COACHCARE | SERVICE LINE STRATEGY

HealthLinc

A federally qualified health center in Northwest Indiana and Michiana: 18 clinics in seven counties since the October 2026 merger with Heart City Health, 7,453 Medicare patients, and Greenway Intergy at every site

Remote Care Service Line Optimization Report

2026 Strategy Report

A scalable, profitable remote care service line for HealthLinc: remote monitoring, chronic care management and advanced primary care management for the Medicare patients the health center already serves, billed under HealthLinc's own NPIs on top of the PPS encounter and run by a CoachCare care team inside Greenway Intergy

Purpose of this document

Prepared by CoachCare, October 2026, as a discussion document for the leadership of HealthLinc. It is the companion to HealthLinc's remote care strategy page and makes the same argument at report length: why Medicare's payment rules make this the year, where HealthLinc stands today, how the service line runs inside Greenway Intergy, what it returns over 24 months at the national Medicare rates health centers bill, and why CoachCare is the partner to run it.

The argument is short. HealthLinc already scores in HRSA's top quartile on blood pressure and diabetes, already runs chronic care management with its own nurses, and now carries an ACO, a federal telehealth award and four new Elkhart sites. What it does not yet have is daily readings and a monthly care team for every eligible Medicare patient at every site. This report shows what that program returns, who does the work, and how it starts without capital or a hire.

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Executive Summary

HealthLinc, Inc. is a federally qualified health center headquartered in Valparaiso, Indiana. It began in 1996 inside a Valparaiso neighborhood house and became a full Section 330 health center in 2006. On October 1, 2026 it merged with Heart City Health, the Elkhart health center, and now runs 18 clinics and a mobile medical and dental unit across Porter, Lake, La Porte, St. Joseph, Elkhart, Starke and Newton counties. Every HealthLinc site runs Greenway Intergy, and the four Elkhart sites are moving onto it.[1]

The two health centers reported **73,555 patients to HRSA for 2025, 7,453 of them on Medicare**. Of those Medicare patients, 3,101 (42%) also qualify for Medicaid; across all ages, 13,573 patients carry hypertension and 7,539 diabetes. HealthLinc's own 2025 report card puts it in HRSA's top quartile on blood-pressure control, diabetes control, statin therapy and depression screening, and HRSA names it a National Quality Leader in heart health and in behavioral health.[2]

In January 2026, after two years in the ACO REACH model, HealthLinc's clinicians began billing inside **an Enhanced-track Medicare Shared Savings Program ACO**, the two-sided track. In September HRSA awarded HealthLinc a Telehealth Nutrition Services Network grant that calls for remote patient monitoring and for billing every covered service.[3]

The observation this report is built on

HealthLinc's dual-eligible mix makes advanced primary care management worth more here than almost anywhere, and the enrollment and engagement work is CoachCare's.

HealthLinc has the panel, the conditions, the record system and the quality scores. It already runs chronic care management at 14 sites and sends Food-as-Medicine patients home with devices a HealthLinc nurse reviews. What it does not yet have is the same daily readings and monthly care team for every eligible Medicare patient at every site, Elkhart included. This service line fills that gap: staffed by CoachCare, governed by HealthLinc's clinicians, billed under HealthLinc's NPIs from inside Greenway Intergy.

What the Value Analysis returns

Full service line	Year 1	Year 2	24 months
Unique patients, end of period	1,015	1,546	1,546
Contribution margin	**$312,712**	**$992,031**	**$1,304,743**

CoachCare Value Analysis: 7,453 Medicare patients across both health centers, all in scope; remote monitoring, chronic care management and advanced primary care management; 65 referring clinicians; one CoachCare-funded on-site enrollment specialist; CY2026 national non-facility amounts. Contribution margin is what HealthLinc keeps from the service line.

HealthLinc can take this two ways, and both return a positive contribution margin. CoachCare can run the remote monitoring while HealthLinc's nurses keep chronic care management as it runs today: **$601,767 of contribution margin over 24 months**, for 1,211 patients. Or CoachCare can run all three programs across the Medicare panel, the forecast of record above, for 1,546 unique patients. Section 6.3 sets that Full Service model beside Self Service, in which HealthLinc's own staff run the same devices and software: Full Service returns $671,457 more contribution margin over 24 months, with no hiring.

[1] healthlincchc.org, October 2026: history timeline; merger announcement, July 15, 2026, effective October 1, 2026; Heart City Health staff FAQ (Intergy as the HealthLinc EMR); HRSA Health Center Service Delivery Sites file, October 21, 2026: 14 HealthLinc clinics, four Elkhart sites, a mobile unit.

[2] HRSA UDS 2025: HealthLinc (H80CS06662) 56,646 patients, 5,987 Medicare, 2,274 dual-eligible, 10,894 hypertension, 5,813 diabetes; Heart City Health (H80CS08221) 16,909, 1,466, 827, 2,679, 1,726.

[3] CMS Shared Savings Program ACO Participants, 2026 (dataset 9767cb68): Enhanced track, prospective assignment; not on the 2025 file. CMS ACO REACH Providers, 2023 and 2024. HRSA Telehealth Nutrition Services Network awards, September 22, 2026.

1. **Positive from month 2, with nobody hired.** Contribution margin runs slightly negative in month 1 while the program ramps; every month after is positive, and by month 24 the monthly contribution margin is $91,528. CoachCare delivers 20,190 care-team hours over 24 months, about 9.7 full-time-equivalent years, with 9 care managers at 165 patients each by month 24.
2. **Enrollment pace sets year one; the Medicare panel sets year two.** Advanced primary care management reaches its ceiling of 522 in month 9, chronic care management 596 in month 14 and remote monitoring 1,211 in month 22. By then the program holds 2,329 active program enrollments across 1,546 unique patients. A second on-site enrollment specialist reaches those ceilings sooner and adds $121,429 of contribution margin; the Medicare chart count by payer sets how high they sit, and it is discovery item number one.
3. **The dual-eligible share is the APCM lever.** Level 3 advanced primary care management (G0558, $117.24 a month) is reserved for Qualified Medicare Beneficiaries, a group within the 42% of HealthLinc's Medicare patients who are dual-eligible. It pays more than twice level 2 (G0557, $53.78).
4. **The program lives in Greenway Intergy.** It is built on Greenway's own Intergy workflows and supported alongside Greenway. A flagged patient reaches the first day of service in under five days, and claims are created in Intergy every month (Section 4).
5. **It works the measures HRSA and the ACO both count.** Blood pressure, diabetes control, depression remission, colorectal screening and admissions for patients with several chronic conditions all move with monthly work between visits (Section 7).
6. **It produces what the HRSA award asks for.** The Telehealth Nutrition Services Network award calls for remote patient monitoring and for billing every covered service. The service line generates both records (Section 8).
7. **The CY2027 proposed rule takes 5.3% off this line.** A 20.6% cut to device supply is 9.5% on the remote-monitoring arm and $162,347 over 24 months on the whole line. Section 9 draws the cascade.

The ask is a working session: confirm the Medicare chart count by payer and ACO assignment across the merged health center, walk through how chronic care management and Food-as-Medicine monitoring run today, map the monitoring and billing requirements of the HRSA award, and scope the Intergy workflow for all 18 clinics with Greenway.

1. Why Now: Medicare Pays Health Centers for the Month Between Visits

Medicare is changing what it pays health centers for. Four shifts are under way at once, and each lands in the same place: the weeks between a patient's visits. For a health center whose Medicare patients carry hypertension, diabetes and depression together, those weeks decide how the year goes.

The shift	What it means for HealthLinc
1. From visits to panels	Four visits a year leave 361 days without a reading. Population health at HealthLinc's scale means knowing which of its 7,453 Medicare patients, across 18 clinics in seven counties, are trending the wrong way before they reach an emergency department. That takes data from home and a team assigned to act on it every month.
2. Accountability for total cost	After two years in the ACO REACH model, HealthLinc's clinicians began 2026 inside an Enhanced-track Medicare Shared Savings Program ACO, the two-sided track. Patients are assigned at the start of each year, the ACO receives a monthly primary-care payment for them, and every admission among them counts against its spending benchmark. The ACO is scored each year on blood pressure, diabetes control, depression screening and admissions for patients with several chronic conditions.

The shift	What it means for HealthLinc
3. Paid for the month, with Medicare Advantage at 48.1%	Since January 1, 2026 health centers bill remote monitoring, chronic care management and advanced primary care management as individual Medicare codes, each paid on top of the PPS encounter. Advanced primary care management pays a monthly amount per patient for running the whole panel, and its top tier is reserved for Qualified Medicare Beneficiaries. 42% of HealthLinc's Medicare patients also qualify for Medicaid. Across its seven counties 48.1% of Medicare beneficiaries are in Medicare Advantage. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families.[4]
4. Codes for the work between visits	Remote monitoring pays when a patient takes readings on 16 or more days in a month, and two codes new in 2026, 99445 and 99470, pay for shorter months; in this forecast they carry 17% of remote-monitoring Medicare payments.[5] At the CY2026 national rates health centers bill, one hypertensive patient on remote monitoring and chronic care management (99454, 99457 and 99490) is worth **$170.01 a month** in Medicare allowed charges.

Each shift pays for, or measures, what happens between visits. A remote care service line is how HealthLinc covers that time for every eligible Medicare patient. HRSA's 2026 Telehealth Nutrition Services Network award to HealthLinc asks for the same thing: remote patient monitoring to track patient progress, and billing for every covered service.

2. HealthLinc Today: One Health Center, Seven Counties

HealthLinc started in 1996 as one health center in a Valparaiso neighborhood house. Today it runs 18 clinics from East Chicago to rural Starke and Newton counties, four of them in Elkhart since the Heart City Health merger. It puts medical, behavioral health and clinical pharmacy care in one building at most sites.

2.1 Eighteen clinics after the Heart City merger

Where	Clinics	What it means for this program
Porter County	Valparaiso, plus the mobile medical and dental unit	The largest site and the family medicine residency's continuity clinic; an in-house pharmacy
Lake County	Three East Chicago clinics	The urban end of the footprint; an in-house pharmacy at Harbor West
La Porte County	La Porte, La Porte Pediatrics, Michigan City	Michigan City opened in a new building in 2024 with its own pharmacy
Starke and Newton	Knox; Morocco	The rural end. The Newton County clinic is NP-led, four days a week, inside a senior nutrition center; readings arrive every day whether or not a clinic is open
St. Joseph County	Mishawaka, IUSB Medical, IUSB Dental, Southeast and Centennial in South Bend	Mishawaka added 26 exam rooms in 2025 and runs an in-house pharmacy
Elkhart County	Four sites, joined October 1, 2026	Two medical clinics, a dental clinic and a women's health clinic, moving onto Intergy; they start the program in its first month

HRSA Health Center Service Delivery Sites file and healthlincchc.org location pages, October 2026. Fifteen of the 18 clinics see primary-care medical patients; two are dental-only and one is a women's health clinic.

[4] CY2026 Physician Fee Schedule final rule: health centers report the individual care-management and remote-monitoring codes, paid in addition to the PPS rate. CMS Medicare Advantage State/County Penetration, October 2026, seven site counties weighted by eligibles (132,270 of 274,778).

[5] CoachCare Value Analysis for HealthLinc, 2026: 99445 and 99470 carry 17.2% of 24-month remote-monitoring Medicare payments.

The CMS Doctors and Clinicians file lists 99 Medicare-enrolled clinicians across HealthLinc and the Elkhart sites: 22 physicians, 51 nurse practitioners, 2 nurse midwives, 13 behavioral health clinicians, and optometry, podiatry and chiropractic. The forecast counts 65 of them as referring clinicians, the adult-medicine prescribers: family physicians, internists and adult and family nurse practitioners. Each patient's care team also includes a medical assistant, a care team nurse, a behavioral health consultant, a clinical pharmacist, a community health worker and a care coordinator.[6]

2.2 The patients HealthLinc serves

HRSA UDS 2025, both health centers	Count	What it means for the service line
Patients served	**73,555**	All ages and payers; the panel the care team already knows
Medicare patients	**7,453**	Traditional Medicare and Medicare Advantage together, up 29% since 2021; the forecast's panel, with no gross-up
Dual-eligible	**3,101 (42%)**	Drives the advanced primary care management tier mix
Hypertension, all ages	13,573	The largest group whose home readings would change treatment
Diabetes, all ages	7,539	Home glucose and the monthly call between lab draws
HealthLinc alone, before the merger	56,646 patients, 5,987 on Medicare	Heart City Health adds 16,909 patients and 1,466 on Medicare

This is the panel remote care is built for. Hypertension and diabetes are the norm, more than a third of Medicare patients also qualify for Medicaid, and the Medicare count has grown every year but one since 2021. HealthLinc says type 2 diabetes rates in its communities are at or above state and national averages. A quarter of its patients are Hispanic or Latino and one in eight has limited English proficiency, so language is part of the program design (Section 5.5).[7]

2.3 How HealthLinc scores where remote care helps

HealthLinc's 2025 HRSA Uniform Data System report card, filed before the merger, places it against every health center in the country. Quartile 1 is the best-performing quarter on HRSA's adjusted ranking.[8]

Clinical quality measure, UDS 2025	Population	HealthLinc	HRSA quartile
Controlling high blood pressure	Hypertensive patients under 140/90 · higher is better	**77.75%**	**Quartile 1**
Statin therapy for cardiovascular disease	Patients at high cardiovascular risk · higher is better	**85.55%**	**Quartile 1**
Depression screening and follow-up	Patients 12 and older · higher is better	**88.51%**	**Quartile 1**
Diabetes: HbA1c poor control (> 9%)	Patients with diabetes · lower is better	**18.01%**	**Quartile 1**
Colorectal cancer screening	Adults 45–75 · higher is better	**52.89%**	**Quartile 2**
Depression remission at twelve months	Patients with major depression · higher is better	**9.08%**	**Quartile 3**

HRSA UDS 2025, HealthLinc's own filing. 2026 HRSA badges: National Quality Leader in heart health and in behavioral health; Health Center Quality Leader, Gold; Patient-Centered Medical Home; Advancing Health Information Technology for Quality; Improving Health Care Access; Preventive Health.

[6] CMS Doctors and Clinicians, October 2026, HealthLinc and Heart City Health group enrollments; healthlincchc.org patient-centered medical home page for the care team.

[7] HRSA UDS 2021 to 2025, Medicare patients across both health centers: 5,772, 6,495, 6,362, 6,916, 7,453. HealthLinc UDS 2025: Hispanic or Latino 25.37%, limited English proficiency 12.58%. healthlincchc.org diabetes care release, 2025.

[8] HRSA UDS 2025 clinical quality measures and adjusted quartiles, HealthLinc (H80CS06662); 2026 Community Health Quality Recognition badges as displayed on healthlincchc.org.

The visit already works at HealthLinc. With blood pressure controlled for 77.75% of hypertensive patients, the next points come from home readings and medication changes between visits, across 13,573 hypertensive patients at both health centers. Depression remission at twelve months, at 9.08% and in the third quartile, is the measure that lags, and it is the one that depends most on follow-up between visits. The program puts the four Elkhart sites on the same between-visit routine from the start.

2.4 Thirty years of growth, and 2026

Year	What happened
1996	HealthLinc begins inside a Valparaiso neighborhood house and sees 732 patients in its first year
2006–2007	Full Section 330 health center in January 2006; the HealthLinc name in 2007
2008–2013	Michigan City and Knox (2008), Mishawaka (2011), East Chicago (2013): the model moves into La Porte, Starke, St. Joseph and Lake counties
2016–2019	A clinic on a South Bend college campus, two South Bend neighborhood health centers taken on in 2019, and La Porte the same year
2022	By 2022 HealthLinc offered chronic care management to Medicare patients with two or more chronic conditions, and that year it launched Food as Medicine: a dietitian, a community health worker and home monitoring devices for food-insecure patients with chronic illness
2024–2025	East Chicago Harbor West and a new Michigan City building, La Porte Pediatrics, accreditation, and an NP-led clinic in Morocco
2026	January: an Enhanced-track Medicare Shared Savings Program ACO, after ACO REACH in 2023 and 2024. September: HRSA's Telehealth Nutrition Services Network award. October: the merger with Heart City Health
Next	**Daily readings and monthly care management for every eligible Medicare patient at all 18 clinics, run by a CoachCare care team inside Intergy and billed under HealthLinc's NPIs**

2.5 What HealthLinc already runs, and the gap

What exists	Status	What it means for this program
Greenway Intergy and MyHealthRecord	**Live at every site**	The program's host: flags, orders, readings, care documents and claims (Section 4). The Elkhart sites are moving onto Intergy
Chronic care management	**Offered at 14 sites**	Credited and kept. HealthLinc's care team nurses keep the patients they manage; CoachCare can carry as much of the rest as HealthLinc wants
Food as Medicine	Dietitian, community health worker, home devices	A HealthLinc nurse reviews the blood pressure, weight and glucose readings. The same monitoring can run for every eligible Medicare patient
Clinical pharmacy	13 clinical pharmacists; four in-house pharmacies	Home trends reach the pharmacist before a titration; missed refills surface as a flag
Integrated behavioral health	Consultants inside primary care	More than 24,000 patients with a behavioral health diagnosis in 2024; positive screens on the monthly call route straight to them
Transition support after a hospital stay	Offered by the care teams	The post-discharge cadence and transitional care codes formalize it

The gap is specific. Daily home readings reach a HealthLinc nurse today for the Food-as-Medicine patients, and chronic care management reaches the patients its nurses carry. The same readings and the same monthly care team do not yet reach every eligible Medicare patient at every site, Elkhart included, with the claims built in Intergy automatically.[9]

[9] healthlincchc.org: chronic care management service page (2022), listed on 14 location pages; Food-as-Medicine releases, 2022 to 2026 (readings transmitted to HealthLinc, where a nurse reviews them).

2.6 The market, and the rate basis

The footprint runs from urban Lake County to rural Starke and Newton counties; HealthLinc describes Newton as HRSA-designated rural and a health professional shortage area. Across the seven site counties 48.1% of Medicare beneficiaries were in a Medicare Advantage plan in October 2026, from 39.9% in Porter County to 53.3% in Elkhart and 55.6% in St. Joseph. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The 7,453 Medicare patients in the UDS count already include HealthLinc's Medicare Advantage patients, so the forecast needs no gross-up; the payer split is the first thing to confirm.[10]

HealthLinc's Medicare contractor is WPS. Health centers bill these codes at the national non-facility amount at every site, in addition to the PPS encounter, so every dollar in this report is priced at the CY2026 national amounts, and every patient is priced at the Medicare amount.[11]

3. The Service Line: RPM, CCM and APCM

3.1 G0511 is gone: each code now pays on its own

Health centers are paid a prospective payment per qualifying visit. For years, the between-visit work for chronic patients was billed under one flat monthly code, G0511, whatever the services, minutes or programs behind it. **Since January 1, 2026 health centers bill remote monitoring, chronic care management and advanced primary care management as individual codes, each paid in addition to the PPS encounter**. Each code carries its own eligibility test, consent, time capture and documentation standard. That is more work for a billing office and more revenue for a health center that does the work; the claims in this forecast are built in Intergy, not by hand.[12]

The forecast counts Medicare only, because Indiana Medicaid pays health centers per face-to-face encounter at the PPS rate and does not pay these codes separately.[13]

3.2 The clinical and billing stack

Three monthly programs on one infrastructure. Remote monitoring supplies the daily signal; chronic care management or advanced primary care management supplies the monthly care plan around it. Enrollment, devices, monitoring, escalation, documentation and claims run on the same CoachCare workflow for all three.

Program	What it does clinically	Who it fits on this panel
Remote physiologic monitoring (RPM)	Cellular cuffs, glucometers and scales send readings between visits against thresholds HealthLinc's clinicians set; 99453, 99454 or 99445, 99457, 99458, 99470	Hypertension and diabetes first, then kidney disease and heart failure; 4,844 eligible
Chronic care management (CCM)	A documented care plan and at least 20 minutes of clinical staff time a month for patients with two or more chronic conditions; 99490, 99439	The multi-chronic core: hypertension with diabetes, kidney disease, heart disease or depression; 2,981 eligible
Advanced primary care management (APCM)	A monthly amount for running the patient's primary care, with no minute count, tiered by complexity; G0556, G0557, G0558	Patients with an ongoing primary-care relationship; level 3 for Qualified Medicare Beneficiaries; 2,609 eligible

[10] CMS Medicare Advantage State/County Penetration, October 2026: Porter 39.9%, Lake 46.5%, La Porte 45.0%, St. Joseph 55.6%, Starke 49.6%, Newton 41.6%, Elkhart 53.3%.

[11] CY2026 Physician Fee Schedule final rule, Addendum B national non-facility amounts, conversion factor $33.4009; health centers bill the individual care-management and remote-monitoring codes at these amounts. WPS is the Medicare contractor for Indiana.

[12] CY2026 Physician Fee Schedule final rule, RHC and FQHC care management: G0511 retired; individual codes billed and paid at the national non-facility amount in addition to the PPS encounter.

[13] Indiana Health Coverage Programs, provider reference module for FQHCs and RHCs, version 7.3, October 13, 2026: a valid encounter is a face-to-face visit billed at the PPS rate; other procedure codes on the claim deny.

One coordination rule, set at enrollment

Chronic care management and advanced primary care management never bill for the same patient in the same month: each patient carries one care-management program, chosen at enrollment. Remote monitoring bills alongside either. The eligible pools overlap; the billing does not.

3.3 Advanced primary care management and the dual-eligible panel

Advanced primary care management pays a monthly amount per patient for the work of running a primary-care panel: access, care planning, coordination and population management, without a minute count. Level 1 (G0556) covers patients with one chronic condition or none, level 2 (G0557) two or more, and level 3 (G0558) Qualified Medicare Beneficiaries with two or more.[14]

That last tier is why HealthLinc's panel matters. 42% of HealthLinc's Medicare patients are dual-eligible, and Qualified Medicare Beneficiaries are a group within them. The forecast sets the tier mix at 15% level 1, 60% level 2 and 25% level 3, anchored to the dual-eligible share and held below it, because not every dual-eligible patient is a Qualified Medicare Beneficiary. At $117.24 a month, a level 3 patient-month pays more than twice a level 2 patient-month at $53.78. Advanced primary care management fills first in the forecast, reaching its ceiling of 522 in month 9. Which patients carry it rather than chronic care management is a program decision to make together.

3.4 The care team, and the hours it keeps

CoachCare hires, trains and manages the care managers, at 165 patients each: 7 care managers at month 12, for 1,015 unique patients, and 9 by month 24. An on-site enrollment specialist on CoachCare's payroll works beside HealthLinc's medical assistants and enrolls patients during the visit, and telephonic outreach reaches the rest. Devices are cellular, with no Wi-Fi, smartphone or pairing needed, which matters as much in Knox and Morocco as in East Chicago and South Bend. Monitoring runs on business hours: devices transmit daily, and care managers review readings, run outreach and send escalations Monday to Friday, 8 a.m. to 5 p.m. in the patient's time zone. Patients are told at consent to call 911 for an emergency and HealthLinc for anything urgent.

3.5 Transitional care, behavioral health and community health

Transitional care management (99495 at $220.11, 99496 at $298.60) pays for the month after a hospital or observation stay: contact within two business days, medication reconciliation and a HealthLinc visit within 14 days, or 7 for high-complexity patients. HealthLinc's care teams already offer transition support. The post-discharge cadence in Section 5.4 is that episode: CoachCare makes the first call and books the visit, and HealthLinc furnishes the visit and bills the code. The forecast carries no dollars for it. The trigger is the hard part: whether a discharge notice reaches HealthLinc from the hospitals where HealthLinc's patients are admitted is discovery item number six.

Behavioral health integration (99484, $57.45 a month) fits the same care-manager calls and the same chart. HealthLinc holds a National Quality Leader badge in behavioral health, and remission at twelve months is the measure this program is aimed at. **Community health integration** (G0019, $86.17) pays for a community health worker's time on the social needs that get in the way of treatment, work HealthLinc's community health workers already do. Both run on the same care team and carry no dollars in this forecast.

3.6 Two deployments, and what HealthLinc keeps

HealthLinc has already built part of the answer to build-versus-partner. It runs chronic care management with its own care team nurses, offered at 14 sites, and its Food-as-Medicine patients send home readings

[14] CY2025 and CY2026 Physician Fee Schedule final rules: APCM (G0556 to G0558) effective January 1, 2025; G0558 for Qualified Medicare Beneficiaries with two or more chronic conditions; billed in place of chronic care management for the same patient and month.

to a HealthLinc nurse. CoachCare can take on as much or as little of the care management as HealthLinc wants.

Deployment	What CoachCare runs	What HealthLinc keeps
RPM alongside HealthLinc's own care management	Remote monitoring for the hypertension, diabetes and heart-failure patients	Chronic care management as it runs today, with home readings in the chart
Full service line, RPM + CCM + APCM (the forecast of record)	All three programs, enrolling every eligible patient into a care-management program as well as monitoring	The patients its own nurses already manage, if it chooses

- **HealthLinc keeps clinical governance, the patients and the revenue.** Its clinicians set thresholds, routing and discharge criteria and sign the care plans; claims go out under HealthLinc's NPIs, and in the full service line HealthLinc keeps $1,304,743 of contribution margin over 24 months.
- **CoachCare supplies the program.** Devices, an on-site enrollment specialist, care managers, business-hours alert triage, monthly documentation and automated claims. None of it is HealthLinc's headcount, inventory or capital.
- **Today's patients stay where they are.** The forecast counts chronic care management and advanced primary care management from zero against the whole eligible panel, so the overlap with the patients HealthLinc's nurses carry today, and with Food-as-Medicine monitoring, is discovery item number three.

3.7 What the codes pay

Codes	What they pay for	CY2026 national
99453	Remote monitoring setup and education, once	$21.71
99454 · 99445	**Device supply, 16+ days · 2 to 15 days in 30 (99445 new in CY2026)**	**$52.11 · $52.11**
99457 · 99458	Treatment management, first 20 minutes · each additional 20	$51.77 · $41.42
99470	**Treatment management, 10 to 19 minutes (new in CY2026)**	**$26.05**
99490 · 99439	Chronic care management, first 20 minutes · each additional 20	$66.13 · $50.44
G0556 · G0557 · G0558	**Advanced primary care management, levels 1 to 3**	**$16.37 · $53.78 · $117.24**
99495 · 99496	Transitional care, visit within 14 days · within 7 days (not in the forecast)	$220.11 · $298.60
99484 · G0019	Behavioral health integration · community health integration (not in the forecast)	$57.45 · $86.17

How the rates apply

CY2026 Medicare Physician Fee Schedule, national non-facility amounts: the rate a federally qualified health center bills for these codes at every site, in addition to the PPS encounter.

One device code (99454 or 99445), one first-tier management code (99457 or 99470) and one care-management program (chronic care management or advanced primary care management) bill for a patient in a given month. One hypertensive patient on remote monitoring and advanced primary care management level 2 (99454, 99457 and G0557) is worth $157.66 a month.

Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The forecast prices every patient at the Medicare amount.

4. Greenway Intergy: The Program Lives in the Chart

The integration is built on Greenway's own Intergy workflows and supported alongside Greenway, so HealthLinc's clinicians and staff never leave the chart they already use. Enrollment flags prompt the order, enrollment status is visible in the clinical workflow at every site, and patients begin receiving care management and remote monitoring in under five days.[15]

Integration area	What happens in Greenway Intergy
Bidirectional enrollment by services	Flags in the chart prompt the order for patients who meet criteria HealthLinc's clinicians approve; the clinician orders by service, at a visit, a wellness visit or from an outreach list, and status flows back to the chart
Exchange of health history	Diagnoses, medications, vitals and labs pass to the care team at intake; the care plan comes back
Integrated discrete vitals	Home readings land in the chart as discrete values, so the clinician sees home averages at the next visit
Escalation tasks	A confirmed trend reaches the clinician or nurse each site designates as an Intergy task, with the readings and a recommended next step attached
Compliance documentation and integrated care summary	Evidence of care, vitals and the care plan attached every month for every enrolled patient
Automated claim generation	Claims built for every patient, every month, once a code's requirements are met: 16 reading days, 20 minutes, two conditions. HealthLinc's billing team reconciles the batch in its own work queue

Enrollment does not wait for a visit. Telephonic enrollment reaches eligible patients from the outreach list, and cellular devices ship ready to use, with no home internet and nothing to pair. The four Elkhart sites are joining Intergy now, so they enter the program on the same workflow as every other HealthLinc clinic rather than on a second system.

5. Clinical Governance & Escalation

Every reading routes through one escalation engine with defined thresholds, trend rules, routing and documentation, so HealthLinc never carries surveillance liability it did not agree to. Thresholds and routing are set with HealthLinc's clinicians, site by site, before the first patient enrolls.[16]

[15] CoachCare Greenway Intergy integration overview: bidirectional enrollment by services, automated claim generation, compliance documentation and integrated care summary, escalation tasks, integrated discrete vitals, exchange of health history; patients begin services in less than five days.

[16] CoachCare Care Management Programs standard operating procedures, March 2026: escalation logic, trend definitions, emergent protocol, care-management hours (Monday to Friday, 8:00 a.m. to 5:00 p.m. local patient time), post-discharge sequence and discharge governance.

5.1 One shared escalation engine

Branch	The rule	Why
Critical value	**Escalate to the site, regardless of symptoms**	No client preference can suppress it. A critical reading on its own goes to the site, not to 911
Out of range, not critical	Retake, then a structured symptom check	Most out-of-range readings resolve here, which keeps clinician inboxes usable
Trend	**Three consecutive readings an hour or more apart for blood pressure or glucose; three within seven days for heart rate; weight gain past the agreed threshold**	A confirmed trend escalates like a single threshold breach
Patient unreachable	Document, leave a callback message, and escalate anyway if the reading was critical or a confirmed trend	Silence never downgrades a clinical finding
Documentation	**Six fields: vital · findings · method · contact · outcome · follow-up**	Any episode can be reconstructed end to end

5.2 The emergent pathway

Non-negotiable, and stated as such

Triggers. Chest pain · new shortness of breath · signs of stroke · syncope · worst-ever headache · sudden swelling, reported by the patient on a call.

Action. The care team calls 911 with the patient on the line, then notifies the HealthLinc site the same day. A critical reading alone, without those symptoms, goes to the site instead.

If the patient refuses. The site is called with the patient still on the line and directs care; if the site cannot be reached, CoachCare activates emergency services.

The floor. CoachCare's emergent policy supersedes any client escalation preference. HealthLinc shapes routing for everything else.

5.3 Three-way routing, on business hours

Route	What goes there	Who sees it
Emergency	Active emergent symptoms reported on a call	911 with the patient on the line; the site notified
Needs the health center	A critical reading, or an out-of-range reading or trend confirmed after a retake	The clinician or nurse each site designates, as an Intergy task, with readings and a recommended next step
Stable or resolved	**Worked, retaken and resolved**	**Documented as an FYI in the chart, without paging anyone**

The matrix is agreed per site. Care managers work readings and escalations Monday to Friday, 8 a.m. to 5 p.m. local patient time; a reading that arrives on a weekend or overnight is worked the next business day, and the patient's standing instruction for anything urgent is HealthLinc's own line or 911. The Newton County clinic is open four days a week, so on the fifth its escalations can route to a designated clinician at another HealthLinc site.

5.4 The post-discharge cadence

Any emergency visit or hospitalization in the previous 60 days triggers the cadence. After a hospital or observation stay it is also the transitional care episode, and inside the ACO each admission it prevents is spending that never posts against the benchmark.

Touch	Window	What happens
1 · Stabilize	**Day 1–2**	What led to the visit; discharge medications reconciled against what is in the house; a HealthLinc follow-up visit confirmed within 7 to 14 days
2 · Detect	**Day 5–8**	Adherence verified, triggers re-checked, appointment and ordered labs confirmed; the in-house pharmacy looped in on new prescriptions
3 · Secure	**Day 12–14**	Medication and risk review, visit outcome, and a handoff into monthly monitoring and care management

5.5 Language access, designed in

In 2025 a quarter of HealthLinc's patients were Hispanic or Latino and 12.6% had limited English proficiency.[17] A patient who cannot follow a welcome call cannot take a reading that counts, so language is a design requirement, settled before launch. Enrollment scripts, consent language, device instructions and outreach are scoped with HealthLinc for Spanish-preferring patients, including who carries their calls and how preferred language is flagged in the chart. HealthLinc's own staff and interpreter practice are part of that design. It is discovery item number seven.

5.6 Continuity and discharge governance

1. **Unreachable patients escalate on a fixed clock.** A monitoring patient unreachable 45 days from enrollment goes to the site; non-compliance at 90 days triggers a second escalation; care management's first escalation comes at six months.
2. **There is a hard backstop.** Without an instruction from the site, discharge from monitoring proceeds at 180 days, with the site notified.
3. **HealthLinc always decides.** Discharge criteria, thresholds and routing belong to HealthLinc's clinicians, with the single exception of the emergent floor in Section 5.2.

6. Value Analysis: The 24-Month Forecast

6.1 The headline economics

The forecast covers all three programs across the 7,453 Medicare patients of both health centers, all in scope, at CY2026 national amounts, with 65 referring clinicians, one CoachCare-funded on-site enrollment specialist at 80 enrollments a month and telephonic outreach. It counts Medicare fee-for-service payments only: no transitional care, behavioral or community health integration, Medicaid, shared savings or grant dollars.[18]

Full service line	Year 1	Year 2	24 months
Unique patients, end of period	1,015	1,546	1,546
Active program enrollments, end of period	1,580	2,329	2,329
Contribution margin	**$312,712**	**$992,031**	**$1,304,743**

The census keeps growing toward its ceilings through year two, which carries most of the value: **$992,031 of the $1,304,743 contribution margin**.

[17] HRSA UDS 2025, HealthLinc: Hispanic or Latino 25.37% of patients with known ethnicity; limited English proficiency 12.58% (7,127 patients).

[18] CoachCare Value Analysis for HealthLinc, 2026, the source of all Section 6 figures; sensitivity runs change one input at a time on the same workbook.

6.2 Two deployments, side by side

Each deployment is shown on its own, and the full service line is the forecast of record. The avoided admissions are the same in both because they come from the monitoring. The full line adds a care-management program for 335 more patients than monitoring reaches alone, and $702,976 more contribution margin over 24 months.

24 months	RPM alongside HealthLinc's own care management	Full service line, RPM + CCM + APCM
Contribution margin	**$601,767**	**$1,304,743**
Unique patients at month 24	1,211	1,546
Hospitalizations avoided	About 97	About 97

CoachCare Value Analysis, each deployment shown on its own.

6.3 Full Service or Self Service

Two ways to run the same program, on the same Medicare panel, the same national rates and the same 24 months. **Full Service** is the forecast of record: devices, software and the CoachCare care team, which staffs enrollment, monitoring, care management and claims preparation inside Intergy and carries the payroll. **Self Service** gives HealthLinc the same devices and software inside Intergy and leaves the care team, enrollment and the monthly minutes to HealthLinc's own staff, the way its nurses run chronic care management today.

Self Service runs the same enrollment engine with two things an in-house team carries: enrollment at three-quarters of the pace, because nobody's whole job is enrolling, and a quarter fewer billable remote-monitoring and chronic-care minutes, because time-based codes pay only when the minutes are logged every month. HealthLinc employs the clinical minutes.

24 months	Full Service	Self Service
Contribution margin	**$1,304,743**	**$633,286**
Unique patients at month 24	1,546	1,316
Program enrollments by month 6	570	428
Contribution margin, Year 1 · Year 2	$312,712 · $992,031	$70,127 · $563,159
First month of positive contribution margin	Month 2	Month 6
HealthLinc hires	None	5.25 clinical FTEs by month 12 (8.5 at the peak), plus a program lead and an enrollment role
CoachCare care managers by month 24	9	None

Where Self Service wins, and where it loses

Self Service keeps the care team on HealthLinc's payroll and under its own supervision, and it gives HealthLinc's nurses the work. It loses on execution: $671,457 less contribution margin over 24 months, hiring ahead of the census while every health center competes for the same nurses, enrollment nobody owns, and minutes nobody logs.

Even at equal execution, Full Service returns more. If an in-house team matched CoachCare's enrollment pace and logged every minute, Full Service would still leave HealthLinc $189,649 more contribution margin, because the panel needs 12 clinical FTEs at its peak on HealthLinc's own payroll.

6.4 Where the patients come from

Program	Active enrollments, month 12	Active enrollments, month 24	Ceiling reached
Remote physiologic monitoring	564	**1,211**	M22
Chronic care management	493	**596**	M14
Advanced primary care management	522	**522**	M9
Unique patients	**1,015**	**1,546**	

Remote monitoring is the largest program, 1,211 enrollments at month 24, and it produces the readings, the alerts and the avoided admissions. Chronic care management reaches 596 enrollments, the multi-chronic core of the panel. Advanced primary care management reaches 522 with no minute count behind it. The **2,329 active program enrollments at month 24 belong to 1,546 unique patients**, because most monitored patients also hold a care-management enrollment.[19]

6.5 The ramp, month by month

Contribution margin runs −$3,938 in month 1 while the program ramps, on 34 enrollments. It is positive from month 2, with $2,755 on 83 enrollments, and 162 by month 3. New enrollments average about 103 a month in the first year, and by month 24 the monthly contribution margin is $91,528. Cumulative contribution margin passes $47,154 at month 6, $312,712 at month 12 and $1,304,743 at month 24.

Month	Active enrollments	Monthly contribution margin	Cumulative contribution margin
M1	34	**−$3,938**	−$3,938
M2	83	$2,755	−$1,182
M3	162	$5,466	$4,283
M4	271	$9,224	$13,507
M5	407	$13,972	$27,479
M6	570	$19,675	$47,154
M9	1,170	$41,640	$148,935
M12	1,580	$60,921	$312,712
M24	**2,329**	**$91,528**	**$1,304,743**

[19] CoachCare Value Analysis: active program enrollments by program, months 12 and 24; a patient on remote monitoring and a care-management program counts once in each.

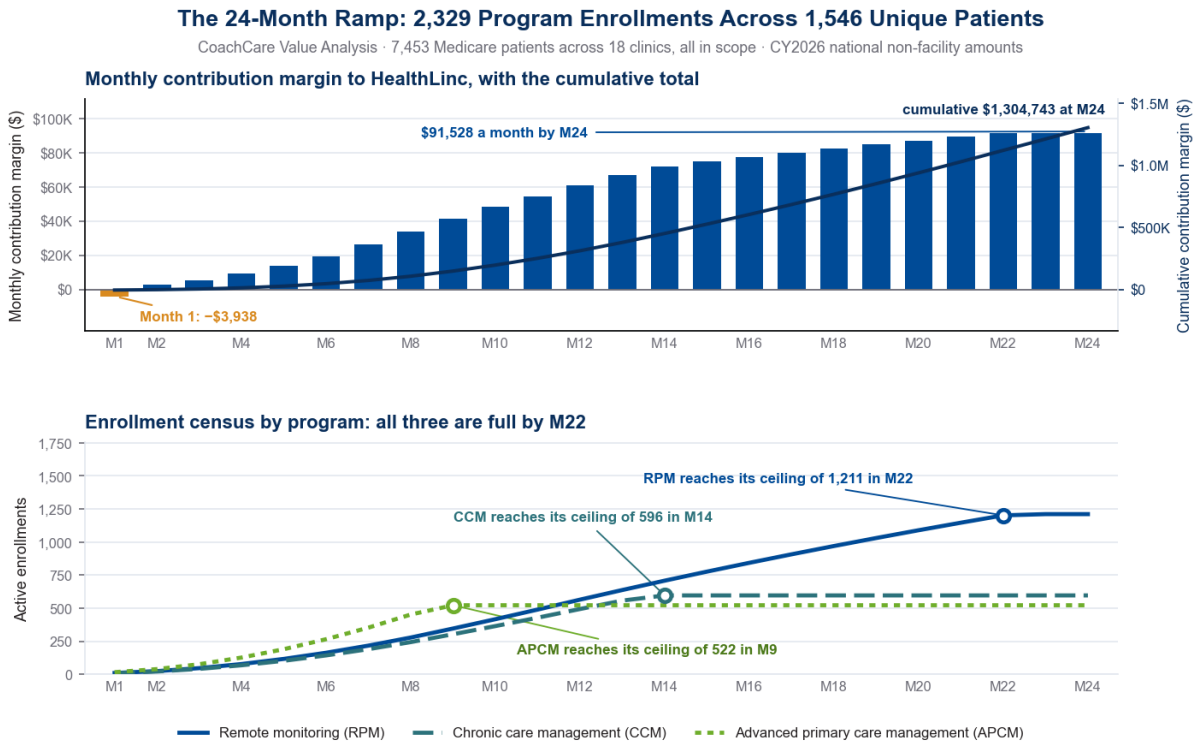


Figure 1. Monthly contribution margin, with cumulative contribution margin, and the enrollment census by program with the three ceiling months marked. CoachCare Value Analysis, full service line.

6.6 Ceilings, and what moves them

Program	Eligible share of the 7,453 in scope	Acceptance	Ceiling	Reached
Advanced primary care management	35%, 2,609 patients	20%	**522**	**M9**
Chronic care management	40%, 2,981 patients	20%	**596**	**M14**
Remote physiologic monitoring	65%, 4,844 patients	25%	**1,211**	**M22**

Say the constraint out loud

Enrollment pace sets the first year and the Medicare panel sets the second. Care management fills first; remote monitoring is still enrolling until month 22, when every patient the three programs can take is enrolled. A second on-site enrollment specialist cannot raise the ceiling but reaches it sooner, remote monitoring in month 19 instead of 22, and adds $121,429 of contribution margin over 24 months ($1,426,172 against $1,304,743). With no on-site specialist remote monitoring never reaches its ceiling inside 24 months and the forecast falls by $189,901, to $1,114,842.

The chart count is discovery item number one. The 7,453 is the two health centers' own UDS Medicare count for 2025. A chart pull by payer and site replaces it, and it sets how high the ceilings sit.

Scenario	24-month contribution margin	Unique patients at M24	Ceilings: RPM · CCM · APCM
Base: panel 7,453, 65 referring clinicians, one enrollment specialist	**$1,304,743**	**1,546**	**M22 · M14 · M9**
No on-site enrollment specialist	$1,114,842	1,352	not reached · M17 · M11

Scenario	24-month contribution margin	Unique patients at M24	Ceilings: RPM · CCM · APCM
A second on-site enrollment specialist	$1,426,172	1,546	M19 · M12 · M8
HealthLinc alone, before the merger: panel 5,987, 58 clinicians	$1,110,655	1,242	M20 · M13 · M9
Panel 6,916, the 2024 combined count	$1,252,936	1,435	M21 · M13 · M9
Panel 8,200	$1,365,147	1,679	not reached · M15 · M10
80 referring clinicians	$1,399,678	1,546	M19 · M13 · M8
45 referring clinicians	$1,120,482	1,338	not reached · M17 · M10
The 20 physicians referring alone	$810,481	1,092	not reached · not reached · M13

CoachCare Value Analysis sensitivity runs, one input changed at a time, every panel fully in scope.

Contribution margin moves with the panel, but less than one for one, because remote monitoring is still enrolling for most of the two years: from HealthLinc's own pre-merger 5,987 patients to 8,200, 24-month contribution margin runs from $1,110,655 to $1,365,147, and a panel 10% larger adds only 5% to it. Enrollment capacity matters as much: fewer referring clinicians or no on-site specialist leaves remote monitoring short of its ceiling at month 24, and more of either reaches the ceilings sooner.

6.7 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	**152,000**	Blood pressure, glucose and weight values arriving between visits
Claims and billable units	**47,055**	Created in Intergy for HealthLinc's billing team
Care-management tasks	94,111	Outreach, care-plan updates and medication reviews
Chart updates	23,528	Care documents and readings filed to the Intergy chart
Patient conversations	14,117	Live contacts across 784 hours of call time
Care-team hours	**20,190**	**About 9.7 full-time-equivalent years of work HealthLinc does not employ**
Hospitalizations avoided	**About 97**	About $1.45 million at $15,000 per admission

CoachCare Value Analysis, 24-month totals, full service line. The avoided-admission count uses the workbook's baseline admission rate; at a 40% annual admission baseline, realistic for a multi-chronic Medicare panel, it is about 194.

Two ledgers, kept separate

Contribution margin funds the program. $1,304,743 of contribution margin over 24 months, on Medicare fee-for-service payments in addition to the PPS encounter.

Avoided admissions and quality speak to the ACO. About 97 admissions avoided, about $1.45 million at $15,000 each, plus monthly work on the measures in Section 7. Under two-sided risk the new Part B care-management spend also sits on the ACO's ledger, which is why avoided admissions and quality carry the argument there, more than the contribution margin does.[20]

6.8 Published results from CoachCare programs

[20] CoachCare Value Analysis: 96.5 hospitalizations avoided over 24 months at the workbook's baseline admission rate, $15,000 each.

- **Blood pressure.** Cardiac Solutions, a physician-owned practice with three offices, put 2,738 patients on CoachCare remote monitoring with home blood-pressure monitoring. Stage 2 hypertension patients saw a 29.1 mmHg average systolic drop, and 94.8% improved. Patients who took readings consistently dropped 8.53 mmHg against 3.54 mmHg for those who did not.[21]
- **Readmissions, at the same practice.** Across 26,689 patients, the 30-day readmission rate was 7% for CoachCare patients against 15% for the rest.[22]
- **Heart failure.** Iowa Heart enrolled 450 advanced heart-failure patients and recorded zero readmissions over six months.[23]

The result followed the patients who kept taking readings, so the care team's monthly work is outreach and engagement, and clinician time goes to the escalations that need it.

7. Quality: The UDS Measures and the ACO

HealthLinc reports clinical quality to HRSA every year, and its clinicians now take part in an Enhanced-track Medicare Shared Savings Program ACO that is scored on an overlapping set. Most of these measures depend on work this program does every month.[24]

Measure	Reported in	HealthLinc 2025	What the program does each month
CMS165 Controlling high blood pressure	HRSA UDS · Shared Savings Program	**77.75%, quartile 1**	Home averages give an accurate reading of control and a monthly chance to act; the documented status reflects home data, not one rushed office reading
CMS122 Diabetes: A1c poor control (> 9%)	HRSA UDS · Shared Savings Program	**18.01%, quartile 1**	Care management keeps A1c testing and medication changes on schedule; home glucose shows slippage before the next lab
CMS159 Depression remission at twelve months	HRSA UDS	**9.08%, quartile 3**	A PHQ-9 on the monthly call for every enrolled patient with depression, routed to HealthLinc behavioral health when the score does not fall
CMS130 Colorectal cancer screening	HRSA UDS · Shared Savings Program	**52.89%, quartile 2**	An overdue screening is flagged on the call, the kit or referral drafted for the clinician to sign, and completion documented in Intergy
Q484 Admissions, multiple chronic conditions	Shared Savings Program, from claims	Calculated by CMS	Daily readings, outreach on a confirmed trend, a fixed cadence after any emergency visit or admission

HealthLinc already sits in HRSA's top half on three of the five. The program's job there is to hold that standing across 13,573 hypertensive and 7,539 diabetic patients at 18 clinics, Elkhart included, with home data behind every documented result. Depression remission is where monthly follow-up has the most room to move a score.

[21] Cardiac Solutions case study, April 2026: 2,738 remote-monitoring patients enrolled 12 months or more.
[22] Cardiac Solutions readmissions case study: 7% against 15% across 26,689 patients.
[23] Iowa Heart case study, 2026: 450 NYHA class III to IV patients over six months.
[24] HRSA UDS 2025 clinical quality measures (CMS165, CMS122, CMS159, CMS130); Shared Savings Program quality reporting through the APM Performance Pathway, with measure 484 calculated by CMS from claims.

How Medicare pays for these programs inside the ACO

For patients assigned to the ACO, Medicare pays for the services on HealthLinc's claims, these programs included, through the ACO's monthly primary-care payment instead of claim by claim, and a CMS guardrail keeps that payment at or above the claims it replaces. For every other Medicare patient the codes pay claim by claim.[25]

The assigned share of HealthLinc's Medicare patients, and how the ACO's primary-care payment reaches HealthLinc for the care-management work, are discovery item number two. Either way the monthly work is the same, and it is the work the ACO's quality score and spending benchmark respond to.

8. The HRSA Telehealth Nutrition Award

In September 2026 HRSA announced a Telehealth Nutrition Services Network award to HealthLinc: **award H2ATH55904, $300,000 for fiscal year 2026**, with a period of performance from September 1, 2026 to August 31, 2031. The program integrates nutrition services into primary care through telehealth networks in rural and medically underserved areas, which describes HealthLinc's Food-as-Medicine work and its rural clinics in Starke and Newton counties.[26]

The funding notice tells recipients they **"should use remote patient monitoring (RPM) … to assess, evaluate, and track patient progress"**. It requires a registered dietitian at one full-time equivalent or more and a community health worker at half-time or more, caps equipment at 20% of grant funds, and requires the network to bill every service covered by a third-party payer.[27]

What the award requires	What the service line produces
Remote patient monitoring to track progress	Daily readings from cellular devices, reviewed against thresholds HealthLinc's clinicians set, with home averages filed to the Intergy chart every month
An RPM approach that works with the EHR	Readings, care plans and documentation live in Greenway Intergy, the record HealthLinc's dietitians and clinicians already use
Billing for every covered service	Claims for each eligible Medicare patient built in Intergy once a code's requirements are met, for HealthLinc's billing team to file
A dietitian and a community health worker on the team	The care-management call and the home readings give them a monthly record of each patient's progress between visits

The award and the service line are separate things. The award funds HealthLinc's nutrition network; the service line is a Medicare program billed under HealthLinc's NPIs. Where a patient is in both, the same monitoring record and the same billing serve each. How HealthLinc plans to meet the award's monitoring and billing requirements is discovery item number five.

[25] CMS Innovation Center technical FAQ, version 3, July 2026, and Request for Applications, May 30, 2024, for the Shared Savings Program's prospective primary-care payment option: health-center claims for beneficiaries assigned through Step 1 or Step 3 are paid through the prospective payment; a quarterly ACO-level guardrail pays the difference when that payment falls below the claims it replaces.

[26] HRSA press release, September 22, 2026, and award table; HRSA Awarded Grants data, award H2ATH55904, period of performance 09/01/2026 to 08/31/2031.

[27] HRSA funding notice HRSA-26-076, Telehealth Nutrition Services Network Grant Program, modified June 18, 2026: remote patient monitoring, staffing, equipment and third-party billing requirements.

9. Policy Watch: The CY2027 Proposed Rule, Repriced on This Forecast

CMS published its proposed CY2027 physician fee schedule in July 2026. The comment period closed September 14, 2026, the final rule is expected in early November 2026, and the changes take effect January 1, 2027. The proposal cuts the remote-monitoring device-supply codes. Every code in this forecast was repriced at the proposed CY2027 national amounts on HealthLinc's own billing mix and tier weights, with enrollment held constant.[28]

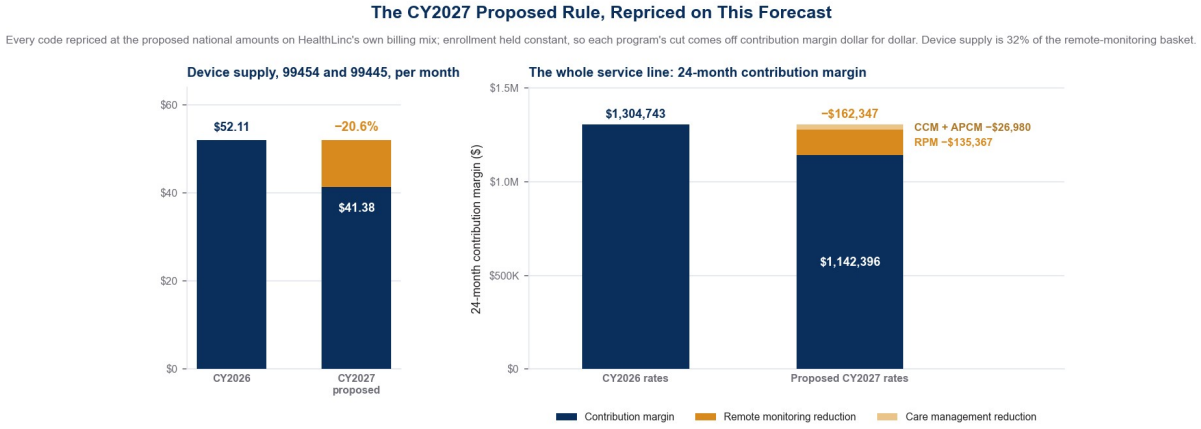


Figure 2. The CY2027 cascade on this forecast: the one code CMS proposes to cut, then the 24-month contribution margin of the whole service line at CY2026 and proposed CY2027 rates, with the reduction from each program in gold. Enrollment held constant.

Level	CY2026 rates	Proposed CY2027 rates	What changes
Device supply, 99454 and 99445	$52.11 a month	**$41.38 a month, −20.6%**	The code CMS proposes to cut
Remote monitoring arm, change in contribution margin		**−$135,367**	Device supply is 32% of the remote monitoring basket
Chronic care management, change in contribution margin		−$22,663	Routine rate changes only (−2.1%); not targeted
Advanced primary care management, change in contribution margin		−$4,317	Routine rate changes only (−0.7%); not targeted
Whole service line, 24-month contribution margin	**$1,304,743**	**$1,142,396 (−$162,347)**	Enrollment held constant, so the repricing passes through dollar for dollar

With enrollment held constant, every dollar of repricing comes off contribution margin: $135,367 from remote monitoring and $26,980 from the two care-management programs, which the proposal does not target, leaving $1,142,396 over 24 months. CoachCare will rerun the forecast at the final rates. The Self Service model in Section 6.3 already shows the unbundled alternative: software and devices on their own, with HealthLinc running the care team.

[28] CMS-1848-P, published July 2026. CoachCare repricing at the proposed CY2027 national amounts, conversion factor $32.8409 against $33.4009: device supply 32.1% of the remote monitoring basket; remote monitoring 46.5% of the line.

Code	What it pays for	CY2026 national	Proposed CY2027 national	Change
99453	Remote monitoring setup	$21.71	$20.03	−7.7%
99454 / 99445	**Device supply, 16+ days / 2–15 days**	**$52.11**	**$41.38**	**−20.6%**
99457	Treatment management, first 20 minutes	$51.77	$49.59	−4.2%
99458	Each additional 20 minutes	$41.42	$40.39	−2.5%
99470	Treatment management, 10–19 minutes	$26.05	$20.69	−20.6%
99490	Chronic care management, first 20 minutes	$66.13	$64.04	−3.2%
99439	Each additional 20 minutes	$50.44	$49.92	−1.0%
G0557	Advanced primary care management, level 2	$53.78	$53.20	−1.1%
G0558	Advanced primary care management, level 3	$117.24	$116.91	−0.3%

CY2026 Addendum B and CMS-1848-P proposed CY2027 Addendum B, national non-facility amounts, the basis of the repricing above. Section 1848(c)(7) of the Act limits how far a code's relative value can fall in one year.

10. Implementation Roadmap

10.1 Who runs what

Function	CoachCare	HealthLinc
Identification and enrollment	Registry query in Intergy starting with the hypertension, diabetes, kidney and heart-failure patients; an on-site enrollment specialist at 80 enrollments a month; telephonic enrollment; devices shipped, cellular-paired and replaced	Approves the criteria and target list by site; clinicians order at the visit or the wellness visit
Language	Scripts, consent, device instructions and outreach scoped for Spanish-preferring patients before launch	Sets the language plan; flags preferred language in the chart
Transitional care	Two-business-day contact and medication reconciliation; visit booked inside the 7- or 14-day window	Furnishes the visit and bills 99495 or 99496
Monitoring and escalation	Reading review, monthly outreach, business-hours alert triage and the post-discharge cadence, at 165 patients per care manager	**Sets thresholds and routing per site; receives escalations as Intergy tasks**
Documentation, billing, reporting	Monthly care documents in Intergy, claims created automatically, operational and clinical outcomes reports aligned with the UDS measures	**Reconciles and files under its own NPIs; keeps the revenue; names a program lead**
Greenway	Builds and supports the integration alongside Greenway	Brings the Elkhart sites onto Intergy on its own schedule

10.2 The model inputs

Input	Value in this forecast
Medicare panel	**7,453 patients across both health centers (HRSA UDS 2025: 5,987 HealthLinc and 1,466 Heart City Health), all in scope**
Referring clinicians	65 adult-medicine prescribers: 58 at HealthLinc (family physicians, internists and adult and family nurse practitioners) and 7 at the Elkhart sites
Programs	Remote monitoring, chronic care management and advanced primary care management; transitional care, behavioral health integration and community health integration at zero dollars

Input	Value in this forecast
Eligibility and acceptance	Remote monitoring 65% eligible, 25% accept; chronic care management 40%, 20%; advanced primary care management 35%, 20%; 5 referrals per clinician a month at 70% acceptance, ramping to full pace over the first 12 months; 70% of monitored patients also in a care-management program; 3% monthly attrition
APCM tier mix	15% level 1, 60% level 2, 25% level 3
Enrollment staffing	One CoachCare-funded on-site enrollment specialist at 80 a month, plus telephonic enrollment
EMR	Greenway Intergy, integrated as described in Section 4
Rates	CY2026 fee schedule, national non-facility amounts, the rate health centers bill; every patient priced at the Medicare amount

10.3 The first 90 days, across 18 clinics

Window	What happens	Result
Weeks 0–6 Integrate and charter	Intergy workshop with Greenway and HealthLinc's clinical, billing and IT leads; chart counts by payer, site and ACO assignment across both health centers; today's chronic care management and Food-as-Medicine patients mapped so nobody is called twice; thresholds, routing and the language plan agreed	Integration live, protocol and language plan signed
Weeks 6–12 First month at the largest sites, Elkhart included	The enrollment specialist working the largest medical schedules, with the two Elkhart medical clinics in the first wave; remote monitoring for hypertension and diabetes, a care-management program for two-plus conditions; the post-discharge cadence live	34 enrollments in month 1, 83 by month 2, 162 by month 3
Months 3–6 Every medical site	Knox, Morocco and the remaining South Bend, La Porte and East Chicago clinics on the same protocols; referral volume building toward full pace	570 enrollments by month 6
Months 7–24 Fill the ceilings	Advanced primary care management reaches 522 in month 9, chronic care management 596 in month 14 and remote monitoring 1,211 in month 22; eligibility re-checked against chart data; behavioral health integration scoped; documentation aligned with the UDS and ACO measures	2,329 enrollments, 1,546 unique patients; year 2: $992,031 of contribution margin

These programs carry Part B coinsurance, so the consent conversation explains the monthly cost plainly; Qualified Medicare Beneficiaries cannot be billed for Medicare cost-sharing.

10.4 What we would confirm together

1. **The Medicare chart count by payer, across both health centers.** Traditional Medicare against each Medicare Advantage plan, by site, and how many patients carry hypertension, diabetes or two or more conditions. Every ceiling in Section 6 moves with it.
2. **ACO assignment.** The number of Medicare patients assigned to the ACO and how the ACO's primary-care payment reaches HealthLinc for the care-management work.
3. **Today's chronic care management and Food-as-Medicine monitoring.** Who the care team nurses carry today, which patients have home devices, and how the two sit beside the new program without anyone being called twice.
4. **Medicare Advantage terms.** Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. Across the seven counties 48.1% of Medicare beneficiaries are in a plan, and more than half in St. Joseph and Elkhart.
5. **The HRSA award's monitoring and billing plan.** How the Telehealth Nutrition Services Network will meet the funding notice's remote monitoring and third-party billing requirements, and which patients it covers.

6. **The hospital feed for transitional care.** Where HealthLinc's patients are admitted, and whether a discharge notice reaches the health center today.
7. **The language plan.** The share of Medicare patients who prefer Spanish, by site, and who carries their calls.
8. **Coinsurance at consent.** How the monthly coinsurance is explained, and how the Medicaid crossover is handled for dual-eligible patients.

11. Recommendations

1. **Launch the full service line in the first month at the largest medical sites, Elkhart included, and reach every medical site by month 6.** $1,304,743 of contribution margin over 24 months, positive from month 2, with nobody hired.
2. **Pull the Medicare chart count by payer and ACO assignment in week one.** The chart count sets how high the ceilings sit, and ACO assignment sets how the money arrives.
3. **Start with the hypertension and diabetes patients.** A care-management program for the plan, a cellular cuff and glucometer for the readings, the wellness visit as the enrollment conversation.
4. **Put the dual-eligible patients on advanced primary care management.** Qualified Medicare Beneficiaries carry level 3 at $117.24 a month; the tier is set at enrollment.
5. **Launch Full Service, and revisit staffing once the census is running.** CoachCare carries the care team while the program fills, which returns $671,457 more contribution margin than Self Service over 24 months; HealthLinc's nurses keep the patients they manage today, and both deployments return a positive contribution margin.
6. **Use the program as the monitoring and billing record for the HRSA award.** The funding notice asks for both, and Intergy already holds them.
7. **Bill transitional care at every discharge HealthLinc learns of.** CoachCare makes the call; HealthLinc bills 99495 or 99496.
8. **Set the language plan before the first patient enrolls.** Scripts, consent, device instructions and outreach for Spanish-preferring patients, flagged in the chart.
9. **Aim the monthly work at the UDS and ACO measures, and keep clinical governance where it is.** Hold the top-quartile scores across 18 clinics, move depression remission, and avoid about 97 admissions over 24 months. HealthLinc's clinicians decide; CoachCare does the work and documents it.

The Medicare panel HealthLinc already serves supports a service line that returns $1,304,743 of contribution margin over 24 months, on staff HealthLinc does not hire and devices it does not buy. What remains is to build it once, inside Intergy, and run it as HealthLinc's own at all 18 clinics.

About CoachCare

> **The experience to get it right**
>
> CoachCare manages more than 500,000 patients across over 400 conditions, with more than 10,000 clinicians running remote care programs on its platform day to day. Its teams have stood up more than 1,000 programs, built the care-plan coding and billing behind more than 5 million claims, and recorded over 100 million vitals.

- **It builds on what HealthLinc already does.** HealthLinc already scores in HRSA's top quartile on blood pressure and diabetes, and its own nurses run care management for many of its patients. Remote monitoring adds daily readings to that work.

- **It runs inside the Greenway chart HealthLinc already uses.** Built on Greenway's own Intergy workflows and supported alongside Greenway; readings, documentation and claims live in the chart.
- **Fully staffed, no hiring.** Care managers at 165 patients each, enrollment, devices, business-hours alert triage and billing preparation on CoachCare's payroll.
- **Clinicians stay in charge.** HealthLinc's physicians and advanced practice clinicians set the protocols, sign the care plans and make every clinical decision.
- **Designed for HealthLinc's patients.** Cellular devices with nothing to pair, for Starke and Newton counties as much as for East Chicago and South Bend, and a language plan scoped with HealthLinc before the first enrollment.
- **Published results.** A 29.1 mmHg drop in Stage 2 hypertension at Cardiac Solutions, half the 30-day readmission rate at the same practice, and zero readmissions among 450 advanced heart-failure patients at Iowa Heart.

The ask is a working session with HealthLinc's leadership to confirm the Medicare chart count by payer and ACO assignment across the merged health center, walk through how chronic care management and Food-as-Medicine monitoring run today, map the monitoring and billing requirements of the HRSA telehealth nutrition award, and scope the Intergy workflow for all 18 clinics with Greenway.

Contact

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References & Data Sources

- **HealthLinc:** healthlincchc.org, retrieved October 2026, for history, locations, services, the care team model, chronic care management, Food as Medicine, the merger with Heart City Health and the patient portal.
- **HRSA:** Uniform Data System 2021 to 2025 for grants H80CS06662 and H80CS08221; Health Center Service Delivery Sites, October 2026; Awarded Grants data; the Telehealth Nutrition Services Network award table and press release, September 22, 2026; funding notice HRSA-26-076.
- **CMS accountable-care and provider files:** Medicare Shared Savings Program ACO Participants, 2025 and 2026; ACO REACH Providers, 2023 and 2024; the Innovation Center's technical FAQ (July 2026) and Request for Applications (May 2024) for the prospective primary-care payment option; NPPES; Doctors and Clinicians, October 2026.
- **Medicare payment rules:** the CY2026 Physician Fee Schedule final rule and Addendum B national non-facility amounts; CMS-1848-P, the CY2027 proposed rule.
- **Indiana Medicaid and the market:** Indiana Health Coverage Programs provider reference module for FQHCs and RHCs, October 2026; CMS Medicare Advantage State/County Penetration, October 2026.
- **CoachCare:** Greenway Intergy integration overview; Care Management Programs standard operating procedures, March 2026; Cardiac Solutions and Iowa Heart case studies; and the Value Analysis for HealthLinc, 2026, the source of every financial, enrollment, clinical-output and operational figure in Sections 6 to 11.

Unique patients and program enrollments are different numbers: 2,329 active program enrollments at month 24 belong to 1,546 unique patients, because a patient may hold a care-management and a monitoring enrollment at once.