COACHCARE | SERVICE LINE STRATEGY

Coffee Regional Medical Center, Inc.

1101 Ocilla Road, Douglas, Georgia · Coffee County — an 88-bed Sole Community Hospital operated by a 501(c)(3) under a county hospital authority lease, with an employed medical group across six towns

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (RPM + CCM, entered at the discharge through TCM) as the operating spine for chronic-disease management across the hospital, the employed medical group and the Rural Health Clinic — and as the shared infrastructure underneath TEAM, the Ambulatory Specialty Model, and an ENHANCED-track Shared Savings ACO

Purpose of this document

Prepared by CoachCare, August 2026, as a discussion document for the leadership of Coffee Regional Medical Center. It assembles the organization's public footprint, its CY2024 Medicare service record, its verified position in three CMS programs, the 2026–2027 payment environment, and a modeled financial forecast into a single argument: the 30 days after a discharge already carry measurable payment consequences for this hospital, and that window is currently neither staffed nor billed — while clinicians on the organization's own roster have already proven the model works.

Figures are drawn from CMS published files current to August 2026 and are cited in the References section. A companion Disclosures and Assumptions document records every modeling assumption, estimate method and source vintage behind the forecast.

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Executive Summary

Coffee Regional Medical Center is an 88-bed Sole Community Hospital in Douglas, Georgia, operated by a 501(c)(3) corporation under a forty-year lease from the Coffee County Hospital Authority, with an employed medical group — CRH Physician Practices — running clinics in six towns across five counties and a provider-based Rural Health Clinic certified under its own CMS number.[1] It is the only hospital in its Core Based Statistical Area, and it carries a Medicare panel substantially sicker than the national average: a beneficiary-weighted HCC risk score of 1.65 against a national reference of 1.00, an average patient age of 74.4, and chronic-disease prevalence of 34.1% for heart failure, 39.1% for chronic kidney disease, 41.3% for diabetes and 31.1% for COPD.[2]

Three CMS programs are simultaneously measuring this organization on the same population, and two of them carry downside risk. The hospital is a **mandatory** participant in the Transforming Episode Accountability Model, which has been live since 1 January 2026 and reconciles all Medicare Part A and Part B spending for 30 days after a qualifying surgical discharge.[3] Two heart-failure cardiologists who reassign their Medicare billing to Coffee Regional Medical Center are named on the CMS preliminary participant list for the Ambulatory Specialty Model, whose first performance year is CY2027.[4] And the hospital is a participant in an **ENHANCED-track** Medicare Shared Savings Program ACO — full two-sided risk on total cost of care, the highest risk level the program offers.[5]

The central argument

Coffee Regional is already accountable for what happens after a patient leaves the building — under an episode model, under a specialist model, and under a two-sided ACO. CMS is already reducing its inpatient payments for readmissions on three of five measured conditions. The layer of care that determines those outcomes — the 30 days after a discharge, and the months between visits for a chronic-disease panel — is currently neither staffed nor billed.

Clinicians on the organization's own roster have already proven the model produces revenue here: roughly $606,000 of remote monitoring, chronic care management and transitional care billing in CY2024. It runs on three people out of seventy-one.

A remote care service line closes that gap on fee-for-service economics alone — a modeled $6,332,846 of net reimbursement over 24 months at a 42.7% retained margin — before any episode, any specialist adjustment or any shared-savings settlement is counted.

The payment consequences are not hypothetical. CMS reduced Coffee Regional's FY2026 inpatient payments by 0.25% under the Hospital Readmissions Reduction Program. Of the five measures with a reported excess readmission ratio, three exceed 1.0 — heart attack at 1.0528, COPD at 1.0390 and heart failure at 1.0076 — and CMS penalized all three.[6] Separately, 490 Medicare beneficiaries passed through comprehensive observation services in CY2024 against 435 inpatient beneficiaries: more patients held for observation than admitted, with pneumonia excess days in acute care flagged at 31 per 100 discharges

[1] CRH Health Care, Inc., Audited Consolidated Financial Statements FY2025 (Forvis Mazars LLP), Note 1; Georgia Department of Community Health Annual Hospital Questionnaire 2025, Part C, filed 23 March 2026; CRH Health Care Consolidating Entities Organizational Chart 2025. Published by Coffee Regional Medical Center at coffeeregional.org.

[2] CMS Medicare Physician & Other Practitioners — by Provider, CY2024 (released 21 May 2026), queried for 75 clinician NPIs resolved from CMS Doctors and Clinicians by organization PAC ID; 71 returned CY2024 fee-for-service activity. Chronic-condition prevalences are beneficiary-weighted.

[3] CMS Transforming Episode Accountability Model participant list, rendition as of 15 April 2026 (cms.gov/team-model-participant-list): Mandatory | 110089 | COFFEE REGIONAL MEDICAL CENTER, INC | 20060 | Douglas, GA | 01/01/2026 | 12/31/2030.

[4] CMS Ambulatory Specialty Model Participants, CY2027 preliminary public file (data.cms.gov dataset 175d576d-0568-4ac2-aec5-d77f3ee02205), filtered to the Heart Failure cohort and matched by individual NPI against CMS Doctors and Clinicians reassignment records. Preliminary list; verdicts will be re-run against the final CY2027 file.

[5] CMS Medicare Shared Savings Program PY2026 participant file (data.cms.gov dataset 9767cb68-8ea9-4f0b-8179-9431abc89f11); participant record for COFFEE REGIONAL MEDICAL CENTER INC, ENHANCED track, high-revenue ACO, agreement period 3, retrospective assignment, SNF three-day rule waiver.

[6] CMS FY2026 Hospital Readmissions Reduction Program payment adjustment factors (Table 15) and supplemental data file. Payment adjustment factor 0.9975; dual proportion 0.2431; peer group 4.

while the pneumonia readmission rate itself is unremarkable.[7] Under FY2026 Hospital Value-Based Purchasing, Clinical Outcomes and Efficiency & Cost Reduction each score 10 out of 100, against 65 for Safety.[8]

Two structural facts make this an unusually well-timed conversation. First, Georgia has already put money behind the capability: the state received $218.9 million from the federal Rural Health Transformation Program, and eighty rural hospitals — Coffee Regional among them — were each awarded $750,000 for pre-implementation work on the state's rural value-based care model.[9] Second, the market is 62.8% Medicare Advantage in Coffee County, so the value-based levers, which attribute fee-for-service beneficiaries only, run on a smaller population than the fee economics do. The service line bills across the whole panel; the models score part of it. Both arguments are real, and they should not be conflated.

2026–2027 Priority Recommendations

#	Recommendation	Why now
1	Validate the eligible population with a chart count across CRH Physician Practices, the hospital clinics and First Care.	The forecast models 7,800 in-scope patients from a Medicare panel of roughly 12,000. This is the single input the whole model scales on, and the only one that cannot be settled from public data.
2	Industrialize the remote monitoring program that already exists on the roster rather than starting a new one.	A working panel, a proven billing pattern and a physician who has run it are already in place. Extending is faster than founding, and it lands directly on the heart failure cohort three CMS programs are scoring.
3	Stand up a structured post-discharge cadence — Day 1–2, Day 5–8, Day 12–14 — triggered by any admission or ED visit in the prior 60 days.	One workflow touches the TEAM episode window, the three penalized HRRP measures and the observation burden at the same time.
4	Bill 99453 at every enrollment, and adopt 99445 and 99470.	Setup does not appear in the CY2024 record at reportable volume, and the two short-window codes did not exist when the current program was built.
5	Route the $750,000 Rural Health Transformation award at the care-management capability the state's value-based model will require.	Budget period 1 runs to 30 October 2026. The capability being funded is the one described in this report.
6	Confirm Medicare Advantage contract treatment of the remote-care and care-management code families before budgeting.	At 62.8% MA penetration, most of the modeled panel's reimbursement is contract-dependent rather than fee-schedule-determined.

[7] CMS Medicare Outpatient Hospitals — by Provider and Service, CY2024, APC 8011 Comprehensive Observation Services for CCN 110089; CMS Care Compare unplanned hospital visits file (632h-zaca), EDAC_30_PN.

[8] CMS Hospital Value-Based Purchasing Total Performance Score, FY2026.

[9] Georgia Department of Community Health announcement, 23 July 2026, “Georgia reaches $103 million in total awards to date to expand rural healthcare”; Georgia GREAT Health Program Value-Based Care Hospital List, current as of 22 July 2026 (greathealth.georgia.gov). Federal award RHTCMS332046-01-00, Assistance Listing 93.798.

1. The Organization & Operating Model

1.1 Structure: an authority, an operator, and an employed group

Coffee Regional is not a simple independent hospital, and the distinction matters for who signs. The Coffee County Hospital Authority, a Georgia public body, owns the facility. Coffee Regional Medical Center, Inc., a 501(c)(3), operates it under a lease and transfer agreement dated 1 January 1995 with a forty-year term at a nominal amount — running to approximately 2035. Above the operator sits CRH Health Care, Inc., a 501(c)(3) holding company.[10] CMS records the ownership as "Government – Hospital District or Authority" while the IRS records a 501(c)(3) and the IPPS impact file records a voluntary nonprofit. All three are correct: the authority owns, the nonprofit operates.

Entity	Role
CRH Health Care, Inc.	501(c)(3) parent holding company
Coffee Regional Medical Center, Inc.	Operates the 88-bed acute care hospital and the provider-based Rural Health Clinic
CRH Physician Practices, LLC	The employed medical group — 37 clinicians
Orthopedic Surgeons of Georgia, LLC	Consolidated subsidiary
Emergency Physicians of Coffee County, LLC	Emergency department staffing
Coffee County Area Providers, LLC	The clinically integrated network vehicle, organized 2017 to coordinate delivery and reduce total cost of care
Coffee County Open Arms Clinic, LLC	501(c)(3) free clinic

The clinically integrated network entity is worth noting. An organization that stood up a physician-hospital organization specifically to coordinate care and reduce cost has already made the strategic decision this report builds on; what it has not yet done is staff the operating layer that makes such an entity perform.

1.2 The clinical footprint

The Medicare designation set is favourable and worth stating precisely, because it determines which programs apply. Coffee Regional is a short-term acute IPPS hospital — provider category 01, subtype 01 — carrying **Sole Community Hospital** status. It is not a Critical Access Hospital and not a Rural Emergency Hospital, which is why TEAM applies to it at all; and both its rural geography and its SCH designation independently qualify it for TEAM Track 2 from performance year 2.[11]

Attribute	Value
Medicare CCN	110089 (hospital) · 113460 (provider-based Rural Health Clinic)
Provider category	01 Hospital, subtype 01 — short-term acute, IPPS
Special designation	Sole Community Hospital
Certified beds	88, including a 14-bed rehabilitation unit
Core Based Statistical Area	20060 — Douglas, GA (Coffee and Atkinson counties)
Rural status	Rural on both geographic and special-payment classification

[10] See note 1.

[11] CMS FY2026 IPPS Final Rule Impact File (Provider Type 16, Sole Community Hospital; URGEO/URSPA rural); CMS Provider of Services file, QIES, Q2 2026; CMS TEAM safety-net and rural hospital fact sheet.

Attribute	Value
Case mix index	1.4432
Hospital overall star rating	3 of 5
Medicare participation since	1 July 1966

The employed enterprise is larger than the hospital. CMS reassignment records place 37 distinct clinicians in CRH Physician Practices, 28 billing through Coffee Regional Medical Center Inc, and a further 17 in the hospitalist group — 75 clinician NPIs across the three entities after deduplication.[12] The employed group's specialty mix is 15 nurse practitioners, 6 cardiologists, 4 physician assistants, 3 obstetrician-gynecologists, 2 family physicians, 2 general surgeons, 2 urologists, and single specialists in neurology, physical medicine and rehabilitation, and hematology-oncology, practising in Douglas, Nicholls, Waycross, Alma, Baxley and Hazlehurst. The hospital's own bench adds six internal medicine physicians against a residency program, five cardiologists and a general surgeon.

One structural fact carries a consequence for the analysis. Coffee Regional First Care is certified as a provider-based Rural Health Clinic with its own CMS number, tied to the hospital as parent.[13] Rural Health Clinic care management is billed institutionally under the clinic's own number and never appears in the physician claims files, so whatever care management the RHC performs is structurally invisible in the CY2024 record examined in Section 4.2. Certified RHCs also bill the unbundled care-management codes at national rather than locality rates. The forecast in this report uses the conservative locality basis across the whole panel; the RHC slice is modestly understated as a result.

1.3 Design principles for the 2026 service line

Principle	What it means here
Bill under the organization's own numbers	Reimbursement accrues to Coffee Regional. CoachCare is a service and technology partner, not a billing intermediary and not a shared-savings claimant.
Add no headcount	The enrollment specialist is staffed and paid by CoachCare. Across 133 open requisitions there is currently no care coordinator, population health, transitional care, navigator or health coach role — recruiting one into a rural market is the alternative this avoids.
One engine, every program	The same enrollment, monitoring, escalation and billing pipeline serves the hospital's post-discharge population, the employed group's chronic panel and the Rural Health Clinic.
Start where it already works	A remote monitoring panel already exists on the roster. The programme extends it rather than competing with it.
Fee-for-service first	The service line is margin-positive on FFS economics alone. Episode, specialist and shared-savings performance are additional, and are modeled separately from the fee forecast.

[12] See note 2.

[13] CMS Provider of Services file, QIES, Q2 2026: CCN 113460, provider category 12 (Rural Health Clinic), hospital-based indicator Y, parent provider number 110089, active. Corroborated by the CMS Rural Health Clinic Enrollments file effective 1 July 2026.

2. The Remote Care Service Line — The Operating Spine

2.1 What it is: the clinical and billing stack

The service line is a single clinical spine that begins at a discharge and continues into longitudinal management. Transitional care management is the on-ramp — a code five clinicians on the roster already bill. Remote physiologic monitoring supplies the objective signal. Chronic care management supplies the documented monthly contact. The three are sequential for a post-discharge patient and concurrent for a stable chronic one.

Layer	Codes	Clinical purpose
Transitional care	99495 · 99496	Contact within two business days of discharge, medication reconciliation, and a face-to-face visit inside 7 or 14 days. The entry point to the 30-day window.
Remote physiologic monitoring	99453 · 99454 · 99445 · 99457 · 99458 · 99470	Daily weight, blood pressure and pulse oximetry against a discharge baseline. Detects decompensation before it presents.
Chronic care management	99490 · 99439	Documented monthly clinical contact and care-plan maintenance for patients with two or more chronic conditions.

The one coordination rule

Chronic care management, principal care management and Advanced Primary Care Management are mutually exclusive for the same patient in the same month. Remote monitoring is not — it is billed alongside any of them. The forecast in this report models remote monitoring and chronic care management only; transitional care is described because it is the clinical entry point, and it is deliberately excluded from the financial model.

2.2 Standalone value: a margin-positive service line

The CY2026 billing stack at this locality

Every rate below is the CY2026 Medicare Physician Fee Schedule non-facility amount for MAC locality 1021299, resolved from the hospital's ZIP code.

Code	Service	2026 rate	Cadence
99453	Remote monitoring setup and patient education	$19.57	Once per episode
99454	Device supply, 16 or more days of readings	$46.58	Monthly
99445	Device supply, 2–15 days of readings (new for 2026)	$46.58	Monthly
99457	Treatment management, first 20 minutes	$48.78	Monthly
99458	Treatment management, each additional 20 minutes	$39.55	Monthly
99470	Treatment management, 10–19 minutes (new for 2026)	$24.56	Monthly
99490	Chronic care management, first 20 minutes	$63.30	Monthly
99439	Chronic care management, each additional 20 minutes	$48.01	Monthly

Modeled economics

The forecast models an in-scope population of 7,800 patients drawn from an estimated Medicare panel of 12,000, with 50 referring clinicians and one CoachCare-funded on-site enrollment specialist. Program

eligibility is 65% for remote monitoring and 75% for chronic care management; acceptance is 35% and 30%. Monthly attrition is 1.5%.

Modeled result	Year 1	Year 2	24-month
Net reimbursement to Coffee Regional	$2,197,579	$4,135,267	$6,332,846
CoachCare fees	$1,279,145	$2,347,249	$3,626,394
Margin retained by Coffee Regional	$918,434	$1,788,018	$2,706,452
Retained margin %	41.8%	43.2%	42.7%
Unique patients in active remote care	—	—	2,301 at month 24
Hospitalizations avoided	83	142	225
Care-team hours delivered	19,172	37,022	56,194

The margin, and how it is defined

Retained margin is 24-month practice profit divided by 24-month net reimbursement: $2,706,452 ÷ $6,332,846 = 42.7%. Year 1 runs lower at 41.8% because fixed implementation and integration fees post in the first month.

Month 1 clears positive at $1,457 after the $2,500 implementation fee and the $1,000 integration setup fee. There is no negative-margin quarter in the forecast.

The on-site enrollment specialist is staffed and paid by CoachCare. That cost sits on CoachCare's side of the model — it is embedded value in the figures above, never a deduction from the margin shown.

The 56,194 hours of care-team work over 24 months is the figure worth dwelling on in a rural market. At a 165-patient caseload it is the equivalent of 27 full-time staff — clinical labour delivered rather than recruited into a county where the alternative is a vacancy.

2.3 Connective tissue: one infrastructure, four programs

The same enrolled patient, the same daily reading and the same documented escalation serve four separate accountabilities. This is the argument for building once.

Program	What it measures	What the service line contributes
Fee-for-service	Nothing — it pays per service	$6,332,846 of net reimbursement over 24 months at a 42.7% retained margin. This layer stands alone.
TEAM	All Part A and Part B spending for 30 days after a qualifying surgical discharge	The post-discharge cadence is the only intervention that operates inside the reconciliation window. Readmissions, ED returns and post-acute utilization are what move episode cost.
Ambulatory Specialty Model	Heart-failure cost and quality at the clinician level, with a payment adjustment of −9% to +9% for the first two performance years widening to −12% to +12%	Heart failure is the largest inpatient DRG and the highest-prevalence chronic condition on the panel. Continuous physiologic data and documented monthly management are the operational requirements of the model.
Shared Savings Program (ENHANCED)	Total cost of care for an assigned population, with full downside risk	Avoided admissions are the principal lever. The ACO also holds a SNF three-day rule waiver, which signals an entity already managing post-acute transitions.

Where the fee model stops, stated plainly

The financial model in this report is fee-for-service. It does not model episode reconciliation under TEAM, specialist payment adjustment under the Ambulatory Specialty Model, or shared-savings settlement under the ACO.

That distinction cuts in a specific direction under two-sided risk. Care-management billing adds Part B spending, which counts inside an ACO's total cost of care, while the avoided admissions it produces subtract from it. For a risk-bearing organization the avoided-admission line — 225 hospitalizations over 24 months in this forecast — is the more important number, and it should be evaluated against the ACO's own benchmark rather than read off the fee forecast.

3. 2026 Policy & Payment Environment

3.1 TEAM: mandatory, live, and measured on the 30 days

Coffee Regional Medical Center appears on the CMS Transforming Episode Accountability Model participant list as a mandatory participant, CCN 110089, in CBSA 20060, for the performance period 1 January 2026 through 31 December 2030.[14] The list rendition current as of 15 April 2026 carries 720 hospitals — 710 mandatory and 10 voluntary electees — across 179 mandatory CBSAs. Coffee Regional is the only hospital listed in its CBSA, and its row reads mandatory, so this is unambiguous mandatory-market exposure rather than a voluntary election.

TEAM reconciles all Medicare Part A and Part B spending for 30 days following a qualifying surgical discharge across five episode categories. The realistic exposure here is modest in volume and should be stated as such: Coffee Regional performs no coronary artery bypass grafting, and hip and knee replacement sits below the CMS reporting threshold. The one TEAM-relevant episode visible above the suppression floor is surgical hip and femur fracture treatment at 11 or more discharges.[15] The accountability is not optional, the performance period has already begun, and the determinant of episode cost is post-discharge utilization — but this is not a large surgical bundle book, and the business case should not be built as though it were.

3.2 The Ambulatory Specialty Model: the specialist layer

CBSA 20060 is one of only seven Georgia areas on the CMS mandatory geography list for the Ambulatory Specialty Model, a 235-area file.[16] Because the geography is selected, the model cannot be ruled out by location and the clinician-level check is required. All 75 clinician NPIs across the three billing entities were matched against the current CMS Ambulatory Specialty Model participant file. **Two heart-failure cohort clinicians who reassign their Medicare billing to Coffee Regional Medical Center are named on the CY2027 preliminary participant list.**[17]

The model scores specialists on heart-failure cost and quality. The payment adjustment is −9% to +9% for the first two performance years and widens to −12% to +12% by the final year; the first performance year is CY2027, paid out in payment year 2029. Both listed clinicians also reassign billing to other organizations, so a share of their measured performance will sit outside Coffee Regional. The list is preliminary and will be re-run against the final CMS file.

3.3 An ENHANCED-track ACO: two-sided risk already accepted

Coffee Regional Medical Center Inc is a participant in an ENHANCED-track Medicare Shared Savings Program ACO on the PY2026 roster, alongside the hospitalist group and four other Douglas entities.[18] ENHANCED is full two-sided risk — the highest risk level in the program. The ACO is classified high-revenue, uses retrospective assignment, is in its third agreement period, and holds a SNF three-day rule waiver.

This changes what the service line is worth, and it changes who the buyer is. An organization carrying downside risk on total cost of care for an assigned population has an operational reason to fund avoidable-utilization reduction rather than debate it, and the SNF waiver signals an entity already working post-acute transitions. It also means the analysis should lead with avoided admissions rather than with billing volume — care-management revenue is Part B spending, and Part B spending counts inside the benchmark.

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[14] See note 3.

[15] CMS Medicare Inpatient Hospitals — by Provider and Service, queried by CCN 110089. CMS suppresses provider-DRG lines under 11 discharges; all counts are floors.

[16] CMS Ambulatory Specialty Model mandatory geographic areas file (235 areas, OMB 2023 CBSA codes): row 20060, CBSA, Douglas, GA — one of seven Georgia areas on the list.

[17] See note 4.

[18] See note 5.

3.4 The Rural Health Transformation Program: the money is already awarded

Georgia received $218,862,169.63 from CMS under the federal Rural Health Transformation Program, a five-year award beginning 2026, administered by the Department of Community Health as the GREAT Health Program. Eighty rural hospitals have completed the application to participate in the state's rural value-based care model — presently envisioned as a version of the CMS Innovation Center's AHEAD model — and have each been awarded $750,000 to support pre-implementation activities.[19] Coffee Regional Medical Center appears on Georgia's Value-Based Care Hospital List, designation Rural, current as of 22 July 2026. Budget period 1 runs to 30 October 2026.

The relevance is direct rather than thematic. Pre-implementation funding for a value-based care model buys exactly the capability this report describes: a consented longitudinal panel, documented monthly care management, continuous physiologic data and a working readmission-prevention loop. Whether the signed participation agreement and spend plan already commit the funds is not public, and is a first-conversation question.

3.5 The CY2026 fee schedule: remote care gets more billable

Two additions to the CY2026 Medicare Physician Fee Schedule matter for a rural panel. **99445** pays for device supply covering 2 to 15 days of readings, where previously a patient had to transmit for 16 days in a 30-day period for the practice to bill anything. **99470** pays for 10 to 19 minutes of treatment management, where previously the floor was 20 minutes. Both close gaps that fall hardest on exactly the patients a rural programme struggles to hold: the intermittently adherent, the newly enrolled, and the stable patient who needs twelve minutes rather than twenty. Neither code existed when the remote monitoring program currently running on the roster was designed.

3.6 The market: 62.8% Medicare Advantage

Coffee County runs 62.8% Medicare Advantage penetration against 56.3% for Georgia and 51.7% nationally; the surrounding catchment averages 61.7%, and Atkinson County — the other half of the TEAM and ASM geography — runs 71.6%.[20] Of 7,669 Medicare beneficiaries in Coffee County, only 2,932 are in Original Medicare. Dual-eligible beneficiaries are 30.4% of the county's Medicare population.

What the payer mix means for this forecast

The forecast prices the entire in-scope panel at the Medicare Physician Fee Schedule locality rate. Medicare Advantage plans must reimburse at no less than 100% of the Medicare rate, but that floor does not establish that a given MA contract pays the remote-monitoring and care-management code families on the same terms, or at all. On this account the majority of the modeled panel's reimbursement is contract-dependent.

Reviewing the top Medicare Advantage contracts for explicit treatment of 99453, 99454, 99445, 99457, 99458, 99470, 99490 and 99439 is the first budgeting step, and it precedes any commitment to the figures in Section 2.2.

The same fact constrains the value-based levers in the opposite direction: TEAM, the Ambulatory Specialty Model and the Shared Savings Program all attribute traditional-Medicare beneficiaries only, so they operate on the smaller part of the book while the fee economics operate on all of it.

[19] See note 9.

[20] CMS State/County Medicare Advantage Penetration file, July 2026; CMS Medicare Monthly Enrollment, April 2026, for the fee-for-service and dual-eligible denominators.

4. Performance Snapshot: The Starting Position

4.1 The panel: 1.65× national acuity

The CY2024 Medicare Physician & Other Practitioners file was queried for all 75 clinician NPIs across the three billing entities; 71 had fee-for-service activity. The resulting profile describes a panel considerably sicker than the national Medicare average.[21]

Measure	Coffee Regional enterprise	Reference
Beneficiary-weighted HCC risk score	1.65	National 1.00
Average beneficiary age	74.4	—
Heart failure	34.1%	—
Ischemic heart disease	46.1%	—
Chronic kidney disease	39.1%	—
Diabetes	41.3%	—
Atrial fibrillation	31.3%	—
COPD	31.1%	—
Depression	27.4%	—
Alzheimer's and non-Alzheimer's dementia	14.2%	—

Beneficiary-weighted across 71 clinicians with CY2024 fee-for-service activity. Hypertension and hyperlipidemia are omitted deliberately: CMS caps published chronic-condition prevalence at 75.0%, and both sit at or immediately below that cap, so neither can be read as a measurement.

The inpatient book matches the panel. Heart failure with major complications is the single largest reported DRG at 46 discharges, followed by pneumonia at 43 across two severity levels, sepsis at 17, renal failure at 12 and cardiac arrhythmia at 12.[22] CMS suppresses any provider-DRG line under 11 discharges, so each of these is a floor and the long tail is invisible. The chronic-disease conditions a remote care service line manages account for the clear majority of reported inpatient volume.

4.2 What is already billed — and by how few

This is not a greenfield account, and presenting it as one would be falsified in the first meeting. In CY2024, clinicians on the Coffee Regional and CRH Physician Practices rosters billed approximately $606,464 across the remote-care and care-management code families.[23]

Family	Codes	Beneficiaries	CY2024 allowed
Remote physiologic monitoring	99454 · 99457 · 99458	up to 268	$268,026
Chronic care management	99490 · 99439 · 99487 · 99491	up to 582	$288,863
Transitional care management	99495 · 99496	184	$46,024
Principal care management	99426	20	$3,551
Total	—	—	$606,464

Beneficiary counts are per-code and are not unique patients; the largest single-code count is shown. Figures are Medicare allowed amounts, decomposed by CPT so that no procedure code inflates the total.

[21] See note 2.
[22] See note 15.
[23] CMS Medicare Physician & Other Practitioners — by Provider and Service, CY2024, queried by NPI across the enterprise roster and decomposed by CPT. CMS suppresses provider-code lines under 11 beneficiaries.

What the data proves, stated precisely

One cardiologist on the roster carries substantially the entire remote monitoring book — 212 beneficiaries on device supply, 250 on treatment management, 222 on additional treatment management — plus 264 chronic care management beneficiaries. A second cardiologist carries 256 chronic care management beneficiaries and 107 on complex chronic care management. One internist runs a remote monitoring panel of roughly 18. Transitional care is spread across five clinicians at 13 to 32 beneficiaries each.

Three clinicians out of seventy-one produce essentially all of it. The programme has been proven and has not been industrialized.

Two absences matter. 99453 — setup and patient education at enrollment — does not appear at reportable volume, which means the enrollment work is being performed and not billed. And the highest-volume remote monitoring record on the roster bills from a second practice location rather than Douglas, so the geographic split of that panel cannot be established from public data and is a discovery question.

CMS suppresses provider-code lines under 11 beneficiaries. The honest reading is that there is no programme at meaningful scale beyond a handful of clinicians — not that no other clinician bills these codes at all.

Two further points of context. Advanced Primary Care Management codes did not exist until 1 January 2025, so their absence from the CY2024 record carries no information. And Rural Health Clinic care management is billed institutionally under the clinic's own CMS number and never appears in this file at all, so First Care's care-management footprint — whatever it is — is structurally invisible here.

4.3 The readmission and observation record

A generic readmissions argument would be imprecise at this hospital, because two different CMS files say different things and only one of them determines payment. Care Compare's public comparison rates every reported 30-day readmission measure as no different from the national rate. The Hospital Readmissions Reduction Program files, which set the payment adjustment, are less forgiving.[24]

HRRP measure	Eligible discharges	Excess readmission ratio	Penalized
Heart attack	41	1.0528	Yes
COPD	70	1.0390	Yes
Heart failure	120	1.0076	Yes
Pneumonia	172	0.9637	No
Hip / knee replacement	3	0.9866	No

FY2026 payment adjustment factor 0.9975 — a 0.25% reduction on all Medicare inpatient payments. Peer group 4 of 5 by dual proportion. A ratio above 1.0 indicates more readmissions than CMS predicts for a comparable case mix.

The pattern rather than the anecdote: five measures carry a reported excess readmission ratio, three exceed 1.0, and CMS penalized all three. Those three — heart attack, COPD and heart failure — are precisely the conditions a remote care service line manages, and they are the conditions the panel already carries at high prevalence.

[24] See note 6.

The second finding is separate and additive. In CY2024, 490 Medicare beneficiaries passed through comprehensive observation services against 435 inpatient beneficiaries — more patients held for observation than admitted, representing roughly $1.27 million of Medicare payment in a single outpatient category.[25] Alongside it, pneumonia excess days in acute care are flagged at 31 per 100 discharges, “More Days Than Average”, while the pneumonia readmission rate is unremarkable and pneumonia is the one chronic-disease measure not penalized. Excess-days measures count emergency department visits and observation stays that readmission measures ignore. The combination describes emergency department and observation churn rather than readmission failure — a pattern invisible in the readmission rate an organization is most likely to watch, and one that structured post-discharge follow-up addresses directly.

4.4 Value-based purchasing: the two lowest domains

FY2026 HVBP domain	Unweighted normalized score	Weighted contribution
Safety	65.0	16.25
Person & Community Engagement	37.0	9.25
Clinical Outcomes	10.0	2.50
Efficiency & Cost Reduction	10.0	2.50
Total Performance Score	—	30.50

Safety scores 65, consistent with six consecutive Leapfrog “A” grades — this is an organization that executes well on what it has staffed.[26] Clinical Outcomes and Efficiency & Cost Reduction each score 10 out of 100. Those are the two domains a remote care service line moves most directly, and they are the two furthest from where the rest of the scorecard sits. The gap is not a quality problem inside the building; it is the absence of a care layer outside it.

[25] See note 7.
[26] See note 8.

5. Target Populations & Clinical Pathways

Four cohorts carry the volume, and they are ranked here by the strength of the case rather than by size.

Cohort	Why this cohort	Pathway
Heart failure	Largest inpatient DRG at 46 discharges; 34.1% panel prevalence; a penalized HRRP measure; the clinical anchor of the Ambulatory Specialty Model the roster's cardiologists are named on. Four CMS programs point at this cohort.	Transitional care at discharge → daily weight and blood pressure → the three-touch cadence → longitudinal remote monitoring with chronic care management.
COPD	31.1% panel prevalence and a penalized HRRP measure at an excess readmission ratio of 1.0390.	Pulse oximetry and symptom monitoring, exacerbation detection, inhaler-adherence support through the monthly contact.
Post-discharge, all causes	490 observation beneficiaries against 435 admitted; pneumonia excess days flagged at +31 per 100 discharges. This cohort is also the TEAM episode window.	Triggered by any admission or ED visit in the prior 60 days, independent of referral.
Chronic kidney disease and diabetes	39.1% and 41.3% panel prevalence; the largest population and the slowest-moving cost.	Blood pressure and glucose monitoring in the employed group and the Rural Health Clinic, with chronic care management as the billing spine.

6. athenahealth Integration & Technology Architecture

Coffee Regional runs two clinical environments, and the distinction determines where this programme is built. The hospital's certified EHR is Altera Digital Health's Paragon for Hospitals, attested to CMS under Promoting Interoperability for program years 2023 and 2024, with a Veradigm FollowMyHealth patient portal.[27] The employed medical group runs athenahealth on a practice-scoped tenant shared across cardiology, oncology, the women's center and bariatrics.

Remote monitoring and care management are ambulatory activities and live on the athenahealth side. That is the favourable half of the split: athenahealth has a well-established integration path, while Paragon is a legacy platform with a narrower integration ecosystem and an active vendor-led migration track. Scoping the programme to the ambulatory environment avoids the harder integration entirely.

Integration capability	What it does
Bi-directional enrollment by service	Enrollment flags and trigger ordering sit inside the existing clinical workflow. The CoachCare team enrolls qualified Medicare patients on the practice's behalf, and enrollment status is visible in the chart in real time.
Exchange of health history	Problem list, medications and history flow bi-directionally at intake.
Integrated discrete vitals	Device readings land in the chart as discrete, trendable vitals rather than PDF attachments.
Escalation tasks	An out-of-range reading that needs the practice becomes a task in the system the team already works, routed to the person who should see it.
Compliance documentation	Time, touches and care-plan updates are written into the record as an audit-ready care summary — which is what a care-management audit asks for.
Automated claim generation	Claims are created by the CoachCare billing engine, removing the manual claim step for each patient every month.

Automated claim generation carries specific weight at this account. The forecast produces roughly 126,000 claims over 24 months. At a hospital where the enrollment work behind 99453 is already being done and not billed, the constraint is demonstrably administrative rather than clinical, and removing the manual claim step is what prevents the same leakage at scale.

[27] Office of the National Coordinator, Certified Health Information Technology Reported by Hospitals for Promoting Interoperability, Facility ID 110089, program years 2023 and 2024 (Altera Digital Health, Paragon for Hospitals EHR); corroborated by Coffee Regional's own physician access tools, forms and ordering pages.

7. Clinical Governance & Escalation

The economics establish that the service line pays. This section establishes that it is safe, which is the question a chief medical officer and a chief nursing officer will ask first. Every reading from every enrolled patient routes through one escalation engine, and the rules do not change by program, by clinic or by who is on shift.

Rule	Definition
Critical values escalate regardless of symptoms	A reading in the critical band moves immediately, whether or not the patient reports feeling unwell.
Out of range triggers a retake and symptom check first	Which is what keeps a mis-placed cuff from becoming a call to the practice.
A trend is defined objectively	Three readings at least one hour apart for blood pressure or glucose, or three within seven days for heart rate. Not a judgment call.
Unreachable is not resolved	Voicemail plus a callback attempt, and the escalation proceeds regardless if the value is critical or the trend is established.
Every escalation is documented	Vital, findings, contact method, who was reached, outcome and follow-up.

The emergent pathway

Chest pain, new shortness of breath, stroke signs, syncope, worst-ever headache or sudden swelling trigger a 911 call with the patient still on the line. If the patient refuses, they are directed to the clinic; if they refuse that and the presentation is emergent, CoachCare activates 911.

CoachCare's urgent and emergent policy supersedes any client-specific escalation preference. That is not negotiable in contracting, and it is what allows the model to run consistently across a six-town footprint.

Escalations route three ways: emergency to 911 with the practice notified; non-critical to a named member of the practice team defined during implementation; stable and resolved documented in the record as information only. The practice sees signal rather than 354,000 raw readings. Patients who cannot be reached are re-escalated on a fixed cadence, with the practice notified at every decision point.

The post-discharge cadence — Day 1–2, Day 5–8, Day 12–14 — is triggered by any emergency department visit or hospitalization in the previous 60 days rather than by referral. That trigger is what makes it reach the patients whose next admission is already forming, and it is the mechanism connecting this section to the readmission and observation findings in Section 4.3.

8. Implementation Playbook

8.1 Scope, and the modeled funnel

Year 1 scope is 7,800 in-scope patients drawn from an estimated Medicare panel of 12,000, across the employed group, the hospital's ambulatory clinics and the Rural Health Clinic. The enrollment engine combines 50 referring clinicians, one CoachCare-funded on-site enrollment specialist and a telephonic channel.

Milestone	Modeled position
Month 1	Net reimbursement $13,141; retained margin $1,457 — positive in the first month
Month 10	Remote monitoring reaches its enrollment ceiling of 1,775 active patients
Month 12	1,774 active on remote monitoring, 1,678 on chronic care management; Year 1 retained margin $918,434
Month 13	Chronic care management reaches its ceiling of 1,755 active patients
Month 24	2,301 unique patients in active remote care; 24-month retained margin $2,706,452

8.2 Staffing: nobody has to be hired

Across 133 open requisitions there is currently no remote monitoring, care coordination, population health, transitional care, navigator or health coach role. The service line does not require any of them to be created. CoachCare supplies the enrollment specialist on site, the monitoring and escalation team, the health coaches and the billing engine. The 56,194 hours of care-team work in the forecast — 27 full-time equivalents at a 165-patient caseload — are delivered rather than recruited.

What Coffee Regional supplies is clinical ownership: a named physician sponsor per cohort, a defined escalation recipient per clinic, and the standing orders that let enrollment happen without a separate visit.

8.3 Clinical workflow

Step	Who	What happens
Identify	CoachCare, from the chart	Eligible patients flagged against the qualifying-condition definition and the post-discharge trigger.
Enroll	CoachCare enrollment specialist, on site	Consent, device set-up and pairing. Cellular devices require no wifi, no smartphone and no app — which is what makes this work across a rural six-county footprint.
Monitor	CoachCare clinical team	Daily readings against the defined thresholds and trend rules in Section 7.
Escalate	CoachCare → the practice	Three-way routing. The practice receives exceptions and decisions.
Document and bill	CoachCare billing engine	Time, touches and care-plan actions captured as they happen; claims generated automatically under Coffee Regional's own numbers.

8.4 What moves the forecast, measured

Both programs reach their enrollment ceilings inside the first 13 months, which makes this a ceiling-limited service line. That has a specific consequence worth stating, because the intuitive answer is wrong: adding enrollment capacity does not raise the ceiling, and the number of patients enrolled at month 24 is identical in every staffing scenario. It does change how quickly the ceiling is reached, and those additional patient-months are real revenue.

Scenario	24-month net reimbursement	Retained margin	Unique patients, month 24
No on-site enrollment specialist	$5,875,550	$2,501,343	2,301
One specialist (modeled)	$6,332,846	$2,706,452	2,301
Two specialists	$6,625,917	$2,837,097	2,301
Three specialists	$6,833,211	$2,929,109	2,301
In-scope population 6,000	$5,173,279	$2,213,121	1,770
In-scope population 9,600	$7,310,937	$3,119,782	2,832

The binding constraint is the eligibility definition, not outreach capacity

Moving from zero to one enrollment specialist is worth $205,109 over 24 months, and from one to three a further $222,657 — real money, and none of it raises the ceiling.

Changing the in-scope population by roughly 1,800 patients moves the forecast by −18.2% or +15.3% — about twice the swing available from tripling enrollment staffing, and it moves the ceiling itself.

This is why the chart count is the first recommendation in this report. How widely Coffee Regional defines the eligible cohort determines the size of the service line; how many people it puts on outreach determines only how fast it arrives.

8.5 Twelve-month roadmap

Phase	Window	Work
Validate	Weeks 1–4	Chart count of the qualifying-condition population. Medicare Advantage contract review against the eight code families. Confirmation of the ambulatory EHR module and the integration scope.
Configure	Weeks 4–10	athenahealth integration, escalation routing per clinic, standing orders, cohort definitions, and the post-discharge trigger.
Launch on the proven cohort	Months 3–5	Extend the existing cardiology remote monitoring panel and stand up the heart failure post-discharge cadence.
Extend	Months 5–9	Chronic care management across the employed group's chronic panel; COPD cohort; the Rural Health Clinic.
Measure	Months 9–12	Readmission and observation rates on the enrolled cohort against the pre-enrollment baseline; billing yield per enrolled patient; escalation volume and disposition.

References & Data Sources

Every figure in this report traces to a CMS published file or to a document published by Coffee Regional Medical Center. The numbered footnotes below give the specific file, query and vintage for each. A companion Disclosures and Assumptions document records the modeling assumptions, estimate methods and open items behind the forecast in Section 2.2.

Source	Vintage
CMS Medicare Physician & Other Practitioners (by Provider; by Provider and Service)	CY2024, released 21 May 2026
CMS Medicare Inpatient Hospitals — by Provider and Service	CY2024
CMS Medicare Outpatient Hospitals — by Provider and Service	CY2024
CMS Care Compare (hospital general information; outcome measures; unplanned visits)	Current rendition, August 2026
CMS FY2026 Hospital Readmissions Reduction Program files	FY2026
CMS FY2026 Hospital Value-Based Purchasing Total Performance Score	FY2026
CMS FY2026 IPPS Final Rule Impact File	FY2026
CMS Provider of Services file (QIES); Rural Health Clinic Enrollments	Q2 2026; 1 July 2026
CMS TEAM participant list	As of 15 April 2026
CMS Ambulatory Specialty Model — mandatory geographies; CY2027 preliminary participants	2026
CMS Medicare Shared Savings Program participant file	PY2026
CMS Doctors and Clinicians (reassignment and roster)	Current, August 2026
CMS State/County Medicare Advantage Penetration; Medicare Monthly Enrollment	July 2026; April 2026
CMS Medicare Physician Fee Schedule, MAC locality 1021299	CY2026
ONC Certified Health IT Reported by Hospitals for Promoting Interoperability	Program years 2023–2024
Georgia DCH / GREAT Health Program rural health transformation awards	July 2026
Coffee Regional Medical Center audited financials, DCH questionnaire and public site	FY2025 / 2026