PHILLIPS COUNTY
HEALTH SYSTEMS

COACHCARE | SERVICE LINE STRATEGY

Phillips County Health Systems

A county-owned, 25-bed Critical Access Hospital in Phillipsburg, Kansas, with a 24/7 emergency department, inpatient and observation care, an outpatient specialty clinic, and one certified provider-based Rural Health Clinic

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line for the Medicare panel of the hospital's Rural Health Clinic: 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 Phillips County Health Systems. It brings together the organization's own utilization and certification record, the Medicare structure of Phillips County, the chronic care management program the clinic already runs, the CY2026 billing rules for Rural Health Clinics, a 24-month Value Analysis for a remote care service line at the clinic, the clinical governance that would run it, the Oracle Health integration it lives in, and the state funding now moving in Kansas.

The argument is short. The clinic already makes the monthly call to its chronic-disease patients. What it cannot see is the other twenty-nine days. Since January, Medicare pays a Rural Health Clinic for that month, code by code, on top of the visit, and nine in ten of this county's beneficiaries are paid on exactly that fee schedule.

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Executive Summary

Phillips County Health Systems is a county-owned, 25-bed Critical Access Hospital in Phillipsburg, Kansas, governed by a Board of Trustees appointed by the County Commission, a Critical Access Hospital since April 2003.[1] It runs a 24/7 emergency department with roughly 1,500 visits a year and a left-without-being-seen rate of 0%, inpatient and observation care, surgery, imaging, rehabilitation, cardiac rehabilitation, respiratory therapy, and an outpatient specialty clinic that brings visiting cardiology, nephrology, surgery and orthopedics to town.[2] It owns one certified provider-based Rural Health Clinic, Phillips County Medical Clinic, staffed by two family-medicine physicians and a group of nurse practitioners and physician assistants who also cover the hospital and the emergency department.[3] The clinic, its patient portal and its billing run on Oracle Health (Cerner).[4]

The organization already runs a chronic care management program: a dedicated care coordinator makes monthly calls, keeps a care plan, offers 24/7 phone access and watches medications, alongside video telehealth visits and a diabetes self-management education program the clinic launched in 2024.[5] What the organization does not yet collect is the physiologic signal between those calls. Across the clinic's own clinicians, CY2024 Medicare fee-for-service claims show **no remote monitoring at meaningful scale in CY2024 claims**; 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 professional-claims file either, so that is the precise claim.[6] One coordinator carries the whole chronic panel, there is no enrollment engine, and no advanced primary care management is on the stack yet.

Phillips County's Medicare population is one of the most Original-Medicare markets in the book: **9.3% Medicare Advantage**, so nine in ten of the county's beneficiaries are paid on the fee schedule this forecast prices, and 7.6% are dual-eligible for Medicaid.[7] Medicare Advantage plans must pay at least 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 plan check a first-week discovery item.

[1] CMS Care Compare Hospital General Information and the CMS Provider of Services file (Q2 2026): Phillips County Hospital, CCN 171353, hospital type Critical Access Hospital, government–local ownership, 25 certified beds; original Critical Access participation April 1, 2003; rural.

[2] CMS Medicare cost report (HCRIS), FY2024, and CMS Care Compare timely-and-effective measures: 213 total discharges (156 Medicare); Medicare 78% of inpatient days and 73% of discharges; emergency-department median time about 116 minutes and a 0% left-without-being-seen rate on a measure denominator of roughly 1,500 visits; inpatient services confirmed on the hospital's own service listing.

[3] CMS Rural Health Clinic Enrollments (July 2026 vintage): Phillips County Medical Clinic, a provider-based Rural Health Clinic (hospital-based indicator Y) enrolled under Phillips County Hospital; original Rural Health Clinic participation April 2002. The clinic's clinicians also cover the hospital and the emergency department per the organization's own clinical listing.

[4] The organization's website (patient portal on Oracle Health / Cerner) and a Cerner billing-services agreement recorded in the hospital's audited financial statements; retrieved September 2026.

[5] The clinic's chronic care management page, retrieved September 2026: patients with two or more chronic conditions; monthly calls; an individualized care plan; 24/7 phone access; medication oversight; coordination with other clinicians; one care coordinator. Video telehealth and a 2024 diabetes self-management education program are on the same site.

[6] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024, queried per National Provider Identifier across every clinician billing under Phillips County Hospital for the remote-monitoring, chronic-care-management, advanced-primary-care and transitional-care codes. No remote-monitoring lines returned. Query mechanics were validated against a known-positive control, so the nulls are absences rather than query failures.

[7] CMS Medicare Advantage State/County Penetration, September 2026 (Phillips County 9.3%), and CMS Medicare Monthly Enrollment, CY2025 (1,473 beneficiaries, 1,299 in traditional Medicare, a 7.6% dual-eligible share).

The observation this report is built on

The clinic already makes the monthly call. What it cannot see is the other twenty-nine days. Since January, Medicare pays a Rural Health Clinic for that month, code by code, on top of the visit, and nine in ten of this county's beneficiaries are paid on exactly that fee schedule.

The county sends about 213 inpatient discharges home a year, 156 of them Medicare, plus roughly 1,500 emergency visits, through a hospital that also owns the inpatient beds and the clinic those patients return to. Those hand-offs are the shape of the between-visit gap: decompensation found in the emergency department rather than at a kitchen table two weeks earlier. G0511, the bundled code Rural Health Clinics used for care management, has been retired. From January 2026 a Rural Health Clinic 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.[8] The new short-window RPM codes (99445, 99470) fit post-discharge monitoring exactly, and the state money is moving under the Kansas Rural Health Transformation Program.

What the Value Analysis returns

The forecast prices a service line for the Medicare panel of Phillips County Medical Clinic, 1,100 patients, traditional Medicare and Medicare Advantage together, referred by the 6 clinicians on the clinic's own roster (2 physicians and 4 nurse practitioners and physician assistants) and delivered by CoachCare under the clinic's clinical direction.[9]

	Year 1	Year 2	24 months
Net reimbursement	**$332,852**	**$495,022**	**$827,874**
CoachCare fees	$197,183	$280,927	$478,110
Net to the hospital	**$135,669**	**$214,095**	**$349,764**
Margin to the hospital	40.76%	43.25%	**42.25%**

CoachCare Value Analysis. CY2026 non-facility Physician Fee Schedule, Kansas statewide locality (carrier 05202, locality 00), a deliberately conservative basis; Rural Health Clinic claims pay national amounts (Section 3.2). 1,100 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 −$5,697 to the hospital, because implementation lands before enrollment revenue does. The first positive month is M2, at $2,559. From M11 the service line runs at $41,252 in monthly net reimbursement and $17,841 net to the hospital.
2. **Nobody is hired.** CoachCare delivers 6,218 hours of care-management work over 24 months, about 3.0 full-time-equivalent years, including an on-site enrollment specialist carried at CoachCare's expense. No capital outlay, and no recruiting in a northwest-Kansas labor market where the hospital already competes for nurses.
3. **The Medicare-eligible pool enrolls inside ten months.** APCM reaches its ceiling in M4, CCM in M7, RPM in M10. At M24 the program holds 498 active program enrollments across 324 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 new clinician's first full year, and confirming which clinicians hold panels on the Rural Health Clinic claim are the three ways the ceiling moves.

[8] 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 Rural Health Clinic payment on the same basis; the CY2026 additions 99445 and 99470.

[9] CoachCare Value Analysis for Phillips County Health Systems, 2026. Basis: CY2026 non-facility Physician Fee Schedule at the Kansas statewide locality; 1,100 Medicare patients in scope; 6 referring clinicians; RPM, CCM and APCM.

4. **The rate basis is deliberately conservative.** The forecast prices at the Kansas statewide locality. Rural Health Clinic claims pay national non-facility amounts, and Kansas sits below the national amount on every code in the basket. Repriced on the national rail, the same census adds $62,615 of 24-month net reimbursement, all of it net to the hospital, and lifts the margin to 46.31%. None of that is in the headline.
5. **The clinical return is concrete.** The forecast projects 31.5 avoided hospitalizations over 24 months, roughly $473,000 at $15,000 per admission, from 49,638 device readings worked through one escalation protocol, with the inpatient and emergency-department discharge as the trigger.
6. **The staffing shape already fits the codes.** The clinic is led by nurse practitioners and physician assistants. CCM, APCM and RPM are general-supervision code families; a clinic built the way this one is 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

Phillips County Health Systems is owned by Phillips County and governed by a Board of Trustees the County Commission appoints; it is a single county hospital, not part of a larger health system.[10] It has been a Critical Access Hospital since April 1, 2003. Around that 25-bed core it keeps a 24/7 emergency department, inpatient and observation care, surgery with imaging and a laboratory, physical, occupational and speech rehabilitation, cardiac rehabilitation and respiratory therapy, and an outpatient specialty clinic that brings visiting cardiology, nephrology, general surgery, orthopedics and other specialties to Phillipsburg on a schedule. In the emergency department the median time patients spend is about two hours, and the left-without-being-seen rate is 0%.[11]

Service	Volume (FY2024 / Care Compare)	What it means for the service line
Inpatient and observation discharges	213 discharges · 156 Medicare	Every discharge home is a hand-off the hospital controls, and an inpatient discharge is also a transitional care episode
Emergency department (24/7)	≈ 1,500 visits · 116-minute median time · 0% left without being seen	The referral engine and the trigger for the post-discharge cadence
Inpatient payer mix	Medicare 78% of inpatient days · 73% of discharges	A Medicare service line reaches nearly the whole inpatient population
Outpatient specialty clinic	Visiting cardiology, nephrology, surgery, orthopedics	Specialists arrive on a schedule; the month between visits is where the data has to live

CMS Medicare cost report FY2024 (discharges, Medicare share of days and discharges); CMS Care Compare timely-and-effective measures (emergency-department time and left-without-being-seen rate, ≈1,500-visit measure denominator).

A county hospital that keeps a 24/7 emergency department, a surgical service and an inpatient service running at this scale, in a county of 4,813 people, has the operating discipline a care-management program needs. Discharge planning and inpatient coordination already exist, and the organization recruited a new clinician to the clinic in August 2026. It has been recognized for top-quartile rural quality performance two years running. What is missing is the layer that follows the patient home between visits.[12]

[10] The hospital's About and history pages and the audited financial statements: owned by Phillips County, governed by a Board of Trustees appointed by the County Commission, operated as a single county hospital; retrieved September 2026.

[11] CMS Care Compare timely-and-effective and unplanned-visit measures (2023–2025): emergency-department volume in the lowest CMS band; median emergency-department time about 116 minutes; left-without-being-seen 0% on a denominator of roughly 1,500 visits. Service list from the hospital's own website.

[12] The clinic's roster and September 2026 news: two board-certified family-medicine physicians and a group of nurse practitioners and physician assistants; a new clinic clinician announced August 2026; a top-quartile rural-quality recognition in two consecutive years.

1.2 One certified provider-based Rural Health Clinic

The clinic side of the organization is where the service line lives. Phillips County Medical Clinic, at 1719 Highway 183 in Phillipsburg, is a certified provider-based Rural Health Clinic enrolled under Phillips County Hospital, with an original participation date of April 2002 and an automatic Health Professional Shortage Area designation that comes with the certification.[13] It is staffed by two board-certified family-medicine physicians and a group of nurse practitioners and physician assistants; the same clinicians cover the hospital and the emergency department, and the clinic offers weekday walk-in access. There is no employed specialist. All specialty care is visiting.

The forecast's referral roster is the 6 clinicians the clinic places in primary care: 2 physicians and 4 nurse practitioners and physician assistants. The emergency and hospitalist advanced practitioners, the behavioral-health prescriber and the visiting specialists are outside the count. One physician also holds enrollments at two other Critical Access Hospitals, so clinic full-time-equivalents may run below six; which clinicians hold panels on the Rural Health Clinic claim is the first item in Section 12.[14]

1.3 Phillips County: older, and paid almost entirely on the fee schedule

Phillips County has 4,813 residents with a median age of 45.7 years, and 25.6% of them are aged 65 or older, against a poverty rate of 15.4% and a median household income of $62,123.[15] The county holds 1,473 Medicare beneficiaries, 1,299 of them in traditional Medicare. Medicare Advantage penetration is 9.3%, one of the lowest shares in the market, so this is a service line whose revenue math sits almost entirely on the fee schedule the model uses. Of the county's beneficiaries, 7.6% are dual-eligible for Medicaid.[16]

Phillips County	Value
Population (ACS 2024 five-year)	4,813
Median age	45.7
Aged 65 and over	1,230 (25.6%)
Poverty rate	15.4%
Median household income	$62,123
Medicare beneficiaries (CY2025)	1,473
Traditional Medicare	**1,299**
Medicare Advantage penetration (September 2026)	**9.3%**
Dual-eligible share of beneficiaries	7.6%

U.S. Census Bureau ACS 2024 five-year estimates; CMS Medicare Monthly Enrollment, CY2025; CMS Medicare Advantage State/County Penetration, September 2026.

[13] CMS Provider of Services file and Rural Health Clinic Enrollments (see notes 1 and 3): one active, provider-based Rural Health Clinic under the hospital, at 1719 Highway 183; automatic Health Professional Shortage Area designation.

[14] The clinic's roster filtered to primary care, and CMS Doctors & Clinicians / Quality Payment Program records for billing organization. The forecast's 6 clinicians exclude the emergency and hospitalist advanced practitioners, the behavioral-health prescriber and the visiting specialists; one physician also holds enrollments at two other Critical Access Hospitals.

[15] U.S. Census Bureau American Community Survey 2024 five-year estimates, profiles DP03 and DP05, Phillips County, Kansas: population 4,813; median age 45.7; 1,230 residents aged 65 and over (25.6%); poverty 15.4%; median household income $62,123.

[16] CMS Medicare Monthly Enrollment, CY2025 (1,473 beneficiaries; 1,299 traditional Medicare; 112 dual-eligible, 7.6%) and CMS Medicare Advantage State/County Penetration, September 2026 (Phillips County 9.3%).

What a 9.3% Medicare Advantage county does to the revenue model

Northwest Kansas is a roughly nine-in-ten traditional-Medicare market, and Phillips County is at the low end of it. The revenue math therefore rides on the Medicare fee schedule the forecast prices, not on plan contracts. Medicare Advantage plans must pay at least the Medicare rate, a floor; individual contracts set their own terms for the care-management code families.

The matching operational move is small and early: confirm RPM, CCM and APCM payment terms with the plans that do cover the county during discovery, contract by contract (Recommendation 3). With nine in ten beneficiaries on the fee schedule, that check is a detail, not a dependency.

1.4 The gap: the month between visits

Between-visit physiologic data is the one thing the organization does not collect. A control-validated sweep of CY2024 Medicare fee-for-service claims across every clinician billing under Phillips County Hospital returns no lines on any remote-monitoring code.[17] CMS suppresses any provider-and-code line under 11 beneficiaries, and care management billed on a Rural Health Clinic 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 monitoring at meaningful scale in CY2024 claims**, worked by one care coordinator, with no enrollment engine behind it.

The county's shape is what makes the gap matter. Phillips County is a Rural Health Clinic shortage area, and a low-income-population shortage designation was added in March 2026; one in four residents is 65 or older, and the regional referral hospitals are 60 or more miles away in every direction.[18] About 1,500 emergency visits and 213 discharges a year, 156 of them Medicare, are the shape of the between-visit gap from inside the building. 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.

2. What the Clinic Has Already Built

2.1 A phone-based chronic care management program, telehealth and diabetes education

This is not whitespace. Phillips County Medical Clinic already runs a chronic care management program for patients with two or more chronic conditions: a dedicated care coordinator makes monthly calls, keeps an individualized care plan, provides 24/7 phone access, oversees medications and coordinates with the patient's other clinicians.[19] Alongside it the clinic offers scheduled video telehealth visits for chronic-disease management, medication management and follow-up, and it launched a diabetes self-management education program in 2024. The organization already does the monthly touch, and it already runs the discharge machinery a readmission-prevention program needs.

2.2 Build or partner: what the program adds

The honest way to describe this account is a build-or-partner decision, not a greenfield one. The existing program is a real asset, and the service line credits it rather than replacing it. What the current program does not cover is specific: no physiologic data between the monthly calls; one coordinator's capacity for the whole chronic panel; no enrollment engine to move eligible patients onto the program at pace; no

[17] CY2024 Medicare Physician & Other Practitioners sweep (see note 6): no remote-monitoring code lines for any clinician billing under Phillips County Hospital. Care management billed on a Rural Health Clinic claim under the clinic's certification does not appear in the professional-claims file.

[18] HRSA shortage-designation files, retrieved September 2026: the Rural Health Clinic automatic Health Professional Shortage Area designation and a low-income-population Health Professional Shortage Area added March 2026. Distances to the nearest regional referral hospitals computed from facility coordinates.

[19] The clinic's chronic care management page and telehealth page, and the 2024 diabetes-education announcement; retrieved September 2026. Whether the Rural Health Clinic bills the individual chronic-care codes for the program, and the current enrollment count, are not public.

advanced primary care management; and, since January, each care-management code now bills individually rather than as a single bundled payment.

The upgrade, plainly

The clinic's care coordinator becomes the clinical lead of a larger program rather than its bottleneck. CoachCare adds the daily physiologic signal, the enrollment engine and the individual-code billing the new rules reward, and carries the recurring monitoring and documentation work so the coordinator's time goes to the patients who need a clinician. Whether the clinic's current chronic care management enrollees sit inside the forecast's 132-patient CCM ceiling or on top of it, and whether the Rural Health Clinic bills the 99490 family today, are two discovery items in Section 12; the current enrollment count is not public.

3. The CY2026 Billing Change for Rural Health Clinics

3.1 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, Rural Health Clinics 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)).[20]

CY2026 also added two codes that matter for a hospital that discharges patients home: 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 hospital on the 20th of the month used to produce an unbillable partial month; now it bills. In this forecast the two codes carry $78,092 of gross reimbursement over 24 months, about 9.4% of net reimbursement, revenue that did not exist two years ago.[21]

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.

3.2 What the codes pay here

The Value Analysis prices every code at the CY2026 non-facility Physician Fee Schedule for the Kansas statewide locality (carrier 05202, locality 00), the jurisdiction that covers ZIP 67661.[22]

Code	What it pays for	Cadence	CY2026 rate, KS locality
99453	RPM setup and patient education	One-time	$19.36
99454	Device supply, 16–30 days of readings	Monthly	$46.97
99445	Device supply, 2–15 days of readings (new 2026)	Monthly	$46.97
99457	RPM management, first 20 minutes	Monthly	$48.22
99470	RPM management, first 10 minutes (new 2026)	Monthly	$24.28
99458	RPM management, each additional 20 minutes	Monthly	$38.86
99490	CCM, first 20 minutes of clinical staff time	Monthly	$62.06

[20] 42 CFR 405.2464(c) and the CY2025 Physician Fee Schedule Final Rule fact sheet (see note 8). CMS allowed a transition period for billing-system updates; individual-code reporting is the standing requirement for 2026 dates of service.

[21] CoachCare Value Analysis, Financial Value detail: 99445 and 99470 together carry $78,092 of gross reimbursement over 24 months against $827,874 of net reimbursement (9.4%), on this forecast's code frequencies.

[22] CY2026 Physician Fee Schedule non-facility amounts, Kansas statewide locality (carrier 05202, locality 00); ZIP 67661 maps to this locality in the CMS ZIP-to-locality crosswalk. These are the rates priced into the Value Analysis.

Code	What it pays for	Cadence	CY2026 rate, KS locality
99439	CCM, each additional 20 minutes	Monthly	$47.17
G0556	APCM, level 1: one chronic condition	Monthly	$15.33
G0557	APCM, level 2: two or more chronic conditions	Monthly	$50.41
G0558	APCM, level 3: Qualified Medicare Beneficiary	Monthly	$109.73
99495	Transitional care management, moderate complexity	Per discharge	$205.36 (named, not in the forecast)
99496	Transitional care management, high complexity	Per discharge	$278.88 (named, not in the forecast)

CY2026 non-facility Physician Fee Schedule, Kansas statewide locality (carrier 05202, locality 00), the Value Analysis basis. The APCM tier blend in the forecast (20% level 1, 70% level 2, 10% level 3) yields $49.33 per patient-month, weighted toward G0557 for a 7.6%-dual county.

The national rail runs in the hospital's favor

On Rural Health Clinic claims these codes pay national non-facility amounts, and the Kansas locality prices below the national amount on every code in the basket, most of all on the device-supply codes.[23]

Repriced at the national amounts, the same census adds $62,615 over 24 months, every dollar of it net to the hospital: $827,874 of net reimbursement becomes $890,489, $349,764 net becomes $412,379, and the margin moves from 42.25% to 46.31%. The forecast keeps the conservative locality basis; the national rail is quantified upside.

These are traditional-Medicare amounts. Medicare Advantage plans must pay at least the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. With nine in ten of the county's Medicare on the fee schedule, that check is a first-week discovery detail rather than a rate question.

3.3 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 14,407 claims over 24 months. A hospital billing office absorbing that by hand would resent every one of them. In the operating model of Section 10, CoachCare carries the load: enrollment, device logistics, monitoring documentation and billing-ready claim generation inside Oracle Health. The hospital's own billing staff file the Rural Health Clinic claims, and the clinic keeps the clinical decisions.

One structural note on Medicaid, because the deal design has to respect it. Kansas Medicaid fee-for-service coverage of the CPT remote-monitoring and chronic-care codes is not confirmed; the only remote benefit found is home-health telemonitoring with prior authorization.[24] The service line in this report is therefore built on the Medicare panel, where the individual-code rail is explicit, and carries no Medicaid figures. Dual-eligible patients are 7.6% of the county, so the point is minor.

[23] CY2026 national non-facility amounts against the Kansas locality: the Kansas locality prices below the national amount on every code in the forecast basket, most of all on the device-supply codes. Rural Health Clinics bill the care-management codes at the national amount on the Rural Health Clinic claim; repricing the same census on the national rail adds $62,615 over 24 months.

[24] The KanCare general-benefits provider manual and a third-party Kansas Medicaid policy summary, retrieved September 2026: fee-for-service coverage of the CPT remote-monitoring and chronic-care codes not confirmed; only home-health telemonitoring with prior authorization located. Dual-eligible beneficiaries are 7.6% of the county.

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

4.1 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	715 of the 1,100 Medicare patients (65%): hypertension, diabetes, heart failure, COPD	Cellular-connected devices (blood-pressure cuff, glucose meter, scale, pulse oximeter); readings monitored against clinical thresholds; monthly management time	99453 setup; 99454/99445 supply; 99457/99470/99458 management
CCM	440 (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	385 (35%): ongoing primary-care relationship; level set by condition count and Qualified Medicare Beneficiary status	Monthly bundle of practice-capability elements; no minute tracking	G0556 / G0557 / G0558
TCM	Any 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 reaches a nurse the same morning, without anyone driving an hour to the clinic. Third, transfer avoidance: a patient whose fluid weight climbs for four days is treated by phone and in clinic, not stabilized in the emergency department and sent 60 miles to a regional referral hospital. That is where the forecast's 31.5 avoided hospitalizations come from, and it keeps the patient in the county, where a needed stay can go to the hospital's own inpatient beds. 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.

4.2 The Medicare panel it runs on

The forecast is built on **1,100 Medicare patients** at Phillips County Medical Clinic, traditional Medicare and Medicare Advantage together. The figure is the midpoint of a range triangulated three ways: the county's 1,473 Medicare beneficiaries against the clinic's position as the county's only Rural Health Clinic;

five to six panel-holding clinicians at 200 to 250 Medicare patients each; and the structure of a provider-based Rural Health Clinic, whose panel is invisible in the Medicare professional file because its encounters bill institutionally under the clinic's own certification. Medicare Advantage is already inside the figure, with no gross-up.[25] From that panel, the eligibility model carves the program pools: 715 patients RPM-eligible (65%), 440 CCM-eligible (40%), 385 APCM-eligible (35%). The pools overlap; the coordination rule keeps the billing disjoint. The first implementation step validates the panel against actual chart counts.

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

The hospital sends about 213 patients home a year, 156 of them Medicare, from its inpatient 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, $205.36 at this locality) or 7 days (99496, $278.88). The clinic can bill those codes today because the hospital is the discharging facility and the clinic is the follow-up site.[26] TCM is on the recommended stack for that reason, and it carries no dollars anywhere in this forecast: the inpatient census, the share of discharges that go home to a clinic patient, 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 5.5 runs on the same contact the TCM code requires.

4.4 Built the way the codes work: a clinic led by advanced-practice clinicians

Phillips County Medical Clinic is led by nurse practitioners and physician assistants working with two family-medicine physicians. 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 built the way this one is 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.

4.5 Staffing: nobody is hired

CoachCare delivers 6,218 hours of care-management work across the 24 months, about **3.0 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 three hires and zero requisitions, and it turns the clinic's one care coordinator into the clinical lead of a larger program instead of its ceiling.

That division of labor is the design. CoachCare's staff carry the recurring work: monitoring review, patient outreach, documentation, escalation handling. The clinic's clinicians contribute the two things only they can, the referral flag that starts each enrollment and clinical judgment at the escalation points. Section 6 prices what that arrangement produces.

[25] CoachCare Value Analysis eligibility model. The panel triangulates the county's 1,473 Medicare beneficiaries against the clinic's position as the county's only Rural Health Clinic, five to six panel-holding clinicians at 200–250 Medicare patients each, and the institutional billing structure of a provider-based Rural Health Clinic. Program eligibility shares: RPM 65%, CCM 40%, APCM 35% of the in-scope panel.

[26] 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 the Kansas locality: $205.36 and $278.88. Discharge counts from the FY2024 Medicare cost report (see note 2). TCM is carried at zero dollars in every figure in this report.

5. The Discharge Loop: Clinical Governance and Escalation

5.1 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 stay, the inpatient bed and the discharge. Every hand-off in Section 1 is one the hospital controls, which means the program learns about an emergency visit or an inpatient 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 at signing: CoachCare's Care Management Programs standard operating procedures, rendered as process maps covering qualification, monitoring, escalation and discharge.[27] 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.

5.2 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.

5.3 The emergent pathway

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

5.4 Qualification, device assignment and routing

Enrollment starts with the panel, not the device inventory. The population is screened by ICD-10 code and routed to the right program and device, and device assignment follows a fixed, ordered hierarchy in which the highest-priority qualifying diagnosis wins: a patient with heart failure and diabetes gets the device the higher-acuity condition needs. Once monitoring runs, escalations route three ways: emergencies to the emergent pathway, non-critical clinical items to the clinic for direction, and informational items documented to the chart. Devices are cellular, not app-dependent, so a patient needs no home broadband and no smartphone to be monitored.

5.5 The post-discharge cadence and discharge governance

An emergency 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 an inpatient 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.

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,

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

and if the clinic has given no instruction by 180 days the discharge proceeds. Nobody quietly falls out of the program, and nobody quietly stays in it either.

6. Value Analysis: The 24-Month Forecast

6.1 Headline economics

Over 24 months the service line produces **$827,874 in net reimbursement** to Phillips County Health Systems. CoachCare's fees total $478,110, including $28,699 of ancillary items: implementation, the Oracle Health integration and telephonic outreach. Net to the hospital is **$349,764, a 42.25% margin** on the program, 40.76% in Year 1 and 43.25% in Year 2.[28]

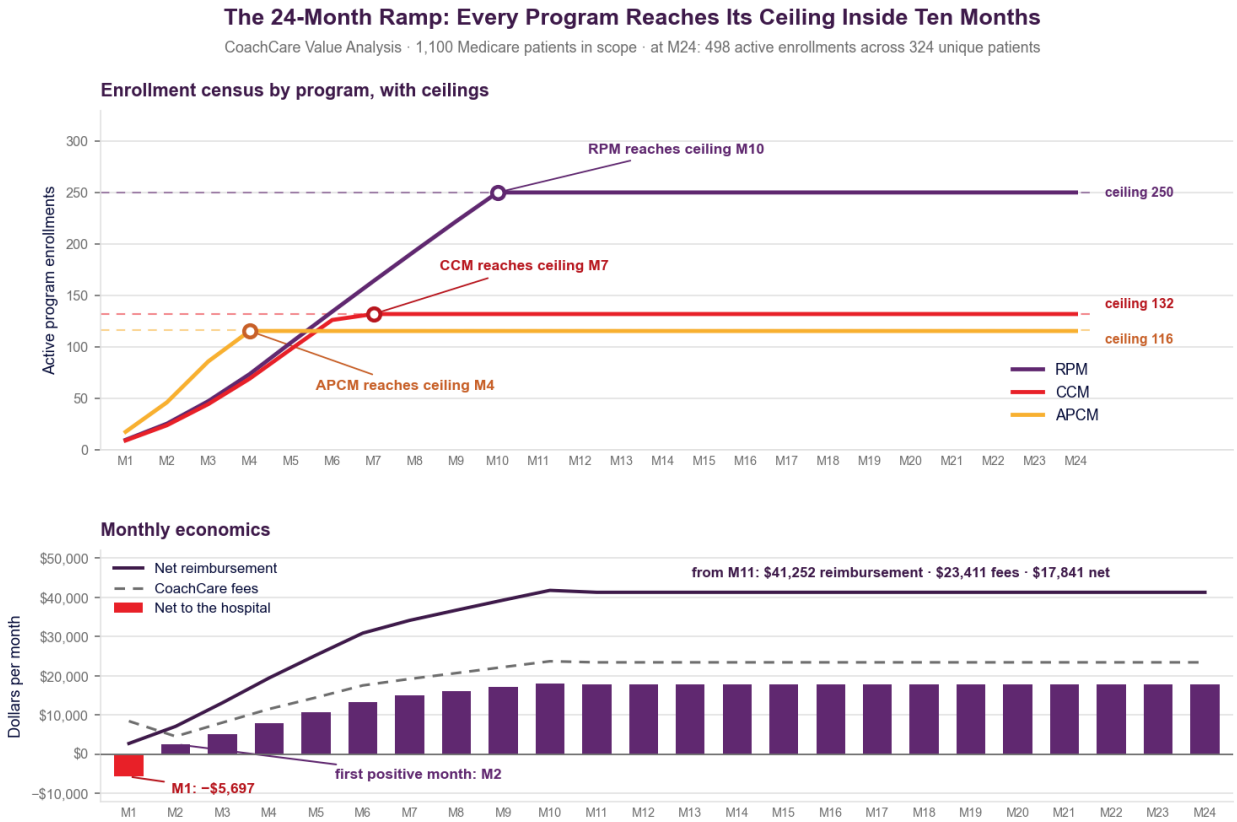

Figure 1. The 24-month ramp: enrollment census by program with ceilings (above) and monthly net reimbursement, CoachCare fees and net to the hospital (below). Month 1 nets −$5,697; the first positive month is M2; from M11 the line holds at $17,841 net per month.

The shape of the curve is worth reading precisely. Month 1 is negative, −$5,697, because implementation and enrollment effort land before the first full billing months do. Month 2 turns positive at $2,559, month 3 nets $5,043, and the line compounds as the three programs fill: by M10, once the last ceiling is reached, net reimbursement peaks at $41,748, then settles at $41,252 of net reimbursement, $23,411 of fees and $17,841 net a month from M11 as the setup codes fall away and the census holds at ceiling.

[28] CoachCare Value Analysis, 24-month forecast: monthly net reimbursement, fees and net-to-hospital series; Year 1 margin 40.76%, Year 2 margin 43.25%, 24-month margin 42.25%, each defined as net to the hospital divided by net reimbursement. Ancillary fees of $28,699 over 24 months: implementation $2,500; Oracle Health integration $4,000 setup, $150 a month and $1.50 per patient; telephonic outreach.

6.2 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	$157,933	$267,339	$425,273	$242,906	$182,367
CCM	$120,602	$164,358	$284,960	$142,236	$142,724
APCM	$54,317	$63,324	$117,641	$64,269	$53,372
Ancillary (implementation, integration, outreach)	—	—	—	$28,699	−$28,699
All programs	**$332,852**	**$495,022**	**$827,874**	**$478,110**	**$349,764**

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

RPM is the volume engine at 4,727 patient-months and $425,273 of net reimbursement. CCM is the yield engine at $103.76 of net reimbursement per patient-month across 2,746 patient-months, against $89.96 for RPM and $45.69 for APCM over its 2,575. APCM earns its place a different way: no minute-tracking and a bundled monthly payment weighted toward the two-condition tier, which is where a rural primary-care panel sits. Year 2 outruns Year 1 by $162,170 of net reimbursement because Year 1 carries the ramp and Year 2 runs at ceiling from its first month.

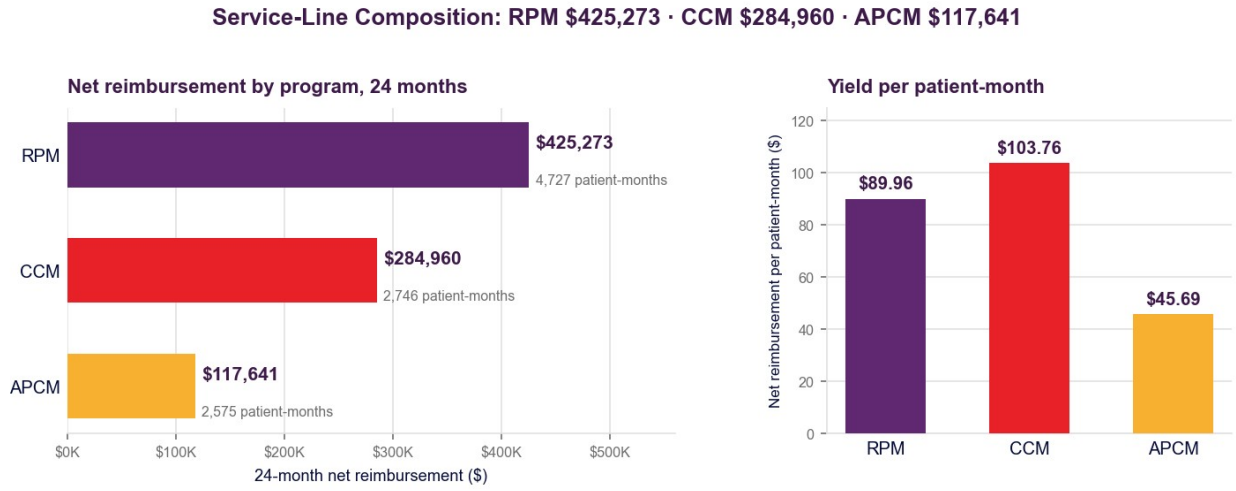

Figure 2. Service-line composition: per-program 24-month net reimbursement and net reimbursement per patient-month.

6.3 The ramp: every ceiling reached inside ten months

This account is ceiling-limited in all three programs. APCM reaches its ceiling of 116 enrollments in month 4, CCM its 132 in month 7, RPM its 250 in month 10. The whole Medicare-eligible pool is enrolled inside ten months, and from month 11 the forecast is flat because there is no one left to add.[29] The first 90 days move fast: 36 active enrollments across the three programs in month 1, 95 by month 2, 177 by month 3.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
RPM	715	250	Month 10	250
CCM	440	132	Month 7	132

[29] CoachCare Value Analysis enrollment model: program ceilings 250 (RPM), 132 (CCM), 116 (APCM); ceilings reached in months 10, 7 and 4; 498 active enrollments across 324 unique patients at month 24. Dedup on the branch where monitoring enrollments exceed the care-management set.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
APCM	385	116	Month 4	116
All programs		**498**		**498 enrollments · 324 unique patients**

Enrollment counts are program enrollments, not unique patients; the 498 enrollments at M24 belong to 324 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 clinic 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 clinician recruited in 2026 reaching a full year of visits, and confirming which clinicians hold panels on the Rural Health Clinic claim. The on-site enrollment specialist cannot raise a ceiling, but it reaches every ceiling months sooner, and Section 11 prices what that is worth.

6.4 What the program produces

24-month output	Volume
Claims generated, billing-ready	14,407
Device readings monitored	49,638
Care-management tasks completed	28,814
Chart updates written to Oracle Health	7,204
Patient conversations held	4,322 (240 hours of call time)
Care-management hours delivered	6,218 (≈ 3.0 FTE-years)
Hospitalizations avoided	**31.5 · ≈ $473,000 at $15,000 per admission**

CoachCare Value Analysis operational and clinical outputs, 24 months.

The avoided-admission line deserves its own sentence. 31.5 avoided hospitalizations over 24 months is roughly $473,000 of cost that never lands on anyone, not on Medicare, not on the plans that cover the county, and not on a 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 inpatient bed rather than a transfer.[30]

7. Oracle Health Integration: The Program Lives in the Record

The hospital, its clinic, its patient portal and its billing run on Oracle Health (Cerner). CoachCare integrates through an HL7/FHIR connection, priced from CoachCare's integration catalog ($4,000 setup, $150 a month and $1.50 per patient in the forecast), with the scope and hosting confirmed in contracting.[31] The program operates inside the record rather than beside it.

[30] CoachCare Value Analysis clinical-outcomes module: 31.5 avoided hospitalizations over 24 months, valued at $15,000 per avoided admission (≈$473,000).

[31] CoachCare integration pricing for an HL7/FHIR connection to Oracle Health (Cerner) as carried in the Value Analysis: $4,000 setup, $150 a month, $1.50 per patient. Interface scope and hosting are confirmed in contracting.

- **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 clinic'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 14,407 claims over 24 months. The hospital's own billing staff file the Rural Health Clinic claims.
- **The discharge feed.** Emergency visits, observation stays and inpatient discharges reach the program from the record, which is what arms the post-discharge cadence in Section 5.5 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.[32]

8. State Momentum: The Kansas Rural Health Transformation Program

Every state received a first-year award under the federal Rural Health Transformation Program on December 29, 2025. Kansas received $221,898,008 for its first year, led by the Kansas Department of Health and Environment. The state's plan funds a statewide remote-monitoring program for rural hospital patients and recently discharged rural residents, expands centralized chronic-care-management and remote-monitoring support for rural clinics, and names Critical Access Hospitals and Rural Health Clinics as the target base.[33]

This section is context, and no award to or participation by Phillips County Health Systems is asserted. 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. A clinic already operating a monitoring program makes a stronger case than one proposing to start one, and can plug into a state program on its own terms rather than a vendor's. The funding is infrastructure money, not a payer change, so it does not alter the Medicare billing rail this report is built on.

9. 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 Kansas locality on this account's own billing mix, with enrollment held constant.[34]

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

[33] CMS fifty-state Rural Health Transformation Program award announcement, December 29, 2025, and the Kansas Department of Health and Environment application: Kansas Year-1 award of $221,898,008; a statewide remote-monitoring program for rural hospital patients and recently discharged rural residents; expanded centralized chronic-care-management and remote-monitoring support for rural clinics; Critical Access Hospitals and Rural Health Clinics named as the target base. No award to or participation by the organization is asserted.

[34] CMS-1848-P, proposed CY2027 Physician Fee Schedule (July 2026); comment period closed September 14, 2026. CoachCare repricing at the Kansas locality on this forecast's code frequencies and APCM tier weights: 99454 and 99445 from $46.97 to $37.28 (−20.6%); remote monitoring arm −9.5% (−$40,524); CCM −2.0% (−$5,752); APCM −0.9% (−$1,109); service line −5.7% (−$47,385, from $827,874 to $780,489). Enrollment held constant; a statutory phase-in caps single-year reductions.

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
Device supply, 99454 and 99445	$46.97 a month	**$37.28 a month, −20.6%**	The code CMS proposes to cut
The remote monitoring arm	$425,273 over 24 months	**−9.5%, −$40,524**	Device supply is 32% of the remote monitoring basket; management time moves little
Chronic care management	$284,960 over 24 months	−2.0%, −$5,752	Conversion-factor and relative-value churn only; the proposal does not target these codes
Advanced primary care management	$117,641 over 24 months	−0.9%, −$1,109	Same churn; the bundle's relative values barely move
The whole service line	$827,874 over 24 months	**−5.7%, −$47,385, to $780,489**	Remote monitoring is 51% of the line; care management is $6,861 of the total

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

A 20.6% cut to one code is a 5.7% 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 Rural Health Clinics bill by law, the same census carries more cushion than the locality basis shows.

10. Implementation and the First 90 Days

10.1 Who runs what

CoachCare delivers	Phillips County Health Systems keeps
Telephonic and on-site enrollment; the enrollment specialist is CoachCare's expense	Referral flags in Oracle Health; clinical oversight under general supervision
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans and escalation preferences
Monitoring, documentation and the escalation protocol of Section 5	Responses to clinic-routed escalations; the discharge feed from the hospital side
Billing-ready claim generation inside Oracle Health	Filing the Rural Health Clinic claims; billing review; the revenue
Monthly operating reports against the dashboard in 10.4	Program governance

10.2 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 15.4% poverty rate and a quarter 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 hospital discharge, not through a portal.

10.3 Model inputs

Input	Value
Medicare panel in scope	1,100 patients at the Rural Health Clinic; validated against chart counts in the first 30 days
Referring clinicians	6 on the clinic's roster (2 physicians + 4 nurse practitioners and physician assistants)
Programs	RPM + CCM + APCM; TCM named, not in the forecast; PCM off
Program-eligible pools	RPM 715 · CCM 440 · APCM 385

Input	Value
Enrollment ceilings	RPM 250 (M10) · CCM 132 (M7) · APCM 116 (M4)
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
Rate basis	CY2026 non-facility Physician Fee Schedule, Kansas statewide locality (carrier 05202, locality 00), ZIP 67661; conservative, since Rural Health Clinic claims pay national amounts (+$62,615 over 24 months, Section 3.2)
APCM tier blend	20% level 1 · 70% level 2 · 10% level 3 = $49.33 per patient-month
Medicare Advantage	9.3% of Phillips County's Medicare (September 2026). Medicare Advantage plans must pay at least 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	Oracle Health (Cerner); HL7/FHIR integration, scope and hosting confirmed in contracting

10.4 The 90-day plan and the operating dashboard

Days 0–30: foundation. Program agreement and the Oracle Health integration workplan. Panel validation against chart counts, and confirmation of which clinicians hold panels on the Rural Health Clinic 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, the discharge feed wired from the inpatient and emergency-department records, and clinician orientation to the general-supervision workflow. The plan check with the county's Medicare Advantage carriers 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 −$5,697 as implementation lands; month 2 turns positive. The forecast carries 36 active enrollments in month 1 and 95 by month 2.

Days 61–90: scale and file. Enrollment at 177 by month 3, with APCM already at ceiling in month 4 and CCM tracking toward month 7. First monthly operating report against the dashboard, and a decision point on the state's rural health program with a live program to describe rather than a proposed one.

The operating dashboard from month one:

- Enrollment census by program against ceiling (250 / 132 / 116)
- Time from referral flag to first billable enrollment (target: under five days from flag to first service)
- Discharges captured: inpatient, observation and emergency 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 $17,841 steady-state line

11. 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 $349,764 of 24-month net one month further out.

2. **Upgrade the existing care-management program rather than starting over.** Credit the clinic's chronic care management program and its coordinator, and add what it lacks: the daily physiologic signal, the enrollment engine, advanced primary care management, and individual-code billing. Confirm current enrollment and whether the Rural Health Clinic bills the 99490 family so existing patients are folded in, not double-counted.
3. **Take the Medicare Advantage question to the plans early, but keep it in proportion.** Nine in ten of the county's beneficiaries are on the fee schedule. 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 county's carriers in the first two weeks.
4. **Bill the Rural Health Clinic rail at national rates from the first claim.** The forecast prices at the Kansas locality; Rural Health Clinic claims pay national non-facility amounts, worth $62,615 more over 24 months, all of it net to the hospital. Configure claims on the national rail and capture it.
5. **Make the hospital discharge the front door.** Wire the discharge feed first, enroll at the bedside, and bill transitional care on every discharge home to a clinic patient. 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 $257,839 of 24-month net reimbursement against the no-specialist case in the table below, where without it RPM never fills inside 24 months.
7. **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: 1,100 panel, 6 clinicians, 1 enrollment specialist	**$827,874**	**$349,764**	42.25%	M10 / M7 / M4
No on-site enrollment specialist	$570,035	$239,030	41.93%	never / M17 / M9
Second on-site enrollment specialist	$882,831	$373,325	42.29%	M7 / M5 / M3
Panel 900 (floor of the credible range)	$697,740	$293,052	42.00%	M9 / M6 / M4
Panel 1,300 (top of the credible range)	$948,842	$402,584	42.43%	M12 / M8 / M5
5 clinicians (one physician at partial time)	$818,920	$345,953	42.24%	M11 / M7 / M4
National Rural Health Clinic rate rail, same census	$890,489	$412,379	46.31%	M10 / M7 / M4

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.

12. What We Would Confirm Together

Every item below is a discovery question, not a condition. The forecast stands on the figures in Section 6; these are the inputs that would move it, in the order they matter.

1. **The Rural Health Clinic practitioner list and chart counts.** Which clinicians hold panels on the Phillips County Medical Clinic claim, including the physician who also bills at two other Critical Access Hospitals, and the Medicare chart count against the 1,100 midpoint.

2. **The current chronic care management enrollment.** How many patients the clinic's care coordinator carries today, and whether the Rural Health Clinic bills the 99490 family for them, so the existing program is folded into the forecast rather than counted twice.
3. **The traditional-Medicare and Medicare Advantage split of the panel, and plan terms.** The county runs 9.3% Medicare Advantage; the clinic's own mix, and the carriers' terms for the care-management code families, settle the small share of the forecast that rides on plan contracts.
4. **The clinic's 2026 accountable-care arrangement.** The status of the clinic's 2026 accountable-care arrangement and what, if anything, replaces it for 2027.
5. **The Oracle Health edition and hosting.** The Cerner edition in use, whether it is locally or vendor-hosted, and the HL7/FHIR interfaces available for the discharge feed from the inpatient and emergency-department records.
6. **Kansas Medicaid coverage.** Whether KanCare fee-for-service or its managed-care plans cover the CPT remote-monitoring and chronic-care codes, to close the Medicaid question at the primary source.
7. **The state's rural health program intent.** Whether the organization plans to apply for, or expects to be offered, the state's statewide remote-monitoring program, and how a program already running would position it.
8. **Inpatient discharge destinations.** The share of the roughly 213 discharges a year that go home to a clinic patient, which sizes the transitional care opportunity this report leaves at zero.

References and Data Sources

- **CMS Care Compare Hospital General Information and Provider of Services file (Q2 2026):** Phillips County Hospital, CCN 171353, Critical Access Hospital, 25 certified beds, government–local ownership, original Critical Access participation April 1, 2003, rural.
- **CMS Rural Health Clinic Enrollments (July 2026 vintage) and Provider of Services file:** Phillips County Medical Clinic, a provider-based Rural Health Clinic enrolled under Phillips County Hospital, original participation April 2002; automatic Health Professional Shortage Area designation.
- **CMS Medicare cost report (HCRIS), hospital cost report FY2024:** 213 total discharges and 156 Medicare discharges; Medicare 78% of inpatient days and 73% of discharges; 25 certified beds.
- **CMS Care Compare timely-and-effective and unplanned-visit measures (2023–2025):** emergency-department median time and a 0% left-without-being-seen rate on a roughly-1,500-visit denominator; Critical Access Hospitals are outside the readmission and value-based-purchasing programs.
- **CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024:** a control-validated sweep of every remote-monitoring, chronic-care-management, advanced-primary-care and transitional-care code across every clinician billing under Phillips County Hospital, returning no remote-monitoring lines. CMS suppresses any provider-and-code line under 11 beneficiaries; care management billed on a Rural Health Clinic claim is not in this file.
- **CMS Medicare Advantage State/County Penetration, September 2026, and CMS Medicare Monthly Enrollment, CY2025:** Phillips County's 1,473 beneficiaries, 1,299 in traditional Medicare, 9.3% Medicare Advantage penetration, and a 7.6% dual-eligible share.
- **U.S. Census Bureau American Community Survey 2024 five-year estimates** (profiles DP03 and DP05), Phillips County: population 4,813, median age 45.7, 25.6% aged 65 and over, 15.4% poverty, $62,123 median household income.
- **HRSA shortage-designation files:** the Rural Health Clinic automatic Health Professional Shortage Area designation, and a low-income-population Health Professional Shortage Area added in March 2026.

- **42 CFR 405.2464(c) and the CY2025 Physician Fee Schedule Final Rule fact sheet:** retirement of G0511; individual-code reporting for Rural Health Clinic care management; payment at national non-facility amounts in addition to the all-inclusive rate; advanced primary care management adopted for Rural Health Clinic payment; and the CY2026 additions 99445 and 99470.
- **CY2026 Physician Fee Schedule rate files:** non-facility amounts for the eleven forecast codes and the two transitional care codes at the Kansas statewide locality (carrier 05202, locality 00; ZIP 67661), and the national-rate comparison producing the +$62,615 differential.
- **Kansas Medicaid coverage:** the KanCare general-benefits provider manual and a third-party Kansas Medicaid policy summary, finding fee-for-service coverage of the CPT remote-monitoring and chronic-care codes not confirmed; only home-health telemonitoring with prior authorization was located.
- **Rural Health Transformation Program records:** the CMS fifty-state award announcement of December 29, 2025 and the Kansas Year-1 award of $221,898,008; the Kansas Department of Health and Environment application naming a statewide remote-monitoring program and centralized care-management support for rural clinics, with Critical Access Hospitals and Rural Health Clinics as the target base.
- **CoachCare Care Management Programs standard operating procedures and the derived process maps:** the shared alert-and-escalation decision logic, trend definitions, the emergent communication protocol, three-way routing, the post-discharge three-touch sequence and the discharge decision flow reproduced in Section 5.
- **CoachCare integration standards** for HL7/FHIR connections to Oracle Health: enrollment flags and orders out of the chart; vitals, documentation, enrollment status and billing-ready claims back into it.
- **CoachCare Value Analysis for Phillips County Health Systems, 2026, and the CY2027 repricing of the same forecast:** every financial, enrollment, clinical-output and operational figure in Sections 3, 6, 9, 10 and 11, built on 1,100 Medicare patients in scope, 6 referring clinicians, one on-site enrollment specialist, and CY2026 non-facility fee schedule rates at the Kansas statewide locality for RPM, CCM and APCM.

How this report counts

Patients and program enrollments are different numbers. At M24 the program holds 498 active program enrollments belonging to 324 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. A provider-based Rural Health Clinic bills its visits under the clinic's certification rather than under individual clinicians, so clinician-level Medicare claims files structurally undercount the panel. The 1,100-patient figure triangulates the county's Medicare denominator, the clinic's primary-care staffing, and the structure of Rural Health Clinic billing, 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.