COACHCARE | SERVICE LINE STRATEGY

Candler County Hospital

A county-owned, 25-bed Critical Access Hospital in Metter, Georgia, with a 24/7 emergency department, a 15-bed swing-bed program, two certified provider-based Rural Health Clinics and a primary-care site in Pulaski

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line for the Medicare panel of the hospital's clinics: remote physiologic monitoring, chronic care management and advanced primary care management, billed under the CY2026 rules that pay a Rural Health Clinic for those codes individually, on top of the all-inclusive rate, and anchored on the discharge loop the hospital already runs

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of Candler County Hospital. It brings together the hospital's own utilization and certification record, the Medicare structure of Candler County, the CY2026 billing rules for Rural Health Clinics, a 24-month Value Analysis for a remote care service line at the hospital's clinics, the clinical governance that would run it, the TruBridge integration it lives in, and the state funding now moving in Georgia.

The argument is short. The hospital already owns every hand-off that decides whether a rural chronic-disease patient stays home: the clinic visit, the emergency department, the swing bed, the discharge. What it does not own yet is the month in between. Since January, Medicare pays a Rural Health Clinic for that month, on top of the visit.

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Executive Summary

Candler County Hospital is a county-owned, 25-bed Critical Access Hospital in Metter, Georgia, governed by the Hospital Authority of Candler County, a Critical Access Hospital since October 2004 and accredited by DNV.[1] It runs a 24/7 emergency department that saw 7,045 visits in 2025, a four-bed ICU, same-day surgery, imaging and rehabilitation, and a 15-bed swing-bed program that is the bulk of its inpatient work: 431 of 635 admissions in 2025, with Medicare paying for 84% of admissions.[2] It owns two certified provider-based Rural Health Clinics, Candler Medical Group (certified 2011; 22,484 visits in CY2024 across 7.1 practitioner FTE) and Candler Family Health Center (certified December 2024), plus Pulaski Health & Wellness, a primary-care site in Pulaski.[3] The hospital, its portal and its billing run on TruBridge.

That is a great deal of hospital for an 11,000-person county, and the organization already runs the discharge machinery a readmission-prevention program needs. What it does not run is the month between visits. Across the hospital's own clinicians, CY2024 Medicare fee-for-service claims show **no remote monitoring, chronic care management or advanced primary care management program at meaningful scale**; CMS suppresses any provider-and-code line under 11 beneficiaries, and care management billed on a Rural Health Clinic claim is not visible in that file either, so that is the precise claim.[4] The website, the organizational chart and current job postings show no care-management function beyond hospital case management; the clinic's one chronic-disease-specific role is a diabetic educator.

Candler County's Medicare population is **63.5% Medicare Advantage** (July 2026), and 30.5% of its beneficiaries are dual-eligible.[5] That mix shapes the revenue math in one specific way. 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. This report prices everything at the fee schedule and makes the contract check a first-week discovery item.

[1] CMS Hospital Enrollments file (July 31, 2026) and Provider of Services file (Q2 2026): Hospital Authority of Candler County d/b/a Candler County Hospital, CCN 111334, Critical Access Hospital, 25 certified beds; CAH designation effective October 1, 2004, per the Authority's audited financial statements. DNV NIAHO Critical Access Hospital certificate (2024) on the hospital's financial-transparency page.

[2] Georgia Department of Community Health Annual Hospital Questionnaire, CY2025, filed by the hospital March 5, 2026: 635 admissions (swing bed 431, medical-surgical 102, ICU 82, hospice 3, respite 17); 7,045 emergency visits; inpatient admissions by payer: Medicare 533 (84%), Medicaid 19, third-party 67, self-pay 16.

[3] CMS Rural Health Clinic Enrollments (July 17, 2026 vintage): CCN 118538 certified June 21, 2011; CCN 118586 certified December 3, 2024; both owned by the Hospital Authority of Candler County. FY2024 Medicare cost report, Worksheet M: 22,484 visits and 7.09 practitioner FTE at Candler Medical Group. Pulaski Health & Wellness is a primary-care site under the Authority with no RHC enrollment.

[4] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024 (released May 2026), queried per National Provider Identifier across every clinician billing under the Hospital Authority for codes 99453, 99454, 99457, 99458, 99091, 99445, 99470, 99490, 99439, 99491, 99424–99427, G0556–G0558, 99495, 99496, G0511 and G0512. No lines returned. Query mechanics were validated against a known-positive control, so the nulls are absences rather than query failures.

[5] CMS Medicare Advantage State/County Penetration, July 2026: Candler County, 2,479 eligibles, 1,574 enrolled in Medicare Advantage (63.5%). CMS Medicare Monthly Enrollment, CY2024: 2,382 beneficiaries, 726 dual-eligible (30.5%; 350 full, 376 partial).

The observation this report is built on

The hospital already owns every hand-off that decides whether a rural chronic-disease patient stays home: the clinic visit, the ED, the swing bed, the discharge. What it does not own yet is the month in between. Since January, Medicare pays a Rural Health Clinic for that month, on top of the visit.

In 2025 the hospital recorded 658 observation cases and 536 transfers out of its emergency department. Those are the shape of the between-visit gap: patients whose decompensation was discovered in the ED rather than at a kitchen table three weeks earlier. G0511, the bundled code Rural Health Clinics used for care management, has been retired. From January 2026 an RHC bills chronic care management, remote physiologic monitoring and advanced primary care management as individual codes at national non-facility Physician Fee Schedule amounts, in addition to the all-inclusive rate.[6] The new short-window RPM codes (99445, 99470) fit post-discharge monitoring exactly. And the state money is moving: Georgia's Rural Health Transformation award, GREAT Health, was funded at $218.8 million for its first year on December 29, 2025, with a further $93.3 million tranche announced August 27, 2026.[7]

What the Value Analysis returns

The forecast prices a service line for the Medicare panel of the hospital's clinics, 1,600 patients across the two Rural Health Clinics and the Pulaski site, traditional Medicare and Medicare Advantage together, referred by the 9 clinicians on the hospital's own clinic roster (4 physicians and 5 nurse practitioners and physician assistants) and delivered by CoachCare under the clinics' clinical direction.[8]

	Year 1	Year 2	24 months
Net reimbursement	**$463,832**	**$754,798**	**$1,218,631**
CoachCare fees	$271,697	$428,397	$700,093
Net to the hospital	**$192,135**	**$326,402**	**$518,537**
Margin to the hospital	41.42%	43.24%	**42.55%**

CoachCare Value Analysis. CY2026 non-facility Physician Fee Schedule, Georgia locality 99 (Rest of Georgia), a deliberately conservative basis; RHC claims pay national amounts (Section 2.2). 1,600 Medicare patients in scope; RPM + CCM + APCM. Margin is 24-month net to the hospital divided by net reimbursement.

1. **The program funds itself from the second month.** Month 1 nets −$5,404 to the hospital, because implementation lands before enrollment revenue does. The first positive month is M2, at $3,360. From M14 the service line runs at $62,898 in monthly net reimbursement and $27,199 net to the hospital.
2. **Nobody is hired.** CoachCare delivers 8,659 hours of care-management work over 24 months, about 4.2 full-time-equivalent years, including an on-site enrollment specialist carried at CoachCare's expense. No capital outlay, and no recruiting in a rural labor market where the hospital already competes for nurses.
3. **The Medicare-eligible pool enrolls inside a year.** APCM reaches its ceiling in M5, CCM in M8, RPM in M12. At M24 the program holds 724 active program enrollments across 472 unique patients. The binding constraint is the size of the Medicare panel, not enrollment capacity. Chart counts at the top of the credible range, the second clinic's first full year, and confirming which clinicians bill on the RHC claim are the three ways the ceiling moves.

[6] 42 CFR 405.2464(c), and the CMS CY2025 Physician Fee Schedule Final Rule fact sheet: Rural Health Clinics report the individual CPT and HCPCS codes for care coordination in place of G0511, paid at national non-facility Physician Fee Schedule amounts in addition to the per-visit all-inclusive rate; advanced primary care management coding was adopted for RHC payment on the same basis.

[7] Georgia Governor's press release, December 29, 2025 (CMS awards $218.8 million for the first year of GREAT Health); CMS press release, August 27, 2026 ($93.3 million further tranche for Georgia, fully committing Year 1).

[8] CoachCare Value Analysis for Candler County Hospital, 2026. Basis: CY2026 non-facility Physician Fee Schedule at Georgia locality 99; 1,600 Medicare patients in scope; 9 referring clinicians; RPM, CCM and APCM.

4. **The rate basis is deliberately conservative.** The forecast prices at Georgia locality 99. RHC claims pay national non-facility amounts, and locality 99 sits below the national amount on every code in the basket. Repriced on the national rail, the same census adds $75,046 of 24-month net reimbursement, all of it net to the hospital, and lifts the margin to 45.88%. None of that is in the headline.
5. **The clinical return is concrete.** The forecast projects 43.4 avoided hospitalizations over 24 months, roughly $651,000 at $15,000 per admission, from 68,369 device readings worked through one escalation protocol, with the swing-bed and ED discharge as the trigger.
6. **The staffing shape already fits the codes.** Nurse practitioners and physician assistants delivered 62.5% of the clinic's CY2024 visits. CCM, APCM and RPM are general-supervision code families; a clinic led by advanced-practice clinicians is the configuration they were written for.

1. The Hospital and Its County

1.1 A 25-bed Critical Access Hospital that kept everything running

Candler County Hospital is owned by the county and governed by the Hospital Authority of Candler County; it is not part of a health system, a holding company or a management arrangement.[9] It has been a Critical Access Hospital since October 1, 2004, and holds DNV accreditation. The state's 2025 hospital questionnaire records what that designation runs on: 635 admissions and 5,295 patient days, of which the 15-bed swing-bed program carried 431 admissions and 4,615 days; 102 medical-surgical admissions across six beds; 82 ICU admissions across four; 7,045 emergency visits with 706 admissions from the ED; 658 observation cases; 536 transfers out; 3,309 surgical and endoscopy procedures; and 16,440 outpatient and clinic visits.[10]

2025 service	Volume	What it means for the service line
Swing-bed program (15 beds)	431 admissions · 4,615 days	Every swing-bed discharge is a hand-off the hospital controls, and a transitional care episode
Emergency department (8 beds, 24/7)	7,045 visits · 706 admitted · 536 transferred	The referral engine and the trigger for the post-discharge cadence
Observation	658 cases	Between-visit decompensation, discovered late
Medical-surgical and ICU	102 + 82 admissions	Acute discharges home into the same loop
Inpatient payer mix	Medicare 84% of admissions	A Medicare service line reaches nearly the whole inpatient population

Georgia Department of Community Health Annual Hospital Questionnaire, CY2025, as filed by the hospital.

Two-thirds of the hospital's inpatient volume originates outside Candler County, across a seven-county catchment.[11] A county hospital that keeps a 24/7 emergency department, an ICU, a surgical service and a swing-bed program running at this scale, and that added a second certified Rural Health Clinic in December 2024, has the operating discipline a care-management program needs. Discharge planning, utilization review and a swing-bed coordinator already exist. What is missing is the layer that follows the patient home.

[9] Georgia Department of Community Health Annual Hospital Questionnaire, CY2025, Part C: facility owner Hospital Authority of Candler County (effective July 1, 1961); parent, operator and outside management arrangement all reported as none; not part of a health system, holding company, alliance or network. The hospital's About page: owned by the county, governed by the Hospital Authority, operated not-for-profit.

[10] Georgia Department of Community Health Annual Hospital Questionnaire, CY2025: admissions and days by unit; ED visits 7,045, admissions from ED 706, transfers out 536, observation cases 658; 3,309 surgical and endoscopy procedures; 16,440 outpatient and clinic (non-ER) visits; 8 ED beds.

[11] Annual Hospital Questionnaire, CY2025, patient-origin table: 208 of the hospital's inpatient admissions originated in Candler County, with the balance drawn from six surrounding counties.

1.2 Two certified Rural Health Clinics and a third primary-care site

The clinic side of the organization is where the service line lives. Candler Medical Group, at 10 Doctors Street in Metter, has been a certified provider-based Rural Health Clinic since June 2011 and is reported on the hospital's own cost report. In CY2024 it recorded 22,484 visits across 7.09 practitioner FTE (2.46 physician, 1.20 physician assistant, 3.43 nurse practitioner); nurse practitioners and physician assistants delivered 14,055 of those visits, 62.5%.[12] Candler Family Health Center, at 637 South Lewis Street, was certified as a second provider-based RHC on December 3, 2024, an expansion whose first full year is 2025. Pulaski Health & Wellness serves the county's second town with internal medicine and is not an RHC.

Site	Status	Since	Roster (hospital clinic pages)
Candler Medical Group, Metter	Provider-based RHC, CCN 118538	June 2011	Family medicine and internal medicine; podiatry; a diabetic-educator clinical nurse specialist; urgent care on the same site
Candler Family Health Center, Metter	Provider-based RHC, CCN 118586	December 2024	Internal medicine and women's health; visiting gastroenterology
Pulaski Health & Wellness, Pulaski	Primary-care site (not an RHC)	—	Internal medicine

CMS Rural Health Clinic enrollment and Provider of Services records, July 2026 vintage; the hospital's FY2024 Medicare cost report; the hospital's clinic pages, September 2026.

The forecast's referral roster is the 9 clinicians the hospital's own clinic pages place in primary care at these three sites: 4 physicians and 5 nurse practitioners and physician assistants. The podiatrist, the diabetic educator, the hospitalists, the emergency physicians and the visiting specialists are outside the count. Two further physicians on the clinic roster bill Medicare under other entities; whether their panels sit on the RHC claim is the first item in Section 11.[13]

1.3 Candler County: older, poorer, and mostly Medicare Advantage

Candler County has 11,043 residents, 19.1% of them aged 65 or older, against a poverty rate of 16.3% and an uninsured rate of 15.1%.[14] Its 2,479 Medicare eligibles were 63.5% enrolled in Medicare Advantage in July 2026; across the seven-county catchment the share is 62.2%. Of the county's 2,382 beneficiaries in CY2024, 726 (30.5%) were dual-eligible for Medicaid, 350 of them fully.[15]

Candler County	Value
Population (ACS 2024 five-year)	11,043
Aged 65 and over	2,110 (19.1%)
Poverty rate	16.3%
Uninsured (civilian, non-institutional)	15.1%

[12] FY2024 Medicare cost report (HCRIS), Worksheet M for RHC #1, Candler Medical Group: 2.46 physician, 1.20 physician-assistant and 3.43 nurse-practitioner FTE (7.09 total); visits by physicians 8,429, by physician assistants 5,510, by nurse practitioners 8,545 (22,484 total). Total RHC cost $5,326,587; cost per visit $234.73.

[13] The hospital's clinic pages (Candler Medical Group, Candler Family Health Center, Pulaski Health & Wellness), retrieved September 2026, filtered to primary-care clinicians; CMS Quality Payment Program eligibility records, 2026, for billing organization. The forecast's 9 clinicians exclude podiatry, the diabetic-educator clinical nurse specialist, hospitalists, emergency physicians and visiting specialists, and the two physicians whose Medicare billing resolves to other entities. The FY2024 cost report's 7.09 practitioner FTE is the corroborating count.

[14] U.S. Census Bureau American Community Survey 2024 five-year estimates, profiles DP03 and DP05, Candler County, Georgia: population 11,043; 2,110 residents aged 65 and over (19.1%); poverty 16.3%; 84.9% insured, 52.3% public coverage, 15.1% uninsured.

[15] CMS Medicare Advantage State/County Penetration, July 2026 (see note 5); the seven-county catchment of the hospital's patient-origin table totals 34,801 eligibles and 21,651 MA enrollees (62.2%). CMS Medicare Monthly Enrollment, CY2024, county file, dual-eligibility columns.

Candler County	Value
Medicare eligibles (July 2026)	2,479
Medicare Advantage penetration (July 2026)	**63.5%**
Seven-county catchment MA penetration	62.2%
Dual-eligible share of beneficiaries (CY2024)	**30.5%** (726 of 2,382)

U.S. Census Bureau ACS 2024 five-year estimates; CMS Medicare Advantage State/County Penetration, July 2026; CMS Medicare Monthly Enrollment, CY2024.

What 63.5% Medicare Advantage does to the revenue model

Medicare Advantage plans are required to cover Part B services and to pay at least the Medicare rate. That is the floor under nearly two-thirds of this panel. What the floor does not settle is whether each plan pays the care-management code families on the same terms and cadence as traditional Medicare; individual contracts set their own terms for those families.

The forecast in Section 5 prices the whole panel at the fee schedule. The matching operational move is early: confirm RPM, CCM and APCM payment terms with the dominant local plans during discovery, contract by contract (Recommendation 3).

The dual share works the other way. Advanced primary care management pays its highest tier, G0558 at $111.80 a month here, for Qualified Medicare Beneficiaries, and a 30.5%-dual county carries more of them than most.

1.4 The gap: the month between visits

Between-visit chronic care is the one service the organization does not deliver. A control-validated sweep of CY2024 Medicare fee-for-service claims across every clinician billing under the Hospital Authority returns no lines on any remote-monitoring code, any chronic-care-management code, any advanced-primary-care code or any transitional-care code.[16] CMS suppresses any provider-and-code line under 11 beneficiaries, and care management billed on an RHC claim under the clinic's own certification does not appear in that professional-claims file at all, so the precise finding is that there is **no remote-care or care-management program at meaningful scale in CY2024 claims**, and no observable care-management operation.

Everything else agrees with the claims data. The hospital's services pages list clinical resource management (case management, utilization review, social services) and the swing-bed program, and no monitoring, telehealth or chronic-care program. The organizational chart, revised December 2024, has case management, quality and a Rural Health Clinic coordinator, and no care-management or population-health function. Current job postings are for nurses, radiology technologists and medical records.[17] A diabetic educator at Candler Medical Group is the only chronic-disease-specific role visible. The 658 observation cases and 536 transfers out in 2025 are what that gap looks like from inside the emergency department. The gap is buildable, and in a county where the round trip to the clinic can be an hour, monitoring replaces windshield time for patients and for the clinic alike.

[16] CY2024 Medicare Physician & Other Practitioners sweep (see note 4). The small chronic-care-management volume that does appear in the file in this ZIP code attributes to a visiting specialist's own group, not to the Hospital Authority.

[17] The hospital's Services, Clinical Resource Management and Swing Bed Program pages; the organizational chart revised December 1, 2024; and the hospital's current listings on public job boards, all retrieved September 2026.

2. The CY2026 Billing Change for Rural Health Clinics

2.1 G0511 is gone; the individual codes pay on top of the all-inclusive rate

Rural Health Clinics are paid an all-inclusive rate per qualifying visit. For years, everything a clinic did for chronic patients between those visits was compressed into one bundled monthly code, G0511, one flat payment regardless of how many services, minutes or programs a patient carried. That code has been retired. From January 2026, RHCs report the individual CPT and HCPCS codes, the CCM, RPM and APCM families among them, and Medicare pays each at the **national non-facility Physician Fee Schedule amount, in addition to the all-inclusive rate** (42 CFR 405.2464(c)).[18]

CY2026 also added two codes that matter for a hospital with a swing-bed program: 99445 pays the device-supply month when a patient transmits 2 to 15 days of readings rather than 16 or more, and 99470 pays the first 10 minutes of monthly management time where 20 minutes is not reached. A patient discharged from the swing bed on the 20th of the month used to produce an unbillable partial month; now it bills. In this forecast the two codes carry $106,981 of gross reimbursement over 24 months, about 8.8% of net reimbursement, revenue that did not exist two years ago.[19]

The structural consequence is the point. Between-visit care stops being a flat bundled payment and becomes a per-service revenue line that scales with enrollment and delivered work, which is what makes a staffed, managed program worth running.

2.2 What the codes pay here

The Value Analysis prices every code at the CY2026 non-facility Physician Fee Schedule for Georgia locality 99, Rest of Georgia, the Palmetto GBA jurisdiction that covers ZIP 30439.[20]

Code	What it pays for	Cadence	CY2026 rate, GA locality 99
99453	RPM setup and patient education	One-time	$19.57
99454	Device supply, 16–30 days of readings	Monthly	$46.58
99445	Device supply, 2–15 days of readings (new 2026)	Monthly	$46.58
99457	RPM management, first 20 minutes	Monthly	$48.78
99470	RPM management, first 10 minutes (new 2026)	Monthly	$24.56
99458	RPM management, each additional 20 minutes	Monthly	$39.55
99490	CCM, first 20 minutes of clinical staff time	Monthly	$63.30
99439	CCM, each additional 20 minutes	Monthly	$48.01
G0556	APCM, level 1: one chronic condition	Monthly	$15.70
G0557	APCM, level 2: two or more chronic conditions	Monthly	$51.25
G0558	APCM, level 3: Qualified Medicare Beneficiary	Monthly	$111.80
99495	Transitional care management, moderate complexity	Per discharge	$208.27 (named, not in the forecast)
99496	Transitional care management, high complexity	Per discharge	$282.43 (named, not in the forecast)

[18] 42 CFR 405.2464(c) and the CY2025 PFS Final Rule fact sheet (see note 6). CMS allowed a transition period for billing-system updates; individual-code reporting is the standing requirement for 2026 dates of service.

[19] CoachCare Value Analysis, Financial Value detail: 99445 and 99470 together carry $106,981 of gross reimbursement over 24 months against $1,218,631 of net reimbursement (8.8%), on this forecast's code frequencies.

[20] CY2026 Physician Fee Schedule non-facility amounts, Georgia locality 99 (Rest of Georgia), Palmetto GBA Jurisdiction J; ZIP 30439 maps to this locality in the CMS ZIP-to-locality crosswalk (April 2026). These are the rates priced into the Value Analysis.

CY2026 non-facility Physician Fee Schedule, Georgia locality 99 (Rest of Georgia), the Value Analysis basis. The APCM tier blend in the forecast (15% level 1, 55% level 2, 30% level 3) yields $59.36 per patient-month, weighted toward G0558 for a 30.5%-dual county.

The national rail runs in the hospital's favor

On RHC claims these codes pay national non-facility amounts, and Georgia locality 99 prices below the national amount on every code in the basket, most of all on the device-supply codes.[21]

Repriced at the national amounts, the same census adds $75,046 over 24 months, every dollar of it net to the hospital: $1,218,631 of net reimbursement becomes $1,293,677, $518,537 net becomes $593,583, and the margin moves from 42.55% to 45.88%. The forecast keeps the conservative locality basis; the national rail is quantified upside.

These are traditional-Medicare amounts. 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. With 63.5% of the county's Medicare in Medicare Advantage, that contract check belongs in the first week of discovery rather than on a rate schedule.

2.3 The work the change creates, and who carries it

Individual-code billing pays more and asks more. Each code carries its own eligibility test, consent, time capture and documentation standard, and the claim volume is real: this forecast generates 20,054 claims over 24 months. A hospital billing office absorbing that by hand would resent every one of them. In the operating model of Section 9, CoachCare carries the load: enrollment, device logistics, monitoring documentation and billing-ready claim generation inside TruBridge. The hospital's own billing staff file the RHC claims, and the clinics keep the clinical decisions.

One structural note on Medicaid, because the deal design has to respect it. Georgia Medicaid fee-for-service does not reimburse remote physiologic monitoring, and Medicaid is roughly one Rural Health Clinic visit in five here.[22] The service line in this report is therefore built on the Medicare panel, where the individual-code rail is explicit, and carries no Medicaid dollars.

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

3.1 The clinical and billing stack

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

Program	Who qualifies	What it is	Billing
RPM	1,040 of the 1,600 Medicare patients (65%): hypertension, diabetes, heart failure, COPD	Cellular-connected devices (blood-pressure cuff, glucose meter, scale, pulse oximeter); readings monitored against clinical thresholds; monthly management time	99453 setup; 99454/99445 supply; 99457/99470/99458 management

[21] CY2026 national non-facility amounts (CMS RVU26A, GPCI 1.000) against Georgia locality 99: 99454 and 99445 $52.11 national versus $46.58; 99453 $21.71 versus $19.57; 99490 $66.13 versus $63.30; G0558 $117.24 versus $111.80. Rural Health Clinics bill the care-management codes at the national amount on the RHC claim.

[22] Center for Connected Health Policy, Georgia Medicaid policy summary (updated May 27, 2026), citing the Georgia Department of Community Health Telehealth Guidance Handbook, April 2026: remote patient monitoring not reimbursed under fee-for-service Medicaid. FY2024 Medicare cost report, Worksheet S-3: 4,745 Medicaid visits of 22,484 at Candler Medical Group (21.1%).

Program	Who qualifies	What it is	Billing
CCM	640 (40%): two or more chronic conditions expected to last twelve months or more	Monthly non-face-to-face coordination: comprehensive care plan, medication reconciliation, referrals, outreach	99490 + 99439
APCM	560 (35%): ongoing primary-care relationship; level set by condition count and Qualified Medicare Beneficiary status	Monthly bundle of thirteen practice-capability elements; no minute tracking	G0556 / G0557 / G0558
TCM	Any swing-bed, inpatient or observation discharge home	Contact within two business days, medication reconciliation, a face-to-face visit within 7 or 14 days	99495 / 99496, named and not in the forecast

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

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

The service line pays the hospital four ways. First, additive professional-fee revenue: every care-management dollar lands on top of the all-inclusive rate, not inside it. Second, it is the answer to geography. A daily blood-pressure reading from a kitchen table in Pulaski reaches a nurse the same morning, without anyone driving to Metter. Third, transfer avoidance: a patient whose fluid weight climbs for four days is treated by phone and in clinic, not stabilized in the ED and transferred to the regional referral hospital. That is where the forecast's 43.4 avoided hospitalizations come from, and it keeps the patient in the county. Fourth, the staffing model is recruiting-proof: CoachCare's clinical staff deliver the monitoring layer, so the program's growth does not depend on hiring nurses in a rural labor market.

3.2 The Medicare panel it runs on

The forecast is built on **1,600 Medicare patients** across the two Rural Health Clinics and the Pulaski site, traditional Medicare and Medicare Advantage together. The figure is the midpoint of a range triangulated from the hospital's CY2024 Medicare cost-report visit counts, the county's Medicare denominator and primary-care supply, and the CY2024 professional-claims bounds; Medicare Advantage is already inside it, with no gross-up. The first implementation step validates it against actual chart counts.[23] From that panel, the eligibility model carves the program pools: 1,040 patients RPM-eligible (65%), 640 CCM-eligible (40%), 560 APCM-eligible (35%). The pools overlap; the coordination rule keeps the billing disjoint.

[23] CoachCare Value Analysis eligibility model. The panel triangulates the FY2024 cost report's Medicare visit counts with the county's 2,382 Medicare beneficiaries, Metter's primary-care supply and the CY2024 professional-claims bounds. Program eligibility shares: RPM 65%, CCM 40%, APCM 35% of the in-scope panel.

3.3 Transitional care at the swing-bed discharge, named and not in the forecast

The hospital discharged 431 patients from its swing-bed program in 2025, and 184 more from medical-surgical and ICU beds. Each discharge home opens a transitional care management episode: an interactive contact within two business days, medication reconciliation, and a face-to-face visit within 14 days (99495, $208.27 at this locality) or 7 days (99496, $282.43). The hospital's clinics can bill those codes today because the hospital is the discharging facility and the clinic is the follow-up site.[24] TCM is on the recommended stack for that reason, and it carries no dollars anywhere in this forecast: the swing-bed census, the share of discharges that go home to a hospital clinic, and the visit-scheduling capacity are all discovery items. What TCM does in the forecast is clinical. A discharge is the highest-yield moment to enroll a patient in monitoring, and the three-touch post-discharge cadence in Section 4.5 runs on the same contact the TCM code requires.

3.4 Built the way the codes work: a clinic led by nurse practitioners and physician assistants

Nurse practitioners and physician assistants delivered 62.5% of Candler Medical Group's CY2024 visits, and the clinic carries 4.63 advanced-practice FTE against 2.46 physician FTE. For this service line that is the right shape, not a gap to apologize for. CCM, APCM and RPM are general-supervision code families: qualified clinical staff deliver the monthly work under a billing clinician's overall direction, without that clinician in the room. A clinic led by advanced-practice clinicians with a physician layer is the configuration these codes were designed to pay. The referral motion is one step, a clinician flags a qualifying patient in the chart, and the program runs from there.

3.5 Staffing: nobody is hired

CoachCare delivers 8,659 hours of care-management work across the 24 months, about **4.2 full-time-equivalent years**, without the hospital hiring anyone. The on-site enrollment specialist is CoachCare's expense, not a program cost. In a county where every growth plan eventually stalls on clinical recruiting, the service line adds the working capacity of four hires and zero requisitions.

That division of labor is the design, not a side effect. CoachCare's staff carry the recurring work: monitoring review, patient outreach, documentation, escalation handling. The hospital's clinicians contribute the two things only they can, the referral flag that starts each enrollment and clinical judgment at the escalation points. Section 5 prices what that arrangement produces.

4. The Discharge Loop: Clinical Governance and Escalation

4.1 The hospital owns every hand-off

Most remote care programs are bolted onto a clinic and hope the hospital tells them about admissions. Here the same organization owns the clinic visit, the emergency department, the observation unit, the swing bed and the discharge. Every one of the 2025 numbers in Section 1.1 is a hand-off the hospital controls, which means the program learns about an ED visit or a swing-bed discharge from the record, not from the patient's memory a month later. A monitoring program is a clinical operation before it is a revenue line. This section sets out the machinery the hospital inherits on day one: CoachCare's Care Management Programs standard operating procedures, March 2026 edition, rendered as seven process maps covering qualification, monitoring, escalation and discharge.[25] Critical Access Hospitals sit outside the Medicare readmission-penalty programs, so the argument here is not penalty avoidance. It is transfer avoidance, and keeping the patient in the county.

[24] CPT 99495 and 99496 requirements (interactive contact within two business days of discharge; face-to-face visit within 14 or 7 days; moderate or high medical decision-making); CY2026 non-facility amounts at Georgia locality 99: $208.27 and $282.43. Discharge counts from the Annual Hospital Questionnaire, CY2025 (see note 2). TCM is carried at zero dollars in every figure in this report.

[25] CoachCare Care Management Programs standard operating procedures, March 2026 edition, and the seven derived process maps: qualification and device assignment; the RPM patient lifecycle; the care-management lifecycle; alert-and-escalation decision logic; the emergent/urgent communication protocol; the post-discharge follow-up sequence; and the discharge decision flow.

4.2 One shared escalation engine

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

4.3 The emergent pathway

An active emergent symptom reported during any outreach contact triggers the 911 pathway. That policy supersedes any site-specific escalation preference: whichever clinic the patient belongs to, the emergent floor does not move. In this county the ambulance goes to Candler County Hospital's own emergency department, which is the point.

4.4 Qualification, device assignment and routing

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

4.5 The post-discharge cadence

An emergency-department visit or hospitalization within the last 60 days fires a fixed three-touch follow-up sequence: a first contact on day 1 or 2, a second on days 5 to 8, and a third on days 12 to 14. Each touch is documented, and any clinical alert surfaced during a touch escalates under the same shared logic; the post-discharge window gets more contact, not a different rulebook. For a swing-bed discharge the first touch is also the interactive contact a transitional care episode requires, and the day-12-to-14 touch lands inside the 14-day visit window. One workflow serves both.

4.6 Discharge governance and continuity

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

5. Value Analysis: The 24-Month Forecast

5.1 Headline economics

Over 24 months the service line produces **$1,218,631 in net reimbursement** to Candler County Hospital. CoachCare's fees total $700,093, including $36,383 of ancillary items: implementation, the TruBridge integration and telephonic outreach. Net to the hospital is **$518,537, a 42.55% margin** on the program, 41.42% in Year 1 and 43.24% in Year 2.[26]

[26] CoachCare Value Analysis, 24-month forecast: monthly net reimbursement, fees and net-to-hospital series; Year 1 margin 41.42%, Year 2 margin 43.24%, 24-month margin 42.55%, each defined as net to the hospital divided by net reimbursement. Ancillary fees of $36,383 over 24 months: implementation $2,500; TruBridge integration $4,000 setup, $150 a month and $1.50 per patient; telephonic outreach.

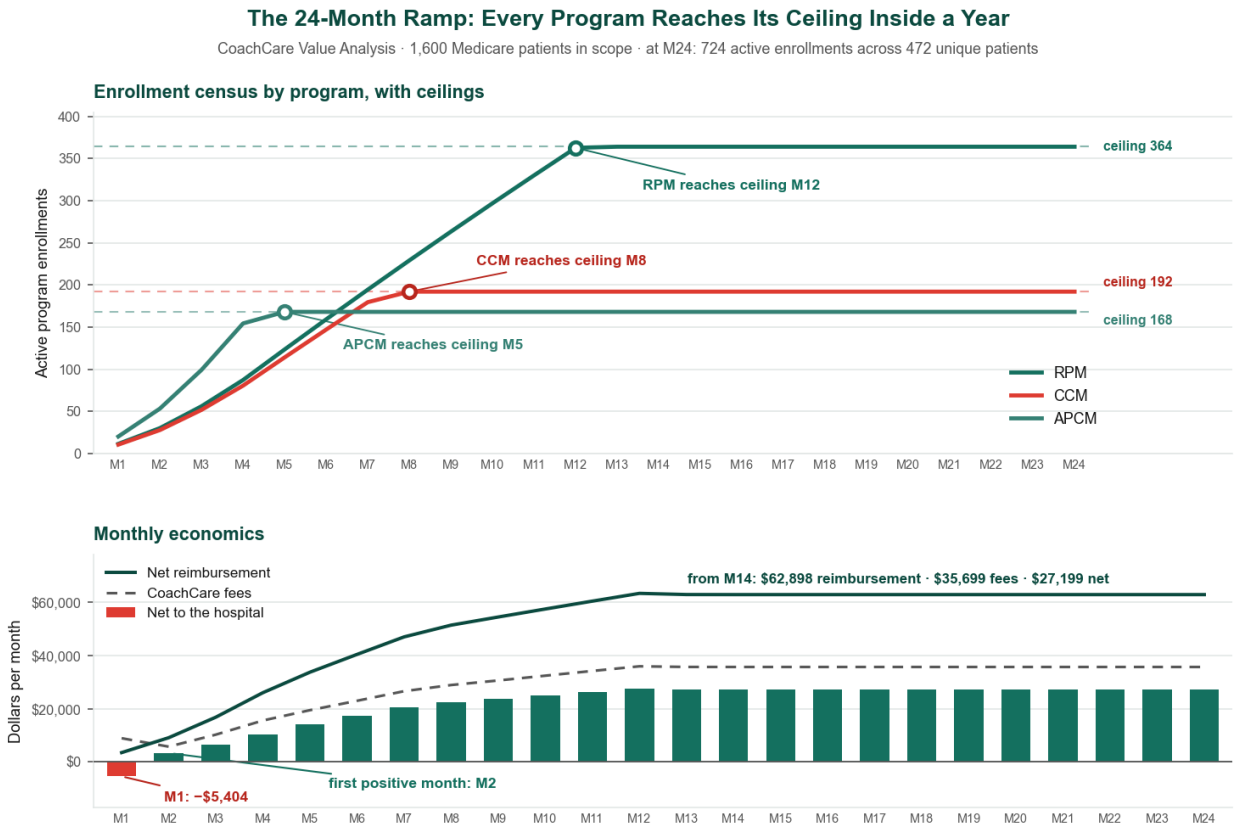


Figure 1. The 24-month ramp: enrollment census by program with ceilings (above) and monthly net reimbursement, CoachCare fees and net to the hospital (below). Month 1 nets −$5,404; the first positive month is M2; from M14 the line holds at $27,199 net per month.

The shape of the curve is worth reading precisely. Month 1 is negative, −$5,404, because implementation and enrollment effort land before the first full billing months do. Month 2 turns positive at $3,360, month 3 nets $6,553, and the line compounds as the three programs fill: by M12, the peak enrollment-plus-setup month, net reimbursement reaches $63,362 and net to the hospital $27,413, settling at $62,898 of net reimbursement, $35,699 of fees and $27,199 net a month from M14 once setup codes fall away and the census holds at ceiling.

5.2 Program economics by year

Program	Year 1 net reimbursement	Year 2 net reimbursement	24-month net reimbursement	24-month CoachCare fees	24-month net to the hospital
RPM	$198,584	$391,539	$590,123	$338,856	$251,267
CCM	$166,083	$243,597	$409,680	$203,259	$206,421
APCM	$99,165	$119,663	$218,827	$121,596	$97,232
Ancillary (implementation, integration, outreach)	—	—	—	$36,383	−$36,383
All programs	**$463,832**	**$754,798**	**$1,218,631**	**$700,093**	**$518,537**

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

RPM is the volume engine at 6,511 patient-months and $590,123 of net reimbursement. CCM is the yield engine at $105.73 of net reimbursement per patient-month across 3,875 patient-months, against $90.63 for RPM and $59.36 for APCM over its 3,687. APCM earns its place a different way: no minute-tracking, a bundled monthly payment, and the level-3 tier for Qualified Medicare Beneficiaries, $111.80 a month, in a county where 30.5% of beneficiaries are dual-eligible. Year 2 outruns Year 1 by $290,966 of net reimbursement because Year 1 carries the ramp and Year 2 runs at ceiling from its first month.

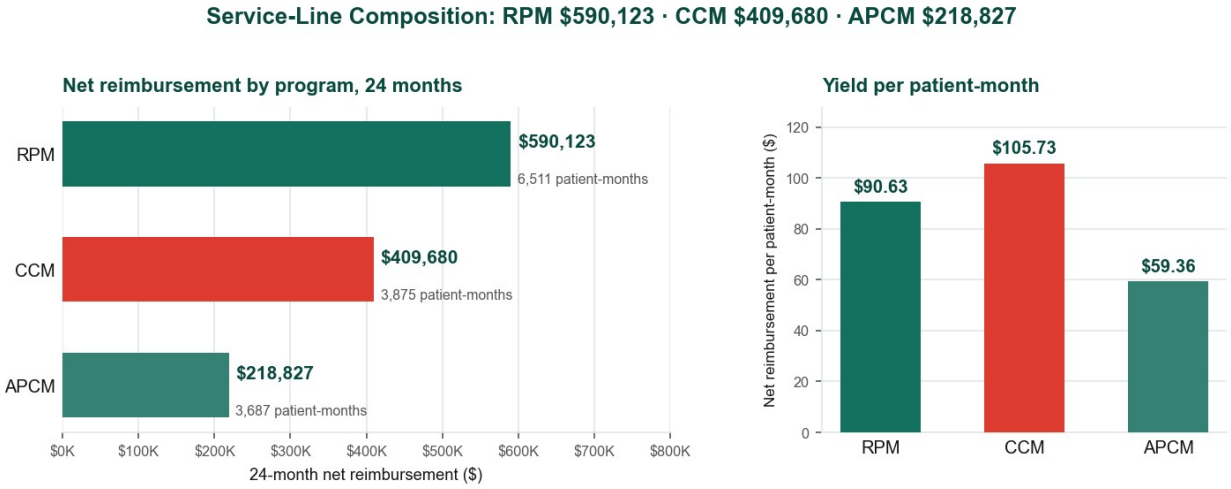


Figure 2. Service-line composition: per-program 24-month net reimbursement and net reimbursement per patient-month.

5.3 The ramp: every ceiling reached inside a year

This account is ceiling-limited in all three programs. APCM reaches its ceiling of 168 enrollments in month 5, CCM its 192 in month 8, RPM its 364 in month 12. The whole Medicare-eligible pool is enrolled inside a year, and from M13 the forecast is flat because there is no one left to add.[27] The first 90 days move fast: 42 enrollments across the three programs in month 1, 111 by month 2, 207 by month 3.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
RPM	1,040	364	Month 12	364
CCM	640	192	Month 8	192
APCM	560	168	Month 5	168
All programs		**724**		**724 enrollments · 472 unique patients**

Enrollment counts are program enrollments, not unique patients; the 724 enrollments at M24 belong to 472 unique patients, because a patient may carry a monitoring enrollment and a care-management enrollment at the same time.

Say the constraint out loud: what binds this program is the size of the Medicare panel, not enrollment capacity. That cuts two ways. It caps the forecast, and it de-risks it, because the model asks the clinics to produce no heroic enrollment performance, only a panel that exists. Three things move the ceiling upward: chart counts at the top of the credible range rather than its midpoint, the second Rural Health Clinic's first full year of visits, and confirmation that the two physicians who bill under other entities sit on the RHC claim. The on-site enrollment specialist cannot raise a ceiling, but it reaches every ceiling months sooner, and Section 10 prices what that is worth.

[27] CoachCare Value Analysis enrollment model: program ceilings 364 (RPM), 192 (CCM), 168 (APCM); ceilings reached in months 12, 8 and 5; 724 active enrollments across 472 unique patients at month 24 (471 at month 12). Dedup: 360 care-management enrollments plus the RPM enrollments not already carrying a wrapper.

5.4 What the program produces

24-month output	Volume
Claims generated, billing-ready	20,054
Device readings monitored	68,369
Care-management tasks completed	40,108
Chart updates written to TruBridge	10,027
Patient conversations held	6,016 (334 hours of call time)
Care-management hours delivered	8,659 (≈ 4.2 FTE-years)
Hospitalizations avoided	**43.4 · ≈ $651,000 at $15,000 per admission**

CoachCare Value Analysis operational and clinical outputs, 24 months.

The avoided-admission line deserves its own sentence. 43.4 avoided hospitalizations over 24 months is roughly $651,000 of cost that never lands on anyone, not on Medicare, not on the plans that cover 63.5% of the county, and not on the regional referral hospital's beds. For a Critical Access Hospital, each of those is also a patient who stayed in the county and, where a stay was needed, a candidate for the hospital's own swing bed rather than a transfer.[28]

6. TruBridge Integration: The Program Lives in the Record

The hospital, its clinics, its patient portal and its billing run on TruBridge. CoachCare integrates through a custom HL7/FHIR connection, priced as a custom integration ($4,000 setup, $150 a month and $1.50 per patient in the forecast), with the scope confirmed in contracting.[29] The program operates inside the record rather than beside it.

- **Out of the chart: eligibility flags and referral orders.** Qualifying patients are flagged and orders triggered inside the clinical workflow; CoachCare enrolls flagged Medicare patients on the hospital's behalf.
- **Back into the chart: vitals, documentation and status.** Device readings land as discrete vitals, not attached PDFs; care documentation, time capture and enrollment status write back to the record.
- **Billing-ready claims.** The CoachCare billing engine assembles the monthly claim lines, the step that makes individual-code billing workable at 20,054 claims over 24 months. The hospital's own billing staff file the RHC claims through TruBridge.
- **The discharge feed.** ED visits, observation stays and swing-bed discharges reach the program from the record, which is what arms the post-discharge cadence in Section 4.5 without anyone relaying a message.

CoachCare runs remote care programs for more than 500,000 patients across 400+ managed conditions, with 10,000+ providers on the platform, 1,000+ implementations completed, more than five million claims generated, and over 100 million vitals recorded.[30]

[28] CoachCare Value Analysis clinical-outcomes module: 43.4 avoided hospitalizations over 24 months, valued at $15,000 per avoided admission (≈$651,000).

[29] The hospital's website: TruBridge patient portal (Thrive) and CPSI web client, retrieved September 2026. CoachCare integration pricing for a custom HL7/FHIR connection as carried in the Value Analysis: $4,000 setup, $150 a month, $1.50 per patient. Interface scope is confirmed in contracting.

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

7. State Momentum: GREAT Health and the Rural Health Transformation Program

All fifty states received first-year awards under the federal Rural Health Transformation Program on December 29, 2025. Georgia's program, GREAT Health, received $218.8 million for its first year, and CMS announced a further $93.3 million tranche on August 27, 2026, naming telehealth access points, care-network continua, and pre-implementation funding for 87 rural hospitals preparing for a rural AHEAD model among the funded strategies.[31] The state's value-based-care track lists hospitals eligible by CMS designation, Critical Access Hospitals among them, and invited them to sign a letter of intent for a three-year pre-implementation period, with technical assistance and fiscal-risk mitigation aimed at small rural hospitals and clinics. Candler County Hospital is on that list by its Critical Access designation.[32]

This section is context. No participation, letter of intent or award is asserted here; the hospital's status on the value-based-care track is a discovery item in Section 11. The permitted argument is narrower and stronger. Every one of those doors has the same entry requirement: a consented longitudinal panel, documented monthly care management, continuous physiologic data and a working readmission-prevention loop. That is what the service line builds anyway, under fee-for-service, before any application is written. An applicant already operating a monitoring program makes a stronger case than one proposing to start one, and the funding is infrastructure money, not a payer change; it does not alter the Medicare billing rail this report is built on. Georgia HEART, the rural hospital tax-credit program the hospital already participates in, brought in about $2.06 million of community contributions in FY2024 and shows the county's willingness to fund its hospital.[33]

8. The CY2027 Proposed Rule, Repriced on This Forecast

CMS published its proposed CY2027 physician fee schedule in July 2026. Comments on CMS-1848-P closed September 14, 2026; the final rule arrives in early November; the changes take effect January 1, 2027, and a statutory phase-in caps how far any code's payment can fall in a single year. The proposal that matters here is a reduction to the remote monitoring device-supply codes. Every code in this forecast was repriced at the Georgia locality on this account's own billing mix, with enrollment held constant.[34]

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
Device supply, 99454 and 99445	$46.58 a month	**$37.01 a month, −20.5%**	The code CMS proposes to cut
The remote monitoring arm	$590,123 over 24 months	**−9.1%, −$53,469**	Device supply is 31% of the remote monitoring basket; management time moves little
Chronic care management	$409,680 over 24 months	−2.2%, −$9,015	Conversion-factor and relative-value churn only; the proposal does not target these codes
Advanced primary care management	$218,827 over 24 months	−0.7%, −$1,624	Same churn; the bundle's relative values barely move

[31] CMS press release, August 27, 2026, on the additional $93.3 million for Georgia's Rural Health Transformation Program, naming telehealth access points, care-network continua, workforce, surgical robotics, dementia capacity, cybersecurity and pre-implementation funding for 87 rural hospitals preparing for a rural AHEAD model; Georgia Governor's press release, December 29, 2025 ($218.8 million first-year award).

[32] GREAT Health, Value-Based Care page and value-based-care hospital list (retrieved September 2026): 93 hospitals eligible by CMS designation (Critical Access, Sole Community and Rural Referral), letter-of-intent deadline March 15, 2026, three-year pre-implementation period. Candler County Hospital appears on the list by its CAH designation. Participation and letter-of-intent status are not asserted here.

[33] Hospital Authority of Candler County audited financial statements, FY2024, note on Georgia HEART contributions (approximately $2,057,000 in FY2024).

[34] CMS-1848-P, proposed CY2027 Physician Fee Schedule (July 2026); comment period closed September 14, 2026. CoachCare repricing at Georgia locality 99 on this forecast's code frequencies and APCM tier weights: 99454 and 99445 from $46.58 to $37.01 (−20.5%); RPM arm −9.1% (−$53,469); CCM −2.2% (−$9,015); APCM −0.7% (−$1,624); service line −5.3% (−$64,107, from $1,218,631 to $1,154,523). Enrollment held constant.

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
The whole service line	$1,218,631 over 24 months	**−5.3%, −$64,107, to $1,154,523**	Remote monitoring is 48% of the line; care management is $10,639 of the total

CoachCare repricing of this forecast at the CY2027 proposed amounts, Georgia locality 99, on the code frequencies and APCM tier weights in this Value Analysis.

Three numbers, each smaller than the last only because its base is larger. A 20.5% cut to one code is a 5.3% change to the service line, because the line is built on three programs and two of them are not the one being repriced. On the national rail RHCs bill by law, the same census carries more cushion than the locality basis shows.

9. Implementation and the First 90 Days

9.1 Who runs what

CoachCare delivers	Candler County Hospital keeps
Telephonic and on-site enrollment; the enrollment specialist is CoachCare's expense	Referral flags in TruBridge; clinical oversight under general supervision
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans and escalation preferences per clinic
Monitoring, documentation and the escalation protocol of Section 4	Responses to clinic-routed escalations; the discharge feed from the hospital side
Billing-ready claim generation inside TruBridge	Filing the RHC claims; billing review; the revenue
Monthly operating reports against the dashboard in 9.4	Program governance

9.2 Devices and patient materials

Devices ship cellular-connected. A cellular cuff transmits the moment it is used: nothing to pair, no app, no password, no home broadband required, which matters in a county with a 16.3% poverty rate and a 19.1% share of residents over 65. Patient-facing materials are written at a low reading level, and enrollment happens by phone, in the clinic, and at the bedside before a swing-bed discharge, not through a portal.

9.3 Model inputs

Input	Value
Medicare panel in scope	1,600 patients across the two RHCs and the Pulaski site; validated against chart counts in the first 30 days
Referring clinicians	9 on the hospital's clinic roster (4 physicians + 5 nurse practitioners and physician assistants)
Programs	RPM + CCM + APCM; TCM named, not in the forecast; PCM off
Program-eligible pools	RPM 1,040 · CCM 640 · APCM 560
Enrollment ceilings	RPM 364 (M12) · CCM 192 (M8) · APCM 168 (M5)
Acceptance	RPM 35% · CCM and APCM 30% of the eligible pool
Enrollment engine	8 referrals per clinician per month at 80% acceptance; one CoachCare-funded on-site enrollment specialist at 80 enrollments a month; telephonic outreach on; 1.5% monthly attrition

Input	Value
Rate basis	CY2026 non-facility Physician Fee Schedule, Georgia locality 99 (Rest of Georgia), ZIP 30439; conservative, since RHC claims pay national amounts (+$75,046 over 24 months, Section 2.2)
APCM tier blend	15% level 1 · 55% level 2 · 30% level 3 = $59.36 per patient-month
Medicare Advantage	63.5% of Candler County's Medicare (July 2026). 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. Care-management payment terms are confirmed contract by contract in discovery.
EMR	TruBridge (CPSI); custom HL7/FHIR integration, scope confirmed in contracting

9.4 The 90-day plan and the operating dashboard

Days 0–30: foundation. Program agreement and the TruBridge integration workplan. Panel validation against chart counts, and confirmation of which clinicians bill on the RHC claim, the two inputs that move the model most. ICD-10 screening of the Medicare panel per the qualification map, device logistics staged, escalation routing localized per clinic, the discharge feed wired from the swing-bed and ED records, and clinician orientation to the general-supervision workflow. The Medicare Advantage contract check with the dominant local plans starts in week one.

Days 31–60: enrollment live. Telephonic, in-clinic and bedside enrollment running; first devices in homes; first billable service months. Month 1 nets −$5,404 as implementation lands; month 2 turns positive. The forecast carries 42 enrollments in month 1 and 111 by month 2.

Days 61–90: scale and file. Enrollment at 207 by month 3 and tracking toward APCM's ceiling in month 5. First monthly operating report against the dashboard. Decision point on the GREAT Health value-based-care track and any subgrant application, with a live program to describe rather than a proposed one.

The operating dashboard from month one:

- Enrollment census by program against ceiling (364 / 192 / 168)
- Time from referral flag to first billable enrollment (target: under five days from flag to first service)
- Discharges captured: swing-bed, inpatient, observation and ED discharges that entered the three-touch cadence, against the hospital's own discharge count
- Device-reading days per patient-month against the 16-day 99454 threshold, with 99445 capturing 2- to 15-day months
- Escalations by pathway: emergent, clinic-routed, documented
- Claims generated against expected claims, and claims filed
- Net to the hospital per month against the $27,199 steady-state line

10. Recommendations

1. **Stand up the service line on the Medicare panel now.** The individual-code rail has been live since January. The ramp is the ramp wherever it starts; each month of delay pushes the full $518,537 of 24-month net one month further out.
2. **Validate the panel and the billing entity in the first 30 days.** The 1,600-patient figure is the midpoint of the credible range and drives every ceiling in the forecast. The chart count is the single input that moves the model most, and the RHC practitioner list settles whether the two physicians who bill under other entities are inside the deal.

3. **Take the Medicare Advantage question to the plans early.** With 63.5% of the county's Medicare in Medicare Advantage, parity is the floor: plans owe at least the Medicare rate, and individual contracts set their own terms for the care-management code families. Confirm RPM, CCM and APCM terms with the dominant local plans in the first two weeks of discovery.
4. **Bill the RHC rail at national rates from the first claim.** The forecast prices at Georgia locality 99; RHC claims pay national non-facility amounts, worth $75,046 more over 24 months, all of it net to the hospital. Configure claims on the RHC rail and capture it.
5. **Make the swing-bed discharge the front door.** Wire the discharge feed first, enroll at the bedside, and bill transitional care on every discharge home to a hospital clinic. TCM is in the forecast at zero dollars; every episode billed is upside, and every episode enrolled is a monitoring patient from the day they most need it.
6. **Keep the CoachCare-funded enrollment specialist in the plan.** The specialist cannot raise the ceilings, but reaches them months sooner, and is worth $318,776 of 24-month net reimbursement against the no-specialist case in the table below.
7. **Apply for the state money as an operator, not an aspirant.** Confirm the hospital's status on the GREAT Health value-based-care track, and take a running program into any subgrant application.
8. **Set the attribution rule at enrollment.** Each patient carries one care-management wrapper, CCM or APCM, never both in a month, plus RPM where indicated and a transitional care episode after a discharge. One rule, set once in the enrollment workflow, prevents every double-billing collision the code families allow.

What moves the number

Scenario	24-month net reimbursement	Net to the hospital	Margin	Ceiling reached RPM / CCM / APCM
Base: 1,600 panel, 9 clinicians, 1 enrollment specialist	**$1,218,631**	**$518,537**	42.55%	M12 / M8 / M5
No on-site enrollment specialist	$899,855	$382,067	42.46%	never / M16 / M9
Second on-site enrollment specialist	$1,309,518	$557,359	42.56%	M9 / M6 / M4
Panel 1,200 (floor of the credible range)	$961,574	$406,679	42.29%	M10 / M6 / M4
Panel 2,000 (top of the credible range)	$1,444,236	$617,084	42.73%	M15 / M9 / M5
11 clinicians (the two physicians who bill under other entities join the RHC claim)	$1,242,217	$528,557	42.55%	M11 / M7 / M4
National RHC rate rail, same census	$1,293,677	$593,583	45.88%	M12 / M8 / M5

CoachCare Value Analysis recalculations at the same pricing. The binding constraint is the size of the Medicare panel, not enrollment capacity; the enrollment specialist changes when each ceiling is reached, not where it sits.

11. What We Would Confirm Together

Every item below is a discovery question, not a condition. The forecast stands on the figures in Section 5; these are the inputs that would move it, in the order they matter.

1. **The RHC practitioner list and chart counts.** Which clinicians bill on the Candler Medical Group and Candler Family Health Center claims, including the two physicians on the clinic roster who bill Medicare under other entities, and the Medicare chart count at each site against the 1,600 midpoint.
2. **The traditional-Medicare and Medicare Advantage split of the panel.** The county runs 63.5% Medicare Advantage; the clinics' own mix decides how much of the forecast rides on plan contracts.

3. **Medicare Advantage plan terms for the care-management code families.** RPM, CCM and APCM payment terms with the dominant local plans, contract by contract.
4. **GREAT Health value-based-care track status.** Whether the hospital signed the letter of intent by the March 15, 2026 deadline, and any subgrant applications in progress.
5. **The Pulaski Health & Wellness billing entity.** Whether the site's Medicare visits bill under the Hospital Authority.
6. **Urgent-care billing at 10 Doctors Street.** Whether urgent-care visits at the Candler Medical Group site bill as RHC encounters or as hospital outpatient.
7. **TruBridge integration scope.** Modules in use, the HL7/FHIR interfaces available, and the discharge feed from the swing-bed and ED records.
8. **The Georgia Medicaid handbook.** The current Department of Community Health telehealth guidance and physician fee schedule, to close the Medicaid coverage question at the primary source.
9. **Swing-bed discharge destinations.** The share of the 431 swing-bed discharges that go home to a patient of a hospital clinic, which sizes the transitional care opportunity this report leaves at zero.

References and Data Sources

- **CMS Hospital Enrollments (July 31, 2026), Provider of Services file (Q2 2026) and Care Compare Hospital General Information:** the Hospital Authority of Candler County, CCN 111334, Critical Access Hospital, 25 certified beds, original CAH participation October 1, 2004.
- **CMS Rural Health Clinic Enrollments (July 17, 2026 vintage) and Provider of Services file:** Candler Medical Group, CCN 118538, certified June 21, 2011; Candler Family Health Center, CCN 118586, certified December 3, 2024; both enrolled by the Hospital Authority under one CMS associate identifier.
- **Georgia Department of Community Health Annual Hospital Questionnaire, CY2025,** as filed by the hospital in March 2026: admissions, patient days, swing-bed, ICU and medical-surgical volumes, emergency visits, observation cases, transfers, surgical procedures, payer mix and patient origin.
- **CMS Healthcare Cost Report Information System, hospital cost reports FY2023 and FY2024, Worksheets M and S-3:** Rural Health Clinic visits, practitioner FTE by type, visits by practitioner type, Medicare and Medicaid visit counts, and the second clinic's first month of activity.
- **The hospital's website,** retrieved September 2026: the About, Clinics, Services, Clinical Resource Management and Swing Bed pages; the clinic sub-pages; the organizational chart revised December 2024; the financial-transparency page carrying the DNV certificate; and the site's TruBridge patient portal and web client.
- **CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024** (released May 2026): the control-validated sweep of every remote-monitoring, care-management, advanced-primary-care and transitional-care code across every clinician billing under the Hospital Authority. CMS suppresses any provider-and-code line under 11 beneficiaries; care management billed on an RHC claim is not in this file.
- **42 CFR 405.2464(c) and the CY2025 Physician Fee Schedule Final Rule** fact sheet: retirement of G0511; individual-code reporting for RHC care management; payment at national non-facility amounts in addition to the all-inclusive rate; APCM adopted for RHC payment; and the CY2026 additions 99445 and 99470.
- **CY2026 Physician Fee Schedule rate files (CMS RVU26A, January 2026 release):** non-facility amounts for the eleven forecast codes and the two transitional care codes at Georgia locality 99 (Rest of Georgia; work GPCI 1.000, practice-expense 0.892, malpractice 1.192), and the national-rate comparison producing the +$75,046 differential.

- **CMS Medicare Advantage State/County Penetration, July 2026, and CMS Medicare Monthly Enrollment, CY2024:** Candler County's 2,479 eligibles and 63.5% MA penetration; the seven-county 62.2%; 2,382 beneficiaries with 726 (30.5%) dual-eligible.
- **U.S. Census Bureau American Community Survey 2024 five-year estimates** (profiles DP03 and DP05), Candler County: population, age, poverty and insurance coverage.
- **CMS Medicare Shared Savings Program PY2026 participant file and the ACO REACH PY2026 participant list:** no participation by the Hospital Authority of Candler County or either Rural Health Clinic; known-positive controls run first to prove the queries functioned.
- **Rural Health Transformation Program records:** the CMS fifty-state award announcement of December 29, 2025 and Georgia's $218.8 million first-year award; the CMS announcement of August 27, 2026 of a further $93.3 million for Georgia; the GREAT Health value-based-care page and hospital list; and the Department of Community Health's June 8, 2026 first-subgrantee announcement.
- **Georgia Medicaid coverage:** the Center for Connected Health Policy's Georgia Medicaid summary (updated May 27, 2026) citing the Department of Community Health Telehealth Guidance Handbook, April 2026, on remote patient monitoring; the primary handbook is a Section 11 item.
- **Georgia HEART rural hospital tax credit:** the Hospital Authority's audited financial statements, FY2024, note on contributions received through the program.
- **CoachCare Care Management Programs standard operating procedures, March 2026,** and the seven process maps derived from them: the shared alert-and-escalation decision logic, trend definitions, the emergent communication protocol, three-way routing, the post-discharge three-touch sequence and the discharge decision flow reproduced in Section 4.
- **CoachCare integration standards** for custom HL7/FHIR connections: enrollment flags and orders out of the chart; vitals, documentation, enrollment status and billing-ready claims back into it.
- **CoachCare Value Analysis for Candler County Hospital, 2026, and the CY2027 repricing of the same forecast:** every financial, enrollment, clinical-output and operational figure in Sections 2, 5, 8, 9 and 10, built on 1,600 Medicare patients in scope, 9 referring clinicians, one on-site enrollment specialist, and CY2026 non-facility fee schedule rates at Georgia locality 99 for RPM, CCM and APCM.

How this report counts

Patients and program enrollments are different numbers. At M24 the program holds 724 active program enrollments belonging to 472 unique patients, because a patient may carry a monitoring enrollment and a care-management enrollment at the same time. Wherever this report gives a patient count it says patients; wherever it gives an enrollment count it says enrollments.

The panel figure is the midpoint of a range, on purpose. RHC visits bill under each clinic's certification rather than under individual clinicians, so clinician-level Medicare claims files structurally undercount an RHC panel. The 1,600-patient figure triangulates the hospital's FY2024 Medicare cost-report visits with the county's Medicare denominator and July 2026 Medicare Advantage penetration, and the first implementation step replaces it with actual chart counts.

No individual is named anywhere in this report. Governance, leadership and clinician composition are described by count and role only.