workers. The program hands them a billable, documented monthly cadence and takes device logistics, reading triage and documentation off their desks; it extends that team rather than replacing it. The clinicians contribute the two things only they can: the referral flag that starts each enrollment and clinical judgment at the escalation points.

4. Value Analysis: The 24-Month Forecast

4.1 Headline economics

Over 24 months the service line produces **\$4,018,082 in net reimbursement** to Jackson-Hinds Comprehensive Health Center. CoachCare's fees total \$2,303,436, including \$97,605 of ancillary items: implementation, the eClinicalWorks integration and telephonic outreach. Net to the health center is **\$1,714,646, a 42.67% margin** on the program, 41.45% in Year 1 and 43.18% in Year 2.²⁹ The panel is the full Medicare count, Medicare Advantage members included. Medicare Advantage plans reimburse these code families at no less than the Medicare amount; that floor is set by law, and individual contracts set their own terms for the care-management code families.

Figure 1 shows the shape month by month. Month 1 is negative, -\$4,121, because implementation and enrollment effort land before the first full billing months do. Month 2 turns positive at \$6,868 and month 3 nets \$13,164. By month 12 the line runs at \$182,513 of net reimbursement and \$78,613 net to the health center a month. It keeps rising after that, more slowly once CCM fills in month 15, because remote monitoring keeps enrolling: month 24 nets \$114,835 on \$267,459 of net reimbursement and \$152,624 of fees. Month 24 is not a plateau; the forecast ends while the largest arm is still growing.

²⁷ CMS Medicare enrollment (PECOS reassignment) and Doctors and Clinicians files for the health center's group, with NPPES taxonomy and 2026 Quality Payment Program records: 27 adult-primary-care clinicians (7 physicians, 20 nurse practitioners) at a Jackson-Hinds site with the health center as their only 2026 billing organization; 45 on the broader roster. HRSA Uniform Data System 2024 staffing: nurse practitioners 29.9 FTE; family and internal medicine physicians 6.0 FTE.

²⁸ CoachCare Value Analysis operational outputs: 25,774 care-team hours over 24 months, about 12.4 FTE-years, including one on-site enrollment specialist carried at CoachCare's expense. HRSA Uniform Data System 2024 staffing: case managers 12.6 FTE; community health workers 1.8 FTE.

²⁹ CoachCare Value Analysis, 24-month forecast: monthly net reimbursement, fees and net-to-health-center series; Year 1 margin 41.45%, Year 2 margin 43.18%, 24-month margin 42.67%, each defined as net to the health center divided by net reimbursement. Ancillary fees of \$97,605 over 24 months: implementation \$2,500; the eClinicalWorks integration \$4,000 setup, \$150 a month and \$1.50 per patient-month; telephonic outreach.

The 24-Month Ramp: APCM Fills in Month 8, CCM in Month 15, RPM Still Climbing at Month 24

CoachCare Value Analysis · 6,578 Medicare patients in scope · at M24: 2,878 active program enrollments across 1,842 unique patients

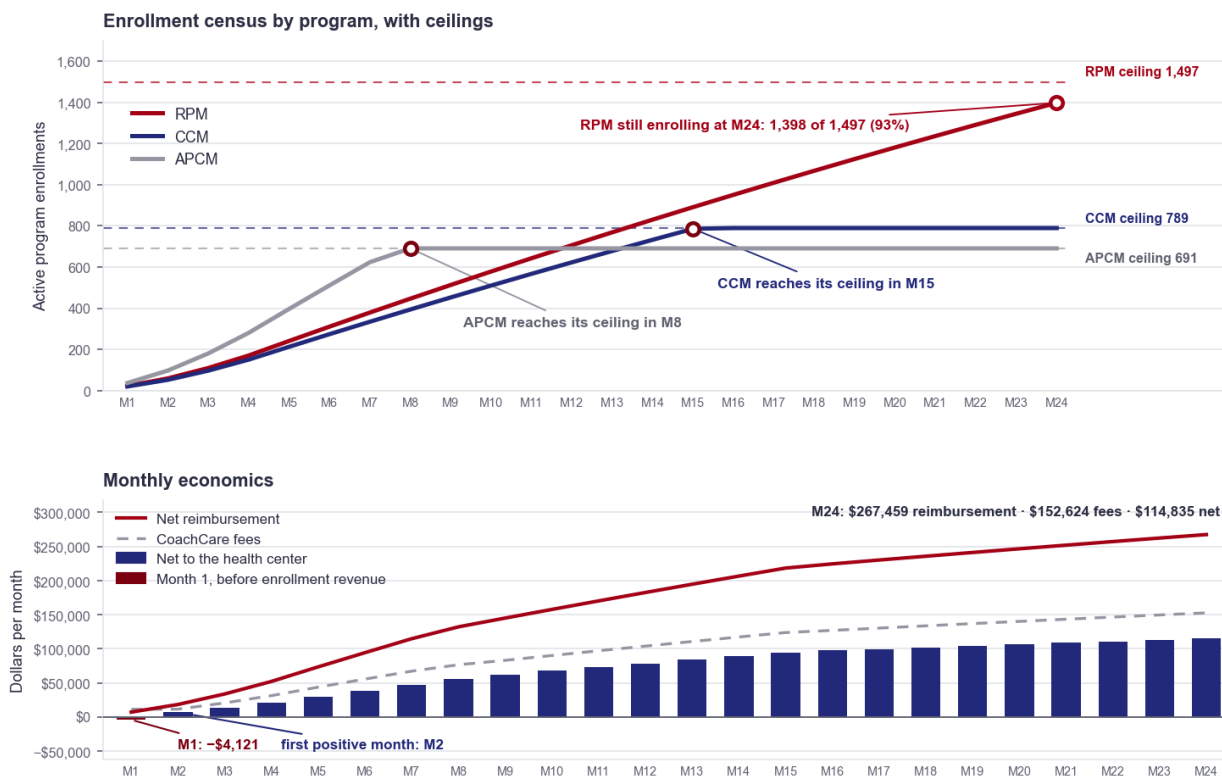


Figure 1. The 24-month ramp: enrollment census by program with ceilings (above) and monthly net reimbursement, CoachCare fees and net to the health center (below). Month 1 nets -\$4,121; the first positive month is M2; the line is still rising at month 24.

4.2 Program economics by year

Program	Year 1 net reimbursement	Year 2 net reimbursement	24-month net reimbursement	24-month CoachCare fees	24-month net to the health center
RPM	\$416,544	\$1,276,294	\$1,692,837	\$966,950	\$725,887
CCM	\$407,872	\$1,029,932	\$1,437,804	\$732,736	\$705,068
APCM	\$356,978	\$530,463	\$887,441	\$506,144	\$381,296
Ancillary (implementation, integration, outreach)	—	—	—	\$97,605	-\$97,605
All programs	\$1,181,393	\$2,836,688	\$4,018,082	\$2,303,436	\$1,714,646

CoachCare Value Analysis, per-program economics by contract year. Ancillary items: implementation \$2,500; the eClinicalWorks integration \$4,000 setup plus \$150 a month and \$1.50 per patient-month; telephonic outreach.

Program	Year 1 fees	Year 1 net	Year 2 fees	Year 2 net
RPM	\$233,765	\$182,778	\$733,185	\$543,109
CCM	\$207,860	\$200,011	\$524,876	\$505,057
APCM	\$203,600	\$153,379	\$302,545	\$227,918

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

Remote monitoring is the volume engine: 17,269 patient-months and \$1,692,837 of net reimbursement, 42% of the line, at \$98.03 per patient-month. Chronic care management is the yield engine at \$110.75 per patient-month across 12,983 patient-months. Advanced primary care management nets \$64.01 per patient-month across 13,864 patient-months and earns its place on the dual-heavy tier mix and the absence of minute-tracking. Year 2 outruns Year 1 by \$1,655,295 of net reimbursement because Year 1 carries the ramp, Year 2 opens with APCM already full, and remote monitoring roughly triples its Year 1 reimbursement as its census keeps climbing.

Service-Line Composition: RPM \$1,692,837 · CCM \$1,437,804 · APCM \$887,441

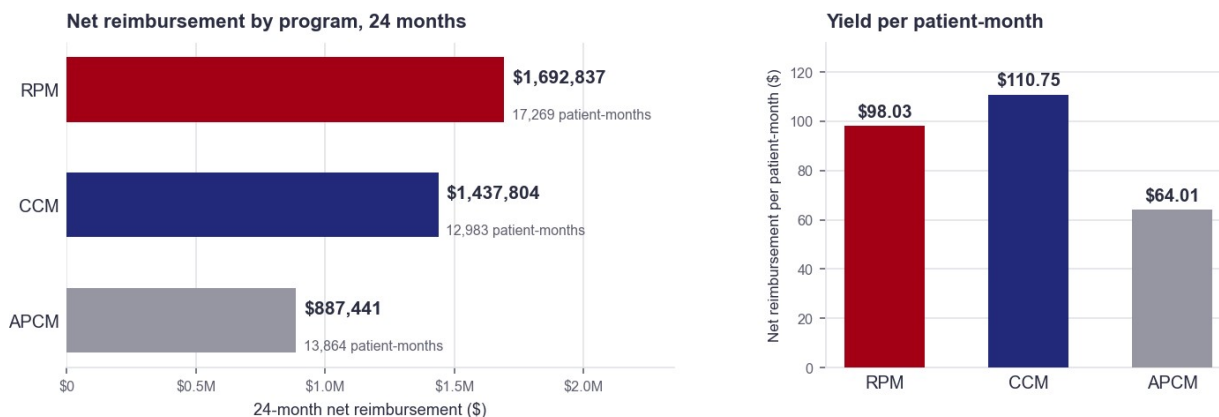


Figure 2. Service-line composition: per-program 24-month net reimbursement and net reimbursement per patient-month.

4.3 The ramp: two programs fill, remote monitoring is still enrolling

This is a split regime, and the programs behave differently. Advanced primary care management reaches its ceiling of 691 enrollments in month 8 and chronic care management its 789 in month 15; both are limited by the size of their eligible pools. Remote monitoring is limited by enrollment pace: at month 24 it holds 1,398 enrollments against a 1,497 ceiling, 93% of the way there.³⁰ The first 90 days move fast: 78 new enrollments across the three programs in month 1, 130 in month 2, 181 in month 3.

Program	Eligible pool	Ceiling	Ceiling reached	Active at M12	Active at M24
RPM	4,276	1,497	Not inside 24 months	706	1,398 (93% of ceiling)
CCM	2,631	789	Month 15	623	789
APCM	2,302	691	Month 8	691	691
All programs					2,878 enrollments · 1,842 unique patients

Enrollment counts are program enrollments, not unique patients; the 2,878 enrollments at M24 belong to 1,842 unique patients (1,313 at M12), because a patient may carry a monitoring enrollment and a care-management enrollment at the same time.

Say the constraint out loud: on remote monitoring, enrollment capacity, not panel size, is what binds. The care-management programs fill on their own schedule; remote monitoring adds about 73 new enrollments

³⁰ CoachCare Value Analysis enrollment model: program ceilings 1,497 (RPM), 789 (CCM), 691 (APCM); CCM ceiling reached in month 15, APCM in month 8, RPM at 1,398 in month 24; 2,878 active enrollments across 1,842 unique patients at month 24 (1,313 unique patients at month 12). Unique patients: the care-management enrollments plus the RPM enrollments beyond 70% of them.

a month from month 5 onward and is still adding them at month 24. That is why the CoachCare-funded on-site enrollment specialist is the largest single lever in this forecast. Without one the line is \$814,995 smaller over 24 months. A second specialist adds \$564,496 of net reimbursement and \$239,066 net to the health center, fills remote monitoring in month 20 and CCM in month 12, and costs the health center nothing. Section 12 prices each case.

4.4 What the program produces

24-month output	Volume
Claims generated, billing-ready	59,227
Device readings monitored	181,323
Care-management tasks completed	118,454
Chart updates written to eClinicalWorks	29,614
Patient conversations held	17,768 (987 hours of call time)
Care-team hours delivered	25,774 (≈ 12.4 FTE-years)
Hospitalizations avoided	115.1 · ≈ \$1.73 million at \$15,000 per admission

CoachCare Value Analysis operational and clinical outputs, 24 months.

The avoided-admission line deserves its own sentence. 115.1 avoided hospitalizations over 24 months is about \$1.73 million of cost that never lands on anyone: not on Medicare, not on the plans that cover most of Hinds County's Medicare, and not on a bed in one of the Jackson acute-care hospitals.³¹ On a two-sided accountable-care track it is also the total-cost-of-care return the health center is measured on, built here under fee-for-service first.

5. The Second Rail: Mississippi Medicaid Covers Remote Monitoring

Medicaid and CHIP cover 31.6% of the health center's patients. Mississippi Medicaid covers remote patient monitoring for chronic conditions under the Mississippi Administrative Code, Title 23, Part 225, Chapter 2; the coverage rule was last revised effective July 1, 2021.³² The rule as written today:

- **Conditions.** Chronic conditions including diabetes, congestive heart failure, COPD, heart disease, mental health conditions and sickle cell disease; the list is not exhaustive.
- **Order and authorization.** Ordered by a physician, physician assistant or nurse practitioner, and prior-authorized through the state's utilization management and quality improvement organization, with a plan of care that sets the transmission frequency.
- **Setting and device.** Delivered in the patient's own home, on an FDA Class II hospital-grade device that transmits blood pressure, glucose or both, used by the patient or a willing helper.
- **Payment structure.** A daily monitoring rate for each day the readings are reviewed, up to 31 days a month, with one set-up per episode.

³¹ CoachCare Value Analysis clinical-outcomes module: 115.1 avoided hospitalizations over 24 months, valued at \$15,000 per avoided admission (about \$1.73 million).

³² 23 Miss. Admin. Code Pt. 225, Ch. 2, Rules 2.3–2.6 (codified copy revised effective August 1, 2026; Rule 2.3 last revised effective July 1, 2021): disease-management remote patient monitoring, order by a physician, physician assistant or nurse practitioner, prior authorization by the utilization management and quality improvement organization, private-residence setting, FDA Class II hospital-grade device, daily monitoring rate up to 31 days a month, one set-up per episode. Miss. Code Ann. § 83-9-353 as amended by 2021 HB 200 (effective July 1, 2021): the prior-hospitalization requirement removed. Mississippi Division of Medicaid fee schedule, rows effective July 1, 2025: 99453, 99454, 99457, 99458 priced.

- **What changed in 2021.** The earlier requirement of prior hospitalizations or emergency visits before a patient qualified was removed from the statute and the rule that year.
- **Codes priced.** The Division of Medicaid's fee schedule prices 99453, 99454, 99457 and 99458 (schedule rows effective July 1, 2025).
- **Codes not covered.** Chronic care management, principal care management, transitional care management, behavioral health integration and advanced primary care management are not covered for any line of service (July 2025 schedule).

How the Medicaid rail is handled in this report

The Medicare forecast on these pages does not include a Medicaid dollar. A Medicaid remote monitoring line is sized in a second working session from the health center's own hypertension and diabetes registries by payer, as its own line beside the Medicare forecast, never folded into it.

Billing is done by the health center as the Medicaid-enrolled provider, and devices come from the health center's own program rather than a medical-equipment supplier or pharmacy. CoachCare manages the devices and the monthly work.

The order of operations follows from the rules. The Medicare service line is built first because its rail is explicit and it is ready to bill. The Medicaid rail is where much of the health center's chronic-disease volume sits, and the same devices, the same escalation engine and the same eClinicalWorks workflow serve it once the registries have been counted by payer. The state is moving the same way: Mississippi's Rural Health Transformation Program, awarded \$205.9 million by CMS for its first year, names telehealth and remote patient monitoring in its plan.³³

6. eClinicalWorks Integration: The Program Lives in the Record

Jackson-Hinds runs eClinicalWorks version 12 at every site, used by every clinician, with a patient portal, automated outreach for care-gap closure and health information exchange already in place.³⁴ The forecast prices CoachCare's eClinicalWorks integration at the catalog tier: \$4,000 setup, \$150 a month and \$1.50 per patient-month. The program operates inside the record rather than beside it. **CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically through its billing engine**, which removes the manual claim step for every patient, every month. Patients begin chronic care management and remote monitoring in under five days, and the health center's clinicians and billing staff learn no new system.³⁵

- **Integrated ordering and enrollment.** Enrollment flags prompt the CoachCare care team to enroll qualifying Medicare patients on the health center's behalf; orders are placed by service and by device; clinicians see enrollment status in real time inside the existing eClinicalWorks workflow.
- **Exchange of health history.** Problem lists, medications and relevant history move between eClinicalWorks and the CoachCare program, so the monthly work starts from the record rather than a separate intake.
- **Integrated vital reports.** Device readings come back to the chart as integrated vital reports, so a blood-pressure or glucose trend is usable clinical data inside eClinicalWorks.

³³ CMS Rural Health Transformation Program state awards, December 29, 2025: Mississippi first-year award \$205,907,220; the Mississippi plan names telehealth and remote patient monitoring among its technology priorities.

³⁴ HRSA Uniform Data System 2025, health information technology table: eClinicalWorks version 12.0.3, installed at all sites and used by all providers; patient portal; automated outreach for care-gap closure; health information exchange. The health center's published patient portal runs on eClinicalWorks.

³⁵ CoachCare eClinicalWorks integration overview: integrated ordering and enrollment, exchange of health history, integrated vital reports, compliance documentation and the integrated care summary, automated claim generation through the CoachCare billing engine; patients begin CCM and RPM in under five days. Integration pricing as carried in the Value Analysis: \$4,000 setup, \$150 a month, \$1.50 per patient-month.

- **Compliance documentation and the integrated care summary.** Evidence of care, vitals and care plans attach to the patient's chart every month, the documentation each code requires, met in the record.
- **Automated claim generation.** The CoachCare billing engine creates the monthly claims automatically, the step that makes individual-code billing workable at 59,227 claims over 24 months; the health center's billing team files them.

7. Clinical Governance and Escalation

7.1 A monitoring program is a clinical operation first

A monitoring program is a clinical operation before it is a revenue line. This section sets out the machinery the health center inherits on the first day of the program: CoachCare's Care Management Programs standard operating procedures, rendered as process maps covering qualification, monitoring, escalation and discharge, for remote monitoring, chronic care management and advanced primary care management alike.³⁶ The purpose is keeping a patient with heart failure or uncontrolled diabetes at home in Hinds, Warren or Copiah County, managed between visits, rather than in a hospital bed.

7.2 One shared escalation engine

Every program routes through one alert-and-escalation decision logic. A critical value escalates immediately, regardless of symptoms. An out-of-range reading that is not critical gets worked before it escalates: the patient retakes the reading and answers a symptom check, so the clinic hears clinical signal rather than cuff artifacts. Trend rules are explicit. Three consecutive out-of-range blood-pressure or glucose readings at least an hour apart, or three abnormal heart-rate readings inside seven days, count as a trend and draw clinical review even when no single reading is critical.

7.3 The emergent pathway

An active emergent symptom reported during any outreach contact triggers the 911 pathway. That policy supersedes any site-specific escalation preference and any quiet window: whichever of the health center's clinics the patient belongs to and whichever day of the week it is, the emergent floor does not move.

7.4 Qualification, device assignment and routing

Enrollment starts with the panel, not the device inventory. The population is screened by ICD-10 code and routed to the right program and device, and device assignment follows a fixed, ordered hierarchy in which the highest-priority qualifying diagnosis wins: a patient with heart failure and diabetes gets the device the higher-acuity condition needs. Once monitoring runs, escalations route three ways: emergencies to the emergent pathway, non-critical clinical items to the patient's clinic for direction, and informational items documented to the chart.

7.5 The post-discharge cadence

A hospitalization within the last 60 days fires a fixed three-touch follow-up sequence: a first contact on day 1 or 2, a second on days 5 to 8, and a third on days 12 to 14. Each touch is documented, and any clinical alert surfaced during a touch escalates under the same shared logic; the post-discharge window gets more contact, not a different rulebook. For a discharge from one of the Jackson acute-care hospitals the first touch is also the interactive contact a transitional care episode requires, and the day-12-to-14 touch lands inside the 14-day visit window. One workflow serves both, and it is where most of the 115.1 avoided hospitalizations in Section 4.4 are won.

³⁶ CoachCare Care Management Programs standard operating procedures and the derived process maps: qualification and device assignment; the RPM patient lifecycle; the care-management lifecycle; alert-and-escalation decision logic; the emergent and urgent communication protocol; the post-discharge follow-up sequence; and the discharge decision flow.

7.6 Discharge governance and continuity

Discharge from the program is governed, not ad hoc. Discharge criteria and unreachable-patient timelines are defined per program, and the clinic is notified in every case. For monitoring patients the sequence is explicit: a recommended discharge first escalates to the clinic for instructions, re-escalates every 30 days, and if the clinic has given no instruction by 180 days the discharge proceeds. Processed discharges post in the first week of the following month. Nobody quietly falls out of the program, and nobody quietly stays in it either.

8. Built for Five Counties: Community and Access Design

The service line has to be built for the footprint the health center actually serves. That footprint runs from the main health center on West Northside Drive to rural clinics in Utica, Edwards and Hazlehurst, a clinic in Vicksburg, two sites in Flowood, six mobile units and school-based clinics as far as the South Delta in Sharkey County. 80.7% of patients with a known income live at or below the federal poverty line, and 4,168 patients were experiencing homelessness in 2025.³⁷ Six design decisions follow.

- **Cellular devices, not app-dependent.** A cellular cuff or glucose meter transmits the moment it is used: nothing to pair, no smartphone, no app, no home broadband. For a rural, low-income panel that is the difference between a reading and a device in a drawer.
- **The monthly documented touch as the equity mechanism.** A documented monthly contact reaches patients in Utica, Edwards, Hazlehurst and Vicksburg that an office schedule and a long drive do not, and it works alongside the mobile units rather than competing with them.
- **The homeless clinic's case managers as an enrollment partner.** The case managers at the homeless clinic on South Gallatin Street know which of their patients have a stable address and a working phone. They are the right partner for deciding, patient by patient, who is ready for a home device and who is better reached first through the monthly care-management call.
- **Enrollment lists pulled by condition, with payer attached.** Lists come from the hypertension, diabetes, heart-disease and COPD registries, screened by ICD-10 code per the qualification map, with payer attached so the Medicare and Medicaid rails stay distinct from the first list.
- **Delivery led by nurse practitioners, fitted to the codes.** CCM, APCM and RPM are general-supervision code families: the monthly work is delivered by qualified clinical staff under a billing clinician's direction, which fits a health center whose adult primary care is led by nurse practitioners.
- **Referrals from the whole adult-primary-care floor.** 27 physicians and nurse practitioners flag patients in eClinicalWorks; the flag is the whole clinician workflow, one step and back to the visit.

³⁷ HRSA Health Center Service Delivery Sites file, October 2026. HRSA Uniform Data System 2025: patients at or below 100% of the federal poverty guideline 38,225 (80.7% of patients with known income); patients experiencing homelessness 4,168.

9. Market Context: Hinds County Medicare

Hinds County had 45,715 Medicare beneficiaries in June 2026, 20,784 of them in Original Medicare and 12,628 (27.6%) dually eligible. Medicare Advantage covers 54.5% of the county's Medicare and its share has risen each year: 49.3% in 2023, 52.2% in 2024, 53.4% in 2025 and 54.5% in June 2026.³⁸ Medicare Advantage plans reimburse these code families at no less than the Medicare amount; that floor is set by law, and individual contracts set their own terms for the care-management code families.

Hinds County Medicare, June 2026	Value
Total Medicare beneficiaries	45,715
Medicare Advantage and other	24,931 (54.5%)
Original fee-for-service Medicare	20,784 (45.5%)
Dual-eligible (Medicare and Medicaid)	12,628 (27.6%)
— Full dual	5,763
— Partial dual	6,865
Aged 65 and over	38,885 (85.1%)
Disabled, under 65	6,830 (14.9%)

CMS Medicare Monthly Enrollment, Hinds County, June 2026 (the latest month).

County the health center serves	Medicare beneficiaries	Medicare Advantage share	Original Medicare share
Hinds	45,715	54.5%	45.5%
Rankin	31,118	35.0%	65.0%
Warren	10,425	43.9%	56.1%
Copiah	6,720	54.0%	46.0%
Sharkey	1,101	52.1%	47.9%

CMS Medicare Monthly Enrollment, June 2026, by county.

Two market facts shape this forecast. The first is the dual-eligible share: Hinds County runs 27.6% dual-eligible and Copiah 29.5%, and the health center's own Medicare panel runs higher still at 43.6%, which is what lifts the advanced primary care management tier mix. The second is the payer split. Hinds County passed half Medicare Advantage in 2024, while Rankin County, where the health center has opened two sites since 2025, is about two-thirds Original Medicare. The forecast prices the whole Medicare panel, Advantage members included, at the national amounts.³⁹

³⁸ CMS Medicare Monthly Enrollment, Hinds County: June 2026, 45,715 beneficiaries, Original Medicare 20,784 (45.5%), dual-eligible 12,628 (27.6%; full 5,763, partial 6,865), aged 65 and over 38,885 (85.1%), disabled 6,830 (14.9%); Medicare Advantage penetration 49.3% (2023), 52.2% (2024), 53.4% (2025), 54.5% (June 2026).

³⁹ CMS Medicare Monthly Enrollment, June 2026: Rankin 31,118 (Medicare Advantage 35.0%), Warren 10,425 (43.9%), Copiah 6,720 (54.0%; dual-eligible 29.5%), Sharkey 1,101 (52.1%).

10. The CY2027 Proposed Rule, Repriced on This Forecast

CMS published its proposed CY2027 physician fee schedule in July 2026. Comments on CMS-1848-P closed September 14, 2026; the final rule arrives in early November; the changes take effect January 1, 2027, and a statutory phase-in caps how far any code's payment can fall in a single year. The proposal that matters here is a reduction to the remote monitoring device-supply codes. Every code in this forecast was repriced at the national amounts on this account's own billing mix and APCM tier weights, with enrollment held constant; the forecast's basis and the repricing use the same national amounts on both sides.⁴⁰

The cascade: one code, one arm, one line

Device supply, 99454 and 99445: \$52.11 → \$41.38 a month, -20.6%. The code CMS proposes to cut.

The remote monitoring arm: \$1,692,837 over 24 months, -9.5%, -\$160,866. Device supply is 32% of the remote monitoring basket; management time moves little.

Chronic care management: \$1,437,804, -2.15%, -\$30,910. Advanced primary care management: \$887,441, -0.65%, -\$5,811. Conversion-factor and relative-value movement only; the proposal does not target these codes. The care-management movement is \$36,721 of the total.

The whole service line: \$4,018,082 over 24 months, -4.9%, -\$197,587, to \$3,820,495. Remote monitoring is 42% of the line, and two of the three programs are not the one being repriced.

The CY2027 Proposed Rule on This Forecast: One Code Cut, One Shared Dollar Scale

Device supply 99454 and 99445: \$52.11 → \$41.38 a month (-20.6%) · the RPM arm -9.5% · the line -4.9%, -\$197,587 of \$4,018,082

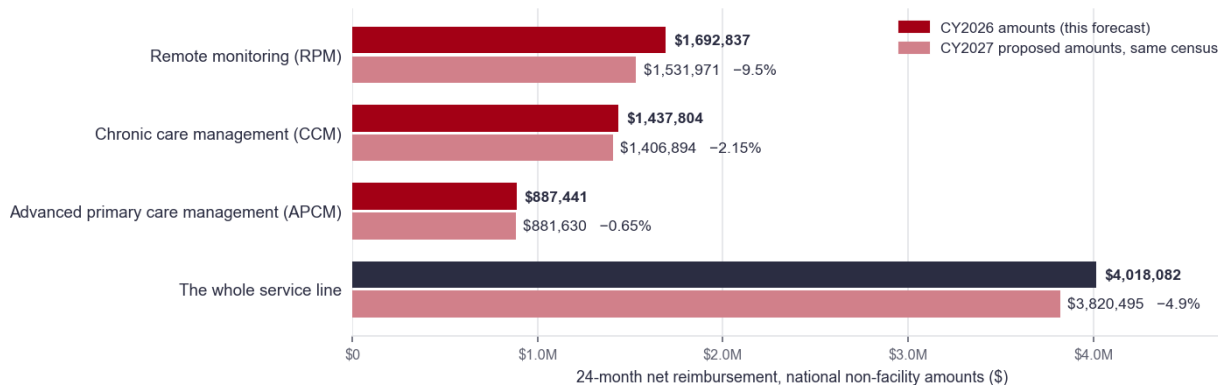


Figure 3. The CY2027 proposed rule on this forecast, at the national amounts on both sides: each arm and the whole line, CY2026 against the CY2027 proposed amounts, same census.

⁴⁰ CMS-1848-P, proposed CY2027 Physician Fee Schedule (July 2026); comment period closed September 14, 2026. CoachCare repricing at the national non-facility amounts on this forecast's code frequencies and APCM tier weights: 99454 and 99445 from \$52.11 to \$41.38 (-20.6%); RPM arm -9.5% (-\$160,866); CCM -2.15% (-\$30,910); APCM -0.65% (-\$5,811); service line -4.9% (-\$197,587, from \$4,018,082 to \$3,820,495). Enrollment held constant.

11. Implementation and the First 90 Days

11.1 Who runs what

CoachCare delivers	Jackson-Hinds Comprehensive Health Center keeps
Telephonic and on-site enrollment; the enrollment specialist is CoachCare's expense	Referral flags in eClinicalWorks; clinical oversight under general supervision
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans and escalation preferences, site by site
Monitoring, documentation and the escalation protocol of Section 7	Responses to clinic-routed escalations; the discharge feed from the Jackson acute-care hospitals
Automated claim creation inside eClinicalWorks	Filing the claims; billing review; the revenue
Monthly operating reports against the dashboard in 11.3	Program governance; the accountable-care relationship the engine supports

11.2 Model inputs

Input	Value
Medicare panel in scope	6,578 Medicare-primary patients (UDS 2025), all in scope from month 1; Medicare Advantage members included
Dual-eligible share	2,869 of 6,578 (43.6%)
Referring clinicians	27 in adult primary care (7 physicians and 20 nurse practitioners); broader roster 45
Programs	RPM + CCM + APCM; TCM and BHI named, not in the forecast; PCM off
Program-eligible pools	RPM 4,276 · CCM 2,631 · APCM 2,302
Enrollment ceilings	RPM 1,497 (not reached; 1,398 at M24) · CCM 789 (M15) · APCM 691 (M8)
Acceptance	RPM 35% · CCM and APCM 30% of the eligible pool
Enrollment engine	8 referrals per clinician per month at 80% acceptance; one CoachCare-funded on-site enrollment specialist at 80 enrollments a month; telephonic outreach on; 1.5% monthly attrition
APCM tier mix	Level 1 15% · level 2 52% · level 3 33%; \$69.11 per patient-month blended
Rate basis	CY2026 national non-facility Physician Fee Schedule amounts, the rail a health center bills care-management codes on
Medicare Advantage	54.5% of Hinds County's Medicare (June 2026). Medicare Advantage plans reimburse these code families at no less than the Medicare amount; that floor is set by law, and individual contracts set their own terms for the care-management code families.
EHR	eClinicalWorks version 12, priced at the catalog integration tier (\$4,000 setup, \$150 a month, \$1.50 per patient-month)

11.3 The 90-day plan and the operating dashboard

Days 0–30: foundation. Program agreement and the eClinicalWorks integration workplan. The hypertension and diabetes registries counted by payer, the Medicare panel split between Original Medicare and Medicare Advantage, and the first sites chosen for the on-site enrollment specialist. ICD-10 screening of the Medicare panel per the qualification map, device logistics staged, escalation routing set site by site, and clinician orientation to the general-supervision workflow.

Days 31–60: enrollment live. Telephonic and in-clinic enrollment running; first devices in homes; first billable service months. Month 1 nets –\$4,121 as implementation lands; month 2 turns positive. The forecast carries 78 new enrollments in month 1 and 130 in month 2.

Days 61–90: scale and file. 181 new enrollments in month 3, with APCM five months from its ceiling. First monthly operating report against the dashboard. A decision on the second CoachCare-funded enrollment specialist, and a second working session on the Mississippi Medicaid remote monitoring rail with the registries counted by payer.

The operating dashboard from month one:

- Enrollment census by program against ceiling (1,497 / 789 / 691), with remote monitoring enrollment pace tracked against the forecast month by month
- Time from referral flag to first billable enrollment (target: under five days)
- Discharges captured: hospital discharges that entered the three-touch cadence
- Device-reading days per patient-month against the 16-day 99454 threshold, with 99445 capturing 2- to 15-day months
- Escalations by pathway: emergent, clinic-routed, documented
- Claims generated against expected claims, and claims filed
- Blood-pressure control among enrolled patients, against the UDS 2025 baseline of 63.1%
- Net to the health center per month against the forecast: \$78,613 at month 12, \$114,835 at month 24

12. Recommendations

1. **Stand up the Medicare service line now, on the full panel.** The individual-code rail has been live since January 2025. On the 6,578-patient Medicare panel this is a \$1,714,646 two-year net line at a 42.67% margin, positive from the second month, and nothing about it waits on a hire or a grant.
2. **Fund the enrollment pace: take the second CoachCare enrollment specialist.** Remote monitoring is limited by enrollment capacity, not by the panel. A second on-site specialist adds \$564,496 of net reimbursement and \$239,066 net to the health center and fills remote monitoring in month 20. Both specialists are CoachCare's payroll.
3. **Lead the care-management arm with APCM for the dual-eligible panel.** 43.6% of the Medicare panel is dually eligible, the tier blend reaches \$69.11 per patient-month, and APCM fills in eight months with no minute-tracking.
4. **Run it as the engine the two-sided ACO needs.** The health center has carried two-sided accountable-care risk since 2020. This service line holds monthly primary-care attribution and avoids admissions, 115.1 of them over 24 months, while paying for itself under fee-for-service.
5. **Start with the hypertension cohort.** Blood-pressure control rose from 49.0% to 63.1% in four years. A 12,435-patient hypertension registry, continuous readings and a monthly documented touch are how that number keeps moving.
6. **Size the Mississippi Medicaid remote monitoring rail as its own line.** Count the hypertension and diabetes registries by payer and price that rail in a second session, beside the Medicare forecast, never inside it.
7. **Build for five counties from the first day.** Cellular devices, condition-based enrollment lists with payer attached, the homeless clinic's case managers as an enrollment partner, and a monthly documented touch that reaches the rural clinics. None of these is a retrofit.
8. **Make the hospital discharge the front door.** Wire the discharge feed from the Jackson acute-care hospitals, enroll at the first post-discharge contact, and run the transitional care visit on the

same three-touch cadence. TCM is in the forecast at zero dollars; every enrolled discharge is a monitoring patient from the day they most need it.

What moves the number

Scenario	24-month net reimbursement	Net to the health center	Margin	Ceiling reached RPM / CCM / APCM
Base: 6,578 panel, 27 clinicians, 1 enrollment specialist	\$4,018,082	\$1,714,646	42.67%	— / M15 / M8
No on-site enrollment specialist	\$3,203,087	\$1,362,534	42.54%	— / M22 / M11
Second on-site enrollment specialist	\$4,582,578	\$1,953,712	42.63%	M20 / M12 / M7
20 referring clinicians	\$3,549,107	\$1,514,663	42.68%	— / M19 / M9
45 referring clinicians (broader roster)	\$4,816,963	\$2,051,531	42.59%	M17 / M11 / M6
Original-Medicare share only (≈2,990 patients)	\$2,436,464	\$1,031,493	42.34%	M12 / M8 / M5

CoachCare Value Analysis recalculations at the same pricing and the national rail. "—" means remote monitoring is still enrolling at month 24. On remote monitoring the binding constraint is enrollment capacity, not panel size.

Read the table by lever. Enrollment capacity is the largest: the gap between no specialist and two is \$1,379,491 of net reimbursement, and every specialist is CoachCare's expense. Clinician count is the second, because more referrers feed the arm that is still enrolling. The margin barely moves in any row, because the economics of each enrolled patient-month are the same; what changes is how many patient-months the engine can produce inside 24 months.⁴¹

13. The Ask: A Working Session

CoachCare asks for one working session with the health center's executive team, clinical leadership, information-technology lead and billing lead. The forecast stands on the figures in Section 4; the session is about the inputs that would move it, in the order they matter.

1. **Enrollment capacity and where it sits.** Which sites host the on-site enrollment specialist first, and whether a second CoachCare-funded specialist starts with the first or follows at day 90. This is the largest lever in the forecast.
2. **The Medicare panel by payer.** How the 6,578 Medicare patients split between Original Medicare and Medicare Advantage, and how the plans the health center contracts with pay the care-management codes.
3. **The hypertension and diabetes registries by payer.** The Medicare slice sizes the remote monitoring cohort in this forecast; the Medicaid slice sizes the second rail.
4. **The accountable-care measures and total-cost targets.** The quality measures and the total cost of care the assigned Medicare patients are graded on, so the service line's clinical dashboard is set to the numbers that matter to the health center.
5. **The eClinicalWorks build.** The interfaces and workflows in place, so the integration workplan and the discharge feed can be written.

Everything else in this report, the discharge feed from each Jackson acute-care hospital, the site-by-site rollout and the Medicaid rail, is a workplan item that follows the session rather than a condition of it.

⁴¹ CoachCare Value Analysis recalculations at the same pricing: no on-site enrollment specialist \$3,203,087 / \$1,362,534 / 42.54%; second specialist \$4,582,578 / \$1,953,712 / 42.63%; 20 clinicians \$3,549,107 / \$1,514,663 / 42.68%; 45 clinicians \$4,816,963 / \$2,051,531 / 42.59%; Original-Medicare share only (Hinds County's 45.5% applied to 6,578, about 2,990 patients) \$2,436,464 / \$1,031,493 / 42.34%.

Contact

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About CoachCare

CoachCare runs remote care programs for health centers, specialty practices and health systems: the enrollment, the devices, the clinical monitoring, the documentation and the claims, inside the EHR the organization already uses.⁴²

Measure	CoachCare, 2026
Patients managed	over 400 managed conditions for 500,000+ patients
Clinicians on the platform	10,000+ providers running remote care programs day to day
Implementations	1,000+ programs stood up and running in market
Claims generated	care-plan coding and billing behind more than 5 million claims
Vitals recorded	over 100 million vitals recorded; 4 million+ care actions enabled

References and Data Sources

- **HRSA Uniform Data System, 2025 reporting year (per-center file, May 2026 release):** 49,054 patients; adults 35,984 and children 13,070; Medicare as primary coverage 6,578, of whom 2,869 dually eligible; Medicaid and CHIP 15,497; uninsured 14,897; patients experiencing homelessness 4,168; hypertension 12,435, diabetes 5,857, heart disease 1,517, COPD 910; clinical quality measures; health information technology and telehealth fields.
- **HRSA health center profile and quality recognitions, 2026:** National Quality Leader for heart health, diabetes health and behavioral health; preventive health; advancing health information technology for quality; controlled-blood-pressure series 2021–2025.
- **HRSA Health Center Service Delivery Sites file (October 2026):** 42 active sites across Hinds, Warren, Copiah, Rankin and Sharkey counties, including permanent clinics, a homeless clinic, six mobile units and school-based clinics.
- **HRSA Uniform Data System, 2024 staffing table:** nurse-practitioner, physician, case-manager and community-health-worker FTEs.
- **CMS Medicare Shared Savings Program participant records, performance year 2026, and the annual participant lists 2020–2025:** the health center is a named participant in a statewide health-center ACO on the ENHANCED (two-sided-risk) track, with retrospective assignment, continuously since 2020, and not under prospective primary-care payments. No shared-savings, benchmark or quality figure is asserted or modeled in this report.
- **CMS Medicare Monthly Enrollment, June 2026 (the latest month):** Hinds County 45,715 beneficiaries, Medicare Advantage and other 54.5%, dual-eligible 27.6%; Rankin, Warren, Copiah and Sharkey counties; Hinds Medicare Advantage share 2023–2026.
- **The CY2025 Physician Fee Schedule Final Rule (CMS-1807-F) and the CY2026 Final Rule (CMS-1832-F):** health centers report the individual care-management, remote monitoring and advanced primary care management codes in place of G0511, paid at national non-facility amounts in addition to the PPS encounter; G0511 permitted through September 30, 2025 and deleted for 2026; APCM behavioral-health add-ons for health centers in CY2026; 99445 and 99470.

⁴² CoachCare company statistics, 2026: patients served, managed conditions, providers on the platform, implementations completed, claims generated and vitals recorded.

- **Medicare Benefit Policy Manual, Chapter 13 (rev. effective January 1, 2026):** care management services paid separately from the PPS encounter, except transitional care management, which is a billable health-center visit.
- **CY2026 Physician Fee Schedule national non-facility amounts and the CMS CY2026 RHC/FQHC non-facility payment rates:** the forecast codes, transitional care management and behavioral health integration, at the national conversion factor with no geographic adjustment.
- **Mississippi Administrative Code, Title 23, Part 225, Chapter 2 (codified copy revised effective August 1, 2026; coverage rule effective July 1, 2021), and Mississippi Code § 83-9-353 as amended in 2021:** Medicaid remote patient monitoring coverage, conditions, order and prior authorization, home setting, device standard and daily-rate payment structure.
- **Mississippi Division of Medicaid fee schedule (rows effective July 1, 2025):** 99453, 99454, 99457 and 99458 priced; CCM, PCM, TCM, BHI and APCM codes not covered for any line of service.
- **CMS Rural Health Transformation Program state awards (December 2025):** Mississippi's first-year award and plan, which names telehealth and remote patient monitoring.
- **CMS-1848-P, the proposed CY2027 Physician Fee Schedule (July 2026):** the proposed national non-facility amounts used in the Section 10 repricing; comment period closed September 14, 2026; statutory single-year phase-in.
- **The health center's eClinicalWorks deployment,** confirmed in its 2025 Uniform Data System health information technology table (version 12, all sites, all clinicians) and its published patient portal; CoachCare integration pricing at the catalog tier: \$4,000 setup, \$150 a month and \$1.50 per patient-month.
- **CoachCare eClinicalWorks integration overview:** integrated ordering and enrollment, exchange of health history, integrated vital reports, compliance documentation and the integrated care summary, and automated claim generation, with patients beginning services in under five days.
- **CoachCare Care Management Programs standard operating procedures and the derived process maps:** the shared alert-and-escalation decision logic, trend definitions, the emergent communication protocol, three-way routing, the post-discharge three-touch sequence and the discharge decision flow reproduced in Section 7.
- **CoachCare Value Analysis for Jackson-Hinds Comprehensive Health Center, 2026, its recalculations, and the CY2027 repricing of the same forecast:** every financial, enrollment, clinical-output and operational figure in Sections 2, 3, 4, 10, 11 and 12, built on 6,578 Medicare patients in scope, 27 referring clinicians, one on-site enrollment specialist, and CY2026 national non-facility amounts for RPM, CCM and APCM.

How this report counts

Patients and program enrollments are different numbers. At M24 the program holds 2,878 active program enrollments belonging to 1,842 unique patients, because a patient may carry a monitoring enrollment and a care-management enrollment at the same time. Wherever this report gives a patient count it says patients; wherever it gives an enrollment count it says enrollments.

The panel figure is the health center's own. Health-center visits and care management bill on the institutional claim rather than under individual clinicians, so clinician-level Medicare claims files do not show a health center's care-management billing. The 6,578-patient Medicare figure is the count the health center reported to HRSA for 2025, by primary payer, which places Medicare Advantage members inside it.